United States Government Accountability Office

Report to Congressional Committees

November 2018

DEFENSE HEALTH CARE

Additional Assessments Needed to Better Ensure an Efficient Total Workforce

Accessible Version

GAO-19-102

GAO Highlights

Highlights of GAO-19-102, a report to congressional committees

November 2018

DEFENSE HEALTH CARE

Additional Assessments Needed to Better Ensure an Efficient Total Workforce

Why GAO Did This Study

The MHS includes more than 241,000 active duty, reserve, federal civilian, and contractor personnel who provide (1) operational medical care in support of war and other contingencies and (2) beneficiary medical care within DOD's hospitals and clinics.

The Senate Report 115-125 accompanying a bill for the National Defense Authorization Act for Fiscal Year 2018 contained a provision for GAO to review how DOD determines its mix of military, federal civilian, and contractor personnel. This report examines the military departments' planning processes for determining (1) operational medical personnel requirements, including an assessment of the mix of federal civilian, contractor, and active and reserve medical personnel; and (2) the most appropriate workforce mix at MTFs and any challenges in executing their desired workforce mix. GAO compared MHS staffing practices with DOD policy, and analyzed fiscal year 2017 budgetary data to determine the proportion of military, federal civilian, and contractor personnel. GAO also interviewed senior leaders at six MTFs.

What GAO Recommends

GAO recommends that DOD, among other things, (1) assess the suitability of federal civilians and contractors to provide operational medical care; (2) develop full cost information for active and reserve component medical personnel; and (3) develop a strategic total workforce plan for the DHA to help ensure execution of an appropriate workforce mix at its MTFs. In commenting on a draft of this report, DOD concurred with each of GAO's recommendations.

View GAO-19-102. For more information, contact Brenda S. Farrell (202) 512-3604 or FarrellB@gao.gov.

What GAO Found

The military departments each have their own processes to determine their operational medical personnel requirements; however, their planning processes to meet those requirements do not consider the use of all medical personnel or the full cost of military personnel. Specifically:

- The Department of Defense (DOD) has not assessed the suitability of federal civilians and contractors to meet operational medical personnel requirements. Federal civilians and contractors play key roles in supporting essential missions, i.e. providing operational assistance via combat support. Military department officials expressed a preference for using military personnel and cited possible difficulties in securing federal civilian and contractor interest in such positions. An assessment of the suitability of federal civilians and contractors could provide options for meeting operational medical personnel requirements.
- When determining the balance of active and reserve component medical personnel, the military departments' processes generally do not consider full personnel costs, including education and benefits. Specifically, officials stated that the Army and the Navy do not consider personnel costs in their assessment of the appropriate balance between active and reserve personnel, and the Air Force's analysis had some limitations. DOD policy states that workforce decisions must be made with an awareness of the full costs. Further, in a 2013 report, DOD identified the cost of unit manning, training, and equipping as one of five factors that play a key role in decisions concerning the mix of active and reserve component forces. By developing full cost information for active and reserve component medical personnel, DOD can better ensure an appropriate and cost-effective mix of personnel.

The military departments have taken actions, such as establishing policies and procedures, to assess the appropriate workforce mix for beneficiary care within Military Treatment Facilities (MTFs), but challenges remain. The military departments distribute military personnel across the MTFs and then use policies and procedures to consider risks, costs, and benefits to determine how to fill the remaining positions with federal civilians and contractors. However, a number of challenges, including lengthy hiring and contracting processes and federal civilian hiring freezes affect DOD's ability to use federal civilians and contractors. For example, senior officials at each of the six MTFs that GAO spoke with cited challenges with the federal civilian hiring process, and five of six MTFs cited challenges with the contracting process. As a result, senior officials from five of six MTFs reported discontinuing some services and referring patients to DOD's TRICARE network of private sector providers or Veterans Affairs facilities. The Military Health System (MHS) is also preparing for the phased transfer of administrative responsibility for MTFs to the Defense Health Agency (DHA), including management of the MTF workforce. According to GAO's report on agency reform efforts, strategic workforce planning should precede any staff realignments or downsizing. However, according to a senior official, the DHA has not developed a strategic workforce plan. Without developing such a plan, the DHA may continue to face the same challenges experienced by the military departments in executing an appropriate and efficient workforce mix at its MTFs.

Contents

Letter 1

Background 6
Department Planning Processes for Operational Medical Personnel Requirements Do Not Include an Assessment of All Medical Personnel or the Full Cost of Military Personnel 14
The Military Departments Have Established a Process to Assess the Appropriate Workforce Mix for Beneficiary Care within MTFs, but Face Challenges in Executing Their Plans 26
Conclusions 44
Recommendations for Executive Action 45
Agency Comments 46

Appendix I: Scope and Methodology 48

Appendix II: Comments from the Department of Defense 53

Appendix III: GAO Contact and Staff Acknowledgments 57

Appendix IV: Accessible Data 58

Data Tables 58
Agency Comment Letter 59

Related GAO Products 63

Figures

Figure 1: Number and Percentage of the Department of Defense's (DOD's) Medical Military and Federal Civilian End Strength and Contracted Medical Services Full-Time Equivalents, Fiscal Year 2017 7
Figure 2: Levels of Operational Military Medical Care Provided by Department of Defense's Total Workforce 8
Figure 3: Number and Percentage of Uniformed Medical Personnel Authorizations by Component, Fiscal Year 2017 16

Figure 4: Number and Percentage of the Department of Defense's (DOD's) Total Workforce Providing and Supporting Care in Military Treatment Facilities (MTFs) by Personnel Type, Fiscal Year 2017 28
Accessible Data for Figure 1: Number and Percentage of the Department of Defense's (DOD's) Medical Military and Federal Civilian End Strength and Contracted Medical Services Full-Time Equivalents, Fiscal Year 2017 58
Accessible Data for Figure 3: Number and Percentage of Uniformed Medical Personnel Authorizations by Component, Fiscal Year 2017 58
Accessible Data for Figure 4: Number and Percentage of the Department of Defense's (DOD's) Total Workforce Providing and Supporting Care in Military Treatment Facilities (MTFs) by Personnel Type, Fiscal Year 2017 58

Abbreviations

ASD(HA)	Assistant Secretary of Defense for Health Affairs
DHA	Defense Health Agency
DOD	Department of Defense
FTE	full-time equivalent
KSA	Knowledge, Skills, and Abilities
MHS	Military Health System
MTF	military treatment facility
OASD(HA)	Office of the Assistant Secretary of Defense for Health Affairs
OPM	Office of Personnel Management
USD(P&R)	Under Secretary of Defense for Personnel and Readiness
VHA	Veterans Health Administration

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

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

November 27, 2018

The Honorable James Inhofe
Chairman
The Honorable Jack Reed
Ranking Member
Committee on Armed Services
United States Senate

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

The Department of Defense's (DOD's) Military Health System (MHS) operates one of the largest and most complex health systems in the nation. DOD's total medical workforce of physicians, dentists, nurses, medics, and other health care providers includes active and reserve military personnel, federal civilian personnel, and private sector contractor personnel.[1] The MHS provides health care in two distinct settings: (1) operational medical care,[2] provided via deployable health care platforms such as forward surgical teams and combat support hospitals, in support of war, named or unnamed contingencies, and other operational

[1]In this report, we refer to the active and reserve military personnel, federal civilian personnel, and private sector contractor personnel working within the MHS as the total workforce. DOD's active components providing medical care include the Army, the Navy (which provides medical care for Marine Corps servicemembers and their beneficiaries), and the Air Force. The five reserve components providing medical care include the Army Reserve, the Army National Guard, the Navy Reserve, the Air Force Reserve, and the Air National Guard.

[2]For the purposes of this report, operational medical care and operational medical personnel requirements refer to health care provided via deployable health care platforms in support of war, named or unnamed contingencies, and other operational missions and the personnel who staff such platforms. In addition to providing health care to military servicemembers in and out of designated combat areas, DOD also provides medical care to communities in need as part of its humanitarian assistance and disaster relief services.

missions; and (2) beneficiary medical care,[3] provided in DOD's military treatment facilities (MTFs), which include 51 military hospitals, 381 ambulatory care and occupational health clinics, and 247 dental clinics that serve to maintain the medical readiness of military personnel and the general health of their dependents and other eligible beneficiaries, such as retirees.[4]

DOD spends billions of dollars annually on its worldwide health care system.[5] Currently, health care costs constitute more than 8 percent of DOD's baseline budget request. For its fiscal year 2019 budget, according to DOD documentation, DOD requested $33.7 billion to fund the Defense Health Program, including the cost of health care activities, federal civilians, and contractor personnel, and an additional $8.9 billion in military personnel costs. The federal government's fiscal challenges, which we reported on in January 2017 and in other products, underscore the importance of DOD employing a strategic approach to determining the most appropriate and cost-effective mix of personnel to perform its mission.[6]

[3]For the purposes of this report, beneficiary medical care and military treatment facility (MTF) personnel requirements refers to health care provided in DOD MTFs and clinics in support of the medical readiness of military personnel and the general health of their dependents and other eligible beneficiaries and the personnel who staff such facilities.

[4]An MTF is established for the purpose of furnishing medical and/or dental care to eligible individuals. Statistics are projections for fiscal year 2018. Defense Health Agency, *Evaluation of the TRICARE: Program Fiscal Year 2018 Report to Congress; Access, Cost, and Quality Data through Fiscal Year 2017* (Feb. 28, 2018).

[5]DOD's fiscal year 2019 budget request of $50.6 billion for its Unified Medical Budget includes $33.7 billion for the Defense Health Program, $8.9 billion for military personnel, $0.4 billion for military construction, and $7.5 billion for health care accrual. The total excludes overseas contingency operations funds and other transfers.

[6]In January 2017, we reported on the nation's fiscal health and demonstrated that the federal government is highly leveraged in debt by historical norms and is on an unsustainable long-term fiscal path caused by a structural imbalance between revenue and spending. We concluded that addressing this imbalance would require significant changes in fiscal policy that will place budgetary strains on the federal government, including DOD, which accounts for approximately half of the federal government's discretionary spending. Discretionary spending refers to outlays from budget authority that are provided in and controlled by appropriation acts, in contrast to mandatory spending, such as that for Social Security, Medicare, or other entitlement programs, which is provided for in law other than appropriation acts. See GAO, *DOD: Actions Needed to Address Five Key Mission Challenges*, GAO-17-369 (Washington, D.C.: June 13, 2017) (citing to GAO, *The Nation's Fiscal Health: Action Is Needed to Address the Federal Government's Fiscal Future,* GAO-17-237SP (Washington, D.C.: Jan. 17, 2017)).

Senate Report 115-125, accompanying a bill for the National Defense Authorization Act for Fiscal Year 2018, included a provision for us to conduct a review of DOD's approach to assess and determine its workforce mix of active and reserve military personnel, federal civilians, and contractors within the MHS.[7] This report examines (1) to what extent the military departments' planning processes for operational medical personnel requirements include an assessment of the mix of federal civilian, contractor, active and reserve medical personnel; and (2) the military departments' processes for determining the most appropriate workforce mix at MTFs and any challenges in executing an appropriate workforce mix as responsibility for MTFs' administration transfers to the Defense Health Agency (DHA).

For objective one, we compared military department efforts in planning for operational medical personnel requirements to DOD and department-level policies and guidance on workforce mix determination and identifying the full cost of personnel. Specifically, DOD Directive 1100.4 states that authorities should consider all available sources when determining workforce mix.[8] Moreover, DOD's 2017 Workforce Rationalization Plan recognizes DOD's federal civilians as an essential enabler of its mission capabilities and operational readiness, and DOD's National Defense Business Operations Plan for Fiscal Years 2018 to 2022 states that workforce rationalization strategies include, among other things, reassessing military manpower allocations for military essentiality and identifying functions and positions that are commercial in nature that may be appropriately or efficiently delivered via private sector support.[9] In addition, DOD Instruction 7041.04 has guidance for departments to identify the full cost of their active component, federal civilian, and contractor workforces, and in a 2013 report, DOD established five factors that play a key role in active and reserve component balance decisions, including the cost of unit manning, training, and equipping.[10] We

[7]S. Rep. No. 115-125, at 171 (2017).

[8]Department of Defense Directive 1100.4, *Guidance for Manpower Management* (Feb. 12, 2005).

[9]Department of Defense, *DOD Workforce Rationalization Plan* (Dec. 12, 2017) and Department of Defense, *FY 2018-FY 2022 National Defense Business Operations Plan* (Apr. 9, 2018).

[10]Department of Defense Instruction 7041.04, *Estimating and Comparing the Full Costs of Civilian and Active Duty Military Manpower and Contract Support* (July 3, 2013).

interviewed officials from the military departments to discuss: (1) how they determine their operational medical requirements and if they identified the full cost of its active and reserve component medical personnel, and (2) the use of the active and reserve components for operational requirements and any efforts to assess the balance of active and reserve component medical personnel.

To determine the extent to which federal civilians and contractors were deployed to provide medical care, we reviewed federal civilian and contractor deployment data from fiscal years 2013 through 2017.[11] To determine the mix of active and reserve component medical personnel, we analyzed authorization data from the Health Manpower and Personnel Data System for fiscal year 2017, which was the most recent year of data at the time of our review. To assess the reliability of both the federal civilian and contractor deployment data and the authorization data, we electronically tested the data to identify obvious problems with completeness or accuracy and interviewed knowledgeable agency officials about the data. We found the authorization data to be sufficiently reliable for the purposes described above. We found the deployment data to be limited in that it may not be sufficiently reliable for identifying the universe of deployments. However, we found the data to be sufficiently reliable for the purposes of reporting that federal civilians and contractors have been deployed to provide medical care. Finally, we interviewed officials from the Office of the Under Secretary of Defense for Personnel and Readiness (USD(P&R)), Office of the Assistant Secretary of Defense for Health Affairs (OASD(HA)), Defense Civilian Personnel Advisory Service, the military departments, selected combatant commands to identify considerations and any challenges of using different personnel categories as workforce alternatives for meeting operational medical requirements.

