



September 2015

DEFENSE HEALTH CARE REFORM

Actions Needed to Help Ensure Defense Health Agency Maintains Implementation Progress

Accessible Version

GAO Highlights

Highlights of [GAO-15-759](#), a report to congressional committees

Why GAO Did This Study

In 2013, DOD created the DHA to provide administrative support for the services' respective medical programs and combine common "shared" services to achieve cost savings. House Report 113-446 included a provision that GAO review DOD's progress in implementing the DHA. This report addresses the extent to which DOD has made progress in (1) assessing the personnel requirements of the DHA and its effect on MHS personnel levels; (2) developing an approach to achieving cost savings through shared services; and (3) fully developing performance measures to assess its shared services.

GAO reviewed DOD's personnel requirements assessment process, business case analyses, and performance measures for the DHA's shared services. GAO compared this information with key management practices and DOD guidance. Additionally, GAO interviewed officials from the DHA and the military services.

What GAO Recommends

In addition to GAO's prior recommendations, GAO is making a number of recommendations related to the DHA's personnel requirements and approach to achieving cost savings. DOD concurred with all but one recommendation to develop a plan for reassessing its personnel requirements, partially concurring and citing existing guidance. GAO continues to believe that current guidance in this area is insufficient, and that DOD would benefit from a plan for reassessing its personnel needs as the DHA's missions and needs evolve.

View [GAO-15-759](#). For more information, contact Brenda S. Farrell at (202) 512-3604 or farrellb@gao.gov.

September 2015

DEFENSE HEALTH CARE REFORM

Actions Needed to Help Ensure Defense Health Agency Maintains Implementation Progress

What GAO Found

Nearly 2 years after the creation of the Defense Health Agency (DHA), the Department of Defense (DOD) has made progress toward completing its implementation process, but has not addressed issues related to GAO's past recommendations regarding personnel requirements, an approach to cost savings, and performance measures.

- *Personnel* - The DHA has initiated the process of assessing personnel requirements, but this process has been delayed, does not have a detailed timeline for completion with milestones and interim steps, and is not comprehensive. It does not address key issues—such as the effect of possible personnel growth in the DHA and workforce composition issues. DOD cannot determine the DHA's effect on the Military Health System's (MHS) administrative and headquarters staff levels because (1) the DHA has not completed the personnel requirements assessment process and (2) it has not, as GAO recommended in November 2013, developed a baseline estimate of personnel in the MHS before the DHA was created. DOD stated that the requirements assessment process will not be completed until September 2016. Further, although DOD does not plan to develop a baseline estimate and is not tracking personnel-related savings, DOD can take steps that would contribute to the development of comprehensive personnel information, such as including information concerning the number and cost of administrative and headquarters personnel within the MHS in annual budget documents.
- *Approach to help achieve cost savings* - The DHA has developed a business case analysis approach to help it achieve cost savings for 8 of its 10 DHA shared services. This approach largely addresses GAO's November 2013 recommendations that DOD provide more information on its cost savings estimates and monitor implementation costs. However, the DHA has not developed comprehensive business case analyses for 2 shared services—Public Health, and Medical Education and Training. Specifically, the DHA has proposed the transfer of their functions from the military services, but has not identified common functions to consolidate in order to achieve cost savings, which is the primary purpose of establishing shared services.
- *Performance measures* – The DHA has made progress in developing measures to assess the progress of its 10 shared services toward achieving their respective goals; however, these measures do not demonstrate some key elements that GAO has found can contribute to success in assessing performance, such as clarity, measurable targets, and baseline data. Specifically, all 10 DHA shared services have measures that demonstrate at least some of these attributes; however, collectively, they do not demonstrate all of the attributes, as GAO recommended in November 2013. These key attributes can help ensure that DOD officials have the information necessary to measure progress toward achieving the stated goals of the shared services. While DOD has made progress in the development of these performance measures, GAO's November 2013 recommendation that DOD develop performance measures that fully exhibit those key attributes is valid and should be completely implemented.

Contents

Letter	1
Background	6
DOD Has Initiated the Process to Determine DHA Personnel Requirements, but Cannot Determine the Effect of the DHA's Establishment on MHS Administrative and Headquarters Personnel Levels	13
DOD Has Developed a Business Case Analysis Approach to Help Achieve Cost Savings in Eight of the Ten Shared Services but Has Not Taken Fundamental Steps for the Remaining Two	21
The DHA Has Made Progress in Developing Performance Measures to Assess Shared Services, but These Measures Do Not Fully Demonstrate Key Attributes of Successful Performance Measures	27
Conclusions	38
Recommendations for Executive Action	39
Agency Comments and Our Evaluation	39
Appendix I: History of Military Health System Governance Reform and Our Related Work	43
Appendix II: Comments from the Department of Defense	48
Appendix III: GAO Contact and Staff Acknowledgments	52
Appendix IV: Accessible Data	53
Accessible Text and Data Tables	53
Agency Comments	60
Related GAO Products	65
Tables	
Table 1: Our Key Attributes of Successful Performance Measures	28
Table 2: Analysis of Extent to Which Performance Measures of Defense Health Agency's (DHA) Shared Services Align with Key Attributes as of April 2015	29
Table 3: Status of the Department of Defense's (DOD) Implementation of Our Recommendations Related to Military Health System (MHS) Governance Reform	45
Figures	
Figure 1: Military Health System (MHS) Organizational Structure	7

Figure 2: Military Health System (MHS) Governance Structure	8
Figure 3: Defense Health Agency's (DHA) Organizational Structure as of July 2015	10
Figure 4: Timeline of GAO Work Related to Military Health System Governance from 2007 to 2015 and Key DOD Documents	44
Accessible Text for Figure 1: Military Health System (MHS) Organizational Structure	53
Accessible Text for Figure 2: Military Health System (MHS) Governance Structure	54
Accessible Text for Figure 3: Defense Health Agency's (DHA) Organizational Structure as of July 2015	54
Accessible Text for Figure 4: Timeline of GAO Work Related to Military Health System Governance from 2007 to 2015 and Key DOD Documents	56
Accessible Text for Appendix II: Comments from the Department of Defense	60

Abbreviations

CAPE	Cost Assessment and Program Evaluation
DHA	Defense Health Agency
DHP	Defense Health Program
DOD	Department of Defense
MDAG	Medical Deputies Action Group
MHS	Military Health System
OASD HA	Office of the Assistant Secretary of Defense for Health Affairs
SMMAC	Senior Military Medical Action Council

This is a work of the U.S. government and is not subject to copyright protection in the United States. The published product may be reproduced and distributed in its entirety without further permission from GAO. However, because this work may contain copyrighted images or other material, permission from the copyright holder may be necessary if you wish to reproduce this material separately.



September 10, 2015

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

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

Since fiscal year 2001, the Department of Defense's (DOD) Military Health System (MHS) budget has grown substantially, from about \$13.6 billion to about \$32.6 billion in fiscal year 2014, an increase of nearly 140 percent.¹ As we reported in 2005, DOD's health care system is an example of a key challenge facing the U.S. government in the 21st century as well as an area in which DOD can achieve economies of scale and improve delivery by combining, realigning, or otherwise changing selected support functions.² In June 2011, the Deputy Secretary of Defense created an internal task force to review the governance of the MHS, and the task force identified (1) cost containment, (2) greater integration, and (3) increased unity of effort as priorities. In March 2012, DOD submitted a report to Congress that, among other things, proposed creating the Defense Health Agency (DHA) to create a more effective and integrated MHS and to achieve cost savings, particularly at headquarters and administrative level organizations—organizations such as the former

¹This figure is for the Defense Health Program, and excludes transfers from the Medicare-Eligible Retiree Health Care Fund.

²GAO, *21st Century Challenges: Reexamining the Base of the Federal Government*, [GAO-05-325SP](#) (Washington, D.C.: February 2005).

TRICARE Management Activity,³ the headquarters of the services' medical commands and agencies, and other management organizations within the MHS that do not directly provide health care services. DOD established the DHA on October 1, 2013, to provide administrative support for the services' respective medical programs, combining common "shared" services,⁴ but also coordinating the work of the services' military treatment facilities and care purchased from the private sector. In its implementation plan, DOD stated that initial operating capability of the DHA was to be achieved by October 1, 2013, and "full operating capability"—that is, the organization would complete its transition period and assume its full responsibilities—would be reached within 2 years.

In the 2011 report on governance reform options by the Task Force on Military Health System Governance, DOD stated that its preferred option, which became the DHA, would (1) result in \$46.5 million⁵ in annual headquarters and administrative personnel cost savings and (2) achieve savings in operations from combining common business operations through the establishment of shared services. During its first year of operation, DHA established ten shared services, combining functions from the Army, the Navy, the Air Force, and the former TRICARE Management Activity. For example, in its Health Information Technology shared service, the DHA consolidated information technology management, infrastructure, and applications functions, creating a single point of accountability for the delivery of information technology services to MHS customers.

³ 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 on October 1, 2013, the Defense Health Agency assumed management responsibility of numerous functions of DOD's medical health system, including the former TRICARE Management Activity, which was terminated on that date.

⁴ According to the Department of Defense, 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.

⁵ In 2013, the Department of Defense, citing internal disagreement over the report's personnel cost savings analysis, identified a more conservative goal of not increasing overall personnel numbers in the Military Health System headquarters through the establishment of the Defense Health Agency.

Since the establishment of the DHA in 2013, we have highlighted weaknesses related to the anticipated cost savings estimates, performance measures, and personnel requirements. Specifically, in November 2013,⁶ we recommended that DOD develop (1) a more thorough explanation of the potential sources of cost savings from DOD's implementation of shared services; (2) performance measures that are clear, quantifiable, objective, and include a baseline assessment of current performance; and (3) a baseline assessment of the number of personnel currently working within the MHS headquarters and an estimate for the DHA at full operating capability. DOD concurred with our recommendations. In February 2014, we testified before the House Armed Services Subcommittee on Military Personnel that it is imperative for DOD to complete these actions so that decision makers will have complete information to gauge reform progress.⁷ We noted that, although a DOD representative had told us since the issuance of our November 2013 report that DOD had begun to take action to address the recommendations, DOD had not addressed them at the time of our testimony.

The House Report accompanying the National Defense Authorization Act for Fiscal Year 2015 included a provision that we review the progress that DOD has made in implementing the DHA. This report examines the extent to which DOD has made progress in: (1) assessing the personnel requirements of the DHA and the effect of its establishment on total MHS administrative and headquarters personnel levels; (2) developing an approach to achieving cost savings through its shared services; and (3) fully developing performance measures to assess progress in achieving the goals of its shared services.

For our first objective, we focused on DHA and military services administrative and headquarters-related personnel working within the MHS. We interviewed relevant DOD, DHA, and military service officials to gather information about DOD's personnel requirements assessment process and MHS personnel before and since the DHA's establishment.

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

⁷GAO, *Military Health System: Sustained Senior Leadership Needed to Fully Develop Plans for Achieving Cost Savings*, [GAO-14-396T](#) (Washington, D.C.: Feb. 26, 2014).

We analyzed this information as well as DHA documentation related to DOD's personnel requirements assessment process for the DHA and its personnel efficiency initiatives and compared them with DOD's *Guidance for Manpower Management*,⁸ which states that resources are to be programmed in accordance with validated personnel requirements and in consideration of all segments of DOD's workforce, including military, civilian, and contractor personnel. We also compared this information with our prior work on results-oriented management⁹ and human capital best practices,¹⁰ which state, among other things, that timelines with milestones and interim steps can be used to show progress toward implementing efforts or to make adjustments to those efforts when necessary and that workforce planning efforts linked to strategic goals and objectives can enable an agency to remain aware of and be prepared for its current and future needs as an organization. We examined any DOD efforts to report to Congress on DHA's personnel requirements as mandated in the National Defense Authorization Act for Fiscal Year 2013¹¹ and to develop a baseline personnel estimate as we had recommended in 2013.¹² We use the term "MHS administrative and headquarters personnel" throughout this report to refer to all personnel

⁸Department of Defense Directive 1100.4, *Guidance for Manpower Management*. February 12, 2005.

⁹GAO, *Agency Performance Plans: Examples of Practices That Can Improve Usefulness to Decisionmakers*, [GAO/GGD/AIMD-99-69](#) (Washington, D.C.: Feb. 26, 1999); GAO, *Executive Guide: Effectively Implementing the Government Performance and Results Act*, [GAO/GGD-96-118](#) (Washington, D.C.: June 1, 1996). In [GAO/GGD/AIMD-99-69](#), we reviewed fiscal year 1999 performance plans of the 24 agencies covered by the Chief Financial Officers Act to identify and describe practices to improve the usefulness of agencies' annual performance plans and to provide examples that illustrate each practice. In [GAO/GGD-96-118](#), we identified key steps and practices of a number of leading public sector organizations that were successfully pursuing management reform initiatives and becoming more results-oriented.

¹⁰ GAO, *A Model of Strategic Human Capital Management*, [GAO-02-373SP](#) (Washington, D.C.: Mar. 15, 2002).

¹¹National Defense Authorization Act for Fiscal Year 2013, Pub. L. No. 112-239, div. A, title VII, § 731 (2013).

¹²[GAO-14-49](#).

working within MHS organizations which do not directly provide health care services within DOD military treatment facilities.¹³

For our second objective, we reviewed documentation of business case analyses for the DHA's ten shared service projects and interviewed relevant officials. Shared services are a subset of the changes being implemented by the DHA, and do not cover all of its activities. We compared DOD's business case analyses with principles in our *Business Process Reengineering Assessment Guide*.¹⁴ These principles require, among other things, clear business case analyses that state the benefits, costs, and risks of a proposed change.

For our third objective, we obtained and reviewed documentation and interviewed relevant officials regarding performance measure information as of April 2015 for the ten DHA shared services, including the measures' names, definitions, and methodologies. To evaluate the extent to which these measures adhered to GAO criteria on key attributes of successful measures, such as measurable targets, baseline and trend data, and clarity, two analysts used a scorecard methodology to independently review the measures for each of the product lines for the ten shared services, comparing them with the key attributes¹⁵ and assigning scores as to whether the performance measures "addressed," "partially addressed," or "did not address" the attributes. The only data we collected and present in this report relate to cost savings and we find that these data are sufficiently reliable for contextual purposes since our focus is on the process and approach to savings (e.g., spelling out savings, implementation costs, having a formal review process, etc.) and not on the actual savings that may result.

¹³Specifically, this definition of administrative personnel includes those other than headquarters personnel who are assigned to MHS organizations, including the DHA, that do not directly provide health care services within DOD military treatment facilities, including personnel performing DHA shared services activities.

¹⁴GAO, *Business Process Reengineering Assessment Guide*, [GAO/AIMD-10.1.15](#) (Washington, D.C.: May 1997). This guide covers a wide range of activities, such as identifying missions and goals, establishing performance measures to gauge progress, developing a business case for implementing the new process, and identifying appropriate staffing levels.

¹⁵GAO, *Tax Administration: IRS Needs to Further Refine Its Tax Filing Season Performance Measures*, [GAO-03-143](#) (Washington, D.C.: Nov. 22, 2002), and [GAO-14-49](#). These two reports identify the key attributes of performance measures used in our analysis.

