United States Government Accountability Office

Report to Congressional Committees

June 2023

DEFENSE HEALTH CARE

Improved Monitoring Could Help Ensure Completion of Mandated Reforms

GAO-23-105710

June 2023

DEFENSE HEALTH CARE

Improved Monitoring Could Help Ensure Completion of Mandated Reforms

GAO Highlights

Highlights of GAO-23-105710, a report to congressional committees

Why GAO Did This Study

For the past decade, DOD has been taking actions to reform its health system. The military health system is a massive enterprise charged with maintaining a medically ready force and ready medical personnel. To achieve this mission, DOD estimated it will provide care to approximately 9.6 million beneficiaries at a cost of more than $55.8 billion in fiscal year 2023.

The NDAA for Fiscal Year 2022 includes a provision for GAO to study DOD's implementation of statutory requirements for military health system reform. This report examines (1) statutory requirements for reform of the military health system that GAO identified within each NDAA for fiscal years 2012 through 2022, and the extent to which DOD has (2) taken actions to address these requirements for military health system reform and assessed the effectiveness of certain reforms, and (3) monitored actions taken in response to the requirements. GAO analyzed NDAAs and DOD documentation, and interviewed DOD senior officials.

What GAO Recommends

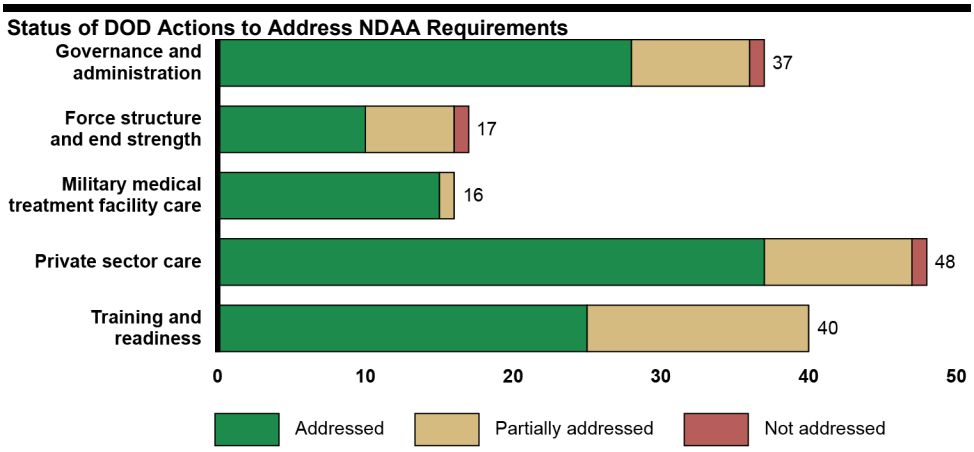
GAO is making four recommendations, including that DOD finalize implementation plans for the transfers of (1) public health and (2) research and development organizations, and establish a process to monitor actions taken to address statutory requirements for the military health system. DOD concurred with each of GAO's recommendations.

View GAO-23-105710. For more information, contact Brenda S. Farrell at (202) 512-3604 or FarrellB@gao.gov.

What GAO Found

The National Defense Authorization Acts (NDAA) for fiscal year 2012 through 2022 contained 158 requirements—actions required for Department of Defense (DOD) to take—that GAO identified as reforms of the military health system. GAO placed each requirement into one of five reform categories.

DOD completed actions to address the majority (approximately 73 percent) of the requirements across the five categories (see figure).



Source: GAO analysis of Department of Defense (DOD) actions to address National Defense Authorization Acts (NDAA) requirements. | GAO-23-105710

Note: GAO assigned each of the NDAAs' 158 requirements to a single category even when a requirement overlapped with another category. Four requirements were not counted because GAO could not determine DOD's past actions for various reasons, such as information posted online for a pilot program that ended.

Many of the requirements DOD addressed were from the NDAA for Fiscal Year 2017. For example, DOD established the TRICARE Select health plan (as required in section 701). Additional work remains for the department to complete actions to address the remaining requirements, which include several significant reforms. For example, GAO found that DOD partially addressed requirements from section 711 of the John S. McCain NDAA for Fiscal Year 2019 to establish public health and research and development organizations within the Defense Health Agency by September 30, 2022. As of April 2023, Defense Health Agency officials stated that the transfer of public health personnel was ongoing as DOD worked to complete Phase I of the transfer. Without finalizing implementation plans with timelines for completion and, although not required, providing them to Congress to improve oversight, DOD could be further delayed in addressing these requirements.

DOD has processes for delegating responsibility for addressing military health system reform requirements and identifying and tracking requirements for reports and briefings to Congress. However, DOD does not have a systematic process to comprehensively monitor actions to address reform requirements. By establishing such a process, DOD could improve oversight of its complex, multi-year reform initiatives, including performance of reforms in relation to the MHS goals of better health, better care, improved readiness, and lower costs.

Contents

Figures

Abbreviations

DHA	Defense Health Agency
DOD	Department of Defense
MHS	Military Health System
MTF	Medical Treatment Facility
NDAA	National Defense Authorization Act
T-5	fifth generation of TRICARE contracts

U.S. GOVERNMENT ACCOUNTABILITY OFFICE
441 G St. N.W.
Washington, DC 20548

June 22, 2023

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

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

For the past decade, the Department of Defense (DOD) has been carrying out historic reforms of its military health system (MHS) in response to statutory mandates. The MHS is a massive enterprise charged with ensuring that service members are medically ready to deploy and that medical personnel are ready to provide medical care in operational settings. Additionally, the MHS provides medical services and support in non-deployed settings to beneficiaries.[1] In order to achieve this mission, the MHS operates more than 700 military medical treatment facilities (MTF) and networks of private-sector civilian health care providers. DOD estimates that in fiscal year 2023 the MHS will provide health care to approximately 9.6 million beneficiaries—including more than 1.6 million active-duty service members—at a cost of more than $55.8 billion.[2]

[1]Eligible beneficiaries of the MHS are active-duty and retired service members and their families, dependent survivors, and certain reserve component members and their families.

[2]The $55.8 billion represents the President's unified medical budget request for fiscal year 2023, which includes requests for funding for the Defense Health Program, Military Personnel, and Military Construction accounts. The Defense Health Program funds the following MHS functions: health care delivery in MTFs; TRICARE; certain medical readiness activities and expeditionary medical capabilities; education and training programs; research, development, test, and evaluation; management and headquarters activities; facilities sustainment; procurement; and civilian and contract personnel.

The annual National Defense Authorization Acts (NDAA) enacted throughout the past decade have mandated numerous MHS reforms. These reforms cover a variety of operations, including planning for the establishment of the Defense Health Agency (DHA); establishing TRICARE Select—a self-managed, preferred provider organization plan for eligible beneficiaries; and establishing the Joint Trauma System, an effort to improve trauma readiness and outcomes. According to a Senate Armed Services Committee report, reforms have sought to enhance access to high quality healthcare, increase the operational readiness of military medical providers, and lower the per capita costs of health care for DOD.[3] These objectives overlap with DOD's goals for the MHS, referred to as the "Quadruple Aim": better health, better care, lower costs, and increased readiness.

We have issued a number of reports about DOD's planning and implementation of some of these MHS reform requirements. For example, we have reported on DOD's efforts to reform the governance of the MHS, including efforts to establish the Defense Health Agency (DHA) and to transition responsibilities for the administration and management of MTFs from the military departments to the DHA. We have also reported on efforts to improve the private-sector care component of the MHS, through which DOD reimburses civilian, private-sector entities for care provided to eligible beneficiaries. Since 2012, we have made at least 88 recommendations to DOD to help oversee its efforts to implement various MHS reform requirements. As of April 2023, DOD has fully or partially implemented 18 of the 88. We discuss our prior work and recommendations throughout this report. Appendix I lists our relevant recommendations since 2012 and the status of each.

Section 742 of the NDAA for Fiscal Year 2022 includes a provision for us to examine DOD's actions to address statutory requirements to reform the MHS.[4] This report examines (1) statutory requirements for reform of the MHS that GAO identified within each NDAA from fiscal year 2012 through fiscal year 2022; (2) the extent to which DOD has taken actions to address these requirements and assessed the effectiveness of certain reform actions as required; and (3) the extent to which DOD has

[3]S. Rep. No. 114-255, at 175-176 (2016). The overall costs for the MHS are projected to reach $69 billion in fiscal year 2037 after increasing by nearly 2 percent per year from 2027 through 2037. Congressional Budget Office, *Long-Term Implications of the 2023 Future Years Defense Program* (January 2023).

[4]Pub. L. No. 117-81, § 742, 135 Stat. 1541, 1805-06 (2021).

monitored actions taken in response to statutory requirements for MHS reform.

For our first objective, we defined "MHS reform" in consultation with DOD officials, and identified the sections that met this definition in the NDAAs from fiscal year 2012 through fiscal year 2022.[5] We then grouped the sections we identified into five categories: Governance and Administration; Force Structure and End Strength; MTF Care; Private-Sector Care; and Training and Readiness. In some instances, requirements overlapped categories; to avoid overcounting, we generally limited the discussion of requirements to one category. We included sections that required the department to assess the effectiveness of reform actions taken.

For our second objective, within each of the five categories, we broke down each section we identified as an MHS reform into separate requirements based on actions that the department would need to take to address that particular reform.[6] We reviewed the categorization approach and list of requirements with DOD officials, who agreed without comment. We collected DOD documentation, reviewed our prior work concerning MHS reform, and interviewed DOD officials regarding actions taken to address the requirements. For each requirement, we assessed this information to determine whether the department had completed actions to address the requirement ("Addressed"), had taken actions to partially address the requirement ("Partially Addressed"), or not addressed the

[5]For the purpose of our review, we define "MHS reform" as enterprise changes affecting the population of beneficiaries, medical providers, and/or administrators (including leadership), or a significant portion thereof and that relate to one or more of the following goals: (1) improving the quality of beneficiary health care, (2) improving the operational readiness of military medical providers, and (3) reducing the cost of the health system overall.

[6]We considered statutory provisions that require one or more components of DOD to take an action to be a requirement. Conversely, we did not consider the following types of provisions to be reform requirements: (1) provisions that provide discretion in taking action; (2) provisions that provide authority; (3) provisions that outline responsibilities; and (4) provisions that prohibit or limit actions (unless DOD was required to take an action because of a prohibition or limitation). We grouped elements (i.e., any subsections, paragraphs, and subparagraphs) together into one requirement when they were inherently part of the same action.

requirement ("Not Addressed").[7] Two analysts independently reviewed and made determinations, subsequently reconciling any differences in assessments. Our assessments of these requirements includes those that mandated DOD to assess the effectiveness of reform action(s) and provide a report or review to Congress. See appendix II for a detailed description of how we assessed requirements.

For our third objective, we discussed with DOD officials their methods for monitoring the status of statutory requirements. In addition, we obtained documentation from various DOD offices about requirements that had been addressed. Specifically, we interviewed officials and collected documents from the Office of the Assistant Secretary of Defense for Health Affairs; DHA; and the Army, Navy, and Air Force medical commands and agencies about their processes for identifying and delegating statutory requirements. For a detailed description of our scope and methodology, see appendix II.

We conducted this performance audit from January 2022 to June 2023 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

[7]"Addressed" means DOD completed actions to address all elements of the requirement. "Partially addressed" means DOD has taken actions to address some, half, or most of the elements of a requirement, irrespective of whether DOD has completed its actions or plans additional actions to address the requirement. "Not addressed" means DOD did not address any elements of the requirement or has no plans to begin addressing it. In assessing DOD's actions to address requirements, we reviewed our prior work concerning MHS reform to make our determinations. In those cases where we made recommendations that are still open, we noted those recommendations in the report in support of partially addressed or unaddressed requirements. We did not assess the timeliness of any requirements. Finally, we identified four requirements in the Private-Sector Care category that were within our scope of MHS reforms but for which we were unable to determine the extent to which DOD addressed them. This occurred for various reasons, such as information that DOD was required to post online no longer being available. We note these requirements as appropriate in the report, but do not include them in our counts of DOD's actions. For requirements for written products or briefings, we determined that the requirement was addressed if the report or briefing was provided, even if one or more individual elements of the required report or briefing were not included. We discuss some elements of requirements for written products or briefings in this report for illustrative purposes.

Background

Overview of MHS

DOD provides health care services to service members and other eligible beneficiaries worldwide through TRICARE, its regionally structured health care program. TRICARE allows beneficiaries to obtain health care services through DOD's direct care system of military hospitals, medical centers, and clinics—referred to as MTFs—or through private-sector care via civilian network providers. TRICARE offers different benefit options with different cost sharing features for care through the civilian network.[8]

With respect to its direct care system infrastructure, DOD estimates it will maintain approximately 700 MTFs (including dental clinics) worldwide in fiscal year 2023. In delivering care to beneficiaries, DOD's facilities also provide essential on-the-job training for active-duty medical providers in support of their operational readiness, along with graduate medical education at some of the largest MTFs.[9] MTFs are also designated to receive wartime casualties, and can provide certain types of assistance to civil authorities during a U.S. national emergency or domestic disaster. In fiscal year 2022, approximately 49,000 active-duty military personnel worked in the MTFs, augmented by about 46,000 federal civilian employees and an estimated 14,500 contracted service providers. Separately, the remainder of DOD's military medical personnel—about

[8]With the exception of active-duty service members (who are assigned to the TRICARE Prime option and pay no out-of-pocket costs for TRICARE coverage), MHS beneficiaries may have a choice of TRICARE plan options depending upon their status (e.g., active-duty family member, retiree, reservist, child under age 26 ineligible for family coverage, Medicare-eligible) and geographic location. TRICARE options include the following: TRICARE Prime—a health maintenance organization-style option in which beneficiaries typically get most care at an MTF; TRICARE Select—a self-managed, preferred-provider option that allows beneficiaries greater flexibility in managing their own health care and typically does not require a referral for specialty care; and TRICARE for Life—coverage provided to certain retired TRICARE beneficiaries who must enroll in Medicare and pay Medicare Part B premiums to retain TRICARE coverage.

[9]For purposes of this report, operational medical force readiness refers to the ability of medical providers—based on their knowledge, skills, and abilities—to meet DOD's operational mission needs and provide those capabilities to combatant commanders. Medical readiness refers to the physical and mental health and fitness of military service members to perform their missions. In order to sustain the medical skills of its providers, DOD policy states that medical services provided within the direct care system of the MHS be prioritized over other types of training. When workload within the direct care system is insufficient, DOD has taken steps to augment this training with additional training modalities, including through the development of training partnerships with civilian medical facilities and the use of medical simulation. Department of Defense Instruction 6000.19, *Military Medical Treatment Facility Support of Medical Readiness Skills of Health Care Providers* (Feb. 7, 2020).

39,000 in fiscal year 2022—were assigned to various duties outside of the MTFs.