For objective two, we reviewed DOD and department-level policies and guidance on workforce mix determination and the departments' efforts in planning, staffing, and filling MTF requirements. To better understand policy and procedure implementation at MTFs we selected six MTFs—

[11]To determine whether federal civilians and contractors were deployed to provide medical care, we reviewed data from Defense Manpower Data Center. Specifically, to identify deployed federal civilians we used data from the Civilian Deployment System and to identify deployed contractors we reviewed data from the Synchronized Predeployment and Operational Tracker. These data may not be sufficiently reliable for identifying the universe of deployments.

two each from the Army, Navy, and Air Force—to allow a cross-section of views concerning the management of the departments' workforce mix at the MTFs and hiring conditions in different types of labor markets. The two MTFs from each department were selected based on consideration of average daily patient load and MTF bed size, which we obtained from the Defense Health Agency. For each MTF, we interviewed officials responsible for the leadership and management of MTF personnel and operations and requested and reviewed relevant documentation. We reviewed their responses, which highlighted some challenges related to achieving an appropriate workforce mix, and DOD's plans for addressing these challenges. We compared these to GAO's key questions to assess agency reform efforts, which note that strategic workforce planning should precede any staff realignments or downsizing.[12] We also reviewed how the planned transfer of administrative responsibility for MTFs from the military departments to the DHA might affect DOD management of military personnel within the MHS.[13] To identify (1) responsibilities of the military departments that may be transferred to the DHA, and (2) challenges that may continue under the new organizational structure, we reviewed relevant documentation and interviewed knowledgeable officials. We compared DOD's efforts to plan for these challenges to leading practices for results-oriented government, which state that cooperating federal agencies need to sustain and enhance their collaboration in several ways, including the development of policies and procedures to operate across agency boundaries and agreement on their respective roles and responsibilities.[14]

To determine the proportion of reported military, federal civilian, and contractor personnel providing or supporting care in MTFs, we obtained budgetary data for fiscal year 2017, which was the most recent full fiscal year of available data at the time of our review. To assess the reliability of

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

[13]The National Defense Authorization Act for Fiscal Year 2017 directed the transfer of administrative responsibility for MTFs from the military departments to the DHA. Specifically, the Director of the DHA shall be responsible for the administration of each MTF, including budgetary matters, information technology, health care administration and management, administrative policy and procedure, military medical construction, and any other matters the Secretary of Defense determines appropriate. Pub. L. No. 114-328, § 702(a) (2016) (codified as amended at 10 U.S.C. § 1073c).

[14]GAO, *Practices That Can Help Enhance and Sustain Collaboration among Federal Agencies*, GAO-06-15 (Washington, D.C.: Oct. 21, 2005).

these data, we compared it to the information reported in the fiscal year 2017 Defense Health Program justification estimates published in February 2018 and interviewed knowledgeable agency officials about the data. We found the data to be sufficiently reliable for the purposes described above.

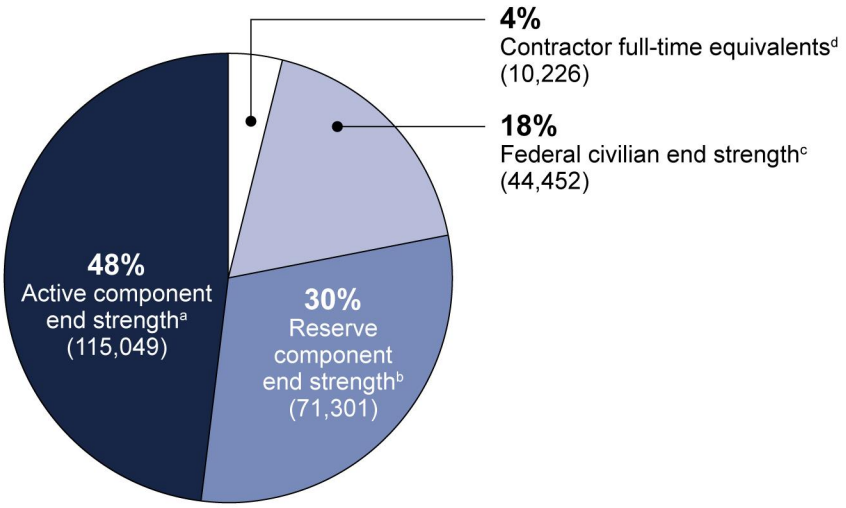
We conducted this performance audit from September 2017 to November 2018 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

Composition of the MHS Total Workforce

The MHS has a dual mission of maintaining the skills of the medical force and providing health care and beneficiary medical care in its MTFs in the United States and overseas. It accomplishes this in part by providing (1) operational medical care via deployable health care platforms in an operational environment, such as forward surgical teams and combat support hospitals, and (2) beneficiary medical care in its MTFs in the United States and around the world. DOD's total workforce supporting this dual mission comprises three main components: military personnel (including active and reserve personnel), federal civilian personnel, and private sector contractor personnel. Active duty medical personnel simultaneously support operational medical care and the delivery of beneficiary health care to patients across the globe. Reserve component medical personnel generally provide health care to deployed military personnel, but may also provide personnel to support MTFs when active duty personnel are deployed or otherwise unavailable. Federal civilians and contractors generally provide beneficiary care within MTFs. Figure 1 shows the number of the active and reserve components of the military, federal civilians, and estimated contractor full-time equivalents (FTEs) that comprised DOD's total medical workforce in fiscal year 2017.

Figure 1: Number and Percentage of the Department of Defense's (DOD's) Medical Military and Federal Civilian End Strength and Contracted Medical Services Full-Time Equivalents, Fiscal Year 2017



Source: GAO analysis of Department of Defense data. | GAO-19-102

Note: This figure represents all military and federal civilian personnel with a primary medical occupation code and an estimated number of contractors providing medical services funded by the Defense Health Program in fiscal year 2017. This figure differs from figure 4 in this report in that figure 4 includes all personnel (i.e., medical and non-medical) supporting military treatment facilities.

[a]The active component end strength data are from GAO analysis of summary table A2 within the Health Manpower Personnel Data System report for fiscal year 2017. End strength represents the actual number of personnel on board at the end of the fiscal year.

[b]The reserve component end strength data are from GAO analysis of summary table R2 within the Health Manpower Personnel Data System report for fiscal year 2017. Reserve component end strength includes 65,123 Selected Reserve, 6,016 Individual Ready Reserve/Inactive National Guard, and 162 stand by reserves.

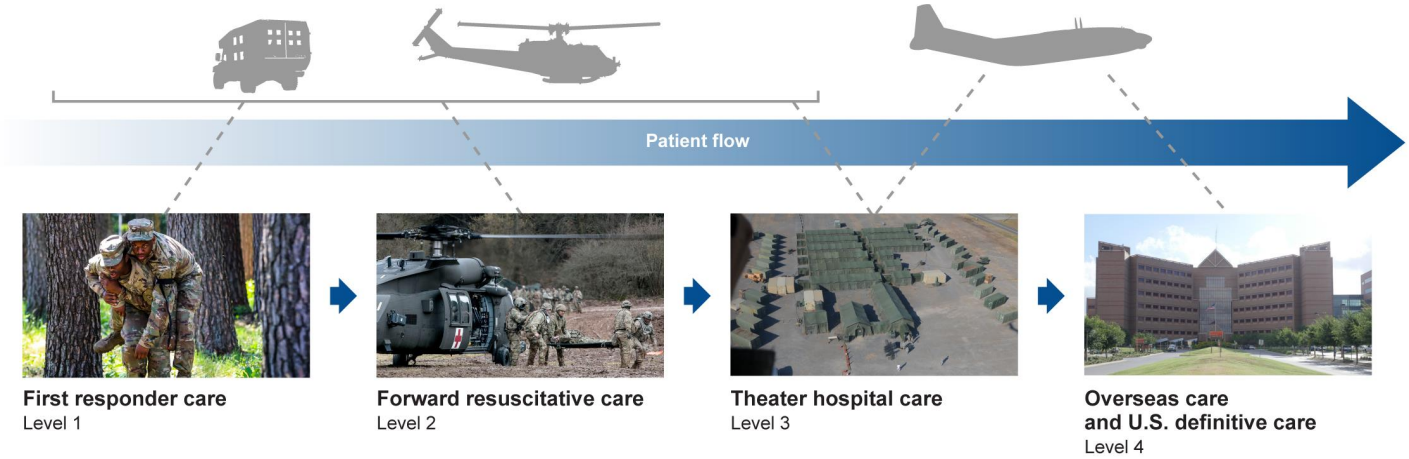
[c]The federal civilian end strength data are from GAO analysis of summary table C2 within the Health Manpower Personnel Data System report for fiscal year 2017. Federal civilian end strength includes only U.S. DOD Civilian Personnel and includes 43,809 full-time and 643 less than full-time federal civilian end strength.

[d]Contractor full-time equivalents were reported by the departments and represent the estimated number of contractor full-time equivalents servicing under medical care contracts funded by the Defense Health Program. According to a Defense Health Agency budget official, reported contractor full-time equivalents are estimates and cannot be validated. We have previously reported that a number of factors limit the accuracy and completeness of contractor full-time equivalent data. See, for example, GAO, *DOD Inventory of Contracted Services: Timely Decisions and Further Actions Needed to Address Long-Standing Issues*, GAO-17-17 (Washington, D.C.: Oct 31, 2016) and GAO, *Defense Acquisitions: Further Actions Needed to Improve Accountability for DOD's Inventory of Contracted Services*, GAO-12-357 (Washington, D.C.: Apr. 6, 2012).

DOD's Total Workforce Provides Operational Medical Care at Four Levels

DOD has established four levels of operational medical care provided to servicemembers and other eligible persons. The levels of care extend from the forward edge of the battle area to the United States, with each level providing progressively more intensive treatment. Level 4 care facilities are MTFs that also provide beneficiary medical care. In addition to the four levels of medical care, en-route care to transport patients is also provided via casualty evacuation, medical evacuation, and/or aeromedical evacuation from the point of patient injury, illness, or wounding.[15] Figure 2 illustrates the different levels of care.

Figure 2: Levels of Operational Military Medical Care Provided by Department of Defense's Total Workforce



Source: GAO analysis; Department of Defense, U.S. Army, and Defense Visual Information Distribution Service (photos). | GAO-19-102

The four levels of care are:

- **Level 1—First responder care.** This level provides immediate medical care and stabilization in preparation for evacuation to the next level, and treatment of common acute minor illnesses. Care can be

[15]Casualty evacuation involves the unregulated movement of casualties aboard ships, land vehicles, or aircraft. Medical evacuation is the timely, efficient movement and en route care by medical personnel of the wounded, injured, or ill persons from the battlefield and/or other locations to and between MTFs. Aeromedical evacuation refers to the movement of patients under medical supervision to and between MTFs by air transportation.

provided by the wounded soldiers, medics or corpsmen, or battalion aid stations.

- **Level 2—Forward resuscitative care.** This level provides advanced emergency medical treatment as close to the point of injury as possible to attain stabilization of the patient. In addition, it can provide postsurgical inpatient services, such as critical care nursing and temporary holding. Examples of level 2 units include forward surgical teams, shock trauma platoons, area support medical companies, and combat stress control units.
- **Level 3—Theater hospital care.** This level provides the most advanced medical care available in Iraq and Afghanistan. Level 3 facilities provide significant preventative and curative health care. Examples include Army combat support hospitals, Air Force theater hospitals, and Navy expeditionary medical facilities.
- **Level 4—U.S. and overseas definitive care.** This level provides the full range of preventative, curative, acute, convalescent, restorative and rehabilitative care. Examples of level 4 facilities include MTFs such as Brooke Army Medical Center at Joint Base San Antonio, Texas and Naval Medical Center Portsmouth at Portsmouth, Virginia.

DOD Provides Beneficiary Medical Care in the United States and around the World

DOD's MHS workforce provides beneficiary medical care to 9.4 million eligible individuals, including active duty personnel and their dependents (i.e., spouse, children), medically eligible Reserve and National Guard personnel and their dependents, and retirees and their dependents and survivors. Located in the United States and around the world and ranging from small clinics to major hospitals, these facilities serve as training platforms for active duty medical personnel to maintain their skills and play a key role in the military departments' Graduate Medical Education programs for training medical professionals.

In addition to the direct provision of health care in its own hospitals and clinics, DOD maintains its TRICARE purchased care system that is used to augment the direct care system when needed. Through regional contracts, TRICARE administers the purchased care system, which

comprises a civilian network of hospitals and providers.[16] Retirees who qualify for care under Department of Veterans Affairs' rules may also be eligible to receive health care within the Veterans Health Administration system of hospitals and clinics.

Legislation, Policies, and Processes Governing the MHS Workforce Mix

DOD's management of its workforce is governed by several workforce management statutes of title 10 of the United States Code, including:

- Section 129a directs the Secretary of Defense to establish policies and procedures for determining the most appropriate and cost-efficient mix of military, civilian, and contracted services to perform the mission of the department.
- Section 2463 directs the Under Secretary of Defense for Personnel and Readiness to devise and implement guidelines and procedures to ensure that consideration is given to using, on a regular basis, DOD civilian employees to perform new functions and functions performed by contractors that could be performed by DOD civilian employees.
- Section 2461 directs that no DOD function performed by civilian employees may be converted, in whole or in part, to performance by a contractor unless the conversion is based on the results of a public–private competition that formally compares the cost of performance by civilian employees with the cost of contractors, among other considerations. There is currently a government-wide moratorium on performing such public-private competitions.

DOD's total workforce management policy generally emphasizes the need for agencies to utilize the least costly mix of personnel while ensuring the workforce is sufficiently sized, and comprised of the appropriate mix of personnel to carry out the mission of DOD.[17] The departments use DOD guidance to assess the use of military, federal civilian, and contractor personnel, which includes the consideration of two

[16]Prior to October 1, 2013, the TRICARE Management Activity, an entity within DOD, was responsible for overseeing DOD's regionally structured health care program. Upon its establishment, the DHA assumed management responsibility of numerous functions of DOD's medical health system, including the former TRICARE Management Activity.

[17]DOD Directive 1100.4.

key factors: (1) the risk to the military mission, and (2) the cost of the workforce. To help assess risk, the departments determine what work should be performed by military, federal civilian, or contractor personnel. For example, work that is inherently governmental[18] must be performed only by military or civilian personnel, while work that is commercial in nature could be performed by any personnel type.[19] To make this determination, DOD Instruction 1100.22 directs components to: use the manpower mix criteria outlined in the instruction to identify inherently governmental and commercial activities; and review the annual inventory of commercial and inherently governmental activities.[20] In addition, DOD and the departments have established policies and procedures to assess the costs and benefits of different workforce mix options. DOD Instruction 1100.22 directs components to conduct a cost comparison of personnel when considering outsourcing[21] new requirements that are not required to

[18]An inherently governmental activity is a function so intimately related to the public interest as to require performance by federal government personnel. Pub. L. No. 105-270, § 5(2)(A) (1998). For example, operational control of combat, combat support and combat service support units; armed fighting or use of force deemed necessary for national defense; some aspects of security provided to protect resource and operations in hostile or volatile areas are inherently governmental activities.

[19]As defined in Office of Management and Budget (OMB) Circular A-76, a commercial activity is not so intimately related to the public interest as to mandate performance by government personnel. It is a recurring service that could be performed by the private sector and is resourced, performed, and controlled by the agency through performance by government personnel, a contract, or a fee-for-service agreement. OMB, Circular No. A-76, *Performance of Commercial Activities* (May 23, 2003).

[20]The annual inventory of commercial and inherently governmental activities is used to comply with reporting requirements set forth in statute and guidance, including requirements established by the Federal Activities Inventory Reform Act of 1998, Pub. L. No. 105-270 (1998), and in OMB Circular A-76.

