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October 2018

# DEFENSE HEALTH CARE

DOD Should  
Demonstrate How Its  
Plan to Transfer the  
Administration of Military  
Treatment Facilities  
Will Improve Efficiency

# GAO Highlights

Highlights of [GAO-19-53](#), a report to congressional committees

## Why GAO Did This Study

In fiscal year 2017, DOD provided health care to 9.4 million beneficiaries, including servicemembers, retirees, and their families at a cost of \$43 billion. For more than a decade, partially in response to congressional mandates, DOD has worked to address inefficiencies in the Military Health System to control costs.

To further achieve efficiencies, the NDAA for Fiscal Year 2017 required DOD to develop an implementation plan that addressed four elements related to transferring the administration of the MTFs to the DHA. DOD issued the plan in June 2018.

The NDAA also included a provision for GAO to review the plan. GAO determined whether (1) DOD's plan included the statutory elements related to the transfer of administration of the MTFs to the DHA and (2) additional information would be useful to demonstrate that the plan will reduce or better manage duplication and improve efficiencies. GAO assessed DOD's plan against the required elements and, where appropriate, considered the extent to which the plan provided detailed information related to key change management practices identified in past GAO work.

## What GAO Recommends

GAO recommends that DOD define and analyze the 16 operational readiness and installation-specific medical functions for duplication, validate headquarters-level personnel requirements, and identify the least costly mix of personnel. DOD concurred with all three recommendations and noted actions it was taking to address each one.

View [GAO-19-53](#). For more information contact Brenda S. Farrell at (202) 512-3604 or [farrellb@gao.gov](mailto:farrellb@gao.gov).

October 2018

## DEFENSE HEALTH CARE

### DOD Should Demonstrate How Its Plan to Transfer the Administration of Military Treatment Facilities Will Improve Efficiency

## What GAO Found

The Department of Defense's (DOD) June 2018 plan addressed the four statutory elements for the transfer of the administration of the military treatment facilities (MTFs) from the military departments to the Defense Health Agency (DHA). Specifically, the plan provided information on (1) how the DHA will take administrative responsibility of the MTFs; (2) efforts to eliminate duplicative activities; (3) efforts to maximize efficiencies in the DHA's activities; and (4) reductions of headquarters-level military, civilian, and contractor personnel. DOD dedicated most of the plan to describing the governance structure of the proposed administrative framework and to describing the timeline for a phased transfer of the approximately 457 MTFs to the DHA by October 1, 2021. Initially, DOD was to transfer responsibility for the administration of the MTFs to the DHA by October 1, 2018. However, Congress in the National Defense Authorization Act (NDAA) for Fiscal Year 2019 amended the law to allow, among other things, DOD to complete the transfer by September 30, 2021.

DOD has taken key steps in its June 2018 plan to improve the effectiveness and efficiency of the administration of MTFs. However, DOD's plan has two weaknesses that could be mitigated with additional information. Specifically,

- **DOD excluded 16 operational readiness and installation-specific medical functions from consideration for transfer to the DHA.** DOD did not define or analyze the potential effect of excluding these functions, which include dental care, substance abuse, and occupational health. Senior officials from the DHA and the Assistant Secretary of Defense for Health Affairs acknowledged that transferring the dental care function, for example, from the military departments to the DHA could potentially reduce duplicative activities.
- **DOD's plans to achieve the stated goal of reducing headquarters-level personnel, including contractor personnel, by 10 percent are unclear.** In its June 2018 plan, DOD states that the DHA will experience personnel growth during each phase of the transition, but that it expects to reduce headquarters-level personnel by 10 percent by 2021. However, the plan does not provide specific details about how DOD will achieve the established goal of reducing headquarters-level personnel by 10 percent while the DHA experiences personnel growth. Further, the plan does not address whether and how contractor personnel factor into the reduction. This lack of clarity exists because DOD has not validated headquarters-level personnel requirements or conducted a comprehensive review to identify the least costly mix of military, civilian, and contractor personnel to meet the validated requirements.

Until DOD takes action to resolve these two weaknesses, DOD will likely not be well positioned to reduce or better manage duplication and improve efficiencies, including reducing headquarters-level personnel across the Military Health System. Furthermore, Congress will lack important information to determine the extent to which the transfer of the administration of the MTFs to the DHA is being planned and implemented effectively and efficiently.

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### **Abbreviations**

|       |                                    |
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| DOD   | Department of Defense              |
| DHA   | Defense Health Agency              |
| MTFs  | military treatment facilities      |
| NDAAs | National Defense Authorization Act |

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October 30, 2018

The Honorable James M. Inhofe  
Chairman  
The Honorable Jack Reed  
Ranking Member  
Committee on Armed Services  
United States Senate

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

In fiscal year 2017, the Department of Defense's (DOD) Military Health System provided health care to 9.4 million beneficiaries including servicemembers, retirees, and their family members at a cost of \$43 billion.<sup>1</sup> For more than a decade, DOD has worked to address congressional concerns about governance-related inefficiencies in the Military Health System, in part by responding to a number of congressional mandates.<sup>2</sup> For example, in September 2013, DOD established the Defense Health Agency (DHA) to create a more integrated Military Health System and achieve cost savings at headquarters-level organizations by, among other things, streamlining the

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<sup>1</sup> Defense Health Agency, *Evaluation of the TRICARE Program: Fiscal Year 2018 Report to Congress, Access, Cost, and Quality Data through Fiscal Year 2017* (Feb. 28, 2018); the cost figure is for the Defense Health Program, including transfers from the Medicare-Eligible Retiree Health Care Fund. Department of Defense, *Defense Health Program Fiscal Year (FY) 2019 Budget Estimates: Operation and Maintenance Procurement Research, Development, Test and Evaluation*, Volume 1: Justification Estimates, Volume 2: Data Book (Feb. 2018). According to officials with the Office of the Under Secretary of Defense for Personnel and Readiness, the cost figure for the Defense Health Program does not include costs that are funded through other accounts.

<sup>2</sup> The National Defense Authorization Act (NDAA) for Fiscal Year 2013 required that DOD create a detailed plan for carrying out its health care system reform, including goals; performance measures; required personnel levels; and a schedule for carrying out the reform goals, among other things. Pub. L. No. 112-239, § 731 (2013). The NDAA for Fiscal Year 2017 directed the transfer of responsibility for the administration of military medical treatment facilities to the Director of the Defense Health Agency. Pub. L. No. 114-328, § 702 (2016).

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administrative support for the military departments' respective medical programs.<sup>3</sup> The DHA also assumed the administrative responsibility for managing military treatment facilities (MTFs) in the National Capital Region—specifically, the Walter Reed National Military Medical Center and the Fort Belvoir Community Hospital.<sup>4</sup> According to National Capital Region Medical Directorate information, the DHA exercises authority, direction, and control over approximately 6 MTFs in the National Capital Region.<sup>5</sup> MTFs, which include military hospitals, ambulatory care clinics, and dental clinics, are part of the direct care system.<sup>6</sup> According to DOD, these MTFs total approximately 679.<sup>7</sup> The direct care system represents health care facilities and medical support organizations owned by DOD and managed by the military departments' respective Surgeons General.<sup>8</sup>

Section 702 of the National Defense Authorization Act (NDAA) for Fiscal Year 2017 amended Chapter 55 of title 10, United States Code, to include a new section entitled “1073c Administration of Defense Health Agency and military medical treatment facilities,” which describes how the DHA

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<sup>3</sup> Headquarters elements of DHA are considered major DOD headquarters activities. Department of Defense Instruction 5100.73, *Major DOD Headquarters Activities* (Dec. 1, 2007) (incorporating change 2, June 12, 2012).

<sup>4</sup> DHA also has authority, direction, and control over subordinate clinics of the Walter Reed National Military Medical Center and the Fort Belvoir Community Hospital. Department of Defense Directive 5136.13, *Defense Health Agency (DHA)* (Sept. 30, 2013). According to a draft DHA concept of operations, “administration” refers to the responsibility for governing MTFs (i.e., execution of day-to-day operations) and “management” refers to the authority, direction, and control to ensure MTF accountability (i.e., authority, direction and control over the organizational structure and management of functional capabilities within that structure to provide oversight). See *Defense Health Agency Concept of Operations: Transfer of Administration and Management of the Military Medical Treatment Facilities to Defense Health Agency Authority, Direction, and Control*, Version 1.53 (June 7, 2018).

<sup>5</sup> This information also states that the DHA exercises authority, direction, and control over the Joint Pathology Center.

<sup>6</sup> MTFs also include other facilities within the direct care system.

<sup>7</sup> DOD estimated that there are about 679 military hospitals, ambulatory care clinics, and dental clinics in fiscal year 2018. See Defense Health Agency, *Evaluation of the TRICARE Program: Fiscal Year 2018 Report to Congress; Access, Cost, and Quality Data through Fiscal Year 2017* (Feb. 28, 2018).

