United States Government Accountability Office

Report to Congressional Committees

July 2023

DEFENSE HEALTH CARE

Additional Assessments Needed to Determine Effects of Active Duty Medical Personnel Reductions

GAO-23-106094

GAO Highlights

Highlights of GAO-23-106094, a report to congressional committees.

July 2023

DEFENSE HEALTH CARE

Additional Assessments Needed to Determine Effects of Active Duty Medical Personnel Reductions

Why GAO Did This Study

DOD relies on more than 108,000 active duty personnel to provide both operational medical care in support of war and other contingencies and beneficiary medical care within the department's hospitals. In 2021, DOD proposed to reduce the number of military medical personnel to increase positions for other missions.

The National Defense Authorization Act for Fiscal Year 2022 included a provision for GAO to review DOD's analyses in support of the reduction or realignment of military medical personnel. This report evaluates the extent to which DOD (1) identified reductions or realignment of active duty medical personnel and strategies to mitigate any potential gaps in health care services at MTFs and assessed any effects; (2) assessed the ability of TRICARE networks to absorb the additional workload that may be caused by reductions; and (3) used wartime scenarios and identified medical capability deficiencies, if any, to determine active duty medical personnel requirements.

GAO analyzed DOD documentation about reduction assessments and medical personnel requirements. GAO also met with cognizant DOD officials.

What GAO Recommends

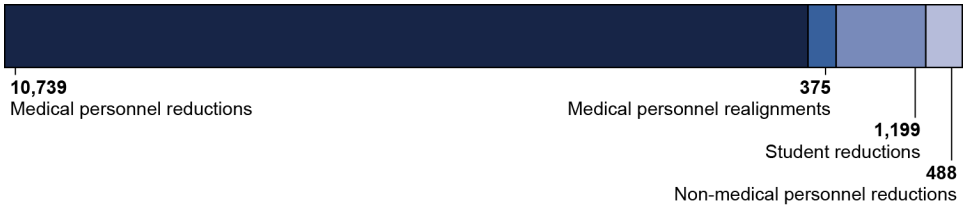
GAO is making nine recommendations, including that DOD (1) develop and use guidance to assess the effects of military medical personnel reductions on MTFs and the ability of TRICARE networks to absorb additional workload resulting from reductions and (2) fully define requirements before deciding on reductions. DOD concurred with all nine recommendations.

View GAO-23-106094. For more information, contact Brenda S. Farrell at (202) 512-3604 or farrellb@gao.gov.

What GAO Found

The Department of Defense (DOD) has not fully or consistently assessed the effects of potential reductions of active duty medical personnel. DOD identified 12,801 military positions to reduce or realign, of which the majority are medical positions. Various medical specialties were selected for reduction, including about 1,000 positions for specialties that are critical for wartime or behavioral health. To mitigate the effect these reductions may have on military medical treatment facilities (MTFs), DOD developed mitigation strategies. These include hiring civilian or contractor replacements, relying on remaining staff to absorb the workload, and sending patients to civilian provider networks under its TRICARE health plan. DOD performed limited assessments on the effect these reductions may have on MTFs. However, DOD did not always consider the feasibility of its mitigation strategies—such as the ability of TRICARE networks to meet any increase in demand for healthcare—because it did not have guidance about how to assess these effects on MTFs. Until DOD develops and uses guidance to comprehensively assess the potential effect that reductions may have on MTFs, it risks taking actions that could decrease the ability of the military health system to achieve its mission of ensuring the medical readiness of the force and caring for military service members and their families.

Proposed Military Positions to Reduce or Realign by Type, Fiscal Years 2020-2027



Source: GAO analysis of Department of Defense information. | GAO-23-106094

DOD developed a methodology for evaluating the adequacy of TRICARE networks, but did not use it to assess the ability of these networks to absorb the potential additional patient workload resulting from MTF medical personnel reductions. Instead, DOD reported the results of a population assessment that did not use its methodology. Moreover, DOD did not provide guidance for using its methodology, such as by defining specific measurable objectives that can facilitate consistent assessment of the TRICARE networks surrounding the 215 MTFs affected by the reductions. Until DOD develops and implements such guidance, decision makers risk not knowing the effect, if any, reductions may have on the TRICARE networks.

The military departments used wartime scenarios to determine active duty medical personnel requirements, but did not fully define such requirements prior to determining military medical personnel reductions. Specifically, deficiencies in medical capability exist, in part, because DOD has experienced challenges with recruitment and retention and has undefined medical personnel requirements. For example, DOD has not fully determined the medical personnel needed to support casualties returning from an overseas large-scale conflict. Without fully defined requirements, DOD will not have all relevant information to make decisions regarding the reduction of military medical personnel.

Contents

Abbreviations

ASD(HA)	Assistant Secretary of Defense for Health Affairs
CAPE	Cost Assessment and Program Evaluation
DHA	Defense Health Agency
DSCA	defense support of civil authorities
DOD	Department of Defense
GME	graduate medical education
HMPDS	Health Manpower Personnel Data System
JME	Joint Medical Estimate
MTF	medical treatment facility
MHS	Military Health System
NDAA	National Defense Authorization Act
USD(P&R)	Under Secretary of Defense for Personnel and Readiness

U.S. GOVERNMENT ACCOUNTABILITY OFFICE
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July 11, 2023

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

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

The Department of Defense's (DOD) Military Health System (MHS) exists to ensure that service members, including its medical workforce, are ready to deploy and accomplish missions. To do this, DOD maintains military medical treatment facilities (MTFs) that provide care to active duty service members and beneficiaries.[1] The MTFs also serve as the primary training platform for active duty medical personnel to help ensure their readiness to deploy and care for service members in an operational environment. DOD's active duty medical workforce simultaneously supports the delivery of medical care in operational environments[2] and to

[1]MTFs provide medical and/or dental care to eligible individuals. DOD reported that there were 49 military hospitals, 465 ambulatory care and occupational health clinics, and 192 dental clinics in fiscal year 2021. Defense Health Agency, *Evaluation of the TRICARE: Program Fiscal Year 2022 Report to Congress; Access, Cost, and Quality Data through Fiscal Year 2021* (Feb. 28, 2022). TRICARE beneficiaries receive health care services through the direct care system of MTFs or through the private sector care system of civilian health care providers in the TRICARE civilian provider networks (referred to as TRICARE networks).

[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 such as forward surgical teams and combat support hospitals, 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 service members 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.

beneficiaries[3] across the globe. As of fiscal year 2022, DOD has about 108,000 active duty service members in its medical workforce—of which approximately 72,000 are enlisted personnel and 36,000 are officers.

In a testimony before the Defense Subcommittee of the Senate Committee on Appropriations in 2019, the Director of the Defense Health Agency (DHA) stated that DOD planned to reduce the active duty medical force for higher priority readiness requirements. Later that year, the National Defense Authorization Act (NDAA) for Fiscal Year 2020 set forth certain conditions that DOD must satisfy prior to reducing or realigning any military medical billets not listed as exceptions in the statute.[4] The act also required DOD to develop a plan for such reductions. In response, DOD issued a report in July 2021 which included a plan (referred to as the 719 Plan) to reduce or realign 12,801 military positions, the majority of which are medical positions, by the end of fiscal year 2027.[5] Subsequently, the NDAAs for Fiscal Year 2021 through Fiscal Year 2023 delayed the reductions until December 2027.[6]

Section 731 of the NDAA for Fiscal Year 2022 included a provision for us to review DOD's analyses in support of reductions or realignment of military medical personnel, including any reduction or realignment of medical billets of the military departments.[7] To address this provision, we are evaluating the extent to which:

[3]DOD provided health care to over 9.6 million beneficiaries of the Military Health System in fiscal year 2021. Eligible beneficiaries include active duty personnel and their dependents (i.e., spouses, children), certain Reserve and National Guard personnel and their dependents, and retirees and their dependents and survivors. For the purposes of this report, beneficiary medical care 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]Pub. L. No. 116–92, § 719 (2019). A billet is a position typically defined by grade and occupation and associated with a specific unit or organization.

[5]Department of Defense, *Report to the Congressional Armed Services Committees: Section 719 of the National Defense Authorization Act for Fiscal Year 2020*, July 2021.

[6]Pub. L. No. 116-283, § 717 (2021); Pub. L. No. 117-81, § 731(a)(1) (2021); and Pub. L. No. 117-263, § 741(a)(1) (2022).

[7]Pub. L. No. 117-81, § 731(a)(2) (2021), *amended by* Pub. L. No. 117-263, § 731 (2022). According to Army and Air Force officials, 1,014 positions were reduced because (1) they met the exceptions that were allowed in section 719 of the NDAA for Fiscal Year 2020 or (2) they were made prior to the pause.

1. DOD identified reductions or realignment of active duty medical personnel and strategies to mitigate any potential gaps in health care services at MTFs, and assessed any effects, including overall costs, on the MHS and DOD,
2. DOD assessed the ability of TRICARE networks to absorb the additional workload that may be caused by the reductions of active duty medical personnel, and
3. the military departments used wartime scenarios and identified medical capability deficiencies, if any, to determine active duty medical personnel requirements.

To address our first objective, we reviewed DOD's 719 Plan and supporting documents related to DOD's determination of reductions and documents of DOD's assessment on the effect reductions may have on the MHS. We reviewed relevant statutes and DOD guidance and compared them to DOD's assessments of the effect of those reductions on the MHS.[8] We also determined that the control activities, information and communication, and monitoring components of internal control were significant to this objective, along with the underlying principles that management should design control activities to achieve objectives and respond to risks, use quality information, establish and operate monitoring activities, and remediate identified deficiencies on a timely basis.[9] We assessed the reliability of military department reduction data by (1) performing electronic testing for errors, such as missing or invalid data, (2) interviewing agency officials knowledgeable about the data, and (3) comparing data to what was reported in the 719 Plan where possible. We determined these data are sufficiently reliable to report on the number of proposed reductions by military department, specialty, and mitigation strategy.

For our second objective, we reviewed DHA's TRICARE network assessments that were reported in its 719 Plan and other supporting documentation. We compared the measure for network adequacy, as

[8]Pub. L. No. 117-263, § 741 (2022); Pub. L. No. 116-92, § 719(b)(2) (2019) *amended by* Pub. L. No. 116-283, § 717 (2021); Pub. L. No. 117-81, § 731 (2021).

[9]GAO, *Standards for Internal Control in the Federal Government,* GAO-14-704G (Washington, D.C.: September 2014). Internal control is a process effected by an entity's oversight body, management, and other personnel that provides reasonable assurance that the objectives of an entity will be achieved.

defined in the 719 Plan, to DHA's TRICARE network assessments that were reported to support the 719 Plan.

For our third objective, we compared military department efforts in planning military medical personnel requirements to section 719(b)(1) of the NDAA for Fiscal Year 2020, and we also compared them to DOD and military department guidance and documents. We reviewed the Joint Medical Estimate (JME) to identify any deficiencies in medical capabilities—that is, gaps between capabilities needed to meet operational requirements and actual capabilities.

To address all of our objectives, we interviewed cognizant officials from Office of the Under Secretary of Defense for Personnel and Readiness, Cost Assessment and Program Evaluation (CAPE), Health Affairs, DHA, Joint Staff, Northern Command, Indo-Pacific Command, and the military departments. We also met with officials from seven selected MTFs to understand their involvement in providing input on potential reductions and to obtain their perspective on the potential effect of reductions on the MTFs. We selected the MTFs to interview based on their military department affiliation, total planned reductions by military department, whether the MTF had a graduate medical education (GME) program, and whether the MTF is in a rural population.[10] We selected for each military department and DHA the MTF that has a GME program with the highest number of reductions. We also selected for each military department the MTF that is a hospital with the highest number of proposed reductions in a less populated area. See appendix I for more information on our scope and methodology.

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

[10]Our selection of the following seven MTFs represent 2,406 of the total 12,801 reductions and realignments: (1) 81st Medical Group, Keesler Air Force Base, Mississippi; (2) 96th Medical Group, Eglin Air Force Base, Florida; (3) Brooke Army Medical Center, Fort Sam Houston, Texas; (4) Walter Reed National Military Medical Center, Maryland; (5) Winn Army Community Hospital, Fort Stewart, Georgia; (6) Naval Medical Center Camp Lejeune, North Carolina; and (7) Naval Medical Center San Diego, California.

Background

Organizational Roles and Responsibilities for Managing the Military Health System

The MHS is a complex organization in which responsibility for health care delivery is shared among the military departments—the Army, the Navy, and the Air Force—and the DHA, with oversight from the Office of the Secretary of Defense and advice from the Joint Staff. As such, several leaders have responsibility for DOD's medical workforces, their readiness, and the MTFs to which many of them are assigned. Specifically:

- The Under Secretary of Defense for Personnel and Readiness is the principal staff assistant and advisor to the Secretary of Defense for health-related matters and, in that capacity, develops policies, plans, and programs for health and medical affairs.[11]
- The Director of Cost Assessment and Program Evaluation (CAPE) is the principal advisor to the Secretary of Defense and other senior officials in the DOD for independent cost assessment, program evaluation, and analysis. Among other things, the CAPE Director reviews, analyzes, and evaluates programs for the execution of approved strategies and policies and also ensures that information on programs is presented accurately and completely.
- The Secretaries of each military department are responsible for organizing, training, and equipping military forces as directed by the Secretary of Defense. The Secretaries are also responsible for ensuring the readiness of military personnel and providing military personnel and other authorized resources in support of the combatant commanders and the DHA.
- The Surgeon General of each respective military department serves as the principal advisor to the Secretary of the military department concerned on all health and medical matters of the military department.
- The Assistant Secretary of Defense for Health Affairs (ASD(HA)) serves as the principal advisor for all DOD health-related policies, programs, and activities.[12] This official has the authority to (1) develop policies, conduct analyses, provide advice, and make recommendations to the Secretary of Defense and others; (2) issue guidance; and (3) provide oversight on matters pertaining to the MHS.

