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Military Health System Reform

The Department of Defense (DOD) administers a statutory health entitlement (under Chapter 55 of Title 10) through the Military Health System (MHS). The MHS offers health care benefits and services to approximately 9.6 million beneficiaries composed of servicemembers, military retirees, and family members. Health care services are available through DOD-operated hospitals and clinics—known as *military treatment facilities* (MTFs)—or through civilian health care providers participating in TRICARE. Currently, various DOD entities administer the MTFs and the TRICARE program. Those entities include the Defense Health Agency (DHA) and the military services’ medical departments (i.e., Army Medical Command, Navy Bureau of Medicine and Surgery, and Air Force Medical Service).

In 2016, the conference report accompanying the National Defense Authorization Act for Fiscal Year 2017 (H.Rept. 114-840) noted that “the current organizational structure of the military health system—essentially three separate health systems each managed by three Services—paralyzes rapid decision-making and stifles innovation in producing a modern health care delivery system that would better serve all beneficiaries.” Subsequently, numerous reforms were directed in law. An overview of the contributing factors, reform mandate, and DOD’s implementation efforts are discussed below.

Contributing Factors to MHS Reform

Over the past three decades, various committees, commissions, and federal government entities have issued reports highlighting a need to re-evaluate, or restructure, the MHS, such as:

- Final Report of the Military Compensation and Retirement Modernization Commission (2015);
- MHS Modernization Study (2013);
- DOD Task Force on MHS Governance (2011);
- Task Force on the Future of Military Health Care (2007);
- Medical Readiness Review of the Quadrennial Defense Review (2006);
- Comprehensive Study of the Military Medical Care System (1993); and
- various assessments by the Government Accountability Office (GAO).

Many of the reports have noted that MHS reform may bring opportunities to enhance medical readiness of the armed forces, improve health care quality and access, increase patient satisfaction, reduce administrative burden on beneficiaries, and lower overall costs.

Congress Mandates MHS Reform

MHS reform was directed in the National Defense Authorization Act for Fiscal Year 2017 (NDAA; P.L. 114-328) and codified in 10 U.S.C. §§1073c-1073d. This reform includes:

- a transfer of MTF administration and management from the Service Surgeons General to the Director of the DHA (§702);
- reorganization of DHA’s internal structure (§702);
- redesignation of the Service Surgeons General as principal advisors for their respective military service and as service chief medical advisors to the DHA (§702); and
- restructure or realignment of MTFs to best support military medical readiness and the readiness of medical personnel (§703).

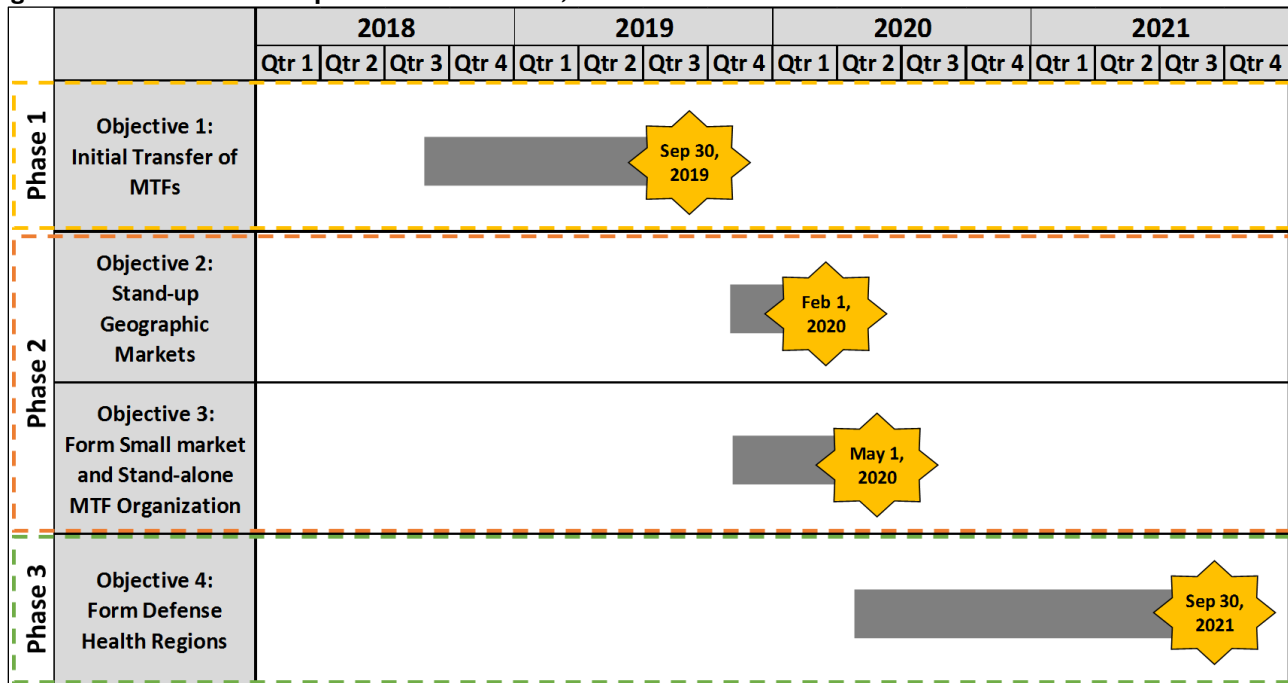
Congress originally directed that MHS reform be completed by October 1, 2018. However, the FY2018 NDAA (P.L. 115-91) and FY2019 NDAA (P.L. 115-232) provided additional clarifications on the transfer of MTFs, the roles and responsibilities of the DHA and the Service Surgeons General, and an extension on implementing reform efforts to September 30, 2021. The reforms do not impact any TRICARE health plan options or its cost-sharing features.