<sup>8</sup> The Department of the Navy administers health care for the Marine Corps. Air Force Major Commands direct MTF activities; the Air Force Medical Operations Agency supports but does not command Air Force MTFs.

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will take administrative responsibility of the MTFs.<sup>9</sup> According to that section, the Director of the DHA shall be responsible for the administration of each MTF, including with respect to budgetary matters; information technology; and health care administration and management, among other things.<sup>10</sup>

Section 702 of the NDAA for Fiscal Year 2017 required that the Secretary of Defense develop a plan that includes four elements, such as how the Secretary will carry out subsection (a) of section 1073c of title 10 of the United States Code and efforts to eliminate duplicative activities, among others.<sup>11</sup> DOD provided three interim reports to Congress in response to section 702. The first two interim reports, dated March 31, 2017, and June 30, 2017, were DOD's preliminary draft of the plan.<sup>12</sup> In these reports, DOD discussed its intent to use the "component model" as the administrative framework. Under the component model, the Director of the DHA would administer each MTF through military department-led intermediary component commands and military department-led MTFs. Congress, in the Conference report accompanying the NDAA for Fiscal Year 2018 that was issued in November 2017, raised concern about the component model.<sup>13</sup> The third interim report, which DOD provided to Congress March 30, 2018, did not include the component model as DOD's administrative framework, but provided details on a new proposed framework to transition MTF administration and management to the

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<sup>9</sup> Pub. L. No. 114-328, § 702 (2016).

<sup>10</sup> Section 1073c of title 10, United States Code, was amended by the John S. McCain NDAA for Fiscal Year 2019. Pub. L. No. 115-232, § 711 (2018). Among other things, the amendment requires that the Secretary of Defense establish a timeline to ensure the transfer of MTF administration from the military departments to the DHA no later than September 30, 2021.

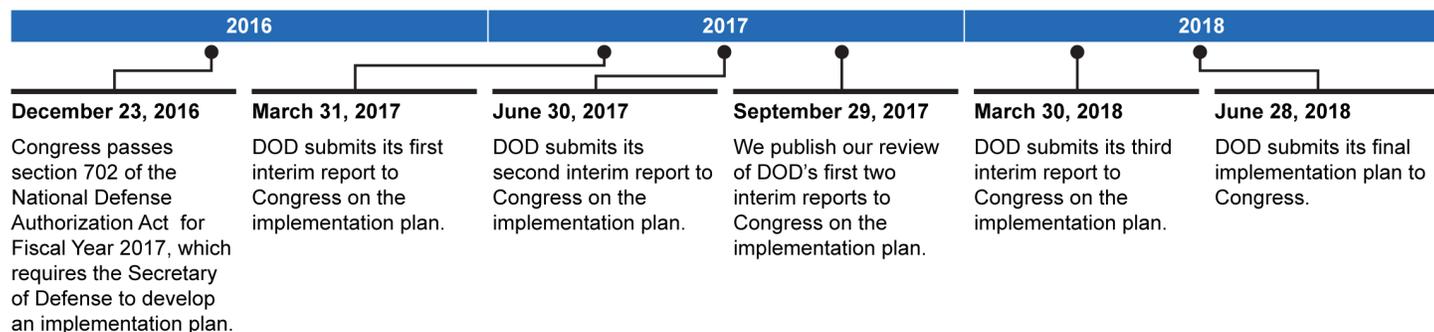
<sup>11</sup> Pub. L. No. 114-328, § 702(d) (2016).

<sup>12</sup> Department of Defense, *Report to the Armed Services Committees of the Senate and House of Representatives, Plan to Implement Section 1073c of Title 10, United States Code, Interim Report – Preliminary Draft* (Mar. 31, 2017) and Department of Defense, *Report to the Armed Services Committees of the Senate and House of Representatives, Plan to Implement Section 1073c of Title 10, United States Code, Second Interim Report* (June 30, 2017). We reported, as required, on DOD's preliminary draft of the plan in September 2017. See GAO, *Defense Health Reform: Steps Taken to Plan the Transfer of the Administration of the Military Treatment Facilities to the Defense Health Agency, but Work Remains to Finalize the Plan*, [GAO-17-791R](#) (Washington, D.C.: Sept. 29, 2017).

<sup>13</sup> H.R. Rep. No. 115-404, at 849-850 (2017) (Conf. Rep.).

DHA.<sup>14</sup> According to the third interim report, DOD decided after deeper analysis and discussions with Congress that the component model did not adequately satisfy the requirements of subsection (a) of section 1073c. DOD submitted its final plan (hereinafter referred to as the plan) to Congress on June 28, 2018.<sup>15</sup> Figure 1 provides a timeline of DOD's efforts in response to section 702.

**Figure 1: Timeline of Department of Defense Efforts to Address Section 702 of the National Defense Authorization Act for Fiscal Year 2017**



Source: GAO. | GAO-19-53

Note: Section 702 of the National Defense Authorization Act for Fiscal Year 2017 amended Chapter 55 of title 10, United States Code, to include a new section entitled "1073c Administration of Defense Health Agency and military medical treatment facilities," which describes how the Defense Health Agency will take administrative responsibility of the military treatment facilities. Section 702 also requires that the Secretary of Defense develop a plan that includes four elements, such as how the Secretary will carry out subsection (a) of section 1073c of title 10 of the United States Code and efforts to eliminate duplicative activities.

Section 702 also includes a provision for us to review the plan by September 1, 2018.<sup>16</sup> In this report, we determined whether (1) DOD's plan included the statutory elements related to the transfer of the

<sup>14</sup> Department of Defense, *Report to the Armed Services Committees of the Senate and House of Representatives, Preliminary Draft Plan to Implement 1073c of Title 10, United States Code, Interim Report* (Mar. 31, 2018).

<sup>15</sup> Department of Defense, *Report to the Armed Services Committees of the Senate and House of Representatives, Final Plan to Implement Section 1073c of Title 10, United States Code, Final Report* (June. 30, 2018). Section 702 of the NDAA for Fiscal Year 2017 required that DOD provide the final plan to the House and Senate Armed Services Committees no later than March 1, 2018. Pub. L. No. 114-328, § 702(e)(2) (2016).

<sup>16</sup> To meet this requirement, we provided a draft report to the defense congressional committees.

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administration of the MTFs to the DHA and (2) additional information would be useful to demonstrate that the plan will reduce or better manage duplication and improve efficiencies.

For objective one, we determined whether DOD's plan included the four elements set forth in the statute.<sup>17</sup> Two analysts independently conducted this assessment and reconciled any differences to reach a consensus on the overall assessment. For objective two, where appropriate, we also considered the extent to which the plan provided detailed information related to key change management practices identified in our prior work, which could help ensure that DOD effectively and efficiently achieves its goals.<sup>18</sup> We also reviewed key planning documents identified by DOD in developing the plan and other relevant documents, such as the Under Secretary of Defense for Personnel and Readiness memorandums related to section 702 and concepts of operations from the Assistant

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<sup>17</sup> Pub. L. No. 114-328, § 702(d) (2016).

<sup>18</sup> GAO, *Government Reorganization: Key Questions to Assess Agency Reform Efforts*, [GAO-18-427](#) (Washington, D.C.: June 13, 2018). This report identifies key questions that Congress, agencies, and others should consider for the development and implementation of agency reforms, based on our prior work. In the report, the term "reforms" was used to broadly include any organizational changes—such as major transformations, mergers, consolidations, and other reorganizations—and efforts to streamline and improve the efficiency and effectiveness of government operations. Key change management practices described in this report are derived from our prior work, such as, but not limited to GAO, *Fragmentation, Overlap, and Duplication: An Evaluation and Management Guide* [GAO-15-49SP](#) (Washington, D.C.: Apr. 14, 2015) and *Streamlining Government: Key Practices from Select Efficiency Initiatives Should Be Shared Governmentwide*, [GAO-11-908](#) (Washington, D.C.: Sept. 30, 2011). We focused on those change management practices that are particularly relevant to assist DOD in achieving its effort to address statutory requirements in its planning to identify efficiencies, potentially reduce duplicative activities, and achieve personnel reduction goals.

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Secretary of Defense for Health Affairs; the DHA; and the Army, the Navy, and the Air Force departments.<sup>19</sup>

For both objectives, we corroborated our understanding of the plan by conducting interviews with officials from the Office of the Under Secretary of Defense for Personnel and Readiness; the Office of the Assistant Secretary of Defense for Health Affairs; the DHA; the Health Care Management Reform Team (one of the reform teams created in 2017 by the DOD to address improved mission effectiveness and efficiencies in DOD); the Office of Cost Assessment and Program Evaluation; the Army Medical Command, Office of the Surgeon General and the Office of the Assistant Secretary of the Army Manpower and Reserve Affairs; the Navy Bureau of Medicine and Surgery; the Air Force Medical Service; and the Joint Staff Surgeon.