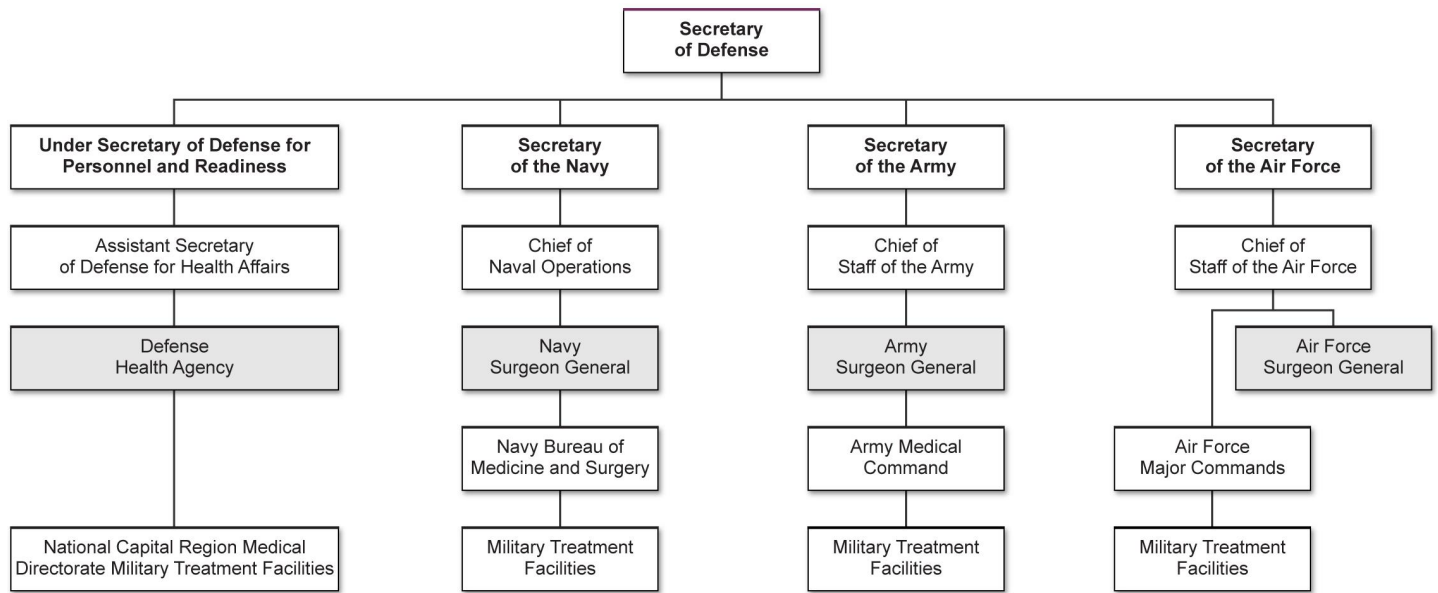
We conducted this performance audit from August 2014 to September 2015 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

Structure and Governance of the MHS

The MHS is a complex organization that provides health services to almost 10 million beneficiaries across a range of care venues, including the battlefield, traditional hospitals and clinics at stationary locations, and authorized civilian providers. Responsibility for the delivery of care is shared among the Office of the Assistant Secretary of Defense for Health Affairs (OASD HA), the military services, and the DHA. The OASD HA reports to the Under Secretary of Defense for Personnel and Readiness, who in turn reports to the Secretary of Defense, whereas the Army, the Navy, and the Air Force medical commands and agencies report through their Service Chiefs to their respective Military Department Secretary and then to the Secretary of Defense. The OASD HA manages the Defense Health Program appropriation, which funds the service medical departments, but the military treatment facilities, including hospitals and clinics, are under the direction and control of the services, which maintain the responsibility to staff, train, and equip those commands to meet mission requirements. The MHS collaboratively develops strategy to meet policy directives and targets, with the service components, the DHA, or both responsible for execution. See figure 1 for the current MHS organizational structure.

Figure 1: Military Health System (MHS) Organizational Structure

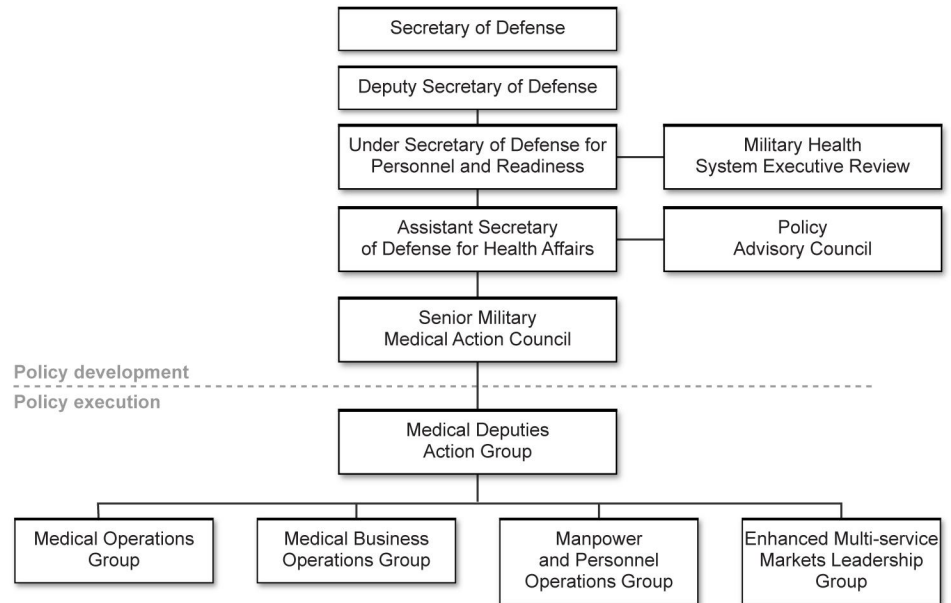


Policy and budget oversight provided by the Under Secretary of Defense for Personnel and Readiness and the Assistant Secretary of Defense for Health Affairs

Source: Department of Defense (DOD). | GAO-15-759

Decision making within the MHS reflects the many actors and complex nature of this relationship. Important decisions are made collaboratively by a number of bodies with representation from each service and the DHA throughout the decision making process. See figure 2 for a diagram of the MHS governance structure.

Figure 2: Military Health System (MHS) Governance Structure



Source: Department of Defense (DOD). | GAO-15-759

The roles and responsibilities within the MHS governance structure are as follows:

- The Military Health System Executive Review, which is chaired by the Under Secretary of Defense for Personnel and Readiness and has other members such as the Vice Chiefs of Staff for the three services as well as the Director of the Joint Staff, serves as a senior-level forum for DOD leadership discussion of strategic, transitional, and emerging issues facing the MHS.
- The Senior Military Medical Action Council, which is chaired by the Assistant Secretary of Defense for Health Affairs and includes the service Surgeons General, the DHA Director, and others, presents enterprise-level guidance and operational issues for decision making by the Assistant Secretary of Defense for Health Affairs.
- The Medical Deputies Action Group, which consists of the service Deputy Surgeons General, the Joint Staff Surgeon, and a DHA representative, and is chaired by the Principal Deputy Assistant Secretary of Defense for Health Affairs, reports to the Senior Military Medical Action Council to ensure that actions are coordinated across

the MHS and are in alignment with strategy, policies, directives, and initiatives of the MHS.

Reporting to the Medical Deputies Action Group are four supporting governing bodies, consisting of flag or general officers from the service medical departments and senior executives from DHA:

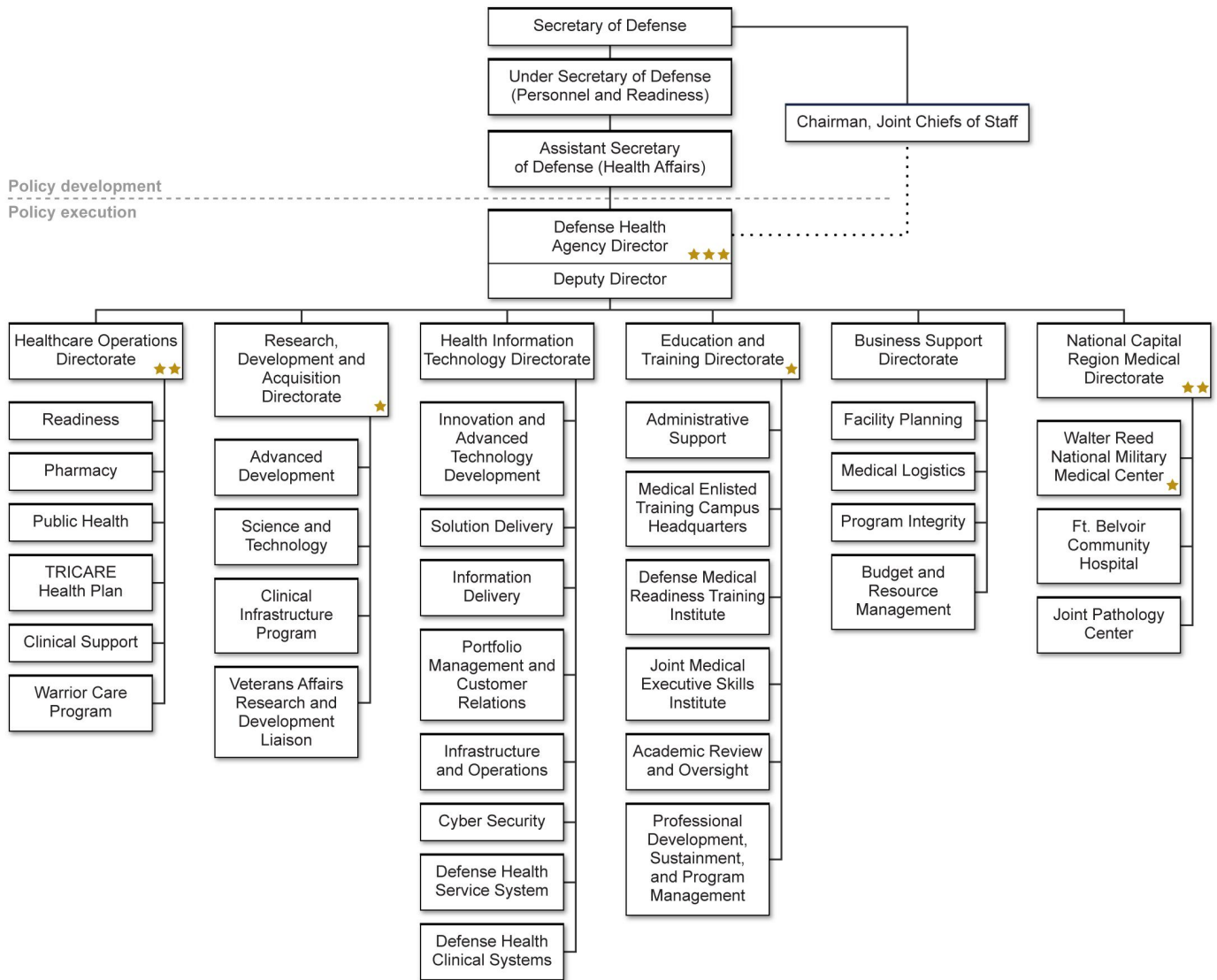
- The Medical Operations Group carries out assigned tasks and provides enterprise-wide oversight of the direct and purchased care systems.
- The Medical Business Operations Group provides a forum for providing resource management input on direct and purchased care issues.
- The Manpower and Personnel Operations Workgroup supports centralized, coordinated policy execution and guidance for development of coordinated human resources and personnel policies and procedures for the MHS.
- The Enhanced Multi-Service Markets Leadership Group provides a forum for managers of geographic MHS markets to discuss clinical and business issues, policies, performance standards, and opportunities.

Structure of the DHA

DOD established the DHA to assume management responsibility for numerous functions of its medical health care system. The DHA supports the delivery of services to MHS beneficiaries and is responsible for integrating clinical and business processes across the MHS. The DHA also exercises management responsibility for the ten joint shared services and the military's health plan and oversees the medical operations within the National Capital Region,¹⁶ which include those at the Walter Reed National Military Medical Center and at the Fort Belvoir Community Hospital. See figure 3 for the organizational structure of the DHA.

¹⁶The National Capital Region is the geographic area that includes Washington, D.C., and other specific surrounding cities and counties in both Maryland and Virginia.

Figure 3: Defense Health Agency's (DHA) Organizational Structure as of July 2015



★ One-star flag officer heads the directorate ★★ Two-star flag officer heads the directorate ★★★ Three-star flag officer heads the Defense Health Agency

Source: Defense Health Agency. | GAO-15-759

DHA Shared Services

According to DOD, a “shared services concept” is a combination of common services performed across the medical community to reduce variation, eliminate redundant processes, and improve performance. Further, according to DOD, the overall purpose and core measure of

success for all shared services is the achievement of cost savings. DHA stood up the following ten shared services during its first year of operation, bringing together elements from the Army, the Navy, the Air Force, and the former TRICARE Management Activity:

- *Budget and Resource Management* promotes the cost-effective use of program and budgeted funds, increased reimbursements, and improved financial transparency and utilization in support of the MHS, and encompasses financial management activities including cost accounting and billing to other health insurance providers as well as to inter-agency entities.
- *Contracting and Procurement* centralizes the strategy for the acquisition of goods and services to meet the needs of shared services and common functions and product lines.
- *Facility Planning* centralizes enterprise facility planning requirements, to better tailor investment decisions to meet future needs, to build and operate less space while better meeting the mission. Additionally, the DHA establishes and strengthens enterprise standards, standard business processes, and performance measurement functions, decreasing variance across the entire facilities business.
- *Health Information Technology* consolidates health information technology services—information technology management, infrastructure, and applications—under the management of the DHA, creating a single point of accountability for the delivery of health information technology services to MHS customers.
- *Medical Education and Training* provides administrative support; academic review and policy oversight; and professional development, sustainment, and program management to the military departments' medical services, the combatant commands, and the Joint Staff.
- *Medical Logistics* standardizes clinical demand signals for medical supplies, equipment, and housekeeping services, and establishes DHA oversight of compliance with best purchasing practices across the MHS.
- *Medical Research, Development, and Acquisition* executes specific activities to improve coordination, process efficiency, and output quality across the enterprise, producing greater operational efficiency, and reducing research costs allowing DOD to recapture funds that can be reinvested into additional research programs.

-
- *Pharmacy* delivers and centrally manages funding for enterprise-wide pharmacy programs, services, and initiatives, and is responsible for leading the strategy, management, and oversight of pharmacy operations across the enterprise.
 - *Public Health* consolidates and centralizes governance for all appropriate public health product lines, including Deployment Health, Health Surveillance, and other processes that promote health, and manage population and individual health risks, to field a fit and medically ready force.
 - *TRICARE Health Plan* supports the MHS integrated health delivery system and the purchase of health care services contracts, executes the requirements determined by the integrated health delivery system, and provides assurance that those requirements are purchased and implemented effectively.

To accomplish the purposes listed above, some of these shared services are composed of a number of projects or “product lines.” For instance, within the Budget and Resource Management shared service, DOD identified three product lines, which involve the (1) implementation of a common cost accounting structure throughout the three military services in support of DHA budget operations; (2) standardization of medical record coding procedures throughout the three military departments through the establishment of a Medical Coding Program Office; and (3) implementation of a joint billing solution to improve the medical treatment facilities’ ability to bill and collect.