Implementing MHS Reform

DOD submitted its implementation plan to Congress in June 2018, describing a “streamlined organizational model that standardizes the delivery of care across the MHS with less overhead, more timely policy-making, and a transparent process for oversight and measurement of performance.” DOD later revised its plan to reflect certain accelerated tasks and milestones, such as the transfer of MTFs to the DHA. Changes are to occur through 2021.

MHS Governance and Financial Management Reform

Since DHA and the service medical departments report to separate senior defense officials, decisions on MHS policy, programs, processes, and resources are vetted in a variety of working groups, boards, and councils. DOD describes the current MHS governance as a “sclerotic decision-making process” that often serves as a barrier to timely improvements. The revised governance process delineates who makes certain decisions. The Assistant Secretary of Defense for Health Affairs is to have primary authority and oversight of the MHS. DHA is to make all decisions relating to health care delivery in MTFs. Meanwhile, each respective service medical department is to make decisions relating to “operational readiness matters.”

Figure 1. MHS Reform – Implementation Phases, 2018-2021

Source: CRS graphic based on DOD, “Plan 3: Implementation Plan for the Complete Transition of Military Medical Treatment Facilities to the Defense Health Agency,” p. 5, June 24, 2019.

Notes: Yellow stars = DOD’s estimated completion date for each objective. Qtr 1 = January-March. Qtr 2 = April-June. Qtr 3 = July-September. Qtr 4 = October-December.

Realign the MTFs

DHA plans to assume control of certain MTFs and establish health care market offices in three phases (see **Figure 1**). *Phase 1*, which began on October 1, 2018, transfers seven MTFs to the DHA. This phase serves as DHA’s testing period to ensure adequate support and infrastructure are in place prior to the next round of transfers. *Phase 2* would transfer all remaining MTFs in the U.S. on October 1, 2019 and establish geographic health care markets—a group of MTFs that operate as a health system. Newly formed health care market offices are to assist with MTF oversight, coordinate health services and resources across MTFs and TRICARE providers, and provide technical assistance to MTFs. *Phase 3* would transfer overseas MTFs on April 1, 2020 and establish similar health care market offices, called *Defense Health Regions*.

Transform the Service Medical Departments

As MTFs are divested to the DHA, service medical departments are to restructure to focus solely on medical readiness and medical capabilities in support of military operations. This includes the creation of “readiness organizations,” respectively named the Army Medical Readiness Command, Navy Medical Readiness and Training Command, and the Air Force Medical Readiness Agency. The responsibilities of these organizations include manning, training, and equipping military medical personnel; delivering clinical services in the operational or non-MTF settings; and establishing and monitoring medical readiness standards.

Considerations for Congress

DOD provides periodic, informal briefings on MHS reform to the congressional defense committees. To date, no formal hearings have been convened. The following lines of inquiry may assist Congress with receiving further

clarification on DOD’s reform efforts and support congressional oversight of the MHS throughout this years-long process.

Status of Reform

- What is the status of the transfer of MTFs from the military services to the DHA?
- What best practices were discovered from the initial transfer of MTFs in 2018 and how will those practices apply to future implementation phases?

Measuring Impacts of Reform

- How are reform efforts impacting beneficiaries, health care providers, medical readiness, military services, combatant commanders, DHA, and non-DOD partners?
- What is DOD’s plan to reshape the size or composition of the medical workforce?
- How will DOD measure effectiveness or cost-savings generated from MHS reform?
- How will DHA and the services’ medical readiness organizations measure its ability to support combatant commander requirements for medical capabilities and forces?

Additional Needs for Reform

- DOD has suggested that changes to current law may be required to successfully implement MHS Reform. What statutory changes are needed?
- Are DHA and the services’ medical readiness organizations appropriately structured and resourced to carry out its revised responsibilities?

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