To provide private-sector care, DOD contracts with private-sector companies—referred to as managed care support contractors—in each of its two TRICARE regions (East and West). These companies are to develop and maintain networks of civilian providers and perform other customer service functions, such as processing claims, enrolling beneficiaries, and assisting beneficiaries with finding providers. In fiscal year 2023, appropriated amounts for private-sector care totaled approximately $18.6 billion, or about 47 percent of the Defense Health Program appropriation.[10] In December 2022, DHA, which administers the TRICARE program, awarded its fifth generation of TRICARE contracts, referred to as the T-5 contracts.

Roles and Responsibilities within the MHS

Various components share the responsibility for health care delivery within the MHS, including the Office of the Secretary of Defense, the military departments, and the DHA. As such, multiple officials and organizations are responsible for DOD's medical personnel, their readiness, and the MTFs to which many of them are assigned.

The Under Secretary of Defense for Personnel and Readiness is the principal staff assistant and advisor to the Secretary of Defense for health-related matters and, in that capacity, develops policies, plans, and programs for health and medical affairs.[11]

The Assistant Secretary of Defense for Health Affairs serves as the principal advisor to the Under Secretary of Defense for Personnel and Readiness for all DOD health-related policies, programs, and activities.[12] The Assistant Secretary of Defense for Health Affairs has the authority to

[10]The cost of private-sector care is increasing as a share of DOD's total operation and maintenance cost for the Defense Health Program, which also includes the cost of operating MTFs and providing medical personnel training, among other things. Specifically, based on DOD budget justification documentation, from fiscal year 2016 through fiscal year 2023, the appropriated amounts for private-sector care increased from about 48 percent to about 52 percent, respectively, relative to the total appropriated operation and maintenance amounts for the Defense Health Program over those fiscal years.

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

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

develop policies, conduct analyses, provide advice, and make recommendations to the Secretary of Defense and others; issue guidance; and provide oversight on matters pertaining to the MHS. Further, the Assistant Secretary of Defense for Health Affairs is to prepare and submit a DOD unified medical program budget that includes, among other things, the Defense Health Program budget to provide resources for MTFs and the TRICARE Health Program.

The Secretaries of the military departments are responsible for organizing, training, and equipping military forces—including medical personnel—as directed by the Secretary of Defense. They are also responsible for ensuring the readiness of military personnel and providing military personnel and authorized resources in support of the combatant commanders and the DHA.

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

The Director of the DHA manages, among other things, the execution of policies issued by the Assistant Secretary of Defense for Health Affairs and manages and executes the Defense Health Program appropriation.[13] The Director of the DHA is also responsible for the TRICARE Health Program. In December 2016, the NDAA for Fiscal Year 2017 expanded the role of the DHA by directing the transfer of responsibility for the administration of each MTF from the military departments to the DHA by September 30, 2021.[14]

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

[14]10 U.S.C. § 1073c(a)(1). Initially, the transfer of responsibilities to the DHA was to occur by October 1, 2018. However, in August 2018, the John S. McCain NDAA for Fiscal Year 2019 amended 10 U.S.C. § 1073c to require this transition to occur by September 30, 2021. Pub. L. No. 115-232, § 711 (2018).

National Defense Authorization Acts in Fiscal Years 2012–2022 Mandated 158 DOD Requirements for Military Health System Reform

Across the NDAAs from fiscal year 2012 through 2022, we identified 158 specific statutory requirements for MHS reform in 39 different sections of those NDAAs.[15] Each statutory requirement was unique and varied in the level of effort required to address it. For example, some statutory requirements call for the establishment of a program, while others require a report to Congress. For the purposes of this report, we categorized these requirements into five reform areas: 1) Governance and Administration, 2) Force Structure and End Strength, 3) MTF Care, 4) Private-Sector Care, and 5) Training and Readiness.[16] Some requirements overlapped categories, which we discuss later in this report as appropriate. We counted each requirement once, and discussed each requirement under one category. Figure 1 describes these categories and provides examples of requirements.

[15]We determined that a requirement existed if it required DOD to take an action to implement the law. We excluded from our scope one section that was repealed. All other requirements we identified remain in force, and we assessed the status of actions taken for requirements as amended through the NDAA for Fiscal Year 2022, where applicable.

[16]See appendix II for a full description of our methodology to define military health system reform and to identify and categorize requirements.

Figure 1: Categories of Statutorily Mandated Requirements for Military Health System Reform in Fiscal Years 2012-2022 that GAO Identified

Governance and administration (37 requirements)
Structure and responsibilities of Department of Defense (DOD) health care entities

Examples of reform requirements:
- Section 731 of the NDAA for Fiscal Year 2013 requires the Secretary of Defense to establish a detailed plan for creating the Defense Health Agency and implementing other reforms.[a]
- Section 730 of the NDAA for Fiscal Year 2017 requires the Secretary of Defense to incorporate measures of accountability for Military Health System (MHS) performance into the annual performance reviews of MHS leaders.[b]

Force structure and end strength (17 requirements)
Number and placement of DOD medical personnel

Examples of reform requirements:
- Section 721 of the NDAA for Fiscal Year 2017 requires the Secretary of Defense to establish a process to define military medical and dental personnel requirements necessary to meet medical force readiness requirements.[c]
- Section 719 of the NDAA for Fiscal Year 2020 requires each military department Secretary to conduct a review of the medical manpower requirements of their respective department that accounts for all national defense strategy scenarios.[d]

Military medical treatment facility (MTF) care (16 requirements)
Health care delivery at military hospitals and clinics

Examples of reform requirements:
- Section 709 of the NDAA for Fiscal Year 2017 requires the Secretary of Defense to implement a standardized scheduling system for medical appointments at MTFs.[e]
- Section 709 also requires the Secretary of Defense to implement standards for the productivity of MTF health care providers.[f]

Private sector care (48 requirements)
Health care delivery through civilian network providers

Examples of reform requirements:
- Section 701 of the NDAA for Fiscal Year 2017 requires the Secretary of Defense to establish a self-managed, preferred provider network option under TRICARE.[g]
- Section 701 also requires the Secretary of Defense to carry out a pilot program to demonstrate and assess the feasibility of incorporating value-based health care methodology into the private sector care component of TRICARE.[h]

Training and readiness (40 requirements)
How DOD ensures medical forces are prepared for warfare

Examples of reform requirements:
- Section 708 of the NDAA for Fiscal Year 2017 requires the Secretary of Defense to establish the Joint Trauma Education and Training Directorate.[i]
- Section 749 of the NDAA for Fiscal Year 2017 requires the Secretary of Defense to establish and implement a process to provide oversight of military department graduate medical education programs to ensure they fully support operational medical force readiness requirements for health care providers of the Armed Forces.[j]

Source: GAO analysis of National Defense Authorization Acts (NDAA). | GAO-23-105710

Note: Although some requirements overlap categories of reform, we assigned each requirement to a single category and counted each requirement once. Additionally, we identified four requirements in the Private-Sector Care category that were within our scope of reforms but for which we were unable to determine the extent to which DOD addressed them because, for example, the information that DOD was required to post online no longer being available. We do not include these requirements in our counts of DOD's actions.

[a]Pub. L. No. 112-239, § 731 (2013).

[b]Pub. L. No. 114-328, § 730 (2016).

[c]Pub. L. No. 114-328, § 721 (2016), codified at 10 U.S.C. § 977.

[d]Pub. L. No. 116-92, § 719 (2019).

[e]Pub. L. No. 114-328, § 709(a) (2016).

[f]Pub. L. No. 114-328, § 709(d) (2016).

[g]Pub. L. No. 114-328, § 701(a) (2016), codified at 10 U.S.C. § 1075.

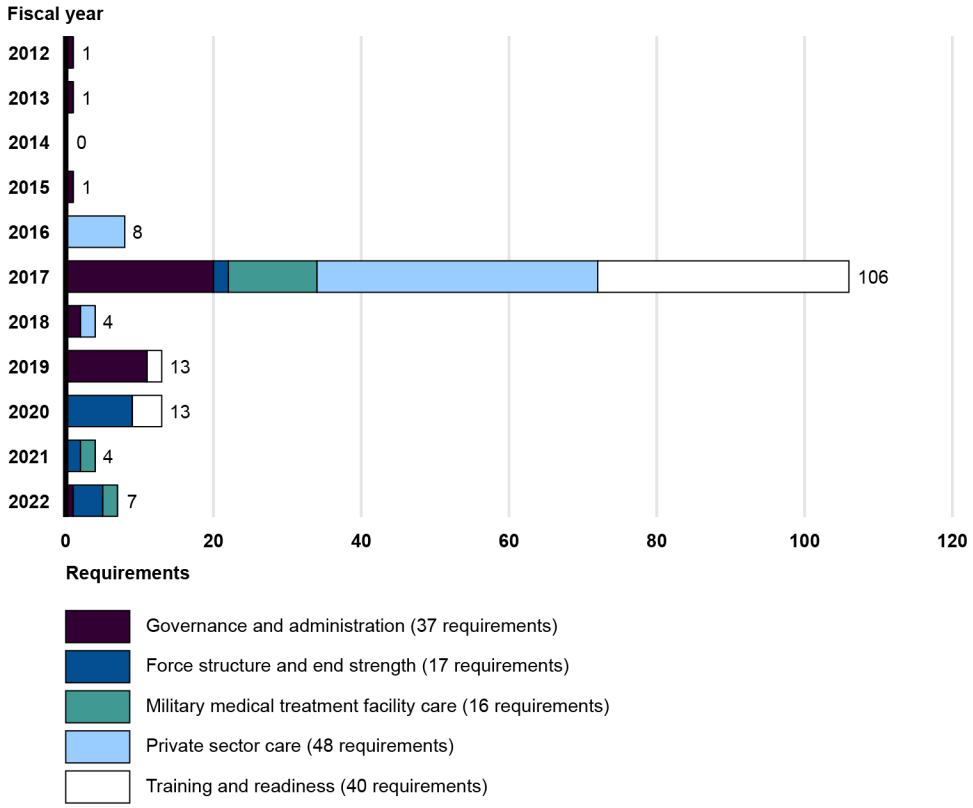
[h]Pub. L. No. 114-328, § 701(h) (2016).

[i]Pub. L. No. 114-328, § 708 (2016).

[j]Pub. L. No. 114-328, § 749 (2016).

We found that the numbers and types of requirements for MHS reform varied over time in the NDAAs. For example, the majority of requirements overall were enacted in the NDAA for Fiscal Year 2017. The majority of requirements related to the governance and administration of the MHS were directed in the fiscal years 2017 and 2019 NDAAs. Force structure and end strength requirements were largely directed in the NDAAs for fiscal year 2020 through 2022 (see fig. 2).

Figure 2: Number of Military Health System Reform Statutory Requirements for the Department of Defense in Each NDAA, Fiscal Years 2012–2022, by Category



Source: GAO analysis of National Defense Authorization Acts (NDAA). | GAO-23-105710

Note: Although some requirements have attributes of more than one category of reform, we assigned each requirement to a single category and counted each requirement once. Additionally, we identified four requirements in the Private-Sector Care category that were within our scope of reforms but for which we were unable to determine the extent to which DOD addressed them because, for example, the information that DOD was required to post online was no longer available. We do not include these requirements in our counts of DOD's actions.

Of the 158 requirements we identified related to MHS reforms, seven included language requiring DOD to assess the effectiveness of reform actions. For example, DOD was required to conduct a pilot program that allowed covered beneficiaries to access urgent care visits without the need for preauthorization and report to Congress on this effort.[17]

[17]Pub. L. No. 114-92, § 725 (2015).

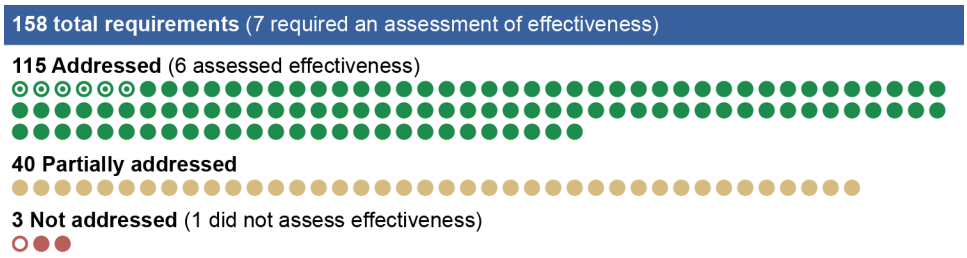
DOD Has Completed Actions to Address Most Requirements, but Additional Work Remains to Complete Some Reforms

DOD has completed actions to address most statutory requirements for MHS reform that we identified in NDAAs for fiscal year 2012 through 2022, including those to assess reform actions. However, additional work remains to address some requirements in each category of reform.

DOD Has Completed Actions to Address Most Statutory MHS Reform Requirements, Including Those to Assess Reform Actions

DOD has completed actions to address approximately 73 percent (115) of the 158 NDAA requirements directing reforms of the MHS. Additionally, DOD has taken actions that partially addressed about 25 percent (40) of the NDAA requirements, but has not addressed approximately 2 percent (three) of them.[18] Figure 3 provides an overview of DOD's efforts to address these statutory requirements, including the seven that required DOD to assess the effectiveness of actions taken to meet them.

Figure 3: Status of DOD's Actions to Address Fiscal Year 2012-2022 National Defense Authorization Act Requirements Related to Military Health System Reform



Source: GAO analysis of National Defense Authorization Acts and Department of Defense (DOD) information. | GAO-23-105710

Note: Although some requirements have attributes of more than one category of reform, we assigned each requirement to a single category and counted each requirement once. Additionally, we identified four requirements in the Private-Sector Care category that were within our scope of reforms but for which we were unable to determine the extent to which DOD addressed them because, for example, the information that DOD was required to post online was no longer available. We do not include these requirements in our counts of DOD's actions.

[18]In assessing DOD's actions to address statutory requirements for MHS reforms, we did not assess the quality of actions taken to address requirements. In a few instances, requirements overlapped categories, which we indicate accordingly. We counted each requirement once, and discussed each requirement under one category.

Of the 115 requirements that DOD has completed actions to address, many of them were in the NDAA for Fiscal Year 2017. For example, DOD established the TRICARE Select health plan (as required in section 701);[19] provided Congress with implementation plans for the transition of MTFs to the DHA (as required in section 702); and established a Joint Trauma System and Joint Trauma Education and Training Directorate within DHA (as required in sections 707 and 708). Appendix III includes a complete list of these and other requirements that DOD completed actions to address.

Of the 158 requirements we identified related to MHS reforms, seven—all related to Private- Sector Care—included language requiring DOD to assess the effectiveness of reform actions. We found that DOD has completed actions to address six of these statutory requirements and had not yet addressed one requirement. See Table 1 for an overview of requirements that included language requiring DOD to assess the effectiveness of reform actions.