DOD Has Initiated the Process to Determine DHA Personnel Requirements, but Cannot Determine the Effect of the DHA's Establishment on MHS Administrative and Headquarters Personnel Levels

DOD has initiated a process for assessing the personnel requirements of the DHA, but it continues to operate without information that would allow it to determine the effect of the DHA's establishment on the number of headquarters and administrative personnel in the MHS. The DHA has started assessing its personnel requirements, but this analysis will not be completed by the DHA's proposed full operating capability in October 2015, and is not comprehensive in that it does not include a complete and detailed timeline, and does not address key issues, including the final size of the agency and its workforce mix. In addition, DOD does not have the information it would need to determine whether creating the DHA resulted in an increase or decrease in the number of MHS headquarters and administrative personnel. As we reported in November 2013, determining the impact of the DHA's creation on MHS personnel levels necessitates finalized personnel requirements for the DHA and a baseline estimate of MHS headquarters and administrative personnel prior to the establishment of the DHA. However, the DHA has just begun its personnel requirements assessment, and DOD does not have a baseline estimate of MHS administrative and headquarters personnel levels that existed before the DHA was established.

DOD Has Initiated a Process for Assessing the DHA's Personnel Requirements, but This Process Has Been Delayed and Does Not Have a Detailed Timeline for Completion

DOD has initiated the process of assessing personnel requirements for the DHA, but this analysis will not be finished by the DHA's proposed full operating capability in October 2015, and does not include a finalized timeline for its completion. According to DHA officials, the assessment will not be completed until September 2016. The National Defense Authorization Act for Fiscal Year 2013 mandated that DOD include personnel requirements for the DHA in its series of three reports to Congress on the DHA's implementation;¹⁷ however, we testified in February 2014¹⁸ that DOD's reports did not include DHA personnel requirements. The DHA Manpower and Organization Division, which is responsible for the DHA personnel requirements assessment, was not established until July 2014, 9 months after the DHA's creation in October 2013. DHA officials said that initial staffing for the office took an additional 6 months and that the office is currently almost completely staffed, but

¹⁷National Defense Authorization Act for Fiscal Year 2013, Pub. L. No. 112-239, title VII, § 731 (Jan. 2, 2013).

¹⁸[GAO-14-396T](#).

that the time necessary to create an operational, fully-functioning office contributed to the assessment's delay.

According to DHA officials, the TRICARE Management Activity—the DHA's predecessor and the only organization that was brought into the DHA in its entirety—did not have personnel requirements. DHA officials stated that they are conducting an assessment of the requirements needed to perform the functions of the former TRICARE Management Activity, which the DHA absorbed. Similarly, in 2010, we reported on the services' medical personnel requirements processes in military treatment facilities, finding that these processes were not validated and verifiable and that the services did not centrally manage civilian personnel requirements.¹⁹

DHA officials stated that the requirements assessment process includes personnel specialists analyzing each part of the agency, documenting its functions, and determining how many personnel hours are needed to execute those functions. DOD Directive 1100.4, *Guidance for Manpower Management*,²⁰ states that resources are to be programmed in accordance with validated personnel requirements. DHA officials said that they are currently developing procedures for the assessment of DHA personnel requirements; however, as of July 2015, officials stated that this document had not been fully developed and were unable to provide specific information.

In addition, DHA provided a tentative timeline as of June 2015 for completion of its requirements assessment process, but this timeline was not complete or finalized. Further, DHA officials stated that they will not complete the personnel requirements assessment when the DHA reaches full operational capability on October 1, 2015. DHA created the tentative personnel requirements assessment timeline that provides estimated personnel days for assessing the different parts of the agency as well as estimated dates for beginning and completing portions of the assessment. According to this timeline, DHA expects to complete the assessment of its Health Information Technology and Business Support directorates by October 9, 2015. However, tentative start and end dates for assessing other parts of the DHA, including the National Capital Region Medical

¹⁹GAO-10-696.

²⁰Department of Defense Directive 1100.4, *Guidance for Manpower Management*, (2005).

Directorate, Medical Education and Training Directorate, Defense Health Agency Support, and the Research, Development and Acquisition Directorate are “To Be Determined.” DHA officials stated that they expect to complete the assessment of DHA’s personnel requirements by fiscal year 2017, but the timeline does not include established timelines for completion of the entire assessment or for all interim steps of the process.

Our reports on performance planning indicate that timelines with milestones and interim steps can be used to show progress toward implementing efforts or to make adjustments to those efforts when necessary.²¹ In 2013, we found that DOD had not consistently identified milestones for all activities between initial operating capability and full operational capability for each of the goals of its reform, and we recommended that DOD develop and present to Congress a timeline with interim milestones for all reform goals that could be used to show implementation progress.²² DOD concurred with the recommendation but has not yet implemented it. The timeline focused on implementation of DOD’s shared services and other reform objectives, but did not specifically address development of personnel requirements for the DHA. By developing a timeline for DHA’s personnel requirements assessment that includes milestones and interim steps for determining those requirements, DOD could provide Congress with important information concerning the size and scope of the DHA that Congress requested 2 years ago.

²¹[GAO/GGD/AIMD-99-69](#) and [GAO/GGD-96-118](#).

²²[GAO-14-49](#).

DOD's Requirements Assessment Process for the DHA Does Not Address Key Issues Related to Size and Workforce Mix

DOD's ongoing assessment does not address key issues that are important to the size and workforce mix of the DHA. Specifically, according to DHA officials, their personnel requirements assessment does not account for the possible addition of other missions or organizations to the DHA, and DOD has not made a decision as to whether military personnel will be permanently assigned to the DHA. The DHA has already incorporated a number of components for which a military service formerly served as executive agent,²³ such as the Joint Medical Executive Skills Institute under the Army, and various DHA and service officials said that the DHA could incorporate additional missions or organizations in the future. DHA officials stated they expect adjustments to personnel requirements with any added mission. However, the current assessment process does not specifically address such potential changes. Our work on effective strategic workforce planning found that agency personnel planning should consider not only the needs of its current workforce, but its future workforce as well.²⁴ Should DOD not take into account the additional skills and competencies required to meet future missions, its requirements assessment will be incomplete.

DOD's assessment also does not address aspects of workforce mix – the proportion of military, civilian, and contractor personnel that perform DOD's functions. DOD Directive 1100.4, *Guidance for Manpower Management*,²⁵ instructs that all three segments of the workforce should be considered when determining how DOD's work should be performed. Further, 10 U.S.C. § 115b requires DOD to address in its strategic workforce plan, among other things, the appropriate mix of military,

²³As defined in Department of Defense (DOD) Directive 5101.1, a DOD executive agent is the head of a DOD component to whom the Secretary of Defense or the Deputy Secretary of Defense has assigned specific responsibilities, functions, and authorities to provide defined levels of support for operational missions, or administrative or other designated activities that involve two or more of the DOD components.

²⁴GAO, *Human Capital: Key Principles for Effective Strategic Workforce Planning*, [GAO-04-39](#) (Washington, D.C.: Dec. 11, 2003). This report describes the key principles of strategic workforce planning and provides illustrative examples of these principles drawn from selected agencies' strategic workforce planning experiences.

²⁵Department of Defense Directive 1100.4, *Guidance for Manpower Management* (2005).

civilian, and contractor personnel capabilities. In 2012, we reported that DOD's plan submissions have not addressed this requirement.²⁶

DHA officials stated that their personnel requirements assessment will include an analysis of whether work should be performed by military, civilian, or contractor personnel. However, officials also stated that the ongoing personnel assessment will not determine whether the DHA will assume full responsibility for military personnel working at the DHA or whether servicemembers' respective military service will retain those functions. The determination of military personnel status would also affect the workforce mix of military, civilian, and contractor personnel within the agency. Officials stated that if responsibility for military personnel were transferred to the DHA, meaning the military billets and associated funding were moved to the DHA budget, then the responsibility for related human capital functions would transfer as well. The DHA's human capital office would require an increase in size to provide this support. Until a decision is made, officials told us that the DHA and services plan to use a specific code to identify assigned military personnel working at the DHA in order to track the number of military personnel working within the DHA. Officials further stated that they did not have an estimated timeframe for the decision about military personnel. If the DHA absorbs additional agencies or missions, or if full responsibility for military personnel transfers to the DHA, DOD will need to reassess requirements in light of these changes. However, DOD does not have a plan for addressing these potential changes or periodically reassessing the personnel needs of the DHA.

DOD Directive 1100.4, *Guidance for Manpower Management*, states that personnel management shall be, among other things, adaptive to program changes and existing policies, procedures, and structures should be periodically evaluated for efficient and effective use of resources and long-range strategies and workforce forecasts should be developed to implement major changes. The DHA published a Directive Type Memorandum on its personnel planning process in January 2014, but this guidance does not specifically address the need for a plan to reassess and revalidate personnel requirements on a regular, recurring basis.²⁷

²⁶GAO, *Human Capital: DOD Needs Complete Assessments to Improve Future Civilian Strategic Workforce Plans*, [GAO-12-1014](#) (Washington, D.C.: Sept. 27, 2012).

²⁷Directive-Type Memorandum 2013-001-DHA, *Defense Health Agency Manpower and Organization Changes*, (2014).

Without addressing the need to periodically reassess the DHA's personnel requirements, DOD cannot effectively plan for, manage, and adjust to future programmatic and organizational changes that may occur within the MHS or the DHA.

DOD Does Not Have Information to Determine the Effect of the DHA's Establishment on MHS Administrative and Headquarters-Related Personnel Levels

DOD decided to implement the DHA, in part, on the assumption that it would result in reduced personnel costs of \$46.5 million annually in MHS administrative and headquarters organizations.²⁸ However, as we reported in November 2013,²⁹ DOD, citing internal disagreement over the report's personnel estimate, identified a more conservative goal of not increasing overall personnel numbers in the MHS headquarters through the establishment of the DHA. We recommended that DOD develop a baseline estimate of headquarters personnel and an estimate of such personnel needs at full operating capability.³⁰ DOD concurred with our recommendation and stated that it would provide this information in its third submission to Congress on the implementation of the DHA, but as we noted in our February 2014 testimony,³¹ DOD did not do so.

By comparing finalized personnel levels with a baseline of MHS personnel levels before the DHA's creation, DOD could demonstrate the effect of the DHA's establishment on the size of MHS administrative and headquarters personnel levels. However, DOD has neither finalized personnel levels for the DHA nor completed a baseline assessment of MHS personnel levels. During the course of this review, officials from the Office of the Assistant Secretary of Defense (Health Affairs) stated that they do not plan to identify a historical baseline estimate of MHS headquarters and administrative personnel levels prior to the establishment of the DHA. Officials stated that it would prove impossible to retroactively establish such a baseline estimate. However, we continue to believe that, as we recommended in 2013, a pre-DHA baseline estimate would provide decision makers with a transparent and complete

²⁸This figure represents estimated civilian personnel cost savings, and does not including military personnel or contractor services.

²⁹GAO, *Defense Health Care Reform: Additional Implementation Details Would Increase Transparency of DOD's Plans and Enhance Accountability*, [GAO-14-49](#) (Washington, D.C.: Nov. 6, 2013).

³⁰[GAO-14-49](#).

³¹[GAO-14-396T](#).

picture of the impact of the DHA's creation on MHS headquarters personnel levels. Our prior work on strategic human capital management states that workforce planning efforts linked to strategic goals and objectives can enable an agency to remain aware of and be prepared for its current and future needs as an organization, such as the size of its workforce.³² By developing a baseline, DOD would be able to demonstrate whether MHS administrative and headquarters organizations are larger or smaller since the establishment of the DHA.

Without reliable baseline and requirements personnel data, decision makers at DOD and in Congress do not have comprehensive information about previous and current personnel levels and needs for the DHA and the MHS. As a result, they do not know whether the DHA has had an effect on personnel costs and cannot make fully informed decisions about future needs and long-term goals. Congressional decision makers have expressed concern regarding the resources devoted to the Office of the Secretary of Defense, the Joint Staff, and the military services' secretariats and military staff, and we have conducted a number of reviews in response to such concerns. We previously reported that DOD has experienced challenges in accounting for headquarters resources, including concerns with the completeness and reliability of data on its headquarters personnel,³³ weaknesses in DOD's process for sizing its geographic combatant commands,³⁴ difficulty accounting for the resources being devoted to management headquarters to use a starting point for tracking reductions,³⁵ and the absence of a systematic requirements-determination process.³⁶ Within DOD, in July 2013, the Secretary of Defense directed a 20-percent cut in management

³²[GAO-02-373SP](#).

³³GAO, *Defense Headquarters: Further Efforts to Examine Resource Needs and Improve Data Could Provide Additional Opportunities for Cost Savings*, [GAO-12-345](#) (Washington, D.C.: Mar. 21, 2012).

³⁴GAO, *Defense Headquarters: DOD Needs to Periodically Review and Improve Visibility of Combatant Commands' Resources*, [GAO-13-293](#) (Washington, D.C.: May 15, 2013).

³⁵GAO, *Defense Headquarters: DOD Needs to Reevaluate Its Approach for Managing Resources Devoted to the Functional Combatant Commands*, [GAO-14-439](#) (Washington, D.C.: June 26, 2014).

³⁶GAO, *Defense Headquarters: DOD Needs to Reassess Personnel Requirements for the Office of Secretary of Defense, Joint Staff, and Military Service Secretariats*, [GAO-15-10](#) (Washington, D.C.: Jan. 21, 2015).

headquarters³⁷ spending throughout the department, to include spending within headquarters organizations such as the Office of the Secretary of Defense, the Joint Staff, and the military services' secretariats and military staff.

DOD can take steps that would positively contribute to the development of transparent and comprehensive personnel information, including associated costs, for decision makers at present and in the future. For example, an annual budget exhibit in the Congressional Budget Justification delineating personnel costs allocated to MHS administrative and headquarters organizations and the costs allocated to military treatment facilities would provide information relevant to decision makers' concerns about the cost of administering the MHS. Such a budget exhibit would be in line with federal accounting standards that are aimed at providing relevant and reliable cost information to assist Congress and executives in making decisions about allocating federal resources.³⁸

³⁷Deputy Secretary of Defense Memorandum, *20% Headquarters Reductions* (July 31, 2013).

³⁸GAO, *Business Modernization: NASA's Integrated Financial Management Program Does Not Fully Address Agency's External Reporting Issues*, [GAO-04-151](#) (Washington, D.C.: Nov. 21, 2003). The Statement of Federal Financial Accounting Standards Number 4, Managerial Cost Accounting Standards, requires agencies to report the full cost of their programs in their general-purpose financial reports aimed at assisting congressional and executive decision makers in allocating federal resources.

DOD Has Developed a Business Case Analysis Approach to Help Achieve Cost Savings in Eight of the Ten Shared Services but Has Not Taken Fundamental Steps for the Remaining Two

DOD has developed a business case analysis approach to help achieve cost savings and has applied this approach to eight of its ten shared services; DOD has not, however, developed comprehensive business case analyses for the remaining two shared services—Public Health and Medical Education and Training. For eight of its shared services, DOD has generally implemented recommendations we made in 2013 by identifying discrete costs and cost savings for each of its shared services' product lines and identifying the major types of implementation costs. Regarding the remaining two shared services, the DHA has not, in accordance with best practices,³⁹ identified a stated problem that those two shared services would be intended to address. Identifying a stated problem is the first step in developing a business case analysis. Specifically, the DHA has not identified any redundant functions to be consolidated in the Public Health and in the Medical Education and Training areas to justify the proposed transfer of responsibility of functions in those areas from a military-service-level entity to a DOD-level one.