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

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

Further, the ASD(HA) prepares and submits a DOD Unified Medical Budget which includes, among other things, the Defense Health Program budget to provide resources for MTFs and the TRICARE Health Program.

- The Director of the DHA manages, among other things, the execution of policies issued by the ASD(HA) and manages and executes the Defense Health Program appropriation.[13] The Director of the DHA is also responsible for the TRICARE Health Program. In December 2016, the President and Congress expanded the role of the DHA by directing the transfer of responsibility for the administration of each MTF from the military departments to the DHA. As of October 2019, the DHA had assumed the administration and management responsibilities for all MTFs within the United States.[14] Specifically, the Director of the DHA is responsible for budgetary matters, information technology, health care administration and management, administrative policy and procedure, and military medical construction for the MTFs, among other things. Moreover, in addition to the other duties of the Director of the DHA, the Director coordinates with the Joint Staff Surgeon to ensure that the Director most effectively carries out the responsibilities of the DHA as a combat support agency. The Director of the DHA carries out their roles and responsibilities in accordance with DOD guidance for combat support agencies.[15]
- The Chairman of the Joint Chiefs of Staff, in coordination with combatant commanders, manages various responsibilities for medical readiness training including predeployment training requirements. The Joint Staff Surgeon serves as the chief medical advisor to the Chairman of the Joint Chiefs of Staff. The Joint Staff Surgeon coordinates all issues related to joint force military health services, to include operational medicine, force health protection, and readiness among the combatant commands, the Office of the Secretary of Defense, and the services. The Joint Staff Surgeon prepares the annual Joint Medical Estimate, which is an independent assessment of the joint force's operational medical capabilities in support of the National Military Strategy, and provides potential shortfalls and

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

[14]The NDAA for Fiscal Year 2017 required the transfer of administrative and management responsibilities of the MTFs from the individual military departments to the DHA. Pub. L. No. 114-328, § 702 (2016), codified as amended at 10 U.S.C. § 1073c.

[15]Department of Defense Directive 3000.06, *Combat Support Agencies (CSAs)* (June 27, 2013) (incorporating change 1, effective July 8, 2016).

barriers to providing health care to service members during the full range of military operations.

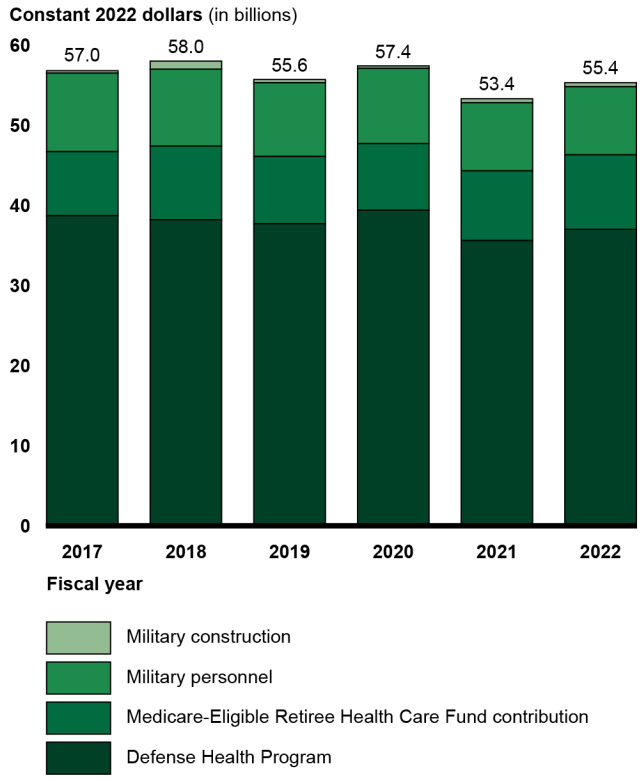
Unified Medical Budget

Generally, the MHS is funded through appropriations that are enacted each year in an appropriations act. These funds for the MHS are appropriated across several accounts, and DOD refers to these collective appropriations as the Unified Medical Budget. This budget consists of the (1) Defense Health Program, (2) Medicare-Eligible Retiree Health Care Fund, (3) Military Personnel account that funds military personnel operating the MHS, and (4) Military Construction account that funds MHS construction projects.[16] Since fiscal year 2017, funds for the Unified Medical Budget, after adjusting for inflation, decreased by about $1.6 billion, from $57 billion in fiscal year 2017 to about $55.4 billion in fiscal year 2022 (see fig. 1).[17] This overall decrease in the fiscal year 2022 budget compared to fiscal year 2017 was due to decreases in the Defense Health Program and the military personnel portion of the Unified Medical Budget.

[16]The DOD Medicare-Eligible Retiree Health Care Fund was established in section 1111 of title 10, U.S. Code, and became operative on October 1, 2002. The fund's purpose is to account for and accumulate funds for the health benefit costs of Medicare-eligible military retirees, and their dependents and survivors who are Medicare eligible. The Fund receives revenues from three sources: interest earnings on Medicare-Eligible Retiree Health Care Fund assets, Uniformed Services normal cost contributions, and Treasury contributions.

[17]This analysis for Defense Health Program and Medicare-Eligible Retiree Health Care Fund are reported as enacted for fiscal year 2017 through fiscal year 2022 as identified in DOD budget documents. Amounts for military personnel and military construction are reported requested for fiscal years 2017 and 2018 and reported enacted for fiscal year 2019 through fiscal year 2022. Enacted amounts, as presented in DOD budget documents, reflect congressionally approved programs supported through appropriations, reprogramming actions that have been approved, congressionally directed undistributed amounts and transfers, and reprogramming of funds implemented by a DOD component using below-threshold reprogramming flexibility. We converted cost data to constant fiscal year 2022 dollars using the appropriate deflators for costs for fiscal year 2017 through fiscal year 2022 published in DOD's *National Defense Budget Estimates for Fiscal Year 2022*. We expressed the costs in inflation-adjusted dollars to obtain a more accurate assessment of the change that occurred over the 6-year period. While there was an overall decrease in amounts when comparing fiscal year 2017 to fiscal year 2022, amounts for the Unified Medical Budget fluctuated and ranged from $53.4 billion in fiscal year 2021 to $58 billion in fiscal year 2018.

Figure 1: Unified Medical Budget Amounts by Account, Fiscal Years 2017–2022



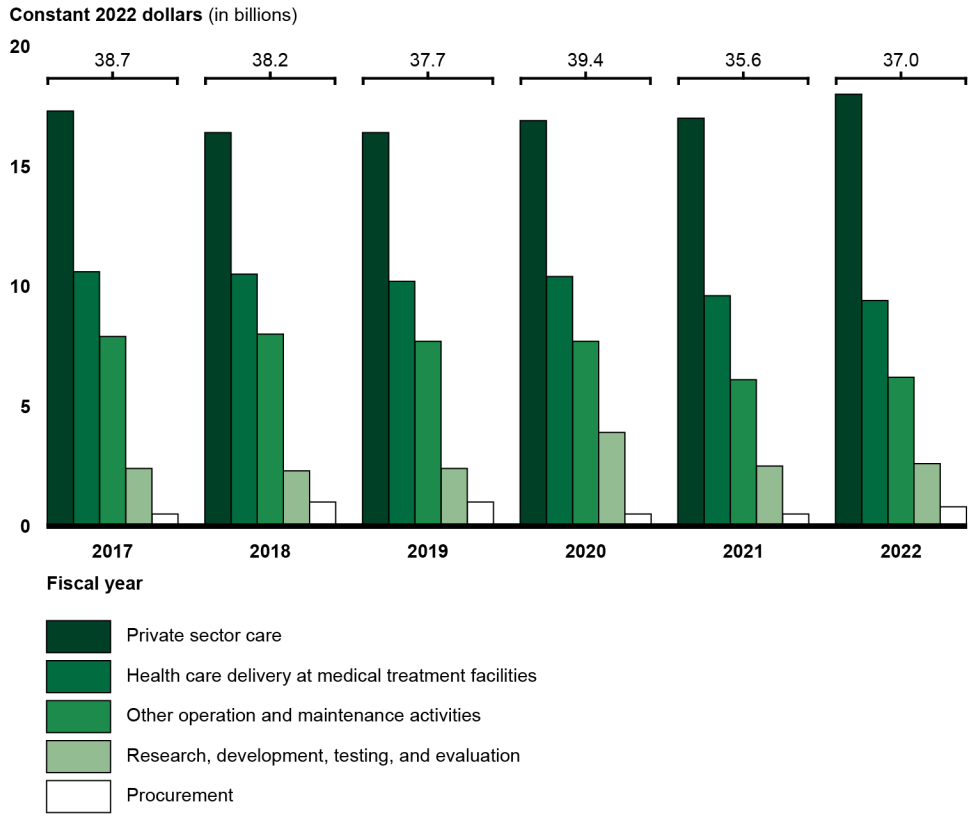
Source: GAO analysis of Department of Defense information. | GAO-23-106094

Note: Amounts for Defense Health Program and Medicare-Eligible Retiree Health Care Fund are reported as enacted for fiscal year 2017 through fiscal year 2022. Amounts for military personnel and military construction are reported requested for fiscal years 2017 and 2018 and reported enacted for fiscal years 2019 through 2022. Enacted amounts, as presented in DOD budget documents, reflect congressionally approved programs supported through appropriations, approved reprogramming actions, congressionally directed undistributed amounts and transfers, and reprogramming of funds implemented by a DOD component using below-threshold reprogramming flexibility.

The Defense Health Program is one component of DOD's Unified Medical Budget, accounting for about 67 percent of the total Unified Medical Budget for fiscal years 2017 through 2022. It funds health care delivery at MTFs, private sector care, and research and development activities and procurement, among other things. Since fiscal year 2017, amounts for the Defense Health Program, after adjusting for inflation, decreased by about $1.7 billion—from $38.7 billion in fiscal year 2017 to about $37 billion in fiscal year 2022 (see fig. 2). This overall decrease in the fiscal year 2022 budget compared to fiscal year 2017 is in part due to decreased amounts for care provided at the MTFs, which decreased by about $1.3 billion—

from $10.6 billion in fiscal year 2017 to $9.4 billion in fiscal year 2022.[18] Conversely, spending on private sector care, which is the largest component of the Defense Health Program, increased by about $.7 billion—from $17.3 billion in fiscal year 2017 to $18 billion in fiscal year 2022.[19]

Figure 2: Defense Health Program Enacted Amounts by Budget Activity, Fiscal Years 2017–2022



Source: GAO analysis of Department of Defense information. | GAO-23-106094

[18]This does not reflect the full cost of care provided at the MTFs because it does not include the cost for military personnel staffed at the MTFs. While there was an overall decrease in amounts when comparing fiscal year 2017 to fiscal year 2022, amounts for the cost of care provided at the MTFs fluctuated and ranged from $9.4 billion in fiscal year 2022 to $10.6 billion in fiscal year 2017.

[19]While there was an overall increase in amounts when comparing fiscal year 2017 to fiscal year 2022, funds for private sector care fluctuated and ranged from $16.4 billion in fiscal years 2018 and 2019 to $18 billion in fiscal year 2022.

Note: Enacted amounts, as presented in DOD budget documents, reflect congressionally approved programs supported through appropriations, reprogramming actions that have been approved, congressionally directed undistributed amounts and transfers, and reprogramming of funds implemented by a DOD component using below-threshold reprogramming flexibility. Amounts for health care delivery at medical treatment facilities (MTFs) does not reflect the full cost of care provided at the MTFs because it does not include the cost for military personnel staffed at the MTFs.

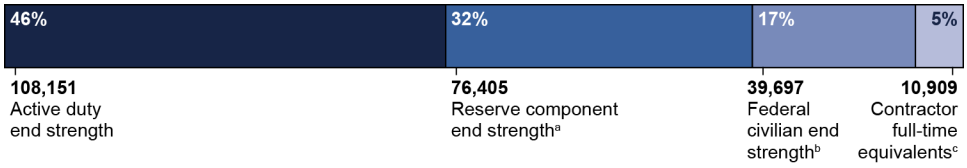
Composition of the MHS Total Workforce

The MHS has a dual mission of generating medical professionals with clinical skills ready to deploy globally and providing health care to service members and beneficiaries. The MHS accomplishes this mission 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 medical workforce supporting this dual mission comprises three main components: military personnel (including active and reserve personnel), federal civilian personnel, and private sector contractor personnel. The active duty medical workforce simultaneously supports the delivery of operational medical care and beneficiary health care to patients across the globe.[20] Reserve component medical personnel are generally used in operational medical care. Federal civilians and contractor personnel generally provide beneficiary care within MTFs. Figure 3 shows the number of active and reserve components of military, federal civilian, and estimated contractor full-time equivalents that comprised DOD's total medical workforce in fiscal year 2022.

[20]Operational medical care refers to health care provided to military service members via deployable health care platforms in support of war, named or unnamed contingencies, and other operational missions. In addition to providing health care to military service members in and out of designated combat areas, DOD provides medical care to communities in need as part of its humanitarian assistance and disaster relief services.