Table 1: Military Health System Reform Requirements from National Defense Authorization Acts for Fiscal Years 2012-2022 Requiring an Assessment of Effectiveness

Requirement details and status	NDAA fiscal year	Public law number	Subsection and paragraph (if applicable)	Number of requirements
Addressed. Section 725 requires DOD to submit two reports assessing a pilot program on urgent care access under TRICARE private-sector care.[a] DOD provided these reports to Congress on Sept. 11, 2017 and June 14, 2018, respectively.	2016	114-92	(c)(1) – (2)	2
Addressed. Section 726 requires DOD to submit two reports assessing a pilot program on value-based incentive programs under TRICARE private-sector care. DOD provided these reports to Congress on Jan. 11, 2018 and Feb. 18, 2020, respectively.	2016	114-92	(d)(1) – (2)	2
Not Addressed. Section 701 requires DOD to submit a report assessing a pilot program on implementing a value-based health care methodology under TRICARE private-sector care for beneficiaries receiving high-value medications and services and the use of high-value providers. DOD has not yet completed this report, which was due to Congress no later than Jan. 1, 2023.	2017	114-328	(h)(5)	1

[19]This requirement is codified, as amended, at section 1075 of title 10, United States Code.

Requirement details and status	NDAA fiscal year	Public law number	Subsection and paragraph (if applicable)	Number of requirements
Addressed. Section 718 requires DOD to submit a report assessing the impact of DOD incorporating the use of telehealth services in the military health system. DOD provided this report to Congress on Aug. 17, 2022.	2017	114-328	(e)(2)	1
Addressed. Section 729 requires DOD to submit a report assessing programs incentivizing beneficiary participation in medical and lifestyle programs. DOD provided this report to Congress on March 3, 2021.	2017	114-328	(d)	1

Source: GAO analysis of National Defense Authorization Acts (NDAA) and Department of Defense (DOD) information. | GAO-23-105710

[a]Section 725(c)(3) of the NDAA for Fiscal Year 2016 requires a third and final report to be issued not later than 180 days after the completion of the pilot program. However, a third report was not prepared because section 704(a) of the NDAA for Fiscal Year 2017 made access to urgent care permanent. Therefore, we did not include a third report in our count of requirements.

Additional Work Remains to Address Some MHS Reform Requirements

Of the 158 NDAA requirements we identified that direct MHS reforms, DOD has not completed actions that would fully address 43 requirements, but has planned to take actions toward completing many of them. Specifically, of the 43 requirements, DOD has taken actions to partially address 40 requirements, which are distributed across the five categories of reform. Furthermore, it has not addressed the other three requirements, which relate to Governance and Administration, Force Structure and End Strength, and Private-Sector Care. We describe the status of DOD's actions to address these 43 requirements in more detail below, by category.

Governance and Administration

DOD has completed actions to address approximately 76 percent of the requirements (28 of 37) related to governance and administration and has taken actions to partially address nearly 22 percent (eight of 37). Finally, it has not taken actions to address about 3 percent (one of 37), as shown in figure 4.

Figure 4: Status of DOD's Actions to Address National Defense Authorization Acts for Fiscal Years 2012-2022 Requirements Related to Governance and Administration

Source: GAO analysis of National Defense Authorization Acts and Department of Defense (DOD) information. | GAO-23-105710

The nine partially- and not-addressed requirements are found in five NDAA sections. These nine requirements relate to (1) MTF advisory committees, (2) congressional briefings on the proposed elimination of inpatient MTF capabilities, (3) new organizations within DHA for public health and research and development, (4) the feasibility of a new DHA organization for education and training, (5) DHA's organizational framework, and (6) MTF staffing.[20]

Establishment of Advisory Committees for MTFs. Section 731 of the NDAA for Fiscal Year 2017 requires the Secretary of Defense to establish, under such regulations as the Secretary may prescribe, an advisory committee for each military treatment facility. We found that DOD had partially addressed this requirement. DHA issued guidance in 2019 requiring that all parent-level MTFs (i.e., large MTFs, such as community hospitals, that are connected to smaller surrounding clinics) establish an advisory committee that they call a Patient and Family Partnership Council.[21] According to DHA records updated in March 2023, 94 of 132 parent-level MTFs had an advisory committee, 18 were re-establishing one, and 14 did not maintain one. DHA officials told us they were confirming the status of the remaining six MTF committees.

[20]The following NDAA sections contain the requirements that DOD had not yet completed actions to address: one requirement in section 731 of the NDAA for Fiscal Year 2017; one requirement in section 711 of the NDAA for Fiscal Year 2018; three requirements in section 711 of the NDAA for Fiscal Year 2019; three requirements in section 712 of the NDAA for Fiscal Year 2019; and one requirement in section 712 of the NDAA for Fiscal Year 2022.

[21]Defense Health Agency Interim Procedures Memorandum 19-002, *Standard Processes for Establishing and Maintaining Patient and Family Partnership Councils (PFPC) as Advisory Committees at Military Medical Treatment Facilities (MTF)* (Feb. 12, 2019).

A senior DHA official provided several reasons why these parent-MTFs did not currently have an advisory committee. Specifically, the official said that multiple committees have not reconvened following a temporary pause in response to the COVID-19 pandemic, though DHA is working to reestablish these. The official stated that others did not currently have a committee because DHA was in the process of determining if geographically-close MTFs can share one.

Briefing on proposed elimination of inpatient capabilities at MTFs outside the United States. Section 711 of the NDAA for Fiscal Year 2018 amended section 1073d of title 10, United States Code, to require the Secretary of Defense to provide a briefing to the House and Senate Armed Services Committees before eliminating inpatient capabilities at any facility located outside the continental United States.[22] In the required briefings, the Secretary must certify that specific actions have been taken and will be taken prior to the elimination of inpatient capabilities.[23] As of April 2023, DOD had not addressed this requirement. Specifically, we found that the Air Force eliminated the inpatient capabilities of the MTF at Aviano Air Force Base in May 2018—approximately 5 months after the NDAA for Fiscal Year 2018 was enacted—without the required briefing. According to Air Force officials, the Surgeon General of the Air Force provided an informal notification—but not the required briefing—to Congress in January 2018. Officials added that a draft briefing is currently being coordinated with DHA and the Joint Staff for review and comment. However, the briefing had not yet been completed and delivered to the required congressional committees at the time of our report.

According to Air Force officials, there are a few reasons that the briefing had not yet been provided to Congress. First, Air Force officials told us they initially believed they had addressed the requirement through an informal notification to Congress. Officials stated that they later determined that a formal briefing was required because the informal

[22]Pub. L. No. 115-91, § 711 (2017). Section 711 of the NDAA for Fiscal Year 2018 amended 10 U.S.C. § 1073d by adding subsection (e).

[23]Before inpatient capabilities are eliminated, the Secretary must certify the following: that the Secretary has entered into agreements with medical facilities in the host nation to replace the eliminated inpatient capabilities and ensure beneficiaries have access to quality health care; that the Secretary has consulted the appropriate geographic combatant command to ensure that the proposed elimination will not impact the geographic combatant command's operational plan; and that the Secretary shall provide each affected beneficiary with a transition plan for continuity of health care and a public forum to discuss their concerns. 10 U.S.C. § 1073d(e).

notification did not contain required details. Second, Air Force officials told us that the draft briefing to fulfill the section 711 requirement has undergone additional review in response to a new, related mandate in section 715 of the NDAA for Fiscal Year 2023 that requires additional congressional notification requirements for any MTF that DOD proposes modifying.[24] However, the officials could not guarantee when they would complete their review, and 5 years have passed since the Air Force eliminated the inpatient capabilities from the MTF at Aviano Air Force Base. Until DOD provides the required briefing, Congress will lack details about the rationale for modifications to this facility and assuredness that beneficiaries' access to care has not been negatively affected.

Requirements regarding the establishment of DHA Public Health and DHA Research and Development organizations. Section 711 of the NDAA for Fiscal Year 2019 requires that, by September 30, 2022, the Secretary of Defense establish within the DHA two new organizations: (1) DHA Public Health, to be led by a director or commander and comprised of the military departments' public health centers or programs; and (2) DHA Research and Development, to be led by a director or commander and comprised of the Army Medical Research and Materiel Command.[25] Additionally, section 712 of the NDAA for Fiscal Year 2022 requires the Secretary of Defense to conduct recurring consultations with each military department as it establishes DHA's Research and Development organization, and to consult with the military departments on at least a

[24]James M. Inhofe National Defense Authorization Act for Fiscal Year 2023, Pub. L. No. 117-263, § 715 (2022). Section 715 of the NDAA for Fiscal Year 2023 amended 10 U.S.C. § 1073d by introducing subsection (f). This subsection requires the Secretary of Defense to provide the House and Senate Armed Services Committees with notification of any proposed modification of an MTF's scope of medical care before those modifications occur. If such modification involves termination or reduction of inpatient capabilities at an MTF outside the United States, the notification must also indicate that the Secretary has provided to each affected beneficiary a transition plan for the continuity of health care. Finally, the notification must also contain information demonstrating the extent to which the commander of the military installation of the affected facility has been consulted to ensure there will be no impact on the operational plan for the installation.

[25]Pub. L. No. 115-232, § 711 (2018), codified as amended at 10 U.S.C. § 1073c(e). Section 711 also states that DHA Research and Development shall also be comprised of any other medical research organizations and activities of the armed forces as the Secretary of Defense considers appropriate. DHA Public Health is to be comprised of the Army Public Health Center, the Navy-Marine Corps Public Health Center, Air Force public health programs, and any other related defense health activities that the Secretary of Defense considers appropriate.

semi-annual basis thereafter.[26] As of April 2023, DOD has taken actions to partially address these three requirements.

- **DHA Public Health organization.** DHA's Campaign Plan for fiscal years 2022 through 2026 states that it will be responsible for managing, executing, and delivering public health support by fiscal year 2026. To that end, the DHA Director appointed a Director of DHA Public Health in February 2022. Additionally, on October 31, 2022, the military departments transferred authority, direction, and control of selected public health functions within the 1) Army Public Health Center, 2) Navy and Marine Corps Public Health Center, and 3) selected Air Force public health programs within the U.S. Air Force School of Aerospace Medicine to DHA as a part of Phase I of the transfer. However, DHA officials stated that, as of April 2023, DHA and the military departments were in the process of executing Phase I of the transfer to realign personnel, property, and systems to DHA Public Health.
- **DHA Research and Development organization.** As with DHA Public Health, DHA's Campaign Plan for fiscal years 2022 through 2026 states that it will be responsible for managing, executing, and delivering military medical research and development by fiscal year 2026. According to a senior DHA official, DOD has programmed and budgeted for the transfer of U.S. Army Medical Research and Development Command personnel to DHA for fiscal years 2024 through 2026. However, as of April 2023, the official stated neither functions nor personnel had been transferred from the U.S. Army Medical Research and Development Command to the new DHA organization. DOD officials were unable to provide a timeline—including milestones or targets—for the completion of the transfer process. The Secretary has also not appointed a Director. With respect to the required consultations between the Secretary and each military department as it establishes DHA Research and Development, officials stated that DOD leaders approved a new governance structure to address this requirement, and the first meeting of the new forum is planned for May 2023. Until then, officials stated that the military departments will continue to coordinate with DHA on medical research through existing forums.

DOD was required to establish the public health and research and development organizations within DHA by September 2022. However, DHA currently expects to complete its establishment by fiscal year 2026.

[26]Pub. L. No. 117-81, § 712 (2021), codified at 10 U.S.C. § 1073c(f).

With respect to DHA Public Health, DHA officials stated that they have begun developing an implementation plan for Phase 2 of the transfer of functions from the military departments. However, officials added that these efforts were paused in response to section 720 of the NDAA for Fiscal Year 2023, which provides the military departments, at the discretion of the Secretary of Defense, the ability to temporarily retain, until not later than February 1, 2024, public health functions under specified conditions.[27]

Similarly, DHA officials stated that they have begun to develop a detailed implementation plan for the transfer of research and development functions from the military departments to DHA, but that the plan has not been finalized. DHA officials explained that they were waiting on key decisions from senior DOD leaders about timelines for remaining functions to be transferred for both organizations, to include personnel transfers.

Leading practices associated with successful reform efforts state that developing an implementation plan with key milestones and deliverables can help an organization track implementation progress.[28] Without finalized implementation plans with timelines for completion of the remaining phases of both the public health transfer and the transfer of research and development, DOD could be further delayed in implementing the transfer of these public health and research and development functions from the military departments to the DHA. Although DOD was not required to provide the plans to Congress, doing so would enhance congressional oversight of these multi-year transition processes to ensure their continued progress.

Feasibility of establishing Defense Health Agency Education and Training. Section 711 of the NDAA for Fiscal Year 2019 requires a report regarding the feasibility of establishing DHA Education and Training,

[27]Pub. L. No. 117-263, § 720 (2022). Under section 720, a military department may retain a covered function if the Secretary of Defense determines that it addresses a need that is unique to the military department and is in direct support of operating forces and necessary to execute strategies relating to national security and defense.

[28]GAO, *Government Reorganization: Key Questions to Assess Agency Reform Efforts*, GAO-18-427 (Washington, D.C.: June 13, 2018).

which DOD took action to partially address.[29] DOD provided the report to the House and Senate Armed Services Committees. However, while the report demonstrated information on the size and complexity of the military medical education and training system, it did not provide a determination regarding the feasibility of establishing DHA Education and Training. Instead, the report noted that the medical education and training enterprise is large, complex, and decentralized, and stated that the department will conduct a more comprehensive assessment of restructuring DOD's medical education and training enterprise after ongoing MHS reform activities are completed. Section 724 of the NDAA for Fiscal Year 2023 requires DOD to conduct another feasibility study for an organization to be known as the MHS Education and Training Directorate, and develop a plan for the establishment of the directorate.[30] DOD is required to submit the study and plan to the House and Senate Armed Services Committees by December 23, 2023.

Establishment of DHA organizational framework. Section 712 of the NDAA for Fiscal Year 2019 requires the Secretary of Defense to develop an MHS organizational framework that supports the medical requirements of the combatant commands.[31] Specifically, section 712 requires that there should be no more than two DHA regions in the continental United States, and no more than two DHA regions outside the United States. DOD has partially addressed this requirement. The department established two DHA regions outside the United States consistent with the requirement—DHA Region Europe and DHA Region Indo-Pacific. However, it implemented a geographically based DHA structure

[29]The report was to include information on the feasibility of establishing a new organization, to be led by the President of the Uniformed Services University of the Health Sciences and to be comprised of the current Medical Education and Training Campus located at Fort Sam Houston, the Uniformed Services University of the Health Sciences, the medical education and training commands of the Armed Forces, and such other elements, facilities, and commands of DOD as the Secretary of Defense considers appropriate. Pub. L. No. 115-232, § 711 (2018).

[30]Pub. L. No. 117-263, § 724 (2022).

[31]Pub. L. No. 115-232, § 712(a) (2018). Section 712(b) also specified that each DHA region within the United States shall be led by a commander or director who is a member of the Armed Forces and serving in a grade not higher than major general or rear admiral. Further, each commander or director shall be selected by the Director of the DHA from among members of the Armed Forces recommended by the Secretaries of the military departments for service in such position, and shall be under the authority, direction, and control of the Director while serving in such position. DOD addressed this provision of the requirement.

comprised of 19 large markets, 17 small markets, and 40 standalone parent MTFs within the continental United States.[32] DHA does not use the term "region" to define its U.S.-based organizational framework, but we found that the markets share key similarities with the overseas regions. We have ongoing work related to DHA's management structure for MTFs. We plan to issue a report in the summer of 2023.[33]

Coordination to ensure MTF staffing supports readiness, and validation of supply and demand for medical services at MTFs. Section 712 of the NDAA for Fiscal Year 2019 also requires the DHA Director to coordinate with the military departments to ensure that staffing at MTFs in each region supports medical readiness requirements for service members of the Armed Forces and military medical personnel.[34] Additionally, it mandates that the DHA Director (1) validate supply and demand requirements for medical and dental services at each MTF and, when the workload is insufficient to meet requirements, (2) identify alternative training and clinical practice sites for uniformed medical and dental personnel and establish military-civilian training partnerships.

