



# Defense Health Program

★★★ Agency Financial Report ★★★

Fiscal Year 2018



# About the Agency Financial Report

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The Defense Health Program (DHP) Enterprise Agency Financial Report (AFR) provides financial and summary performance results enabling the president, Congress, and the American people to assess its accomplishments, and to understand its financial results and operational functions. This AFR satisfies the reporting requirements of the following:

- Federal Managers' Financial Integrity Act of 1982;
- Chief Financial Officers Act of 1990;
- Government Management Reform Act of 1994;
- Reports Consolidation Act of 2000;
- Office of Management and Budget Circular No. A-136, *Financial Reporting Requirements*;
- Improper Payments Elimination and Recovery Improvement Act of 2012;
- Office of Management and Budget Memorandum M-12-12, *Promoting Efficient Spending to Support Agency Operations*; and
- Fraud Reduction and Data Analytics Act of 2015.

The DHP Enterprise chooses to produce an AFR rather than the alternative Performance and Accountability Report. The Annual Performance Report, with detailed performance information that meets the requirements of the Government Performance and Results Modernization Act of 2010 (GPRAMA), will be provided within the Annual Performance Plan and Report and transmitted with the release of the Fiscal Year (FY) 2019 Congressional Budget Justification. The AFR may be viewed online at [www.health.mil/HealthAffairs](http://www.health.mil/HealthAffairs). The AFR consists of three primary sections:

## Management's Discussion and Analysis

Provides a high-level overview of the DHP Enterprise, including its history, mission, and organizational structure; the DHP Enterprise's overall performance related to its strategic goals and primary objectives; management's assurance on internal controls; and forward-looking information.

## Financial Section

Contains financial statements, accompanying notes, required supplementary stewardship information, required supplementary information, as well as the independent auditor's report on the financial statements and management's response to that report.

## Other Information

Details DHP Enterprise's compliance with, and commitment to, specific regulations, including performance and management analyses and recommendations from the Office of the Inspector General, payment integrity reporting results, and the Combining Statement of Budgetary Resources.

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# **I. Management's Discussion and Analysis**

## Agency Head Message



The Military Health System (MHS) and the Office of the Assistant Secretary of Defense (Health Affairs) serve as the Department of Defense's singular entity responsible and accountable for effectively and efficiently maintaining and advancing our dual missions of readiness and health-care delivery for our 9.4 million service member, retiree, and family member beneficiaries.

The MHS prides itself on its commitment to service, and its corporate culture includes a dedication to transparency, especially as we create a more integrated, higher-performing enterprise in light of our significant reforms directed by the Secretary and Congressionally mandated reforms directed by the FY 2017 and FY 2019 National Defense Authorization Acts. The mission of the MHS remains to support the service member, and care for our service member families. The collective goal of military health reforms is a more integrated, efficient and effective system of readiness and health that best supports the lethality of the force. In order to achieve that goal, the MHS must ensure proper controls are in place, that they are functioning as intended, and that we are maximizing our value to

our beneficiaries and to the Department.

The ongoing auditability of the MHS is a priority for each and every member of our team. Each of us directly contributes to our shared mission, regardless of rank or level, and the entire enterprise is committed to achieving an unmodified opinion. We understand it will take everyone's support to improve the reliability and accuracy of our data to enable informed decisions both now and in the future and make the best use of our available resources in order to achieve our strategic goals and objectives. In order to continue our progress towards this goal, we have undertaken corrective actions based on deficiencies and internal control weaknesses that our team has identified. More information regarding the status of the internal control environment within the DHP Enterprise and the steps we are taking to address these issues can be found in the Management Assurance section of this report.

I encourage all of our stakeholders to read this report. It will be clear that the MHS is committed to transparency, efficiency, and effectiveness as we ensure mission alignment with Secretary Mattis' Department priorities to increase lethality, leverage strategic partnerships, and improve our business processes. I thank the staff of the MHS for their tireless dedication and perseverance in delivering these strategic priorities every day, our beneficiaries for their service and being the most deserving customers in the world, and all our stakeholders for their incredible support as we engage in this endeavor.

*Signed*

Tom McCaffery  
Principal Deputy Assistant Secretary of Defense for Health Affairs

# Mission and Organization Structure

## History

In 2011, the Deputy Secretary of Defense's Task Force on Reform of the Military Health System led to the creation of the Defense Health Agency (DHA), a Combat Support Agency (CSA) and a component of the Defense Health Program (DHP) Enterprise.<sup>1</sup> On September 30, 2013, the Department of Defense (DoD or the Department) issued a directive formally establishing the DHA as part of the DHP Enterprise, and on October 1, 2015, the DHA achieved full operating capability.

In early 2017, in response to the FY 2017 National Defense Authorization Act (NDAA), the DHA began preparing to assume responsibility for the administration and management of Military Treatment Facilities (MTFs) worldwide. The assumption of these responsibilities will commence on October 1, 2018 and be phased in over a three-year period. The DHA published the FY 2017 Strategic Plan, to communicate its mission, vision, goals and objectives to best support DHP Enterprise's workforce, patients, services, and Combatant Commands (CCMDs).

The FY 2017 NDAA enacted other significant reforms to the DHP Enterprise, including changes to the TRICARE Health Plan and existing internal management structures within the DHA. The centralized administration of the MTFs under the authority, direction and control of the DHA provided the opportunity to improve readiness, standardize and improve the patient experience and lower costs through the elimination of unnecessary redundancies.

The provisions in the FY 2017 NDAA work together to (1) ensure a trained and ready health team to support the Joint Force, (2) deliver an improved experience to MHS beneficiaries, and (3) enable the DHP Enterprise to act as one. The FY 2017 NDAA intends to improve health care for service members, retirees, and their families, while enhancing medical readiness by:

- Improving and maintaining operational medical force readiness
- Enhancing access to high-quality health care
- Improving beneficiaries' health outcomes
- Creating health value
- Modernizing TRICARE support contracts
- Driving efficiencies and eliminating waste
- Demanding performance accountability

### What is the Defense Health Program?

The Defense Health Program itself is an appropriation from Congress, Apportioned by the Office of Management and Budget to the Office of the Undersecretary of Defense (Comptroller) who then allots these funds to the Assistant Secretary of Defense for Health Affairs. The Assistant Secretary of Defense for Health Affairs then issues Funding Authorization Documents (FADs) to fund the seven financial statement reporting components supporting the Military Health System consisting of: U.S. Army Medical Command, The Navy Bureau of Medicine and Surgery, U.S. Air Force Medical Services, Defense Health Agency (FOD), Contract Resource Management Office, the Uniformed Services University of the Health Sciences, and the National Capital Region Medical Directorate. Based on DoD Directive 5136.01, the Assistant Secretary of Defense for Health Affairs exercises authority, direction and control over these entities and directs the use of the Defense Health Program appropriation. These entities are often collectively known as the entities that comprise the Defense Health Program Enterprise (DHP Enterprise).

<sup>1</sup> This will represent the Defense Health Agency once the changes outlined in the FY 2017 NDAA have been implemented.

## **Mission**

The DHP Enterprise's overarching mission is to support a medically ready force and a ready medical force, supporting a more agile MHS. The DHP Enterprise aims to enhance the DoD and our nation's security by providing health care support for the full range of military operations and sustaining the health of all those entrusted to our care. This includes active duty personnel, military retirees, certain members of the Reserve Component, family members, widows, survivors, ex-spouses, and other eligible members. These beneficiaries receive direct care through MTFs, private sector care through TRICARE's civilian provider networks and other authorized TRICARE providers, and prescription and mail order coverage through the TRICARE Pharmacy Program (TPharm).

## **What We Do**

The DHP Enterprise supports the delivery of integrated, affordable, high-quality health services to DoD beneficiaries and is responsible for driving greater global integration of clinical and business processes by:

- Implementing Enterprise Activities with common measurements of outcomes
- Enabling rapid adoption of proven practices, helping reduce unwanted variation, and improving the coordination of care across treatment venues
- Exercising management responsibility for joint shared services and the TRICARE Health Plan
- Acting as the market manager for the National Capital Region (NCR) enhanced Multi-Service Market, which includes Walter Reed National Military Medical Center (WRNMMC) and Fort Belvoir Community Hospital (FBCH)

In support of a cohesive, globally integrated, affordable, and high-quality health services, the DHP Enterprise directs the execution of eleven joint Directorates and manages and administers the following Enterprise Activities (EAs):

- TRICARE Health Plan
- Pharmacy Programs
- Health Information Technology (IT)
- Education & Training
- Public Health
- Medical Logistics
- Facility Management
- Budget & Resource Management
- Research, Development & Acquisition
- Procurement & Contracting

## How We Accomplish Our Mission

The MHS is a global, comprehensive, integrated system that provides health care to active duty, retired U.S. military personnel and their families, retirees and their families, and certain other beneficiaries. Army, Navy, and Air Force medical professionals help ensure those in uniform are medically ready to deploy anywhere around the globe on a moment's notice.

With over \$50 billion in the unified medical budget and serving 9.4 million active duty personnel, certain reserve component members, retirees and their eligible enrolled beneficiaries, MHS employs more than 147,000 personnel in 51 hospitals, 381 clinics, and 247 dental clinics at facilities around the globe, as well as in contingency and combat-theater operations worldwide. MHS is more than just combat medicine – it is a complex system that globally integrates:

- Health care delivery
- Public health and medical education
- Private sector partnerships
- Cutting-edge medical research and development

MHS is led by the Office of the Assistant Secretary of Defense for Health Affairs under the Office of the Undersecretary of Defense for Personnel & Readiness.