Figure 3: DOD's Medical Active Duty and Reserve Component, Federal Civilian, and Contracted Full-Time Equivalent Personnel, by Total Number and as a Percentage, Fiscal Year 2022



Source: GAO analysis of Department of Defense data. | GAO-23-106094

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 2022. End strength for the active duty, reserve component, and federal civilians are from GAO analysis of summary tables A2, R2, and C2 within the *Health Manpower Personnel Data System* report for fiscal year 2022. End strength represents the actual number of personnel on board at the end of the fiscal year.

[a]Reserve component end strength includes 65,302 Selected Reserve, 10,835 Individual Ready Reserve/Inactive National Guard, and 268 standby reserves.

[b]Federal civilian end strength includes only U.S. DOD Civilian Personnel and includes 39,374 full-time and 323 less than full-time federal civilian end strength.

[c]Contractor full-time equivalents represent the estimated number of contractor full-time equivalents supporting medical care contracts funded by the Defense Health Program. 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).

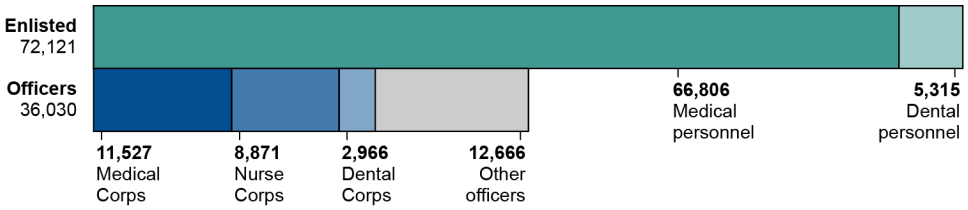
Although the personnel distribution varies by military department, collectively the active duty and reserve workforces make up the majority of the medical workforce. According to military department officials, the workforce mix of civilians and military vary by MTF. For example, MTFs that were formerly managed by the Air Force rely more on military personnel than the Army and the Navy.

As of fiscal year 2022, DOD had about 108,000 active duty service members in its medical workforce—of which approximately 72,000 are enlisted personnel and 36,000 are officers. The military departments group their occupations for its medical workforce of officers into the following categories: Medical Corps, Dental Corps, Nurse Corps, Medical Service Corps, Army Medical Specialist Corps, Biomedical Science Corps, Veterinary Corps, and Warrant Officers.[21] The enlisted workforce

[21]For purposes of this report, we used the term "other medical officers" to capture the Medical Service Corps, Army Medical Specialist Corps, Biomedical Science Corps, Veterinary Corps, and Warrant Officers.

is broken out by enlisted medical and enlisted dental personnel. See figure 4 for number of active duty service members by medical group.

Figure 4: Number of Active Duty Medical Personnel by Medical Group, Fiscal Year 2022



Source: GAO analysis of Department of Defense data. | GAO-23-106094

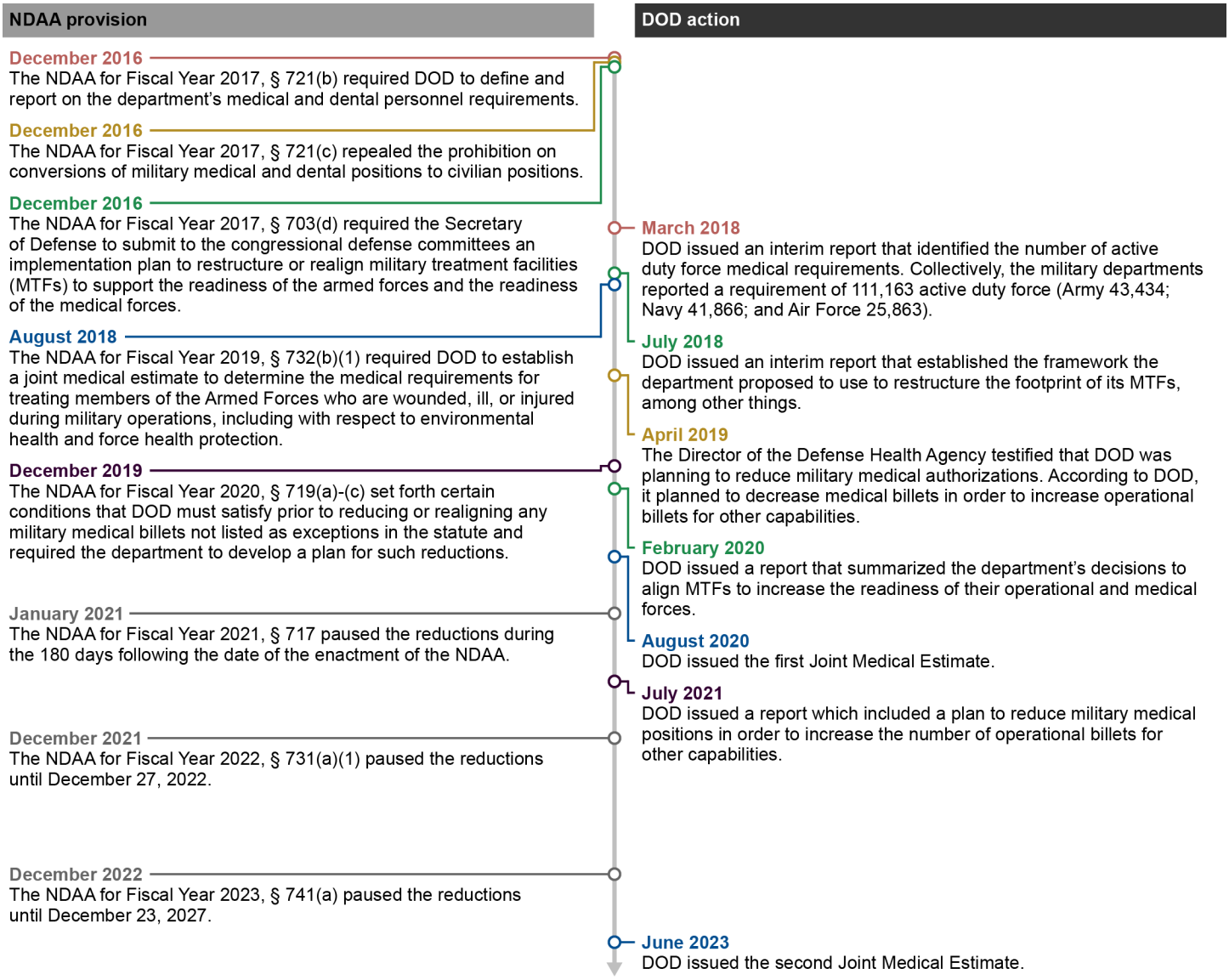
Recent Legislation and Actions by DOD Related to Active Duty Medical Workforce

Over the past 7 years, a number of NDAAs have included provisions related to the active duty medical workforce. For example, section 719 of the NDAA for Fiscal Year 2020 included conditions that DOD must satisfy prior to reducing or realigning any military medical positions not listed as exceptions in the statute.[22] Section 719 also required DOD to report on these conditions and its plan for such reductions.

In response, DOD issued a report in July 2021 that included its 719 Plan to reduce 12,801 military positions, the majority of which are medical positions, by the end of fiscal year 2027 to increase the number of operational positions for other capabilities. Subsequently, the NDAAs for Fiscal Year 2021 through Fiscal Year 2023 paused the reductions. Figure 5 shows selected provisions in the NDAA and actions taken by DOD related to the active duty medical workforce.

[22]Pub. L. No. 116-92, § 719 (2019), *amended by* Pub. L. No. 116-283, § 717 (2021) and Pub. L. No. 117-81, § 731 (2021).

Figure 5: Provisions in the National Defense Authorization Acts (NDAA) Related to Active Duty Medical Workforce Requirements and DOD Actions Taken



Source: GAO analysis of National Defense Authorization Acts and Department of Defense (DOD) information. | GAO-23-106094

As shown in the figure above, while DOD was determining reductions to military medical personnel, the department was also undergoing a review of its MTFs. The NDAA for Fiscal Year 2017 included a provision requiring DOD to restructure and realign military MTFs and report on their plans for implementation.[23] In July 2018, DOD issued a report on the department's implementation plan for restructuring and realignment. Subsequently, in February 2020, the department issued a report that summarized DOD's decisions to realign MTFs.

TRICARE Civilian Provider Networks and Health Plans

In addition to providing health care in its own hospitals and clinics, DOD uses a private sector care system of civilian providers to augment the direct care system of MTFs when needed. Specifically, under TRICARE, DOD contracts with private-sector companies—referred to as managed care support contractors—to develop and maintain networks of civilian providers in each TRICARE region (East and West). Specifically, the contractors are required to establish and maintain networks of civilian providers in designated geographic locations—called Prime Service Areas—that generally encompass a 40-mile radius around MTFs and Base Realignment and Closure sites. The contractors are required to adjust their civilian provider networks and services as necessary to compensate for changes in MTF capabilities and capacities, when and where they occur over the life of the contract, including those resulting from unanticipated facility expansion, MTF provider deployment, downsizing and/or closures. They also perform other customer service functions, such as processing claims, enrolling beneficiaries, and assisting beneficiaries with finding providers. The Director of DHA awards and oversees the managed care support contracts.

TRICARE beneficiaries are able to obtain health care from TRICARE-authorized providers, which consists of network and non-network civilian providers. Both network and non-network providers must be authorized or certified in accordance with section 199.6 of title 32, Code of Federal Regulations. Network providers sign a contract with the TRICARE contractor and non-network providers do not.

- **Network providers.** Network providers provide care to TRICARE beneficiaries at a negotiated rate and file claims with TRICARE for the remaining amount. Beneficiaries pay their cost share.

[23]Pub. L. No. 114-328, § 703 (2016), codified in part at 10 U.S.C. § 1073d.

- **Non-network providers.** Non-network providers can charge up to 15 percent more than the TRICARE allowable charge as payment for their services.[24] Beneficiaries pay their cost share and any charges that are over the TRICARE allowable charge.

TRICARE beneficiaries generally obtain coverage through two health plan options—TRICARE Prime and TRICARE Select.[25]

- **TRICARE Prime.** TRICARE Prime is a managed care plan. Beneficiaries receive most of their care from MTFs and may also receive care purchased from the private sector networks of civilian providers. TRICARE Prime has the lowest out-of-pocket costs for beneficiaries, as care provided at MTFs does not have a copayment. TRICARE Prime beneficiaries are to access medical care in accordance with established access standards that set requirements for (1) travel time to provider sites, (2) appointment wait time, (3) availability and accessibility of emergency services, (4) composition of network specialists, and (5) office wait time.[26]
- **TRICARE Select.** TRICARE Select is a self-managed, preferred provider organization option. Beneficiaries can also receive care from MTFs, but they have a lower priority for receiving care than TRICARE Prime beneficiaries and are seen on a space-available basis. In April 2023, we reported that, according to DHA officials, the time and distance metrics used to monitor access for TRICARE Prime

[24]Non-network providers that accept the TRICARE allowable charge as payment in full are referred to as "participating" and those who charge up to 15 percent over that amount are considered "non-participating." "Participating" providers file claims for beneficiaries and "non-participating" providers typically do not file claims.

[25]Beneficiaries eligible for TRICARE include active duty and retired service members and their families, dependent survivors, certain reserve component members and their families, and certain other eligible groups. Additionally, there are some beneficiaries who are eligible for TRICARE who are also eligible for Medicare. Medicare is available, generally, to people age 65 or older, younger people with disabilities, and people with end-stage renal disease. TRICARE's Medicare-eligible beneficiaries who enroll in Medicare Part B may obtain coverage through TRICARE for Life. Under the TRICARE for Life program, TRICARE processes claims after they have been adjudicated by Medicare. TRICARE offers several other plans, including TRICARE Reserve Select (for certain Selected Reserve members and their dependents), TRICARE Retired Reserve (for certain retired Reserve service members and their families), and TRICARE Young Adult (for service members' dependents who are at least age 21 but not yet 26 years old).

[26]32 C.F.R. § 199.17(p)(5) (2022). These standards apply when a TRICARE Prime enrollee seeks care from a network provider. If care is not accessible within the requirements established by these standards, an enrollee is authorized to receive care from a non-network provider without incurring additional fees.

beneficiaries cannot be used for TRICARE Select beneficiaries because individuals enrolled in TRICARE Select self-manage their own appointments.[27]

All active duty service members are required to enroll in the TRICARE Prime. Active duty dependents (e.g., spouses and children of service members) are eligible to enroll in TRICARE Prime or Select.

DOD Has Identified Medical Personnel Reductions and Mitigations, but Has Not Fully Assessed Effects on MTFs or Overall Costs to DOD

In DOD's 719 Plan, military departments identified active duty positions to reduce or realign and collaboratively developed strategies with DHA to mitigate the impact of reductions to affected MTFs. However, the 719 Plan and DOD officials identified a number of challenges to implementing them. DHA and military departments conducted limited assessments to determine the effect of implementing the 719 Plan, but these assessments did not fully or consistently assess the effects reductions may have on the MTFs or consider the feasibility of implementing mitigation strategies. Moreover, DOD has not fully assessed the costs of implementing planned personnel reductions and, as a result, the cost of implementing the 719 Plan is not known.