[21]In the National Defense Authorization Act for Fiscal Year 2008, Congress enacted a moratorium on any study or competition relating to the possible conversion to performance by a contractor of any DOD function carried out at an MTF, until the submission of a certification and report by the Secretary of Defense. Pub. L. No. 110-181, § 1676 (2008). In 2009, Congress enacted both a DOD-specific and government-wide moratorium on public-private competitions regarding conversion to contractor performance of functions performed by federal employees. Pub. L. No. 111-8, § 737 (2009); Pub. L. No. 111-84, § 325 (2009).

be performed by government personnel, or when considering in-sourcing functions that are currently performed by private sector contractors.[22]

Roles and Responsibilities for Managing the MHS Workforce

Several officials have responsibility for governing DOD's management of its total workforce, including

- **The Under Secretary of Defense for Personnel and Readiness (USD(P&R)).** This official has overall responsibility for issuing guidance on total workforce management to be used by the DOD components, providing guidance on manpower levels of the components, and developing manpower mix criteria and other information to be used by the components to determine their workforce mix.
- **The Under Secretary of Defense (Comptroller).** This official is responsible for ensuring that the budget for DOD is consistent with the total workforce management policies and procedures.[23]
- **The Secretaries of the military departments and heads of the defense agencies.** These officials have overall responsibility for the requirements determination, planning, programming, and budgeting execution for total workforce management policies and procedures,[24] as well as having numerous responsibilities related to total workforce management as detailed in DOD guidance.[25]
- **The Assistant Secretary of Defense for Health Affairs (ASD(HA)).** This official serves as the principal advisor for all DOD health related

[22] Department of Defense Instruction 1100.22, *Policy and Procedures for Determining Workforce Mix* (Apr. 12, 2010) (incorporating change 1, Dec. 1, 2017). DOD Instruction 1100.22 states that risk mitigation shall take precedence over cost savings when necessary to maintain appropriate control of Government operations and missions, or core capabilities and readiness. Furthermore, commercial activities shall be designated for civilian performance unless the private sector is the lower-cost provider or there is a legal, regulatory, or procedural impediment to using civilian personnel.

[23] 10 U.S.C. § 129a(c)(4).

[24] 10 U.S.C. § 129a(c)(2).

[25] *See, e.g.*, DOD Directive 1100.4.

policies, programs, and activities.[26] The ASD(HA) has the authority to: develop policies, conduct analyses, provide advice, and make recommendations to the USD(P&R), the Secretary of Defense, and others; issue guidance; and provide oversight to the DOD Components on matters pertaining to the MHS. Further, the ASD(HA) prepares and submits a DOD unified medical program budget which includes, among other things, the defense health program budget to provide resources for the DOD MHS.

- **The Director of the Defense Health Agency (DHA).** This official, among other things, manages the execution of policies issued by the ASD(HA) and manages and executes the Defense Health Program appropriation, which partially funds the MHS.[27]

Recent MHS Personnel Reform Efforts

The National Defense Authorization Act for Fiscal Year 2017 directed the transfer of administrative responsibility for MTFs from the military departments to the DHA. Specifically, the Director of the DHA shall be responsible for the administration of each MTF, including budgetary matters, information technology, health care administration and management, administrative policy and procedure, military medical construction, and any other matters the Secretary of Defense determines appropriate.[28] Since 2016, DHA's responsibilities in the administration of MTFs have been further articulated in DOD memoranda and in statute. In 2018, DOD directed that the DHA shall be responsible for: (1) the planning, programming, budgeting, and execution processes for the MTFs; (2) clinical and health delivery services in each MTF; and (3) for these services, the hiring and management of federal civilians and contract staffing.[29] Further, in 2018, Congress amended the law to specify that at each MTF, the Director of the DHA has the authority to determine

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

[27]In September 2013, the Defense Health Agency was established to support greater integration of clinical and business processes across the MHS.

[28]Pub. L. No. 114-328, § 702(a) (2016) (codified as amended at 10 U.S.C. § 1073c).

[29]Under Secretary of Defense for Personnel and Readiness Memorandum, *Authorities and Responsibilities of Military Treatment Facility Leaders, Service Leaders and the Military Medical Departments,* (Feb. 21, 2018). Under Secretary of Defense for Personnel and Readiness Memorandum, *Construct for Implementation of Section 702*, (May 22, 2018).

total workforce requirements, direct joint manning, and address personnel staffing shortages, among other things.[30]

Also in December 2016, Congress enacted legislation that allows the prohibition of converting military medical and dental positions to federal civilian positions, which had been in place since 2008, to be lifted.[31] This change is contingent upon DOD satisfying a reporting requirement on the size and composition of its operational medical force. Specifically, Congress directed DOD to report on the process established to define the military medical and dental requirements necessary to meet operational medical force readiness requirements, and provide a list of those military medical and dental requirements.

Department Planning Processes for Operational Medical Personnel Requirements Do Not Include an Assessment of All Medical Personnel or the Full Cost of Military Personnel

The military departments each have their own process to determine their operational medical personnel requirements. After determining the number of medical personnel needed to support operational needs, the military departments generally consider only military personnel when conducting their planning processes to meet these requirements, and have not formally assessed the extent to which federal civilians and contractor personnel could be utilized. Further, the departments do not generally consider the full cost of active and reserve component medical personnel when determining their balance of active and reserve component medical personnel, and they have not developed such information to use in their assessment of active and reserve balance.[32]

[30]Pub. L. No. 115-232, § 711 (2018) (codified at 10 U.S.C. § 1073c).

[31]Pub. L. No. 114-328, § 721 (2016).

[32]For purposes of this report we refer to the fully-burdened costs as full cost. The full cost of active duty military personnel includes, among other things, basic pay, special and incentive pays, allowances, permanent change of station, health and retirement benefits, education assistance, commissary benefits, and Veterans' benefits. For more information, see Department of Defense Instruction 7041.04*, Estimating and Comparing the Full Costs of Civilian and Active Duty Military Manpower and Contract Support* (July 3, 2013).

Each Military Department Has Its Own Process to Plan for Operational Medical Personnel Requirements, Including the Balance of Active and Reserve Component Personnel

Each military department has its own process to plan for operational medical personnel requirements. The departments' operational medical personnel requirements are based on their analysis of DOD's Defense Planning Guidance and Defense Planning Scenarios.[33] Specifically, possible casualty streams are estimated based on the scenarios, and the required medical support is determined in conjunction with department-specific medical planning factors, such as rotation policy, the population at risk, and evacuation policy, among others. Each military department incorporates these factors to estimate the number of medical personnel needed. The Army integrates medical planning into its general process for estimating all operational requirements, whereas the Navy and Air Force have separate, medical-specific processes. The following represents an overview of each military department's approach:

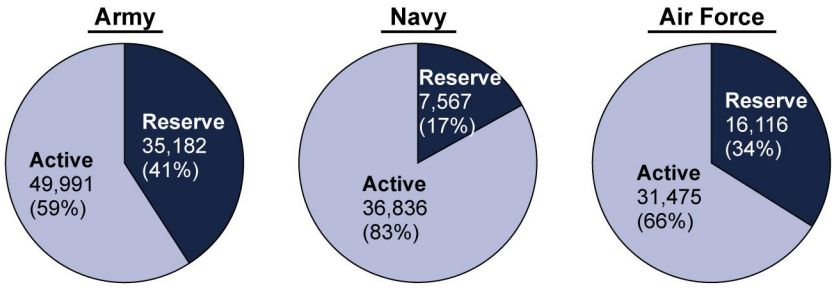
- **Army.** The Army uses its Total Army Analysis model to determine the number and type of support units across the Army, including medical forces, which will be needed to support the Army's combat forces in operational settings.
- **Navy.** The Navy uses a medical-specific model, called the Medical Manpower All Corps Requirements Estimator, to estimate its total medical personnel readiness requirements. The Navy readiness mission is to support all Navy and Marine Corps operational missions, including operational operations (such as hospital ships and expeditionary medical facilities) and day-to-day operations (such as ships, submarines, and Special Forces).
- **Air Force.** The Air Force uses a medical-specific sizing model named the Critical Operational Readiness Requirements tool to project its

[33]The Defense Planning Guidance operationalizes the National Defense Strategy and provides guidance to the services on their use of approved scenarios, among other things, which serve as their starting point for making force structure decisions and assessing risk. These classified scenarios are used to illustrate the missions articulated in the National Defense Strategy, including the need to defeat one regional adversary while deterring a second adversary in another region, homeland defense, and forward presence.

minimum military personnel requirements. This tool identifies the number of military medical personnel needed to meet requirements, including requirements for en-route casualty support, theater hospitals, and critical care air transport teams.

According to military department officials, the decision to apportion medical personnel requirements among the active and reserve components is based on an assessment of risk across a range of factors. In a 2013 DOD report issued in response to section 1080A of the National Defense Authorization Act for Fiscal Year 2012.[34] DOD noted that there are several important factors in active component and reserve component mix decisions, including, among others, the timing, duration, and skills required for anticipated missions.[35] Moreover, the report notes that active components are best suited for unpredictable and frequent deployments, dealing with complex operational environments, and unexpected contingencies and the reserve components are best suited for predictable and infrequent deployments. As noted in the report, active component personnel typically mobilize and deploy to theater the fastest. The sum of these considerations results in a different mix of active and reserve component medical personnel within each military department. Specifically, reserve personnel (as a percentage of the total workforce) varied by military department in fiscal year 2017, with reservists representing 41 percent of medical personnel of the Army, 17 percent of the Navy, and 34 percent of the Air Force, as shown in figure 3.

Figure 3: Number and Percentage of Uniformed Medical Personnel Authorizations by Component, Fiscal Year 2017



Source: GAO analysis of Department of Defense data. | GAO-19-102

[34]Pub. L. No. 112-81, § 1080A (2011).

[35]DOD, *Unit Cost and Readiness for the Active and Reserve Components of the Armed Forces* (December 2013).

Note: Authorizations included in our analysis were reported in the Health Manpower Personnel Data System report for fiscal year 2017. Authorizations are for all medical personnel, regardless of funding. For our analysis of the reserve components, we analyzed authorization data for the Selected Reserve within the reserve components.

DOD Has Not Assessed Using Federal Civilians or Contractors to Meet Operational Medical Personnel Requirements

The military departments have not assessed the extent to which federal civilians and contractor personnel can be used to meet identified operational medical personnel requirements. Specifically, after the military departments have determined their operational medical personnel requirements, they generally have designated all such positions as "military-essential" (i.e., the activity must be performed by a military servicemember) and have not formally assessed the extent to which civilians or contractors could be utilized to fill these positions, according to officials. Army, Navy, and Air Force officials stated that they have historically relied on active and reserve component military personnel when planning for operational medical requirements, with a few exceptions. For example, according to Navy officials, the few federal civilians that are planned to fill operational medical requirements are technical representatives who do not travel on ships for extended periods of time.

In interviews, military department officials cited key reasons for not incorporating federal civilians and contractors into their planning for operational medical care. Specifically, officials said they did not believe that federal civilians or contractors were viable workforce alternatives to military servicemembers for operational medical care roles and functions due to the unique nature of such assignments (e.g. providing medical care in a deployed setting). Moreover, officials noted that federal civilians and contractors supporting operational medical requirements are generally considered to be a temporary solution. Officials also expressed concern regarding their military department's ability to identify and recruit federal civilians and contractors for such positions. Officials stated that while there is currently no guidance outlining the potential role of federal civilians and contractors providing medical care in operational settings, they noted that DOD workforce mix guidance includes a provision that highlights the military-essential nature of medical personnel embedded in

non-medical units engaged in hostile action.[36] However, this instruction does not otherwise address the role of federal civilians and contractors in providing medical care, including whether they can serve in medical-specific operational platforms, such as combat support hospitals providing level 3 care.

To ensure that its federal civilian employees will deploy to combat zones and perform operational roles such as critical combat support functions in theater, DOD established the emergency-essential civilian program in 1985. Under this program, DOD designates as "emergency-essential" those federal civilian employees whose positions are required to ensure the success of combat operations or the availability of combat-essential systems.[37] DOD's emergency-essential workforce is now governed under the Expeditionary Civilian Workforce program. DOD can deploy emergency-essential federal civilian employees either on a voluntary or involuntary basis to accomplish the DOD mission.[38] In certain DOD functional communities, federal civilians and contractors play a critical role in combat support roles. For example, as we previously reported, DOD relies on the federal civilian personnel it deploys to support a range of essential missions, including logistics support and maintenance, intelligence collection, criminal investigations, and weapons system acquisition and maintenance.[39] Further, as we have previously reported, DOD has long used contractors to provide supplies and services to

[36]DOD Instruction 1100.22.

[37]*See* 10 U.S.C. § 1508. DOD established the Civilian Expeditionary Workforce, which is now called the Expeditionary Civilian Workforce, in 2009 to create a cadre of federal civilians trained, cleared, and equipped to respond urgently to expeditionary requirements. Directive-Type Memorandum (DTM)-17-004 is the current guidance governing this workforce and states that it is DOD policy to identify and rely on a mix of capable military members and DOD federal civilians to meet global national security missions, and to include federal civilian employees in DOD's Global Force Management allocation process. Directive-Type Memorandum (DTM)-17-004, *Department of Defense Expeditionary Civilian Workforce* (Jan. 25, 2017) (incorporating change 1, effective Jan. 4, 2018).

[38]*See* DTM-17-004. Capability-based volunteers are employees who may be asked to volunteer for deployment.

[39]See GAO, *DOD Civilian Personnel: Medical Policies for Deployed DOD Federal Civilians and Associated Compensation for Those Deployed*, GAO-07-1235T (Washington, D.C.: Sept. 18, 2007) and GAO, *Human Capital: Improved Tracking and Additional Actions Needed to Ensure the Timely and Accurate Delivery of Compensation and Medical Benefits to Deployed Civilians*, GAO-09-1019T (Washington, D.C.: Sept. 16, 2009).

deployed forces.[40] Since the early 1990s, much of this support has come from logistics support contracts—contracts that are awarded prior to the beginning of contingencies and are available to support the troops as needed.

Although they are generally not a part of the military departments' planning processes, and there is no guidance dedicated to delineating the role of federal civilians and contractors in providing care in deployed operational settings according to officials, these personnel have deployed within the past 5 years. Based on our analysis of DOD federal civilian deployment data—for fiscal years 2013 through 2017—about 120 DOD federal civilians, including nurses, physicians, and technicians, were deployed to provide medical services. U.S. Central Command officials stated that they have used federal civilians minimally, and U.S. Africa Command officials stated they have not used federal civilians.[41] In addition, based on our analysis of DOD contractor deployment data for deployments from fiscal years 2013 through 2017, there were more than 1,900 deployed contractors providing medical services. U.S. Central Command officials told us that they have not used contractors to provide care to military personnel. Officials noted that the deployed contractors were not contracted by DOD for purposes of providing medical care and instead provided medical care to other contractors as they were part of a larger contract for other services, such as security services or logistics support.[42] U.S. Africa Command officials told us that they have used contractors to provide medical care to support casualty evacuation[43] and

[40]See GAO, *Military Operations, DOD's Extensive Use of Logistics Support Contracts Requires Strengthened Oversight*, GAO-04-854 (Washington, D.C.: July 19, 2004).