Those of us who work in military health are justifiably proud of how ready the MHS is to respond, not just to the needs of our service members and our TRICARE beneficiaries, but also to the needs of our entire country. – VADM Bono





Figure 1: The DHP MHS by the numbers- 2017<sup>2</sup>

**MILITARY HEALTH SYSTEM BY THE NUMBERS- 2017**

TYPE OF CARE	AVERAGE NUMBER PER WEEK	ANNUAL SUMMARY
<b>Inpatient Admissions</b>	<b>Total: 19,274</b>	<b>Total: 1,005,700</b>
	Military Facilities: 4,337	Military Facilities: 226,300
	Network Facilities: 7,133	Network Facilities: 372,200
	TRICARE For Life: 7,804	TRICARE For Life: 407,200
<b>Outpatient Visits</b>	<b>Total: 2,033,402</b>	<b>Total: 106,100,000</b>
	Military Facilities: 793,429	Military Facilities: 41,400,000
	Network Facilities: 657,358	Network Facilities: 34,300,000
	TRICARE For Life: 582,615	TRICARE For Life: 30,400,000
<b>Births</b>	<b>Total: 2,116</b>	<b>Total: 110,394</b>
	Military Facilities: 789	Military Facilities: 41,164
	Network Facilities: 1,327	Network Facilities: 69,230
<b>Prescription Workload</b>	<b>Total: 2,288,296</b>	<b>Total: 119,400,000</b>
	Military Pharmacies: 860,507	Military Pharmacies: 44,900,000
	Network Pharmacies: 442,710	Network Pharmacies: 23,100,000
	Home Delivery: 155,236	Home Delivery: 8,100,000
	TRICARE For Life: 829,843	TRICARE For Life: 43,300,000

**What is TRICARE**

TRICARE is the worldwide DoD health care program serving 9.4 million service members (Active and Guard/Reserve) on Active Duty (greater than 30 days) and their families; as well as retirees, their families, survivors, and certain former spouses (<https://www.tricare.mil>). As a major component of the Military Health System (MHS; [www.health.mil](http://www.health.mil)), TRICARE brings together the military hospitals and clinics worldwide (often referred to as “direct care,” usually in military treatment facilities, or MTFs) with network and non-network TRICARE-authorized civilian health care professionals, institutions, pharmacies, and suppliers (often referred to as “purchased care”) to provide access to the full array of high-quality health care services while maintaining the capability to support military operations.

**Health Care Plans:** Starting in January 2018, the DoD offers two health plan options: Prime and Select. TRICARE Prime features a cost-sharing structure similar to a health management organization (HMO) plan. TRICARE Select is a preferred provider organization (PPO) option with an annual enrollment fee. Co-pays for beneficiaries are streamlined and simplified, which may yield some cost savings to the Department. Individuals have access to different levels and types of benefits depending on their beneficiary status. Active duty service members (ADSMs) generally obtain care from MTFs. When necessary, active duty personnel may obtain care from civilian providers at government expense. Family members of active duty personnel as well as military retirees and dependents who are not eligible for Medicare can choose from one of these main options:

- **TRICARE Prime:** Is a managed care option and an HMO like program. It generally features the use of military hospitals and clinics and reduces out-of-pocket cost for authorized care provided outside military hospitals and clinics by

<sup>2</sup> The Defense Health Agency Stakeholder Report 2017

TRICARE network providers. TRICARE Prime is mandatory for active duty services members (ADSMs) and is an option for their family members and certain TRICARE-eligible beneficiaries located in Prime Service Areas (PSAs) in the U.S.

- **TRICARE Select:** Is a self-managed, preferred-provider option for eligible beneficiaries (except ADSMs and TRICARE for Life beneficiaries) not enrolled in TRICARE Prime. TRICARE Select allows beneficiaries to choose their own TRICARE-authorized providers and manage their own health care. (See TRICARE Program Changes below for additional information regarding TRICARE Select).
- **TRICARE Extra:** This is a fee-for-service plan similar to a civilian preferred provider organization (PPO) available to all non-active duty service members. When beneficiaries not enrolled in TRICARE Prime obtain services from TRICARE network professionals, hospitals, and suppliers, they pay the same deductible as TRICARE Standard; however, TRICARE Extra cost shares are reduced by 5 percent. TRICARE network providers file claims for the beneficiary.
- **TRICARE Standard:** This non-network benefit, formerly known as the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), is open to eligible DoD beneficiaries (except ADSMs). This is a fee-for-service plan that allows beneficiaries to obtain care from any civilian provider and be reimbursed for a portion of the costs after paying co-payments and meeting deductibles. Beneficiaries who are eligible for Medicare Part B are also covered by TRICARE Standard for any services covered by TRICARE but not covered by Medicare.

**Other Plans and Programs:** Some beneficiaries may qualify for other benefit options depending on their location, Active/Reserve status, and other factors. These plans and programs provide additional benefits or offer benefits that are a blend of the Prime and Standard/Extra options with some limitations. Below are the available additional plans:

**TRICARE For Life (TFL):** The TFL was created as wraparound coverage to Medicare-eligible military retirees by Section 712 of the Floyd D. Spence National Defense Authorization Act for FY 2001 (P.L. 106-398). TFL functions as a secondary payer to Medicare, paying out-of-pocket costs for medical services covered under Medicare for beneficiaries who are entitled to Medicare Part A and who have Medicare Part B based on age, disability, or end-stage renal disease (ESRD). TFL serves as the final payer for Medicare Covered Benefits, and first payer for TRICARE benefits that are not covered in the Medicare, or other health care insurance programs.

**TRICARE Prime Remote (TPR) and TRICARE Prime Remote for Active Duty Family Members (TPRADFM):** Provides TRICARE Prime like benefits to ADSMs and family members who reside with the TPR enrolled sponsor in remote location in the U.S, usually more than 50 miles or 1-hour drive, from a military hospital or clinic.

**TRICARE Prime Overseas (Remote/Non-Remote):** A TRICARE Prime option offered in remote and non-remote overseas locations for permanently assigned active duty service members or Guard/Reserve members and their command sponsored dependents to receive care from a network of licensed, qualified physicians. Beneficiaries enrolled in Prime Overseas will be assigned an MTF PCM. There are no out-of-pocket costs as long as care is received from the PCM or with a referral. Care received without a referral is subject to POS fees.

**TRICARE Overseas Program (TOP) Standard:** Provides comprehensive coverage in all overseas areas. This plan allows beneficiaries to seek care from any civilian provider, although prior authorization may be needed from the overseas contractor. Costs vary based on the sponsor's military status. Beneficiaries will be reimbursed for a portion of the costs after paying co-payments and meeting deductibles.

**Effective January 1, 2018, the TOP Standard was replaced by TOP Select, an enrollment-based plan. See below for additional information on the TOP Select plan.**

**TRICARE Reserve Select:** A premium-based TRICARE health plan available for purchase by qualified members of the Selected Reserve and their qualified survivors; delivers the TRICARE Select benefit with cost-sharing at the Group B retiree level.

**TRICARE Retired Reserve:** A premium-based TRICARE health plan available for purchase by qualified members of the Retired Reserve and their qualified survivors; delivers the TRICARE Select benefit with cost-sharing at the Group B active duty family member level.

**TRICARE Young Adult Program (TYA):** A premium-based health plan that implements NDAA of FY 2011, allowing coverage for adult children until age 26 comparable to the Patient Protection and Affordable Care Act of 2010 requiring civilian health plans to offer such coverage.

**Dental Benefits:** Includes the TRICARE Dental Program (TDP), the TRICARE Retiree Dental Program (TRDP), and the Active Duty Dental Program (ADDP). The TDP and TRDP offer access to a worldwide dental benefit to active duty family members and retired service members and their family members. The TDP and TRDP are premium-based programs with the Government contributing a portion of the premium for certain plan types, however, effective December 31,

2018 the TDP and TRDP programs will end replaced by the Federal Employees Dental and Vision Insurance Program (FEDVIP) effective January 1, 2019. <https://www.opm.gov/healthcare-insurance/dental-vision/>

The ADDP provides private sector dental care to ADSMs who are unable to receive required care from a military dental treatment facility in order to ensure dental health and deployment readiness for ADSMs.

**Pharmacy Benefits:** Provides prescription drug coverage through military pharmacies, TRICARE Pharmacy Home Delivery, and TRICARE retail network and non-network pharmacies. The TRICARE Pharmacy Program is available to all TRICARE-eligible beneficiaries registered in the Defense Enrollment Eligibility Reporting System (DEERS), except those enrolled in the Uniformed Services Family Health Plan (USFHP) who are also eligible for the same pharmacy benefits that are provided under the USFHP plan.

**Uniformed Services Family Health Plan (USFHP)/Designated Providers Program (DPP):** Provides the full TRICARE Prime benefit, including pharmacy, under capitated payment to non-Active duty DHP Enterprise enrollees at six statutory specified locations: Washington, Texas, Maine, Massachusetts, Maryland, and New York.

**Clinical and Education Services Demonstration Programs:** Examples include chiropractic care, autism services, and TRICARE Assistance Program.

**Continued Health Care Benefits Program (CHCBP) and Transitional Assistance Management Program (TAMP):** Provides a Consolidated Omnibus Budget Reconciliation Act-like benefit.

### TRICARE Program Changes in 2018

In fulfillment of section 701 of the FY 2017 NDAA, the DoD implemented the most sweeping changes to the TRICARE benefit structure since TRICARE was established in 1995. Contract management adjusted to synchronize these changes with the DoD's transition to the TRICARE 2017 contracts and regional oversight. The TRICARE changes expand beneficiary choice, improve access to network providers, modernize beneficiary cost-sharing, and enhance administrative efficiency.

#### TRICARE Select.

Named by Congress "TRICARE Select", this single plan features an enrollment requirement for purchased care with non-network and network care. All TRICARE beneficiaries in December 2017 were enrolled in their TRICARE plan effective January 1, 2018. TRICARE Prime enrollees remained in TRICARE Prime, while TRICARE Standard and Extra beneficiaries were automatically enrolled in TRICARE Select. No referral or authorization is needed for TRICARE Select enrollees to obtain care from any TRICARE-authorized providers and fixed-fee copayments apply for most network care in TRICARE Select after the annual deductible is met. Fixed-fee copayments apply for most network care in TRICARE Select after the annual deductible is met. Non-enrolled beneficiaries may only receive care at a military clinic or hospital on a space-available basis; non-enrollment means no coverage for civilian care. TRICARE beneficiaries enrolled to TRICARE Select and residing overseas have the same enrollment fees as those TRICARE Select beneficiaries residing in the 50 United States (U.S.) and the District of Columbia.

#### During Calendar Year 2018

Calendar year 2018 has been a transition year with a grace period for enrollment. The first year of TRICARE Select implementation is treated as a transition year with beneficiaries being permitted to make coverage changes from the beginning of the year through the first open season, which is offered fall 2018. An annual open enrollment period (November – December 2018) will be established, when beneficiaries are free to change or enroll in TRICARE Prime or TRICARE Select for coverage effective January 1, 2019.