We conducted this performance audit from March 2018 to October 2018 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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<sup>19</sup> We reviewed the following Under Secretary of Defense for Personnel and Readiness memorandums: *Authorities and Responsibilities of Military Treatment Facility Leaders, Service Leaders and the Military Medical Departments* (Feb. 21, 2018); *Managing the Transformation of the Military Health System* (Mar. 21, 2018); *Construct for Implementation of Section 702* (May 22, 2018); *Manpower Requirements Validation for the Defense Health Agency Headquarters* (June 7, 2018); and *Zero-Based Review of Military Department Medical Manpower* (June 15, 2018). We also reviewed the following documents: the Assistant Secretary of Defense for Health Affairs, *Military Health System Concept of Operations, Version 9* (2018); the DHA Draft *Defense Health Agency Concept of Operations: Transfer of Administration and Management of Military Medical Treatment Facilities To Defense Health Agency Authority, Direction, and Control, Version 1.53* (June 7, 2018); the Army Pre-decisional Draft of its *Army Service Concept of Operations, Transfer of Administration and Management of Military Medical Treatment Facilities to Defense Health Agency, Version 26* (May 2018); the Navy Bureau of Medicine and Surgery Draft *Navy Medicine Readiness and Training Commands: Concept of Operations* (May 2018); and the Office of the Air Force Surgeon General Pre-decisional Draft *Air Force Medical Service Operational Readiness Platform Concept of Operations (CONOPS)* (May 23, 2018).

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## Background

### History of Military Health System Reforms

For over a decade, Congress and DOD have led a series of efforts to address the governance structure of the Military Health System, including recommending and implementing significant organizational realignments. DOD undertook a significant organizational realignment effort in June 2011, creating an internal task force to review the governance of the Military Health System and subsequently identified as priorities cost containment, greater integration, and increased unity of effort. In March 2012, DOD submitted a report to Congress that, among other things, proposed creating the DHA to achieve cost savings at headquarters- and administrative-level organizations, TRICARE, the headquarters of military departments' medical commands and agencies, and other management organizations within the Military Health System that do not directly provide health care services.<sup>20</sup> DOD established the DHA in September 2013 to provide administrative support for the military departments' respective medical programs by adopting common clinical and business processes, combining common shared services, and coordinating the work of the military departments' respective MTFs and care purchased from the private sector.<sup>21</sup> The DHA also assumed the administrative responsibility for managing the MTFs in the National Capital Region.

The NDAA for Fiscal Year 2013 required that DOD create a detailed plan for carrying out its health care system reform to include the goals of the reform and performance measures to achieve them; the personnel levels required for the DHA and the National Capital Region Medical Directorate; and specific information on the shared services, among other things.<sup>22</sup> In 2015, we reported on DOD's establishment of the DHA and made five recommendations, and DOD concurred or partially concurred

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<sup>20</sup> Through regional contracts, TRICARE administers the purchased care system, which comprises a civilian network of hospitals and providers. Prior to October 1, 2013, the TRICARE Management Activity, an entity within the Department of Defense (DOD), was responsible for overseeing DOD's regionally structured health care program. Upon its establishment, the DHA assumed management responsibility of numerous functions of DOD's medical health system, including the former TRICARE Management Activity.

<sup>21</sup> According to the 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, Development, and Acquisition.

<sup>22</sup> Pub. L. No. 112-239, § 731 (2013).

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with all of these recommendations.<sup>23</sup> DOD has implemented two of the five recommendations by completing some baseline personnel assessments of the DHA workforce and reporting the number and cost of administrative headquarters personnel within the Military Health System in DOD's fiscal year 2018 Defense Health Program budget estimates. Of the three open recommendations, two relate directly to assessing personnel requirements within the DHA. As of January 2018, these recommendations have not been fully addressed and remain open because DOD has not established processes and procedures to create an overall personnel management process for the DHA.

In December 2016, Congress expanded the role of the DHA by directing the transfer of responsibility for the administration of each MTF from the military departments to the DHA.<sup>24</sup> Pursuant to section 1073c(a) of title 10, United States Code, the Director of the DHA shall be responsible for the administration of each MTF, including with respect to budgetary matters, information technology, health care administration and management, administrative policy and procedure, military medical construction, and any other matters the Secretary of Defense determines appropriate.<sup>25</sup> Section 702 of the NDAA for Fiscal Year 2017 required that the Secretary of Defense develop a plan to implement section 1073c of title 10, United States Code, that includes the following four elements:<sup>26</sup>

- A. how the Secretary will carry out subsection (a) of section 1073c of title 10 of the United States Code;<sup>27</sup>
- B. efforts to eliminate duplicative activities carried out by the elements of the DHA and military departments;
- C. efforts to maximize efficiencies in the activities carried out by the DHA; and

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<sup>23</sup> GAO, *Defense Health Care Reform: Actions Needed to Help Ensure Defense Health Agency Maintains Implementation Progress*, [GAO-15-759](#) (Washington, D.C.: Sept. 10, 2015).

<sup>24</sup> Pub. L. No. 114-328, § 702 (2016).

<sup>25</sup> 10 U.S.C. § 1073c.

<sup>26</sup> The interim report on DOD's preliminary draft of the implementation plan was due by March 1, 2017, and the final report on the implementation plan was due by March 1, 2018.

<sup>27</sup> As previously noted, Chapter 55 of title 10, United States Code, included a new section entitled, "1073c Administration of Defense Health Agency and military medical treatment facilities," which describes how the DHA will take administrative responsibility of the MTFs.

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D. how the Secretary will implement section 1073c in a manner that reduces the number of members of the armed forces, civilian employees who are full-time equivalent employees, and contractors relating to the headquarters activities of the Military Health System, as of the date of the enactment of the act.

Section 702 of the NDAA for Fiscal Year 2017 also included a provision for us to review DOD's interim and final reports on the implementation plan.<sup>28</sup> In our review of DOD's plan in September 2017, we noted that DOD had selected the component model—in which the Director of the DHA would administer each MTF through military department-led intermediary component commands and military department-led MTFs—as the administrative model DOD would use to meet the requirements specified in section 702.<sup>29</sup> Congress, in the Conference report accompanying the NDAA for Fiscal Year 2018 that was issued in November 2017, raised concern about DOD's lack of progress on the development of the plan and about the component model.<sup>30</sup> Specifically, Congress noted that the component model was an attempt to maintain current stove-piped organizational constructs that risk continued inefficiencies in the Military Health System command and governance structure. In the third interim report, DOD found that the component model would not be adequate to satisfy statutory requirements and subsequently changed from the component model to a new administrative framework.<sup>31</sup>

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## Amendments from the NDAA for Fiscal Year 2019

The NDAA for Fiscal Year 2019 amended section 1073c of title 10, United States Code.<sup>32</sup> The NDAA for Fiscal Year 2019, among other things, provided additional authorities to the Director of the DHA, such as the authority to determine total workforce requirements at each MTF and established within the DHA two subordinate organizations—one for research and development, and one for public health. Additionally, the

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<sup>28</sup> Pub. L. No. 114-328, § 702(e)(3) (2016).

<sup>29</sup> [GAO-17-791R](#).

<sup>30</sup> H.R. Rep. No. 115-404 at 849-850 (2017) (Conf. Rep.).

<sup>31</sup> Department of Defense, *Report to the Armed Services Committees of the Senate and House of Representatives, Preliminary Draft Plan to Implement 1073c of Title 10, United States Code, Interim Report* (Mar. 31, 2018).

<sup>32</sup> Pub. L. No. 115-232, § 711 (2018).

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NDAAs for Fiscal Year 2019 extended the date for the transfer of the administration of the MTFs to the DHA from the original deadline of October 1, 2018, to September 30, 2021. Section 1073c of title 10, United States Code, including these amendments, is reproduced in appendix I.

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## Roles and Responsibilities of Key DOD Entities in the Military Health System

Currently, the Under Secretary of Defense for Personnel and Readiness, the Assistant Secretary of Defense for Health Affairs, the DHA, and the military departments have various responsibilities for the oversight and management of the Military Health System:

- The Under Secretary of Defense for Personnel and Readiness is the principal staff assistant and advisor to the Secretary and Deputy Secretary of Defense for health affairs and, in that capacity, develops policies, plans, and programs for health and medical affairs.<sup>33</sup>
- The Assistant Secretary of Defense for Health Affairs has the primary responsibility for the Military Health System and serves as the principal advisor to the Under Secretary of Defense for Personnel and Readiness for all DOD health policies, programs, and activities.<sup>34</sup> The Assistant Secretary of Defense for Health Affairs also has the authority to develop policies; conduct analyses; issue guidance; provide advice and make recommendations to the Secretary of Defense, the Under Secretary of Defense for Personnel and Readiness, and others; and provide oversight to the DOD components on matters pertaining to the Military Health System. Further, the Assistant Secretary of Defense for Health Affairs prepares and submits a DOD Unified Medical Program budget<sup>35</sup> to provide resources for the Military Health System.
- The Director of the DHA, in addition to carrying out the responsibilities outlined above, manages the execution of policy developed by the Assistant Secretary of Defense for Health Affairs.<sup>36</sup>

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<sup>33</sup> Department of Defense Directive 5124.02, *Under Secretary of Defense for Personnel and Readiness (USD(P&R))* (June 23, 2008).