DHA has taken actions to partially address these two requirements. Specifically, DHA and the military departments developed a process called the Human Capital Distribution Framework by which to coordinate military medical personnel assignments across all MTFs. However, they had not fully implemented the new process as of April 2023. According to a senior DHA official, DHA and the military departments implemented the process for a subset of personnel and MTFs in 2021. The official expected that the process would be implemented for all personnel and MTFs in the summer of 2023. Consistent with the statutory requirement, the process was designed to account for the staffing levels needed to support readiness requirements and uses historical data on demand for health care services. In addition to this effort to meet the statutory requirement, MTFs submit performance plans to DHA that identify the demand for healthcare services, the supply of providers to meet this

[32]Parent MTFs are larger facilities—such as community hospitals—that are connected to smaller surrounding clinics. DOD also maintains 36 subordinate clinics reporting to 21 of the standalone parent MTFs. DHA's market offices, including its Small and Stand-Alone MTF Organization, as well as its regional offices for the DHA Region Europe and DHA Region Indo-Pacific, handle administration and management activities for the their constituent MTFs.

[33]*See* GAO-23-105441, when available.

[34]Pub. L. No. 115-232, § 712 (2018).

demand, and mitigation strategies to address gaps in the ability to meet demand. This includes identifying MTF personnel available to support health service delivery when service readiness activities take providers outside the MTF.[35]

With respect to identifying alternative training when MTF workload is insufficient, we found that DHA has taken steps to facilitate the development of military-civilian training partnerships, pursuant to DOD guidance.[36] This work has been limited to partnerships for trauma-related training, according to DHA officials. Specifically, DHA's Joint Trauma Education and Training Branch—a branch of DHA's Joint Trauma System—has developed criteria to evaluate civilian academic trauma center partnerships opportunities for use by trauma teams of the military departments. However, in December 2022, DHA officials stated that they had not yet established partnerships. Instead, military MTF leaders have locally developed the majority of partnerships, augmented by military department medical organizations, which—according to officials—established other MTF partnerships with civilian hospitals.

Because the transition of MTF administration and management to the DHA occurred from 2019 through 2022, DHA's market offices now manage partnerships, including the continuation of preexisting partnerships and the creation of new ones.[37] We continue to believe that fully implementing our prior recommendation that the DHA Director establish a process to streamline or add new military-civilian training partnerships would help DOD facilitate these partnerships and ensure its alignment with statutory responsibilities.

Force Structure and End Strength

DOD has completed actions to address approximately 59 percent of the requirements (10 of 17) related to force structure and end strength and

[35]According to DHA documentation, markets will submit one plan for fiscal years 2023 through 2025 for all MTFs and dental activities within their market. Plans should contain information on proposed initiatives to address gaps and are reviewed at various levels within DHA and the services, including reviews for readiness implications. Ultimately, initiatives recommended as a result of various reviews are briefed to DHA's Assistant Director, Health Care Administration, for approval.

[36]DOD Instruction 6000.19.

[37]In June 2021, we reported that the DHA did not have a process to streamline or add new military-civilian training partnerships and recommended that the Secretary of Defense ensure that the DHA Director establish such a process. GAO, *Defense Health Care: Actions Needed to Define and Sustain Wartime Medical Skills for Enlisted Personnel,* GAO-21-337 (Washington, D.C.: June 21, 2021). DOD concurred with this recommendation but has not yet implemented it as of April 2023.

has taken actions to partially address approximately 35 percent of them (six of 17). Finally, it has not taken actions to address about 6 percent of the requirements (one of 17), as shown in figure 5.

Figure 5: Status of DOD's Actions to Address National Defense Authorization Acts for Fiscal Years 2012-2022 Requirements Related to Force Structure and End Strength

Source: GAO analysis of National Defense Authorization Acts and Department of Defense (DOD) information. | GAO-23-105710

The six partially-addressed requirements and the one not addressed are found in three NDAA sections and relate to (1) defining medical and dental personnel requirements, (2) developing a measure of network adequacy, and (3) reporting on force mix options.

Process to define military medical and dental personnel requirements. Section 721 of the NDAA for Fiscal Year 2017 requires the Secretary of Defense, in collaboration with the military departments, to (1) establish a process to define military medical and dental personnel requirements necessary to meet operational medical force readiness requirements, and (2) report to the House and Senate Armed Services Committees on the process and the defined personnel requirements.[38] Further, section 719 of the NDAA for Fiscal Year 2020 requires each of the three military departments to review medical personnel requirements, in coordination with the Joint Chiefs of Staff, including any requirements

[38]Pub. L. No. 114-328, § 721 (2016). Section 721 codified the requirement for a process at section 977 of title 10, United States Code.

determined pursuant to estimates provided in the Joint Medical Estimate.[39]

DOD took actions to partially address four requirements related to personnel in these two sections. Specifically, DOD provided the House and Senate Armed Services Committees with interim and final reports on the two sections. In its March 2018 interim report, DOD stated that the individual military departments completed the majority of the work to define personnel requirements in coordination with the Joint Staff, and that additional work was required to develop a DOD-wide process.[40] The interim report also noted that DOD would address a department-wide process in a follow-on report to the House and Senate Armed Services Committees. However, in its final report in August 2021, DOD restated its description of the processes the military departments use to identify requirements individually, having not established the singular DOD-wide joint process that it described working toward in its interim report to address the requirement in section 721.[41] Moreover, according to the Joint Staff Surgeon, the military departments' respective analyses did not fully address Joint Staff comments, including input from the Joint Medical Estimate.[42]

Our prior work reviewed DOD's progress toward addressing section 721. We reported in February 2019 that, among other things, the military

[39]Pub. L. No. 116-92, § 719 (2019), as amended by Pub. L. No. 116-283, § 717 (2021) and Pub. L. No. 117-81, § 731 (2021). The Joint Medical Estimate is an independent assessment, prepared by the Joint Staff Surgeon, of the Joint Force's operational medical capabilities in support of the National Military Strategy, and provides potential shortfalls and barriers to providing health care to service members during the full range of military operations. Chairman of the Joint Chiefs of Staff Instruction 3100.01E, *Joint Strategic Planning System* (May 21, 2021).

[40]Department of Defense, *Substantive Interim Report to the Armed Services Committees of the Senate and House of Representatives, Section 721 of the National Defense Authorization Act for Fiscal Year 2017 (Public Law 114–328), Authority to Convert Military Medical and Dental Positions to Civilian Medical and Dental Positions* (March 2018).

[41]Department of Defense, *Report to the Congressional Armed Services Committees, Section 719 of the National Defense Authorization Act for Fiscal Year 2020, (Public Law 116 – 92)* (July 2021). DOD states in this final report that the report addresses the remaining requirements in section 721 of the NDAA for Fiscal Year 2017, in addition to requirements in section 719 of the NDAA for Fiscal Year 2020.

[42]We have ongoing work on the military departments' use of the Joint Medical Estimate in their processes to determine medical personnel requirements. We plan to issue a report on this topic later this year. *See* GAO-23-106094, when available.

departments applied different planning assumptions in estimating required personnel, such as developing varying definitions for operational requirements.[43] We recommended that DOD (1) establish joint planning assumptions for developing operational medical and dental personnel requirements, (2) establish a method to assess options for achieving joint efficiencies in those requirements, and (3) apply joint planning assumptions and a method for assessing efficiencies and risk to determine requirements. DOD concurred with these recommendations.

As of April 2023, DOD had not fully implemented the three recommendations. We continue to believe that fully implementing these recommendations will help align DOD's actions with statutory requirements. Until DOD fully implements the recommendations, the department will not be able to apply consistent assumptions to determine medical and dental personnel requirements and will not have a method for assessing options for joint efficiencies. Without such a method, the department will not know whether it has an optimal size and composition of medical and dental personnel for achieving its missions within acceptable risk levels.

Development and use of a network adequacy measure. Section 719 of the NDAA for Fiscal Year 2020 also requires the Secretary of Defense to develop a standard measurement for network adequacy to determine the capacity of the local health care network to provide care for covered beneficiaries in the area of an MTF that would be affected by a proposed military medical end strength realignment or reduction. Additionally, section 719 requires that the Secretary use such measurement in carrying out this section and otherwise evaluating proposed military medical end strength realignment or reductions. DOD took actions to partially address these two requirements.

In May 2020, we reported that DOD had not decided how to define and measure its objectives for MTF restructuring transitions, including an objective to ensure that civilian health care facilities and providers adequately support the health care needs of beneficiaries near each MTF.[44] We recommended that DOD collect complete and accurate

[43]GAO, Defense Health Care: Actions Needed to Determine the Required Size and Readiness of Operational Medical and Dental Forces, GAO-19-206 (Washington, D.C.: Feb. 21, 2019).

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

information about civilian health care providers and define measurable objectives, among other things. DOD concurred or partially concurred with, but has not yet fully implemented, these recommendations.

In its final report on sections 721 and 719, DOD defined network adequacy and described a methodology for assessing it. We have ongoing work related to the sufficiency of DOD's methodology and the extent they used it to assess the ability of local health care networks to absorb additional workload caused by military medical reductions. We plan to issue a report later this year.[45]

Report on force mix options and service models. Section 757 of the NDAA for Fiscal Year 2021 requires the Secretary of Defense to enter into an agreement with a federally funded research and development center or an independent entity to conduct a study on force mix options and service models.[46] The options and models are to enhance the readiness of the medical force of the Armed Forces to deliver combat care on the battlefield, and assist public health responses to pandemics or other national public health emergencies. The section also requires the Secretary of Defense to submit a report to the House and Senate Armed Services Committees on the findings and recommendations resulting from the study.[47] DOD entered into an agreement with a research and development center, consistent with the requirement. However, DOD had not submitted the report to appropriate congressional committees as of April 2023. According to DOD officials, the department was reviewing a draft report internally at that time. Officials noted it was a priority to provide it to Congress as soon as possible.

MTF Care

DOD has completed actions to address nearly 94 percent of the requirements (15 of 16) related to MTF care and has taken actions to partially address approximately 6 percent (one of 16), as shown in figure 6.

[45]*See* GAO-23-106094, when available.

[46]William M. (Mac) Thornberry NDAA for Fiscal Year 2021, Pub. L. No. 116-283, § 757 (2021).

[47]This report was due not later than 15 months after the enactment of the NDAA (i.e., not later than 15 months from January 1, 2021).

Figure 6: Status of DOD's Actions to Address National Defense Authorization Acts for Fiscal Years 2012-2022 Requirements Related to Military Medical Treatment Facility Care

Source: GAO analysis of National Defense Authorization Acts and Department of Defense (DOD) information. | GAO-23-105710

The requirement that DOD has partially addressed is found in section 726 of the NDAA for Fiscal Year 2017, which requires the Secretary of Defense to implement a program to eliminate variability of care at MTFs.[48] As part of the program, DOD is required to develop, implement, monitor, and update clinical practice guidelines, which are evidence-based recommendations intended to help providers improve the consistency and quality of care in determining the best treatment options for a particular disease or condition.

DOD has partially addressed this requirement because it has not implemented a process to systematically monitor the use of its clinical practice guidelines. DOD and the Department of Veterans Affairs began jointly developing and implementing clinical practice guidelines in 1998, and as of April 2023, they had jointly developed 22 of them. These guidelines address specific health conditions, including those related to chronic diseases, mental health issues, pain management, and rehabilitation. Providers at MTFs and Veterans Affairs medical centers may refer to these guidelines when determining the best course of treatment for their patients. However, providers are not required to use the guidelines.

In February 2021, we reported that DHA and the military services are not systematically monitoring MTFs' implementation of these guidelines.[49] For example, while the Army tracks education and training on the clinical practice guidelines at its MTFs, officials with DHA, the Navy, and the Air Force explained that they have not been monitoring MTF implementation. We reported that DHA officials agreed that they need to develop a

[48]Pub. L. No. 114-328, § 726 (2016).

[49]GAO, *DOD Health Care: DOD Should Monitor Implementation of Its Clinical Practice Guidelines*, GAO-21-237 (Washington, D.C.: Feb. 5, 2021).

monitoring process as they assume administrative and oversight responsibilities for the military services' MTFs, but had not developed a plan to do so at the time of our prior review. As a result, we recommended that the Director of DHA collaborate with the Surgeons General of the military services to develop and implement a process to monitor the implementation of clinical practice guidelines. DOD concurred with our recommendation, and in February 2023, the department provided an updated plan to implement it with an anticipated completion date of March 2024.

Private-Sector Care

DOD has completed actions to address approximately 77 percent of the requirements (37 of 48) related to private-sector care and has taken actions to partially address nearly 21 percent (10 of 48). Finally, it has not taken actions to address approximately 2 percent (one of 48), as shown in figure 7.

Figure 7: Status of DOD's Actions to Address Fiscal Year 2012-2022 National Defense Authorization Act Requirements Related to Private-Sector Care

Source: GAO analysis of National Defense Authorization Acts and Department of Defense (DOD) information. | GAO-23-105710

Note: We identified four requirements in the Private-Sector Care category that were within our scope of reforms but for which we were unable to determine the extent to which DOD addressed them because, for example, the information that DOD was required to post online was no longer available. We do not include these requirements in our counts of DOD's actions.

The 11 partially and not-addressed requirements are found in four NDAA sections and relate to the (1) TRICARE Select implementation plan, (2) TRICARE contract acquisition strategy, (3) implementation of value-based care initiatives, and (4) core quality performance metrics.

TRICARE Select implementation plan. Section 701 of the NDAA for FY 2017 requires DOD to establish a new preferred provider network health plan option called TRICARE Select.[50] It also requires DOD to develop a

[50]Pub. L. No. 114-328, § 701(a) (2016), codified as amended at 10 U.S.C. § 1075.

related implementation plan that addresses specific elements that target issues such as access to care, beneficiary complaints, and quality metrics for network providers. DOD took actions to partially implement the requirement for this implementation plan because it has not fully addressed one of the implementation plan's elements.

In April 2018, we reported on DOD's implementation plan for TRICARE Select.[51] We found that DOD was in the process of developing its approach for the element related to defining access standards when it submitted the plan. As a result, the implementation plan does not include current information about how access standards will be established for this benefit option. We recommended that DOD provide Congress written documentation of its approach for developing and approving access standards, as well as the final access standards. DOD agreed with our recommendation, but as of April 2023, had not taken action to address it.