DOD Identified Military Medical Personnel Reductions and Strategies to Mitigate Gaps in Health Care Availability at MTFs Caused by Such Reductions

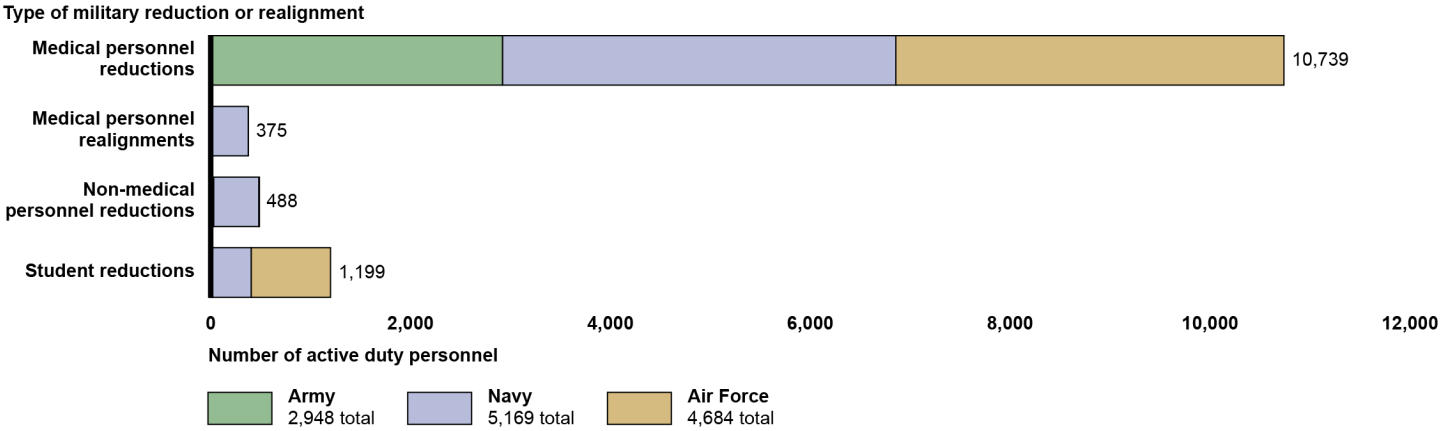
Potential Active Duty Personnel Reductions and Realignments Identified

As required by section 719(b)(2) of the NDAA for Fiscal Year 2020, DOD identified in its 719 Plan positions at MTFs that would be affected by a proposed active duty medical realignment or reduction. Specifically, military departments identified 12,801 military positions to reduce or realign—10,739 active duty medical authorizations at MTFs would be reduced and 375 authorizations would be realigned as a different medical

[27]GAO, *Coast Guard Health Care: Additional Actions Could Help Ensure Beneficiaries' Access*, GAO-23-105574 (Washington, D.C.: Apr. 4, 2023).

position.[28] The remaining positions are for non-medical personnel or students.[29] The 719 Plan noted that the reductions would be phased in over time—beginning in fiscal year 2020 and ending in fiscal year 2027. See figure 6 for the number of proposed reductions and realignments by military department.

Figure 6: Proposed Number of Medical, Non-Medical, and Student Active Duty Personnel Reductions and Realignments by Military Department, Fiscal Years 2020–2027



Source: GAO analysis of Department of Defense information. | GAO-23-106094

Note: Reductions will decrease the authorized number of active duty medical personnel. Realignments will be repurposed and converted to another medical specialty and will not decrease the authorized number of active duty medical personnel.

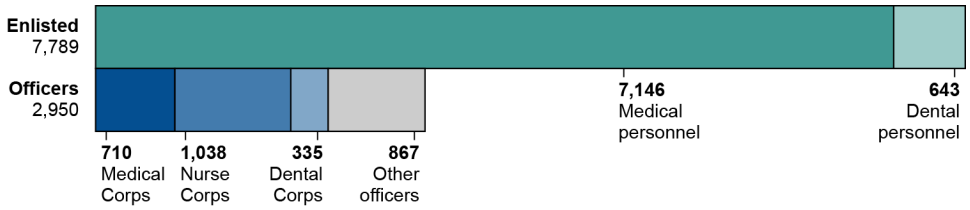
The 10,739 military medical personnel reductions cover various types of active duty medical personnel, including 2,950 officers (physicians, dentists, nurses, other medical officers) and 7,789 enlisted medical and

[28]For purposes of this report, a reduced position will decrease the authorized number of active duty medical personnel. A realigned positon is repurposed and converted to another medical specialty and will not decrease the authorized number of active duty medical personnel.

[29]All three medical departments reported reducing some non-medical specialties—Army 29, Navy 453, and Air Force six. Examples of non-medical specialties include chaplains, law enforcement, and food service workers. The Navy and Air Force reported student reductions—Navy 404 and Air Force 795. According to Navy officials, the reductions of student positions did not include reductions to GME positions. Rather, these reductions represent positions associated with corpsman A and C schools and other training associated with officers. According to Air Force officials, the student reductions did include some GME positions.

enlisted dental personnel.[30] Figure 7 provides an overview of the types of active duty medical personnel affected by the proposed reductions.

Figure 7: Proposed Number of Active Duty Medical Personnel Reductions by Workforce Type, Fiscal Years 2020–2027



Source: GAO analysis of Department of Defense information. | GAO-23-106094

The proposed reductions affected over a 100 medical specialties, including several critical specialties.[31] For example, of the 10,739 military medical personnel reductions, 855 were associated with specialties considered critical by DOD. A number of these specialties had personnel gaps by one or more military departments in fiscal year 2022, even after adjusting for any proposed reductions to authorizations.[32] See table 1 for the number of proposed reductions for critical specialties and the extent to which there was a personnel gap by one or more military department.

[30]We use the term "physicians" for those in the Medical Corps, "dentists" those in the Dental Corps, and "nurses" for those in the Nurse Corps. Reductions for "other medical officers" include those serving in the Medical Service Corps, Medical Specialist Corps, and Biomedical Science Corps.

[31]For purposes of this report, we define specialties as critical if they are included in DOD's *Final Report and Implementation Plan in response to Section 708 of the National Defense Authorization Act for Fiscal Year 2017 (Public Law 114–328)* list of critical wartime specialties or if DOD offered a Critically Short Wartime Specialty Accession Bonus in fiscal year 2023. Department of Defense Financial Regulation 7000.14-R, vol. 7A, ch. 5, *Health Professions Officer (HPO) Special and Incentive Pay* (April 2023).

[32]For purposes of this report, "authorizations" refers to the number of positions for which resources have been allocated to fulfill the departments' medical mission, as identified in the *Health Manpower Personnel Data System* report for fiscal year 2022. Assistant Secretary of Defense for Health Affairs, *HMPDS Health Manpower Personnel Data System, Fiscal Year Statistics 2022*. End strength numbers represent the number of medical personnel fulfilling specific billet positions at the end of the fiscal year. For purposes of this report, we define a "gap" as the difference between the military department's end strength and authorization, which we reduced by the proposed reduction.

Table 1: Proposed Reductions of Active Duty Medical Personnel, by Personnel Gaps and Critical Specialties

Personnel gap between end strength and modified authorization[a]	Corps	Critical specialties[b]	Army	Navy	Air Force	Total
Below 80 percent	Medical Corps	Aviation/Aerospace Medicine	9	0	0	**9**
		Critical Care/Trauma, Medicine	0	5	0	**5**
		General Medicine	0	2	0	**2**
		Preventive Medicine	6	9	0	**15**
		Pulmonary Disease	2	0	0	**2**
		Psychiatry	0	5	0	**5**
	Nurse Corps	Critical Care Nurse	9	31	0	**40**
80 through 89.9 percent	Medical Corps	Anesthesiology	7	8	0	**15**
		Infectious Disease	1	5	1	**7**
		Orthopedic Surgery	0	12	3	**15**
	Nurse Corps	Operating Room Nurse	42	64	0	**106**
	Other officer Corps	Psychology, Clinical	0	6	3	**9**
90 through 99.9 percent	Medical Corps	Cardiology	3	10	0	**13**
	Medical Corps	Urology	1	11	4	**16**
	Dental Corps	Comprehensive Dentistry	14	40	38	**92**
		Oral Maxillofacial Surgery	0	1	6	**7**
	Nurse Corps	Emergency/Trauma Nurse	2	35	0	**37**
		Mental Health Nurse Practitioner	0	12	0	**12**
		Nurse Anesthetist	2	25	0	**27**
No gap identified	Medical Corps	Emergency Medicine	0	1	0	**1**
		Family Practice	47	89	12	**148**
		Internal Medicine	12	18	0	**30**
		Ophthalmology	3	16	9	**28**
		Radiology, Diagnostic	6	38	7	**51**
	Dental Corps	General Dentistry	3	95	40	**138**
		Prosthodontics	3	14	8	**25**
Total Reductions			**172**	**552**	**131**	**855**

Source: GAO analysis of Department of Defense (DOD) information. | GAO-23-106094

Note: Names of specialties in this table are based on DOD's Health Manpower Personnel Data System report and may be characterized in a slightly different manner than those listed in the DOD Financial Management Regulation. Department of Defense Financial Regulation 7000.14-R, vol. 7A, ch. 5, *Health Professions Officer (HPO) Special and Incentive Pay* (April 2023). Table includes reductions and does not include realignments for 32 positions that are critical specialties.

[a]We identified a personnel gap as the difference between the military department's fiscal year 2022 end strength and authorization, as reported in DOD's *Health Manpower Personnel Data System* report for fiscal year 2022. We reduced the fiscal year 2022 authorizations by the proposed reduction. Gaps shown represent the largest personnel gap shown by one or more military departments.

[b]While the table assesses personnel gaps for fiscal year 2022, the critical specialties listed in the table are defined as those that are listed in DOD's *Final Report and Implementation Plan in response to Section 708 of the National Defense Authorization Act for Fiscal Year 2017* (Public Law 114–328) as critical wartime specialties or those for which DOD offered a Critically Short Wartime Specialty Accession Bonus in fiscal year 2023. Department of Defense Financial Regulation 7000.14-R, vol. 7A, ch. 5, *Health Professions Officer (HPO) Special and Incentive Pay* (April 2023).

Despite DOD noting in its 719 Plan that behavioral health is a community shortfall in most TRICARE Prime service areas, and that these types of providers should not be reduced at MTFs, the Navy and Air Force identified a number of behavioral health specialties for potential reductions. Specifically, there were 141 proposed military medical personnel reductions within behavioral health specialties (see table 2).[33] All of these behavioral health specialties had personnel gaps by one or more military departments in fiscal year 2022, even after adjusting for any proposed reductions to authorizations.

Table 2: Proposed Reductions of Active Duty Medical Personnel, by Personnel Gaps and Behavioral Health Specialties

Personnel gap between end strength and modified authorization[a]	Corps	Behavioral Health Specialty	Army	Navy	Air Force	Total
Below 80 percent	Medical Corps	Psychiatry	0	5	0	**5**
	Enlisted medical	Behavioral Sciences/Mental Health Services	0	20	48	**68**
80 and 89.9 percent	Nurse Corps	Mental Health Nurse	0	10	0	**10**
	Other officer Corps	Psychology, Clinical	0	6	3	**9**
	Other officer Corps	Social Work	0	36	1	**37**
90 and 99.9 percent	Nurse Corps	Mental Health Nurse Practitioner	0	12	0	**12**
Total Reductions			**0**	**89**	**52**	**141**

Source: GAO analysis of Department of Defense (DOD) information. | GAO-23-106094

Note: Names of specialties in this table are based on DOD's *Health Manpower Personnel Data System* report and may be characterized in a slightly different manner than those listed in the DOD *Financial Management Regulation*. Department of Defense Financial Regulation 7000.14-R, vol. 7A, ch. 5, *Health Professions Officer (HPO) Special and Incentive Pay* (April 2023). Table includes reductions and does not include realignments for two positions that are behavioral health specialties.

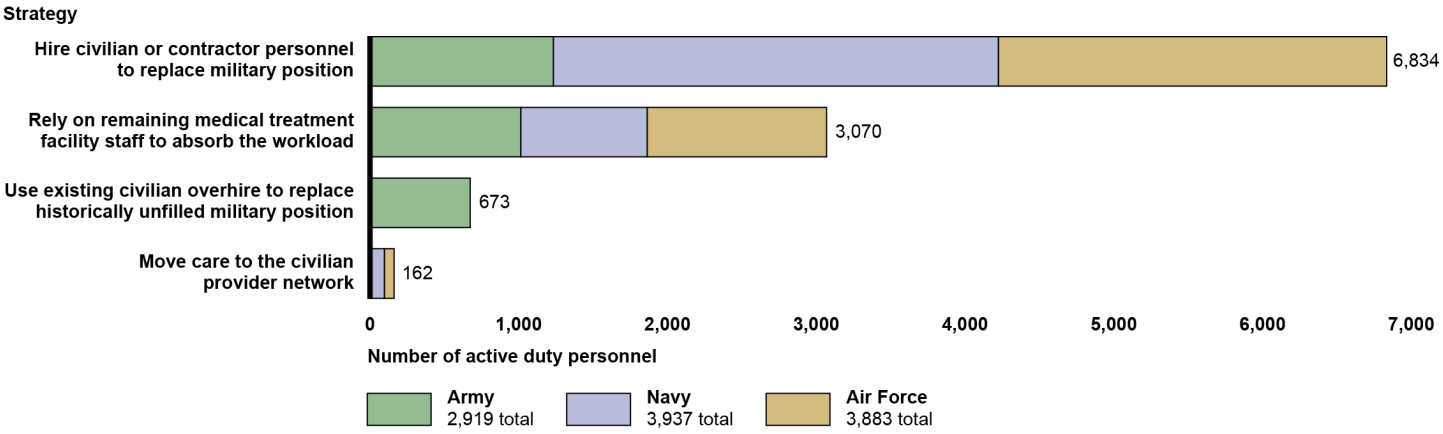
[a]We identified a personnel gap as the difference between the military department's fiscal year 2022 end strength and authorization as reported in DOD's *Health Manpower Personnel Data System* report for fiscal year 2022. We reduced the fiscal year 2022 authorizations by the proposed reduction. Gaps shown represent the largest personnel gap shown by one or more military departments.