[41]For this review we selected two combatant commands (U.S. Central Command and U.S. Africa Command) in order to get their perspectives regarding workforce mix in theater. U.S. Central Command officials noted that individual services may have utilized federal civilians to provide care, a decision which would not have involved approval from their office.

[42]Responsibility for providing health services to contractors, whether it is the responsibility of the contractor or military, must be fully delineated in planning documents to ensure appropriate medical staffing. Joint Chiefs of Staff, Joint Pub. 4-02, *Joint Health Services* (Dec. 11, 2017)

[43]Casualty evacuation involves the unregulated movement of casualties aboard ships, land vehicles, or aircraft.

personnel recovery[44] requirements, which includes providing medical care to military personnel and other eligible persons.

Officials with the Joint Staff Surgeon's Office and the Surgeon's offices at U.S. Central Command and U.S. Africa Command agreed with the possibility of using federal civilians and contractors for certain operational medical personnel requirements. Specifically, officials stated that federal civilians and contractors likely represent an acceptable workforce alternative if they are medically ready to deploy and appropriately trained for the unique environment at a fixed facility in theater, such as a level 3 fixed expeditionary medical facility or theater hospital.

While agreeing that the use of federal civilians and contractors for certain operational medical personnel requirements may be acceptable, officials also expressed concerns with this approach. A senior official with the U.S. Central Command Surgeon's office noted concerns regarding the pre-deployment training provided to contractors.[45] Specifically, the official stressed the importance of such training to operating effectively in the unique operational environment of a deployed medical team and that such training is only required to be completed by military personnel and DOD expeditionary civilians. U.S. Africa Command officials expressed concerns regarding challenges in obtaining clinical privileging rights (i.e., the right for a physician to perform specific health care services) for contractors supporting small teams in an operational setting. Further, OASD(HA) officials noted that a key factor to determining if federal civilians or contractors should be used to provide operational medical care is whether or not using those workforces would achieve any cost savings.

Moreover, officials with the Defense Civilian Personnel Advisory Service noted that they have had limited success with using DOD's Expeditionary Civilian Workforce program for the provision of medical administrative support and medical advising functions. A senior official from the U.S. Central Command Surgeon's office noted this was due to relatively few

[44]Personnel recovery is the sum of military, diplomatic, and civil efforts to prepare for and execute the recovery and reintegration of isolated personnel.

[45]Military personnel and DOD expeditionary civilians complete pre-deployment training to receive tactical combat casualty care certification. The tactical combat casualty care course is intended to provide skills to assess and manage a combat casualty from point of injury to a higher level of care. Department of Defense Instruction 1322.24, *Medical Readiness Training (MRT)* (Mar. 16, 2018).

qualified federal civilians within the program with medical skills. Defense Civilian Personnel Advisory Service officials noted that the fiscal year 2019 force pool that defines the number and types of federal civilian requirements needed for the program included 7 medical related positions and none of these were for medical care; 1 was administrative and 6 were medical advisors. Defense Civilian Personnel Advisory Service officials stated that the DHA has a responsibility to build 1 or 2 of the medical advisor positions in the force pool into their planning as a continuing requirement, and noted that DHA has made some recent progress with 1 medical advisor scheduled to deploy in fiscal year 2019. While there may be challenges with utilizing federal civilian personnel to fulfill operational medical requirements, DOD also faces challenges with regard to military personnel. In 2018, we reported that DOD has experienced gaps between its military physician authorizations (i.e., funded positions) and end strengths (i.e., number of physicians), and that it did not have targeted and coordinated strategies to address key physician shortages.[46]

DOD has issued several documents to guide total workforce and personnel planning. DOD Directive 1100.4 states that authorities should consider all available sources when determining workforce mix, including federal civilians and contractors. Moreover, DOD's 2017 Workforce Rationalization Plan recognizes DOD's federal civilians as an essential enabler of its mission capabilities and operational readiness and noted that there are numerous opportunities for the military departments, combatant commands, and others to make well-reasoned adjustments to workforce mix. Further, DOD's National Defense Business Operations Plan for Fiscal Years 2018 to 2022 states that workforce rationalization strategies include, among other things, reassessing military manpower allocations for military essentiality, determining whether workload requires deployments and whether traditional military performance is necessary, and identifying functions and positions that are commercial in nature that may be appropriately or efficiently delivered via private sector support.

Federal civilians and contractors are not incorporated into the military departments' planning to meet operational medical requirements because DOD has not performed an assessment of the suitability of federal civilian or contractor personnel to provide operational medical care. Such an assessment could assist in developing policy for use by medical planners

[46]GAO, *Military Personnel: Additional Actions Needed to Address Gaps in Military Physician Specialties,* GAO-18-77 (Washington, D.C.: Feb. 28, 2018).

in determining when, where, and how federal civilians or contractors may serve in operational roles. For example, an assessment may include what level(s) of care would be appropriate for federal civilians and contractors to support, if any, and factors to take into consideration in making such decisions, such as exposure to danger and cost. By conducting such an assessment and incorporating the results into relevant policies, DOD can have greater certainty that it is planning for the most appropriate and cost-effective mix of personnel to meet the mission, and, depending on the outcome of the assessment, more options to meet its operational medical personnel requirements.

The Military Departments Do Not Consider the Full Cost of Active and Reserve Component Medical Personnel When Planning for Operational Requirements and Do Not Have Full Cost Information

The military departments' planning to meet DOD's operational personnel requirements generally do not consider the full cost of active and reserve component personnel when determining the balance of active and reserve component medical forces. Officials from Army and Navy medical headquarters stated that cost generally does not inform their decisions about the balance of active and reserve personnel. Army officials noted they consider cost of a unit when making tradeoffs within the reserve component; however, cost was not cited by Army officials as a factor when determining between the active and reserve components. Navy officials noted that while it uses certain cost information when preparing the President's budget submission, cost is not explicitly considered when determining the balance of the active and reserve components. The Air Force is the only military department that has performed an assessment of the cost effectiveness of using active or reserve component medical personnel, although it had some limitations and did not impact the Air Force's active and reserve component mix decisions. Army, Navy, and Air Force officials cited other key factors which they consider in determining the balance of active and reserve component personnel, such as the availability of forces to deploy quickly, length of time needed in theater, capability needed, and frequency of deployments.

Moreover, the military departments have not developed full cost information of medical personnel to use in their assessment of active and reserve balance. Army and Navy officials stated that they do not maintain full cost information on its active component and reserve component medical personnel. Navy provided programming cost for the reserve

component but these rates were averages across the reserve component and not specific to medical. The Air Force's 2016 High Velocity Analysis attempted to assess the cost of active and reserve medical personnel and identify potential efficiencies within its medical workforce. However, this study was limited because it did not include the full cost of active and reserve component medical personnel. Specifically, the Air Force analysis considered only compensation and did not consider other benefits, such as medical education costs, and used average pay for officers and enlisted personnel regardless of the specialty or skill level. However, the full costs for certain medical personnel, such as officers, are generally higher than average military pay, as they are eligible for a significant number of special pays and benefits, such as graduate medical education and training.[47] In fiscal year 2017, DOD obligated $788 million for special pays for active duty medical personnel, representing approximately 24 percent of the $3.3 billion obligated for all special pays across DOD, and $707 million for medical education. While the Air Force had full cost data for active component personnel, according to officials, they did not include it in their analysis because they did not have comparable cost data for the reserve component. Reserve medical personnel, when not mobilized, receive a fraction of what active duty personnel receive, and typically do not encumber significant education and training costs as reserve medical personnel generally are recruited as fully trained medical professionals.[48]

We have previously reported that when the reserve forces can successfully meet deployment and operational requirements, individual reserve-component units are generally less costly than similar active-

[47]DOD uses special pay programs as tools in its compensation system to help ensure that military pay is sufficient to field a high-quality, all-volunteer force, including those in hard-to-fill or critical specialties. Special pays are authorized in chapter 5 of title 37 of the U.S. Code.

[48]Reserve component personnel may be eligible for special and incentive pays, including special pays for health professionals. Reservists are generally eligible for special and incentive pays during active duty training under the same conditions as active component personnel. Typically, they may receive a pro-rated portion of the full monthly amount corresponding to the number of days served. Reserve component members may also be eligible for special and incentive pays during inactive duty for training, and they typically receive such compensation at a rate proportional to the amount of inactive duty compensation they receive (i.e., one-thirtieth of the monthly rate for each unit training assembly).

component units.[49] However, the full cost of medical personnel can vary based on a number of factors. Specifically, more than one reserve-component unit may be needed to achieve the same output as a single active-component unit. For example, the Army has a policy that states reserve-component physicians, dentists, and nurse anesthetists shall not be deployed for longer than 90 days.[50] Thus, the Army would need to deploy four different reserve component physicians for successive 90-day rotations to fill a single 1-year active component requirement. Therefore, in some cases, using reserve units to achieve the same operational capacity over time may be more costly than using active units. However, the lack of full cost information on active and reserve component medical personnel is a barrier to an analytical-based determination on the balance between active and reserve component medical personnel.

In 2013, we reported limitations with the DOD-wide software tool developed by Cost Assessment and Program Evaluation—the Full Cost of Manpower—which, among other things, is used to identify the full cost of active duty military personnel. [51] Specifically, we reported that this tool has certain limitations for determining cost for certain cost elements. For example, instead of determining training cost by specialty, it estimates such costs by dividing total funding for such cost estimates by the number of military personnel. We recommended, among other things, that DOD, in order to improve its estimates and comparisons of the full cost of its workforces, develop guidance for cost elements that users have identified as challenging to calculate, such as general and administrative, overhead, advertising and recruiting, and training. DOD partially concurred with this recommendation but has not implemented this recommendation. We continue to believe that developing such costs is needed, especially for the medical community since training and education costs can be higher than in other communities. Moreover, in that report we also found that DOD did not include Reserve and National Guard personnel in their methodology for estimating and comparing the

[49]See GAO, *Active and Reserve Unit Costs: DOD Report to Congress Generally Addressed the Statutory Requirements but Lacks Detail*, GAO-14-711R (Washington, D.C.: July 31, 2014).

[50]Office of the Assistant Secretary for Manpower and Reserve Affairs Memorandum, *Army Medical Department (AMEDD) Reserve Component (RC) 90-Day "Boots-on-the-Ground" (BOG) Rotation Policy* (May 7, 2018).

[51]GAO, *Human Capital: Opportunities Exist to Further Improve DOD's Methodology for Estimating the Costs of Its Workforces*, GAO-13-792 (Washington, D.C.: Sept. 25, 2013).

full cost to the taxpayer of work performed.[52] We recommended DOD, among other things, develop business rules for estimating the full cost of National Guard and Reserve personnel. DOD partially concurred with this recommendation but has not implemented the recommendation and noted that a cost estimating function for reserve component personnel would be more complex than for active component and DOD federal civilian cost estimates. While we agree that developing cost estimates for the reserve component could be more complex, we continue to believe it is advisable for DOD to implement our recommendation.

In a 2013 DOD report, DOD identified the cost of unit manning, training, and equipping as one of five factors that play a key role in decisions concerning the mix of active and reserve component forces.[53] According to the report, cost is often outweighed by other factors when making active component and reserve component mix decisions, but should always be considered in active component and reserve component mix decisions. Further, DOD policy states that workforce decisions must be made with an awareness of the full costs of personnel to DOD and more broadly to the federal government, and highlights that the full cost of active duty personnel extends beyond cash compensation, and also includes other costs such as education and training.[54]

The military departments do not assess the full cost of personnel when determining the balance of active and reserve component medical forces because there is no DOD requirement to do so. Although DOD guidance states that cost is one of several factors that should be considered in active and reserve component balance decisions, the military departments have not conducted assessments of the full cost of active and reserve component personnel to inform their decisionmaking. Further, DOD and the military departments are unable to conduct any

[52]GAO-13-792.

[53]DOD, *Unit Cost and Readiness for the Active and Reserve Components of the Armed Forces* (December 2013). The first three factors relate to the mission and include: sourcing for continuous operations (forward and homeland), surge and post-surge demands; mission predictability and frequency (force employment policy); and responsiveness of the force based on urgency of the task, unit integration, mission, or role. The fourth factor, retention and sustainment, adds stress on the force and should be considered, and the fifth factor, cost, is often outweighed by other factors when making active component and reserve component mix decisions, but should also be considered, according to the report.

[54]DOD Instruction 7041.04.

such assessments because they have not developed full cost information for active and reserve component medical personnel. Without developing full cost information for active and reserve component medical personnel and using that information in its determinations regarding the correct balance of such personnel, decision makers will not have complete information to make cost-effective choices about the balance of active and reserve component medical personnel.

The Military Departments Have Established a Process to Assess the Appropriate Workforce Mix for Beneficiary Care within MTFs, but Face Challenges in Executing Their Plans

The military departments have taken actions, such as establishing policies and procedures, to aid the execution of the appropriate workforce mix for providing beneficiary health care within MTFs. However, the military departments face challenges in executing their plans in several areas, including lengthy hiring and contracting processes and uncompetitive salaries and compensation. Further, the transfer of administrative responsibility for MTFs from the military departments to the DHA may present challenges to the management of the military medical personnel.

The Military Departments Have Established Policies and Procedures to Evaluate the Risks, Costs, and Benefits of the Use of Personnel within Its Military Treatment Facilities

The military departments manage the workforce within their MTFs by using various policies and procedures to determine their workforce needs and help assess the risks, costs, and benefits of using military, federal civilian, and contractor personnel to carry out their missions. Currently, each military department is responsible for determining its MTF personnel requirements: that is, the number of personnel needed to operate its MTFs based on predicted demand for health care from their military and beneficiary populations. To determine MTF personnel requirements, the military departments use their respective suite of manpower models or standards based on a number of factors, including historical medical workload information and the size of population eligible for care.

According to Army and Navy medical command officials, the Army and Navy suites of models respectively include at least 36 and 46 medical specialties, and generally express historical medical workload in relative value units, a metric of the level of professional time, skill, training and intensity to provide a given clinical service. In contrast, according to Air Force medical agency officials, the Air Force suite of standards includes 11 medical specialties and expresses workload in patient encounters.