TRICARE contract acquisition strategy. Section 705 of the NDAA for Fiscal Year 2017 requires DOD to develop an acquisition strategy for its TRICARE managed care support contracts that includes 13 specific elements, including actions related to provider networks; telehealth; value-based methodologies; and access to care in rural, remote, and isolated areas.[52] DOD took actions to partially address four requirements related to this section.

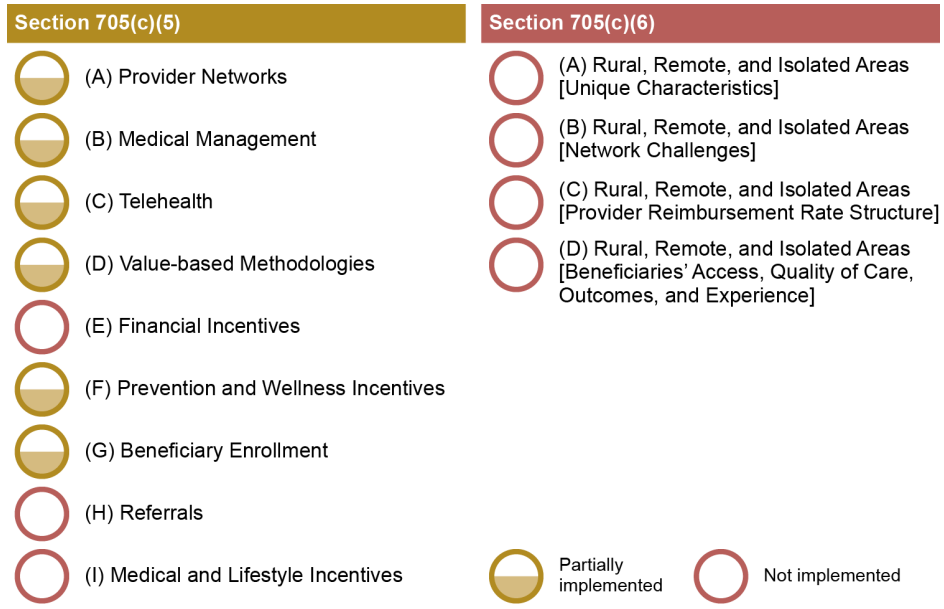
In February 2020, we reported that DOD had partially implemented six of the 13 elements in its T-2017 (fourth generation) managed care support contracts, as shown in figure 8.[53]

[51]GAO, Defense Health Care: TRICARE Select Implementation Plan Included Mandated Elements, but Access Standards Should Be Clarified, GAO-18-358 (Washington, D.C.: April 13, 2018).

[52]Pub. L. No. 114-328, § 705(c) (2016).

[53]GAO, *Defense Health Care: Plans Needed to Ensure Implementation of Required Elements for TRICARE's Managed Care Support Contracts,* GAO-20-197 (Washington, D.C.: Feb. 7, 2020).

Figure 8: Elements of Section 705(c) of the National Defense Authorization Act (NDAA) for Fiscal Year 2017 Implemented by DOD in the T-2017 Contracts, as of January 2020



Source: GAO analysis of section 705(c) of the NDAA for Fiscal Year 2017 and Department of Defense (DOD) information. | GAO-23-105710

At that time, DOD leadership explained that they decided to implement each of the 13 elements separately rather than developing a single strategy that addressed all of the elements. We further reported that DOD lacked plans with specific time frames and actions needed to fully implement all of the elements, and we recommended that DOD develop and implement plans with time frames and specific actions needed for all 13 required elements to be reflected in the TRICARE contracts. DOD concurred with our recommendation and implemented it by providing a planning document that contained the actions and time frames the department will use to guide its implementation of all 13 required elements.[54] DOD estimates that all of the 13 elements will be implemented by January 2026.

[54]In October 2020, DOD reported that achievement of the 13 elements in section 705(c) of the National Defense Authorization Act for Fiscal Year 2017 relies on demonstrations and pilots in the T-2017 contracts, rulemaking, and the development of new contract requirements for T-5 (the fifth generation of TRICARE contracts).

Implementation of value-based care initiatives. Sections 701, 705, and 729 of the NDAA for Fiscal Year 2017 collectively direct DOD to implement value-based care initiatives in TRICARE for civilian providers. This includes initiatives such as with programs that link payment with improved performance, as well as value-based initiatives for beneficiaries, such as with incentive programs that encourage a healthy lifestyle.[55] Value-based health care seeks to reward value over volume, with value generally measured in terms of improved health outcomes, enhanced experience of care for the patient, and reduced health care costs over time. DOD took actions to partially address three requirements related to these sections and has not taken actions to address one requirement. In September 2020, we reported on all of the value-based initiatives the department had identified, as well as the status of each initiative.[56]

We consider these three requirements to be partially addressed because the department is piloting value-based initiatives in its T-2017 (fourth generation) contracts with the intent to more fully implement this methodology in its T-5 (fifth generation) contracts, as we reported in February 2020.[57] DOD awarded the fifth generation contracts in December 2022 with a health care delivery start date in 2024.[58] The T-5 request for proposal includes both short term and long term value-based initiatives. However, we cannot determine the implementation status of these initiatives until health care delivery is underway.

Additionally, as of March 2023, DOD had not completed actions to address one requirement in section 701 for the department to provide a report to Congress on its efforts to implement value-based initiatives by January 1, 2023. Officials informed us in April 2023 that the report is going through internal review. This is the final report according to the requirements we reviewed. DOD has previously provided three reports to

[55]Pub. L. No. 114-328, §§ 701(h), 705, 729 (2016).

[56]GAO, *Defense Health Care: Implementation of Value-Based Initiatives in TRICARE*, GAO-20-695R (Washington, D.C.: Sept. 17, 2020).

[57]GAO-20-197.

[58]As of June 2023, there is a pending bid protest regarding the award of the TRICARE West region contract.

the House and Senate Armed Services Committees as required on its implementation of value-based initiatives.[59]

Core quality performance metrics. Section 728 of the NDAA for Fiscal Year 2017 requires DOD to adopt, to the extent appropriate, certain core quality performance metrics for specific types of health care providers (e.g., accountable care organizations, patient centered medical homes, and primary care) as well as for specific specialties (e.g., gastroenterology, obstetrics and gynecology).[60] DOD took actions to partially address two requirements related to this section. Specifically, DHA has developed the core quality metrics, but we consider these requirements to be partially addressed because DHA officials told us they are waiting until health care delivery begins under the T-5 contracts to publish the metrics online.

Training and Readiness

DOD has completed actions to address approximately 63 percent of the requirements (25 of 40) related to training and readiness and has taken action to partially address nearly 38 percent (15 of 40), as shown in figure 9.

Figure 9: Status of DOD's Actions to Address National Defense Authorization Acts for Fiscal Years 2012-2022 Requirements Related to Training and Readiness

Source: GAO analysis of National Defense Authorization Acts and Department of Defense (DOD) information. | GAO-23-105710

[59]Department of Defense, *Report to Congressional Defense Committees on Pilot Program on Incentive Programs to Improve Health Care Provided Under the TRICARE Program* (Jan. 11, 2018); *Report to the Armed Services Committees on Pilot Program on Incorporation of Value-Based Health Care in Purchased Care Component of TRICARE Program* (Jan. 31, 2018); and *Report to Congressional Defense Committees: Pilot Program on Incentive Programs to Improve Health Care Provided under the TRICARE Program* (Feb. 18, 2020). The report on the incorporation of value-based health care addressed two requirements included in section 701(h)(3) and section 705(d) of the NDAA for Fiscal Year 2017.

[60]Pub. L. No. 114-328, § 728 (2016).

The 15 requirements that DOD has partially addressed are found in two NDAA sections and relate to (1) military-civilian integrated health delivery systems, and (2) efforts to maintain clinical wartime medical readiness skills and core competencies.

Military-civilian integrated health delivery systems. Section 706 of the NDAA for Fiscal Year 2017 requires the Secretary of Defense to establish military-civilian integrated health delivery systems through partnerships with other health systems, including local or regional health systems in the private sector.[61] DOD took actions to partially address 14 requirements from section 706.

In DOD's September 2022 report to Congress regarding these systems, submitted in response to section 743, the department stated that no contracts between MTFs and local civilian health care systems exist outside of TRICARE contracts.[62] DOD further stated in the report that their TRICARE contracts are how they establish an integrated military-civilian health delivery system. We found that DOD is partially addressing this reform through its TRICARE contracts. Specifically, DOD incorporated some of the required elements of section 706 into its solicitation for the T-5 contracts, such as through explicit requirements related to its civilian provider network.

[61]Pub. L. No. 114-328, § 706 (2016). A related section, section 743 of the NDAA for Fiscal Year 2020, requires the Secretary of Defense to conduct a study on the use of local military-civilian integrated health delivery systems pursuant to section 706 of the NDAA for Fiscal Year 2017 and develop a plan for the further development of the use of those systems. Pub. L. No. 116-92, § 743 (2019). DOD addressed section 743 by completing the study and submitting a report to the House and Senate Armed Services Committees in September 2022. *See* Department of Defense, *Report to Congress, Section 743 of the National Defense Authorization Act for Fiscal Year 2020 (Public Law 116-92), Study and Plan on the Use of Military-Civilian Integrated Health Delivery Systems* (Sept. 21, 2022). Sections 706 and 743 include requirements related to private-sector care as well as requirements related to training and readiness. We assigned both sections to the Training and Readiness category because some requirements pertain to maintenance of operational medical force readiness skills of health care providers of the Department and to providing members of the Armed Forces with additional training opportunities to maintain such readiness skills.

[62]Department of Defense, *Report to Congress, Section 743 of the National Defense Authorization Act for Fiscal Year 2020 (Public Law 116-92), Study and Plan on the Use of Military-Civilian Integrated Health Delivery Systems* (Sept. 21, 2022). DOD contracts with private-sector companies—referred to as managed care support contractors—to deliver health care services to its TRICARE program beneficiaries through networks of civilian providers.

Additionally, as outlined in its T-5 solicitation, DOD cites the potential use of its demonstration authority to compete for additional contracts within the managed care support contractor's geographic area of responsibility to provide beneficiaries with options for local and regional providers. According to DOD, demonstration projects will allow DHA to test the efficacy of having local and regional contracts that balance the need for accessible, high quality care for TRICARE beneficiaries with a need for hospital based readiness platforms for its medical personnel. We consider the related requirements for this section to be partially addressed because health care delivery under the T-5 contracts is scheduled to begin in 2024, and we cannot determine the implementation status of these initiatives until health care delivery is underway.

Outside of TRICARE contracts, DOD's September 2022 report on sections 743 and 706 described four other types of partnerships with local civilian health care facilities in proximity to 49 military installations. According to DOD's report, (1) Memorandums of Understanding, (2) Training Affiliation Agreements, and (3) Medical Training Agreements expand services of the MTF or allow health care providers and students to attain critical wartime readiness skills and training by providing hands-on experience that is not seen on a regular basis in the direct care system. The report further discusses a fourth partnership type—External Resource Sharing Agreements. These written agreements between TRICARE contractors, the MTF, and a TRICARE network facility assist MTFs in providing staff augmentation due to difficulties in filling open positions or personnel shortages to meet a given demand or in support of an MTF contingency.

Measures to maintain critical wartime medical readiness skills and core competencies. Section 725 of the NDAA for Fiscal Year 2017 requires the Secretary of Defense to implement measures to maintain the critical wartime medical readiness skills and core competencies of health care providers within the Armed Forces.[63] DOD took actions to partially address one requirement related to this section. We reported in February 2019, that DOD had begun several initiatives related to section 725, such as developing policy, involving leaders, and realigning governance structures.[64] However, we reported that the department's methodology for assessing the clinical readiness of its providers was limited and

[63]Pub. L. No. 114-328, § 725 (2016).

[64]GAO-19-206.

recommended improvements with which the department concurred but had not fully implemented as of April 2023.

Specifically, we recommended that DOD identify and mitigate limitations in the clinical readiness metric and prioritize critical wartime specialties to which the clinical readiness metric could be expanded. We also recommended that it estimate the cost and benefits, by specialty, of implementing a clinical readiness metric and use that information to determine whether it should revise its approach. According to its latest plan to implement these recommendations, DOD expects to finish its framework for expanding the readiness metric by June 2023. Likewise, DOD estimates completing the other recommendations by the end of fiscal year 2025 by publishing guidance and improving data collection and analysis in connection with the reliability of the metric.

DOD Does Not Systematically or Comprehensively Monitor Actions Taken in Response to Requirements for MHS Reform

MHS components maintain processes to identify and delegate responsibility for addressing requirements for reform found in annual NDAAs, and DOD maintains a process for identifying and tracking requirements for reports and briefings to Congress. However, the Office of the Assistant Secretary of Defense for Health Affairs' monitoring of actions taken to address requirements for reform is not systematic or comprehensive.

MHS Components Maintain Processes to Delegate Requirements for MHS Reform and Identify and Track Reporting Requirements

MHS components—including the Office of the Assistant Secretary of Defense for Health Affairs (hereafter referred to as Health Affairs), DHA, and the military departments' medical headquarters—maintain similar processes for identifying and delegating responsibilities for MHS reform requirements included in the annual NDAA. For example, a Health Affairs official explained that Health Affairs' Congressional Affairs office tracks NDAA bills throughout their development until enactment, identifying potential requirements for reform and officials responsible for affected MHS functions. For each NDAA enacted, the Congressional Affairs office delegates responsibility for implementing reform requirements to the

appropriate officials in Health Affairs and DHA.[65] The official also explained that the Congressional Affairs office coordinates with the military departments regarding requirements where coordination may be needed between the Health Affairs, DHA, and the military department medical headquarters to implement.

Likewise, officials from each of the military departments' medical organizations stated that their respective offices of legislative affairs, as well as their services' headquarters-level offices of legislative affairs, track the annual NDAA through the legislative process to identify potential reform requirements. This includes both those that their respective department must lead, and those for which it will not have lead responsibilities but must provide input. Military department officials stated that their respective offices of the Assistant Secretary of the Army, the Navy, or the Air Force for Manpower and Reserve Affairs typically receive requests for input from other DOD components (e.g., Health Affairs, Office of the Under Secretary of Defense for Acquisition and Sustainment) regarding requirements for each enacted NDAA. According to officials, upon receiving the requests, these military department offices task their subordinate organizations, including the Surgeons General and medical headquarters, with implementing actions to address requirements.[66] Officials stated that their Surgeons General or respective medical headquarters then task the appropriate offices and subject matter experts with executing their role in implementing the requirement.

[65]The official explained that the Congressional Affairs office may identify MHS reform requirements for which Health Affairs and DHA are not responsible; in these cases, the Congressional Affairs office identifies and communicates with the appropriate element (e.g., the Office of the Under Secretary of Defense for Acquisition and Sustainment, Policy, or Personnel and Readiness) about the requirement.

[66]Officials explained that this is a consequence of most reform requirements being directed to the Secretary of Defense or DHA. They stated that, for requirements enacted into law that are directed exclusively to the military departments, formal delegations within the military departments are sent to their respective surgeons general, which will then task the appropriate offices and individuals with implementing the requirements.

