



Testimony

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MILITARY HEALTH SYSTEM

Sustained Senior Leadership Needed to Fully Develop Plans for Achieving Cost Savings

Statement of Brenda S. Farrell, Director,
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GAO Highlights

Highlights of [GAO-14-396T](#), a testimony before the Subcommittee on Military Personnel, Committee on Armed Services, House of Representatives

Why GAO Did This Study

DOD's MHS costs almost \$50 billion annually and is expected to grow to \$70 billion by 2028. The MHS governance structure has been the subject of many studies, some recommending major changes. In 2006, DOD considered potential governance structure changes but left its existing structure in place, approving instead a shared-services directorate to consolidate common MHS functions (e.g., shared information-technology services) that ultimately was never developed. In 2012, DOD announced the creation of the DHA by October 1, 2013, with seven main goals: (1) consolidate functions (shared services) common to DOD, (2) deliver more-integrated health care in areas with more than one military service, (3) establish more-standardized processes, (4) more-closely align financial incentives with health and readiness outcomes, (5) match other resources with missions, (6) deliver more primary care and other health services, and (7) better coordinate care over time and across treatment settings. Section 731 of the National Defense Authorization Act for Fiscal Year 2013 required DOD to provide three submissions in March, June, and September 2013, detailing its plan to reform the MHS.

This testimony addresses the additional actions that would increase transparency and enhance accountability of DOD's reform plans. It is based primarily on (1) GAO's November 2013 report which assessed DOD's first two submissions of its reform plans to Congress and (2) selected updates. For the updates, GAO analyzed DOD's third reform plan and interviewed a DOD representative.

View [GAO-14-396T](#). For more information, contact Brenda S. Farrell at (202) 512-3604 or farrellb@gao.gov.

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MILITARY HEALTH SYSTEM

Sustained Senior Leadership Needed to Fully Develop Plans for Achieving Cost Savings

What GAO Found

Department of Defense (DOD) senior leadership has demonstrated a commitment to oversee implementation of its military health system's (MHS) reform and has taken a number of actions to enhance the reform efforts. For example, in March 2013, DOD chartered the MHS Governance Transition Organization to provide oversight, management, and support for the implementation. This entity is chartered to exist until October 2015, when the Defense Health Agency (DHA) is expected to reach full operating capability. Formation of this entity addresses an issue GAO reported on in April 2012—that DOD did not form such a team to oversee its 2006 MHS reform effort.

GAO's November 2013 report identified several areas in DOD's implementation plan where sustained senior leadership attention is needed to help ensure the reform achieves its goals including:

- **Undetermined staffing requirements:** DOD did not have the data to determine how the creation of the DHA will affect the total number of MHS headquarters staff because it had not conducted an accurate baseline assessment of current staffing levels. Notwithstanding, using data that service officials later believed were inaccurate, in 2011, DOD identified anticipated annual personnel savings of \$46.5 million as part of the rationale for creating the DHA.
- **Unclear cost estimates:** DOD's cost savings estimates were missing key details such as the source of the savings. DOD aggregated the separate functions of its shared services, which obscures the size and cost of planned efficiencies for each function. A business case analysis requires detailed information to convince customers and stakeholders that the selected business process is the appropriate means for achieving performance. In addition, business-case analyses should demonstrate the sensitivity of the outcome to changes in assumptions. However, DOD did not assess the risk that implementation costs could increase.
- **Incomplete performance measures:** DOD did not develop explanations for how each measure relates to the goals of the reform effort, did not define the specific measure to be developed; did not provide a baseline assessment of the current performance that is to be measured; and, most importantly, did not identify quantifiable targets for assessing progress. In its third submission, DOD provided some additional information, but did not provide fully developed performance measures for any of its seven reform goals.

DOD concurred with all of GAO's recommendations, including: (1) develop a baseline assessment of the number of personnel currently working within the MHS headquarters and an estimate for the DHA at full operating capability; (2) develop a more thorough explanation of the potential sources of cost savings from DOD's implementation of shared services; and (3) develop performance measures that are clear, quantifiable, objective, and include a baseline assessment of current performance. In February 2014, a DOD representative said that DOD has taken action to address the recommendations, but it has not completed implementation. GAO continues to believe that it is imperative for DOD to complete these actions so decision makers will have complete information to gauge reform progress.