#### How TRICARE Is Administered

As the administrative agency for TRICARE, the DHP Enterprise serves as program manager for the TRICARE health plan. DHP Enterprise manages the execution of policy as issued by Office of the Assistant Secretary of Defense for Health Affairs (OASD (HA)) and the oversight, payment, and management of private sector care administered by contracted claims processors. DHP Enterprise also monitors the identification, recovery, and reporting of improper payments under the TRICARE program as required by Improper Payments Information Act (IPIA) and as amended by the Improper Payments Elimination and Recovery Act (IPERA) and Improper Payments Elimination and Recovery Improvement Act (IPERIA). DHP Enterprise also manages the dental program, Uniformed Services Family Health Plans and pharmacy programs (retail and mail order), and Medicare-Eligible Retiree Health Care Fund (MERHCF).

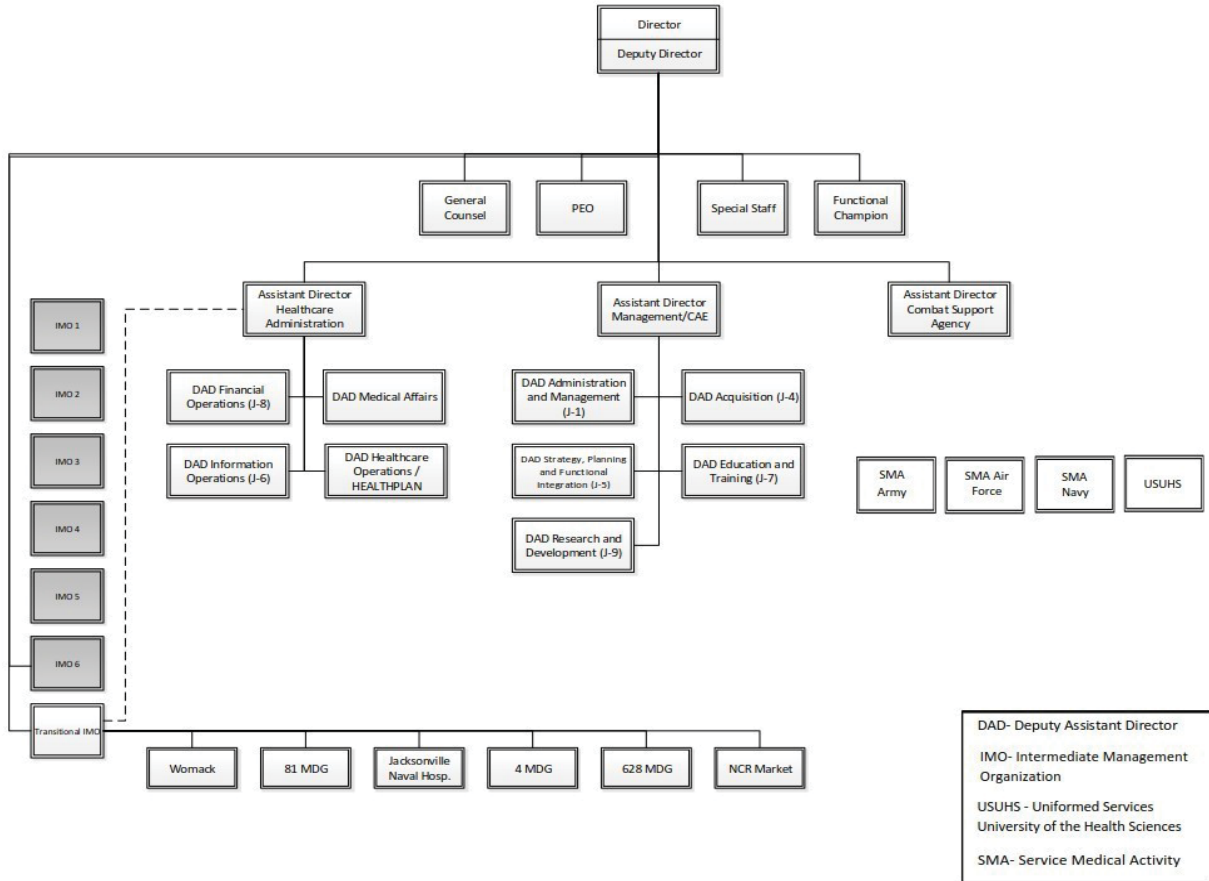
TRICARE is administered on a regional basis, with two regional private sector contractors in the United States. Outside of the United States, a pharmacy contractor and active duty dental and overseas contractors work with their TRICARE Regional Offices (TROs) to manage purchased care operations and coordinate medical, dental, and pharmacy services available through civilian health care providers within and outside of the MTFs. The TROs and various other DHP Enterprise Program Offices do the following:

- Provide oversight of regional operations and health plan administration
- Manage the contracts with regional contractors
- Support MTF Commanders
- Develop business plans for areas not served by MTFs (e.g., remote areas)

The DHP Enterprise continues to meet the challenge of providing the world's finest combat medicine and aeromedical evacuation, while supporting the TRICARE benefit to DoD beneficiaries at home and abroad. Since its inception more than a decade ago, TRICARE continues to offer an increasingly comprehensive health care plan to uniformed services members, retirees, and their families. As DHP Enterprise aggressively works to sustain the TRICARE program through good fiscal stewardship, it also refines and enhances the benefits.

## Organizational Structure

Figure 2: DHP Enterprise organization chart<sup>3</sup>



<sup>3</sup> SMAs are still direct reports to the Military Departments.

Figure 3: Defense Health Program O&M DHP Enterprise

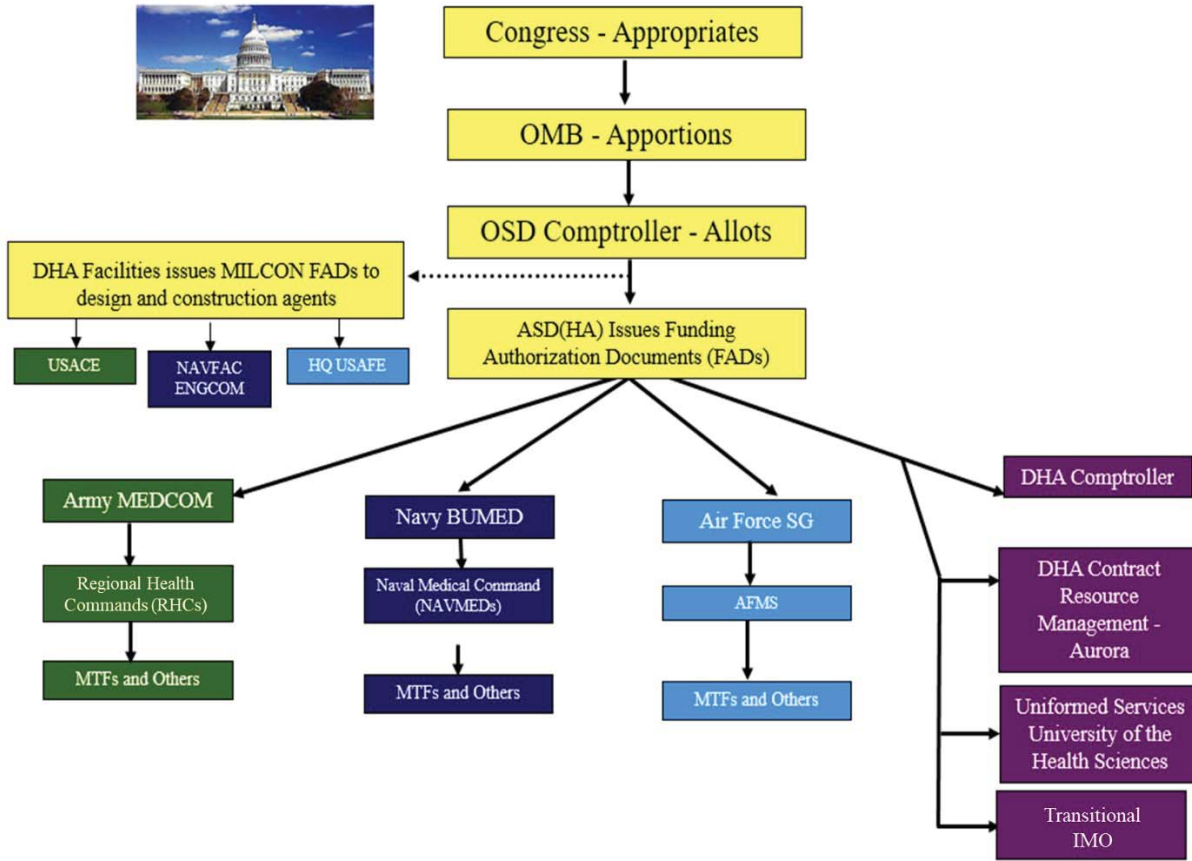


Figure 4: DHP Enterprise Defense Department Reporting System (DDRS) Audited Financial Statement (AFS) Compilation Structure



## Integrated Components of DHP Enterprise

DHP Enterprise is made up of seven components:

- **U.S. Army Medical Command (Army MEDCOM):** Army MEDCOM provides sustained health services and research in support of the total force to enable readiness and conserve the fighting strength while caring for soldiers for life and their families. As the Army is foundational to the Joint Force, Army MEDCOM is foundational to the Joint Health Services Enterprise. Army MEDCOM maintain the diversity and depth to respond to our nation's most demanding expeditionary missions. Army MEDCOM must ensure the health readiness of the force and maintain responsive medical capabilities to support the Army's three strategic roles: preventing conflict, shaping the strategic security environment, and winning in ground combat.
- **The Navy Bureau of Medicine and Surgery (Navy BUMED):** Navy Medicine is a global health care network of 63,000 personnel who provide health care support to the U.S. Navy, Marine Corps, their families, and veterans in high operational tempo environments, at expeditionary medical facilities, medical treatment facilities, hospitals, clinics, hospital ships, and research units around the world. Navy Medicine is led by the Navy Surgeon General, with headquarters in the Navy BUMED in Falls Church, Virginia. The Navy Medicine team of physicians, dentists, nurses, corpsmen, allied health providers, and support personnel also work in tandem with the Army and Air Force medical personnel and coalition forces to ensure the physical and mental well-being of service members and civilians. This care is provided via the Defense Health Program and coordinated by the Office of Assistant Secretary of Defense (Health Affairs) with support from the Defense Health Agency.
- **U.S. Air Force Medical Service (AFMS):** The AFMS mission is to ensure medically fit forces, provide expeditionary medics, and deliver trusted care to all it serves. The AFMS vision is for its supported population to be the healthiest and highest-performing segment of the U.S. population. Air Force Medics work for Line of the Air Force, which entails them to be mission-focused. AFMS supports benefit execution and readiness to provide: Healthy/fit force, resilient families, and trained medics. Air Force Warrior Medics...Mission Focused, Excellence Driven.
- **Defense Health Agency (DHA or the Agency):** The DHA was formed October 1, 2013, as a joint, integrated combat support agency to enable the Army, Navy, and Air Force medical services to provide a medically ready force and ready medical force to CCMDs in both peacetime and wartime. DHP Enterprise leads the MHS integrated system of readiness and health to deliver the MHS Quadruple Aim: increased readiness, better health, better care, and lower cost. The DHA oversees the execution of the \$33.4 billion Defense Health Program to support the delivery of integrated, affordable, and high-quality health services to the DoD's 9.4 million eligible beneficiaries. The DHA is responsible for driving greater integration of clinical and business processes across the contracted health care networks and MTFs. The DHA respects the core values its staff brings to the Agency while upholding an organizational culture that operates by six guiding principles of transparency, accountability, leading change, empowerment, nurturing, and being team oriented.
- **Uniformed Services University of the Health Sciences (USUHS):** The mission of USUHS is to educate, train, and comprehensively prepare uniformed services health professionals, scientists, and leaders to support the Military and Public Health Systems, the national security and national defense strategies of the United States, and the readiness of our Uniformed Services. Located in Bethesda, Maryland, USUHS educates and trains outstanding physicians, advanced practice nurses, dentists, allied health professionals, scientists, administrators, and military leaders who are dedicated to career service and leadership in the DoD, United States Public Health Service, and across the U.S. government. By the end of calendar year (CY) 2021, the vision for the Uniformed Services University of the Health Sciences will be widely recognized as the pre-eminent national educational institution for the creation of career uniformed services leaders in the health sciences who are prepared to serve the nation. USUHS will be a focal point for the Uniformed Services in health-related education and training, research and scholarship, leadership development, and support to operational military units around the world. Each USUHS graduate will be a health professional and leader prepared with an outstanding health education, inter-professional health training, leadership training, and a deep and abiding commitment to selfless service, the uniformed services ethos, and the security of the United States.
- **National Capital Region Medical Directorate (NCR MD):** The NCR MD is a Joint Tri-Service network of healthcare facilities that provide a medically ready force and ready medical force to CCMDs in both peacetime and wartime. The NCR MD supports the delivery of integrated, affordable, and high-quality health services and is responsible for driving greater integration of clinical and business processes across the national capital region. NCR MD is a subordinate organization of the DHP Enterprise and was officially established as a Financial Statement Reporting Entity (FSRE) on October 1, 2013. The FSRE combines the funding activity of FBCH, WRNMMC, Joint Pathology Center (JPC), and various

other clinics within the Greater Washington D.C. Area. The NCR MD mission proudly states they are the Flagship of our MHS. They ensure patient friendly access to high quality health care for all they are privileged to serve, while setting the standard in Readiness, Education and Research. The NCR MD vision leads them to believing the patient will be at the center of all that they do. The extraordinary will be ordinary and the exceptional routine in serving the physical, behavioral, social, and spiritual needs of their patients and of their people.

- **Contract Resource Management Office (CRM):** The CRM Office in Aurora, Colorado, is responsible for the accounting, financial support, and financial reporting for TRICARE's centrally funded private sector care programs and the TRICARE Retail Pharmacy Refunds Program. The CRM provides budget formulation input, carries out budget execution, and prepares component financial statements and footnotes. In addition, CRM is responsible for processing invoices received electronically from its contractors and through the TRICARE Encounter Data Set (TEDS), and reporting these transactions through accessible electronic media. CRM provides funding availability certification and financial program tracking for the centrally funded private sector care programs and monitors budget execution through analysis of current year and prior year's spending and program developments. It also assists DHP Enterprise's Contract Management, Program Integrity (fraud), and Case Recoupment division activities related to private sector care. CRM uses DHP funds provided by annual appropriations from the Congress of the United States to reimburse private sector health care providers for services rendered to TRICARE beneficiaries and funding from MERHCF for the health care provided through TRICARE For Life programs.

The DHP Enterprise audit opinion includes the results of CRM's audit. CRM has maintained an unmodified audit opinion as a result of the audit of its FY 2018 financial statements.



# Analysis of Performance Goals, Objectives, and Results

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## Overview

The Defense Health Program funds the MHS under the policy direction and guidance of the Assistant Secretary of Defense for Health Affairs. In 2009, the MHS adopted the Quadruple Aim of increased readiness, better health, better care, and lower cost for all components funded by the program. The Quadruple Aim provides direction for each of the MHS components and ensures alignment to the National Defense Strategy. The MHS, including DHA, the Service Medical Departments, and USUHS develop strategies within their organizations to achieve these four aims. The Quadruple Aim is defined as:

- **Increased Readiness** means ensuring that the total military force is medically ready to deploy and that the medical force is ready to deliver support health services anytime and anywhere in support of the full range of military operations, including on the battlefield or disaster response and humanitarian aid missions.
- **Better Health** is realized by reducing the generators of disease and injury, encouraging healthy behaviors, increasing health resilience, decreasing the likelihood of illness through focused prevention, and improving the health of those with chronic illness.
- **Better Care** advances health care services that are safe, timely, effective, efficient, equitable, and patient and family centered. Better care focuses on the health outcomes that matter to patients and their families.
- **Lower Cost** is achieved by focusing on quality, eliminating waste, and reducing unwarranted variation.

Strategic performance against each of the four aims is described below. Performance assurance, plans to achieve missed targets, reporting limitations, and the future state of performance measurement follow.

## Increased Readiness

The MHS exists to provide medical and health support to the Uniformed Service Members of the United States for war, combat, humanitarian aid, and disasters. A medically ready fighting force is physically ready to go into combat or support a full range of military operations across the world. A ready medical force has the knowledge, skills, and abilities to provide combat casualty care and other military-relevant health services, anytime and anywhere.

During the Global War on Terror and resulting wars in Afghanistan and Iraq, the MHS made tremendous improvements in combat casualty care. Since 2001, investment in research and clinical care, "produced the lowest case-fatality rate among combat casualties in the history of armed conflict." At the beginning of Operations Enduring Freedom and Iraqi Freedom, the combat-injuring case fatality rate was 18 percent. That rate steadily decreased to 5 percent while injury severity increased,<sup>4</sup> helped in part by a Joint Trauma System that accelerated the pace of learning across the MHS. Lessons learned were translated to the civilian community.

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<sup>4</sup> "The Laboratory Of War: How Military Trauma Care Advances Are Benefiting Soldiers And Civilians," *Health Affairs Blog*. 2013. DOI: 10.1377/hblog20131218.035947

In April 2018 the Assistant Secretary of Defense for Health Affairs determined critical readiness measures (Table 1). These measures will be developed, tested, and implemented for FY 2019.

**Table 1:** FY 2019 Military Health System core measures, readiness subset, current as of May 7, 2018

Quadruple Aim	Measure	Development Status
Readiness	Individual medical readiness	Currently used
Readiness	Percent of providers meeting knowledge, skills, and abilities for general surgery	In testing
Readiness	Percent of providers meeting knowledge, skills, and abilities for orthopedic surgery	In testing
Readiness	Active duty access for primary and specialty care	Under development
Readiness	Success in meeting request for forces rate and other validated service personnel requirements	Under development
Readiness	Percent of fill against authorized billets	Under development
Readiness	Base or Operating Commander assessment of health services support	To be developed
Readiness	Defense Readiness Reporting System	To be developed
Readiness	Residency review committee (Accreditation Council for Graduate Medical Education (ACGME)) pass rate	To be developed
Readiness	Integrated disability evaluation system cycle time	To be developed

### Better Health

Measuring health outcomes is a newer, less developed field across the health care industry. The MHS is exploring the applicability of patient-reported outcomes. New evidence illuminates the power of patient-reported health outcomes to inform clinical decisions and processes that are more patient-centric than traditional process measures.<sup>5</sup>

The DoD fielded the Centers for Disease Control and Prevention's Health-Related Quality of Life measure in 2016 beneficiary survey. This metric measures self-reported well-being and number of days lost of illness or injury. The measure data is collected annually and will be ready for use by FY 2019 after three years of data collection to establish a baseline for the military.

Tobacco use and obesity are leading drivers of early mortality and poor health in the United States, potentially decreasing the medical readiness of the military force. The DoD developed health-related measures associated with tobacco use, cessation, and obesity for use in FY 2019. The medical community provides tools and programs to help patients achieve an optimal weight and live tobacco-free.

<sup>5</sup> Weldring T, Smith SMS, "Patient-Reported Outcomes and Patient-Reported Outcome Measures," *Health Serv Insights*. 2013; 6:61-68. DOI: 10.4137/HSI.S11093

## Better Care

Patient-centric improvements were made to health care delivered by TRICARE programs. There were specific improvements in access, evidenced-based quality of care, and preventable harm events. The measures and longitudinal performance are presented in Table 2, below.<sup>6</sup>

**Table 2:** Quality of health care services performance in the Military Health System as of September 2017

Measure Name	Current Performance	Refresh Date	Performance	Longitudinal Time Period
Risk-adjusted mortality	0.97 standard mortality ratio	December 2017	0.99 to 0.97; positive improvement	September 2016 to December 2017
Recommend hospital	77.57% recommend	December 2017	75.43% to 77.57%; positive improvement	June 2016 to December 2017
Provider communication	85.93% satisfaction with outpatient provider	December 2017	79.00% to 83.14%; positive improvement	June 2014 to December 2017
Diabetes A1c testing	92.30% 18–75 with diabetes tested	March 2018	89.71% to 92.30%; positive improvement	January 2013 to March 2018
Low back pain	82.53% with low back pain not imaged	November 2017	75.13% to 82.53%; positive improvement	January 2016 to March 2018
Children with pharyngitis appropriate testing	92.41% 3–18-year-olds tested and prescribed an antibiotic	March 2018	82.55% to 92.41%; positive improvement	January 2016 to March 2017
Breast cancer screening	76.76% 52–74-year-old women with screening in past 27 months	March 2018	73.91% to 76.76%; positive improvement	January 2013 to March 2018
Cervical cancer screening	80.77% 24–64-year-old women with screening in past 3 years	March 2018	83.17% to 80.77%; declining performance	January 2013 to March 2018
Colon cancer screening	76.21% 51–75-year-old screened past 2 years	March 2018	72.78% to 76.21%; positive improvement	January 2013 to March 2018
Seven-day mental health follow-up	77.66% seen within 7 days post-discharge	October 2017	64.25% to 77.66%; positive improvement	January 2013 to October 2017
All cause readmissions	0.87 out of 1.00; benchmarked to HEDIS	February 2018	0.92 to 0.87; positive improvement	June 2014 to February 2018
Well child	89.36% at 15 months with 6+ well child visits	March 2018	77.03% to 89.36%; positive improvement	January 2013 to March 2018
IQI #33 primary cesarean section	13.09% first-time delivery without hysterectomy	September 2017	16.05% to 13.09%; positive improvement	March 2016 to September 2017
Postpartum hemorrhage	2.85% women who delivered, diagnosed with hemorrhage	September 2017	2.43% to 2.85%; declining performance	March 2016 to September 2017
Unexpected newborn complication	4.23% of babies without pre-existing conditions with complications	September 2017	5.34% to 4.23%; positive improvement	March 2016 to September 2017