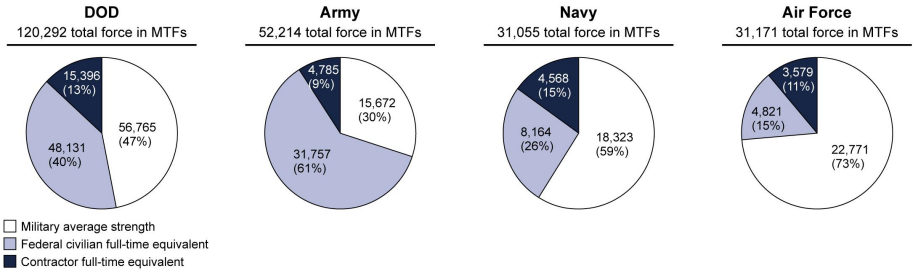
According to military department officials, when considering how to meet their MTF personnel requirements given available resources, the number of military personnel is fixed and must be preserved since the operational medical personnel requirements support the readiness mission. The military departments therefore prioritize the distribution of military personnel across MTFs, and then consider how to fill the remaining authorizations with federal civilian personnel or by contracting medical services as appropriate. To make these decisions, the military departments utilize DOD workforce guidance, which requires a balance of risk and cost, but states that risk mitigation shall take precedence over cost-related concerns when necessary.[55] DOD total workforce policies and procedures are outlined in: (1) DOD Directive 1100.4, which establishes guidance for total workforce management; and (2) DOD Instruction 1100.22, which outlines policies and procedures for determining the appropriate mix of personnel. In 2018, we reported that a DOD study found that the cost of federal civilian and contractor full-time equivalents varied by organization, location, and function being performed.[56] According to Army, Navy, and Air Force officials, any changes to funded positions are made through formal processes and require an evaluation of the cost of the personnel options and the approval of the military departments' respective medical commands or agencies.

The military departments' collective decisions determine their workforce mix. Figure 4 shows the number and percentage of each personnel type that provided or supported care in DOD-owned and operated MTFs for fiscal year 2017, in the United States and overseas.

[55]DOD Instruction 1100.22.

[56]GAO, *Civilian and Contractor workforces: DOD's Cost Comparisons Addressed Most Report Elements but Excluded Some Costs,* GAO-18-399 (Washington, D.C.: Apr. 2018).

Figure 4: Number and Percentage of the Department of Defense's (DOD's) Total Workforce Providing and Supporting Care in Military Treatment Facilities (MTFs) by Personnel Type, Fiscal Year 2017



Source: Defense Health Program Operations and Maintenance, In-House Budget Activity Group data. | GAO-19-102

Note: This figure represents all personnel (i.e., medical and non-medical) supporting in-house care in fiscal year 2017, which includes, among other things, military treatment facilities, medical center laboratories, and substance abuse programs. This figure differs from figure 1 in this report in that figure 1 includes all military and federal civilian personnel with a primary medical occupation code and an estimated number of contractors providing medical services. According to a DHA budget official, contractor full-time equivalents (FTEs) reported in the in-house budget activity group represent the estimated number of contractors supporting in-house care and cannot be validated. We have previously reported that a number of factors limit the accuracy and completeness of contractor FTE data, see, for example, GAO, *DOD Inventory of Contracted Services: Timely Decisions and Further Actions Needed to Address Long-Standing Issues*, GAO-17-17 (Washington, D.C.: Oct. 31, 2016) and GAO, *Defense Acquisitions: Further Actions Needed to Improve Accountability for DOD's Inventory of Contracted Services*, GAO-12-357 (Washington, D.C.: Apr. 6, 2012). The military average strength does not equal the total DOD due to rounding. The contractor and federal civilian total DOD force does not equal the sum of Army, Navy, and Air Force. The DOD total also includes 3,389 federal civilian FTEs and 2,464 contractors FTEs. These additional personnel are designated to provide services in the National Capital Region Medical Directorate and other DOD entities. Totals may not sum to one hundred percent due to rounding.

Military Departments Face Challenges in Executing Workforce Mixes at Military Treatment Facilities, and DHA Does Not Plan to Develop a Strategy to Address These Challenges

The military departments face challenges to implementing their workforce mix of military, federal civilian, and contractor personnel. Our review, including interviews with military department officials responsible for medical personnel management and with the senior leadership of six MTFs, highlighted, as discussed below, the following distinct challenges: (1) the length of federal civilian hiring and contracting process, (2) uncompetitive federal civilian salaries and contractor compensation, and (3) FTE targets and hiring freezes.

Length of Federal Civilian Hiring and Contracting Process

Federal civilian hiring process. Senior officials at each of the six MTFs we spoke with stated the federal civilian hiring process, including its length and restrictions imposed by statute or policy, impedes their ability to hire desirable federal civilian candidates. Officials primarily attributed delays to the extended time for human resources offices to post a position and to process and refer applicants for interviews. For federal civilian personnel in DOD medical locations in fiscal year 2018, DOD officials reported an average hiring time of: 121 days for the Army, 157 days for the Navy, and 134 days for the Air Force.[57]

Legal restrictions can also extend the hiring process and hinder hiring desirable federal civilian candidates. For example, senior officials at five of six MTFs cited a statute requiring a 180-day waiting period before retired military personnel can be hired as DOD federal civilians and noted valuable candidates with military-specific subject matter expertise will instead seek employment in the private sector.[58] Senior officials from one Air Force MTF stated they successfully submitted waivers to bypass the 180-day waiting period, but senior officials from one Army and one Navy MTF stated that the waiver process often takes as long as the waiting period.

Senior officials from each of the six MTFs stated that hiring authorities, such as direct or expedited hiring authority, can help address challenges, but officials at four of six MTFs also expressed concerns about the adequacy of such flexibilities. Direct-hire authority allows agencies to fill occupations that have a severe candidate shortage or a critical hiring need, and is meant to expedite hiring.[59] DOD designated a number of health care occupations as shortage category positions or critical need

[57]Defense Civilian Personnel Advisory Service officials provided this information, which depicts the average of the overall time-to-hire days for all hiring actions in DOD medical locations and includes medical occupations as well as other support occupations. According to officials, time-to-hire represents the initiation of the request for personnel action and ends with the entrance on duty, and medical locations represent locations where there are personnel supporting the medical community.

[58]Section 3326 of title 5, U.S. Code, requires that 180 days pass before retired military personnel can move into a DOD federal civilian position, unless specific exceptions set forth in the statute apply.

[59]Direct hire authority was included in title XIII of the Homeland Security Act of 2002 and is codified in 5 U.S.C. § 3304(a)(3).

occupations in accordance with this expedited hiring authority.[60] In 2017, DOD reported that it used expedited hiring authority in approximately 30 percent of hiring actions for its medical employees.[61] Officials from one Navy MTF stated they have direct hiring authority, but their human resources office extends the process by requiring that the position be announced within the last 90 days, or else be re-announced, before they can utilize it. Army officials from one MTF stated interest in expanding the list of medical specialties granted direct hiring authority. Air Force officials from one MTF stated direct hire authority can help obtain qualified candidates, but does not necessarily shorten the hiring process.

Challenges in the federal hiring process are a longstanding issue. In 2003, we reported on the need to improve executive agencies' hiring process, with the majority of federal agencies included in our review reporting that it takes too long to hire quality employees.[62] Our 2016 review of the extent to which federal hiring authorities were meeting agency needs found that the Office of Personnel Management (OPM) and other agencies do not know if the authorities are meeting their intended purposes.[63] In 2018, we reported that DOD's review of selected sites, including two MTFs, found: varying use of hiring authorities, management unfamiliarity with all available authorities, and a belief among managers that expanded use of some authorities is needed to produce more quality hires.[64] Finally, our 2018 review of DOD laboratories' use of hiring authorities found that officials used hiring authorities, but identified

[60]Under Secretary of Defense for Personnel and Readiness Memorandum, *Extension of Expedited Hiring Authority for Shortage Category and/or Critical Need Health Care Occupations* (Dec. 14, 2015).

[61]DOD reported this was for the first three quarters of fiscal year 2017. Department of Defense, *Health Care Provider Appointment and Compensation Authorities: Fiscal Year 2017 Interim Report* (Washington, D.C.: Oct. 29, 2017).

[62]GAO, *Human Capital: Opportunities to Improve Executive Agencies' Hiring Processes*, GAO-03-450 (Washington, D.C.: May 30, 2003).

[63]GAO, *Federal Hiring: OPM Needs to Improve Management and Oversight of Hiring Authorities,* GAO-16-521 (Washington, D.C. August 2016).

[64]GAO-18-399.

challenges such as delays in processing the personnel action and the overall length of the hiring process.[65]

Contracting process. Senior officials at five of six MTFs stated there are challenges in obtaining contractor services, including the process time before personnel are available to perform work and restrictions imposed by statute. Senior officials from two Air Force MTFs stated that after the contract is awarded, contractors may have up to 60 days to present a candidate; officials from one MTF stated if the MTF rejects the candidate, then the vendor has another 30 to 60 days to find a candidate. According to officials at one Air Force MTF, at times they have to consider whether to accept a subpar candidate or leave a position vacant. Further, senior Air Force officials stated that controls on contract spending limit their flexibility in hiring. To help fill temporary contract positions, which are less attractive to candidates, officials stated the Air Force pays higher rates to the vendor that include the salaries of the personnel and vendor's overhead costs. In 2018, we reported that DOD's negotiated price of a contract includes direct costs, such as labor and non-labor costs, and indirect costs, such as overhead, and service contractor profit.[66] Senior officials from the two Army MTFs stated that the moratorium on public-private competitions is a challenge because they cannot outsource federal civilian functions to contracted services when there are shortages of military or federal civilian personnel, even when it is the optimal choice. For example, according to officials, contractors cannot perform the functions of a civilian position when a civilian position is vacated.

Uncompetitive Federal Civilian Salaries and Contractor Compensation

Federal civilian employee salaries. Senior officials at each of the six MTFs stated it is a challenge to fill federal civilian medical positions because of lower salaries compared to the private sector. In 2017, DOD reported difficulty hiring and retaining health care workers due to competition from the private sector, among other things.[67] We have

[65]GAO, *DOD Personnel: Further Actions Needed to Strengthen Oversight and Coordination of Defense Laboratories' Hiring Efforts,* GAO-18-417 (Washington, D.C.; May 2018).

[66]GAO-18-399.

[67]Department of Defense. *Health Care Provider Appointment and Compensation Authorities: Fiscal Year 2016* (Washington, D.C.: Feb. 27, 2017).

previously reported challenges related to the ability to provide competitive salaries for some DOD health care providers. Specifically, in 2015 we reported that officials from all three military departments stated their inability to create compensation packages for federal civilian mental health providers to compete with the private sector affected their recruiting and retention of providers.[68] In 2018, we noted similar concerns in recruiting military physicians.[69]

Senior officials from each of the six MTFs we spoke with stated that the ability to utilize hiring flexibilities, such as special salary rates, helps mitigate this challenge, but at four of six MTFs also expressed concerns about their adequacy. To provide higher pay for some occupations, OPM may establish a higher salary rate for an occupation or group of occupations in one or more geographic areas to address existing or likely significant handicaps in recruiting or retaining well-qualified employees.[70] Senior officials from four of six MTFs stated special salary rates are helpful but not sufficient. Officials at one Navy MTF noted that two primary care providers left within the last year for better pay in the private sector, negatively affecting access to care. Officials at one Army MTF noted that the application for special salary rates can take 2 years or more, and therefore may not address short-term hiring needs. Further, officials from one Navy MTF stated they continue to face difficulty hiring for positions allowed special salary rates, such as pharmacist and registered nurse positions. Our 2017 review of federal agency use of special payment authorities approved by OPM—such as special salary rates—found that agencies reported that access to authorities had positive effects—such as on staff retention and applicant quality—but had few documented effectiveness assessments.[71]

DOD is also authorized to offer DOD health care personnel a number of salary rates established for Veterans Health Administration (VHA)

[68]GAO, *Defense Health Care: Additional Information Needed About Mental Health Provider Staffing Needs,* GAO-15-184 (Washington, D.C.: January 2015).

[69]GAO-18-77.

[70]5 U.S.C. § 5305; 5 C.F.R. §§ 530.301-323 (2018).

[71]GAO, *Federal Pay: Opportunities Exist to Enhance Strategic Use of Special Payments,* GAO-18-91 (Washington, D.C.: December 2017).

personnel.[72] For example, DOD established a civilian physicians and dentists pay plan using this authority.[73] However, officials stated concerns about the rates' usefulness. Senior officials from one Air Force hospital noted that although the VHA salary levels are higher than the General Schedule levels that DOD typically offers, they may not be competitive with the private sector. Moreover, senior officials from one Army MTF expressed an interest in accessing VHA salary rates for additional occupations because Army personnel often leave to work at a nearby Veterans Affairs hospital for higher pay. In 2017, we reported on VHA physician recruitment and retention strategies and officials from the six VA medical centers in our review stated that physician salaries were often below those offered by local private sector, academic, and some state government employers.[74]

Contractor compensation. Senior officials from five of six MTFs stated private sector contractor vendors face the same challenges as the government regarding uncompetitive salaries. As a result, some contracts have low fill rates or go unfilled. For example, senior officials at one Navy MTF said one of its vendors has not been able to fill a clinical pharmacy position for more than a year. Additionally, senior officials at the other Navy MTF we spoke with stated that a vendor was not meeting its local needs because the fill rate at their MTF is lower than the average fill rate across all Navy MTFs, which is what the vendor is required to meet. Further, senior officials at two of six MTFs—one Navy and one Air Force—stated some of their vendors have attempted to fill positions by sending multiple providers on a part-time basis to fill the equivalent of one

[72]OPM, under the authority of sections 1104 and 5371 of title 5, United States Code, authorized DOD to use certain personnel authorities for health care occupations under title 38, United States Code, chapter 74, subject to certain requirements and restrictions. *Delegation Agreement Between the Office of Personnel Management and the Department of Defense on the Use of Title 38 Authorities* (July 1, 2012).

[73]Department of Defense Instruction 1400.25, vol. 543*, DOD Civilian Personnel Management System: DOD Civilian Physicians and Dentists Pay Plan (PDPP)* (Feb. 12, 2018). In 2017, DOD reported that it had approximately 2,200 physicians and dentists under the PDPP. Department of Defense, *Health Care Provider Appointment and Compensation Authorities: Fiscal Year 2017 Interim Report* (Washington, D.C.: Oct. 29, 2017).

[74]GAO, *Veterans Health Administration: Better Data Evaluation Could Help Improve Physician Staffing, Recruitment, and Retention Strategies,* GAO-18-124 (Washington, D.C.: October 2017).

full-time position; they noted the part-time assignments are undesirable and can affect the quality of care.

FTE Targets and Hiring Freezes

Federal civilian FTE targets. Headquarters officials from each of the military departments stated that federal civilian FTE targets are a barrier to effective workforce mix management because they reduce flexibility in utilizing the most efficient personnel type to accomplish the beneficiary mission of the MHS. From fiscal years 2012 to 2017, OSD guidance directed the military departments to manage to a federal civilian FTE target.[75] These targets were intended to prevent an increase in the size of the federal civilian workforce, even when federal civilians' performance of work is most cost-effective. For example, Air Force headquarters officials stated that due to the federal civilian FTE target, they generally default to hiring contractor personnel when new personnel needs arise. Further, Air Force headquarters officials stated they have not pursued in-sourcing of some contracted functions even though such actions might result in cost savings.

The federal civilian FTE targets had varying effects on the operations of the six MTF's we spoke with. Senior officials at two of six MTFs—one Navy and one Air Force—stated that they have not been adversely affected by the federal civilian FTE targets because the relatively high number of vacancies in their funded federal civilian positions means that they never exceed their target. Conversely, officials at one Air Force MTF stated they have considered hiring additional private sector contractor services when they reach their allowed federal civilian FTEs.