DOD Has Developed a Business Case Analysis Approach for Eight of Its Ten Shared Services

The National Defense Authorization Act for Fiscal Year 2013 required DOD to develop business case analyses for its shared service proposals as part of its submissions on its plans for the implementation of the DHA, including, among other things, the purpose of the shared service and the anticipated cost savings. According to the implementation plan that the DHA submitted, the DHA would establish ten shared services to achieve cost savings. In November 2013, we highlighted concerns regarding the basis of cost savings estimates and the potential impact of implementation costs on the DHA's shared service projects. Since then, the DHA has developed a business case analysis approach for eight of its shared services that generally reflects best practices.⁴⁰ We based our assessment on discussions with officials from the various shared services and their quarterly briefings to the Medical Deputies Action Group, which includes the Deputy Surgeons General of each service and representatives from Health Affairs and the DHA. In general, these briefings indicate that the business cases for Budget and Resource Management, Contracting and Procurement, Facility Planning, Health

³⁹[GAO/AIMD-10.1.15](#).

⁴⁰These cost savings estimates generally concern non-personnel program costs. As previously discussed, the Department of Defense does not have the information needed to determine the effect of the Defense Health Agency's establishment on Military Health System's administrative and headquarters-related personnel levels.

Information Technology, TRICARE Health Plan, Medical Logistics, Pharmacy, and Medical Research, Development, and Acquisition generally reflect the characteristics of business case analyses outlined in GAO's *Business Process Reengineering Assessment Guide*.⁴¹ The guide identifies a number of best practices that help make the business case for change. In addition, the guide recommends the use of an investment review process to evaluate the business case and decide whether to proceed with proposed changes.

In November 2013, we reported⁴² that, while the information in DOD's implementation plans generally reflected key characteristics of business case analyses, DOD did not present sufficient information to explain the basis for its cost-savings estimates. Specifically, we reported that DOD did not include detailed quantitative analysis regarding the sources of its cost-savings estimates or provide a basis for or an explanation of key assumptions and rationales used in estimating such savings. For example, we noted that while the Medical Logistics shared service is composed of three product lines, DOD presented one net savings estimate for Medical Logistics, but did not provide estimates for each of its three product lines. We noted that a business case should include detailed qualitative and quantitative analysis in support of selecting and implementing the new process that includes a statement regarding benefits, costs, and risks. We recommended that DOD provide a more thorough explanation of the potential sources of cost savings from the implementation of its shared services, and DOD concurred.

During our current review, we found that in its quarterly reports to the Medical Deputies Action Group, DOD provided additional information on each of the eight shared services. For example, the Medical Logistics shared service team now identifies discrete costs and cost savings for each product line—Supply Management, Health Care Technology, and MEDLOG Services (Housekeeping). After accounting for implementation costs, the net savings estimate for each product line within this shared service from fiscal years 2014 through 2019 range from \$5.96 million for services to \$197.86 million for supplies. By differentiating between these product lines, decision makers are able to obtain a sense of the relative size and scope of each proposed change.

⁴¹[GAO/AIMD-10.1.15](#).

⁴²[GAO-14-49](#).

In addition, in 2013 we reported on the effect of potential increases in implementation costs on net cost savings. We noted DOD's past experience in managing the implementation of large-scale projects, particularly those involving investments in information technology, illustrates such risk. According to the guide,⁴³ business case analyses should demonstrate the sensitivity of the outcome to changes in assumptions, with a focus on the dominant benefit and cost elements and the areas of greatest uncertainty. We recommended that DOD monitor implementation costs to assess whether the shared services are on track to achieve projected net cost savings or if corrective actions are needed, and DOD concurred.

During our current review, we found that briefings to the Medical Deputies Action Group now identify the major types of implementation costs where relevant, or otherwise address their potential impact. For example, information technology costs are identified as one primary type of costs for the Health Information Technology and Medical Logistics shared services, while contract costs are identified for the Budget and Resource Management, Medical Logistics, and Health Information Technology shared services. By identifying the major types of implementation costs, decision makers are better able to gauge the sensitivity of areas of uncertainty as they make decisions concerning future investments in shared services.

DHA has also developed and implemented an investment review process to assess the business case for shared services on their merits. Our *Business Process Reengineering Assessment Guide* states that use of an agency's investment review process to evaluate a business case and decide whether to proceed with a given change is a vital aspect of business process reengineering. These estimates were reviewed by the Council of Cost Assessment and Program Evaluation bodies, a group of cost assessment subject matter experts from the services and the DHA. Shared service teams presented the basis and reasoning for developing costs and savings for each product line, and cost assessment experts commented on the proposals. For example, when reviewing the business case analysis for the health information technology shared service, the Council of Cost Assessment and Program Evaluation's report stated that the analysis was based on an estimated reduction from current spending

⁴³[GAO/AIMD-10.1.15](#).

based on, among other things, industry benchmarks and estimates from subject matter experts. Each representative registered their agreement or objection to the estimates and voted to express concurrence or non-concurrence. Ultimately, this process includes review by the Medical Deputies Action Group, which includes the Deputy Surgeons General and the Deputy Director of the DHA, followed by the Senior Military Medical Action Council, which includes the Surgeons General, the Director of the DHA, and is chaired by the Assistant Secretary. By sustaining its current approach to shared services, DOD can help ensure it has a framework to help it achieve cost savings.

DOD Has Not Fully Developed Business Case Analyses for the Public Health and the Medical Education and Training Shared Services

The DHA has proposed transferring existing public health and medical education and training organizations from the services to the DHA; however, the DHA has not developed a business case about how doing so would consolidate activities to eliminate redundancies and result in cost savings. During the process of planning for MHS governance reform, the Deputy Secretary of Defense noted in a March 2012 memorandum that this process should “realize savings in the MHS through the adoption of common clinical and business processes and the consolidation and standardization of various shared services.”⁴⁴ This focus on achieving savings through consolidation differentiates the objective of establishing shared services from the six other objectives outlined in DOD’s plans for the implementation of the DHA. However, in the case of both the Public Health and Medical Education and Training shared services, the transfer of responsibility for military-service level organizations to a defense agency without consolidation of programs runs contrary to the stated purpose of shared services. While these two shared services propose some efficiencies in their operations, they either overlap with other shared services or propose changes which could have been implemented without a transfer of responsibility to the DHA.

The Public Health shared service consists of, in part, the adoption of a number of Army public health agencies into the DHA. One proposed efficiency initiative of this shared service, including the consolidation of several redundant databases with an estimated net savings, accounting for implementation costs, of about \$1 million between fiscal years 2014

⁴⁴ Deputy Secretary of Defense, *Memorandum: Planning for Reform of the Governance of the Military Health System*, March 2, 2012.

and 2019, partially overlaps with the responsibilities of the Health Information Technology shared service. In addition, in briefings to the Medical Deputies Action Group, the Public Health shared service team stated that the “vision for health surveillance may not be fully realized in terms of a true shared service.” Further, DHA officials stated that cost savings was not a major goal of the Public Health shared service, contrary to DOD’s stated intention for shared services.

Similarly, the Education and Training shared service adopts a number of existing organizations, and the additional small changes it has proposed overlap with other shared services. In 2014, we reported on this shared service, and highlighted problems regarding its rationale. For example, we noted that the “product line” proposals concerning modeling and simulation and online learning overlap with the DHA’s Contracting and Procurement and Health Information Technology shared services. Specifically, while cost savings for modeling and simulation are allocated to the Education and Training Directorate, implementation costs are to be incurred by the Contracting and Procurement shared service. In addition, the savings for the online learning project are found within the Health Information Technology shared service portfolio.

We have previously highlighted the challenges DOD faces when it does not fully analyze potential changes to business processes. For example, in 2007,⁴⁵ we reported that DOD did not comprehensively analyze the costs, benefits, or risks of any of the four options for governance reform under consideration at the time. Further, DOD developed and decided to implement the fourth option as a compromise among the military departments and the Office of the Secretary of Defense (Health Affairs) similar to the current shared services concept, but did not develop a supporting business case analysis. When we later reviewed implementation of this compromise option, we found that DOD had only implemented those steps that related to implementation of the Base

⁴⁵GAO, *Defense Health Care: DOD Needs to Address the Expected Benefits, Costs, and Risks for Its Newly Approved Medical Command Structure*, [GAO-08-122](#) (Washington, D.C.: Oct. 12, 2007).

Realignment and Closure process, while others had not been sufficiently addressed.⁴⁶

The *Business Process Reengineering Assessment Guide* states that a business case analysis begins with (1) measuring performance and identifying problems in meeting mission goals, which is then addressed through (2) the development and selection of a new process. The new process is to include a description of estimated benefits, costs, and risks. However, in developing the Public Health and Medical Education and Training shared services, the DHA did not address this first step of the business case analysis process.

Without first identifying what redundant functions can be consolidated to achieve efficiencies, the reason for creating these shared services will remain unclear. Some shared services, such as the TRICARE Health Plan shared service, entail more efficient provision of previously centralized services provided by the former TRICARE Management Activity, an agency which was absorbed into the DHA. However, both Public Health and Medical Education and Training were not previously centralized. Therefore, this central rationale of consolidation for shared services that were not previously centralized is absent from the approach to Public Health and Medical Education and Training and, as a result, their purpose is inconsistent with the spirit of shared services. DOD could articulate an alternative reason for the transfer of responsibility for these services to the DHA. However, absent such an alternative explanation, the rationale for the transfer of responsibility of the functions of these services to the DHA remains unclear.

⁴⁶ GAO, *Defense Health Care: Applying Key Management Practices Should Help Achieve Efficiencies within the Military Health System*, [GAO-12-224](#) (Washington, D.C.: April 12, 2012).

The DHA Has Made Progress in Developing Performance Measures to Assess Shared Services, but These Measures Do Not Fully Demonstrate Key Attributes of Successful Performance Measures

The DHA has made progress in developing measures to assess the progress of its ten shared services toward achieving their respective goals; however, these measures continue to not fully demonstrate key elements that can contribute to success in assessing performance. In November 2013, we found that the performance measures DOD provided in its 2013 congressionally required MHS reform implementation plans did not fully exhibit attributes that can help agencies determine whether they are achieving their goals, such as accompanying explanations, definitions, quantifiable targets, or baselines. To provide decision makers with more complete information on the planned implementation, management, and oversight of the DHA, we recommended⁴⁷ that DOD develop and present to Congress performance measures that are clear, quantifiable, objective, and include a baseline assessment of current performance. Through our prior work on performance measurement, we have identified several important attributes of performance measures (see table 1).⁴⁸ While these attributes may not cover all the attributes of successful performance measures, we believe they address important areas.

⁴⁷[GAO-14-49](#).

⁴⁸[GAO-03-143](#). In this review, we identified attributes of performance measures from various sources, such as earlier GAO work, Office of Management and Budget Circular No. A-11, the Government Performance and Results Act, and the IRS's handbook on Managing Statistics in a Balanced Measures System. In addition, we drew on previous GAO work including: [GAO/GGD-96-118](#) and GAO, *The Results Act: An Evaluator's Guide to Assessing Agency Annual Performance Plans*, [GAO/GGD-10.1.20](#) (Washington, D.C.: Apr. 1998). Further, we identified important key attributes of performance measures in [GAO-14-49](#).

Table 1: Our Key Attributes of Successful Performance Measures

Attribute	Definition	Potentially adverse consequences of not meeting attribute
Linkage	Measure is aligned with division and agency-wide goals and mission and clearly communicated throughout the organization.	Behaviors and incentives created by measures do not support achieving division or agency-wide goals or mission.
Clarity	Measure is clearly stated, and the name and definition are consistent with the methodology used to calculate it.	Data could be confusing and misleading to users.
Measurable target	Measure has a numerical goal.	Managers may not be able to tell whether performance is meeting expectations.
Objectivity	Measure is reasonably free from significant bias or manipulation.	Performance assessments may be systematically over- or understated.
Reliability	Measure produces the same result under similar conditions.	Reported performance data may be inconsistent and add uncertainty.
Baseline and trend data	Measure has a baseline and trend data associated with it to identify, monitor, and report changes in performance and to help ensure that performance is viewed in context.	Without adequate baseline data, goals may not permit subsequent comparison with actual performance.
Core program activities	Measures cover the activities that an entity is expected to perform to support the intent of the program.	Information available to managers and stakeholders in core program areas may be insufficient.
Limited overlap	Measure should provide new information beyond that provided by other measures.	Managers may have to sort through redundant, costly information that does not add value.
Balance	Taken together, measures ensure that an organization's various priorities are covered.	Measures may over emphasize some goals and skew incentives.
Government-wide priorities	Each measure should cover a priority, such as quality, timeliness, and cost of service.	A program's overall success is at risk if all priorities are not addressed.

Source: GAO. | GAO-15-759

DOD provided us performance measures for the DHA shared services in April 2015. To assess the extent of their development, we compared the performance measures with the ten key attributes of successful performance measures. The results of our analysis are depicted in table 2.

Table 2: Analysis of Extent to Which Performance Measures of Defense Health Agency's (DHA) Shared Services Align with Key Attributes as of April 2015

Shared service and product line (if applicable)	Linkage	Clarity	Measurable target	Objectivity	Reliability	Baseline and trend data	Core program activity	Limited overlap	Balance	Government-wide priority
TRICARE Health Plan	Yes	Partially	Yes	Partially	Partially	Partially	Yes	Yes	Yes	Partially
Pharmacy	Yes	Yes	Partially	Yes	Yes	Partially	Partially	Yes	Yes	Yes
Medical Research, Development, and Acquisition	Yes	Yes	Partially	Yes	Partially	Partially	Partially	Yes	Partially	Yes
Facility Planning: Achieve Enterprise Asset Visibility	Yes	Yes	Partially	Yes	Partially	Partially	Yes	Yes	Yes	Yes
Facility Planning: Standardize Support Processes	Yes	Yes	Yes	Yes	Partially	Yes	No	Yes	No	Partially
Facility Planning: Standardize Requirements Planning	Yes	Yes	Yes	Yes	Yes	Partially	Partially	Yes	No	Partially
Facility Planning: Standardize Design Construction, Initial Outfitting and Training	Yes	Yes	Partially	Partially	Partially	Partially	No	Partially	No	Partially
Health Information Technology	Yes	Yes	Partially	Yes	Yes	Partially	Partially	Yes	Yes	Yes
Medical Logistics: Supply Management (MEDSURG)	Yes	Yes	Yes	Yes	Yes	Yes	Partially	Yes	Yes	Yes
Medical Logistics: Health Care Technology	Yes	Yes	Yes	Yes	Partially	Partially	Yes	Yes	Yes	Yes

Shared service and product line (if applicable)	Linkage	Clarity	Measurable target	Objectivity	Reliability	Baseline and trend data	Core program activity	Limited overlap	Balance	Government-wide priority
Medical Logistics: MEDLOG Services (Housekeeping)	Yes	Yes	Partially	Partially	Partially	Partially	Partially	Yes	Partially	Partially
Budget and Resource Management: Implementation of Common Cost Accounting Structure	Yes	Partially	Yes	Yes	Partially	No	Yes	Partially	Partially	Yes
Budget and Resource Management: Medical Coding Program Office	Yes	Partially	Yes	Yes	Yes	Yes	Partially	Yes	Yes	Yes
Budget and Resource Management: Joint Billing Solution (Post-ABACUS)	Yes	Partially	No	Partially	Yes	No	Partially	Yes	Yes	Yes
Contracting and Procurement: Contract Execution, Management, and Administration	Yes	Yes	Partially	Partially	No	No	Partially	Yes	No	Partially
Contracting and Procurement: Acquisition Planning and Program Management	Yes	No	Partially	No	No	No	Partially	Yes	No	Partially
Medical Education and Training [Note A]	Yes	Yes	Yes	Yes	Yes	Partially	Partially	Yes	Partially	Partially
Public Health: Deployment Health	Yes	Yes	Partially	Yes	Partially	No	Partially	Yes	Partially	Yes

Shared service and product line (if applicable)	Linkage	Clarity	Measurable target	Objectivity	Reliability	Baseline and trend data	Core program activity	Limited overlap	Balance	Government-wide priority
Public Health: Immunization Healthcare [Note B]	No	No	No	No	No	No	No	No	No	No
Public Health: Veterinary Services [Note B]	No	No	No	No	No	No	No	No	No	No

Source: GAO analysis of DOD information. | GAO-15-759

Legend: We scored a rating as “addressed” (“Yes”) if all the metrics for a particular shared service or product line met the relevant key attribute definition; “partially addressed” (“Partially”) if some, but not all, of the metrics met the relevant key attribute definition; and “not addressed” (“No”) if none of the metrics met the relevant key attribute definition. As noted previously, not all shared services are subdivided into product lines.