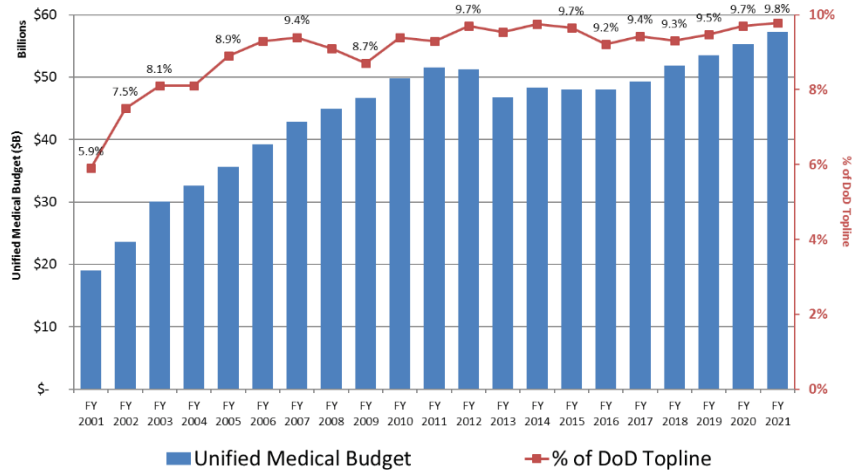
Red denotes significantly below target, yellow/amber below target, green on target, and blue exceeding target. For more information about measures, methodology, and performance visit <https://carepoint.health.mil>.

<sup>6</sup> Performance data presented from FY 2017 is as of September 2017.

### Lower Cost

The U.S. Department of Health and Human Services reports that health care expenditures rose from 5.0 percent of GDP in 1960 to 17.4 percent of GDP in 2013.<sup>7</sup> The rise in health care costs to the DoD is commensurate with the private sector in the United States. The Unified Medical Budget as a total percent of the total Defense budget is 9.3 percent for FY 2018 (Figure 5). The MHS managed to slow the accelerating rate of health costs with greater centralization of processes and decision-making, including more robust enterprise-supporting shared services. Health care cost containment is a priority for the DoD. However, Defense Health Program activities are inextricably linked to the civilian health care market.

Figure 5: Military medical costs as a percentage of the Department of Defense budget



In Fiscal Year 2018, the Unified Medical Budget topped US \$50 billion. These costs include health care for active duty service members, reservists, activated guard, family members, military retirees, and other secretarial designee.

The Military Health System tracks monthly per member per month costs. The goal is a 2.0 percent increase per year, a target benchmarked against the Henry J. Kaiser Family Foundation’s optimal rate of health care cost increase year over year in the United States. Per member per month rate increase for beneficiaries was 1.25 percent in 2017. Total cost per member per month is \$346.65 as of September 2017.

Pharmaceutical costs drive a considerable portion of health care spending in the United States. As with overall expenditures as a percent of GDP, the DoD is comparable with regard to this. The Department measures pharmaceutical costs from inpatient facilities, retail pharmacies, and mail-order pharmacies, with retail pharmacies being the primary drivers of spending. Retail pharmacies are a primary driver of the increased cost of health care and 24.1 percent of pharmaceuticals were filled in retail pharmacies in January 2018, exceeding performance targets of a 43 percent decrease in retail pharmacy costs.

### Performance Information Assurance

The MHS performance data is stored and retrieved in a standardized, controlled process from the MHS Data Repository. The repository, in turn, is accessed through the MHS Mart (M2). These systems are automated with data pushed directly from the legacy electronic health records such as Composite Health Care System and Armed Forces Health Longitudinal Technology Application. MHS GENESIS, the new commercial off the shelf Cerner electronic health record, will integrate with the repository or another platform with similar functionality.

<sup>7</sup> Caitlin AC, Cowan CA. *History of Health Spending in the United States, 1960-2013*. US Department of Health and Human Services/Centers for Medicare and Medicaid. 2015.

Strategic data, trends, and information are populated on an interactive, web-based platform called CarePoint, accessible at <https://carepoint.health.mil>. Data is available to all with a DoD Common Access Card. The data cannot be altered by those viewing the dashboards. The Partnership for Improvement Steering Committee controls the algorithms and benchmarks developed against standard best practices in the health care industry (e.g., Healthcare Effectiveness Data and Information Set, National Surgical Quality Improvement Program).

Analysts in the field also pull data from the M2, although it is for specific data calls at the request of their commands. M2 training is centralized by the DHP Enterprise, ensuring a common lexicon and data dictionary across the MHS.

Three measure sets represent current strategic performance: (1) Fiscal Year 2018 MHS Core Measures; (2) Quadruple Aim Performance Plan Measures; and (3) National Defense Authorization Act for Fiscal Year 2017, Section 702-related Transition Measures. In FY 2019, the strategic measure sets will merge into one core dashboard, streamlining decision-making and decreasing potential for performance data misinterpretation. The single set will be the Fiscal Year 2019 MHS Core Measures.

The Assistant Secretary of Defense for Health Affairs hosts an MHS Review and Analysis meeting on a recurring basis, analyzing performance trends across the enterprise with representation from the Army, Navy, Air Force, DHP Enterprise, Joint Staff, and Uniformed Services University of the Health Sciences. Monthly, the Military Deputies Action Group with senior leader representation from each component and the Office of the Secretary of Defense review enterprise performance. A full evaluation of the program is delivered to Congress annually.

### **Plans to Achieve Missed Targets**

In June 2016, the Assistant Secretary of Defense for Health Affairs issued policy to improve in four domains, referred to as MHS Process Improvement Priorities: (1) achieve zero patient harm, (2) improve condition-based quality care, (3) improve access, and (4) increase effectiveness and efficiency of the direct care platform. The MHS continues to work towards achieving targets in the Process Improvement Priorities (Table 3).

**Table 3.** MHS Process Improvement Priorities and associated performance measures. Measures are reviewed monthly by the Medical Deputies Action Group

Quadruple Aim	Process Improvement Priority	Measure
<b>Better Care</b>	Achieve Zero Patient Harm	Central line-associated bloodstream infection standardized infection ratio
		Wrong site surgery
		Unintended retained foreign objects
	Improve Condition Based Quality Care	Diabetes A1c Testing
		Low back pain
		Children with pharyngitis
	Improve Access	24-hour appointments
		Future appointments
		Secure messaging enrollment
		Getting care when needed
Specialty referral to book		
Specialty booked to appointment		
<b>Lower Cost</b>	Increase effectiveness and efficiency of the direct care platform	Active duty specialty care provider efficiency

Process Improvement Priorities will be folded into Quadruple Aim Performance Plans as the DHP Enterprise assumes management and administration responsibilities for military medical treatment facilities. DHP Enterprise management echelons will create and execute an annual plan (i.e., Quadruple Aim Performance Plans) to achieve the MHS Quadruple Aim using seven critical initiatives directed by the DHP Enterprise:

1. Increase deployability
2. Improve medical force readiness
3. Encourage healthy behaviors
4. Optimize and standardize access
5. Improve condition-based quality of care
6. Achieve zero patient harm
7. Improve effectiveness and efficiency of the direct care platform

The Department is transforming the management of the delivery of health care service to the Clinical Communities model, comprising thirteen clinical domains. Clinical Communities will improve the processes within their respective domains to increase the quality, safety, and outcomes to achieve high reliability.

**Performance Measurement Limitations**

A work group, called the Partnership for Improvement, was established following the 90-Day MHS Review in 2014. The group is coordinated by the DHP Enterprise with representation from each MHS component. The group maintains a common platform for enterprise measurement across the MHS. This performance management dashboard became operational in 2015.

The Department is striving to standardize measures across the three military services. Challenges include different measure definitions, difficulty reaching consensus on single measures, and data quality and timeliness. Health care measures in general are often lagging, sometimes outside of the current fiscal year, due to limitations in survey data gathering. Measures from the TRICARE network are limited by availability of data other than claims-based administrative data.

### **Future Performance Management and Accountability**

The NDAA for FY 2017 directs the DoD to streamline the TRICARE health plan for Active Duty, Reservists, and military retirees; transfer authorities related to the management and administration of MTFs to the DHP; and determine an optimal footprint.<sup>8</sup> This transition is expected to reduce the management headquarters burden across the system.

For FY 2019, the MHS core dashboard consists of sixty-four strategic measures, forty of which are retained from the previous iteration of the strategic dashboard and twenty-four of which are new performance measures. Measures remain aligned to the Quadruple Aim. The core dashboard includes Quadruple Aim Performance Plan measures, DoD Reform Management Group measures, and transition measures related to the transition of military medical treatment facility administration and management to the DHP. The new measures are listed below (Table 4).

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<sup>8</sup> Public Law 114-328, Title VII, Health Care Provisions. 114<sup>th</sup> Congress of the United States. 2016.

The Quadruple Aim will not change. The four aims are broad and will stand the test of time; there will always be opportunities to improve readiness, health, care, and cost. The same is true of any health system anywhere in the world, albeit without the added challenge of medical readiness.

**Table 4:** New strategic measures for FY 2019 per the memorandum, "Way Forward for Military Health System Measures for Fiscal Year 2019," signed by the Acting Assistant Secretary of Defense Mr. Thomas McCaffery on May 4, 2018

Quadruple Aim	Measure Name
<b>Increased Readiness</b>	Percent of providers meeting Knowledge, Skills and Abilities (KSAs) for general surgery
	Percent of providers meeting KSAs for orthopedic surgery
	Active duty non-deployability
	Capacity to provide health services for validated request for forces ISO conventional force requirements*
	Capacity to provide health services for validate request for forces ISO non-conventional force requirements*
	Percent of fill against authorized billets
	Defense Readiness Reporting System (DRRS)
<b>Better Health</b>	Health related quality of life (HRQOL)
	Obesity prevalence in adults
	Obesity prevalence in children
	Overweight prevalence in adults
	Overweight prevalence in children
	Smoking cessation
	Tobacco use rate
<b>Better Care</b>	Active duty access for primary care
	Active duty access for specialty care
	Base/operating commander assessment of health services support
	Integrated disability evaluation system (cycle time)
	Residency review committee (ACGME) pass rate
	Joint Commission (accreditation)
	College of American Pathologists (CAP)
<b>Lower Cost</b>	PCM empanelment
	Savings from enterprise shared services and reform initiatives
	Average daily patient load
	Intensive care unit bed days

Measures marked with an asterisk (\*) are counted as one measure, "Request for forces." New measures are expected to be reported, at least in draft, by October 1, 2018. There are twenty four new measures.