DOD-Wide Process to Report to Congress Has Limitations

We reported in February 2022 on challenges with the DOD-wide process for responding to congressional reporting requirements. We found that DOD officials sometimes independently assigned and tracked their reporting requirements using separate systems, and that DOD had limited performance data on its process, among other challenges.

We recommended that DOD modernize this process by ensuring responsible officials in the Office of the Secretary of Defense consult with internal stakeholders, establish performance measures, and collect the necessary data to assess progress towards goals. DOD concurred. As of April 2023, DOD had not yet implemented the recommendations.

Source: GAO-22-105183. | GAO-23-105710

DOD also maintains a process for identifying and tracking reports and briefings to congressional recipients. Specifically, officials from the Office of the Assistant Secretary of Defense for Legislative Affairs (Legislative Affairs) review the NDAA to identify reporting requirements for DOD. Legislative Affairs officials then assign reporting requirements to the appropriate DOD components (e.g., military departments, defense agencies) through a central database. As DOD components prepare reports and briefings in response to congressional reporting requirements, they provide Legislative Affairs with status updates. According to officials from Health Affairs and DHA, Legislative Affairs officials provide them and other DOD components with assistance, as necessary, and track the status of reporting requirements. After DOD components complete a draft report in response to a congressional reporting requirement, the report is coordinated within DOD for review and signature, and an electronic copy is uploaded to the Legislative Affairs database. In February 2022, we reported on and made recommendations related to the limitations with DOD's congressional reporting process (see sidebar).[67]

Health Affairs Monitoring of Actions Taken to Address Requirements for Reform Is Not Systematic or Comprehensive

Health Affairs is charged with carrying out management oversight of the MHS and directing changes in the execution of health-related matters across DOD, which it executes at a strategic level. Specifically, Health Affairs conducts high-level monitoring of efforts to address some MHS reform requirements, including participation in MHS governance forums and ad hoc working groups. For example, Health Affairs participates in the following MHS governance forums:

- The **Military Health System Executive Review**, which is a senior-level forum for DOD leadership to help maintain focus on MHS interrelated issues—including responding to statutory mandates and other congressional special interests—and implementing MHS governance reforms.[68]
- The **Senior Military Medical Advisory Council**, which is the executive-level forum for establishing comparability, consistency, and

[67]GAO, *Defense Management: DOD Should Collect More Stakeholder Input and Performance Data on Its Congressional Reporting Process*, GAO-22-105183 (Washington, D.C.: Feb. 10, 2022).

[68]A draft update to the charter of the Military Health System Executive Review Board states that the Board will ensure implementation of NDAA and other legal requirements. However, a Health Affairs official explained that the Board will continue to focus on the subset of statutory requirements that involve multiple MHS components.

standardization, and providing the Assistant Secretary of Defense for Health Affairs with advice on executing his or her responsibilities.

- The **Deputy Military Medical Action Council**, which is the governance body through which Health Affairs performs oversight of the system, monitors the performance of the MHS, and provides decision support to the Assistant Secretary of Defense for Health Affairs through the **Senior Military Medical Advisory Council**.

Health Affairs also participates in the execution and monitoring of reform requirements on a limited basis. For example, according to a charter signed in September 2017, the Acting Assistant Secretary of Defense for Health Affairs established a temporary Program Management Office to plan and track the MHS components' efforts to address reform requirements from the NDAA for Fiscal Year 2017. Health Affairs officials also participated in various working groups that conducted implementation planning for specific sections of the NDAA. The Program Management Office disbanded in May 2018 after it determined that the MHS components had addressed requirements, or handed off responsibilities for continuing implementation oversight to a responsible component. However, we found that several requirements from the NDAA for Fiscal Year 2017—such sections 706 and 721—were partially addressed.

The MHS governance forums and ad hoc Program Management Office and working groups do not provide Health Affairs with a systematic or comprehensive view of MHS reform efforts. In addition, these groups do not provide Health Affairs with a mechanism for ensuring accountability of reform implementation. For example, the governance forums provide an opportunity for various levels of MHS leadership to discuss, among other things, achievement of strategic priorities and key reform efforts. However, according to a Health Affairs official, it is not within the scope of their responsibilities to actively monitor the universe of MHS reform efforts. Furthermore, with respect to ad hoc working groups, a Health Affairs official we interviewed stated that Health Affairs participates in these efforts when the implementation of a reform requirement necessitates multiple components' involvement, but generally delegates execution and monitoring of requirements to MHS components. The department has also reported on the limitations of monitoring and executing MHS reforms through a working group construct. Specifically, in an August 2022 report on medical headquarters manpower requirements, a DOD study team concluded that they should replace the

working group structure of implementation and monitoring with a more permanent structure in the future.[69]

DOD Directive 5136.01 states that Health Affairs provides oversight to the DOD components on matters pertaining to the MHS, and oversees and directs changes in the execution of health-related matters across the DOD.[70] To carry out its oversight responsibilities, among other things, the Assistant Secretary of Defense for Health Affairs is responsible for developing and managing an MHS-wide strategic management program and organizational improvement measures that demonstrate value across the MHS enterprise. The Assistant Secretary also ensures the DOD components of the MHS are attentive and responsive to the requirements of their organizational customers, both internal and external to DOD. Furthermore, *Standards for Internal Control in the Federal Government* state that management should use quality information and should design control activities to achieve objectives, such as by clearly documenting significant actions in a manner that allows the documentation to be readily available for examination.[71] Applied to Health Affairs in its oversight responsibilities, this internal control principle would include monitoring the implementation actions related to legislative requirements for MHS reform.

Health Affairs has not monitored the full scope of reform implementation by the MHS components because it has not established a process to do so—such as by consolidating in a single data source the responsible leaders, actions taken, and time frames. In the absence of a process for monitoring actions taken to address all requirements, Health Affairs did not have information about the implementation status of certain requirements. For example, Health Affairs did not have information on the actions taken to develop a strategic sourcing acquisition strategy for health care professional staff in response to section 727 of the NDAA for Fiscal Year 2017. Health Affairs officials provided us with contacts in DHA's Contracting Activity to discuss these actions. Similarly, Health Affairs did not have information on actions to address section 706 of the NDAA for Fiscal Year 2017 and could not provide a contact in another

[69]Under Secretary of Defense for Personnel & Readiness, *Zero-Based Review of Medical Headquarters Manpower Requirements* (August 2022).

[70]DOD Directive 5136.01.

[71]GAO, *Standards for Internal Control in the Federal Government*, GAO-14-704G (Washington, D.C.: Sept. 10, 2014).

MHS component who could discuss actions to implement this section. A DOD report to Congress from September 2022 on the use of local military-civilian integrated health delivery systems provided some information on DOD's actions to address section 706, as described previously.[72] However, DHA was not able to identify subject matter experts to discuss questions about this report or the future implementation plans the report described.

Establishing a monitoring process could provide complete information on MHS reforms for Health Affairs to use in performing monitoring efforts. Health Affairs sets some strategic priorities and monitors some performance measures to assess progress in achieving MHS goals.[73] Officials stated they review these measures quarterly and brief the results to MHS governance bodies and the Deputy Secretary of Defense. A Health Affairs official also stated that Health Affairs recently started performing ad hoc root cause analyses when they identify negative trends in these performance measures, and added that these analyses sometimes allow them to identify the effects of reform efforts. A monitoring process for MHS reform requirements would strengthen Health Affairs' ability to investigate fluctuations in MHS performance by enhancing awareness of changes within the system that could drive performance trends.

MHS components—especially DHA—have made substantial progress in taking actions to address MHS reform requirements, as evidenced by the number of reforms addressed; however, many of the partially addressed reforms have large scopes. Establishing a systematic process to comprehensively monitor implementation actions would better position Health Affairs to have visibility over the full scope of MHS components' efforts to address reform requirements. Such visibility could help Health Affairs provide effective oversight of these multi-year initiatives that relate to the MHS goals of better health, better care, improved readiness, and lower costs. Furthermore, without sustained monitoring to improve oversight, the length of major transformations, which can span several

[72]Section 743 of the NDAA for Fiscal Year 2020 requires the Secretary of Defense to conduct a study on the use of local military-civilian integrated health delivery systems pursuant to section 706 of the NDAA for Fiscal Year 2017 and develop a plan for the further development of the use of those systems. Pub. L. No. 116-92, § 743 (2019). DOD addressed section 743 by completing the study and submitting a report to the House and Senate Armed Services Committees in September 2022.

[73]Health Affairs officials stated that 17 of 27 of these performance measures are complete and in use, and another five will become available when DOD completes implementation of its new electronic health record, MHS Genesis.

years, coupled with interim leadership changes across administrations could place DOD at risk of reform requirements losing momentum and not being completed.

Conclusions

DOD has made significant progress in addressing reforms included in the annual NDAAs from fiscal year 2012 through fiscal year 2022—taking actions to address 115 of the 158 (approximately 73 percent) of requirements.

However, additional actions remain to address the remaining requirements. Specifically:

- DOD has not provided a briefing to the House and Senate Armed Services Committees regarding the closure of inpatient capabilities at Aviano Air Force Base's MTF, despite a statutory requirement that it do so prior to eliminating inpatient capabilities. By providing this information, DOD will facilitate Congress's ability to execute oversight of actions to restructure MHS facilities.
- DOD has not completed the transfer of public health and research and development functions from the military departments to DHA. By completing implementation plans with time frames to address these requirements, DOD will improve the likelihood that efforts to complete these two transfers—which were supposed to have been completed by the end of fiscal year 2022—do not stagnate.
- Health Affairs has set strategic priorities and monitors a set of performance measures in order to evaluate MHS outcomes. It also performs ad hoc analyses in response to negative performance trends. By establishing a process to comprehensively monitor the actions taken and remaining to address statutory requirements for the military health system, Health Affairs will be better positioned to oversee the full scope of efforts to address reform requirements, including multi-year initiatives that relate to the MHS goals of better health, better care, improved readiness, and lower costs. Furthermore, without sustained monitoring to improve oversight, the length of major transformations—which can span several years—coupled with interim leadership changes across administrations, could put DOD at risk of reform requirements losing momentum and not being completed.

Completing these reforms and monitoring the full scope of these and other statutory MHS reform efforts will better position DOD to ensure it is achieving its goals for better health, better care, improved readiness, and lower costs.

Recommendations for Executive Action

We are making the following four recommendations to DOD:

The Secretary of Defense should ensure that the Secretary of the Air Force, in coordination with the Surgeon General of the Air Force and the Director of the DHA, completes a briefing to the House and Senate Armed Services Committees regarding the previous elimination of inpatient capabilities from its MTF at Aviano Air Force Base. (Recommendation 1)

The Secretary of Defense should ensure that the Director of the DHA, in coordination with the Surgeons General of the military departments, completes an implementation plan with related timelines for the remaining phases of the public health transfer and provides the plan to Congress. (Recommendation 2)

The Secretary of Defense should ensure that the Director of the DHA, in coordination with the Surgeons General of the military departments, completes an implementation plan with related timelines for the transfer of research and development, and provides the plan to Congress. (Recommendation 3)

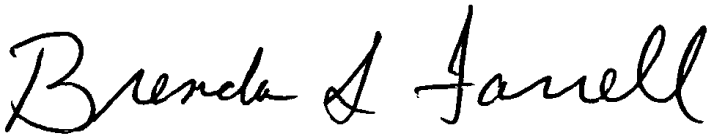
The Secretary of Defense should ensure that the Assistant Secretary of Defense for Health Affairs establishes a systematic process to comprehensively monitor the actions taken to address statutory requirements for the MHS, and incorporates the information in its MHS evaluation activities. The process could include consolidating in a single data source the responsible leaders, actions taken, and time frames. (Recommendation 4)

Agency Comments

We provided a draft of this report to DOD for review and comment. DOD provided an official comment letter, reproduced in appendix IV, which concurred with each of the four recommendations. DOD also provided technical comments that we incorporated where appropriate.

We are sending copies of this report to the appropriate congressional committees, the Secretary of Defense, the Assistant Secretary of Defense for Health Affairs, and the Secretaries of the Army, the Navy, and the Air Force. In addition, the report is available at no charge on the GAO website at http://www.gao.gov.

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



Brenda S. Farrell
Director, Defense Capabilities and Management

Appendix I: Prior GAO Reports Related to Military Health System Reform and Recommendation Status

Table 2: GAO Reports Related to Military Health System (MHS) Reform and Recommendations Status, As of April 2023

GAO report	Corresponding MHS reform requirements	Recommendation status
GAO-12-911 *Defense Health Care: Additional Analysis of Costs and Benefits of Potential Governance Structures Is Needed* (September 2012)	National Defense Authorization Act (NDAA) for Fiscal Year 2012, Section 716	We recommended that the Department of Defense (DOD) develop (1) a comprehensive cost analysis for its potential MHS governance structures, (2) a business case analysis and strategy for implementing its shared services concept, and (3) more complete analyses of the options' strengths and weaknesses. • DOD implemented the second recommendation. • DOD did not concur with the other two recommendations. We closed them as not implemented.
GAO-12-224 *Defense Health Care: Applying Key Management Practices Should Help Achieve Efficiencies within the Military Health System* (April 2012)	NDAA for Fiscal Year 2012, Section 716	We recommended that DOD (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; and (3) complete its governance initiatives and employ key management practices to show financial and nonfinancial outcomes and evaluate interim and long-term progress. • DOD concurred with the first recommendation, and stated in 2015 that it established a consolidated strategic plan to address the recommendation; however, the plan was not published. Given the lack of action on DOD's part, in July 2017, we closed the recommendation as not implemented. • DOD implemented the other two recommendations.
GAO-14-49 *Defense Health Care Reform: Additional Implementation Details Would Increase Transparency of DOD's Plans and Enhance Accountability* (November 2013)	NDAA for Fiscal Year 2013, Section 731	We recommended DOD develop and present to Congress fully developed performance measures related to the newly created Defense Health Agency, interim timelines, staffing baseline assessments, and refined cost savings estimates. • DOD concurred with the recommendation regarding timelines but did not develop the timelines. In June 2017, we closed the recommendation as not implemented because the Defense Health Agency was fully implemented, therefore, timelines to show progress were no longer relevant. • DOD implemented the other four recommendations.
GAO-14-396T *Military Health System: Sustained Senior Leadership Needed to Fully Develop Plans for Achieving Cost Savings* (February 2014)	NDAA for Fiscal Year 2013, Section 731	There are no recommendations associated with this report.
GAO-15-759 *Defense Health Care Reform: Actions Needed to Help Ensure Defense Health Agency Maintains Implementation Progress* (September 2015)	NDAA for Fiscal Year 2013, Section 731	We made five recommendations related to the Defense Health Agency's personnel requirements and approach to achieving cost savings. • DOD implemented all of the recommendations.