Chairman Wilson, Ranking Member Davis, and Members of the Subcommittee:

Thank you for the opportunity to be here today to discuss whether the Defense Health Agency (DHA) is positioned to achieve the goals of the Department of Defense's (DOD) efforts to reform the military health system (MHS). DOD plans to spend almost \$50 billion on the MHS in fiscal year 2014. This number has grown from approximately \$20 billion in fiscal year 2000, and is projected by the Congressional Budget Office to continue to grow to \$70 billion in 2028. In an effort to create a more integrated and cost effective MHS, in March 2012, the Deputy Secretary of Defense directed the establishment of a Defense Health Agency, which officially began operations on October 1, 2013. Throughout the implementation of the DHA, senior DOD leadership, including the Deputy Secretary of Defense, the Assistant Secretary of Defense (Health Affairs), and the service Surgeons General have demonstrated a commitment to oversee implementation for reform of the MHS. However, we have identified several areas where sustained senior leadership, including additional information, is needed to help ensure the reform achieves its goals, including greater cost effectiveness.

My statement today summarizes key findings from our November 2013 report¹ which assessed DOD's implementation plans for reform of the MHS and includes selected updates. Specifically, it addresses: (1) the staffing requirements of the DHA; (2) the sources of the cost savings that DOD estimates will be realized from its shared-services goal, and the importance of monitoring and more fully developing the associated implementation costs; (3) milestones to assess progress in implementing all seven goals of the reform efforts; and (4) performance measures to evaluate achievement of the reform's goals.

The National Defense Authorization Act for Fiscal Year 2013 required DOD to submit its plans for implementing its reform effort in three submissions—the first in March 2013, the second in June 2013, and the third in September 2013—and mandated that we review DOD's first two submissions.² We examined the March and June 2013 submissions as

¹GAO, *Defense Health Care Reform: Additional Implementation Details Would Increase Transparency of DOD's Plans and Enhance Accountability* [GAO-14-49](#) (Washington, D.C.: Nov.6, 2013).

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

well as an August 2013 supplemental report to Congress of DOD's plan to implement the reform effort and reported the results in November 2013. For that report, we compared DOD's submissions for reforming the MHS governance structure with the statutory requirements and key management practices contained in GAO's Business Process Reengineering Assessment Guide and other relevant GAO work.³ In the course of our work, we interviewed officials from the Office of the Assistant Secretary of Defense for Health Affairs, MHS Transition Office, and the military Surgeons General. For the purposes of this testimony, in February 2014, we subsequently examined DOD's third and final reform plan, which was submitted to Congress in November 2013, and discussed the status of our November 2013 report recommendations with an official within the Office of the Secretary of Defense (Health Affairs) who represented the department. The work upon which this statement is based was conducted 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. Additional details about the scope and methodology can be found in our November 2013 report, and a list of related products appears at the end of my statement.

Background

Since 1949, the governance structure of the MHS has been the subject of numerous studies conducted by DOD internal and external boards, commissions, task forces, and GAO, and several of those studies have led to recommendations for a major organizational realignment. After studying several options for reorganizing the defense organizations that constitute the MHS, in 2006 the Deputy Secretary of Defense approved multiple initiatives including a shared services directorate to integrate the services these organizations provide, such as information technology, and make the MHS more cost-effective. DOD implemented those initiatives to varying extents; however, the directorate was never formed and the overarching governance structure of the MHS did not change. Further, Congress expressed concern that DOD had not yet developed a

³GAO, *Business Process Reengineering Assessment Guide*, [GAO/AIMD-10.1.15](#) (Washington, D.C.: May 1997); *Streamlining Government: Questions to Consider When Evaluating Proposals to Consolidate Physical Infrastructure and Management Functions*, [GAO-12-542](#) (Washington, D.C.: May 23, 2012); GAO, *Defense Health Care: Applying Key Management Practices Should Help Achieve Efficiencies within the Military Health System* [GAO-12-224](#) (Washington, D.C.: Apr. 12, 2012).