<sup>34</sup> Department of Defense Directive 5136.01, *Assistant Secretary of Defense for Health Affairs (ASD(HA))* (Sept. 30, 2013) (incorporating change 1, effective Aug. 10, 2017).

<sup>35</sup> The DOD Unified Medical Program consists of the Defense Health Program appropriation, the medical military construction appropriation, military personnel funds for military personnel supporting the Military Health System, and the estimated payments to the DOD Medicare-Eligible Retiree Health Care Fund.

<sup>36</sup> DOD Directive 5136.13.

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- The Secretaries of the military departments coordinate with the Assistant Secretary of Defense for Health Affairs to develop certain Military Health System policies, standards, and procedures and provide military personnel and other authorized resources to support the activities of the DHA, among other things. The Surgeon General of each military department serves as the principal advisor to the Secretary of the military department concerned on all health and medical matters of the military department.

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## DOD Addressed the Statutory Elements for the Transfer of the Administration of the MTFs to the DHA

DOD addressed each of the four statutory elements in its June 2018 plan. DOD dedicated most of the plan to describing the governance structure of DOD's new administrative framework and to describing the schedule for the phased transfer of the administration of approximately 457 MTFs to the DHA by October 1, 2021.<sup>37</sup> DOD's plan provided less detail on addressing efforts to eliminate duplicative activities; maximizing efficiency; and reducing the number of headquarters-level military, civilian, and contractor personnel. The following provides a summary of what DOD's plan included for each of the four elements in the statute:

- **Information on efforts to transfer the administration of the MTFs to the DHA.**<sup>38</sup> In its plan, DOD described the transfer of the MTFs to the DHA, including budgetary matters, information technology, health care administration and management, administrative policy and procedure, military medical construction, and all other MTF operations. DOD dedicated most of the plan to describing the (1) new governance structure of the proposed administrative framework model and (2) timeline for the phased transfer of the administration of the 457 MTFs from the military departments' respective medical commands to the DHA. For example, DOD states that Military Health System governance will shift its focus from consensus-driven bodies that address both policy and management issues to a smaller, streamlined set of oversight councils that focus on high-level, Military Health System-wide policy and budgetary matters. According to the plan, the Assistant Secretary of Defense for Health Affairs will resolve matters that involve both the military departments and the DHA. DOD also stated that the DHA plans to establish six intermediate

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<sup>37</sup> As noted earlier, the NDAA for Fiscal Year 2019 extended the date for the transfer of the administration of the MTFs to the DHA to September 30, 2021.

<sup>38</sup> This section corresponds to how the Secretary will carry out subsection (a) of section 1073c of title 10 of the United States Code. Pub. L. No. 114-328, § 702(d)(2)(A) (2016).

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management organizations (two for each region) to assist with the administration and management of the MTFs, which are broken out as follows: an East Region, a West Region, and outside the United States.<sup>39</sup> Further, DOD stated that the DHA had established an Assistant Director position for Health Care Administration, as well as four Deputy Assistant Director positions for Information Operations, Financial Operations, Health Care Operations, and Medical Affairs.

Regarding the timeline for the phased transfer, beginning no later than October 1, 2018, DOD will transfer 5 of its approximately 679<sup>40</sup> MTFs to the DHA for the first phase of the transition. MTFs transferring to the DHA for the first phase include the Womack Army Medical Center, Fort Bragg; the Naval Hospital Jacksonville; Force 81st Medical Group, Keesler Air Force Base; 4th Medical Group, Seymour Johnson Air Force Base; and 628th Medical Group, Joint Base Charleston. In the second phase of the transition, which will begin no later than October 1, 2019, DOD will transfer 244 MTFs from the East Region to the DHA. The third phase will begin no later than October 1, 2020, and will include 134 MTFs from the West Region. The fourth phase will include 79 MTFs outside the United States and begin no later than October 1, 2021. DOD also provided DHA organizational charts for each of the four phases.

- **Information on efforts to eliminate duplicative activities carried out by the DHA and the military departments.**<sup>41</sup> In its plan, DOD noted that it is undertaking an analysis of the functions that will be performed at DHA headquarters and at the military departments' respective medical department headquarters. In the plan, DOD provided three figures listing the functions, functional responsibilities, and functional requirements that will be carried out by the DHA, the DHA intermediate management organizations, and the military

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<sup>39</sup> According to the plan, the Director of the DHA will be responsible for the administration of each MTF through DHA-established intermediate management organizations with respect to budgetary matters, information technology, health care administration and management, administrative policy and procedure, military medical construction, and all other MTF operations.

<sup>40</sup> DOD estimated that there are about 679 military hospitals, ambulatory care clinics, and dental clinics in fiscal year 2018. See Defense Health Agency, *Evaluation of the TRICARE Program: Fiscal Year 2018 Report to Congress; Access, Cost, and Quality Data through Fiscal Year 2017* (Feb. 28, 2018).

<sup>41</sup> This section corresponds to efforts to eliminate duplicative activities carried out by the elements of the DHA and by the military departments. Pub. L. No. 114-328, § 702(d)(2)(B) (2016).

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departments' medical department headquarters. Specifically, the functions listed included those functions that should be with the DHA intermediate management organizations, such as Emergency Planning and Preparation, and those functions that should be with the military departments' medical department intermediate commands or headquarters, such as Quality and Safety for Healthcare in the Operational Setting. The three figures primarily focused on functions to be performed during the first phase of the transition.

- **Information on efforts to maximize efficiencies in the activities carried out by the DHA.**<sup>42</sup> In its plan, DOD included information about its three principle efforts currently underway to address efficiencies. Specifically, DOD describes its broader efforts to streamline clinical and business processes across the Military Health System and links some of these broader initiatives to section 702.<sup>43</sup> According to the plan, efforts such as the use of centralized contract support functions and common purchasing, among others, are made possible because of the transfer of the administration of the MTFs to the DHA. Specific to the transfer of MTFs to the DHA as required by section 1073c of title 10 of the United States Code, DOD's plan stated that the DHA is developing, publishing, and implementing procedural instructions to help administer and manage the MTFs. The plan also states that each MTF transferring to the DHA will establish a performance plan—referred to as a quadruple aim performance plan—to monitor performance. According to the plan, Military Health System leadership adopted the quadruple aim performance plan to monitor MTF performance, which they believe will improve performance and contribute to better outcomes and increased efficiencies.<sup>44</sup> The plan states that the performance of all MTFs in the Military Health System will be monitored using the Military Health

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<sup>42</sup> This section corresponds to efforts to maximize efficiencies in the activities carried out by the DHA. Pub. L. No. 114-328, § 702(d)(2)(C) (2016).

<sup>43</sup> These broader reform efforts began in 2017 when the Secretary of Defense first directed DOD's components to conduct a thorough business review. Components were asked to identify viable reform initiatives to make DOD more effective and efficient and achieve the business reforms necessary to restore military lethality and readiness. The Health Care Reform Management Team identified ten initiatives as part of the reform efforts.

<sup>44</sup> The DHA 2017 report to stakeholders states that the Military Health System Quadruple Aim includes increased readiness, better care, better health, and lower cost, which collectively serve as the strategic framework for the Military Health System. See Defense Health Agency, *2017 Stakeholder Report* (2017).

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System quadruple aim performance plan measures beginning October 1, 2018.

- **Information on reducing headquarters-level military, civilian, and contractor personnel within the Military Health System.**<sup>45</sup> In its plan, DOD noted that it has already programmed a 25-percent reduction in personnel positions aligned to medical headquarters across the enterprise.<sup>46</sup> Specific to the transfer of MTFs to the DHA as required by section 1073c of title 10 of the United States Code, DOD states that the DHA will experience personnel growth during each subsequent phase of the transition in order to undertake its new responsibilities. Additionally, the plan states that DOD expects at least a 10-percent reduction (approximately 695 positions from the current baseline) in headquarters military and civilian personnel by the end of the transition. However, the plan does not provide specific details about how it will achieve the 10-percent reduction while the DHA experiences personnel growth during each phase. The plan includes a figure depicting military and civilian full-time equivalent positions for the current baseline of the DHA and the military departments' respective medical department headquarters and intermediate commands. Contractors are also mentioned in the plan at a high level, but without specific data. Additionally, DOD continues to take steps to evaluate personnel requirements. Specifically, according to two June 2018 Under Secretary of Defense for Personnel and Readiness memorandums, DOD is conducting a review and validation of headquarters-level personnel requirements, which we discuss in more depth later in this report.<sup>47</sup>

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<sup>45</sup> This section corresponds to how the Secretary will implement section 1073c in a manner that reduces the number of members of the armed forces, civilian employees who are full-time equivalent employees, and contractors relating to the headquarters activities of the Military Health System, as of the date of the enactment of the act. Pub. L. No. 114-328, § 702(d)(2)(D) (2016).