[33]Psychiatry, clinical psychology, and mental health nurse practitioner specialties are considered behavioral health and identified as critical by DOD.

Mitigation Strategies

As required by section 719(b)(2) of the NDAA for Fiscal Year 2020, we found that DOD's 719 Plan developed strategies for mitigating any potential gap in health care services caused by realignment or reduction of personnel. According to DOD's 719 Plan, DHA and the military departments collaboratively developed strategies to mitigate the impact of reductions to affected MTFs. These included hiring civilian or contractor personnel replacements, relying on remaining staff to absorb the workload, relying on existing civilian or contractor personnel replacements, and sending patients to civilian provider networks under its TRICARE health plan. The military departments identified a plan for using these mitigation strategies by location and specialty. As seen in figure 8, hiring a civilian or contractor personnel replacement was the most common strategy identified.

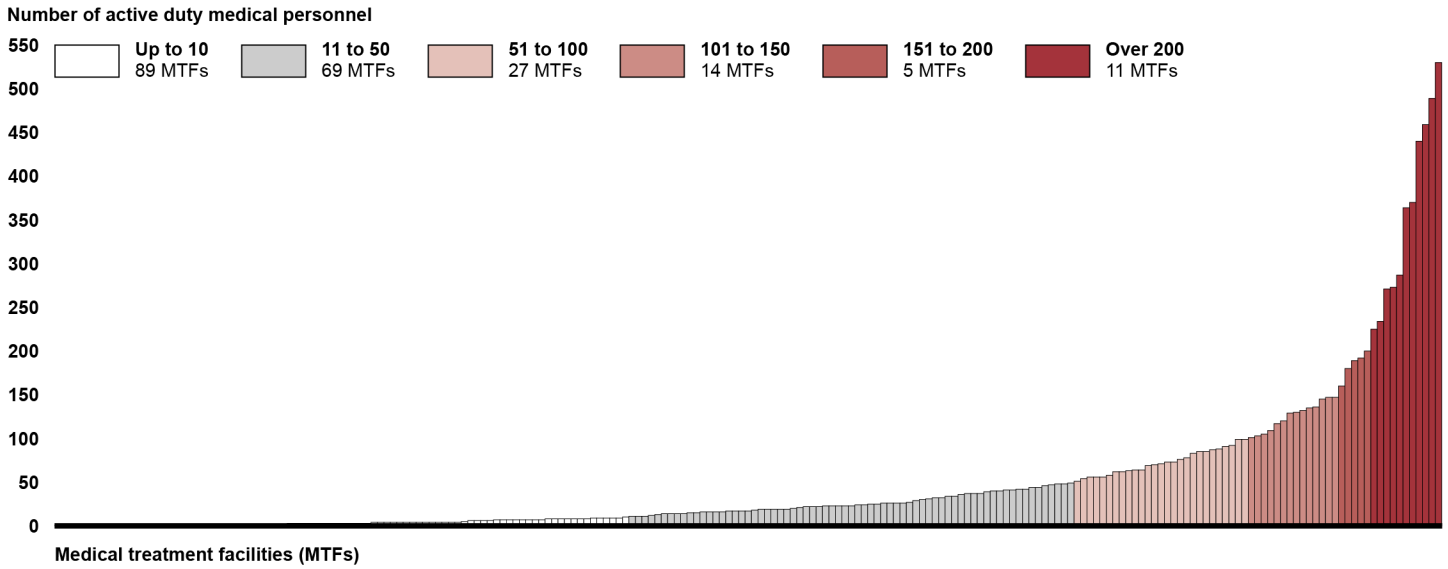
Figure 8: Proposed Number of Active Duty Medical Personnel Reductions by Mitigation Strategy and Military Department, Fiscal Years 2020–2027



Source: GAO analysis of Department of Defense information. | GAO-23-106094

The proposed military medical personnel reductions will affect the available number of active duty workforce authorizations at the MTFs. Based on our analysis, medical personnel reductions represent about 9 percent (10,739 of 119,454) of the total active duty medical workforce authorizations for fiscal year 2022. These proposed personnel reductions will affect 215 of the over 700 MTFs, according to DOD's plan. Of the affected MTFs, 89 MTFs will be reduced by 10 or fewer positions, 69 MTFs will be reduced by 11 to 50 positions, 27 MTFs will be reduced by 51 to 100 positions, and the remaining 30 MTFs will be reduced by over 100 positions (see fig. 9).

Figure 9: Proposed Number of Active Duty Medical Personnel Reductions per MTF, Fiscal Years 2020–2027



Source: GAO analysis of Department of Defense information. | GAO-23-106094

According to military department officials, once authorized to do so, Army and Navy generally intend to reduce the number of positions by location, strategy, and specialty as outlined in the 719 Plan. According to Air Force officials, the Air Force generally supports its number of reductions and specialties to reduce but no longer supports reducing the number by location and strategy as it reported in the 719 Plan. Air Force officials noted that with constrained DHA funding and limited ability to hire civilian and contractor personnel, they no longer support the by-location reductions as reported in the 719 Plan. Instead, according to Air Force officials, the Air Force proposes to right-size MTFs that have a low operational requirement and are located in an area with an adequate market to allow non-active duty patients to enroll off base.

DOD Cites Challenges to Implementing Its Military Medical Personnel Reduction Plans

DOD cites a number of potential challenges to mitigating gaps caused by the proposed military medical personnel reductions. These included:

- **Nationwide shortage of medical professionals.** DOD's 719 Plan noted challenges to hiring replacements due to shortages of certain medical professionals. Moreover, MTF officials from all seven MTFs we interviewed noted that hiring challenges are compounded by the shortage of certain medical professionals. Health Affairs, DHA, and MTF officials noted that ability to hire has only worsened since the start of the pandemic. Recent research has reported concerns about

growing nationwide shortages of medical professionals. For example, a June 2021 study by the Association of American Medical Colleges reported that the United States faces a projected physician shortage of up to 124,000 physicians by 2034, with demand for physicians outpacing supply.[34] According to DOD officials, the US health care system is constrained. DOD officials further noted that during wartime scenarios, DOD deploys Reserve forces away from peacetime employment in the US health care system which may also decrease the number of health care workers in the US health care system.

- **Competition with the private sector and Department of Veterans Affairs.** MTF officials from all seven MTFs we interviewed noted that they face challenges with competing with other entities. Specifically, MTF officials noted they face challenges in attracting applicants because they cannot offer competitive pay when compared to the private sector and the Department of Veterans Affairs. Officials noted they are unable to match private sector pay where salaries are well over the civilian pay limit.[35] DOD's 719 Plan also noted that the Navy included plans to reduce 110 positions that are known to be difficult to hire due to inability to hire a quality candidate within the civilian pay limit.

  A labor market analysis concluded that DHA was at a disadvantage in terms of hiring physicians when compared to private sector hospitals, as it is unable to compete with private sector compensation across multiple specialties.[36] We reported in January 2020 that DOD does not consistently collect information to help inform investment decisions in its package of incentives to recruit and retain military physicians and dentists.[37] We recommended, among other things, that DOD collect consistent information on private sector civilian wages and use this information to help inform investment decisions in the package of incentives to recruit and retain military physicians and

[34]Association of American Medical Colleges, "The Complexities of Physician Supply and Demand: Projections from 2019 to 2034" (updated June 2021).

[35]Pursuant to section 5307 of title 5, U.S. Code, there is a limit on the total amount of allowances, differentials, bonuses, awards, or other similar payments a covered civilian employee may receive in a calendar year, when combined with the employee's basic pay.

[36]DeMay, Jordan (MAJ), Chris Priest, and MAJ Jason Unsworth. *Labor Market Assessment to Determine the Feasibility of the Projected Civilian Physician Hiring Plan.* Army Baylor University Residency Project, 2019-2020.

[37]GAO, *Defense Health Care: DOD Should Collect and Use Key Information to Make Decisions about Incentives for Physicians and Dentists*, GAO-20-165 (Washington, D.C.: Jan. 15, 2020).

dentists. DOD concurred with our recommendation. In its January 2023 status update, DOD stated that it plans to evaluate its current sources of private sector civilian wage information, consider alternatives, and develop a plan to use this information to help inform investment decisions in the package of incentives to recruit and retain military physicians and dentists. DOD estimates this recommendation will be fully implemented by September 2026.

Moreover, MTF officials also noted that the hiring process also makes it difficult to compete with other entities. In its 719 Plan, DOD noted that current hiring times to replace military staff can take up to 180 days to complete. According to a Health Affairs official, hiring times remain about the same, while for certain specialties it can be higher, but effort is underway to reduce number of days to hire once a candidate is identified.

- **Concerns about whether remaining MTF staff can absorb additional workload.** MTF officials from all seven MTFs we interviewed noted that they face challenges in absorbing additional workload caused by reductions. According to MTF officials, about 70 to 80 percent of authorized military positions are filled at the MTFs and other needs, such as operational requirements, take higher priority. MTF officials noted that lengthy vacancies may be due to the military department not having sufficient medical personnel in its inventory who possess the required specialty skills for placement in that position.

According to DOD's 719 Plan, hiring civilian employees would help mitigate the loss of active duty medical personnel. However, according to DOD officials, this is not always an available option, as previously noted. Officials stated if MTFs are unable to hire replacements or absorb additional patient workload, reductions may lead to patients being sent to the TRICARE network and non-network civilian providers that would otherwise have received care at MTFs. MTF officials noted that more patients, including active duty service members, are being sent to the TRICARE network. This could lead to a number of undesirable outcomes, including:

- **Adverse effect on training opportunities.** MTF officials from all seven MTFs we interviewed noted that reductions may affect training opportunities. According to MTF officials, increased numbers of patients being sent to receive care outside of the MTF decreases the number of cases that can be treated at the MTF, thereby reducing training opportunities. MTF officials stated that some reductions would also reduce the number of instructor positions. According to MTF

officials, training programs for enlisted personnel at MTFs are important because they often are not able to train at civilian hospitals, unlike other medical personnel. We reported in June 2021 that licensing requirements and other issues present challenges to establishing and operationalizing civilian partnerships for enlisted personnel.[38] We made 30 related recommendations, including that DHA develop metrics to assess the contributions of MTF workload to sustaining wartime medical skills that include the medical care provided by enlisted medical personnel. DOD concurred with our recommendations; however, as of April 2023, had not yet taken sufficient actions to implement them.

- **Potential loss of GME accreditation.** According to MTF officials at hospitals with GME programs, the potential for less training opportunities may affect the programs' accreditation status. Moreover, officials from MTFs with GME programs noted concern that reductions may negatively affect their GME programs, especially if the lost military positions are not replaced with civilians. Hiring civilians would help mitigate the loss, but military staff add value in that they have the relevant experiences in the field, according to MTF officials.
- **Potential loss of trauma level designations.** According to MTF officials at hospitals with trauma level designations, reductions may affect trauma level designation. MTF officials from one facility noted that to maintain level 1 trauma designation they must provide the continuum of care—from emergency through rehabilitation—to a trauma patient, but that the reductions could affect their ability to do so.
- **Increased difficulty in meeting access to care standards.** According to MTF officials from all seven MTFs we interviewed, a potential concern with MTF military personnel reductions is the effect on access to care for beneficiaries. Specifically, reductions may hinder MTFs' ability to provide care to beneficiaries within DOD's access to care standards because this may result in fewer available appointments. Additionally, MTF officials noted that beneficiaries referred to the TRICARE networks, especially for those health care services the MTF is no longer providing, also may not receive care within DOD's access to care standards. For example, some beneficiaries would have to drive farther for care, potentially outside of DOD's access to care standards for drive times. Moreover, MTF

[38]GAO, *Defense Health Care: Actions Needed to Define and Sustain Wartime Medical Skills for Enlisted Personnel*, GAO-21-337 (Washington, D.C.: June 17, 2021).

officials noted that the TRICARE network is not always able to absorb additional patient workload.

- **Decreased oversight of care provided to active duty service members.** MTF officials from all seven MTFs we interviewed noted that personnel reductions in their facilities would likely result in decreased oversight of care provided to active duty service members. According to officials, military commanders may have less visibility into service members' deployability and military readiness.[39] For care provided outside the MTFs, military providers depend on clear and legible reports submitted by civilian providers to coordinate their patients' plans of care, according to officials. TRICARE civilian providers and local urgent care centers are required to submit clear and legible reports to referring or local MTFs within specified time frames. Not receiving timely reports from the civilian providers can impact military readiness or fitness for duty, among other things, according to MTF officials.

  Moreover, DOD's guidance states that deployability status shall be assessed during every provider encounter within the MHS. DOD providers will determine if conditions identified during each patient encounter affect the service member's ability to deploy, perform job-specific duties, meet retention medical standards, or complete the fitness assessment.[40] According to MTF officials, civilian providers in the TRICARE network do not make these same assessments. In addition, according to MTF officials, certain treatment and diagnoses may affect mission and deployment readiness. For example, active duty service members may be diagnosed with a non-service-compatible condition and treated with service-limiting medication by a civilian provider. Comparatively, MTF providers may make certain diagnoses or try treatments that are not service-limiting but still provide the care that the service member needs, according to MTF officials. MTF officials expressed concern with increased numbers of active duty service members obtaining behavioral health care outside of the MTF. As a result, this hinders DOD's oversight of prescribed

[39]Federal regulation permits protected health information of military personnel that would otherwise be protected under the Health Insurance Portability and Accountability Act to be used and disclosed under special circumstances. Commonly referred to as the "Military Command Exception," covered entities such as MTFs may disclose the protected health information of service members to command authorities for authorized activities. These activities include fitness for duty determinations, fitness to perform a particular assignment, or other activities necessary for the military mission.