comprehensive plan to enhance quality, efficiencies, and savings in the MHS. DOD's senior leadership established a task force in 2011 to review various options for changing the governance structure of the system. This task force reported the results of its review to the congressional defense committees in March 2012 and, in October 2013, implemented its recommended course of action by establishing the DHA. According to DOD, with the creation of the DHA, the military services' respective Surgeons General will continue to oversee medical forces and the operation of health care systems, including their military hospitals, and the DHA will support the services in executing their respective medical missions.

DOD created the DHA with the intent of creating a more cost-effective and integrated MHS. This reform effort comprises seven overarching goals:

- consolidate functions (shared services) common to DOD;
- deliver more-integrated health care in areas with more than one military service;
- establish more-standardized processes;
- more-closely align financial incentives with health and readiness outcomes;
- match other resources with missions;
- deliver more primary care and other health services; and
- better coordinate care over time and across treatment settings.

The Deputy Secretary of Defense directed the formation of a team to develop an implementation plan for the governance changes. As a result, in March 2013, the Assistant Secretary of Defense for Health Affairs chartered the MHS Governance Transition Organization to provide oversight, management, and support for the implementation of MHS governance reforms. The formation of this MHS Governance Transition Organization addresses an issue we previously reported on—that DOD

had not formed an overarching team to manage the implementation of the 2006 attempt to improve the department's medical governance structure.⁴

DOD Does Not Have an Accurate Baseline Assessment of Current Staffing to Determine Potential Savings and Future Staffing Needs of the DHA

As we reported in November 2013, DOD has not conducted an accurate baseline assessment of the headquarters personnel currently working in the MHS—that is, personnel working at each military service's headquarters and at the Office of the Secretary of Defense. In addition, DOD has not determined the number of personnel required for the DHA when it is fully operational in 2015, as currently planned. Our previous work⁵ highlighted the need for federal agencies to have valid, reliable data and to be aware of the size of their workforce, its deployment across the organization, and the knowledge, skills, and abilities needed for the agency to accomplish its mission.⁶ A baseline assessment of the number of current headquarters personnel is a crucial first step for developing an estimate of the number of personnel that will be required once DHA is fully operational.

In its September 2011 analysis of options to reform the MHS, DOD identified anticipated personnel savings as part of the rationale for the reform effort and estimated a resulting estimated annual personnel cost savings of \$46.5 million. The Deputy Secretary of Defense based the decision to establish the DHA, in part, on this estimate of personnel savings. In contrast, we reported in November 2013 that DOD officials told us that there would be no net increase in personnel numbers across the MHS headquarters as a result of the creation of the DHA. Further, we reported that, according to DOD officials, military service officials believed that DOD's previous baseline assessment that was reflected in the \$46.5 million cost savings estimate did not accurately reflect the current number of headquarters personnel working in the MHS.⁷

We also reported in November 2013 that, according to DOD officials, the number of military, civilian, and contractor positions required when the

⁴ [GAO-12-224](#).

⁵ [GAO/AIMD-10.1.15](#).

⁶ GAO, *A Model of Strategic Human Capital Management*, [GAO-02-373SP](#) (Washington, D.C.: March 2002).

⁷ [GAO-14-49](#).

DHA is fully operational in 2015 could be significantly higher for certain headquarters functions than the estimates for the number of positions required at the time of the DHA's establishment in October 2013. For example, we reported that according to a senior official responsible for information technology in the MHS, the number of staff required to provide information-technology services when DHA began initial operations in October 2013 was estimated at about 400 military and civilian positions; however, that estimate could increase to about 3,500 military and civilian positions and about 5,000 contractor equivalent positions once the DHA becomes fully operational in 2015. We concluded that DOD was unable to determine whether the establishment of the DHA would result in an increase or decrease in the number of headquarters personnel because the department had not completed an accurate baseline assessment of the number of headquarters personnel working in the MHS across the services and the Office of the Secretary of Defense.