During the course of our review, DOD issued its National Defense Business Operations Plan for Fiscal Years 2018 to 2022, which states that it would discontinue the use of federal civilian FTE targets because they acted as artificial and arbitrary constraints on the workforce, and encouraged the military departments to utilize hiring flexibilities to identify the most appropriate and economical personnel type to achieve their mission.[76] In 2002 we reported that federal hiring policies should, among

[75]According to senior DOD officials, this policy was prompted by DOD's efficiency initiatives first announced in 2010.

[76]DOD. *FY18-FY22 National Defense Business Operations Plan* (Washington, D.C.: April 2018)

other things, avoid arbitrary full-time equivalent or other arbitrary numerical goals.[77]

Federal civilian hiring freezes. Senior officials at five of six MTFs stated that federal civilian hiring freezes adversely affect MTF operations. As part of planning for sequestration in fiscal year 2013, DOD imposed hiring freezes on federal civilian personnel.[78] Further, there was a federal civilian hiring freeze from January 2017 to April 2017.[79] Senior officials from three of six MTFs reported that hiring freezes lower morale and elongate the already lengthy hiring process, even when they are granted waivers to continue to hire. Further, senior officials from one Army MTF stated hiring freezes limit their ability to shape their workforce, and often result in higher costs when they increase the size of their contracted workforce in accordance with their needs. We reported in 2018 that defense laboratory officials we surveyed identified government-wide hiring freezes as a challenge to hiring candidates, stating that candidates accepted other offers due to delays created by the freeze and that hiring efforts continue to be adversely affected even after a freeze is lifted.[80]

These three key hiring challenges limit the military departments' ability to strategically consider the advantages of converting one source of support to another, and limit their ability to hire the appropriate personnel type or for contract vendors to fill positions. According to senior MTF officials, these key hiring challenges and low fill rates in some areas can result in personnel gaps that can adversely affect the operations of MTFs. When personnel gaps arise, officials stated, military personnel often must work additional hours or must be borrowed from other facilities. Senior officials from one Navy MTF cited the example of a cost of about $16,000 in travel expenses for the temporary transfer of an active duty nurse stationed in

[77]GAO, *Commercial Activities Panel: Improving the Sourcing Decisions of the Federal Government*, GAO-02-847T (Washington, D.C.: September 2002).

[78]On March 1, 2013, pursuant to the Balanced Budget and Emergency Deficit Control Act of 1985, Pub. L. No. 99-177 (1985), as amended by the Budget Control Act of 2011, Pub. L. No. 112-25 (2011), the President ordered the sequestration of budgetary resources across the federal government. DOD's discretionary budget was reduced by about $37.2 billion, or about 7 percent in fiscal year 2013.

[79]*Presidential Memorandum on the Hiring Freeze*, 82 Fed. Reg. 8493 (Jan. 23, 2017); OMB, *Comprehensive Plan for Reforming the Federal Government and Reducing the Federal Civilian Workforce*, M-17-22 (Apr. 12, 2017).

[80]GAO-18-417.

Japan to work for a MTF in the United States for 3 months because the MTF was not able to fill the position by other means. Additionally, senior officials from one Air Force MTF noted that morale of its military staff is negatively affected by extra hours and additional responsibilities placed on them to ensure continued operations.

Further, officials stated that personnel gaps can negatively affect care. Due to concerns about patient safety, MTFs may decide to discontinue some services at MTFs. Senior officials from five of six MTFs reported discontinuing some services as a result of these challenges and referred patients to the TRICARE network or to Veterans Affairs facilities. Referring patients to the private sector can have secondary effects on MTF operations, such as on hospital accreditations. Senior officials from one Navy MTF noted that in the past fiscal year they had to refer patients to private sector care after two hematology-oncology physicians resigned, which may affect their hematology-oncology program's accreditation. Senior officials at the other Navy MTF stated that in the last fiscal year they could not meet the minimum staffing standards for labor and delivery staff and therefore sent patients to the TRICARE network. They noted they are also having difficulty filling key administrative positions related to quality control of laboratory services and are concerned about maintaining their pathology program accreditation.

Senior officials from MTFs reported varying fill rates for military and civilian personnel, and for the contractor personnel provided by private sector vendors.[81] However, officials from the MTFs we spoke with stated that fill rates may not illustrate the availability of personnel. For example, officials stated that authorizations for military personnel are counted as filled even when a servicemember is deployed and therefore not working at the MTF. In addition, MTF officials stated that any on-board civilians without corresponding authorizations inflate the civilian fill rate, resulting in a fill rate of greater than 100 percent. In addition, DOD officials noted that DOD pays for contracted services and does not directly employ contractor personnel. Therefore, the fill rate for contractors represents either the number of authorized FTEs in the individual contract or positions filled by contactors noted on the MTF's force planning document, which could also result in fill rates of greater than 100 percent,

[81]We did not assess the reliability of the MTFs self-reported fill rate data. For military and federal civilian personnel, the fill rate represents the number of personnel on-hand (i.e. inventory) divided by the number of personnel authorized to work at the MTF.

even as other positions remain unfilled. The MTFs that we spoke with reported the following fill rates:

- **Two Navy MTFs.** The fill rates for military personnel, federal civilian personnel, and funded positions designated for contracted services were 79 percent, 81 percent, and 94 percent, respectively, at one Navy MTF[82] and 93 percent, 53 percent, and 62 percent, respectively, at the other MTF. [83]
- **Two Air Force MTFs.** The fill rates for military personnel, federal civilian personnel, and funded positions designated for contracted services were 98 percent, 86 percent, and 91 percent, respectively at one Air Force MTF[84] and 94 percent, 74 percent, and 90 percent, respectively at the other MTF.[85]
- **Two Army MTFs.** The fill rates for military personnel, federal civilian personnel, and funded positions designated for contracted services were 91 percent, 118 percent, and 87 percent, respectively at one Army MTF.[86] At the other MTF, the fill rate for military personnel fill rate was 94 percent and for federal civilian personnel was 107 percent, but the MTF officials did not provide fill rate information for

[82]According to officials, data are as of July 2018, and military personnel information includes active duty members only, information for health care providers and nurses only, and contractor authorizations represent authorizations documented on the activity manpower document.

[83]According to officials, data represent fiscal year 2018, military personnel information includes active duty members only, and contractor authorizations represent FTEs authorized on each contract.

[84]According to officials, data represent fiscal year 2017 and include 9 federal civilian over hires or overages. Further, officials stated that contractor authorizations represent FTEs authorized on each contract.

[85]According to officials, data represent fiscal year 2018, and generally exclude residents, students, federal civilian over hires, and contracts funded outside of the normal budgeting process. Further, officials stated that contractor authorizations represent FTEs authorized during the budgeting process.

[86]According to officials, data represent fiscal year 2018, 10 military personnel are in training positions that do not have corresponding authorizations, and contractor authorizations represent FTEs authorized on each contract.

positions designated for contracted services because there are no corresponding authorizations on their force planning document. [87]

DOD has been taking some steps to attempt to address these key hiring challenges. Specifically, DOD's 2016 Strategic Workforce Plan included steps DOD was taking to address personnel gaps, such as a targeted recruitment program for critical skills, including 27 harder-to-fill medical occupations. In 2018, DOD published a Human Capital Operating Plan which states that it replaces the previously required Strategic Workforce Plan, but DOD does not yet have a plan of action specific to the medical professions.[88] Further, DOD officials stated that components are encouraged to consider developing their own human capital operating plans. With regard to contracting, in response to a requirement in the National Defense Authorization Act for Fiscal Year 2017, DOD issued a status report in January 2018 on the development of its acquisition strategy for health care services at MTFs.[89] The report notes that contracting for health care services is fragmented, and the report outlines DOD's plan to move toward a single contract vehicle for health care services and to establish metrics for the strategy, such as measurement of contract fill rates.[90]

While these steps represent efforts to address these challenges, responsibility for management of the federal civilian and contractor workforces within the MHS will soon see significant changes. Specifically, in December 2016, Congress directed the transfer of administrative responsibility for MTFs from the military departments to the DHA.[91] Further, Congress amended the law in 2018 to specify that the transfer

[87]According to officials, data represent fiscal year 2018 and the federal civilian fill rate is over 100 percent because it includes 235 federal civilian over hires that do not have a corresponding authorization on the force planning document.

[88]The Human Capital Operating Plan supports the National Defense Business Operations Plan—a supplement to the National Defense Strategy—and is part of an ongoing DOD effort to align and implement human capital strategy with overall performance strategy. Effective April 11, 2017, OPM updated 5 C.F.R. § 250 subpart B to replace the previously required strategic human capital plan and DOD Strategic Workforce Plan with the Human Capital Operating Plan.

[89]Pub. L. No. 114-328, § 727 (2016).

[90]DOD, *Report on Section 727 of the National Defense Authorization Act for Fiscal Year 2017 (Public Law 114-328)* (Washington, D.C.: Jan. 11, 2018).

[91]Pub. L. No. 114-328, § 702 (2016) (codified as amended at 10 U.S.C. § 1073c).

should be completed by September 30, 2021.[92] The law also states that at each MTF, the Director of the DHA has the authority to determine total workforce requirements, direct joint manning, and address personnel staffing shortages, among other things.

Although the DHA will soon begin to assume these responsibilities and the challenges associated with them, a senior OASD(HA) official responsible for human capital issues stated that the DHA currently has no strategic total workforce plan, or similar document, to help ensure execution of an appropriate workforce mix at its MTFs. According to GAO's key questions to assess agency reform efforts, strategic workforce planning should precede any staff realignments or downsizing, so that changed staff levels do not inadvertently produce skills gaps or other adverse effects that could result in increased use of overtime and contracting.[93] GAO's key principles for effective strategic workforce planning and applicable federal regulations have shown that addressing a critical human capital challenge—such as closing or reducing personnel gaps—requires tailored human capital strategies and tools and metrics by which to monitor and evaluate progress toward reducing gaps.[94] Although many hiring challenges are longstanding government-wide issues, GAO's model of strategic human capital management states that agencies need not wait for comprehensive civil service reform to modernize their human capital approaches.[95] In addition, according to OPM's standards for strategic workforce planning, human capital strategies should be integrated with acquisition plans, among other things, such as DOD's acquisition strategy for health care services at MTFs.[96]

As the DHA finalizes its plans for assuming administrative control of MTFs, senior leaders may find that they face the same challenges reported by the military departments in executing an appropriate workforce mix. DHA could mitigate these challenges to executing the

[92]Pub. L. No. 115-232, § 711 (2018) (codified at 10 U.S.C. § 1073c).

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

[94]GAO-04-39; and 5 C.F.R. § 250.204 (2018).

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

[96]5 C.F.R. § 250.203 (2018).

appropriate workforce mix in the MTFs by engaging in strategic workforce planning, including tailored human capital strategies, tools, and metrics by which to monitor and evaluate progress toward reducing gaps, and integrating this planning with DOD's acquisition strategy for health care services at MTFs.

The Military Departments and DHA Have Not Decided How Military Personnel Will Meet Operational and Beneficiary Missions after the Transfer of Administrative Responsibility for MTFs to DHA

The planned transfer of administrative responsibility for MTFs from the military departments to the DHA may present challenges to DOD's management of military personnel. Specifically, the military departments and DHA have not determined how military personnel will meet both the operational and beneficiary missions of the MHS after the transfer of administrative responsibility for MTFs to the DHA. Historically, each military department has been responsible for managing its military personnel to ensure it meets its operational mission and appropriately staffs its MTFs, and the challenge of balancing these missions was the responsibility of each respective military department. However, the transfer of administrative responsibility for MTFs to the DHA will separate these missions—the operational mission will be the responsibility of the military departments, and the beneficiary mission will be the responsibility of the DHA, with military personnel used to support both missions. The plan for transfer of administrative responsibility for MTFs to the DHA states that the military departments will retain ultimate control over military personnel, who will work within the MTFs on a day-to-day basis to maintain their readiness to provide operational medical care, while the DHA will eventually assume responsibility for federal civilian and contractor personnel and all other aspects of MTF management.[97] DOD officials stated that the planned transfer will allow the military departments to focus their attention on readiness to provide operational medical care, while the DHA will focus its attention on efficient management of beneficiary health care operations.[98] As a result of this separation of missions, challenges in the management of military personnel could be

[97]DOD, *Final Plan to Implement 1073c of Title 10, United States Code Final Report,* (June 30, 2018).

[98]*Final Plan to Implement 1073c of Title 10, United States Code Final Report.*

exacerbated by transfer of responsibility for achieving these missions to separate organizations in the following three ways.

First, DHA and the military departments have not clearly identified how they will manage the assignment of military personnel to MTFs. The implementation plan for transfer of administrative responsibility for MTFs to the DHA states that the departments will continue to be responsible for assignment of military personnel to MTFs. However, DOD's stated desire to place greater emphasis on the readiness mission may affect current MTF staffing practices. For example, military department officials told us that it is common practice to assign military personnel to locations that face challenges in hiring federal civilian and contractor medical personnel to maintain access to medical care in these locations. However, the transfer implementation plan states that the departments will provide military personnel to the MTFs only to the extent that the MTFs can provide sufficient workload to maintain providers' military medical Knowledge, Skills, and Abilities (KSAs). KSAs are a metric for military operational readiness that DOD has not yet finalized. Officials responsible for planning the transfer of administrative responsibility for MTFs to the DHA stated that the emphasis on fulfilling KSAs in the future may result in concentrating military providers in larger MTFs, which can provide opportunities for providers to fulfill KSAs. However, this change could create a disadvantage for smaller facilities, which may not be able to provide military providers with as much practice and already face challenges in hiring federal civilian and contractor personnel.

Second, DHA and the military departments have not clearly identified how they will mitigate the effect of deployments of military medical personnel on MTF operations. When medical personnel are deployed out of MTFs to provide operational care, their absence can create a gap or reduction in capability at the affected MTF, according to military department officials. The military departments, prior to the transfer, manage deployments and are responsible for ensuring appropriate staffing at the MTFs in the absence of deployed personnel. Officials at all six of the MTFs we visited cited challenges with mitigating the effect of deployments on MTF operations. DOD has stated that after the transition, there will be no barriers to the military departments' access to personnel for deployment, and has highlighted options for addressing staffing gaps, such as using borrowed military personnel, contractors, or referral to the TRICARE network. However, officials at all six of the MTFs we spoke with stated that contracting for medical services was not sufficiently timely or effective, and officials at one MTF noted that referral to the TRICARE network was difficult in their area.

According to officials within the MTFs of the National Capital Region, which is directly managed by the DHA and not the military departments, management of deployments and their adverse effect on hospital staffing has been a challenge. For example, officials cited a period in the summer of 2017 when, due to overlapping deployments across military departments, 8 of 9 general surgeons at Fort Belvoir Community Hospital in Virginia were simultaneously deployed, and patients had to be referred to private providers within the TRICARE network or sent to Walter Reed National Military Medical Center in Maryland.