[40]Department of Defense Instruction 6025.19, *Individual Medical Readiness Program* (July 13, 2022).

medicines that could affect service members' ability to deploy or complete their mission safely.

- **Increased time away from duty for active duty service members.** MTF officials from three hospitals we interviewed also noted that service members may spend more time away from duty when receiving care outside the MTFs. For example, officials noted that longer drive times to access care in the TRICARE network extends service members' time away from duty. Moreover, there is not a way to prioritize appointments for active duty service members who receive care in the TRICARE networks, according to MTF officials.

In its 719 Plan, DOD noted that, as MTFs rely less on military personnel, it will be important to closely monitor the ability of TRICARE networks to absorb any additional workloads. Moreover, it will also be important to monitor the ability of MTFs to hire or contract for replacement staff. DOD noted that it will closely monitor these aspects of the transition and will adjust its plans as needed. DHA noted that changes at all affected facilities will be implemented at a deliberate, measured pace to ensure that transfer of affected beneficiaries to civilian care proceeds smoothly.

DOD Did Not Fully Assess the Effect Reductions May Have on MTFs, and Military Departments' Use of Information Varied

DOD has not fully or consistently assessed the effects reductions may have on MTFs. Some assessments were performed by DHA and the military departments, but information was not always complete or consistently assessed. Moreover, each of the military departments' approaches to determine where to reduce positions and mitigate potential gaps in health care services at MTFs varied.

DHA-Led Assessments Did Not Fully or Consistently Assess Effect of Reductions

We requested documentation of any DHA-led assessments used to determine the effect reductions may have on MTFs, but the whereabouts of such documentation was not known, according to DOD officials. According to DOD officials, a number of activities were conducted to assess the effects of the reductions. Specifically:

- DHA conducted site visits at selected MTFs to assess the potential effect reductions in medical personnel will have on the MTFs. However, officials stated DHA did not look at every MTF due to time constraints. In particular, there were limited hiring feasibility assessments performed for GME positions and positions in rural MTFs.
- DHA also led a number of working group meetings with military department representatives and discussed how reductions might affect the MTFs, according to DOD officials. According to

documentation of the working group meetings, participants expressed concerns about the ability to hire, the ability to conduct detailed assessments of the TRICARE network, and the potential effect of reductions on GME programs, among others.

- Assessments of the TRICARE network used to inform DOD's response to section 703 of the NDAA for Fiscal Year 2017, which set forth a plan for the realignment of MTFs, were used in part to inform DOD's 719 Plan reductions, according to DOD officials. However, these TRICARE network assessments did not specifically consider the 719 Plan military personnel reductions.

DHA's efforts provided some insight into effects of the planned reductions. However, the efforts were limited (e.g., number of site visits), qualitative and lacking additional analysis (e.g., working group meetings), and not specifically focused on the planned reductions (e.g., 2018-2019 assessments). As a result of these shortcomings, DHA could not fully or consistently assess the effects of reductions across the MHS and its MTFs.

Military Departments' MTF-Level Assessments Did Not Fully or Consistently Assess Effect of Reductions and Use of Information Varied

According to the military departments, to determine the effect planned reductions might have had on the MTFs, requests for information were sent to MTF commanders or other MTF personnel. We requested the completed request for information from DHA and the military departments for all MTFs that informed the 719 Plan reductions, but the whereabouts of such information was not known, according to officials. We requested the same documentation from the MTF officials at the seven MTFs selected that we included in our review. Of the seven MTFs, officials from four provided documentation on their response to the military departments' requests, officials from one were aware of requests but the whereabouts of the documentation were not known, and officials from two noted they were not aware of any requests for information made prior to the publication of the 719 Plan.

Based on our review of MTF documentation available, we found that the military departments' request did not fully or consistently collect information that could be used to identify the effect the reductions would have on the MTF. Additionally, the information could not be used to assess the feasibility of carrying out plans to mitigate gaps in health care services. For example, we found that:

- documentation for three of the four MTFs that provided assessments on the impact of the reductions did not explicitly ask about the

feasibility to absorb additional workload, hire civilian or contractor personnel, and use the TRICARE network.

- documentation from one of the four MTFs that provided assessments of the effect of the reductions explicitly asked about the feasibility to absorb additional workload, hire civilian or contractor personnel, and use the TRICARE network. However, officials we asked at the MTF noted that there were not clear instructions regarding how to identify risk and understand the effect of the reductions.
- MTF concerns were not always reflected in the reduction decisions.

Using available information, the military departments determined the number of reductions, where to reduce positions, and created plans to mitigate potential gaps in health care services at MTFs. However, each of the military departments considered different information. Moreover, some of the military departments' assessments evolved regarding the reductions.

- **Army.** As reported by the Army in the 719 Plan, the Army decreased the number of reductions it proposed in 2019 and reduced or realigned only those authorizations that it (1) determined were currently vacant military authorizations filled with civilian over-hires, or (2) assessed with a high degree of confidence it would be able to offset with civilian hires in that health care market. The Army did not recommend care to be transferred to the TRICARE network. Based on its updated approach, the Army decreased the number of reductions from 6,935 to 2,948. According to Army officials, the Army did not select positions at geographic locations where it would be difficult to hire.
- **Navy.** For the 719 Plan, the Navy did not make changes to the total number of Defense Health Program authorization personnel reductions proposed in 2019 but did change reductions by location for about 500 positions, according to Navy officials. According to Navy officials, changes were based on concerns about using the TRICARE network in certain markets. According to Navy officials, the Navy was willing to accept a certain level of risk.[41]

[41]The Navy reported in its 719 Plan that there are anticipated risks associated with hiring. These risks include a potentially lengthy civilian hiring process, which is highly dependent on the specialty skill and market availability sought, as well as the ability to compete with market salaries in private sector health systems. Any challenges that may arise for civilian hires may result in access to care issues.

- **Air Force.** For the 719 Plan, the Air Force did not make any substantial changes to its personnel reduction plans proposed in 2019, according to Air Force officials. According to the Air Force, to lessen the risk and effect of the reductions on any one MTF, it evenly spread reductions relative to the size of the MTFs. However, the Air Force's approach has changed and it no longer supports its approach as outlined in the 719 Plan.

DOD Lacked Department-Wide Guidance Focused on Ensuring a Full and Consistent Assessment of the Effects of Reductions

DOD did not develop department-wide guidance focused on fully and consistently assessing the potential effects of reductions on the MTFs or assess the feasibility of its mitigation strategies. DHA provided limited guidance on the types of mitigation strategies that could be used to lessen the effect that reductions would have on health care services at the MTFs. However, it did not include guidance about how to assess the feasibility of using mitigation strategies or conduct a risk analysis associated with the hiring, onboarding, and retention of civilian personnel. According to DOD officials, DHA did not provide such guidance to the military departments. As a result, the military departments used only the limited assessments performed when determining the number of active duty medical personnel reductions.

When DOD first proposed to reduce military medical positions, the military departments managed the MTFs. However, the Director of DHA is now responsible for the administration of each MTF, which includes responsibility for staffing MTFs. DHA relies on the military departments to assign active duty medical personnel to the MTFs. As a result, the operations of the MTFs and the health care services that MTFs are able to offer continue to embody decisions made by the military departments, such as how and when to reduce active duty medical personnel who would normally be assigned to the MTFs.

Section 741 of the James M. Inhofe NDAA for Fiscal Year 2023 pauses implementation of military medical personnel reductions until December 2027.[42] It also requires that DOD must, among other things, conduct a risk analysis associated with the hiring, onboarding, and retention of civilian personnel. The mandated analysis must take into account

[42]Pub. L. No. 117-263, § 741 (2022). The provision further requires a waiver from the Secretary of Defense prior to any reductions made after this date. It also includes certain exceptions to the prohibitions.

provider shortfalls across the United States and requires DOD to develop a comprehensive plan to mitigate any risks identified.

DOD Directive 5124.02 states that the Under Secretary of Defense for Personnel and Readiness (USD(P&R)) shall ensure that its policies and programs are designed and managed to improve standards of performance, economy, and efficiency.[43] Moreover, Standards for *Internal Control in the Federal Government* states that management should establish guidance, such as procedures, techniques, and mechanisms, to achieve the entity's objectives and address related risks. It also states that documentation should be readily available by examination.

Without developing guidance that establishes how to assess the effect of any planned reductions, DOD cannot ensure that its assessments are consistent, comprehensive, and reflect the effect reductions may have on the MTFs nor assess the feasibility of implementing its mitigation strategies. Moreover, until DOD develops and implements such guidance, it risks taking actions that could decrease the capability of the military health system to achieve the multi-purpose mission of ensuring the medical readiness of the force, generating ready medical force professionals to deploy, and caring for military service members and their families globally. Moreover, the military departments may make reduction decisions without complete information. Decision-making with limited information creates undue risk that can negatively affect the operation of MTFs, cause shutdowns of health care services that only the MTF can provide in the surrounding area, and increase odds that beneficiaries will not receive care within DOD's access to care standards. By documenting the results of these assessments, such information can help DOD ensure information to make decisions has been collected and used consistently.

[43]DOD Directive 5124.02. The directive further directs USD(P&R) to (1) develop policies, plans, and programs to ensure efficient and effective support of wartime and peacetime operations, contingency planning, and preparedness; (2) analyze the total force structure as related to quantitative and qualitative military and civilian personnel requirements, utilization, readiness, and support; (3) administer and implement controls over military and civilian personnel strengths and compositions for all DoD Components; and (4) establish and issue guidance to be used by all DOD Components regarding manpower management, including manpower mix criteria and DOD function codes to determine workforce mix and annual commercial activities inventories; among other responsibilities.

DOD Has Not Fully Assessed the Relative Costs of Implementing Planned Personnel Reductions

DOD does not know the potential costs of implementing the personnel reductions and planned mitigation strategies reflected in its 719 Plan. Specifically, DOD did not identify the full costs to hire replacements or costs for care provided in the private sector resulting from an inability to provide care at the MTFs due to the personnel reductions.

According to CAPE officials, to determine the civilian staff resources necessary to offset the military medical personnel reductions, CAPE's analysis used DHA's workload standards—which are based on a third-party standard—for civilian, contractor, and military personnel working in the MTFs. Using DHA's workload standards, CAPE determined that the MTFs would not need a one-for-one replacement of civilian hires for each military personnel reduction because military medical staff have additional staffing requirements, such as training, that limit their availability to work in the MTFs. Thus, CAPE assumed fewer civilian staff are needed to replace military providers. However, according to MTF officials, this may not always be the case because, for example, certain military staff may work more hours at the MTF than civilian and contractor personnel. DHA officials noted they no longer believe the standard is accurate, and they are working to create a new one.

DOD's 719 Plan included 162 medical personnel reductions, with a mitigation strategy of using the TRICARE network to meet health care gaps caused by those reductions in MTF personnel. According to a CAPE official, CAPE did not assess the cost of using the TRICARE network for these reductions. This official noted that direct care at the MTFs is generally less expensive than private sector care, however it depends on the location and the type of medical services being provided. Officials from one MTF noted that with reductions in personnel and potential shortages with TRICARE network providers, the military will have no choice but to send patients to non-network civilian providers, potentially at a higher overall cost since TRICARE network providers may agree to accept discounted reimbursement.

In May 2020, we reported that DOD concluded that civilian health care was more cost-effective than care in its MTFs without considering other assumptions that could affect its conclusions.[44] For example, we reported that DOD applied assumptions about the cost of military personnel salaries, MTF workloads, and reimbursement rates for TRICARE that

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

likely underestimated the cost-effectiveness of MTFs. We recommended, among other things, that DOD conduct a sensitivity analysis of the relative cost-effectiveness of MTF-provided care compared to civilian-provided care under varying assumptions, and document that information for decision makers to help inform recommendations on future MTF restructuring decisions. DOD partially concurred with our recommendation, and has taken action but has not fully implemented the recommendation. We continue to believe this recommendation is valid.

Section 741 of the James M. Inhofe NDAA for Fiscal Year 2023 pauses the implementation of reductions until December 2027 and requires that prior to reducing active duty military medical authorizations, DOD develop a process that considers funding required for any such proposed modification to the workforce mix.[45] In addition, the Under Secretary of Defense (Comptroller) has established budgetary information as a priority area for DOD's Financial Improvement and Audit Readiness Plan.[46] The Comptroller's memorandum establishing these priorities states that, because budgetary information is used widely and regularly for management, DOD must prioritize improving its budgetary information and processes. Furthermore, we have previously reported that reliable cost estimates are critical to the success of any program, and that it is important for cost estimates to be timely and available to decision makers as early as possible.[47]

DOD's assessment of the relative costs of providing care to beneficiaries did not consider the full cost of military medical personnel reductions because the department did not conduct a comprehensive review of the cost of any future proposed reductions on the unified medical budget and use that assessment to inform reduction decisions. Instead, according to CAPE officials, DOD based its assessment on assumptions that there would be minimal reliance on TRICARE networks and that hiring civilians to replace military personnel would be possible without increasing overall costs. Moreover, CAPE's assessment of the cost of implementing reductions in DOD's 719 Plan assumed the 719 Plan mitigation strategies were feasible. According to CAPE officials, CAPE concurred with the 719 Plan but due to the timing of the report and related resourcing impacts,

[45]Pub. L. No. 117-263, § 741(a)(1) (2022).