In our November 2013 report, we recommended that DOD develop a baseline assessment of the current number of military, civilian, and contractor personnel currently working within the MHS headquarters and an estimate for the DHA at full operating capability, including estimates of changes in contractor full-time equivalents.⁸ DOD concurred with our recommendation. In our November 2013 report, we noted that DOD officials told us that they planned to conduct a baseline assessment of headquarters staffing levels and submit a revised estimate of its staffing needs in the department's third and final implementation plan submission. In the final submission which we reviewed for this statement, DOD did not include a baseline assessment of the number of personnel currently working in the MHS headquarters across the services and the Office of the Secretary of Defense, nor did it include an estimate of the staffing needs once the DHA is fully operational in 2015. Instead, DOD reported that the DHA would include 1,941 military and civilian personnel as of its initial operating capability on October 1, 2013. Additionally, the plan's estimate of staffing in October 2013 does not account for any contractor positions currently associated with the MHS's headquarters functions. As the DHA moves toward full operating capability, accurate baseline staffing data is critical for senior leadership to make informed decisions about the resources required to manage the MHS. Such data have become even more critical since the Deputy Secretary of Defense announced a

⁸[GAO-14-49](#).

20 percent reduction in DOD management headquarters spending over 5 fiscal years beginning in fiscal year 2014.

DOD Has Not Clarified the Sources of Cost Savings and Its Plan to Monitor Implementation Costs

DOD has not provided discrete cost savings estimates for the various functions it has identified as part of its 10 shared service projects it is planning as part of the MHS reform. In addition, DOD has not clarified its plan to monitor implementation costs. According to GAO's *Business Process Reengineering Assessment Guide*, an initial business case is a high-level document aimed at convincing customers and stakeholders that reengineering the selected business process is the appropriate means for achieving performance and cost-savings goals.⁹ The Guide identifies that as the reengineering process matures, the business case should include detailed qualitative and quantitative analysis in support of selecting and implementing the new process that includes a statement regarding benefits, costs, and risks. In addition, business-case analyses should demonstrate the sensitivity of the outcome to changes in assumptions, with a focus on the dominant benefit and cost elements and the areas of greatest uncertainty. In the context of major business-process reengineering efforts, such as DOD's shared services, implementation costs can be the dominant cost element and the area of greatest uncertainty.

In November 2013, we reported¹⁰ that DOD officials stated that while some efficiencies in the reform effort might be achieved by reducing headquarters staffing levels, DOD expected that the greatest cost savings would be realized through a more integrated approach to the MHS, standardization, and the implementation of shared services, such as such as information technology, medical logistics, and contracting. In our September 2012 report¹¹ on DOD's analysis of options for governance of the MHS, we recommended that DOD perform a business-case analysis to demonstrate the extent to which sharing services would result in cost savings. In its second and third implementation plan submissions for the DHA, DOD identified the functions it would consolidate and the anticipated aggregate savings and implementation costs. However,

⁹GAO/AIMD-10.1.15.

¹⁰GAO-14-49.

¹¹GAO, *Defense Health Care: Additional Analysis of Costs and Benefits of Potential Governance Structures Is Needed*, GAO-12-911 (Washington, D.C.: Sept. 26, 2012).

DOD's submissions did not include detailed quantitative analysis regarding the sources of its cost-savings estimates or provide a basis for or an explanation of key assumptions and rationales used in estimating such savings. For example, DOD identified the consolidation of medical logistics functions and a resulting aggregated cost-savings range of between \$132 million and \$353 million from fiscal years 2014 through 2019. However, the plan did not explain which function within this area (e.g., equipment or housekeeping) would be the larger source of those savings. Similarly, DOD's second implementation plan submission identified that DOD plans to achieve savings in administration of its health care plan for servicemembers, TRICARE, by closing walk-in help centers and transitioning to a phone-based system. Further, it plans to achieve savings through better coordination of TRICARE benefit payments with other health insurers. However, as in the case of the consolidation of medical logistics functions, DOD did not identify separate cost-savings estimates for each planned effort (e.g., transitioning to a phone-based system) and instead presented the estimated cost savings as an aggregated amount of between \$503 million and \$787 million.