Although the military departments and the DHA have executed a Memorandum of Agreement concerning coordination for service personnel to fill scheduled deployments, this does not always prevent gaps in medical specialties. For example, officials noted that requests for volunteer deployments are not always vetted through NCR management. Further, addressing these gaps can be challenging. Specifically, officials cited difficulties in successfully contracting for medical services and reported that requests for backfill support from the reserve components has associated costs and is difficult to execute.

Third, DHA and the military departments have not clearly identified how they will manage changes to the size or composition of the active duty medical workforce that affect workforce balance within MTFs. Since 2008, the military departments have been prohibited from converting medical positions designated for military personnel to positions that can be filled by federal civilians—even when such conversions would result in cost savings.[99] Air Force headquarters officials noted that they have identified more than 4,000 medical positions to review for possible conversion to achieve cost savings, particularly in medical specialties with excess military personnel, such as family practice and pharmacy. Air Force officials previously identified 4,724 positions for conversion beginning in fiscal year 2005, of which 1,449 were completed before the prohibition was enacted. The Army planned to convert 4,340 military positions from fiscal year 2006 through fiscal year 2011, of which 1,459 were completed before the prohibition was enacted. The Army restored 165 of planned conversions for fiscal year 2007, and reversed, or offset the remaining through growth in the active duty medical force after the prohibition was enacted.

[99]Pub. L. No. 110-181, § 721 (2008).

The National Defense Authorization Act for Fiscal Year 2017 allows for the prohibition on such conversions to be lifted after DOD submits a report that defines the military medical and dental requirements necessary to meet operational medical force readiness requirements, and lists the positions necessary to meet such requirements.[100] However, decisions on conversions taken by the departments could affect MTF operations. Specifically, existing challenges with hiring federal civilian personnel could create challenges with military-to-civilian conversions. For example, DOD has stated that during the previous round of military to federal civilian conversions, changes in local market conditions affected the ability of the military departments to fill converted positions with civilians in a timely fashion.[101] Medical headquarters officials the Army stated that they currently have no intention to use conversions if the prohibition is lifted; Navy officials stated they currently do not plan to use conversions since their military personnel requirements exceed their authorizations. Senior officials from one Navy MTF we spoke with stated that if conversions occurred, recruitment and retention challenges related to hiring federal civilian employees would need to be addressed to ensure such positions are filled.

In addition, military department policies can affect workforce balance within MTFs. Specifically, in its modeling for operational medical personnel requirements, the Air Force includes a preference for uniformed personnel to receive primary care from uniformed medical personnel. Officials told us that this approach, known as the Critical Home Station, is because Air Force leadership believes that performance of this function by military personnel provides for increased accountability for medical readiness. For example, senior officials from one Air Force MTF stated they believe the policy is important for the Air Force to maintain access to information about health factors that could render a servicemember not medically qualified to deploy. Air Force medical headquarters officials estimate that the policy results in 2,000 positons reserved for military personnel that could be designated for federal civilian or contractor performance.

Leading practices for results-oriented government state that cooperating federal agencies need to sustain and enhance their collaboration in several ways, including the development of policies and procedures to

[100]Pub. L. No. 114-328, § 721 (2016).

[101]DOD, *Military Health System Modernization Study Team Report* (May 29, 2015).

operate across agency boundaries and agreement on their respective roles and responsibilities.[102] However, planning for the transition by the DHA and the military departments has not yet included development of policies and procedures for management of military personnel and agreement on specific roles and responsibilities for the military departments and the DHA in this process. The MHS process for collaborating across agency boundaries, known as MHS Governance, emphasizes collaborative work in the management of the MHS. This forum could provide an opportunity for the military departments and the DHA to develop policies and procedures for management of military personnel and agree on specific roles and responsibilities for the military departments and the DHA in this process. Until DHA and the military departments develop such policies and procedures and agrees on roles and responsibilities, the MHS may continue to face a number of challenges related to the transfer of administrative responsibility for MTFs to the DHA.

Conclusions

Given the size of the MHS, its central importance to the success of DOD's mission, and its cost, having the right mix of military, federal civilian, and contractor personnel providing medical care within MTFs and in deployed operational settings should be a key priority for DOD leadership. While the military departments have policies and procedures in place to assess medical workforce mix in both settings, the shortcomings we have highlighted present barriers to achieving an appropriate workforce mix. Recently, such as in the 2018 National Defense Business Operations Plan, DOD has emphasized the need to reassess who can most efficiently perform all aspects of DOD's mission. However, the military departments' planning processes for operational medical personnel requirements continue to rely solely on military personnel, despite the use of federal civilians and contractors in operational settings, and the military departments have not developed full information on the cost of their medical forces and incorporated such information into decision-making processes about the mix of active and reserve component personnel. Similarly, the transfer of administrative responsibility for MTFs to the DHA represents an opportunity to reassess workforce mix at the MTFs.

[102]GAO, *Practices That Can Help Enhance and Sustain Collaboration among Federal Agencies*, GAO-06-15 (Washington, D.C.: Oct. 21, 2005).

However, long-standing challenges in the management of federal civilian and contractor personnel, coupled with challenges related to the management of medical personnel after the transfer, could overshadow and cast doubt on the success of that reform. Without addressing the concerns we have highlighted, DOD may miss the opportunity presented by current transformation efforts in the MHS to ensure it has in place the most cost-effective mix of personnel in its workforce to accomplish its medical mission.

Recommendations for Executive Action

We are making five recommendations to the Department of Defense.

The Secretary of Defense should ensure that the Assistant Secretary of Defense for Health Affairs, in coordination with the military departments, perform an assessment of the suitability of federal civilian and contractor personnel to provide operational medical care and incorporate the results of the assessment into relevant policies, if warranted. (Recommendation 1)

The Secretary of Defense should ensure that the Under Secretary of Defense for Personnel and Readiness require consideration of cost when making determinations regarding the mix of active and reserve component medical personnel. (Recommendation 2)

The Secretary of Defense should ensure that the Assistant Secretary of Defense for Health Affairs, in collaboration with the Director of Cost Assessment and Program Evaluation and the military departments, develop full cost information for active and reserve component medical personnel, and the military departments use that information in its determinations regarding the mix of active and reserve component medical personnel. (Recommendation 3)

The Secretary of Defense should ensure that the Director of the Defense Health Agency develop a strategic total workforce plan which includes, among other things: (1) tailored human capital strategies, tools, and metrics by which to monitor and evaluate progress toward reducing personnel gaps, and; (2) integration of human capital strategies with acquisition plans, such as DOD's acquisition strategy for health care services at DOD's military treatment facilities. (Recommendation 4)

The Secretary of Defense and the Secretaries of the Army, the Navy, and the Air Force, respectively, should ensure that accompanying the transfer of administrative responsibility for military treatment facilities to the Defense Health Agency, that the Defense Health Agency and the military departments develop policies and procedures for management of military personnel, including agreement on specific roles and responsibilities for the military departments and the Defense Health Agency in this process. (Recommendation 5)

Agency Comments

In written comments on a draft of this report, DOD concurred with our five recommendations concerning additional assessments needed to better ensure an efficient MHS total workforce. DOD's comments are reprinted in appendix II.

We are sending copies of this report to the appropriate congressional committees, the Secretary of Defense, the Under Secretary of Defense for Personnel and Readiness, the Assistant Secretary of Defense for Health Affairs, the Director of Cost Assessment and Program Evaluation, the Director of the Defense Health Agency, and the Secretaries of the Army, the Navy, and the Air Force. In addition, this report will be available at no charge on the GAO website at http://www.gao.gov.

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

Brenda S. Farrell
Director
Defense Capabilities and Management

Appendix I: Scope and Methodology

To address the extent to which the military departments' planning process for operational medical personnel requirements have assessed the mix of federal civilian, contractor, active and reserve medical personnel (i.e. workforce mix), we compared the military departments' efforts in planning for operational medical personnel requirements to the Department of Defense (DOD) and department-level policies and guidance on workforce mix determination and identifying the full cost of its military medical personnel. DOD Directive 1100.4 states that authorities should consider all available sources when determining workforce mix.[1] DOD Instruction 1100.22 directs the steps that workforce planning authorities must take in planning for personnel requirements and emphasizes consideration of all potential workforce sources and an accurate understanding of personnel costs.[2] We also reviewed related DOD documentation on identifying military essential positons and the use of alternative workforces. Specifically, DOD's National Defense Business Operations Plan for fiscal years 2018 through 2022 states that workforce rationalization strategies include, among other things, reassessing military manpower allocations for military essentiality and identifying functions and positions that are commercial in nature that may be appropriately or efficiently delivered via private sector support.[3] Moreover, DOD's 2017 Workforce Rationalization Plan recognizes DOD's civilians as an essential enabler of its mission capabilities and operational readiness and noted that there are numerous opportunities for the military departments, combatant commands, and others to make well-reasoned adjustments to workforce mix.[4]

[1]Department of Defense Directive 1100.4, *Guidance for Manpower Management* (Feb. 12, 2005).

[2]Department of Defense Instruction 1100.22, *Policy and Procedures for Determining Workforce Mix* (Apr. 12, 2010) (incorporating change 1 Dec. 1 2017).

[3]Department of Defense, *FY 2018-FY 2022 National Defense Business Operations Plan* (Apr. 9, 2018).

[4]Department of Defense, *DOD Workforce Rationalization Plan* (Dec. 12, 2017).

To determine the extent to which federal civilians and contractors were deployed to provide medical care we reviewed federal civilian and contractor deployment data from fiscal years 2013 through 2017.[5] We analyzed data for this timeframe to enable us to identify deployments over the last 5 years, and fiscal year 2017 was the most recent full fiscal year of available data at the time of our review. To assess the reliability of these data, we electronically tested the data to identify obvious problems with completeness or accuracy and interviewed knowledgeable agency officials about the data. We found the data to be limited in that the deployment data may not be sufficiently reliable for identifying the universe of deployments. However, we found the data to be sufficiently reliable for the purposes of reporting that federal civilians and contractors have been deployed to provide medical care. Further, we interviewed officials from the Office of the Under Secretary of Defense for Personnel and Readiness (USD(P&R)), Office of the Assistant Secretary of Defense for Health Affairs (OASD(HA)), Defense Civilian Personnel Advisory Service, the military departments, and selected combatant commands to identify considerations and any challenges of using different personnel categories as workforce alternatives for meeting operational medical requirements.[6]

To determine the appropriate use of the active and reserve components for DOD's operational medical personnel military requirements, we compared the military departments' efforts in assessing their active and reserve balance to DOD and department-level policies and guidance. Specifically, in a 2013 DOD report issued in response to section 1080A of the National Defense Authorization Act for Fiscal Year 2012, DOD established five factors that play a key role in active and reserve component balance decisions, including the cost of unit manning, training, and equipping. According to the report, cost is often outweighed by other factors when making active component and reserve component mix decisions, but should always be considered in active component and reserve component mix decisions. DOD Instruction 7041.04 has guidance

[5]To determine whether federal civilians and contractors were deployed to provide medical care, we reviewed data from the Defense Manpower Data Center. Specifically, to identify deployed federal civilians we used data from the Civilian Deployment System and to identify deployed contractors we reviewed data from the Synchronized Predeployment and Operational Tracker. These data may not be sufficiently reliable for identifying the universe of deployments.

[6] For this review we selected two combatant commands (U.S. Central Command and U.S. Africa Command) in order to get their perspectives regarding workforce mix in theater.

for military departments to use to identify the full cost of their active component, federal civilian, and contractor workforces.[7] Moreover, we interviewed officials from the military departments to discuss: (1) how they determine their operational medical requirements and if they identified the full cost of active and reserve component medical personnel, and (2) the use of the active and reserve components for operational requirements and any efforts to assess the balance of active and reserve component medical personnel.

To determine the mix of active and reserve component medical personnel, we analyzed authorization data from the Health Manpower and Personnel Data System for fiscal year 2017. We analyzed data for fiscal year 2017 because this was the most recent year of available data at the time of our review. To assess the reliability of these data, we electronically tested the data to identify obvious problems with completeness or accuracy and interviewed knowledgeable agency officials about the data. We found the data to be sufficiently reliable for reporting on the allocation of authorizations for active and reserve component medical personnel.

To address how the military departments determine the most appropriate workforce mix at military treatment facilities (MTFs) and any challenges in executing an appropriate workforce mix, we reviewed DOD and department-level policies and guidance on workforce mix determination. We also reviewed the military departments' efforts in planning, staffing, and filling MTF requirements. We spoke with knowledgeable officials from the Office of the USD(P&R), OASD(HA), DHA, and the military departments and requested documentation related to how they oversee or implement legal or policy requirements, such as DOD Instruction 1100.22's manpower mix criteria, and the annual inventory of inherently governmental and commercial activity. To determine the proportion of reported military, federal civilian, and contractor personnel providing or supporting care in MTFs, we obtained budgetary data for fiscal year 2017, which was the most recent full fiscal year of available data at the time of our review. To assess the reliability of these data, we compared them to the information reported in the fiscal year 2017 Defense Health Program justification estimates published in February 2018 to identify key differences and interviewed knowledgeable agency officials about the

[7] Department of Defense Instruction 7041.04, *Estimating and Comparing the Full Costs of Civilian and Active Duty Military Manpower and Contract Support* (July 3, 2013).

data. We found the data to be sufficiently reliable for the purposes of describing workforce mix of military, federal civilian, and contractor personnel within MTFs.

To understand how policies and procedures to determine and execute an appropriate workforce mix are implemented at MTFs, we interviewed military department medical command or agency officials responsible for implementing DOD total force policy. To better understand policy and procedure implementation at MTFs we selected six MTFs - two each from the Army, Navy, and Air Force - to allow a cross-section of views concerning the management of the military departments' workforce mix at the MTFs and hiring conditions in different types of labor markets.[8] The two MTFs from each military department were selected based on consideration of average daily patient load and MTF bed size, which we obtained from the Defense Health Agency.

For each MTF, we interviewed officials responsible for the leadership and management of MTF personnel and operations and requested and reviewed relevant documentation. We reviewed their responses, which highlighted some challenges related to achieving an appropriate workforce mix, and DOD's plans for addressing these challenges. We compared these to GAO's key questions to assess agency reform efforts, which note that strategic workforce planning should precede any staff realignments or downsizing,[9] and GAO's key principles for effective strategic workforce planning, which state that addressing a critical human capital challenge—such as closing or reducing personnel gaps—requires tailored human capital strategies and tools and metrics by which to monitor and evaluate progress toward reducing gaps.[10] We also reviewed these plans in light of OPM's standards for strategic workforce planning, which note that human capital strategies should be integrated with acquisition plans, among other things, such as DOD's acquisition strategy

[8] We selected the following six MTFs for interviews: (1) Brooke Army Medical Center at Joint Base San Antonio, TX; (2) Carl R. Darnall Army Medical Center in Ft. Hood, TX; (3) Naval Medical Center Portsmouth in Portsmouth, VA; (4) Naval Hospital Twentynine Palms in Twentynine Palms, CA; (5) David Grant Medical Center in Travis AFB, CA; and (6) Air Force Hospital Langley in Hampton, VA.