Note A: The Medical Education and Training shared service consists of three product lines: (1) Professional Development, Sustainment, and Program Management; (2) Academic Review and Policy Oversight; and (3) Administrative Support Functions. However, the initial measures for this shared service were not aligned by these product lines. Instead, they were aligned by overall shared service deliverables.

Note B: While these product lines were integrated into the Public Health shared service at initial operating capability on September 30, 2014, the respective business case analysis and business process reengineering plans were not conducted. No metrics had been developed for these areas as of April 24, 2015; thus, we were unable to assess performance measures for these product lines. A fourth product line, Health Surveillance, is pending transfer to the Defense Health Agency in July 2015. As such, we did not review measures for that product line, either.

Since our November 2013 review, DHA has made progress in developing performance measures to assess its shared services. Specifically, all ten shared services have measures that demonstrate at least some of these attributes; however, collectively, they do not demonstrate all of the attributes, as we had previously recommended. In our analysis of the ten shared services and their associated product lines, we made the following observations:

- *Linkage.* We found that the measures for all of the shared service product lines we assessed addressed the attribute of linkage. A measure demonstrates linkage when it is aligned with division and agency-wide goals and mission and is clearly communicated throughout the organization. DHA officials have communicated the shared service performance measures throughout the organization through the 2013 implementation plan submissions and through regular updates to leadership and all the measures were aligned with shared service goals as defined in those submissions and updates.

-
- *Clarity.* We found that the measures for 13 of the 18 shared service product lines we assessed addressed the attribute of clarity, while 4 partially demonstrated this attribute, and 1 did not address clarity. A measure achieves clarity when it is clearly stated and the name and definition are consistent with the methodology used for calculating the measure. For instance, we found that although the name and definitions for both measures under the Contracting and Procurement shared service Acquisition Planning and Program Management product line were consistent and clearly stated, the methodology for those measures was under review, preventing a comparison of the names and definitions with the methodology. We have previously reported that a measure that is not clearly stated can confuse users and cause managers or other stakeholders to think that performance was better or worse than it actually was.
 - *Measurable Target.* We found that the measures for 8 of the 18 shared service product lines we assessed addressed the attribute of measurable targets, while 9 partially demonstrated this attribute, and 1 did not have measurable targets. Where appropriate, performance goals and measures should have quantifiable, numerical targets or other measurable values. Some of DOD's measures, however, lacked such targets. For instance, DHA officials within the Joint Billing Solution product line of the Budget and Resource Management shared service have proposed 10 measures, such as "Billing Turnaround" or "Revenue Collected" for various functions, but none of these measures had targets.
 - *Objectivity.* We found that the measures for 12 of the 18 shared service product lines we assessed addressed the attribute of objectivity, while 5 partially demonstrated this attribute, and 1 did not address objectivity. We have previously reported that to be objective, measures should indicate specifically what is to be observed, in which population or conditions, and in what time frame, and be free of opinion and judgment. However, for instance, within the MEDLOG Services (Housekeeping) product line of the Medical Logistics shared service, one of the measures is "Frequency of Complaints," but it is not specific as to how complaints will be evaluated or remedied, or what the comparison standard or criteria is for assessing the measure.
 - *Reliability.* We found that the measures for 7 of the 18 shared service product lines we assessed addressed the attribute of reliability, while 9 partially demonstrated this attribute, and 2 did not address reliability. Reliability refers to whether a measure is designed to collect data or

calculate results such that the measure would be likely to produce the same results if applied repeatedly to the same situation. We have previously reported that if errors occur in the collection of data or the calculation of their results, it may affect conclusions about the extent to which performance goals have been achieved. Officials provided information indicating specific data quality control processes for several measures, such as the frequency of when data are reviewed and whether the reviews are automated or done manually; however, other measures we reviewed did not have any data quality control processes specified or those processes were still in development. For instance, within the Budget and Resource Management shared service, officials indicated that a technical solutions working group had been established to assess the data needs and to determine applicable data quality control processes for each of the product line performance measures, but did not indicate whether any quality control processes had been developed.

- *Baseline and Trend Data.* We found that 3 of the 18 shared service product lines we assessed had baselines for each of their measures, addressing this attribute, while 10 had baselines for only some of their measures, and 5 did not have baselines for any of their measures. Several measures that did not have baselines had expected dates by when the baselines would be available. For instance, the baselines for all of the metrics within the Contracting and Procurement shared service were in the process of being re-established, but officials anticipated that these baselines would be developed between fiscal year 2018 and fiscal year 2019. Without adequate baseline data, goals may not permit subsequent comparison with actual performance or allow determination of whether net savings have been achieved.
- *Core Program Activities.* We found that the measures for 4 of the 18 shared service product lines we assessed addressed the attribute of core program activities, while 12 partially demonstrated this attribute, and 2 did not address core program activities. Several of the sets of measures did not address all program activities that would be expected based on the descriptions of the shared services provided by DOD in its 2013 submissions to Congress. For example, within the Supply Management product line of the Medical Logistics shared service, the two proposed measures were “Use of Standardized Items” and “Use of eCommerce by All Enterprise.” These measures align with the stated product line objective to “increase usage of standardized consumable supplies across the services.” However, another product line objective is to “increase visibility and controls on purchase card usage and other local contracts,” which did not appear

to be addressed by the proposed measures. We have previously reported that core program activities are the activities that an entity is expected to perform to support the intent of the program, and that performance measures should be scoped to evaluate those activities.

- *Limited Overlap.* We found that the measures for 16 shared service projects we reviewed demonstrated limited overlap, while 2 had the potential for overlap. We have reported that each performance measure in a set should provide additional information beyond that provided by other measures. We found that, within the various product lines of the Budget and Resource Management shared service, the potential for overlap existed because the definitions were unclear as to whether they would provide new information. Specifically, two of the measures are “Percent of transactions including valid Budget Activity, Budget Sub Activity, and Budget Line Item data” and “Percent of transactions captured” in both legacy and up-to-date systems that “include valid Budget Activity, Budget Sub Activity and Budget Line Item data.” As written, it was unclear whether data for the legacy and up-to-date systems are captured in both measures. When an agency has overlapping measures, it can create unnecessary or duplicate information, which does not benefit program management.
- *Balance.* We found that the measures for 8 of the 18 shared service product lines we assessed addressed the attribute of balance, while 5 partially demonstrated this attribute, and 5 did not address balance. We have previously reported that balance exists when a set of measures ensures that an organization’s various priorities are covered. Some of the sets of measures are not balanced. For instance, the measures we reviewed for the Contracting and Procurement shared service were only focused on cost savings attributed to the product line initiatives, but they did not address other program activities, such as variation reduction, redundancy elimination, and ensuring the timely completion of contractor performance evaluations. Officials explained that the initial metrics focused on savings, but they plan to develop and track other metrics after initial operating capability in a phased approach. Performance measurement efforts that lack balance overemphasize certain aspects of performance at the expense of others, and may keep DOD from understanding the effectiveness of its overall mission and goals.
- *Government-wide Priorities.* We found that the measures for 10 of the 18 shared service product lines we assessed addressed the attribute of government-wide priorities, while 8 partially demonstrated this attribute. We have previously reported that agencies should develop a

range of related performance measures to address government-wide priorities, such as quality, timeliness, efficiency, cost of service, and outcome. For instance, within the Medical Logistics shared service, the MEDLOG Services (Housekeeping) product line has a measure “Cost per Square Foot,” which addresses cost. Shared service officials are also developing a measure that would address “Frequency of Complaints,” which will address quality of service when completed. When measures do not cover government-wide priorities managers may not be able to balance priorities to ensure the overall success of the program.

A senior DHA official noted that the development of metrics for the DHA shared services continues as a work in progress, with the more mature shared services having made more progress on their specific measures, and further noted that officials are continuing to evolve these measures through the shared services work groups. DOD implemented the ten DHA shared services in a phased approach between October 1, 2013, and September 30, 2014.⁴⁹

We found that the maturity of the shared services’ metrics is determined in part by the date they reached initial operating capability and also by the extent to which those services were already consolidated prior to incorporation into the DHA:

- *Already Joint Areas:* According to DOD, 3 of the 10 shared services represent areas that were already joint efforts prior to DHA. These shared services had either previously been executed by the former TRICARE Management Activity, including the TRICARE Health Plan and the Pharmacy shared services, or were led by a single service and managed through a series of joint program committees, such as the Medical Research and Development shared service. According to DOD, these shared services required the development of new measures related to their respective business process reengineering

⁴⁹ Five shared services reached initial operating capability on October 1, 2013: Facility Planning, Medical Logistics, Health Information Technology, TRICARE Health Plan, and Pharmacy. The five remaining shared services reached their respective initial operating capability dates throughout 2014: Budget and Resource Management on February 1, 2014; Contracting and Procurement on March 1, 2014; Medical Research and Development on June 1, 2014; Medical Education and Training on August 10, 2014; and Public Health on September 30, 2014.

plan initiatives and improvements to be developed and included in an enterprise-level “dashboard” set of metrics.

- *Newly Consolidated Areas with Mature Measurement Capabilities:* According to DOD, 5 of the 10 shared services already had mature measurement capabilities within their respective communities prior to their incorporation as a shared service into the DHA and required the development of some enterprise-wide standard measures to be included in enhanced dashboards. The shared services in this category include Facility Planning, Medical Logistics, Health Information Technology, Budget and Resource Management, and Contracting and Procurement.
- *Newly Consolidated Areas without Mature Measurement Capabilities:* The final two shared services to reach initial operating capability, Medical Education and Training and Public Health, are newly consolidated areas that did not have mature measurement capabilities prior to incorporation into DHA. Within both of these shared services, DOD developed preliminary metrics prior to initial operating capability to aid leadership, with continued development and implementation of measures to occur after initial operating capability. As the least mature shared services, we identified the following issues with the performance measures in these areas:
 - DHA officials told us that the Medical Education and Training shared service represents the first instance of Office of the Secretary of Defense-level oversight in that area, and initial performance measures in this area were not developed until April 2015. While we found that the measures address six of the attributes and partially address four attributes, as noted previously, the Education and Training shared service overlaps with other shared services, including Health Information Technology and Contracting and Procurement, and does not directly address the consolidation of education programs. For instance, four of the five measures address cost savings related to the implementation of a single learning management system across the MHS, savings for which are being applied within the Health Information Technology shared service. Additionally, as we reported in July 2014,⁵⁰ the Medical Education and Training

⁵⁰GAO-14-630.

shared service consists of three product lines, involving: (1) management of professional development, sustainment, and related programs; (2) academic review and policy oversight functions, including management of online courses and modeling and simulation programs; and (3) management of academic and administrative support functions. However, the initial measures provided by DOD were not aligned by product line, but by overall shared service deliverables. Out of twelve proposed deliverables, the measures only addressed two.

- Within Public Health, officials told us that deployment health data elements and reporting requirements were standardized prior to initial operating capability; however, the services varied in how they captured and exported the data. For example, the Deployment Health product line has several measures for assessing the percentage of the total force that is medically ready; however, these metrics are tracked and reported at the service level. While officials noted that a working group including the three military services developed these metrics, the services may differ in how they collect the data. Further, officials have not yet developed joint metrics to assess their progress in meeting the goals of the shared service. Shared service officials have begun to develop additional metrics, such as “Business Process Reengineering Savings Achieved” and “Completion of Periodic Health Assessments”; however these metrics do not yet have enough information to determine the extent to which they address the key attributes and officials do not anticipate completing these metrics until September 2015 and March 2016 respectively. Further, Public Health officials have not yet conducted business case analyses and business process reengineering plans for the remaining Public Health product lines, precluding the development of metrics for those areas; however, officials have developed a timeline outlining their plans to conduct each of these assessments.

DOD’s further development of performance measures for the ten DHA shared service projects shows progress toward addressing our prior recommendation—to develop and present to Congress performance measures that fully exhibit those key attributes identified in our prior work. However, because these measures continue to lack key elements that can contribute to success in assessing performance, we continue to believe that our prior recommendation is still valid and should be completely implemented for all the objectives of the MHS reform. DOD officials have stated, among other criteria, the shared services will be

considered to have reached full operating capability when they have developed performance measures to help manage actions, report progress, identify gaps, and identify areas for improvement. By developing measures that reflect these attributes, DOD can help ensure that decision makers have information needed to assess the DHA shared services' efforts and to measure progress toward achieving their stated goals and whether, as part of DOD's overall medical governance reform effort, they are on track to achieve desired results.

Conclusions

In general, DOD has made progress in addressing concerns we highlighted in our two most recent reviews of its implementation process for the DHA. However, while the DHA plans to reach its formal full operating capability in October 2015, some issues will remain unresolved into late 2016. As such, the DHA may not be fully operational in practical terms until it definitively addresses these issues. As the personnel requirements assessment process for the DHA moves forward, it does so without a detailed timeline, a clear understanding of the size and scope of the DHA's mission, a lack of a baseline to measure against, and the status of responsibility for military personnel. Further, the DHA has made significant improvements to its approach to achieving cost savings through shared services. In general, the DHA's approach provides more detail, recognizes the impact of changing events, and reflects a review of investments for eight of ten of the shared services. However, the DHA has not sufficiently explained the role of its public health and medical education and training shared services, as these do not currently reflect the primary goal of achieving cost savings through consolidation.

Finally, while the DHA has made improvements to its performance measures for shared services, some aspects of these metrics are still evolving, and our analysis identified a number of instances where DHA's measures do not contain key attributes of successful performance measures. As we noted in our February 2014 testimony, the successful implementation of the DHA will require committed senior leadership to sustain the momentum created by the current reform effort. However, senior leaders need appropriate information to make decisions and guide the reform. Given that the DHA's evolution will continue far beyond its formal full operating capability, DOD leaders will need to continue to strengthen their framework for managing this major reform to the MHS with attention to these areas.