DOD's second implementation plan submission included risk-adjusted estimates of net cost savings for shared services based on uncertainty regarding these projects' effectiveness and that are presented as a range, with a 10 percent to 100 percent chance of achieving the maximum estimated savings for each shared service. However, while DOD assessed the risk of its reforms failing to achieve their maximum potential cost savings, it did not similarly assess the risk that estimated implementation costs may increase and affect net savings. As noted above, our prior work emphasizes that business-case analyses should demonstrate the sensitivity of the outcome to changes in assumptions, with a focus on the dominant benefit and cost elements and the areas of greatest uncertainty. DOD's analysis did not assess the risk that estimated implementation costs may increase. In instances where estimated implementation costs increase, overall savings may be negatively affected.

DOD's past experience with large-scale projects demonstrates its difficulties in controlling rising implementation costs. For example, in October 2010, we previously found that after obligating approximately \$2 billion over the 13-year life of its initiative to acquire an electronic health record system, as of September 2010 DOD had delivered various capabilities for outpatient care and dental care documentation, but scaled back other capabilities it had originally planned to deliver, such as replacement of legacy systems and inpatient-care management. In

addition, users continued to experience significant problems with the performance (speed, usability, and availability) of the portions of the system that have been deployed.¹² According to DOD's estimates, collectively, the 10 shared services to be implemented as part of the MHS reform effort require an investment in information-technology capabilities of about \$273 million between fiscal years 2014 and 2019. Given DOD's past experience in this area, rising implementation costs are an area of specific concern.

In our November 2013 report, we recommended that DOD develop a more thorough explanation of the potential sources of cost savings from the implementation of its shared-services projects and monitor the cost of the implementation process, and DOD concurred with our recommendations.¹³ However, DOD's third implementation plan submission did not provide additional information concerning the potential sources of cost savings, nor did it clarify its plan to monitor implementation costs. In February 2014, a DOD representative told us that DOD has developed a process for leadership to monitor implementation costs, and we plan to review DOD's process to determine if it addresses our recommendation. As DOD implements its shared services, greater clarity with regard to the sources of cost savings is also needed to allow senior leaders to monitor progress in achieving cost savings.

DOD Does Not Have Interim Milestones For All Reform Goals

DOD has developed some milestones and activities associated with each of its reform goals, including identifying steps to reach each reform goal's initial operating capability. However, DOD did not consistently identify milestones between initial operating capability and final operating capability, nor did it include steps to achieve all seven reform goals. Practices of successful performance management show that interim milestones can be used to show progress towards implementing efforts or to make adjustments when necessary.¹⁴ Specifically, we found that

¹² GAO, *Information Technology: Opportunities Exist to Improve Management of DOD's Electronic Health Record Initiative*, [GAO-11-50](#), (Washington, D.C.: Oct. 6, 2010).

¹³ [GAO-14-49](#).

¹⁴ GAO, *Agency Performance Plans: Examples of Practices That Can Improve Usefulness to Decisionmakers*, [GAO/GGD/AIMD-99-69](#) (Washington, D.C.: Feb. 26, 1999) and *Executive Guide: Effectively Implementing the Government Performance and Results Act*, [GAO/GGD-96-118](#) (Washington, D.C.: June 1996).

developing and using specific milestones and timelines to guide and gauge progress toward achieving an agency's desired results informs management of the rate of progress toward achieving goals and whether adjustments need to be made in order to maintain progress within given time frames.

DOD's March 2013 submission was required to include a detailed schedule for carrying out the reform of the governance of the MHS, including a schedule for meeting the goals of the reform. However, in that submission, DOD provided a schedule of activities leading up to its first major milestone—initial operating capability of October 1, 2013. This schedule of activities did not provide information related to activities beyond this first major milestone, and it did not present milestones for achieving each of the supporting seven goals of the reform. In that March 2013 submission, DOD also did not include some key features of effective schedules identified in our prior work, such as interim milestones or related timelines for all of the activities supporting the reform. Specifically, the submission did not contain any interim actions or milestones between October 1, 2013 and October 1, 2015—the planned final operating capability date. Furthermore, the schedule provided in the submission does not clearly establish how each of the supporting seven goals of the reform will be met.