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

[10] GAO-04-39; and 5 C.F.R. § 250.204 (2018).

for health care services at MTFs.[11] Finally, we requested from officials at each MTF information on personnel inventory and authorizations to understand their ability to fill military and civilian positions, and the contract vendors' ability to fill positions designated for contracted services.

We also reviewed how the planned transfer of administrative responsibility for MTFs from the military departments to the DHA might affect DOD management of military personnel within the MHS. To identify (1) responsibilities of the military departments that may be transferred to the DHA, and (2) challenges that may continue under the new organizational structure, we reviewed relevant documentation and interviewed knowledgeable officials. To understand potential challenges related to the assignment of military personnel to MTFs, we interviewed military department officials responsible for the assignment of military personnel. To identify how deployments affect MTF operations, if at all, we interviewed officials responsible for the leadership and management of MTF personnel and operations. Lastly, to understand how the military departments manage the size and composition of the active duty medical workforce, we requested documentation related to the development of operational personnel requirements and interviewed knowledgeable officials. We also reviewed previous efforts to alter the size or composition of the active duty medical workforce, such as military to civilian conversions. We compared DOD's efforts to plan for these challenges to leading practices for results-oriented government, which state that cooperating federal agencies need to sustain and enhance their collaboration in several ways, including the development of policies and procedures to operate across agency boundaries and agreement on their respective roles and responsibilities.[12]

We conducted this performance audit from September 2017 to November 2018 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.

[11]5 C.F.R. § 250.203 (2018).

[12]GAO, *Practices That Can Help Enhance and Sustain Collaboration among Federal Agencies*, GAO-06-15 (Washington, D.C.: Oct. 21, 2005).

Appendix II: Comments from the Department of Defense

MANPOWER AND
RESERVE AFFAIRS

OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
1500 DEFENSE PENTAGON
WASHINGTON, D.C. 20301-4000

NOV - 8 2018

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

Dear Ms. Farrell,

This is the Department of Defense (DoD) response to the GAO Draft Report GAO-19-102, "Defense Health Care: Additional Assessments Needed to Better Ensure an Efficient Total Workforce," dated October 5, 2018 (GAO Code 102291).

As you know, the Military Health System (MHS) is the subject of a number of ongoing transformation efforts, as the result not only of internal Departmental reform, but also Congressional oversight and interest. The Department welcomes the GAO's contributions to these efforts, which will help to build a more efficient and effective MHS.

The Department's responses to the specific recommendations made by the GAO are in the enclosure. We look forward to continuing to work with the GAO in this area, and appreciate the opportunity to engage with you and your team throughout this process. Should you have any questions, please contact my primary action officer for this engagement, Mr. Jason Beck who can be reached at jason.m.beck10.civ@mail.mil and phone (703) 697-1735.

Sincerely,

Lernes Hebert
Acting Director, Total Force Manpower & Resources

GAO DRAFT REPORT DATED OCTOBER 5, 2018
GAO-19-102 (GAO CODE 102291)

"DEFENSE HEALTH CARE: ADDITIONAL ASSESSMENTS NEEDED TO BETTER ENSURE AN EFFICIENT TOTAL WORKFORCE"

DEPARTMENT OF DEFENSE COMMENTS TO THE GAO RECOMMENDATION

RECOMMENDATION 1: The GAO recommends that the Secretary of Defense should ensure that the Assistant Secretary of Defense for Health Affairs, in coordination with the military departments, perform an assessment of the suitability of federal civilian and contractor personnel to provide operation medical care and incorporating the results into relevant policies, if warranted. (Recommendation 1)

DoD RESPONSE: Concur. The Department agrees that assessing the current manpower mix within the Military Health System (MHS) could provide valuable insight into the MHS's overall operations, and identify opportunities for the use of more cost-effective types of labor to accomplish the MHS's missions, as well as the potential for the divestiture of certain services based on cost analysis of network care versus private sector care. This kind of assessment should be iterative, rather than a one-time event, and be an organic part of the requirements determination process used across the MHS, with results being integrated/incorporated, as appropriate, into the Department's programming, planning, budgeting, and execution processes.

RECOMMENDATION 2: The GAO recommends that the Secretary of Defense should ensure that the Under Secretary of Defense for Personnel and Readiness require consideration of cost when making determinations regarding the mix of active and reserve component medical personnel. (Recommendation 2)

DoD RESPONSE: Concur. Cost considerations can be an important factor when determining the most appropriate source of labor to execute a mission or function, and the Department's governing policies for manpower mix and determinations already require consideration not only of cost, but of a variety of factors. As noted in the response to Recommendation 3, below, the Department's governing instruction for costing manpower does not include reserve component military personnel costs, and the inability to include true fully burdened, life-cycle costs of all the types of labor available to the Department inhibits its ability to make informed, cost-effective, and sustainable force mix decisions.

RECOMMENDATION 3: The Secretary of Defense should ensure that the Assistant Secretary of Defense for Health Affairs, in collaboration with the Director of Cost Assessment and Program Evaluation and the military departments, develop full cost information for active and reserve component medical personnel, and the military departments use that information in its determinations regarding the mix of active and reserve component medical personnel. (Recommendation 3)

DoD RESPONSE: Concur. The Department already uses Department of Defense Instruction (DoDI) 7041.04, *Estimating and Comparing the Full Costs of Civilian and Active Duty Military Manpower and Contractor Support* for determining the cost of active component military personnel, though it does not address determination of cost for reserve component military personnel.

RECOMMENDATION 4: The GAO recommends that the Secretary of Defense should ensure that the Director of the DHA develop a strategic total workforce plan which includes, among other things: (1) tailored human capital strategies, tools, and metrics by which to monitor and evaluate progress toward reducing personnel gaps, and; (2) integration of human capital strategies with acquisition plans, such as DOD's acquisition strategy for health care services at DOD's military treatment facilities. (Recommendation 4)

DoD RESPONSE: Concur. The Department agrees that the recommended considerations are critical to strategic total workforce planning, and that any plan needs to take into account the unique particulars surrounding the MHS, so as to avoid a "one-size-fits-all" solution. Additionally, strategic total workforce planning should be part of an iterative process, integrated with and complementary to the Department's programming, planning, budgeting, and execution processes rather than a one-time event or stand-alone product.

RECOMMENDATION 5: The GAO recommends that the Secretary of Defense and the Secretaries of the Army, the Navy, and the Air Force, respectively, should ensure that accompanying the transfer of MTFs to the DHA, that the DHA and the military departments develop policies and procedure for management of military personnel, including agreement on specific roles and responsibilities for the departments and the DHA in this process. (Recommendation 5)

DoD RESPONSE: Concur. The Department agrees that policies and procedures for managing military personnel throughout the transition of MTFs are necessary, though this issue can be handled within existing business processes and does not necessarily need to be elevated to the level of the Service Secretaries or Secretary of Defense.

Appendix III: GAO Contact and Staff Acknowledgments

GAO Contact

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

Staff Acknowledgments

In addition to the contact named above, Lori Atkinson, Assistant Director; Tracy Barnes; Alexandra Gonzalez; Adam Howell-Smith; Kirsten Leikem; Amie Lesser; Richard Powelson; Clarice Ransom; Stephanie Santoso; Amber Sinclair, and John Van Schaik; made key contributions to this report.

Appendix IV: Accessible Data

Data Tables

Accessible Data for Figure 1: Number and Percentage of the Department of Defense's (DOD's) Medical Military and Federal Civilian End Strength and Contracted Medical Services Full-Time Equivalents, Fiscal Year 2017

Category	Percentage
Active component end strength	48%
Reserve component end strength	30%
Federal civilian end strength	18%
Contractor full-time equivalents	4%

Accessible Data for Figure 3: Number and Percentage of Uniformed Medical Personnel Authorizations by Component, Fiscal Year 2017

Military branch	Active percentage	Reserve percentage
Army	59%	41%
Navy	83%	17%
Air Force	66%	34%

Accessible Data for Figure 4: Number and Percentage of the Department of Defense's (DOD's) Total Workforce Providing and Supporting Care in Military Treatment Facilities (MTFs) by Personnel Type, Fiscal Year 2017

Category	Military average strength	Federal civilian full-time equivalent	Contractor full-time equivalent
DOD	47%	40%	13%
Army	30%	61%	9%
Navy	59%	26%	15%
Air Force	73%	15%	11%

Agency Comment Letter

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

Page 1

NOV - 8 2018

Ms. Brenda Farrell

Director, Defense Capabilities Management

U.S. Government Accountability Office

441 G Street, NW

Washington DC 20548 Dear Ms. Farrell,

This is the Department of Defense (DoD) response to the GAO Draft Report GAO-19-102, "Defense Health Care: Additional Assessments Needed to Better Ensure an Efficient Total Workforce," dated October 5, 2018 (GAO Code 102291).

As you know, the Military Health System (MHS) is the subject of a number of ongoing transformation efforts, as the result not only of internal Departmental reform, but also Congressional oversight and interest. The Department welcomes the GAO's contributions to these efforts, which will help to build a more efficient and effective MHS.

The Department's responses to the specific recommendations made by the GAO are in the enclosure. We look forward to continuing to work with the GAO in this area, and appreciate the opportunity to engage with you and your team throughout this process. Should you have any questions, please contact my primary action officer for this engagement, Mr. Jason Beck who can be reached at jason.m.beck10.civ@mail.mil and phone (703) 697-1735.

Sincerely,

Lernes Hebert

Acting Director, Total Force Manpower & Resources

Page 2

RECOMMENDATION 1: The GAO recommends that the Secretary of Defense should ensure that the Assistant Secretary of Defense for Health Affairs, in coordination with the military departments, perform an assessment of the suitability of federal civilian and contractor personnel to provide operation medical care and incorporating the results into relevant policies, if warranted. (Recommendation 1)

DoD RESPONSE: Concur. The Department agrees that assessing the current manpower mix within the Military Health System (MHS) could provide valuable insight into the MHS's overall operations, and identify opportunities for the use of more cost-effective types of labor to accomplish the MHS's missions, as well as the potential for the divestiture of certain services based on cost analysis of network care versus private sector care. This kind of assessment should be iterative, rather than a one-time event, and be an organic part of the requirements determination process used across the MHS, with results being integrated/incorporated, as appropriate, into the Department's programming, planning, budgeting, and execution processes.

RECOMMENDATION 2: The GAO recommends that the Secretary of Defense should ensure that the Under Secretary of Defense for Personnel and Readiness require consideration of cost when making determinations regarding the mix of active and reserve component medical personnel. (Recommendation 2)

DoD RESPONSE: Concur. Cost considerations can be an important factor when determining the most appropriate source of labor to execute a mission or function, and the Department's governing policies for manpower mix and determinations already require consideration not only of cost, but of a variety of factors. As noted in the response to Recommendation 3, below, the Department's governing instruction for costing manpower does not include reserve component military personnel costs, and the inability to include true fully burdened, life-cycle costs of all the types of labor available to the Department inhibits its ability to make informed, cost- effective, and sustainable force mix decisions.

RECOMMENDATION 3: The Secretary of Defense should ensure that the Assistant Secretary of Defense for Health Affairs, in collaboration with the Director of Cost Assessment and Program Evaluation and the military

departments, develop full cost information for active and reserve component medical personnel, and the military departments use that information in its determinations regarding the mix of active and reserve component medical personnel. (Recommendation 3)

Page 3

DoD RESPONSE: Concur. The Department already uses Department of Defense Instruction (DoDI) 7041.04, Estimating and Comparing the Full Costs of Civilian and Active Duty Military Manpower and Contractor Support for determining the cost of active component military personnel, though it does not address determination of cost for reserve component military personnel.

RECOMMENDATION 4: The GAO recommends that the Secretary of Defense should ensure that the Director of the DHA develop a strategic total workforce plan which includes, among other things: (1) tailored human capital strategies, tools, and metrics by which to monitor and evaluate progress toward reducing personnel gaps, and; (2) integration of human capital strategies with acquisition plans, such as DOD's acquisition strategy for health care services at DOD's military treatment facilities. (Recommendation 4)

DoD RESPONSE: Concur. The Department agrees that the recommended considerations are critical to strategic total workforce planning, and that any plan needs to take into account the unique particulars surrounding the MHS, so as to avoid a "one-size-fits-all" solution. Additionally, strategic total workforce planning should be part of an iterative process, integrated with and complementary to the Department's programming, planning, budgeting, and execution processes rather than a one-time event or stand-alone product.

RECOMMENDATION 5: The GAO recommends that the Secretary of Defense and the Secretaries of the Army, the Navy, and the Air Force, respectively, should ensure that accompanying the transfer of MTFs to the DHA, that the DHA and the military departments develop policies and procedure for management of military personnel, including agreement on specific roles and responsibilities for the departments and the DHA in this process. (Recommendation 5)

DoD RESPONSE: Concur. The Department agrees that policies and procedures for managing military personnel throughout the transition of MTFs are necessary, though this issue can be handled within existing

business processes and does not necessarily need to be elevated to the level of the Service Secretaries or Secretary of Defense.

Related GAO Products

Military Personnel: Additional Actions Needed to Address Gaps in Military Physician Specialties. GAO-18-77. Washington, D.C.: February 28, 2018.

Defense Health Reform: Steps Taken to Plan the Transfer of the Administration of the Military Treatment Facilities to the Defense Health Agency, but Work Remains to Finalize the Plan. GAO-17-791R. Washington, D.C.: September 29, 2017.

Defense Health Care Reform: DOD Needs Further Analysis of the Size, Readiness, and Efficiency of the Medical Force. GAO-16-820. Washington, D.C.: September 21, 2016.

Human Capital: Additional Steps Needed to Help Determine the Right Size and Composition of DOD's Total Workforce. GAO-13-470. Washington, D.C.: May 29, 2013.

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.

Military Personnel: Status of Accession, Retention, and End Strength for Military Medical Officers and Preliminary Observations Regarding Accession and Retention Challenges. GAO-09-469R. Washington, D.C.: April 16, 2009.

GAO's Mission

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

Obtaining Copies of GAO Reports and Testimony

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

Order by Phone

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

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

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

Connect with GAO

Connect with GAO on Facebook, Flickr, Twitter, and YouTube.
Subscribe to our RSS Feeds or E-mail Updates. Listen to our Podcasts.
Visit GAO on the web at https://www.gao.gov.

To Report Fraud, Waste, and Abuse in Federal Programs

Contact:

Website: https://www.gao.gov/fraudnet/fraudnet.htm

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

Congressional Relations

Orice Williams Brown, Managing Director, WilliamsO@gao.gov, (202) 512-4400,
U.S. Government Accountability Office, 441 G Street NW, Room 7125,
Washington, DC 20548

Public Affairs

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

Strategic Planning and External Liaison

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

Please Print on Recycled Paper.