GAO report	Corresponding MHS reform requirements	Recommendation status
GAO-16-820 *Defense Health Care Reform: DOD Needs Further Analysis of the Size, Readiness, and Efficiency of the Medical Force* (September 2016)	Carl Levin and Howard P. "Buck" McKeon NDAA for Fiscal Year 2015, Section 713	We recommended that DOD (1) conduct a new analysis of the required number of active-duty and civilian medical personnel that mitigates known limitations; (2) identify and mitigate limitations regarding the standard for maintaining providers' clinical skills; (3) develop a strategy for achieving its goals for transferring health care to DOD facilities and increasing the productivity of active-duty providers; (4) modify its provider model to reflect the military service of the physicians and military treatment facilities included in the model; and, when considering proposed changes to facilities, (5) describe steps taken to assess the reliability of data supporting the assessment, and (6) include in any accompanying cost estimates an appropriate level of detail. • DOD concurred with all six recommendations and they remain open (that is, not implemented).
GAO-17-791R *Defense Health Reform: Steps Taken to Plan the Transfer of the Administration of the Military Treatment Facilities to the Defense Health Agency, but Work Remains to Finalize the Plan* (September 2017)	NDAA for Fiscal Year 2017, Section 702	There are no recommendations associated with this report.
GAO-18-108R *Department of Defense: Telehealth Use in Fiscal Year 2016* (November 2017)	NDAA for Fiscal Year 2017, Section 718	There are no recommendations associated with this report.
GAO-18-300 *New Trauma Care System: DOD Should Fully Incorporate Leading Practices into Its Planning for Effective Implementation* (March 2018)	NDAA for Fiscal Year 2017, Section 707	We recommended DOD incorporate leading practices in its planning to guide implementation efforts. • DOD implemented this recommendation.
GAO-18-361 *Defense Health Care: TRICARE Surveys Indicate Nonenrolled Beneficiaries' Access to Care Has Generally Improved* (March 2018)	NDAA for Fiscal Year 2012, section 721 NDAA for Fiscal Year 2017, Section 701	There are no recommendations associated with this report.
GAO-18-358 *Defense Health Care: TRICARE Select Implementation Plan Included Mandated Elements, but Access Standards Should Be Clarified* (April 2018)	NDAA for Fiscal Year 2017, Section 701	We recommended DOD provide written documentation of its approach for developing and approving the TRICARE Select access standards, as well as the final access standards, to Congress. • DOD concurred with this recommendation and it remains open.

GAO report	Corresponding MHS reform requirements	Recommendation status
GAO-18-574 *Defense Health Care: Expanded Use of Quality Measures Could Enhance Oversight of Provider Performance* (September 2018)	NDAA for Fiscal Year 2016, Section 730	We recommended that DOD (1) prioritize, as appropriate, selecting quality measures common for both direct and purchased care that expand the range of quality areas covered by the measures and (2) establish consistent performance standards and corrective action requirements for direct and purchased care providers. • DOD concurred with both recommendations and they remain open.
GAO-19-53 *Defense Health Care: DOD Should Demonstrate How Its Plan to Transfer the Administration of Military Treatment Facilities Will Improve Efficiency* (October 2018)	NDAA for Fiscal Year 2017, Section 702	We recommended that DOD (1) define and analyze the 16 operational readiness and installation-specific medical functions for duplication, (2) validate headquarters-level personnel requirements, and (3) identify the least costly mix of personnel. • DOD concurred with these recommendations. It has partially addressed one recommendation and it remains open. The other two recommendations remain open.
GAO-19-102 *Defense Health Care: Additional Assessments Needed to Better Ensure an Efficient Total Workforce* (November 2018)	NDAA for Fiscal Year 2017, Section 721	We made five recommendations including that DOD, among other things, (1) assess the suitability of federal civilians and contractors to provide operational medical care; (2) develop full cost information for active and reserve component medical personnel; and (3) develop a strategic total workforce plan for the DHA to help ensure execution of an appropriate workforce mix at its Military Medical Treatment Facilities (MTFs). • DOD concurred with each recommendation and they remain open.
GAO-19-206 *Defense Health Care: Actions Needed to Determine the Required Size and Readiness of Operational Medical and Dental Forces* (February 2019)	NDAA for Fiscal Year 2017, Section 721 NDAA for Fiscal Year 2017, Section 725	We made six recommendations, including that DOD establish joint planning assumptions and a definition, as well as a method for assessing medical and dental personnel requirements; identify and mitigate limitations in a clinical readiness metric for medical providers; and determine specialties and estimate costs and benefits for applying a readiness metric. • DOD concurred with each recommendation and they remain open.
GAO-19-338 *Defense Health Care: DOD's Proposed Plan for Oversight of Graduate Medical Education Programs* (March 2019)	NDAA for Fiscal Year 2017, Section 749	There are no recommendations associated with this report.
GAO-20-39 *Defense Health Care: Opportunities to Improve Future TRICARE Managed Care Support Contract Transitions* (November 2019)	NDAA for Fiscal Year 2017, Section 701	GAO made three recommendations to improve future contract transitions, including that DOD improve the specificity of its transition guidance and have subject matter experts review oversight requirements. • DOD implemented all the recommendations.
GAO-20-165 *Defense Health Care: DOD Should Collect and Use Key Information to Make Decisions about Incentives for Physicians and Dentists* (January 2020)	NDAA for Fiscal Year 2017, Section 708	We recommended that DOD collect and use information on (1) replacement costs of military physicians and dentists, (2) retention, and (3) private-sector civilian wages to inform its investment decisions. • DOD concurred with these three recommendations and they remain open.

GAO report	Corresponding MHS reform requirements	Recommendation status
GAO-20-197 *Defense Health Care: Plans Needed to Ensure Implementation of Required Elements for TRICARE's Managed Care Support Contracts* (February 2020)	NDAA for Fiscal Year 2017, Section 705	We recommended that DOD develop and implement plans with time frames and specific actions needed for all 13 required elements in the TRICARE contracts. • DOD implemented this recommendation.
GAO-20-371 *Defense Health Care: Additional Information and Monitoring Needed to Better Position DOD for Restructuring Medical Treatment Facilities* (May 2020)	NDAA for Fiscal Year 2017, Section 703	We made six recommendations, including that future MTF assessments use more complete and accurate information about civilian health care quality, access, and cost-effectiveness; and that DOD establish roles, responsibilities, and progress thresholds for MTF transitions. • DOD partially concurred with four recommendations and concurred with two. All six recommendations remain open.
GAO-21-237 *DOD Health Care: DOD Should Monitor Implementation of Its Clinical Practice Guidelines* (February 2021)	NDAA for Fiscal Year 2017, Section 726	We recommended that DHA work with the military services to develop and implement a systematic process to monitor MTFs' implementation of Veterans Affairs/DOD clinical practice guidelines. • DOD concurred with this recommendation and it remains open.
GAO-21-337 *Defense Health Care: Actions Needed to Define and Sustain Wartime Medical Skills for Enlisted Personnel* (June 2021)	NDAA for Fiscal Year 2017, Section 725	We made 30 recommendations, including that military departments fully define and implement wartime medical skills for enlisted medical personnel subspecialties, track skills training, and establish performance goals and targets for training completion, as appropriate; and that DOD develop metrics to assess how military medical treatment facility workload and civilian partnerships sustain these skills and assess risks to skills sustainment. • DOD concurred with each of these recommendations and they remain open.
GAO-22-104770 *Defense Health Care: Actions Needed to Improve Billing and Collection of Debt for Civilian Emergency Care* (July 2022)	NDAA for Fiscal Year 2017, Section 717	We recommended that DOD assess and monitor how providing civilian emergency care maintains medical readiness, issue guidance to update systems with complete collection information, track and monitor waiver requests, and communicate financial relief options. • DOD did not provide comments on a draft of this report. These four recommendations remain open.
GAO-22-105149 *Defense Health Care: DOD Expanded Telehealth for Mental Health Care during the COVID-19 Pandemic* (February 2022)	NDAA for Fiscal Year 2017, Section 718	There are no recommendations associated with this report.

Source: GAO. | GAO-23-105710

Note: To view the status and details of all GAO recommendations concerning the reports noted above, click on the respective report number provided in each row of the table.

Appendix II: Objectives, Scope, and Methodology

Section 742 of the National Defense Authorization Act (NDAA) for Fiscal Year 2022 included a provision for us to report on the Department of Defense's (DOD) efforts to address statutory requirements to reform the Military Health System (MHS) from fiscal years 2012 through 2021.[1] We also included relevant statutory requirements from the NDAA for Fiscal Year 2022 as part of our analysis.

In this report we examine,

- statutory requirements for reforms of the MHS that GAO identified within each NDAA for Fiscal Years 2012 through 2022;
- the extent to which DOD has taken actions to address these requirements and assessed the effectiveness of certain reforms as required, and
- the extent to which DOD has monitored actions taken in response to statutory requirements for MHS reform.

Objective One

For objective one, we first developed a definition of MHS reform in order to identify statutory requirements for MHS reform. To accomplish this, we identified relevant Congressional and DOD sources on MHS reform during the in-scope time period. These sources include Senate Report 114-255, which accompanied a bill for the NDAA for Fiscal Year 2017 and outlines the reform objectives of the Senate Armed Services Committee, as well as specific provisions to accomplish these objectives.[2] Senate Report 114-255 also references the findings and recommendations of DOD's Military Compensation and Retirement Modernization Commission, which was formed to provide recommendations to modernize pay and benefits of the services and includes recommendations regarding the health benefits of service members and their dependents. DOD provided Congress with a report on the Commission's recommendations in January 2015, which we reviewed in order to identify language describing MHS reform activities.

Based on the language identified in these sources, we defined MHS reform as enterprise changes affecting the population of beneficiaries, medical providers, and/or administrators (including leadership), or a significant portion thereof and that relate to one or more of the following goals: (1) improving the quality of beneficiary health care, (2) improving

[1]Pub. L. No. 117-81, § 742 (2021).

[2]S. Rep. No. 114-255, at 173-205 (2016).

the operational readiness of military medical providers, and (3) reducing the cost of the health system overall. We excluded electronic health records modernization from our definition of MHS reform because it was not discussed in the aforementioned sources and because we have a substantial body of work reporting on DOD's efforts in this area.[3] To ensure the appropriateness of our definition, we reviewed it with officials from MHS component organizations, including the Office of the Assistant Secretary of Defense for Health Affairs, the Defense Health Agency, and the military departments. The officials generally agreed and made suggestions that we incorporated as appropriate.

Next, we reviewed Title VII's "Health Care Provisions," of each NDAA from Fiscal Years 2012 through 2022 to identify NDAA sections meeting our definition of MHS reform. We assigned each section into one of five categories of reform which we developed based on common issue areas in the NDAAs: Governance and Administration; Force Structure and End Strength; Military Medical Treatment Facility Care; Private-Sector Care; and Training and Readiness. In multiple cases, requirements for reform related to two or more of these categories. However, in order to avoid double counting of requirements when reporting results, we assigned each section to the category that the requirements in the section focused on most.

After identifying and categorizing in-scope NDAA sections, within each of the five categories, we broke down each section we identified as an MHS reform into separate requirements based on actions that the department would need to take to address each particular reform. We considered provisions that require one or more components of DOD to take an action to be a requirement. Conversely, we did not consider the following types of provisions to be reform requirements: 1) provisions that provide discretion in taking action; 2) provisions that provide authority; 3) provisions that outline responsibilities; and 4) provisions that only prohibit or limit actions (without requiring DOD to take an action because of a prohibition or limitation). Finally, we grouped elements (i.e., any subsections, paragraphs, and subparagraphs) together into one

[3]See GAO, *Electronic Health Records: Additional DOD Actions Could Improve Cost and Schedule Estimating for New System*, GAO-22-104521 (Washington, D.C.: June 8, 2022); GAO, *Defense Health Care: DOD Expects New IT System Capabilities to Improve Other Health Insurance Processing*, GAO-22-105131 (Washington, D.C.: Mar. 29, 2022); and GAO, *Electronic Health Records: DOD Has Made Progress in Implementing a New System, but Challenges Persist*, GAO-21-571 (Washington, D.C.: Sept. 20, 2021).

requirement when they were inherently part of the same action. We excluded one section and its requirements that were repealed by a subsequent NDAA.[4] We reviewed our categorization approach and list of requirements with MHS component officials and they agreed without comment. For figure 1, which includes the categories of requirements and example requirements, we selected examples illustrative of the range of topic areas within each category.

From among all the requirements identified, we also identified those that mandated DOD assess the effectiveness of actions taken in response to reform requirements. In order to identify these requirements, an analyst reviewed all statutory requirements identified above. A separate analyst also reviewed all statutory requirements and the determinations of the first analyst, and the two reconciled any discrepancies through discussion.

Objective Two

For objective two, to assess the extent to which DOD took actions to address statutory requirements for MHS reform and assessed the effectiveness of reform actions, we first analyzed publicly available information regarding DOD's actions to address in-scope reform requirements. We also reviewed our prior work that assessed DOD's efforts to meet select requirements. We collected additional documentation and conducted interviews with DOD offices involved in the execution of these requirements, as necessary.

After reviewing the documentation collected for each statutory requirement, an analyst assessed each requirement as "Addressed," "Partially Addressed," or "Not Addressed."[5] "Addressed" means DOD completed actions to address the requirement. "Partially Addressed" means DOD has taken actions to address some, half, or most of the elements of a requirement, irrespective of whether DOD has completed its actions or plans additional actions to address the requirement. "Not

[4]Section 727 of the NDAA for Fiscal Year 2017 repealed section 725 of the NDAA for Fiscal Year 2015, which we originally determined to be within the scope of our review based on our definition of MHS reform.

[5]In making these assessments, we identified four requirements in the Private-Sector Care category that were within our scope of MHS reforms but for which we were unable to determine the extent to which DOD addressed them. This occurred for various reasons, such as information that DOD was required to post online no longer being available. We note these requirements as appropriate in the report, but do not include them in our counts of DOD's actions.

Addressed" means DOD did not address any elements of the requirement or has no plans to begin addressing it. In those cases where we have made a recommendation(s) regarding a "Partially Addressed" or "Not Addressed" requirement and the recommendation(s) remain Open–Partially Addressed or Open–Unaddressed, we noted this in the report. In assessing DOD's actions to address statutory requirements for MHS reforms, we did not assess the quality of actions to address these requirements.[6]

Furthermore, for requirements requiring the delivery of a written product or briefing to Congress (e.g., report, study, etc.), we did not assess the extent to which required elements were included in the product or briefing, but instead identified whether or not a report was provided.[7] For such requirements, we provide references to our prior work that examined reports for these elements, as applicable. After the analyst made a determination for each requirement, a separate team member also reviewed the supporting documentation and made an independent determination, and the team reconciled any differences through discussion. This analysis also included those requirements mandating that DOD assess the effectiveness of reform action(s), as identified in the second objective above.

For all requirements, we assessed DOD's actions against the statutory requirements related to reform. In addition, for multiple requirements related to the establishment of new organizations within the MHS, we examined DOD's efforts against GAO-18-427, *Government Reorganization: Key Questions to Assess Agency Reform Efforts*, which states that successful reform efforts entail the development of an implementation plan with key milestones and deliverables, which can help an organization track implementation progress.[8]

Objective Three

For objective three, to assess DOD's oversight of actions to address statutory requirements related to MHS reform, we discussed with DOD officials their methods for monitoring the status of statutory requirements. In addition, we obtained documentation from various DOD offices about

[6]While we did not assess the quality of DOD's actions to address these requirements, we discuss various actions taken in response to reform requirements for illustrative purposes.