Subsequent to DOD's March 2013 submission, the House Report accompanying a bill for the National Defense Authorization Act for Fiscal Year 2014 directed the Secretary of Defense to provide the House Armed Services Committee with, among other things, a detailed schedule for managing the reform effort. In response, DOD submitted a supplemental report on August 16, 2013, that included estimated interim milestones for the achievement of three of the reform goals that it had not initially provided in either of its earlier submissions.

In our November 2013 report, we recommended that DOD develop a comprehensive timeline that includes interim milestones for all reform goals that could be used to show implementation progress, and DOD concurred with our recommendation.¹⁵ DOD's third implementation plan submission contained additional timeline activities for its reform goal concerning the implementation of shared services, with milestones

¹⁵[GAO-14-49](#).

leading up to each shared services' initial operating capability. However, DOD has not consistently identified milestones for all activities between initial operating capability and final operating capability for each of the goals of its reform. While senior leaders now have more interim milestones by which to track the implementation of the DHA, they continue to lack milestones subsequent to initial operating capability in a number of areas. Unless DOD develops interim milestones for its reform timelines, it may not be able to adequately monitor its progress toward achieving its goals by October 2015.

DOD Does Not Have Fully Developed Performance Measures That Could Be Used to Assess Progress in Establishing the DHA

DOD did not include critical details in the performance measures it developed to assess progress in achieving the seven goals of the reform effort. Specifically, DOD did not develop explanations for how each measure relates to the goals of the reform effort; did not define the specific measure to be developed; did not provide a baseline assessment of the current performance that is to be measured; and, most importantly, did not identify quantifiable targets for assessing the progress of each reform goal.

We have previously concluded that federal agencies engaging in large projects, including the consolidation of management functions, can use performance measures to determine how well they are achieving their goals and identify areas for improvement, if needed.¹⁶ Additionally, we have found that by tracking and developing a performance baseline for all measures, agencies can better evaluate progress made and determine whether goals are being achieved. Identifying and reporting deviations from the baseline as a program proceeds provides valuable information for these decision makers as they identify areas of risk and diagnose their causes.

In November 2013, we reported that in its June submission of its implementation plan, DOD had listed 87 performance measures to assess progress in achieving the seven objectives of the reform effort,¹⁷ but that those measures did not exhibit important attributes of successful

¹⁶GAO-12-542.

¹⁷GAO-14-49. As noted in our report, some performance measures were used to assess multiple objectives.

performance measures that we had established in our prior work.¹⁸ Specifically, we found that DOD provided only the measures' names, with no accompanying explanation for how each measure relates to the goals of the reform effort, definition of the specific measure to be developed, or quantifiable, numerical target for performance, nor had DOD provided a baseline assessment of the current performance to be measured. For example, DOD listed "Emergency Room Utilization Rate" as a performance measure, but did not explain how that measure relates to the objective of consolidating delivery of health care in areas with more than one military service. Further, we found that DOD did not provide an explanation of what each measure will evaluate, which could be used to determine the extent to which each measure provides new information beyond that provided by other measures. For example, two of the measures listed under the objective to deliver more-comprehensive primary care and integrated health services using advanced patient-centered medical homes are "satisfaction with provider communications" and "satisfaction with health care." As presented in DOD's June submission of its implementation plan, it is unclear whether there is any overlap between these measures, because the aspects of satisfaction are not clarified by any accompanying explanation or definition.

We also reported that decision makers would not be able to determine the objectivity of DOD's measures because there is no information accompanying the measures that indicates specifically what is to be observed, in which population or conditions, and in what time frame. For example, one of the measures is "savings achieved versus savings projected." This measure does not indicate specifically how savings will be measured, and does not indicate what time frame will be used to compare what savings were projected versus what were actually achieved.