[46]Under Secretary of Defense (Comptroller) Memorandum, *Priorities for Improving Financial Information and Processes and Achieving Audit Readiness* (Aug. 11, 2009).

[47]GAO, *GAO Cost Estimating and Assessment Guide: Best Practices for Developing and Managing Capital Program Costs*, GAO-09-3SP (Washington, D.C.: Mar. 2, 2009).

CAPE recommended that the analysis be further evaluated during the next program budget review.

Fully assessing the costs of any planned future reductions would enable DOD to accurately determine the full cost of active duty medical personnel reduction decisions and would provide the department with opportunities to enhance overall cost-effectiveness. Without such an assessment, senior leaders may unknowingly take on additional risk by divesting active duty medical personnel, at additional cost to the unified medical budget.

DOD Methodology to Assess the Ability of TRICARE Networks to Absorb Additional Workload Resulting from Planned Reductions Has Weaknesses and Was Not Used

In its section 719 Plan to the congressional armed services committees, DOD outlined a methodology to assess the ability of TRICARE networks to absorb the additional patient workload that could result from planned reductions of active duty medical personnel at MTFs. However, DOD's methodology does not define specific measures that can facilitate consistent assessments of the TRICARE networks that may be affected by proposed MTF military medical personnel reductions. Moreover, DOD did not use this methodology to assess the TRICARE networks with planned reductions.

DOD's Methodology to Assess the Ability of TRICARE Networks to Absorb Additional Workload Lacks a Process for Measuring Effect of MTF Personnel Reductions

The 719 Plan includes a methodology for evaluating TRICARE networks' ability to absorb patient workload that may be shifted away from the MTFs due to personnel reductions. The methodology directs the department to use reports routinely provided by the TRICARE managed care support contractors, among other methods, to perform this assessment.[48] Specifically, the 719 Plan states that DOD's evaluation can use data about (1) monthly updates on network status (data on the number of contracted civilian providers), (2) access to care (average days to care for TRICARE enrollees' specialty referrals), (3) drive times from beneficiaries' residences to providers' offices, and (4) the percentage of referrals sent to network providers and MTFs versus non-network providers, among other information. DOD also reported in the 719 Plan that it defines network adequacy as a network with a sufficient number of providers to

[48]The TRICARE managed care support contractors are responsible for developing networks of civilian providers to provide health care services and augment care provided at MTFs.

meet access to care standards for TRICARE Prime enrollees, as defined in regulation, unless there is an absence of providers in the area.[49]

While the 719 Plan methodology outlines information sources for evaluation, we found that it lacks measureable objectives for assessment. Instead, the 719 Plan describes "adequacy screens" for primary care and specialty care.

For example, as shown below, the 719 Plan lists the types of reports DOD can use and the steps officials can take to conduct an "adequacy screen" of specialty care in a TRICARE network.

> When evaluating proposals to reduce MTF specialty care capacity, the DHA uses the Days-to-Care Reports and Drive Time Reports to provide an initial evaluation of the potential adequacy of the network. To evaluate the potential impact of removing specialty care providers from the MTF, the DHA uses the NSR [Network Status Reports], days-to-care, new network demand, and network provider capacity to project future days-to-care. Following this initial screening, DHA coordinates with the MCSC [Managed Care Support Contractors] to conduct further analysis prior to implementation planning.

While these evaluation steps are informative, the 719 Plan does not define a measurable objective of how to use the "adequacy screen" for specialty care to determine if the TRICARE network can absorb additional patient workload. For example, the specialty care adequacy screen does not explain how to perform a consistent measurement to project future days-to-care using the listed data sources. Similarly, for urgent care, emergent care, and inpatient care, the 719 Plan does not include measurable objectives for assessment.

Section 719(b) of the NDAA for Fiscal Year 2020 required DOD to develop a standard measurement for network adequacy.[50] Moreover, *Standards for Internal Control in the Federal Government* states that

[49]Access to care standards are defined in section 199.17(p)(5) of title 32 of the Code of Federal Regulations (CFR). The 719 Plan also says that network adequacy is a product of the number of civilian providers contracted and their ability to see TRICARE beneficiaries within access to care standards. For example, one standard requires that the wait time for an appointment for a well-patient visit or a specialty care referral shall not exceed 4 weeks.

[50]Pub. L. No. 116-92, § 719(b) (2019), *amended by* Pub. L. No. 116-283, § 717 (2021) and Pub. L. No. 117-81, § 731 (2021).

management should define objectives in measureable terms so that performance can be assessed. It further states that measurable objectives are generally free of bias and do not require subjective judgements to dominate their measurement. Measurable objectives are also stated in a quantitative or qualitative form that permits reasonably consistent measurement.

DHA has not developed guidance that translates the 719 Plan methodology into measureable objectives that can facilitate consistent assessments of civilian provider networks' ability to absorb additional patient workload where personnel reductions are planned across military departments. Without such guidance, officials will not have objective measures and may inconsistently apply the methodology in their assessment of the effect any planned MTF personnel reductions will have on the TRICARE networks.

DOD Did Not Use Its Methodology to Assess the Ability of TRICARE Networks to Absorb Additional Patient Workload Resulting from 719 Reductions

DOD did not use its 719 Plan methodology to assess the effect proposed reductions may have on the TRICARE networks. Instead, in the 719 Plan, DOD used the results from a population assessment which, according to officials, was originally conducted in response to section 703(c) of the NDAA for Fiscal Year 2017.[51] The reported assessment included a review of 122 MTFs and analyzed data on the (1) community population, (2) TRICARE eligible population, and (3) number of MTF enrollees. In addition to these quantitative data points, the assessment included notes on any known limitations of the TRICARE networks. Collectively, these data points do not apply the 719 Plan methodology to evaluate the TRICARE networks. Moreover, according to officials, this population assessment was performed in December 2018.[52] This is approximately one year before section 719 of the NDAA for Fiscal Year 2020 required DOD to assess the effect of proposed MTF personnel reductions on the local health care network.

DOD officials were unable to demonstrate how the department used the population assessment to determine the MTF personnel reductions in the 719 Plan. For example, over half of the MTFs (68 of 122) assessed in the

[51]Section 703(c) of the NDAA for Fiscal Year 2017 required DOD to update its Military Health System Modernization Study dated May 29, 2015, to address the restructuring or realignment of MTFs, including with respect to any expansions or consolidations of such facilities.

[52]The 2018 assessment was also completed prior to the COVID-19 pandemic, which has left the U.S. health care sector with shortages of health care providers, some of which may have affected the civilian provider networks.

719 Plan were determined to be of high or extreme risk, meaning that the TRICARE networks may be unable to absorb the additional patient workload caused by proposed MTF personnel reductions. Further, the 719 Plan reported that 32 MTFs were to use the TRICARE network as a mitigation strategy for their planned reductions. However, based on our analysis of the population assessment, only 53 percent of them could absorb the additional patient workload without issue. Specifically, of the 32 MTFs

- seven were in areas where DOD determined the TRICARE network could not absorb the additional patient workload;
- eight were in areas where DOD determined that the TRICARE network would have major issues trying to absorb the additional patient workload;
- four were in areas where DOD determined the TRICARE network should be able to absorb the additional patient workload with some minor impact; and
- the remaining 13 were in areas where DOD determined the TRICARE network could absorb the additional patient workload.

As stated previously, section 719(b) required DOD to develop a standard measurement for network adequacy and use it to assess the effect of proposed reductions of MTF medical personnel on the local health care network. However, DOD did not use the methodology it developed in the 719 Plan to assess the ability of TRICARE networks to absorb additional workload resulting from planned military medical personnel reductions. By using guidance with measureable objectives to assess the capabilities of civilian provider networks, DOD can ensure that decision makers will be better positioned to know the risks, if any, such reductions may have on the department's ability to provide health care services.

The 719 Plan also states that DHA will closely monitor TRICARE network adequacy in locations where military medical personnel have been reduced to ensure beneficiaries receive care within established access to care standards. As more beneficiaries begin to obtain care from TRICARE civilian providers, DHA will monitor TRICARE network performance and slow or halt transitions as necessary to ensure beneficiaries' access to care. However, according to officials, DOD has not developed plans to facilitate periodic monitoring of the ability of TRICARE networks to absorb the additional patient workload resulting from planned reductions of MTF medical personnel.

It is important for periodic monitoring to occur, particularly given that, according to officials, reductions may result in greater reliance on TRICARE networks due to the inability to hire replacements for military medical personnel at the MTFs. Moreover, DOD will benefit from having plans to periodically assess TRICARE networks affected by the reductions.

Medical Personnel Requirements Consider Wartime Needs, but Deficiencies in Medical Capabilities Exist

The military departments primarily consider wartime scenario needs in determining active duty medical personnel requirements. However, the military departments do not have an integrated process for determining those requirements. Furthermore, deficiencies in medical capabilities exist, according to DOD documentation and officials.

Military Departments Primarily Consider Wartime Scenario Needs in Determining Active Duty Medical Personnel Requirements

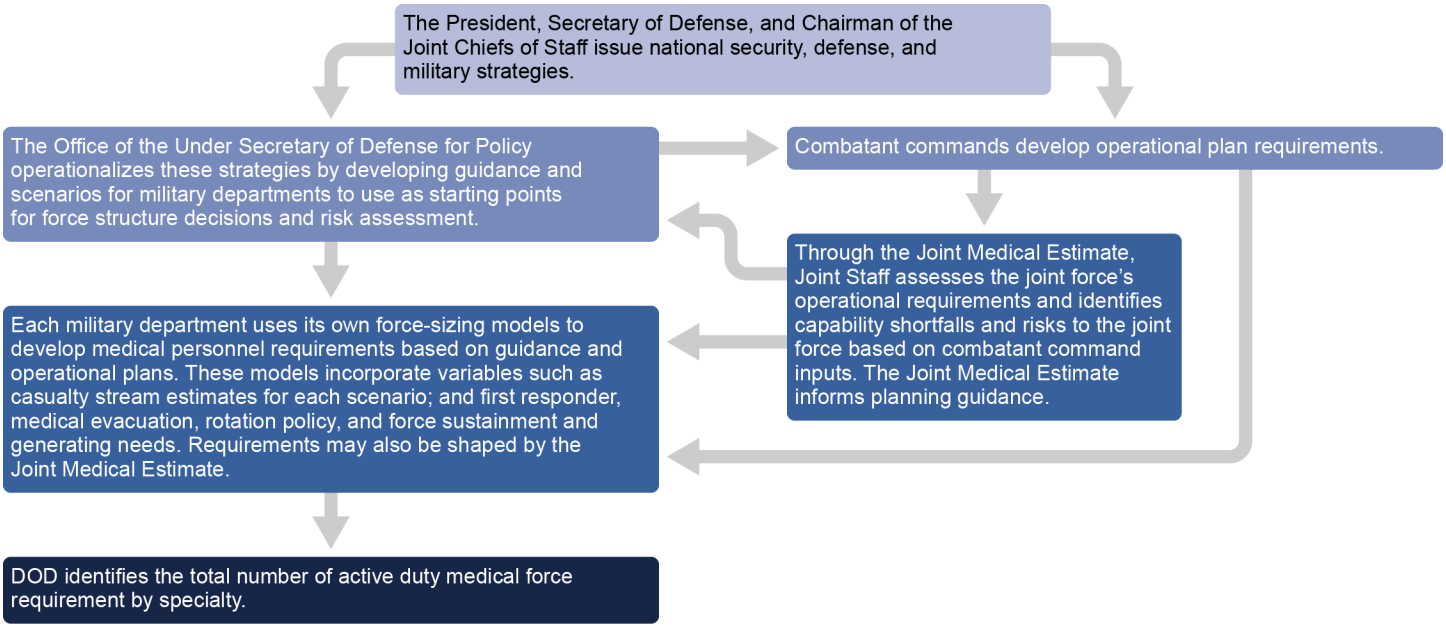
The military departments use existing processes and tools to determine how to meet medical personnel requirements under wartime scenarios, according to senior officials and based on our review of strategic guidance and policy.[53] This process for determining requirements begins with overarching strategy set by the President, Secretary of Defense, and Chairman of the Joint Chiefs of Staff. The Office of the Under Secretary of Defense for Policy then operationalizes these strategies to develop DOD's Defense Planning Guidance and Defense Planning Scenarios, to include wartime scenario needs.[54] Combatant commands, informed by the planning guidance and scenarios, define what their operational plans and concept plans require. Then, using these sources, the military departments individually use existing models to develop the number of

[53]Each military department decides how to organize, train, and equip the people who compose its authorized end strength to meet combatant commander or service-specific requirements. This decision includes determining the number of military medical personnel required in each service. The size of each service's medical force is often dependent on total end strength levels authorized by law, demands for medical capabilities in military operations (to include wartime needs), and the priority of those demands compared to other nonmedical capabilities.

[54]The Defense Planning Guidance operationalizes the National Defense Strategy and provides guidance to the military departments on their use of approved scenarios, among other things. These scenarios serve as the starting point for making force structure decisions and assessing risk and 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.

active duty medical personnel requirements, and the department identifies the total number by specialty (see fig. 10).