Recommendations for Executive Action

To provide decision makers with appropriate and more complete information on the continuing implementation, management, and oversight of the DHA, we recommend that the Secretary of Defense direct the Assistant Secretary of Defense (Health Affairs) to take the following five actions:

- Develop a timeline for completion of the personnel requirements assessment that includes milestones and interim steps;
- 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 workforce composition through the determination of the final status of military personnel within the DHA;
- Develop a plan for reassessing and revalidating personnel requirements as the missions and needs of the DHA evolve over time;
- Develop information concerning the number and cost of administrative and headquarters personnel within the MHS and provide this information as an annual exhibit in the President's budget; and
- Determine the future of the Public Health and Medical Education and Training shared services by either identifying common functions to consolidate to achieve cost savings or by developing a justification for the transfer of these functions from the military services to the DHA that is not premised on cost savings.

Agency Comments and Our Evaluation

In written comments provided in response to our draft report, DOD concurred with four of our five recommendations and partially concurred with a fifth. DOD's written comments are reprinted in appendix II of this report.

In concurring with our recommendation that DOD develop a timeline for completion of the personnel requirements assessment that includes milestones and interim steps, DOD stated that it had developed a project plan to track progress in this area. This action is a positive development in DOD's progress toward developing staffing requirements for the DHA. At the time of our review, DOD provided a timeline with tentative dates for completion of personnel requirements assessments for parts of the DHA. In its response, DOD provided scheduled completion dates for assessments of the National Capital Region Medical Directorate, DHA Special Staff, Medical Education and Training Directorate, and the Research, Development and Acquisition Directorate. However, as of June 2015, assessment dates for these divisions, with the exception of the

DHA Special Staff, were listed as “To Be Determined.” In addition, DOD’s response does not address one of the DHA’s divisions, Defense Health Agency Support, which was similarly listed as “To Be Determined” in DOD’s initial timeline. Establishing a milestone for this division, along with the milestones set for the other DHA divisions, will help DOD to complete its assessment of staffing requirements. DOD’s response states that it will complete this assessment by the end of fiscal year 2016.

DOD concurred with our recommendation to develop a comprehensive requirements assessment process that accounts for needed future skills through consideration of potential organizational changes and helps ensure appropriate consideration of workforce composition, through determination of the final status of military personnel within the DHA. DOD stated that it had drafted a “desktop reference” document to guide this process. We noted in our report that as of July 2015, DOD stated that this document had not yet been fully developed. In its comments, DOD stated that this document was still not yet finalized, but that it had implemented the associated processes. We look forward to the finalization of this document and are encouraged that DOD stated it will take into account the current and future needs of the agency, including required skills and workforce mix.

DOD partially concurred with our recommendation that it develop a plan for reassessing and revalidating personnel requirements as the missions and needs of the DHA evolve over time. In its response, DOD stated that it had issued temporary guidance, expiring in January 2016, which established processes for manpower and organization changes to the DHA. However, as discussed in our report, this guidance does not specifically address the need for a plan to reassess and revalidate personnel requirements on a regular, recurring basis. Therefore, we continue to believe that our recommendation is valid. Further, DOD noted in its comments that it concurs that an Administrative Instruction detailing the ongoing process for personnel requirements determination and management within the DHA should be formalized before the current guidance expires.

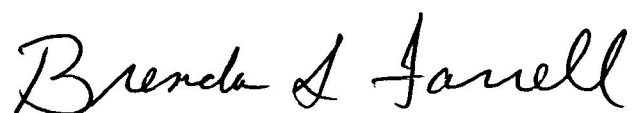
In concurring with our recommendation that DOD develop information concerning the number and cost of administrative and headquarters personnel within the MHS and provide this information as an annual exhibit in the President’s budget, DOD stated that such an effort is currently underway as part of a larger DOD initiative to better define and account for management headquarters functions. However, DOD noted that it does not agree with the inclusion of administrative personnel in this

assessment given the lack of a department-wide definition of what constitutes such personnel. For purposes of this report, we have defined administrative personnel to include those other than headquarters personnel who are assigned to MHS organizations, including the DHA, that do not directly provide health care services within DOD military treatment facilities. This includes personnel performing DHA shared services activities. We believe the inclusion of administrative personnel as defined in this report is crucial to accurately determining the number and cost of personnel serving within MHS. As a result, we continue to recommend that DOD include the number and costs of administrative personnel in combination with similar information on headquarters personnel within the MHS.

DOD concurred with our recommendation that it determine the future of the Public Health and Medical Education and Training shared services by either identifying common functions to consolidate to achieve cost savings or develop a justification for the transfer of these functions from the military services to the DHA that is not premised on cost savings. In its response, DOD stated that it plans to revisit the application of the business case analysis process to this shared service, including the development of a “recommended future state.” Further, DOD stated that it plans to employ its governance process to resolve issues related to responsibilities and authorities within its Medical Education and Training shared service to identify opportunities to reduce and eliminate redundancies in this area. DOD also highlighted the status of its “eLearning” and Modeling and Simulation product lines. We are encouraged by the steps outlined in DOD’s response. However, as we noted in our report, these product lines significantly overlap with the Health Information Technology and Contracting and Procurement shared services, with some associated costs and cost savings attributed to these shared services. As a result, the reason for creating this shared service remains unclear.

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

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

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

Brenda S. Farrell
Director
Defense Capabilities and Management

Appendix I: History of Military Health System Governance Reform and Our Related Work

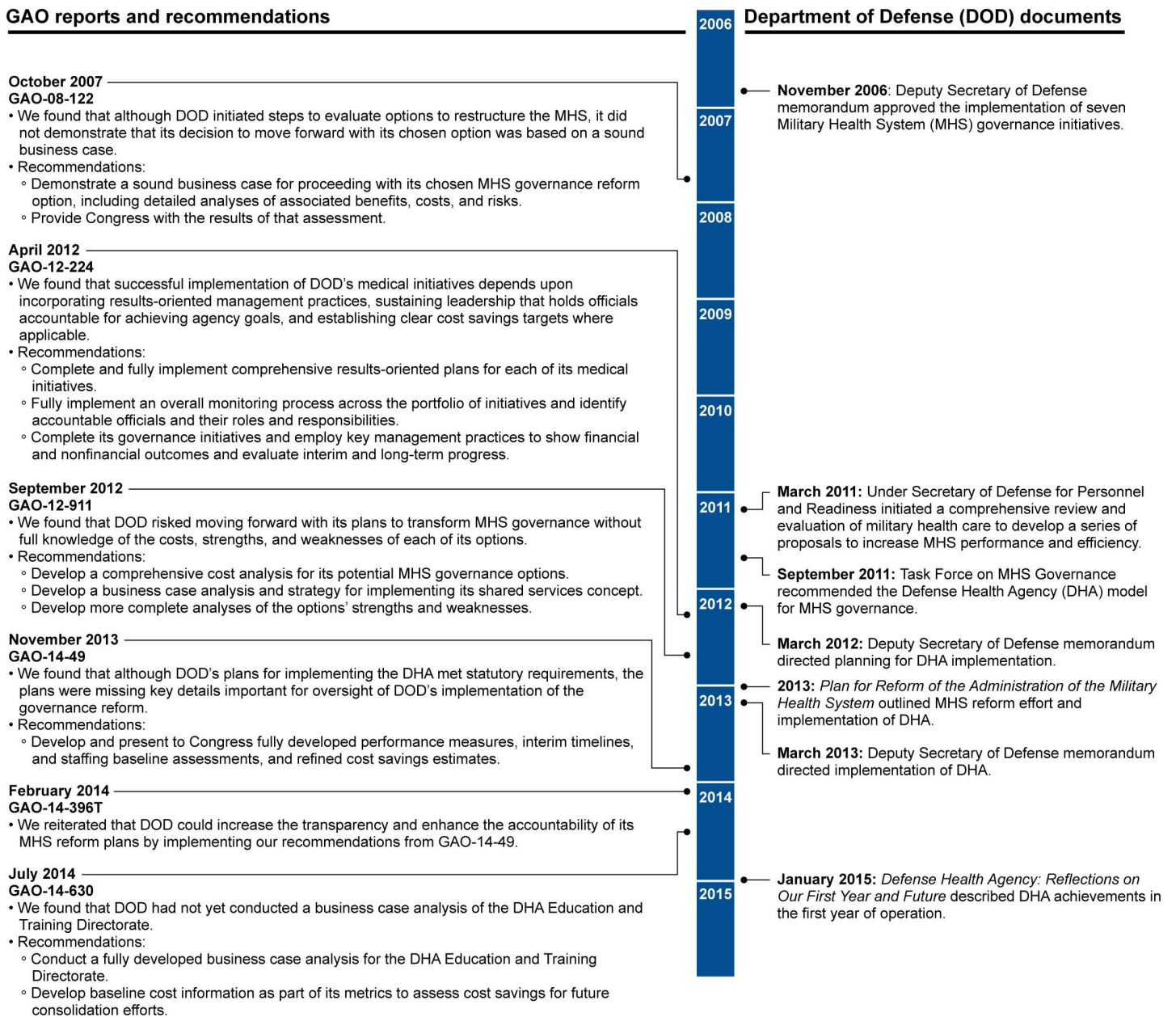
For many years, we and other organizations have highlighted long-standing issues surrounding the Department of Defense's (DOD) Military Health System (MHS) and DOD's efforts to reorganize its governance structure. Over the years, many efforts to control the increase in health care costs led to a long series of studies to address the governance structure of the MHS and to recommend major organizational realignments. Recently, as a result of the report of the 2011 Task Force on Military Health System Governance, the department began implementation planning for the creation of a new Defense Health Agency (DHA). Subsequently, the National Defense Authorization Act for Fiscal Year 2013 required DOD to submit its plans for implementing its reform effort in three submissions—the first in March 2013, the second in June 2013, and the third in September 2013—and mandated that GAO review DOD's first two submissions.¹

We examined the March and June 2013 submissions as well as an August 2013 supplemental report to Congress of DOD's plan to implement the reform effort and reported the results in November 2013. In February 2014, we examined DOD's third and final reform plan, which was submitted to Congress in November 2013.² In reviewing the submissions, we identified several areas in DOD's implementation plan where sustained senior leadership attention is needed to help ensure the reform achieves its goals including determining personnel requirements, clarifying cost estimates, and fully developing performance measures. DHA officially began operations in October 2013 and DOD anticipates that the organization will be fully operational in October 2015. See figure 4 for a timeline of our work related to DOD's MHS governance reform and key DOD documents.

¹National Defense Authorization Act for Fiscal Year 2013, Pub. L. No. 112-239, § 731 (2013).

² This submission was due in September 2013, but was not provided to Congress until November 2013.

Figure 4: Timeline of GAO Work Related to Military Health System Governance from 2007 to 2015 and Key DOD Documents



Source: GAO analysis of GAO and DOD information. | GAO-15-759

For more detailed information on our past recommendations to DOD on MHS governance issues and the status of DOD’s implementation of them, see table 3.

Table 3: Status of the Department of Defense’s (DOD) Implementation of Our Recommendations Related to Military Health System (MHS) Governance Reform

Recommendation (report number)	Status of recommendation/action taken
<p>Demonstrate a sound business case for proceeding with DOD’s chosen MHS governance reform option, including detailed analyses of associated benefits, costs, and risks. (GAO-08-122)</p>	<p>Action closed – not implemented</p> <p>While DOD concurred with our recommendation, stating that an implementation team will conduct comprehensive planning to include an assessment of implications for doctrine, organization, training, material, leadership, personnel, and facilities, no implementation team was ever formed. Due to other governance studies that have taken place in the meantime, DOD is moving forward with other options, so this recommendation has been overtaken by events and is not applicable anymore.</p>
<p>Provide Congress with the results of the assessment of the business case for proceeding with DOD’s chosen option. (GAO-08-122)</p>	<p>Action closed –not implemented</p> <p>While DOD concurred with our recommendation, stating that Congress will be provided with the results of the analysis, the analysis has not been conducted and DOD does not intend to conduct an analysis. Due to other governance studies that have taken place in the meantime, DOD is moving forward with other options, so this recommendation has been overtaken by events and is not applicable anymore.</p>
<p>Establish and monitor outcome-focused performance measures to help guide the transformation. (GAO-08-122)</p>	<p>Action closed – not implemented</p> <p>While DOD concurred with our recommendation, noting that it will implement specific outcome-focused performance measures. However, DOD is moving forward with other options, so this recommendation has been overtaken by events and is not applicable anymore.</p>
<p>Complete and fully implement the dashboards^a and detailed implementation plans for each of the approved health care initiatives in a manner consistent with results-oriented management practices, such as the inclusion of upfront investment costs and cost savings estimates. (GAO-12-243SP)</p>	<p>Partially addressed</p> <p>As of March 2015, DOD has taken steps to develop plans that incorporate desired characteristics of results-oriented management practices for each of its 11 health initiatives, as we recommended in April 2012, but has not yet completed this process. In light of the establishment of the Defense Health Agency (DHA) in October 2013, DOD identified a link from each of the 11 initiatives to the new agency’s seven objectives and identified an organization within the DHA responsible for oversight of each initiative. In response to a congressional mandate, DOD presented a plan for implementing the seven objectives of the DHA. However, in November 2013, we found that DOD’s plan for implementation of the DHA did not fully incorporate several key management practices, including attributes of successful performance measures such as measurable targets and baseline data. In addition, DOD did not provide separate cost estimates for the product lines of each shared service, obscuring the size and cost of each business line’s planned efficiencies. In our ongoing review of the implementation of DHA, we plan to assess DOD’s progress in addressing these and other concerns with the implementation of the DHA’s seven objectives. Without fully developing performance metrics and cost estimates, decision makers will continue to lack key information for assessing the status and progress of DOD’s efforts to reform its health system.</p>

**Appendix I: History of Military Health System
Governance Reform and Our Related Work**

Recommendation (report number)	Status of recommendation/action taken
Complete the implementation of an overall monitoring process across DOD's portfolio of initiatives for overseeing the initiatives' progress and identifying accountable officials and their roles and responsibilities for all of DOD's initiatives. (GAO-12-243SP)	Addressed DOD completed the implementation of its overall monitoring process of its health care initiatives consistent with our April 2012 recommendation by identifying accountable officials and their roles and responsibilities and approving a standardized process that implements an 11-step project plan.
Complete and fully implement comprehensive, results-oriented plans for each of DOD's medical initiatives. (GAO-12-224)	Open As of September 2014, DOD had not fully completed or implemented plans that incorporate desired characteristics of results-oriented management practices for each of its 11 initiatives
Fully implement an overall monitoring process across the portfolio of initiatives and identify accountable officials and their roles and responsibilities. (GAO-12-224)	Addressed DOD completed the implementation of its overall monitoring process of its health care initiatives consistent with our April 2012 recommendation by identifying accountable officials and their roles and responsibilities and approving a standardized process that implements an 11-step project plan.
Complete DOD's governance initiatives and employ key management practices to show financial and nonfinancial outcomes and evaluate interim and long-term progress. (GAO-12-224)	Open DOD established the Defense Health Agency (DHA) on October 1, 2013. As part of its implementation plan, DOD developed seven objectives for the DHA, including several of the governance initiatives underway at the time of our prior review. In November 2013, we reviewed DOD's plan and recommended additional details that would increase the transparency of and improve the implementation process.
Develop a comprehensive cost analysis for DOD's potential MHS governance options. (GAO-12-911)	Action closed – not implemented DOD disagreed with our recommendation to perform a more detailed and comprehensive cost analysis of the various potential MHS governance structures studied by the Task Force on Military Health System Governance. The department stated that it did not believe that doing so would be prudent because it had definitively decided on which governance structure to pursue, and that re-directing their efforts to further analyze various other potential governance structures would delay the department from implementing reforms in the short term.
Develop a business case analysis and strategy for implementing DOD's shared services concept. (GAO-12-911)	Open According to the National Defense Authorization Act for Fiscal Year 2013, Congress directed DOD to submit implementation plans that detailed the timelines, the purpose, the scope of responsibilities, the cost to implement, and the anticipated savings with respect to the shared services that it was going to implement during fiscal years 2013 and 2014. To support these details, DOD is in the process of developing business case analyses for each of the ten shared services that it has identified for implementation.
Develop more complete analyses of the options' strengths and weaknesses. (GAO-12-911)	Action closed –not implemented DOD officials have not taken action related to this recommendation and according to their official response to our report, DOD does not intend to continue to study options for potential transformation efforts. DOD is highly unlikely to address this issue since a decision has been made to move forward with the DHA.
Develop and present to Congress performance measures that are clear, quantifiable, objective, and include a baseline assessment of current performance. (GAO-14-49)	Open In the House Report accompanying the National Defense Authorization Act for Fiscal Year 2015, the Committee directed DOD to submit a report to both the Senate and House Armed Services Committees by January 31, 2015, containing a status report of how DOD is addressing this specific recommendation. DOD has not yet issued this report. Until that report is issued, this recommendation should remain open.