[7]While we did not assess the inclusion of individual elements of requirements in written products or briefings, we discuss some elements of requirements for written products or briefings in this report for illustrative purposes.

[8]GAO-18-427.

requirements that had been addressed. Specifically, we interviewed officials and collected documents from MHS components about their processes for identifying and delegating implementation of statutory requirements.

We assessed DOD's efforts against Department of Defense Directive 5136.01, *Assistant Secretary of Defense for Health Affairs (ASD(HA))*, which states that the Assistant Secretary of Defense for Health Affairs provides oversight to the DOD components on matters pertaining to the MHS, and oversees and directs changes in the execution of health-related matters across the DOD.[9] We also determined that the 1) control activities and 2) information and communication components of *Standards for Internal Control in the Federal Government* were significant to this objective, along with the underlying principles that management should 1) design control activities and 2) use quality information to achieve the entity's objectives.

To address objectives two and three, we also conducted interviews with officials from several organizations within DOD having key responsibilities concerning the MHS. These included the Office of the Assistant Secretary of Defense for Health Affairs; multiple offices within the Defense Health Agency; the Joint Staff Surgeon's Office; U.S. Army Medical Command; Navy Bureau of Medicine and Surgery; and U.S. Air Force's Office of the Surgeon General.

We conducted this performance audit from January 2022 to June 2023 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

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

Appendix III: Military Health System Reform Requirements from Fiscal Years 2012 through 2022 that DOD Completed Actions to Address

From fiscal years 2012 through 2022, there were 158 requirements for reform to the Military Health System across 39 National Defense Authorization Act sections. The table below lists the 115 requirements that the Department of Defense has completed actions to address.

Table 3: Military Health System Reform Requirements that DOD Completed Actions to Address, by Category

NDAA fiscal year[a]	Public Law number	NDAA section number and title	NDAA subsection(s)	Number of requirements	Related GAO reports
Category: Governance and administration					
2012	112-81	Sec. 716, Review of the Administration of the Military Health System	(a)(2)	1	GAO-12-911
2013	112-239	Sec. 731, Plan For Reform of the Administration of the Military Health System	(a)	1	GAO-14-49 & GAO-14-396T
2015	113-291	Sec. 713, Review of Military Health System Modernization Study	(a)(2)	1	GAO-16-820
2017	114-328	Sec. 702, Reform of Administration of the Defense Health Agency and Military Medical Treatment Facilities	(a)(1), (c), (d)(1), (e)(1)-(2)	10	GAO-17-791R GAO-19-53
2017	114-328	Sec. 703, Military Medical Treatment Facilities (as amended by FY21 NDAA Sec. 718)[b]	(a)(1), (c), (d)(1)	5	GAO-20-371
2017	114-328	Sec. 727, Acquisition Strategy for Health Care Professional Staffing Services	(a)(1), (b)	2	N/A
2017	114-328	Sec. 730, Accountability for the Performance of The Military Health System of Certain Leaders Within The System	(a), (b), (c)(1)	2	N/A
2018	115-91	Sec. 722, Selection of Military Commanders and Directors of Military Medical Treatment Facilities	(a), (c)	1	N/A
2019	115-232	Sec. 711, Improvement of Administration of the Defense Health Agency and Military Medical Treatment Facilities	(a)(1)(D), (c)(1)	2	N/A
2019	115-232	Sec. 712, Support by Military Healthcare System of Medical Requirements of Combatant Commands (as amended by FY20 Sec. 712)	(e)(1)(A), (e)(2)(A), (f)	3	GAO-23-105441
Category: Force structure and end strength					
2017	114-328	Sec. 721, Authority to Convert Military Medical and Dental Positions to Civilian Medical and Dental Positions	(b)	1	GAO-19-206
2020	116-92	Sec. 719, Limitation on the Realignment or Reduction of Military Medical Manning End Strength	(b)(2), (c)	4	GAO-19-206

NDAA fiscal year[a]	Public Law number	NDAA section number and title	NDAA subsection(s)	Number of requirements	Related GAO reports
2021	116-283	Sec. 757, Study on Force Mix Options and Service Models to Enhance Readiness of Medical Force of the Armed Forces	(a)	1	N/A
2022	117-81	Sec. 731, Modifications and Reports Related to Military Medical Manning and Medical Billets	(b)(2),[c] (b)(3)(A)	4	GAO-19-206
Category: Military medical treatment facility care					
2017	114-328	Sec. 704, Access to Urgent and Primary Care Under TRICARE Program	(a)	1	N/A
2017	114-328	Sec. 709, Standardized System for Scheduling Medical Appointments at Military Treatment Facilities	(a)(1), (c)(1), (d), (e)(1), (f), (g)(1)	9	N/A
2017	114-328	Sec. 726, Program to Eliminate Variability in Health Outcomes and Improve Quality of Health Care Services Delivered in Military Medical Treatment Facilities	(a)	1	GAO-21-237
2021	116-283	Sec. 756, Study and Report on Increasing Telehealth Services Across Armed Forces	(a), (b)	2	N/A
2022	117-81	Sec. 723, Digital Health Strategy of Department of Defense	(a)(1), (b)	2	N/A
Category: Private-sector care					
2016	114-92	Sec. 725, Pilot Program on Urgent Care Under TRICARE Program	(a)(1)-(3), (c)(1)-(2)	4	N/A
2016	114-92	Sec. 726, Pilot Program on Incentive Programs to Improve Health Care Provided Under the TRICARE Program	(a), (d)(1)-(3)	3	N/A
2016	114-92	Sec. 730, Report On Plans To Improve Experience With and Eliminate Performance Variability of Health Care Provided by the Department of Defense	(a)	1	GAO-18-574
2017	114-328	Sec. 701, TRICARE Select and Other TRICARE Reform	(a)(1), (b)(1), (c)-(d), (h)(1)-(3)	9	GAO-20-695R
2017	114-328	Sec. 704, Access to Urgent and Primary Care under TRICARE Program	(a)	6	N/A
2017	114-328	Sec. 705, Value-Based Purchasing and Acquisition of Managed Care Support Contracts For TRICARE Program (as amended by FY18 Sec. 715 and FY20 Sec. 716)	(b),(d)	2	N/A
2017	114-328	Sec. 718, Enhancement of Use of Telehealth Services In Military Health System	(a)(1)-(2), (b)-(d), (e)(1)-(2), (f)(1)-(3)	8	N/A

NDAA fiscal year[a]	Public Law number	NDAA section number and title	NDAA subsection(s)	Number of requirements	Related GAO reports
2017	114-328	Sec. 729, Improvement of Health Outcomes and Control of Costs of Health Care Under TRICARE Program Through Programs to Involve Covered Beneficiaries (as amended by FY22 Sec. 719)	(a)-(e)	2	GAO-20-695R
2018	115-91	Sec. 702, Modifications of Cost-Sharing Requirements for the TRICARE Pharmacy Benefits Program and Treatment of Certain Pharmaceutical Agents	(a)	2	N/A
Category: Training and readiness					
2017	114-328	Sec. 707, Joint Trauma System	(a)(1)-(2)	2	GAO-18-300
2017	114-328	Sec. 708, Joint Trauma Education and Training Directorate	(a), (c)(1)-(4), (d)(1),(d)(3), (e)	10	GAO-20-165
2017	114-328	Sec. 717, Evaluation and Treatment of Veterans and Civilians at Military Treatment Facilities (as amended by FY18, Sec. 712)	(a), (b)(1), (c)(1)-(3)	5	GAO-22-104770
2017	114-328	Sec. 749, Oversight of Graduate Medical Education Programs of Military Departments	(a), (b)	2	GAO-19-338
2019	115-232	Sec. 732, Joint Forces Medical Capabilities Development and Standardization	(a), (c)	2	N/A
2020	116-92	Sec. 743, Study and Plan on the Use of Military-Civilian Integrated Health Delivery Systems	(a), (b), (c)(1)-(2)	4	N/A

Legend: N/A = not applicable.

Source: GAO analysis of National Defense Authorization Acts (NDAA) and Department of Defense (DOD) information. | GAO-23-105710

Notes: We identified requirements related to reforming the military health system in the NDAAs from fiscal years 2012 through 2022 and grouped the requirements into five categories: Governance and Administration; Force Structure and End Strength; Medical Treatment Facility Care; Private-Sector Care; and Training and Readiness. Although some requirements overlap categories of reform, we assigned each requirement to a single category and counted each requirement once. For example, sections 706 of the NDAA for Fiscal Year 2017 and 743 of the NDAA for Fiscal year 2020 include requirements related to private-sector care as well as requirements related to training and readiness. We assigned both sections to the Training and Readiness category. Additionally, we identified four requirements in the Private-Sector Care category that were within our scope of MHS reforms but for which we were unable to determine the extent to which DOD addressed them. This occurred for various reasons, such as information that DOD was required to post online no longer being available, and as a result, we are not including them in our counts of DOD's actions. Citations to specific subsections, paragraphs, or subparagraphs of NDAA sections listed in the table as requirements may not be inclusive of all subordinate paragraphs, sub-paragraphs, or clauses. In some instances, subordinate provisions related to the requirement; in other instances, the subordinate provisions did not relate to requirements within our scope. While some of these requirements were codified in various sections of the U.S. Code, we only include citations to the original public law section in which each requirement was enacted or amended. Subsections identified in this table reflect amendments enacted through the NDAA for Fiscal Year 2022.

[a]The table does not include the dates that the NDAAs were enacted.

[b]Section 718 of the NDAA for Fiscal Year 2021 amends section 703(d) of the NDAA for Fiscal Year 2017 by requiring the Secretary of Defense to submit additional information to the congressional defense committees as a part of the implementation plan for restructure or realignment of military

medical treatment facilities. The Secretary provided this information to the congressional defense committees in July 2022. Pub. L. No. 116-283, § 718(1) (2021).

[c]Pub. L. No. 117-81, § 731(b)(2) is a forward-looking requirement that extends through fiscal year 2027. DOD has addressed it so far by reporting current personnel levels and projections.

Appendix IV: Comments from the Department of Defense

THE ASSISTANT SECRETARY OF DEFENSE

1200 DEFENSE PENTAGON
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

June 2, 2023

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

Dear Ms. Farrell:

This is the Department of Defense (DoD) response to the Government Accountability Office (GAO) draft report GAO-23-105710, " DEFENSE HEALTH CARE: Improved Monitoring Could Help Ensure Completion of Mandated Reforms," (GAO Code 105710).

The Surgeon General of the Air Force provided the following technical comment: Page 15, paragraph 15 states, "Section 711 of the NDAA for FY19 requires that, by Sept 30, 2023, the Secretary of Defense establish within the DHA two new organizations…" The above sentence is inaccurate by stating two Public Health Centers from the Army and Navy and AF Public Health programs. Should state Military Departments (MILDEPs) public health centers or programs. The correct language is in footnote #25 on page 16 and fiscal year 23 National Defense Authorization Act, Sec 720 which allows the MILDEPs to temporarily retain some capabilities.

Footnote 27 on page 16 appears to be predecisional. If this information is not public information, the footnote should be removed according to FOIA Exemption 5 (deliberative process privilege) because it infringes on the decision space of the Secretary of Defense.

Attached is DoD's response to this report. My point of contact is Timothy Stockdale, who can be reached at timothy.r.stockdale.civ@mail.mil and (571) 309-0352.

Sincerely,

MULLEN.SEILEEN.MARIE.1519853007 Digitally signed by MULLEN.SEILEEN.MARIE.1519853007 Date: 2023.06.02 15:53:46 -04'00'

Lester Martínez-López, M.D., M.P.H.

Attachment:
Summary of Recommendations DoD Response

GAO DRAFT REPORT DATED MAY 1, 2023
GAO-23-105710 (GAO CODE 105710)

"DEFENSE HEALTH CARE: IMPROVED MONITORING COULD HELP ENSURE COMPLETION OF MANDATED REFORMS"

DEPARTMENT OF DEFENSE COMMENTS TO THE GAO RECOMMENDATION

RECOMMENDATION 1: The Secretary of Defense should ensure that the Secretary of the Air Force, in coordination with the Surgeon General of the Air Force and the Director of the DHA, completes a briefing to the House and Senate Armed Services Committees regarding the previous elimination of inpatient capabilities from its MTF at Aviano Air Force Base.

DoD RESPONSE: The Defense Health Agency concurs that the Secretary of the Air Force, in coordination with the Surgeon General of the Air Force, and in coordination with DHA, completes a briefing to the House and Senate Armed Services Committees regarding the previous elimination of inpatient capabilities from its MTF at Aviano Air Force Base.

RECOMMENDATION 2: The Secretary of Defense should ensure that the Director of the DHA, in coordination with the Surgeons General of the military departments, completes the implementation plan with related timelines for the remaining phases of the public health transfer and provides the plan to Congress.

DoD RESPONSE: Concur that the Director, DHA, in coordination with the Surgeons General of the military departments, completes the implementation plan with related estimated timelines for the remaining phases of the public health transfer and provide the final approved plan to Congress.

RECOMMENDATION 3: The Secretary of Defense should ensure that the Director of the DHA, in coordination with the Surgeons General of the military departments, completes an implementation plan with related timelines for the transfer of research and development, and provides the plan to Congress.

DoD RESPONSE: The DHA concurs that the Director of the DHA, in coordination with the Surgeons General of the military departments, completes an implementation plan with related estimated timelines for the transfer of research and development, and provides the final approved plan to Congress.

RECOMMENDATION 4: The Secretary of Defense should ensure that the Assistant Secretary of Defense for Health Affairs establishes a systematic process to comprehensively monitor the actions taken to address statutory requirements for the military health system (MHS), and incorporates the information in its MHS evaluation activities. The process could include consolidating in a single data source the responsible leaders, actions taken, and timeframes.

DoD RESPONSE: Concur with recommendation.

Appendix V: 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), Melissa Blanco (Analyst in Charge), Bonnie Anderson (Assistant Director), Kaitlin Asaly, Danielle Bernstein, Christopher Gezon, Alexandra Gonzalez, Jacquelyn Hamilton, Jesse Jordan, Lillian Ofili, Patricia Powell, Michael Shaughnessy, William Tedrick, and Lillian Moyano Yob made key contributions to this report.

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 our website. Each weekday afternoon, GAO posts on its website newly released reports, testimony, and correspondence. You can also subscribe to GAO's email updates to receive notification of newly posted products.

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, https://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 Email Updates. Listen to our Podcasts.
Visit GAO on the web at https://www.gao.gov.

To Report Fraud, Waste, and Abuse in Federal Programs

Contact FraudNet:

Website: https://www.gao.gov/about/what-gao-does/fraudnet

Automated answering system: (800) 424-5454 or (202) 512-7700

Congressional Relations

A. Nicole Clowers, Managing Director, ClowersA@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

Strategic Planning and External Liaison

Stephen J. Sanford, Managing Director, spel@gao.gov, (202) 512-4707
U.S. Government Accountability Office, 441 G Street NW, Room 7814,
Washington, DC 20548