<sup>46</sup> According to the Resource Management Decision we reviewed from February 2016, the 25-percent reduction was specific to defense agency and field activity civilian personnel reductions. Specifically, the decision identified reductions to funds and personnel to implement management headquarters civilian reductions. The Resource Management Decision applied to, for example, the Office of the Under Secretary of Defense for Personnel and Readiness; the Army; the Navy; the Air Force; and the Defense Health Agency, among others. Personnel reductions for this effort were to begin in fiscal year 2017.

<sup>47</sup> Under Secretary of Defense for Personnel and Readiness Memorandum, *Manpower Requirements Validation for the Defense Health Agency Headquarters* (June 7, 2018); Under Secretary of Defense for Personnel and Readiness Memorandum, *Zero-Based Review of Military Department Medical Manpower* (June 15, 2018).

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## Additional Information Would Be Useful to Demonstrate How the Plan Will Reduce or Better Manage Duplication and Improve Efficiencies

DOD's June 2018 plan takes steps toward reducing duplication and improving effectiveness and efficiency, as previously discussed. However, the plan has two weaknesses that could be mitigated with additional information from DOD. Specifically, DOD cannot be reasonably assured that its plan will reduce or better manage duplication and improve efficiency since (1) certain functions are excluded from the transfer to the DHA and (2) it is unclear, based on the information in the plan and supporting planning documents, how implementation of the plan will result in the achievement of the stated goal of reducing headquarters-level personnel, including contractor personnel, by 10 percent.

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## DOD Excluded Certain Functions from the Planned Transfer to the DHA That Could Reduce or Better Manage Duplication

As part of its approach for addressing the requirements of section 702 of the NDAA for Fiscal Year 2017, DOD excluded 16 medical functions from the transfer to the DHA. In a February 2018 Under Secretary of Defense for Personnel and Readiness memorandum, these functions were identified as being related to operational readiness and installation-specific missions.<sup>48</sup> That memorandum and another memorandum from the Under Secretary of Defense for Personnel Readiness dated May 2018 listed 16 functions that DOD identified as operational readiness and installation-specific medical functions and that would therefore be excluded from the planned transfer to the DHA (see table 1).<sup>49</sup>

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<sup>48</sup> Under Secretary of Defense for Personnel and Readiness Memorandum, *Authorities and Responsibilities of Military Treatment Facility Leaders, Service Leaders and the Military Medical Departments* (Feb. 21, 2018).

<sup>49</sup> Under Secretary of Defense for Personnel and Readiness Memorandum, *Authorities and Responsibilities of Military Treatment Facility Leaders, Service Leaders and the Military Medical Departments* (Feb. 21, 2018); Under Secretary of Defense for Personnel and Readiness Memorandum, *Construct for Implementation of Section 702* (May 22, 2018). These memorandums did not identify all the medical functions being transferred to the DHA.

**Table 1: Functions DOD Excluded from the Planned Transfer to the Defense Health Agency**

| <b>16 Functions to be Excluded</b>   |   |
|--|---|
| 1. Occupational health   | 9. Animal medicine  |
| 2. Environmental health  | 10. Dental care (except for oral and maxillofacial surgery) |
| 3. Substance abuse programs  | 11. Installation emergency response                         |
| 4. Food protection   | 12. Deployment-related functions                            |
| 5. Aerospace physiology  | 13. Drug demand reduction                                   |
| 6. Aerospace medicine (specifically, non-military treatment facility health care for aviation personnel) | 14. Medical logistics for operational units                 |
| 7. Bioenvironmental engineering  | 15. Embedded behavioral health                              |
| 8. Nuclear power and other personnel reliability programs  | 16. Military aeromedical evacuation (patient movement)      |

Source: GAO analysis of Department of Defense information. | GAO-19-53

Note: These functions were identified as operational readiness and installation-specific medical functions and were listed in the following two Under Secretary of Defense for Personnel and Readiness memorandums: *Authorities and Responsibilities of Military Treatment Facility Leaders, Service Leaders and the Military Medical Departments* (Feb. 21, 2018) and *Construct for Implementation of Section 702* (May 22, 2018).

DOD cannot be reasonably assured that its plans are reducing or better managing duplication because DOD has not defined the functions or analyzed the potential for the 16 functions to be transferred to the DHA.<sup>50</sup> These functions are not defined in the February or May 2018 memorandums or DOD’s plan. The two memorandums list only the functions and state that they are separate from MTF health care delivery services and MTF business operations. One of the memorandums explains that these functions are tied to organizing, training, and equipping personnel for operational readiness missions.<sup>51</sup> These

<sup>50</sup> June 2018 meeting minutes concerning DOD’s transition efforts highlighted that DOD was considering analyzing the 16 functions. This analysis would be a part of DOD’s review and validation of headquarters-level personnel requirements in response to the June 2018 Under Secretary of Defense for Personnel and Readiness memorandums. Under Secretary of Defense for Personnel and Readiness Memorandum, *Manpower Requirements Validation for the Defense Health Agency Headquarters* (June 7, 2018); Under Secretary of Defense for Personnel and Readiness Memorandum, *Zero-Based Review of Military Department Medical Manpower* (June 15, 2018). According to the memorandums, the reports from the review and validation are required to be completed no later than September 1, 2018. The Office of the Under Secretary of Defense for Personnel and Readiness issued the report on DHA personnel requirements in September 2018. See Office of the Under Secretary of Defense for Personnel and Readiness, *Defense Health Agency: Manpower Requirements Assessment Report* (Sept. 2018).

<sup>51</sup> Under Secretary of Defense for Personnel and Readiness Memorandum, *Authorities and Responsibilities of Military Treatment Facility Leaders, Service Leaders and the Military Medical Departments* (Feb. 21, 2018).

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memorandums also do not explain the rationale used to determine that the 16 functions were different from the other MTF health care functions DOD plans to transfer to the DHA. Further, DOD did not provide any analysis or documentation regarding the decision to exclude these 16 functions in the supporting documentation that we reviewed, such as in the concepts of operations for the Assistant Secretary of Defense for Health Affairs, the DHA, the Army, the Navy, and the Air Force. According to senior-level officials from the Assistant Secretary of Defense for Health Affairs and the DHA, there was no formal analysis or documentation to support the decision.

With respect to the exclusion of the transfer of the dental care function to the DHA, Assistant Secretary of Defense for Health Affairs and DHA senior-level officials stated that dental clinics serve only servicemembers, not retirees or family member beneficiaries. Therefore, dental care was considered to be an operational readiness function rather than a health care delivery function, according to these same officials.<sup>52</sup> However, this statement is not completely in line with DOD information regarding overseas dental care and family member beneficiaries. According to DOD information regarding dental care overseas, family members of active-duty servicemembers can receive dental care from military dental clinics. As such, in some instances the delivery of dental care is not solely for ensuring the readiness of servicemembers. Further, senior-level officials from the Assistant Secretary of Defense for Health Affairs and the DHA acknowledged that transferring the dental care function from the military departments to the DHA could potentially reduce duplicative activities and result in more efficiencies. According to a senior-level DHA official, splitting health care and dental care results in two separate health care delivery organizations.

Across the Military Health System there are approximately 247 (200 in the United States) dental clinics, which represent about a third of DOD's facilities within the direct care system when including dental clinics, military hospitals, and ambulatory care clinics (i.e., approximately 679 facilities in total).<sup>53</sup> Moreover, senior-level officials from the Assistant

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<sup>52</sup> The Military Health System is responsible for the overall oral health and readiness of servicemembers—both in the active-duty and reserve components. Active-duty servicemembers get most dental care from military dental clinics.

<sup>53</sup> Included in DOD's estimate for the 679 facilities are military hospitals, ambulatory care clinics, and dental clinics in fiscal year 2018. See Defense Health Agency, *Evaluation of the TRICARE Program: Fiscal Year 2018 Report to Congress; Access, Cost, and Quality Data through Fiscal Year 2017* (Feb. 28, 2018).

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Secretary of Defense for Health Affairs and the DHA stated that by transferring a function from the military departments to the DHA, DOD reduces the number of managers of a function from four (i.e., at the Army, the Navy, the Air Force, and the DHA) to only one at the DHA.

In our prior work, we have reported that agencies can act to improve the efficiency of their programs by maximizing the level of services provided for a given level of resources, as well as improving programs' effectiveness in achieving their objectives.<sup>54</sup> In particular, we have highlighted the need for agencies to define their mission, functions, activities, services, and processes when identifying fragmentation, overlap, and duplication among programs. Agencies should also assess how, if at all, the fragmented, overlapping, or duplicative functions are related and how they are being coordinated between agencies. Understanding this relationship will help inform decisions about whether and how to increase efficiency or reduce or better manage fragmentation, overlap, or duplication. Also, agencies should assess whether potential effects in areas such as program implementation, outcomes, and costs are positive or negative. Identifying the positive and negative effects of fragmentation, overlap, or duplication will help agencies determine whether or not actions to reduce or better manage the fragmentation, overlap, or duplication are economical and efficient.