**Appendix I: History of Military Health System
Governance Reform and Our Related Work**

Recommendation (report number)	Status of recommendation/action taken
Develop and present to Congress a comprehensive timeline that includes interim milestones for all reform goals that could be used to show implementation progress. (GAO-14-49)	Open As part of an ongoing review, we are assessing DOD's development of comprehensive timelines and interim milestones to measure implementation progress. Until our review is completed, this recommendation will remain open.
Provide Congress with a more thorough explanation of the potential sources of cost savings from the implementation of DOD's shared services projects. (GAO-14-49)	Open In the House Report accompanying the National Defense Authorization Act for Fiscal Year 2015, the Committee directed DOD to submit a report to both the Senate and House Armed Services Committees by January 31, 2015 containing a status report of how DOD is addressing this specific recommendation. DOD has not yet issued this report. Until that report is issued and assessed, this recommendation should remain open.
Monitor implementation costs to assess whether the shared services projects are on track to achieve projected net cost savings or if corrective actions are needed. (GAO-14-49)	Open As part of an ongoing review, we are assessing DOD's ability to monitor costs and what, if any, savings have been achieved. Until our review is completed, this recommendation will remain open.
Develop and present to Congress a baseline assessment of the current number of military, civilian, and contractor personnel currently working within the MHS headquarters and an estimate for DHA at full operating capability, including estimates of changes in contractor full-time equivalents. (GAO-14-49)	Open In the House Report accompanying the National Defense Authorization Act for Fiscal Year 2015, the Committee directed DOD to submit a report to both the Senate and House Armed Services Committees by January 31, 2015, containing a status report of how DOD is addressing this specific recommendation. DOD has not yet issued this report. Until that report is issued and assessed, this recommendation will remain open.
Conduct a fully developed business case analysis for the DHA Education and Training Directorate. (GAO-14-630)	Open In a September 2014 letter, the Assistant Secretary of Defense for Health Affairs stated that baseline costing? would be a key component of the Medical Education and Training Directorate's strategic plan and would be presented in the form of a "deliverable" in moving forward to the Directorate's final operating capability. The letter also noted that an inventory of all education and training products and services within the MHS will be undertaken shortly, and that this had never been accomplished before. However, the letter did not specifically address the development of metrics to assess achievement of any cost savings as we recommended.
Develop baseline cost information as part of its metrics to assess cost savings for future consolidation efforts. (GAO-14-630)	Open According to a September 2014 letter from the Assistant Secretary of Defense for Health Affairs, the completion of a business case analysis will be a key component of the Directorate's strategic plan and will be presented in the form of a "deliverable" to achieve its final operating capability scheduled for not later than October 1, 2015. The letter did not specifically identify the cost-related problem that DOD seeks to address by establishing the Directorate nor did it specifically state if this would be addressed in its business case analysis under development as we recommended.

Source: GAO analysis. | GAO-15-759

^aDOD developed a series of "dashboards" for these projects, a management tool consisting of a collection of relevant metrics.

Appendix II: Comments from the Department of Defense



THE ASSISTANT SECRETARY OF DEFENSE

1200 DEFENSE PENTAGON
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

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

AUG 21 2015

Dear Ms. Farrell:

This is the Department of Defense (DoD) response to the GAO Draft Report, GAO-15-759, "DEFENSE HEALTH CARE REFORM: Actions Needed to Help Ensure Defense Health Agency Maintains Implementation Progress," (GAO-15-759), dated July 27, 2015, (GAO Code 351956). Thank you for the opportunity to review the GAO #351956 Draft Report. I have offered some comments to support each of the recommendations (Enclosed). In addition, I would like to thank you and your analysts for working with us over the last two years to develop a business case analysis approach for the shared services that is now considered a best practice. I appreciate your willingness to be a part of the solution in the Defense Health Agency (DHA) implementation.

As you know, building and shaping the DHA, while simultaneously managing it, has been challenging. Fostering a joint culture and assessing the manpower requirements within the DHA requires a great deal of information gathering and assessment. I am pleased to report our progress in validating manpower requirements and planning for future skills as our mission evolves over time. We are shaping a culture in which all uniformed Service and civilian staff are working toward the same goal. This is most evident in the shared services where shared solutions are allowing the DHA to become more effective, efficient, and integrated. We agree with your recommendations and remain focused on common functions to consolidate under Medical Education and Training and Public Health.

My points of contact are Dr. Michael Dinneen (Functional) and Mr. Gunther Zimmerman. Dr. Dinneen may be reached at (703) 681-1712 or Michael.p.dinneen.civ@mail.mil. Mr. Gunther Zimmerman (Audit Liaison) may be reached at (703) 681-4360, or Gunther.j.zimmerman.civ@mail.mil. Thank you for your interest in the health and well-being of our Service members, veterans and their families.

Sincerely,

A handwritten signature in black ink, appearing to read "Jonathan Woodson".

Jonathan Woodson, M.D.

Enclosure:
As stated

GAO DRAFT REPORT DATED JULY 27 2015
GAO-15-759 (GAO CODE 351956)

**“DEFENSE HEALTH CARE REFORM: ACTIONS NEEDED TO HELP ENSURE
DEFENSE HEALTH AGENCY MAINTAINS IMPLEMENTATION PROGRESS”**

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

To provide decision makers with appropriate and more complete information on the continuing implementation, management, and oversight of the Defense Health Agency (DHA), we recommend that the Secretary of Defense direct the Assistant Secretary of Defense (Health Affairs) to take the following five actions:

RECOMMENDATION 1: Develop a timeline for completion of the personnel requirements assessment that includes milestones and interim steps.

DOD RESPONSE: I concur with the recommendation to provide a detailed timeline for the completion of the manpower requirements assessment that includes critical steps for completion of the DHA manpower requirements baseline.

DHA leadership has tasked the Manpower and Organization (M&O) Division, which was formally established in July of 2014, to complete a manpower requirements baseline for the DHA by the end of Fiscal Year 2016. M&O has created a project plan to track progress on this critical task. To date, M&O has completed baseline manpower assessments for 100 percent of the Healthcare Operations Directorate. Assessments of the Business Support and Health Information Technology (HIT) Directorates are ongoing, with scheduled completion dates of January and March 2016, respectively. Assessment of the National Capital Region (NCR) Medical Directorate is scheduled to be complete in April 2016, followed by the DHA Special Staff in May of 2016, the Education and Training Directorate in July 2016, and the Research, Development and Acquisition Directorate (RDA) completing the baselining effort in September 2016.

RECOMMENDATION 2: Develop a comprehensive approach to the requirements assessment that accounts for needed future skills through consideration of potential organizational changes and helps ensure appropriate consideration of workforce composition, through determination of the final status of military personnel within the DHA.

DOD RESPONSE: I concur with the request to develop a comprehensive approach to manpower requirements determination for the DHA. The M&O Division has drafted a desktop reference guide to explain the overall manpower management process, provide a manpower requirements overview, describe manpower programming, reprogramming and authorization, as well as provide general guidance to manpower analysts with planning, data gathering and

analysis, documentation, reporting and implementation of manpower requirements for the DHA. While this document has not yet been finalized we have implemented the processes, which take into account the current and future needs of the agency, including required skills, organizational alignment of functions, and workforce mix (military, civilian, or contract).

RECOMMENDATION 3: Develop a plan for reassessing and revalidating personnel requirements as the missions and needs of the DHA evolve over time.

DOD RESPONSE: I partially concur with this recommendation. In January of 2014, DHA issued Directive-Type Memorandum (DTM) 2013-001-DHA to establish processes for manpower and organization changes and provide guidance consistent with requirements and functional capabilities. This DTM speaks to the baselining of organization and manpower requirements and addresses the formalized process for reassessment and revalidation of organization and manpower requirements as the mission and needs of the DHA evolve over time. This policy is effective until January 2016. I do concur that DHA should finalize the Administrative Instruction (AI) detailing the ongoing process for manpower requirements determination and management within the DHA prior to the expiration of DTM 2013-001-DHA.

RECOMMENDATION 4: Develop information concerning the number and cost of administrative and headquarters personnel within the Military Health System (MHS) and provide this information as an annual exhibit in the President's budget.

DOD RESPONSE: I concur with the recommendation to provide the number and cost of headquarters personnel within the Military Health System (both DHA and Services, for an MHS enterprise view) as an annual exhibit in the President's Budget. This is currently underway as part of a larger DoD initiative to better define and account for management headquarters functions within the Department. I do not concur with including administrative personnel at this time given the lack of a Department-wide definition of what constitutes administrative personnel.

RECOMMENDATION 5: Determine the future of the Public Health (PH) and Medical Education and Training (MET) shared services by either identifying common functions to consolidate to achieve cost savings or develop a justification for the transfer of these functions from the military Services to the DHA that is not premised on cost savings.

DOD RESPONSE: I concur with the recommendation that the PH and MET shared services still have work to do to consolidate and achieve cost savings.

The DHA reached initial operating capability (IOC) on October 1, 2013. The PH Division reached IOC one year later, and integration of the Armed Forces Health Surveillance Center has been further delayed until August 23, 2015. The PH concept of operations (CONOPs) is currently under revision to 1) clarify the use of the approved MHS business case analysis/business process reengineering (BCA/BPR) methodology and, 2) communicate the

timeline for analysis of the remaining product lines. The future work, as outlined in the revised CONOPS, includes conducting a BCA/BPR on each remaining product line to look for new opportunities for improvement and efficiencies. This includes identifying drivers of cost and variation, as well as the potential for consolidation, standardization, and integration. The BCA/BPR will conclude with estimated cost savings from improvement areas, as well as a recommended future state with business rules and performance measures. Furthermore, a BCA re-baselining effort is currently underway for the Deployment Health Branch with an estimated completion date of October 2015. Finally, while the BCA/BPR process is intended to identify cost savings, there likely will be more product line analyses that result in significant efficiencies rather than significant cost savings.

The MET shared service identified estimated cost savings from improvement opportunities in its Innovative Teaching and Learning product line, which includes eLearning and Modeling and Simulation. The shared service exceeded its initial savings goals related to eLearning and has developed a robust course of action to continue consolidation of the DHA and the Services' eLearning products. Medical Modeling and Simulation savings are not scheduled to be realized until Fiscal Year 2017. In the interim, the DHA commissioned a Joint Capabilities Integration and Development Systems (JCIDS) study to determine the overall direction of Medical Modeling and Simulation. The Shared Service is working through MHS governance to resolve issues related to responsibilities and authorities for Education and Training to facilitate identification of future opportunities that reduce/eliminate redundancies and those lines of effort that improve efficiencies across the MHS.

Appendix III: GAO Contact and Staff Acknowledgments

GAO Contact

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

Staff Acknowledgments

In addition to the contact named above, Lori Atkinson, Assistant Director; Rebekah Boone; Jeffrey Heit; Mae Jones; Amie Lesser; Felicia Lopez; Carol Petersen; Terry Richardson; Adam Smith; and Sabrina Streagle made key contributions to this report.

Appendix IV: Accessible Data

Accessible Text and Data Tables

Accessible Text for Figure 1: Military Health System (MHS) Organizational Structure

Secretary of Defense:

- 1) Under Secretary for Personnel and Readiness;
 - a) Assistant Secretary of Defense for Health Affairs;
 - i) Defense Health Agency [Note A];
 - (1) National Capital Region Medical Directorate Military Treatment Facilities.
- 2) Secretary of the Navy;
 - a) Chief of Naval Operations;
 - i) Navy Surgeon General [Note A];
 - (1) Navy Bureau of Medicine and Surgery;
 - (a) Military Treatment Facilities.
- 3) Secretary of the Army;
 - a) Chief of Staff of the Army;
 - i) Army Surgeon General [Note A];
 - (1) Army Medical Command;
 - (a) Military Treatment Facilities.
- 4) Secretary of the Air Force;
 - a) Chief of Staff of the Air Force;
 - i) Air Force Surgeon General [Note A];
 - ii) Air Force Major Commands;
 - (1) Military Treatment Facilities.

Source: Department of Defense (DOD). | GAO-15-759

Note A: Policy and budget oversight provided by the Under Secretary of Defense for Personnel and Readiness and the Assistant Secretary of Defense for Health Affairs.

Accessible Text for Figure 2: Military Health System (MHS) Governance Structure

Secretary of Defense:

- 1) Deputy Secretary of Defense;
 - a) Under Secretary of Defense for Personnel and Readiness:
 - i) Military Health System Executive Review;
 - ii) Assistant Secretary of Defense for Health Affairs:
 - (1) Policy Advisory Council;
 - (2) Senior Military Medical Action Council

Above = Policy Development; Below = Policy execution

- (a) Medical Deputies Action Group:
 - (i) Medical Operations Group;
 - (ii) Medical Business Operations Group;
 - (iii) Manpower and Personnel Operations Group;
 - (iv) Enhanced Multi-service Markets Leadership Group.

Source: Department of Defense (DOD). | GAO-15-759

Accessible Text for Figure 3: Defense Health Agency's (DHA) Organizational Structure as of July 2015

Secretary of Defense;

Chairman, Joint Chiefs of Staff;

- 1) Under Secretary of Defense (Personnel and Readiness);
 - a) Assistant Secretary of Defense (Health Affairs);

Above = Policy Development; Below = Policy execution

- i) Defense Health Agency Director (Three-star flag officer heads the Defense Health Agency), Deputy Director;

(1) Healthcare Operations Directorate (Two-star flag officer heads the directorate):

- (a) Readiness;
- (b) Pharmacy;
- (c) Public Health;
- (d) TRICARE Health Plan;
- (e) Clinical Support;
- (f) Warrior Care Program.

(2) Research, Development and Acquisition Directorate (One-star flag officer heads the directorate):

- (a) Advanced Development;
- (b) Science and Technology;
- (c) Clinical Infrastructure Program;
- (d) Veterans Affairs Research and Development Liaison.