## Analysis of Financial Statements and Stewardship Information

The financial statements of DHP Enterprise reflect and evaluate its execution of its mission to provide a medically ready force and a ready medical force to CCMDs in both peacetime and wartime. This analysis summarizes the DHP Enterprise's financial position and results of operations and addresses the relevance of major types and/or amounts of assets, liabilities, costs, revenues, obligations, and outlays.

The principal statements include a consolidated balance sheet, a consolidated statement of net cost, a consolidated statement of changes in net position, and a combined statement of budgetary resources. These principal statements are included in the "Financial Section" of this report. The DHP Enterprise also prepares a combining schedule of budgetary resources within required supplementary information.

### Overview of Financial Position

**Table 5:** Summary of DHP Enterprise's major financial activities in FY 2018.

<b>DHP Enterprise Major Financial Activities</b>	
<i>(dollars in thousands)</i>	
<b>Net Financial Condition</b>	<b>FY 2018</b>
Fund Balance with Treasury	\$ 20,533,206
Accounts Receivable, Net	1,165,538
Inventory and Other Assets	64,003
Property, Plant, and Equipment, Net	<u>3,725,741</u>
<b>Total Assets</b>	<b><u>\$ 25,488,488</u></b>
Accounts Payable	\$ 1,001,187
Military Retirement and Other Federal Employment Benefits	251,338,190
Accrued Unfunded Annual Leave	335,237
Accrued Funded Payroll and Benefits	215,602
Environmental, Disposal & Other Liabilities	<u>148,617</u>
<b>Total Liabilities</b>	<b><u>\$ 253,038,833</u></b>
Unexpended Appropriations	\$ 19,243,749
Cumulative Results of Operations	<u>(246,794,094)</u>
<b>Total Net Position</b>	<b><u>\$ (227,550,345)</u></b>
<b>Net Program Cost</b>	<b><u>\$ 29,521,822</u></b>
<b>Net Cost of Operations</b>	<b><u>\$ 29,242,709</u></b>
<b>Budgetary Resources</b>	<b><u>\$ 44,101,975</u></b>

Preparing the DHP Enterprise financial statements is a vital component of sound financial management and provides information that is useful for assessing performance, allocating resources, and targeting areas for future programmatic emphasis. The DHP Enterprise's management is responsible for the integrity of the financial information presented in its financial statements. The DHP Enterprise is committed to financial management excellence and maintains a rigorous system of internal controls to safeguard its widely dispersed assets against loss from unauthorized acquisition, use, or disposition. As the DHP Enterprise broadens its global relevance and impact, it will continue to promote local partnerships through delivering assistance by hosting government systems and community organizations.

A summary of the DHP Enterprise's major financial activities in FY 2018 is presented in table 5 at the left. This table represents the resources available, assets on hand to pay liabilities, and the corresponding net position. The net cost of operations is the cost of operating the DHP Enterprise's lines of business, less earned revenue. Budgetary resources are funds available to the agency to incur obligations and fund operations.

## Balance Sheet Summary

### Assets – What We Own and Manage

Total assets were \$25,488,488 thousand as of September 30, 2018. The most significant assets are the fund balance with treasury (FBwT) and property, plant, and equipment, net, which represent 95 percent of total DHP Enterprise's assets. The largest, FBwT, consists of cash appropriated to DHP Enterprise by Congress or transferred from other federal agencies and held in the U.S. Department of Treasury's accounts that are accessible by DHP Enterprise to pay the obligations it incurs.

### Liabilities – What We Owe

Total liabilities of \$253,038,833 thousand as of September 30, 2018, of which \$251,338,190 thousand, or 99 percent, comprises military retirement and other federal employment benefits. These liabilities represent funds calculated by the DoD's Office of the Actuary at the end of each FY using the current active and retired military population plus assumptions (inflation, discount rate, and medical trend) about future demographic and economic conditions.

### Net Position – What We Have Done Over Time

Net position represents the DHP Enterprise's net results of activity over the years and includes unexpended appropriations and the cumulative net earnings. The DHP Enterprise's net position is shown on the *Consolidated Balance Sheet* and the *Consolidated Statement of Changes in Net Position*. The reported net position balance as of September 30, 2018, was \$(227,550,345) thousand.

## Results of Program Cost

### Net Costs – What Cost We Incurred for the Year

The net results of operations are reported in the *Consolidated Statement of Net Cost* and the *Consolidated Statement of Changes in Net Position*. The *Consolidated Statement of Net Cost* represents the cost of operating (net of earned revenues) the DHP Enterprise's programs. In FY 2018, the DHP Enterprise contains the following four programs:

- **Operations, Readiness, and Support:** Support the total military force by ensuring the medical force is medically ready and prepared to deliver health care anytime, anywhere in support of the full range of military operations, including humanitarian missions.
- **Procurement:** The DHP Enterprise appropriation procurement program funds acquisition of capital equipment in MTFs and other selected health care activities.
- **Research, Development, Test, and Evaluation (RDT&E):** Aid medical force through effective and accountable investments in education and research to establish sustainable improvements in the well-being and productivity of the MHS.
- **Family Housing & Military Construction:** Assist military force on the basis of need according to principles of universality, impartiality, and human dignity to save lives, alleviate suffering, and minimize the economic costs of conflict, disasters, and displacement.

Figure 6: Summarizes total net program cost by the DHP Enterprise's programs.

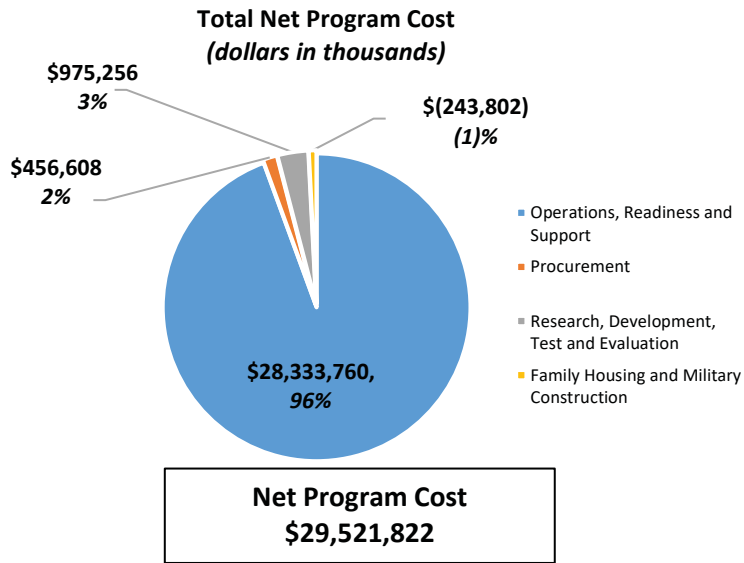


Figure 6 to the left shows the total net program cost of operations of \$29,521,822 thousand to operate each of these DHP Enterprise's program. These costs do not include the gain from actuarial assumption changes.

## Budgetary Resources

### Our Funds

The *Combined Statement of Budgetary Resources* provides information on the budgetary resources that were made available to DHP Enterprise during the fiscal year and the status of those resources at the end of the fiscal year. The DHP Enterprise receives most of its funding from general government funds administered by Treasury and appropriated by Congress for use by DHP Enterprise. Budgetary resources consist of the resources available to the DHP Enterprise at the beginning of the year, plus the appropriations received, spending authority from offsetting collections, and other budgetary resources received during the year.

**Figure 7:** Summarizes obligations incurred, unobligated balances, and total budgetary resources for the DHP Enterprise for FY 2018.

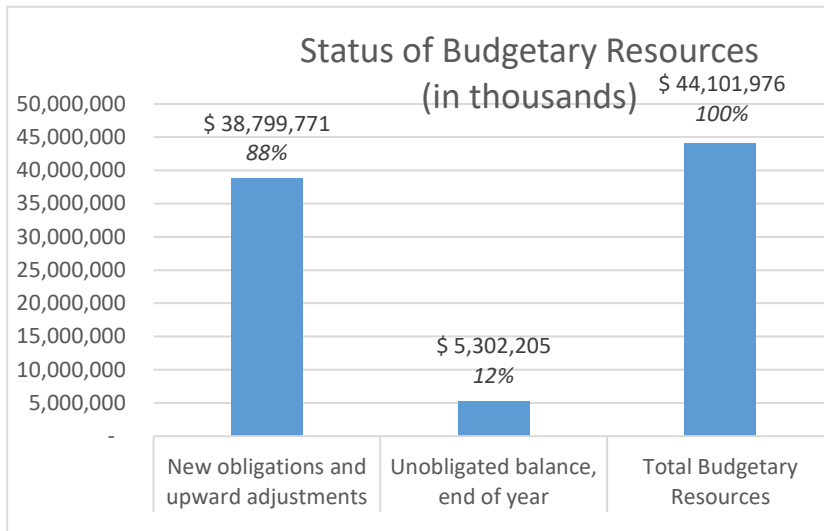


Figure 7 to the left shows the obligations incurred, unobligated balances, and total budgetary resources for DHP Enterprise for FY 2018. The DHP Enterprise received \$44,101,975 thousand in cumulative budgetary resources in FY 2018, of which it has obligated \$38,799,770 thousand.

**Obligations and Net Outlays**

The status of budgetary resources (Figure 7) shown above shows the overall total budgetary resources received and whether obligations were incurred or the funding remains unobligated balances at FY 2018. As shown in the chart, the DHP Enterprise’s total budgetary resources for FY 2018 was \$44,101,975 thousand. The net outlays for the DHP Enterprise for FY 2018 is \$32,921,290 thousand.

# Analysis of Systems, Controls, and Legal Compliance

The DHP Enterprise management is required to comply with various laws and regulations in establishing, maintaining, and monitoring internal controls over operations, financial reporting, and financial management systems as discussed below.