However, DOD has not fully determined whether opportunities exist to achieve additional savings due to the lack of analysis, including clear definitions, of the 16 functions that were excluded by DOD. According to senior-level officials from the Assistant Secretary of Defense for Health Affairs and the DHA, there are potential savings by transferring the 16 functions to the DHA, but these have not been adequately analyzed. Without defining and analyzing the 16 functions, DOD cannot assure decisionmakers that it has fully considered all opportunities for reducing or better managing duplication in its plan to transfer the administration of the MTFs to the DHA.

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<sup>54</sup> [GAO-18-427](#) and [GAO-15-49SP](#).

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## DOD Has Not Demonstrated That Its Plan Will Lead to Reductions in Headquarters Personnel

As previously discussed, DOD's plan identifies the functions that will transfer to the DHA. However, DOD's plan and supporting documents do not provide details on how DOD established the 10-percent reduction of headquarters-level military, civilian, and contractor personnel by 2021, when the administration of the 457 MTFs is to have been transferred to DHA. The plan also states that DHA personnel will grow during each subsequent phase of the transition. Further, information in other related supporting documentation indicates that headquarters-level personnel will increase rather than decrease to achieve the 10-percent reduction goal. Lastly, DOD did not include information in the plan or in its supporting documents concerning contractor personnel reductions.

Officials from the Army, the Navy, the Air Force, the DHA, and the Office of Cost Assessment and Program Evaluation could not identify for us what office within DOD established the 10-percent reduction goal. Our review of key planning documents—the concepts of operations for the Assistant Secretary of Defense for Health Affairs, the DHA, the Army, the Navy, and the Air Force—found that these documents also did not provide details for the 10-percent reduction of headquarters personnel. Specifically, although these documents included some information regarding personnel reductions, they did not include specific details concerning the 10-percent reduction of headquarters personnel.

DOD states in the plan that the DHA will experience incremental growth in staffing during each phase of the transition in order to undertake its new responsibilities, but does not explain how it will achieve its 10-percent reduction goal given the projected growth. Further, DOD does not provide any data in the plan about how much the DHA will grow during each phase. Senior-level officials from the offices of the Assistant Secretary of Defense for Health Affairs and the DHA stated that there were no explicit restrictions in section 702 of the NDAA for Fiscal Year 2017 that would prohibit the DHA from increasing its number of personnel. However, section 702 does require that the Secretary implement section 1073c in a manner that reduces the number of members of the armed forces; civilian employees who are full-time equivalent employees; and contractors relating to the headquarters activities of the military health system, which includes the DHA.

Further, the projected growth described in DOD's plan is also consistent with a June 2018 DHA pre-decisional draft briefing concerning full-time equivalent positions based on current information provided by the military departments, which describes a transfer of personnel to the DHA from the

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military departments rather than a reduction in personnel. According to the briefing, full-time equivalents to support future DHA headquarters and intermediate management organizations would not lead to any reductions in personnel. On the contrary, the briefing states that full-time equivalents for military and civilian personnel would increase by 38 percent at the DHA and result in additional costs. A senior-level DHA official confirmed that the information in the briefing relates to a transfer of personnel from the military headquarters to the DHA for health care delivery, not a reduction in personnel that would result in no cost savings. The briefing also states that information related to current and future state full-time equivalent positions is misleading because contractor data, as well as other relevant personnel data, are not included.

Regarding contractor data, DOD did not include any detailed information related to the reduction of contractor personnel in the plan. Specifically, information concerning contractor personnel reductions was not included in the figure or other parts of the section concerning headquarters-level personnel reductions. Overall, contractors are referenced only five times in the entire plan:

- Three of the references are simply repeating the language from the statutory requirement.
- Another reference reiterates that the DHA will assume management responsibilities for civilian and contractor personnel performing health care delivery functions and operations.
- The last reference from the section of the plan related to personnel reductions states that DOD is planning for headquarters personnel reductions, to include military, civilian, and contractor personnel.

In reviewing the concepts of operations for the Assistant Secretary of Defense for Health Affairs, the DHA, the Army, the Navy, and the Air Force for details on contractor personnel, we found that most of these documents did not provide details regarding contractors. Four out of five of the aforementioned concepts of operations did not include information concerning contractors in the context of personnel reductions. Although the Assistant Secretary of Defense for Health Affairs' concept of operations does include information about contractors in the context of personnel reductions, the information does not provide further details about DOD's plans for this effort.

According to DOD Directive 1100.4, *Guidance for Manpower Management*, it is DOD policy that personnel requirements are driven by

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workload and shall be established at the minimum levels necessary to accomplish mission and performance objectives.<sup>55</sup> This directive states that personnel is a resource and that changes in personnel shall be preceded by changes to the programs, missions, and functions that require personnel resources. Additionally, the directive states that assigned missions shall be accomplished using the least costly mix of personnel (military, civilian, and contract) consistent with military requirements, among other considerations. The directive also states that military (active and reserve) and civilian manpower resources shall be programmed in accordance with validated personnel requirements, among others. Moreover, key change management practices concerning workforce reductions state that before implementing workforce reduction strategies, it is critical that agencies carefully consider how to strategically downsize the workforce and maintain the staff resources to carry out its mission.<sup>56</sup> These same key change management practices also define “efficiency” as maintaining federal government services or outcomes using fewer resources (such as time and money) or improving or increasing the quality or quantity of services or outcomes while maintaining (or reducing) resources.<sup>57</sup>

However, DOD’s ability to develop an analytically-based goal for personnel reductions associated with the transfer of administration to DHA, a plan to achieve that goal given that it is projecting growth in personnel, and how contractors factor into its plan has been limited for two reasons. First, DOD has not validated headquarters-level personnel requirements. Second, DOD has not conducted a comprehensive review—a review that, per DOD’s own guidance, would involve establishing at minimum levels the requirements necessary to accomplish mission and performance objectives and reflect the consideration of the least costly mix of personnel (i.e., military, civilian and contract) consistent with military requirements, among other considerations, to meet the validated requirements.<sup>58</sup>

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<sup>55</sup> Department of Defense Directive 1100.4, *Guidance for Manpower Management* (Feb. 12, 2005).

<sup>56</sup> [GAO-18-427](#).

<sup>57</sup> [GAO-18-427](#) and [GAO-11-908](#).

<sup>58</sup> DOD Directive 1100.4.

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Senior-level officials from the offices of the Assistant Secretary of Defense for Health Affairs and the DHA stated that information regarding contractor personnel reductions was not included in the plan because DOD probably did not have these data. These same officials said that it is difficult to obtain contractor personnel data.<sup>59</sup> As we previously noted, DOD has faced challenges with understanding DHA headquarters personnel requirements and composition. In 2015, we reported on DOD's establishment of the DHA and on how, among other things, DOD could not determine DHA's effect on Military Health System administrative and headquarters personnel levels. We found that the DHA had not completed the personnel requirements assessment process or developed a baseline estimate of personnel in the Military Health System before the DHA was created. As discussed previously, we made five recommendations, with which DOD concurred or partially concurred. As of January 2018, DOD had not taken action to fully address three of these recommendations. Of the three recommendations that had not been fully addressed, two relate directly to DHA personnel requirements. Specifically, we recommended the following:

- To provide decision makers with appropriate and more complete information on the continuing implementation, management, and oversight of the DHA, the Secretary of Defense should direct the Assistant Secretary of Defense for Health Affairs to develop a comprehensive requirements assessment process that accounts for needed future skills through the consideration of potential organizational changes and helps ensure appropriate consideration of

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<sup>59</sup> Senate Report 114-49, accompanying a bill for the NDAA for Fiscal Year 2016, included a provision for DOD to report on the results of a study comparing the costs of functions performed by federal civilians and service contractor personnel at selected installations, among other things. The provision included specific elements for DOD to report, such as an accounting of the full cost of federal civilian and service contractor personnel at the selected installations. S. Rep. No. 114-49, at 223-224 (2015). In April 2018, we reported that DOD's April 2017 report addressed most of the reporting elements, but had only partially addressed the reporting element related to the accounting of the full cost of federal civilian and service contractor personnel. Specifically, we found that DOD had excluded certain non-labor costs from its cost calculations. According to DOD's report, identifying service contractor full-time equivalents is a significant challenge because the level of detail available in each contract varied such that DOD could not employ a single methodology and, unlike federal civilian pay data, there is no centralized database on service-contractor pay. DOD reported that contracts are rarely written to address the cost-per-contractor as a full-time equivalent, and some contracts do not differentiate between labor and non-labor costs. See GAO, *Civilian and Contractor Workforces: DOD's Cost Comparisons Addressed Most Report Elements but Excluded Some Costs*, [GAO-18-399](#) (Washington, D.C.: Apr. 17, 2018).

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workforce composition through the determination of the final status of military personnel within the DHA.