(3) Health Information Technology Directorate:

- (a) Innovation and Advanced Technology Development;
- (b) Solution Delivery;
- (c) Information Delivery;
- (d) Portfolio Management and Customer Relations;
- (e) Infrastructure and Operations;
- (f) Cyber Security;
- (g) Defense Health Service System;
- (h) Defense Health Clinical Systems.

(4) Education and Training Directorate (One-star flag officer heads the directorate):

- (a) Administrative Support;
 - (b) Medical Enlisted Training Campus Headquarters;
 - (c) Defense Medical Readiness Training Institute;
 - (d) Joint Medical Executive Skills Institute;
 - (e) Academic Review and Oversight;
 - (f) Professional Development, Sustainment, and Program Management.
- (5) Business Support Directorate:
- (a) Facility Planning;
 - (b) Medical Logistics;
 - (c) Program Integrity;
 - (d) Budget and Resource Management.
- (6) National Capital Region Medical Directorate (Two-star flag officer heads the directorate):
- (a) Walter Reed National Military Medical Center (One-star flag officer heads the directorate);
 - (b) Ft. Belvoir Community Hospital;
 - (c) Joint Pathology Center.

Source: Defense Health Agency. | GAO-15-759

Accessible Text for Figure 4: Timeline of GAO Work Related to Military Health System Governance from 2007 to 2015 and Key DOD Documents

- 1) **November 2006** (Department of Defense document): Deputy Secretary of Defense memorandum approved the implementation of seven Military Health System (MHS) governance initiatives.;
- 2) **October 2007** (GAO report and recommendation):
 - a) **GAO-08-122**:

- i) We found that although DOD initiated steps to evaluate options to restructure the MHS, it did not demonstrate that its decision to move forward with its chosen option was based on a sound business case.
- ii) Recommendations:
 - (1) Demonstrate a sound business case for proceeding with its chosen MHS governance reform option, including detailed analyses of associated benefits, costs, and risks.
 - (2) Provide Congress with the results of that assessment.
- 3) **March 2011** (Department of Defense document): Under Secretary of Defense for Personnel and Readiness initiated a comprehensive review and evaluation of military health care to develop a series of proposals to increase MHS performance and efficiency.
- 4) **September 2011** (Department of Defense document): Task Force on MHS Governance recommended the Defense Health Agency (DHA) model for MHS governance.
- 5) **March 2012** (Department of Defense document): Deputy Secretary of Defense memorandum directed planning for DHA implementation.
- 6) **April 2012** (GAO report and recommendation):
 - a) **GAO-12-224:**
 - i) We found that successful implementation of DOD's medical initiatives depends upon incorporating results-oriented management practices, sustaining leadership that holds officials accountable for achieving agency goals, and establishing clear cost savings targets where applicable.
 - ii) Recommendations:
 - (1) Complete and fully implement comprehensive results-oriented plans for each of its medical initiatives.
 - (2) Fully implement an overall monitoring process across the portfolio of initiatives and identify accountable officials and their roles and responsibilities.

- (3) Complete its governance initiatives and employ key management practices to show financial and nonfinancial outcomes and evaluate interim and long-term progress.

7) **September 2012** (GAO report and recommendation):

a) **GAO-12-911:**

- i) We found that DOD risked moving forward with its plans to transform MHS governance without full knowledge of the costs, strengths, and weaknesses of each of its options.

ii) Recommendations:

- (1) Develop a comprehensive cost analysis for its potential MHS governance options.
- (2) Develop a business case analysis and strategy for implementing its shared services concept.
- (3) Develop more complete analyses of the options' strengths and weaknesses.

8) **2013** (Department of Defense document): *Plan for Reform of the Administration of the Military Health System* outlined MHS reform effort and implementation of DHA.

9) **March 2013** (Department of Defense document): Deputy Secretary of Defense memorandum directed implementation of DHA.

10) **November 2013** (GAO report and recommendation):

a) **GAO-14-49:**

- i) We found that although DOD's plans for implementing the DHA met statutory requirements, the plans were missing key details important for oversight of DOD's implementation of the governance reform.

ii) Recommendations:

- (1) Develop and present to Congress fully developed performance measures, interim timelines, and staffing baseline assessments, and refined cost savings estimates.

11) **February 2014** (GAO report and recommendation):

a) **GAO-14-396T:**

- i) We reiterated that DOD could increase the transparency and enhance the accountability of its MHS reform plans by implementing our recommendations from GAO-14-49.

12) **July 2014** (GAO report and recommendation):

a) **GAO-14-630:**

- i) We found that DOD had not yet conducted a business case analysis of the DHA Education and Training Directorate.

- ii) Recommendations:

- (1) Conduct a fully developed business case analysis for the DHA Education and Training Directorate.

- (2) Develop baseline cost information as part of its metrics to assess cost savings for future consolidation efforts.

13) **January 2015** (Department of Defense document): *Defense Health Agency: Reflections on Our First Year and Future* described DHA achievements in the first year of operation.

Source: GAO analysis of GAO and DOD information. | GAO-15-759

Agency Comments

Department of Defense

Page 1

Accessible Text for Appendix II: Comments from the Department of Defense

**THE ASSISTANT SECRETARY OF-DEFENSE
HEALTH AFFAIRS
1200 DEFENSE PENTAGON
WASHINGTON, DC 20301-1200**

August 21, 2015

Ms. Brenda S. Farrell
Directorate, 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 GAO Draft Report, GAO-15- 759, "DEFENSE HEALTH CARE REFORM: Actions Needed to Help Ensure Defense Health Agency Maintains Implementation Progress,"(GAO-15-759), dated July 27, 2015,(GAO Code 351956). Thank you for the opportunity to review the GAO #351956 Draft Report. I have offered some comments to support each of the recommendations (Enclosed). In addition, I would like to thank you and your analysts for working with us over the last two years to develop a business case analysis approach for the shared services that is now considered a best practice. I appreciate your willingness to be a part of the solution in the Defense Health Agency (DHA) implementation.

As you know, building and shaping the DHA, while simultaneously managing it, has been challenging. Fostering a joint culture and assessing the manpower requirements within the DHA requires a great deal of information gathering and assessment. I am pleased to report our progress in validating manpower requirements and planning for future skills as our mission

evolves over time. We are shaping a culture in which all uniformed Service and civilian staff are working toward the same goal. This is most evident in the shared services where shared solutions are allowing the DHA to become more effective, efficient, and integrated. We agree with

your recommendations and remain focused on common functions to consolidate under Medical Education and Training and Public Health.

My points of contact are Dr. Michael Dinneen (Functional) and Mr. Gunther Zimmerman. Dr. Dinneen may be reached at (703) 681-1712 or Michael.p.dinneen.civ@mail.mil. Mr. Gunther Zimmerman (Audit Liaison) may be reached at (703) 681-4360, or Gunther.j.zimmerman.civ@mail.mil. Thank you for your interest in the health and well-being of our Service members, veterans and their families.

Sincerely,
Signed in place of Jonathan Wood, M.D.

Enclosure: As stated

Page 2

GAO DRAFT REPORT DATED JULY 27 2015 GAO-15-759 (GAO CODE 351956)

"DEFENSE HEALTH CARE REFORM: ACTIONS NEEDED TO HELP ENSURE DEFENSE HEALTH AGENCY MAINTAINS IMPLEMENTATION PROGRESS"

DEPARTMENT OF DEFENSE COMMENTS TO THE GAO RECOMMENDATIONS

To provide decision makers with appropriate and more complete information on the continuing implementation management and oversight of the Defense Health Agency (DHA), we recommend that the Secretary of Defense direct the Assistant Secretary of Defense (Health Affairs) to take the following five actions:

RECOMMENDATION 1: Develop a timeline for completion of the personnel requirements assessment that includes milestones and interim steps.

DOD RESPONSE: I concur with the recommendation to provide a detailed timeline for the completion of the manpower requirements assessment that includes critical steps for completion of the DHA manpower requirements baseline.

DHA leadership has tasked the Manpower and Organization (M&O) Division which was formally established in July of 2014, to complete a manpower requirements baseline for the DHA by the end of Fiscal Year 2016. M&O has created a project plan to track progress on this critical task. To date, M&O has completed baseline manpower assessments for

100 percent of the Healthcare Operations Directorate. Assessments of the Business Support and Health Information Technology (HIT) Directorates are ongoing, with scheduled completion dates of January and March 2016t respectively. Assessment of the National Capital Region (NCR) Medical Directorate is scheduled to be complete in April 2016t followed by the DHA Special Staff in May of 2016, the Education and Training Directorate in July 2016t and the Research, Development and Acquisition Directorate (RDA) completing the baselining effort in September 2016.

RECOMMENDATION 2: Develop a comprehensive approach to the requirements assessment that accounts for needed future skills through consideration of potential organizational changes and helps ensure appropriate consideration of workforce composition, through determination of the final status of military personnel within the DHA.

DOD RESPONSE: I concur with the request to develop a comprehensive approach to manpower requirements determination for the DHA. The M&O Division has drafted a desktop reference guide to explain the overall manpower management process, provide a manpower requirements overview, describe manpower programming, reprogramming and authorization, as well as provide general guidance to manpower analysts with planning, data gathering and

Page 3

analysis, documentation, reporting and implementation of manpower requirements for the DHA. While this document has not yet been finalized we have implemented the processes, which take into account the current and future needs of the agency, including required skills, organizational alignment of functions, and workforce mix (military, civilian, or contract).

RECOMMENDATION 3: Develop a plan for reassessing and revalidating personnel requirements as the missions and needs of the DHA evolve over time.

DOD RESPONSE: I partially concur with this recommendation. In January of 2014, DHA issued Directive-Type Memorandum (DTM} 2013-001-DHA to establish processes for manpower and organization changes and provide guidance consistent with requirements and functional capabilities. This DTM speaks to the baselining of organization and manpower requirements and addresses the formalized process for reassessment and revalidation of organization and manpower requirements as the mission and needs of the DHA evolve over time. This policy is effective until January 2016. I do concur that DHA should finalize

the Administrative Instruction (AI} detailing the ongoing process for manpower requirements determination and management within the DHA prior to the expiration of DTM 2013-001-DHA.

RECOMMENDATION 4: Develop information concerning the number and cost of administrative and headquarters personnel within the Military Health System (MHS}and provide this information as an annual exhibit in the President's budget.

DOD RESPONSE: I concur with the recommendation to provide the number and cost of headquarters personnel within the Military Health System (both DHA and Services, for an MHS enterprise view) as an annual exhibit in the President's Budget. This is currently underway as part of a larger DoD initiative to better define and account for management headquarters functions within the Department. I do not concur with including administrative personnel at this time given the lack of a Department-wide definition of what constitutes administrative personnel.

RECOMMENDATION 5: Determine the future of the Public Health (PH) and Medical Education and Training (MET) shared services by either identifying common functions to consolidate to achieve cost savings or develop a justification for the transfer of these functions from the military Services to the DHA that is not premised on cost savings.

DOD RESPONSE: I concur with the recommendation that the PH and MET shared services still have work to do to consolidate and achieve cost savings.

The DHA reached initial operating capability (IOC) on October 1, 2013. The PH Division reached IOC one year later, and integration of the Armed Forces Health Surveillance Center has been further delayed until August 23, 2015. The PH concept of operations (CONOPS) is currently wider revision to 1) clarify the use of the approved MHS business case analysis/business process reengineering (BCA/BPR) methodology and, 2) communicate the

timeline for analysis of the remaining product lines. The future work, as outlined in the revised CONOPS, includes conducting a BCAIBPR on each remaining product line to look for new opportunities for improvement and efficiencies. 1bis includes identifying drivers of cost and variation, as well as the potential for consolidation, standardization, and integration. The BCA/BPR will conclude with estimated cost savings from

improvement areas, as well as a recommended future state with business rules and performance measures. Furthermore, a BCA re-baselining effort is currently underway for the Deployment Health Branch with an estimated completion date of October 2015. Finally, while the BCA/BPR process is intended to identify cost savings, there likely will be more product line analyses that result in significant efficiencies rather than significant cost savings.

The MET shared service identified estimated cost savings from improvement opportunities in its Innovative Teaching and Learning product line, which includes eLearning and Modeling and Simulation. The shared service exceeded its initial savings goals related to eLearning and has developed a robust course of action to continue consolidation of the DHA and the Services' eLearning products. Medical Modeling and Simulation savings are not scheduled to be realized until Fiscal Year 2017. In the interim, the DHA commissioned a Joint Capabilities Integration and Development Systems (JCIDS) study to determine the overall direction of Medical Modeling and Simulation. The Shared Service is working through MHS governance to resolve issues related to responsibilities and authorities for Education and Training to facilitate identification of future opportunities that reduce/eliminate redundancies and those lines of effort that improve efficiencies across the MHS.

Related GAO Products

Defense Health Care Reform: Actions Needed to Help Realize Potential Cost Savings from Medical Education and Training. [GAO-14-630](#). Washington, D.C.: July 31, 2014.

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

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

Defense Health Care: Additional Analysis of Costs and Benefits of Potential Governance Structures Is Needed. [GAO-12-911](#). Washington, D.C.: September 26, 2012.

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

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

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

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

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

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

GAO's Mission

The Government Accountability Office, the audit, evaluation, and investigative arm of Congress, exists to support Congress in meeting its constitutional responsibilities and to help improve the performance and accountability of the federal government for the American people. GAO examines the use of public funds; evaluates federal programs and policies; and provides analyses, recommendations, and other assistance to help Congress make informed oversight, policy, and funding decisions. GAO's commitment to good government is reflected in its core values of accountability, integrity, and reliability.

Obtaining Copies of GAO Reports and Testimony

The fastest and easiest way to obtain copies of GAO documents at no cost is through GAO's website (<http://www.gao.gov>). Each weekday afternoon, GAO posts on its website newly released reports, testimony, and correspondence. To have GAO e-mail you a list of newly posted products, go to <http://www.gao.gov> and select "E-mail Updates."

Order by Phone

The price of each GAO publication reflects GAO's actual cost of production and distribution and depends on the number of pages in the publication and whether the publication is printed in color or black and white. Pricing and ordering information is posted on GAO's website, <http://www.gao.gov/ordering.htm>.

Place orders by calling (202) 512-6000, toll free (866) 801-7077, or TDD (202) 512-2537.

Orders may be paid for using American Express, Discover Card, MasterCard, Visa, check, or money order. Call for additional information.

Connect with GAO

Connect with GAO on [Facebook](#), [Flickr](#), [Twitter](#), and [YouTube](#).
Subscribe to our [RSS Feeds](#) or [E-mail Updates](#).
Listen to our [Podcasts](#) and read [The Watchblog](#).
Visit GAO on the web at www.gao.gov.

To Report Fraud, Waste, and Abuse in Federal Programs

Contact:

Website: <http://www.gao.gov/fraudnet/fraudnet.htm>

E-mail: fraudnet@gao.gov

Automated answering system: (800) 424-5454 or (202) 512-7470

Congressional Relations

Katherine Siggerud, Managing Director, siggerudk@gao.gov, (202) 512-4400, U.S. Government Accountability Office, 441 G Street NW, Room 7125, Washington, DC 20548

Public Affairs

Chuck Young, Managing Director, youngc1@gao.gov, (202) 512-4800
U.S. Government Accountability Office, 441 G Street NW, Room 7149
Washington, DC 20548