In our November 2013 report, we recommended that DOD provide more detailed information on its performance measures—specifically, that DOD develop and present to Congress measures that are clear, quantifiable,

¹⁸GAO, *Tax Administration: IRS Needs to Further Refine Its Tax Filing Season Performance Measures*, [GAO-03-143](#) (Washington, D.C.: Nov. 22, 2002); *GPRA Performance Reports*, [GAO/GGD-96-66R](#) (Washington, D.C.: Feb. 14, 1996); *Missile Defense: Opportunity to Refocus on Strengthening Acquisition Management*, [GAO-13-432](#) (Washington, D.C.: Apr. 26, 2013); *Performance Measurement and Evaluation: Definitions and Relationships*, [GAO-11-646SP](#) (Washington, D.C.: May 2011); and [GAO/GGD/AIMD-99-69](#).

objective, and include a baseline assessment of current performance.¹⁹ In the third submission of its implementation plan, DOD provided some additional information, such as baselines and performance targets, for the performance measures under two of its seven reform goals. In this submission, DOD included tables with expanded information for the performance measures for its goals related to (1) delivering more-comprehensive primary care and integrated health services using advanced patient-centered medical homes, and (2) coordinating care over time and across treatment settings to improve outcomes in the management of chronic illness, particularly for patients with complex medical and social problems. For these objectives, DOD listed the measures' names, and, where available, estimates of current and target performance. For those measures without a definition or baseline, DOD provided a date by when the measures would be defined and when the baseline performance level would be established.

As of DOD's final submission, much of the information to be included in these two tables was still to be determined. As a result, many of the entries in the tables represented placeholders for information, rather than actual baselines or performance targets. Further, DOD did not include this additional information for any of the performance measures listed under its other five reform goals. In this third submission, DOD noted that it was in the process of developing measures and respective performance targets to be published in its 2014 strategic plan for the MHS, which it expected to issue in December 2013. In February 2014, a DOD representative told us that the strategic plan is now expected to be released in May 2014. Fully developed performance measures are key to senior leaders' ability to assess if DOD's reform effort is achieving its goals or if corrective action is required.

In summary, DOD's reform efforts represent positive steps to improve the efficiency of the governance of the MHS, and these reforms have progressed much further than previous attempts to improve the governance structure. As we noted in previous reports, the successful implementation of the DHA will require committed senior leadership to sustain the momentum created by the current reform effort. This leadership, in turn, will help to provide oversight and accountability for the improvement process. However, senior leaders need appropriate

¹⁹ [GAO-14-49](#).

information to make decisions and guide the reform. The first step to determine what is needed for the implementation of the DHA is a baseline assessment of current MHS staffing, followed by an estimate of DHA staffing at full operating capability. In addition, a detailed quantitative analysis regarding the sources of cost savings and a plan to monitor implementation costs would provide greater clarity to DOD's shared-service consolidation projects. Moreover, the development of comprehensive milestones for all of the reform goals would allow decision makers to track the progress of DOD's reform efforts toward achieving its goals. Finally, the completion of a set of fully developed performance measures across all seven of DOD's stated goals for the DHA would ensure that DOD's senior leaders and other decision makers have the necessary information to assess DOD's progress in creating a more cost-effective and integrated MHS.

Chairman Wilson, Ranking Member Davis, and Members of the Subcommittee, this concludes my prepared statement. I would be pleased to respond to any questions that you may have at this time.

GAO Contact and Staff Acknowledgments

For further information about this statement, please contact Brenda S. Farrell 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 statement. Individuals who made key contributions to this testimony are Lori Atkinson, Assistant Director; Beckie Beale; Jeff Heit; Mae Jones; and Adam Smith.

Related GAO Products

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

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

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

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

Military Personnel: DOD Addressing Challenges in Iraq and Afghanistan but Opportunities Exist to Enhance the Planning Process for Army Medical Personnel Requirements. [GAO-11-163](#). Washington, D.C.: February 10, 2011.

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

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

Defense Health Care: Tri-Service Strategy Needed to Justify Medical Resources for Readiness and Peacetime Care. [GAO/HEHS-00-10](#). Washington, D.C.: November 3, 1999.

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