- To provide decision makers with appropriate and more complete information on the continuing implementation, management, and oversight of the DHA, the Secretary of Defense should direct the Assistant Secretary of Defense (Health Affairs) to develop a plan for reassessing and revalidating personnel requirements as the missions and needs of the DHA evolve over time.

Since the recommendations concerning DHA personnel requirements have not been fully addressed and DHA is in the middle of a significant organizational change, it would be timely for DOD to validate headquarters-level personnel requirements and conduct a comprehensive review to determine the appropriate mix of personnel. This validation and comprehensive review should occur prior to transferring authority, direction, and control of the MTFs to the DHA for the third phase, which, as previously noted, is scheduled to begin no later than October 1, 2020.

In June 2018, DOD directed a review and validation of headquarters-level personnel requirements. The Under Secretary of Defense for Personnel and Readiness issued two memorandums concerning the review of headquarters-level personnel requirements.<sup>60</sup> The June 7, 2018, memorandum directs the establishment of cross-service manpower teams to conduct a baseline review of DHA headquarters' current and future personnel requirements. Similarly, the June 15, 2018, memorandum directs the establishment of a working group to determine the appropriate manning of all above MTF-level medical activities in the military departments. This memorandum also requires the working group to review and validate the results of the cross-services manpower teams' assessment of DHA headquarters activities, among other requirements.

Officials with the Office of the Under Secretary of Defense for Personnel and Readiness involved in these efforts said that the goal of the current

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<sup>60</sup> Under Secretary of Defense for Personnel and Readiness Memorandum, *Manpower Requirements Validation for the Defense Health Agency Headquarters* (June 7, 2018); Under Secretary of Defense for Personnel and Readiness Memorandum, *Zero-Based Review of Military Department Medical Manpower* (June 15, 2018). According to the memorandums, the reports from the review and validation are required to be completed no later than September 1, 2018. The Office of the Under Secretary of Defense for Personnel and Readiness issued the report on DHA personnel requirements in September 2018. See Office of the Under Secretary of Defense for Personnel and Readiness, *Defense Health Agency: Manpower Requirements Assessment Report* (Sept. 2018).

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review is to identify the DHA's current and future baseline personnel requirements. However, according to these same officials, the review will not (1) validate personnel requirements because of time constraints, (2) identify potential personnel reductions, or (3) consider workforce composition. These officials also clarified that a comprehensive personnel requirements study would take a considerable amount of time and would generate more technical estimates of the work being performed. They said such a study would review major functions and subfunctions, as well as get down to the task level and analyze work processes, which would allow for making process improvement suggestions.

In September 2018, the Office of the Under Secretary of Defense for Personnel and Readiness issued the report on DHA's personnel requirements.<sup>61</sup> The report stated that DHA personnel requirements would increase to support an expanded mission and included several recommendations one of which was to conduct a military essentiality review of DHA positions and functions. According to officials with the Office of the Under Secretary of Defense for Personnel and Readiness, each military department provided headquarters personnel data, which will be reviewed as part of the upcoming Program Budget Review cycle.

Until DOD validates headquarters-level personnel requirements and conducts a comprehensive review that considers the least costly mix of personnel, DOD may not be able to achieve its goal of reducing headquarters-level personnel by 10 percent while maintaining the efficient and effective provision of healthcare services. Furthermore, Congress will lack important information to determine the extent to which the transfer of the administration of the MTFs to the DHA is being planned and implemented effectively and efficiently.

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## Conclusions

Congress required DOD to provide a plan to transfer the administration of the MTFs from the military departments to the DHA. DOD provided a final implementation plan, which made significant changes to the administrative approach described in two of DOD's initial interim plans. In

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<sup>61</sup> According to the report, manpower teams that included representatives from the Army, Navy, and Air Force assessed DHA's baseline and projected future workloads (which considered a future state excluding the 16 operational readiness and installation-specific medical functions and a future state including the 16 functions), among other things. Office of the Under Secretary of Defense for Personnel and Readiness, *Defense Health Agency: Manpower Requirements Assessment Report* (Sept. 2018).

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its final plan, DOD addressed all of the elements of the statute. However, the plan did not provide details to demonstrate how DOD will reduce duplicative activities or headquarters-level personnel. Without defining and analyzing the 16 functions currently excluded from transfer to the DHA, validating headquarters-level personnel requirements, and conducting a comprehensive review to determine, per DOD guidance, the least costly mix of personnel, DOD and congressional decisionmakers are not positioned to know how, whether, and to what extent undertaking this significant reform effort will improve effectiveness and efficiency in the administration of the MTFs.

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## Recommendations for Executive Action

We are making the following three recommendations to the DOD:

The Secretary of Defense should ensure that the Assistant Secretary of Defense for Health Affairs, in coordination with Director of the DHA and the Surgeons General of the military departments, define and analyze the 16 operational readiness and installation-specific medical functions currently excluded from transfer to the DHA to determine whether opportunities exist to reduce or better manage duplicative functions and improve efficiencies in the administration of the MTFs. (Recommendation 1)

The Secretary of Defense should ensure that the Assistant Secretary of Defense for Health Affairs, in coordination with DHA Assistant Director for Health Care Administration and the Secretaries of the military departments, validate headquarters-level personnel requirements to determine that they are established at the minimum levels necessary—per DOD guidance—to accomplish missions and achieve objectives before transferring authority, direction, and control of the MTFs to the DHA for the third phase. (Recommendation 2)

The Secretary of Defense should ensure that the Assistant Secretary of Defense for Health Affairs, in coordination with DHA Assistant Director for Health Care Administration and the Secretaries of the military departments, conduct a comprehensive review to identify the least costly mix—per DOD guidance—of military, civilian, and contractors needed to meet validated requirements—that is, to perform the functions identified at the DHA headquarters and intermediate management organizations and at the military departments' headquarters and intermediate commands. Additionally, this comprehensive review should be completed before transferring authority, direction, and control of the MTFs to the DHA for the third phase. (Recommendation 3)

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## Agency Comments and Our Evaluation

In written comments reproduced in appendix II, DOD concurred with all three recommendations and noted the actions it was taking to address each recommendation.

In response to our third recommendation, DOD noted that it has completed an extensive review of manpower requirements for the management structure of the DHA. The September 2018 report by the Office of the Under Secretary of Defense for Personnel and Readiness is a first step toward addressing our recommendation. The report provided initial information concerning DHA's personnel requirements. As we noted in our report, however, DOD needs to identify the least costly mix—per DOD guidance—of military, civilian, and contractors once it has validated requirements for DHA.

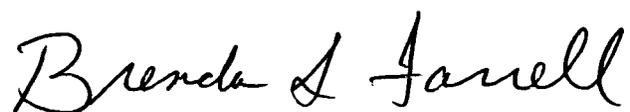
As an additional comment, DOD noted that since our draft report was provided for comment it has refined the estimated projected growth in full-time equivalents for military and civilian personnel at the DHA from 38 percent to 14 percent. In its comments, DOD stated that it continues to believe that it will achieve a 10 percent reduction. However, as we stated in this report, DOD has not demonstrated the extent to which its plan to transfer the MTFs to the DHA will lead to reductions in headquarters-level personnel.

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We are sending copies of this report to the appropriate congressional committees. We are also sending copies to the Secretary of Defense; the Under Secretary of Defense for Personnel and Readiness; the Assistant Secretary of Defense for Health Affairs; the Director, Cost Assessment and Program Evaluation; the Director, Defense Health Agency; the Surgeon General of the Army; the Surgeon General of the Navy; and the Surgeon General of the Air Force.

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If you or your staff have any questions concerning this report, please contact me at (202) 512-3604 or [farrellb@gao.gov](mailto:farrellb@gao.gov). Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff members who made key contributions to this report are listed in appendix III.

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

Brenda S. Farrell  
Director, Defense Capabilities and Management

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

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The National Defense Authorization Act (NDAA) for Fiscal Year 2017 amended Chapter 55 of title 10, United States Code to include a new section: § 1073c Administration of Defense Health Agency and military medical treatment facilities. Section 1073c of title 10, United States Code, as amended by Pub. L. No. 115-91, §§ 713, 1081 (2017), and Pub. L. No. 115-232, § 711 (2018) reads as follows:

**§ 1073c. Administration of Defense Health Agency and military medical treatment facilities**

(a) Administration of military medical treatment facilities.

- (1) In accordance with paragraph (4), by not later than September 30, 2021, the Director of the Defense Health Agency shall be responsible for the administration of each military medical treatment facility, including with respect to--
  - (A) budgetary matters;
  - (B) information technology;
  - (C) health care administration and management;
  - (D) administrative policy and procedure;
  - (E) military medical construction; and
  - (F) any other matters the Secretary of Defense determines appropriate.
- (2) In addition to the responsibilities set forth in paragraph (1), the Director of the Defense Health Agency shall, commencing when the Director begins to exercise responsibilities under that paragraph, have the authority—
  - (A) to direct, control, and serve as the primary rater of the performance of commanders or directors of military medical treatment facilities;
  - (B) to direct and control any intermediary organizations between the Defense Health Agency and military medical treatment facilities;
  - (C) to determine the scope of medical care provided at each military medical treatment facility to meet the military personnel readiness requirements of the senior military operational commander of the military installation;
  - (D) to determine total workforce requirements at each military

medical treatment facility;

(E) to direct joint manning at military medical treatment facilities and intermediary organizations;

(F) to address personnel staffing shortages at military medical treatment facilities; and

(G) to select among service nominations for commanders or directors of military medical treatment facilities.