## Management Assurances

The Assurance Statements below were provided for FY 2018 Federal Manager's Financial Integrity Act for FY 2018 (FMFIA).



OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE  
1200 DEFENSE PENTAGON  
WASHINGTON, DC 20301-1200

September 28, 2018

SUBJECT: Annual Statement of Assurance Required Under the Federal Managers' Financial Integrity Act for Fiscal Year 2018

As Acting Deputy Assistant Secretary of Defense, Health Resources Management and Policy of the Defense Health Program (DHP), I recognize that the DHP is responsible for managing risks and maintaining effective internal control to meet the objectives of Sections 2 and 4 of the Federal Managers' Financial Integrity Act (FMFIA) of 1982. The DHP conducted its assessment of risk and internal control in accordance with the Office of the Management and Budget (OMB) Circular No. A-123, *Management's Responsibility for Enterprise Risk Management and Internal Control* and the Green Book, Government Accountability Office (GAO)-14-704G, *Standards for Internal Control in the Federal Government*. Based on the results of the assessment, the DHP can provide reasonable assurance, except for the 59 material weaknesses reported in the "Material Weakness and Significant Deficiencies Template" that internal controls over operations, reporting, and compliance were operating effectively as of September 30, 2018.

The DHP conducted its assessment of the effectiveness of internal controls over operations in accordance with OMB Circular No. A-123, the GAO Green Book, and the FMFIA. The "Internal Control Evaluation" section provides specific information on how the DHP conducted this assessment. Based on the results of the assessment, the DHP can provide reasonable assurance, except for the 23 material weaknesses reported in the "Material Weakness and Significant Deficiencies Template" that internal controls over operations, reporting, and compliance were operating effectively as of September 30, 2018.

The DHP conducted its assessment of the effectiveness of internal controls over reporting (including internal and external financial reporting) in accordance with OMB Circular No. A-123, Appendix A. The "Internal Control Evaluation" section provides specific information on how the DHP conducted this assessment. Based on the results of the assessment, the DHP can provide reasonable assurance, except for the 35 material weaknesses reported in the "Material Weakness and Significant Deficiencies Template" that internal controls over operations, reporting (including internal and external reporting), and compliance were operating effectively as of September 30, 2018.

The DHP also conducted an internal review of the effectiveness of the internal controls over the integrated financial management systems in accordance with Federal Financial Management Improvement Act (FFMIA) of 1996 (Public Law 104-208) and OMB Circular No. A-123, Appendix D. The "Internal Control Evaluation" section provides specific information on how the DHP conducted this assessment. Based on the results of this assessment, the DHP can

provide reasonable assurance, except for one nonconformance reported in the "Significant Deficiencies/Material Weaknesses and Corrective Action Plans Template" that the internal controls over the financial systems are in compliance with the FMFIA and OMB Circular No. A-123, Appendix D, as of September 30, 2018.

*Signed*

Darrell W. Landreaux  
Acting Deputy Assistant Secretary of Defense  
Health Resources Management and Policy

Attachments:

1. Appendix B - Material Weakness Removal Memorandum
2. Appendix D - Internal Control Evaluation
3. Appendix E - Risk Assessment
4. Appendix F - Material Weaknesses and Significant Deficiencies
5. Appendix G - Reportable Anti-Deficiency Act Violations
6. Appendix H - Significant Manager's Internal Control Program Accomplishments
7. Appendix I - DHP Component Organizations/Service Medical Activities Statement of Assurance

2

## Summary of Internal Control Assessment

The DHP Enterprise conducted its assessment of the effectiveness of internal controls over operations (ICO) in accordance with the FMFIA and the Office of Management and Budget (OMB) Circular No. A-123 *Management's Responsibility for Enterprise Risk Management and Internal Control*. Each evaluation occurred at the component level and was reported to the DHP Enterprise with the results and testing methodology used to evaluate the status of the control. Based on the results of the assessment, the DHP Enterprise can provide reasonable assurance, except for the twenty three material weaknesses<sup>9</sup> reported in the "Material Weaknesses and Significant Deficiencies Template" that internal controls over operations, reporting, and compliance were operating effectively as of September 30, 2018.

The DHP Enterprise assessed the effectiveness of internal controls over financial reporting (ICFR), including external financial reporting, in accordance with OMB Circular No. A-123, Appendix A, *Internal Control over Financial Report*. Each

<sup>9</sup> Total material weakness reported include nineteen material weaknesses and 4 significant deficiencies.

evaluation occurred at the component level and was reported to the DHP Enterprise with the results and testing methodology used to evaluate the status of the control. Based on the results of the assessment, the DHP Enterprise can provide reasonable assurance, except for the thirty five material weaknesses<sup>10</sup> reported in the "Material Weaknesses and Significant Deficiencies Template" that internal controls over reporting were operating effectively as of September 30, 2018.

The DHP Enterprise also conducted an internal review of the effectiveness of internal controls over the integrated financial systems (ICOFs) in accordance with FFMIA of 1996 (Public Law 104-208) and OMB Circular No. A-123, Appendix D. Each evaluation occurred at the component level and was reported to DHP Enterprise with the results and testing methodology used to evaluate the status of the control. Based on the results of the assessment, the DHP Enterprise can provide reasonable assurance, except for the one material weaknesses reported in the "Material Weaknesses and Significant Deficiencies Template" that internal controls over the financial systems are in compliance with FFMIA and OMB Circular No. A-123, Appendix D, *Compliance with the Federal Financial Management Improvement Act of 1996* as of September 30, 2018.

Management's assessment of FFMIA compliance was completed prior to the results of the FY 2018 financial statement audit. Our auditor has noted the DHP Enterprise financial management systems did not comply substantially with the Federal financial management system's requirements, applicable Federal accounting standards, or application of the United States Standard General Ledger (USSGL) at the transaction level, as a result of material weaknesses noted in the Independent Auditor's Report on Internal Control over Financial Reporting. The DHP Enterprise is in process of evaluating the FY 2018 audit findings contributing to noncompliance to begin the process of remediation plans necessary to bring the financial managements systems into substantial compliance.

## Compliance with Laws and Regulations

### **Anti-Deficiency Act, 31 U.S.C. §§ 1341, 1342, 1350, 1351, 1517: ANTI-DEFICIENCY ACT**

The Anti-deficiency Act (ADA) prohibits federal employees from obligating in excess of an appropriation, before funds are available or from accepting voluntary services. As required by the ADA, DHP Enterprise notifies all appropriate authorities of any ADA violations. The DHP Enterprise management has taken and continues to take necessary steps to prevent ADA violations. Investigations of any violations will be completed in a thorough and expedient manner. DHP Enterprise remains fully committed to resolving ADA violations appropriately and in compliance with all aspects of the law.

### **Pay and Allowance System for Civilian Employees as provided in 5 U.S.C. Chapters 51–59**

5 U.S.C. Chapters 51–59 codify the statutory provisions concerning the pay and allowances afforded federal employees. DHP Enterprise is fully committed to complying with these provisions, periodically reviewing its compliance with them, and taking appropriate action to achieve compliance if and when any errors are identified. [Link to 5 U.S.C Chapter 51:](#)

<https://www.gpo.gov/fdsys/granule/USCODE-2011-title5/USCODE-2011-title5-partIII-subpartD-chap51/content-detail.html>

### **Prompt Payment Act, 31 U.S.C. §§ 3901–3907**

In 1982, Congress enacted the Prompt Payment Act (PPA) to require federal agencies to pay their bills on a timely basis, to pay interest penalties when payments are made late, and to take discounts only when payments are made by the discount date. DHP Enterprise uses the Invoice Receipt, Acceptance and Property Transfer (iRAPT) (formerly Wide Area Workflow) system to ensure compliance with this statutory requirement.

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<sup>10</sup> Total material weakness reported include thirty one material weaknesses and 4 significant deficiencies.

**Provisions Governing Claims of the United States Government as provided in 31 U.S.C. §§ 3711-3720E (including provisions of the Debt Collection Improvement Act of 1996, (DCIA), as amended by the Digital Accountability and Transparency Act of 2014)**

The Debt Collection Improvement Act of 1996 (DCIA), as amended by the DATA Act, requires that Federal agencies refer delinquent debts to Treasury within 120 days and take all appropriate steps prior to discharging debts. DHP Enterprise follows applicable requirements for establishing and collecting validated debts, ensuring compliance with Debt Collection statutes and regulations.

**Government Charge Card Abuse Prevention Act of 2012, Pub. L. No. 112-194; Public Law 112-194 (Government Charge Card Abuse Prevention Act of 2012)**

The Charge Card Abuse Prevention Act (Charge Card Act) requires agencies to establish and maintain safeguards and internal controls for purchase cards, travel cards, integrated cards, and centrally billed accounts. Furthermore, the Charge Card Act requires agencies to report purchase card violations, and the Inspector General to conduct periodic risk assessments of government charge card programs. DHP Enterprise, through implemented internal controls, is committed to continued compliance with all aspects of the public law.

**Federal Information Security Modernization Act of 2014, 44 U.S.C. § 3551 et seq.; FEDERAL FINANCIAL MANAGEMENT IMPROVEMENT ACT OF 1996**

The FFMIA requires agencies to implement and maintain financial systems that comply substantially with Federal Financial System (FFS) requirements, applicable federal accounting standards, and the U.S. Standard General Ledger (USSGL) at the transaction level.

**Digital Accountability and Transparency Act of 2014 (DATA Act), 31 U.S.C. § 6101 note. The DATA Act amended the Federal Funding Accountability and Transparency Act of 2006 (FFATA). DIGITAL ACCOUNTABILITY AND TRANSPARENCY ACT OF 2014**

The Digital Accountability and Transparency Act of 2014 (DATA Act) expands the Federal Funding Accountability and Transparency Act of 2006 to increase accountability and transparency in federal spending, making federal expenditure information more accessible to the public. It directs the Federal Government to use government-wide data standards for developing and publishing reports and to make more information, including award-related data, available on the USASpending.gov Web site. The standards and Web site allow stakeholders to track federal spending more effectively. Among other goals, the DATA Act aims to improve the quality of the information on USASpending.gov, as verified through regular audits of the posted data, and to streamline and simplify reporting requirements through clear data standards. DHP Enterprise complies with the DATA Act; making its expenditures accessible to the public on USASpending.gov.