(3) The military commander or director of each military medical treatment facility shall be responsible for--

(A) ensuring the readiness of the members of the armed forces and civilian employees at such facility; and

(B) furnishing the health care and medical treatment provided at such facility.

(4) The Secretary of Defense shall establish a timeline to ensure that each Secretary of a military department transitions the administration of military medical treatment facilities from such Secretary to the Director of the Defense Health Agency pursuant to paragraph (1) by the date specified in such paragraph.

(5) The Secretary of Defense shall establish within the Defense Health Agency a professional staff to provide policy, oversight, and direction to carry out paragraphs (1) and (2). The Secretary shall carry out this paragraph by appointing the positions specified in subsections (b) and (c).

(b) DHA Assistant Director.

(1) There is in the Defense Health Agency an Assistant Director for Health Care Administration. The Assistant Director shall--

(A) be a career appointee within the Department; and

(B) report directly to the Director of the Defense Health Agency.

(2) The Assistant Director shall be appointed from among individuals who have equivalent education and experience as a chief executive officer leading a large, civilian health care system.

(3) The Assistant Director shall be responsible for the following:

- (A) Establishing priorities for health care administration and management.
- (B) Establishing policies, procedures, and direction for the provision of direct care at military medical treatment facilities.
- (C) Establishing priorities for budgeting matters with respect to the provision of direct care at military medical treatment facilities.
- (D) Establishing policies, procedures, and direction for clinic management and operations at military medical treatment facilities.
- (E) Establishing priorities for information technology at and between the military medical treatment facilities.

(c) DHA Deputy Assistant Directors.

- (1) (A) There is in the Defense Health Agency a Deputy Assistant Director for Information Operations.  
(B) The Deputy Assistant Director for Information Operations shall be responsible for policies, management, and execution of information technology operations at and between the military medical treatment facilities.
- (2) (A) There is in the Defense Health Agency a Deputy Assistant Director for Financial Operations.  
(B) The Deputy Assistant Director for Financial Operations shall be responsible for the policy, procedures, and direction of budgeting matters and financial management with respect to the provision of direct care across the military health system.
- (3) (A) There is in the Defense Health Agency a Deputy Assistant Director for Health Care Operations.  
(B) The Deputy Assistant Director for Health Care Operations shall be responsible for the policy, procedures, and direction of health care administration in the military medical treatment facilities.
- (4) (A) There is in the Defense Health Agency a Deputy Assistant Director for Medical Affairs.  
(B) The Deputy Assistant Director for Medical Affairs shall be responsible for policy, procedures, and direction of clinical quality and process improvement, patient safety,

infection control, graduate medical education, clinical integration, utilization review, risk management, patient experience, and civilian physician recruiting.

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

(d) Certain responsibilities of DHA Director.

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

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

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

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

(C) Ensuring that the Defense Health Agency meets the military medical readiness requirements of the senior military operational commanders of the military installations.

(e) ADDITIONAL DHA ORGANIZATIONS.—Not later than September 30, 2022, the Secretary of Defense shall, acting through the Director of the Defense Health Agency, establish within the Defense Health Agency the following:

(1) A subordinate organization, to be called the Defense Health Agency Research and Development—

(A) led, at the election of the Director, by a director or commander (to be called the Director or Commander of Defense Health Agency Research and Development);

(B) comprised of the Army Medical Research and Materiel Command and such other medical research organizations and activities of the armed forces as the Secretary considers appropriate; and



# Appendix II: Comments from the Department of Defense



## OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE

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WASHINGTON, DC 20301-1200

### HEALTH AFFAIRS

SEP 25 2018

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

Dear Ms. Farrell:

This is the Department of Defense (DoD) response to the Government Accountability Office (GAO) Draft Report, GAO-19-53SU, "DEFENSE HEALTH CARE: DOD Should Demonstrate How Its Plan to Transfer the Administration of Military Treatment Facilities Will Improve Efficiency," dated August 31, 2018 (GAO Code 102682).

The Department is providing the enclosed official written comments for inclusion in the report. My point of contact is Dr. David J. Smith. Dr. Smith can be reached at (703) 681-6893 or via email at david.j.smith152.civ@mail.mil.

Sincerely,

A handwritten signature in black ink, appearing to read "Tom McCaffery", is written over a faint, larger version of the signature.

Tom McCaffery  
Principal Deputy Assistant Secretary of Defense  
for Health Affairs

Enclosure:  
As stated

GOVERNMENT ACCOUNTABILITY OFFICE (GAO) DRAFT REPORT  
DATED AUGUST 31, 2018  
GAO-19-53SU (GAO CODE 102682)

“DEFENSE HEALTH CARE: DOD Should Demonstrate How Its Plan to Transfer the  
Administration of Military Treatment Facilities Will Improve Efficiency”

DEPARTMENT OF DEFENSE COMMENTS  
TO THE GAO RECOMMENDATIONS

**RECOMMENDATION #1:**

*The Secretary of Defense should ensure that the Assistant Secretary of Defense for Health Affairs, in coordination with Director of the Defense Health Agency (DHA) and the Surgeon General of the military departments, define and analyze the 16 operational readiness and installation-specific medical functions currently excluded from transfer to the DHA to determine whether opportunities exist to reduce or better manage duplicative functions and improve efficiencies in the administration of the MTFs.*

**Department of Defense (DoD) RESPONSE:** Concur. The Department is actively assessing the 16 operational readiness and installation-specific medical functions previously identified for exclusion from transfer to the DHA with the intent of determining the allocation of functions and activities between the Services and the DHA, consistent with revised statutory requirements. This assessment includes representatives from the Services and DHA and will be reviewed through the established transition process.

**RECOMMENDATION #2:**

*The Secretary of Defense should ensure that the Assistant Secretary of Defense for Health Affairs, in coordination with DHA Assistant Director for Health Care Administration and the Secretaries of the military departments validate headquarters-level personnel requirements to determine that they are established at the minimum levels necessary-per DoD guidance-to accomplish missions and achieve objective before transferring authority, direction, and control of MTFs to the DHA for the third phase.*

**DoD RESPONSE:** Concur. The Department is reviewing missions/functions which will transfer from the Services to the DHA and ensuring these functional transitions are fully-synchronized with the Services and DHA. Manpower requirements are being addressed as well, to ensure DHA has the resources needed to meet the requirements of law and DoD policy.

**RECOMMENDATION #3:**

*The Secretary of Defense should ensure that the Assistant Secretary of Defense for Health Affairs, in coordination with the DHA Assistant Director for Health Care Administration and the Secretaries of the military department conduct a comprehensive review to identify the least*

*costly mix-per DOD guidance-of military, civilian, and contractors needed to meet validated requirements-that is, to perform the functions identified at the DHA headquarters and intermediate management organizations and at the military departments' headquarters and intermediate commands. Additionally, this comprehensive review should be completed before transferring authority, direction, and control of the MTFs to the DHA for the third phase.*

**DoD RESPONSE:** Concur. The Department has completed an extensive review of the manpower requirements for the management structure of the DHA. This review was led and conducted by a team composed of manpower professionals outside the DHA, in order to render an objective requirement. The Department is using this data in conjunction with Service inputs to inform programming actions for Fiscal Year 2020. Manpower mix will be evaluated throughout the transition process, optimizing the mix to maximize effectiveness and efficiency.

**ADDITIONAL COMMENTS:**

The Department would like to provide additional clarification for GAO's statement, "DoD is projecting a growth of 38 percent" on page 18 of this report although it is not a requested response to a recommendation item. The Department believes it is important to explain the context of the information as it may not capture a comprehensive picture. GAO obtained the number from a pre-decisional/deliberative document where the Department was defining a range of possibilities for savings or costs. The cited data point came from a time when planning figures were still in flux and there was clearly double counting or lack of clarity of some requirements that resulted in this high figure. The DHA believes the number will be 14% and believes that the GAO did not have an opportunity to review more refined estimates since they were not available at the time of the study. Moreover, the Department believes there will be at least 10 percent reduction in MTF administration after the completion of the 702 consolidation.

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# Appendix III: GAO Contact and Staff Acknowledgments

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## GAO Contact:

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

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## Staff Acknowledgments

In addition to the contact named above, Lori Atkinson, Assistant Director; Alexandra Gonzalez; Rebecca Guerrero; Mae Jones; Mary Jo LaCasse; Kirsten Leikem; Steven Putansu; and Sarah Veale made key contributions to this report.

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