**Grants Oversight and New Efficiency Act**

The Grants Oversight and New Efficiency (GONE) Act requires the head of each agency to submit to Congress, in coordination with the Secretary of Health and Human Services, a report on Federal grant cooperative agreement awards that have not yet been closed out and for which the period of performance, including any extensions, elapsed for more than two years. The GONE Act also sets forth follow-on reporting and analysis requirements by various entities."

## Financial Systems Framework

### Financial Management Systems Strategy

The NDAA FY 2017 has called for the reform of the DHP Enterprise and military medical treatment facilities. According to Section 702 of the FY 2017 NDAA, "Beginning on October 1, 2018 the Director of the Defense Health Agency shall be responsible for the administration of each military medical treatment facility, including with respect to budgetary matters, IT, health care administration and management, administrative policy and procedure, military medical construction, and any other matters the Secretary of Defense determines appropriate." The rationale behind this legislation revolves around the strength of a centralized organization serving the medical needs of all branches of the military. In the prior state, despite having a common funding source, the individual MHS components operated on separate accounting systems. This arrangement made it difficult to get comparable financial data and hindered leadership from making well-informed decisions. It also complicates audit preparation, as the DHP Enterprise is undergoing audit as a single entity. In an effort to adhere to the FY 2017 NDAA, to enhance auditability, and provide seamless medical care across all services, the Assistant Secretary of Defense – Health Affairs office (ASD(HA)) has decided to work towards a single accounting system solution.

MEDCOM implemented the General Funds Enterprise Business System (GFEBS) in FY 2010, and in FY 2015, a proof of concept GFEBS deployment to the NCR MD, to include WRNMMC was executed. The notable factor of this implementation was WRNMMC's classification as a Navy chassis. This implementation effectively illustrated the ability of a non-Army entity to successfully deploy GFEBS. With MEDCOM and NCR MD on GFEBS, roughly 50 percent of the DHP Enterprise funding was accounted for in this single system. Following the resounding success of this proof of concept, leadership became interested in pursuing a system-wide deployment in a realistic, sequential manner that would bring the remaining balance of the DHP on GFEBS.

ASD (HA)'s FY 2017 NDAA compliance strategy is being executed by using a single accounting solution, GFEBS. This commercial, off the shelf Enterprise Resource Planning (ERP) software implemented by the U.S. Army provides financial information in real time and reveals cost drivers to provide decision support information for leadership, in turn enabling a sustained warfighting capability for the Army. GFEBS also provides analytics data and tools, reduces the cost of business operations, and improves accountability. The system has enabled the Army to meet congressional mandates, requiring audit compliance and an accurate accounting of all financial transactions, and will allow the MHS to meet similar requirements and needs.

The DHA/FOD and USUHS deployed GFEBS on April 2, 2018, resulting in approximately 66 percent of the DHP funds in GFEBS. Plans are currently in place to transition the BUMED next, with a phased implementation set to be begin during FY 2020. Once BUMED's migration to GFEBS is complete, an estimated 85 percent of MHS will be executing within GFEBS. For these and other future deployments, ASD (HA) has agreed to deploy GFEBS "as-is" with basic Army functionality.

### Current and Future Financial Management Systems Framework

Due to the FY 2017 NDAA's intent in driving the DHP Enterprise towards standardized business practices to help achieve auditability through a single, system-wide accounting solution, it is important that the MHS aligns common interests and interacts with Army as "one voice." This new protocol will apply to communication with Army in regard to the GFEBS Functional Governance Board (FGB) for requesting system enhancements, the Army GFEBS Process Owners Group (POG) and audit support requests from Army. As MHS's use of GFEBS matures, the one-voice protocol may expand into additional areas. It is important to note here that this will be a marked departure from the previous "way of life" for organizations such as MEDCOM and NCR MD and an entirely new process for DHA/FOD, USUHS, and BUMED.

Prior to the one-voice initiative, MEDCOM was one of the commands represented as a stand-alone advisory member at the Army FGB; however, MEDCOM and all other organizations under the purview of the DHP Enterprise per the 2017 NDAA will



now be represented by ASD(HA)'s designated department defined below. To cover the requirements in this new environment, organizations such as NCR MD, MEDCOM, and others must speak with one voice when submitting requests to Army in regard to GFEBS.

In the concerted effort to consolidate the varying voices of MHS into a single, focused entity, the Health Affairs Functional Champion (HAFC) will represent MHS at GFEBS FGB meetings as an FGB Advisory Member and at POG meetings. Prior to the escalation of issues to GFEBS FGB's Voting Members for official consideration, an internal DHP Enterprise process will be established to identify, validate, and set priorities for GFEBS enhancements for the MHS. This process will identify MHS priorities while also highlighting audit compliance and cost savings/avoidance where applicable. The process will be initiated through HAFC's own Governance Board as the first step in submission to GFEBS FGB. Once the prioritization is made within HAFC and an FGB Voting Member has sponsored the case (by Army FGB rules, all cases brought forth require sponsorship by a GFEBS FGB Voting Member), the various MHS cases from the field will exit HAFC's vetting process and officially enter GFEBS FGB's consideration phase for discussion and an eventual vote.

This consolidation of MHS as required by the FY 2017 NDAA will strengthen MHS as a whole by uniting such a large, joint force community with uniquely converging interests into one focused voice. Prior to the legislation, MHS faced potential challenges as voices of the MHS community could be overlooked as the requirement would impact fewer users. With this new measure, however, MHS will now make up approximately 10 percent of GFEBS's total user base. With a united voice, MHS will be able to clearly and effectively organize and effect change when necessary and to obtain clear guidance from HAFC when needed, while eliminating the risk of duplicated work efforts of a fragmented MHS community.

## Forward-Looking Information

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### Changes and the Future of DHP Enterprise

In December 2016, the 114<sup>th</sup> Congress of the United States of America passed the National Defense Authorization Act for FY 2017. Title VII contains fifty-one provisions intended to fundamentally transform military health care management. Three of the most important transformations are Sections 701, *TRICARE Select and other TRICARE reform*; 702, *Reform of administration of the Defense Health Agency and military medical treatment facilities*; and 703, *Military medical treatment facilities*. These sections modernize the military's health plan, health care management, and the footprint of military hospitals and clinics, respectively.

Section 701 simplifies the TRICARE health plan options and increases the beneficiary pool to include military reservists. Starting in January 2018, the DoD offers two health plan options: Prime and Select. TRICARE Prime is similar to an HMO plan. TRICARE Select is a PPO option with an annual enrollment fee. Co-pays for beneficiaries are streamlined and simplified, which may yield some cost savings to the Department.

Section 702 is the most complex section of the law. The late Senator John McCain (R-AZ) called the legislation, "The most sweeping overhaul of the MHS in a generation."<sup>11</sup> The DHP Enterprise is given responsibility for the administration and management of all military medical treatment facilities beginning October 1, 2018. The Armed Services Committees of Congress intend to reduce management complexity and costs associated with operating four health systems within the same federal department. Doing so requires careful analysis of all the processes and procedures associated with managing and administering hospitals and clinics and removing unnecessary redundancy.

Section 703 directs the Department to study the footprint of military hospitals and clinics to optimize their utilization while fully supporting the readiness mission. In response, criteria were developed to designate medical centers, hospitals, and ambulatory care centers. Continued analysis may result in services at some facilities being changed.

The DHP Enterprise is establishing a value-based health care program informed by best practices across the global health care industry. Value-based care efforts in other American health systems have shown some success in reducing costs, although starting such a program often requires an up-front investment to improve long-term gains. The Agency plans to use a variety of payment methods (e.g., global capitation, bundled payments) to move away from legacy fee-for-service models that predominate the TRICARE health plan. As Section 702 is implemented, there may be further opportunities to explore value-based budgets for the Department's military medical treatment facilities.

The Undersecretary of Defense (Comptroller) and Defense Chief Information Officer took a \$1.5 billion decrement against the Department's health IT program over the Future Year Defense Program (FY 2019 – FY 2023). As the new electronic health record rolls out across the military medical treatment facilities, legacy IT systems will wind down. However, electronic health record implementations are extremely difficult. Some of the legacy systems may remain active for longer than intended. The Department may have to determine which non-critical systems could be disabled in order to meet the required budget savings.

As a result of the secretary's 90-day review of the MHS in 2014, the system is transforming into a high-reliability organization. In 2016, the DHP Enterprise and Military Departments determined that a Clinical Communities model of health care delivery focusing on clinical process improvements would best support the principle of high reliability.

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<sup>11</sup> McCain J. Remarks by Senate Armed Services Committee Chairman John McCain on the National Defense Authorization Act for FY17. Washington, DC: Brookings Institution; May 19, 2016

The Department's Reform Management Group targeted health care management as a business function within military in need of modernization and reform to reduce costs. The group supports the various reforms and savings already targeted by the Department and Congress while seeking out additional opportunities.

The MHS Quadruple Aim will endure. Based on the Institute for Healthcare Improvement's Triple Aim architecture, the four aims of improved readiness, better care, better health, and lower cost provide a unifying vector for the various reform efforts and clearly articulates value. These aims underpin all of the health strategies within the military and are best achieved by an integrated system of readiness and health.

## Limitations of the Financial Statements

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These financial statements have been prepared to report the financial position and results of operations of the DHP Enterprise, as required by the Chief Financial Officers Act of 1990, expanded by the Government Management Reform Act of 1994, and 31 U.S.C. § 3515(b). The DHP Enterprise is unable to fully implement all elements of U.S. generally accepted accounting principles (U.S. GAAP) as promulgated by the Federal Accounting Standards Advisory Board (FASAB) and the form and content requirements for federal government entities specified by the OMB in Circular A-136, *Financial Reporting Requirements*, due to limitations of financial and nonfinancial management processes and systems of certain component entities that support the financial statements.

The DHP Enterprise derives reported values and information for major asset and liability categories largely from nonfinancial systems, such as logistical systems. These systems were designed to support reporting requirements for maintaining accountability over assets and reporting the status of federal appropriations rather than preparing financial statements in accordance with U.S. GAAP. The DHP Enterprise continues to implement process and system improvements addressing these limitations.

In addition, the financial management systems used by the DHP Enterprise are unable to meet all full accrual accounting requirements as many of their component's financial and nonfinancial feeder systems and processes were designed and implemented prior to the issuance of U.S. GAAP. These systems were not designed to collect and record financial information on the full accrual accounting basis as required by U.S. GAAP, and most of the financial management systems used by the components of the DHP Enterprise were designed to record information on a budgetary basis.

These financial statements have been prepared from the books and records of the DHP Enterprise. The accompanying financial statements account for all resources for which the DHP Enterprise is responsible for unless otherwise noted.