Figure 10: Determination Process for DOD Active Duty Medical Personnel Requirements



Source: GAO analysis of Department of Defense (DOD) documentation and interviews with officials. | GAO-23-106094

This process determines the total number of active duty medical personnel the military departments identified to meet the needs of the operating force— whose primary mission is to participate in combat and the integral supporting elements thereof; and the generating force— whose primary mission is to generate and sustain the operating force.

The operating force executes DOD's assigned missions, to include deterring and defeating enemy forces. Active duty medical personnel may be used, if available, to meet other missions, such as defense support of

civil authorities (DSCA), which includes pandemic influenza missions.[55] For additional missions like DSCA support, which are ad hoc, DOD can decide to repurpose capabilities prepared for its assigned missions.[56] Similarly, DOD does not factor homeland defense into medical personnel requirements directly; rather, homeland defense is broadly part of the National Defense Strategy and part of combatant command operational plans. DOD uses available medical personnel to meet homeland defense missions.[57]

Military Departments Do Not Have an Integrated Process for Determining Active Duty Medical Personnel Requirements

The military departments' processes for determining the number of active duty medical personnel needed are not integrated. DOD provided the House and Senate Armed Services Committees with interim and final reports on their individual processes for determining medical personnel requirements. In its March 2018 interim report, DOD stated that the majority of the work to define personnel requirements was completed by the individual military departments in coordination with the Joint Staff, and that additional work was required to develop a DOD-wide process.[58] The interim report also noted that DOD would address a department-wide process in a follow-on report to the House and Senate Armed Services

[55]DSCA is support provided by federal military forces; DOD civilians; DOD contract personnel; and DOD component assets, to include National Guard forces (when activated in title 32 status), in response to a request for assistance from civil authorities for domestic emergencies, cyberspace incident response, law enforcement support, and other domestic activities or from qualifying entities for special events. DSCA includes support to prepare, prevent, protect, respond, and recover from domestic incidents. DOD provides DSCA support in response to requests from civil authorities and upon approval from appropriate authorities. DSCA missions include pandemic influenza and infectious disease response. Joint Publication 3-28, *Defense Support of Civil Authorities* (Oct. 29, 2018).

[56]There are legal constraints for building force elements specifically for training and equipping to respond to DCSA, according to DOD officials. Exceptions to this include local scenario home-station medical response for Air Force and public health and medical research and development for Navy and Army, which military department officials stated are factored in to total active duty medical personnel requirements. DOD can also prepare capabilities for executing pandemic response as it relates to protecting its own forces, according to Joint Staff officials.

[57]DOD defines homeland defense as the protection of United States sovereignty, territory, domestic population, and critical infrastructure against external threats and aggression or other threats as directed by the President. DOD executes homeland defense by detecting, deterring, preventing, and defeating threats from actors of concern as far forward from the homeland as possible. Joint Publication 3-27, *Homeland Defense* (Apr. 10, 2018).

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

Committees. However, in its final report, DOD restated its description of the processes the military departments use to identify requirements individually, having not established the singular DOD-wide joint process that it described working toward in its interim report.[59]

Navy officials stated they are revisiting their process for determining requirements to better align personnel requirements to operational needs. Specifically, the Navy is conducting a "bottom-up" analysis of defining military medical requirements that potentially may affect the number of required active duty personnel, according to Navy officials. Air Force and Army officials stated they continue to support their requirements determination processes.

In February 2019, we reported on the lack of integration between the military departments' processes for determining requirements.[60] Specifically, we reported that leaders from the Office of the Secretary of Defense disagreed with the military departments' initial estimates of required personnel that were developed to report to the House and Senate Armed Services Committees in 2018. Office of the Secretary of Defense officials cited concerns that the departments had not applied assumptions for operating jointly in a deployed environment and for leveraging efficiencies among personnel and units. We found that the military departments applied different planning assumptions in estimating required personnel, such as developing varying definitions for operational requirements. We recommended that DOD (1) establish joint planning assumptions for developing operational medical and dental personnel requirements, (2) establish a method to assess options for achieving joint efficiencies in those requirements, and (3) apply joint planning assumptions and a method for assessing efficiencies and risk to determine requirements. DOD concurred with these recommendations.

As of April 2023, DOD had not fully implemented the three recommendations. We continue to believe that our recommendations remain valid, and that fully implementing them will help align DOD's actions with statutory requirements. Until DOD fully implements the recommendations, the department will not be able to apply consistent

[59]Department of Defense, *Report to the Congressional Armed Services Committees, Section 719 of the National Defense Authorization Act for Fiscal Year 2020 (Public Law 116 – 92)* (July 2021).

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

assumptions to determine medical and dental personnel requirements and will not have a method for assessing options for joint efficiencies. Without such a method, the department will not know whether it has an optimal size and composition of medical and dental personnel for achieving its missions within acceptable risk levels.

Deficiencies in Medical Capabilities Exist Due to a Variety of Factors, but DOD Has Not Defined Fully Its Medical Personnel Requirements

DOD has identified deficiencies in medical capabilities, including through the JME. While the JME is not an integrated process for determining medical requirements or a means to determine the size of the medical force, it is one input into the military departments' requirements process. Specifically, the JME provides an independent assessment of the joint force's operational medical capabilities and identifies deficiencies in those capabilities.[61] Military departments can use this information to evaluate how to resource medical personnel (i.e., determine how many personnel to recruit, train, and equip), and how much risk they are willing to accept in making that determination. DOD issued the initial JME in August 2020.

Based on our review of the 2020 JME and our discussions with DOD officials, we found that DOD has deficiencies in medical capabilities identified for operational missions, in part, because it has (1) undefined requirements; (2) accepted risks by funding less medical personnel to fund other priorities; and (3) experienced challenges with recruitment and retention. These causes of deficiencies lead to differences between the number of required, authorized, and actual medical personnel (see fig. 11).

[61]Chairman of the Joint Chiefs of Staff Instruction 3100.01E, *Joint Strategic Planning System* (May 21, 2021). The JME came out of a requirement in section 732 of the John S. McCain NDAA for Fiscal Year 2019 that the Secretary of Defense, in coordination with the Secretaries of the military departments and the Chairman of the Joint Chiefs of Staff, develop a process to establish required joint force medical capabilities for members of the Armed Forces that meet the operational planning requirements of the combatant commands. This process was to include, among other elements, a JME to determine the medical requirements for treating members of the Armed Forces who are wounded, ill, or injured during military operations.

Figure 11: Causes of Deficiencies in DOD Medical Capabilities

Source: GAO analysis of Department of Defense (DOD) documentation and interviews with officials. | GAO-23-106094

Undefined Requirements Lead to Medical Personnel Deficiencies

According to the JME, not all personnel requirements have been fully defined—specifically across three areas. First, DOD has not updated the plan that defines the medical assets needed to support DOD casualties in a large-scale conflict since 1998.[62] According to DOD officials, the department is currently updating the plan to clarify medical personnel needed for the reception, care, and redistribution of casualties from an attack on the homeland and/or returning from an overseas large-scale conflict. Officials expect to finalize the plan by December 2024.

In 2020, the Department of Health and Human Services assessed the U.S. health care system's capacity to receive and treat large numbers of military and civilian casualties resulting from conventional warfare and chemical, biological, radiological, and nuclear military contingency casualties.[63] The analysis took into consideration DOD's planned reductions of the medical force. The analysis found that the civilian health system is unable to absorb and provide sustained care for the volume and types of admissions resulting from a potential military conflict. This is in large part due to financial incentives that preclude the development and maintenance of excess capabilities in the civilian hospital system.

Second, pandemic response is another area in which DOD has not yet fully defined requirements. The initial JME did not consider this topic. According to Joint Staff officials, the updated JME discusses pandemic considerations.[64] Further, officials stated that DOD used active duty

[62]Department of Defense, *Integrated CONUS Medical Operations* Plan (1998).

[63]Department of Health and Human Services, Assistant Secretary for Preparedness and Response Memorandum, *U.S. Healthcare System Capacity for Treatment of Military Casualties* (Jan. 14, 2020).

[64]The updated JME, issued June 2023, was finalized while our draft report was with DOD for official comment. It was not included in our review.

personnel to support the whole of government during the COVID-19 pandemic while they were also expected to maintain their pre-existing health service mission. Furthermore, Reserve Component medical personnel deployed under DSCA created deficits in the local communities where those personnel had been serving.

A March 2023 DOD review of the MHS's response to the COVID-19 pandemic, which included lessons learned, found that although the military departments had adequate staffing at the beginning of the pandemic to support civil authorities, the deployment of uniformed personnel away from their MTFs created gaps in MTF coverage that resulted in the reduction of clinical and public health services, with associated effects on the "Medically Ready Force."[65] Stress to the medical systems around installations outside the continental United States limited the ability for personnel to transfer, halting and delaying medical evacuation operations and expanding gaps in hiring actions.

Third, according to DHA and military department officials, DHA has not yet fully defined what the staffing requirements are at MTFs. DHA officials stated that as part of a Military Health System Executive Review study, the military departments are working with DHA to ensure that both parties coordinate on and define the clinical capabilities and capacities needed at each MTF.

Resource Allocation Decisions and Competing Priorities Create Risks of Medical Personnel Deficiencies

Military departments may decide to accept deficiencies in the medical capabilities (i.e., authorized medical personnel) available to them to allocate those capabilities and their funds to other operational priorities needed to support the National Defense Strategy. These deficiencies create risks that the military departments deem acceptable to fulfil their priorities, according to the officials. DOD must balance priorities between medical and nonmedical capabilities, such as lethality, while working within the total end strength and appropriations authorized by law. Military department officials stated that to support the National Defense Strategy,

[65]Under Secretary of Defense for Personnel and Readiness, *Report to the Congressional Defense Committees, COVID-19 Military Health System Review Panel*, (Washington, D.C.: March 10, 2023).

they are seeking to reduce the military medical force to increase personnel for other operational requirements.[66]

Recruitment and Retention Challenges Create Medical Personnel Shortages

According to the JME and our prior work, personnel shortages caused by recruitment and retention challenges in certain critical wartime specialties, such as surgery, are another challenge to medical capabilities. In February 2018, we reported that DOD has experienced gaps between its physician authorizations (i.e., funded positions) and end strengths (i.e., actual number of physicians).[67] We made 10 recommendations, including that the services develop targeted and coordinated strategies to alleviate military physician gaps; the services improve the tracking of medical student data; the Navy and the Air Force use medical student performance information to evaluate accession programs; and DOD's scholarship program develops a method to accurately determine the costs to educate medical students. DOD implemented five of our recommendations and five remain open.[68]

Shortages of personnel can also affect the military GME system, according to the JME and the Accreditation Council for Graduate Medical Education. In October 2019, the council's president, writing to DOD, expressed concern for the GME system; namely, that reductions in clinical faculty will jeopardize accreditation of military GME programs, and the civilian system cannot fill in the gap. If the capacity of the military GME system were reduced, the hundreds of military physicians who would normally be trained in the military GME system would be required to receive their training through the civilian GME system. However, according to the council's president, there is no excess capacity within the civilian GME system in the United States to absorb the hundreds of physicians annually who enter GME in preparation for careers of service to military personnel. He cited an example that during the prior year, more

[66]In response to section 719 of the NDAA for Fiscal Year 2020, DOD submitted its plan to better align military medical personnel with operational medical requirements by reducing the active duty medical workforce. Subsequent NDAAs paused the proposed reductions in medical personnel pending further analysis of their effects, as discussed earlier in this report.

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

[68]For example, Army and Air Force implemented the recommendations to develop targeted and coordinated strategies to alleviate military physician gaps. According to Navy officials, it completed a study that evaluated the effectiveness of recruitment and retention programs for military medical personnel; however, our recommendation remains open pending additional information about its status.

than 1,000 civilian medical school graduates did not receive a position in the civilian GME system's residency program, and more than 500 were without positions at graduation. Hundreds of military-bound physicians entering the pool would only exacerbate the problem, according to the council's president.

Finally, the COVID-19 pandemic also highlighted shortages in critical specialties. DOD's March 2023 review of the MHS's COVID-19 response found that the medical specialties in highest demand from the civilian sector for DOD to provide were many of the same specialties required for warfighting and for which DOD has had chronic shortages. In addition, the review found that COVID-19 adversely affected recruiting, accession, and entry-level training activities.

Military Medical Personnel Requirements That Are Not Fully Defined Limit DOD's Ability to Assess Planned Reductions

Congress has required DOD to define its medical personnel requirements through provisions in multiple NDAAs. First, section 719 of the NDAA for Fiscal Year 2020, as amended, required each military department, in coordination with the Chairman of the Joint Chiefs of Staff, to conduct a review of the medical staffing requirements of their respective departments that includes any personnel validation requirements determined pursuant to estimates provided in the JME under section 732 of the John S. McCain NDAA for Fiscal Year 2019. Such review was to account for all national defense strategy scenarios, including with respect to both the homeland defense mission and pandemic influenza. Section 719 also required the Secretary of Defense to report to the House and Senate Armed Services Committees on the proposed military medical personnel reductions, including the reviews the military departments developed.

Second, section 741 of the James M. Inhofe NDAA for Fiscal Year 2023 pauses implementation of personnel reductions until December 2027 and requires that prior to reducing active duty military medical authorizations, DOD, among other things, conduct an assessment of current military medical staffing requirements (taking into consideration factors including future operational planning, training, and beneficiary health care).

However, as previously discussed, DOD has not defined fully its medical personnel requirements. According to Joint Staff and military department officials, the military departments used Joint Staff's JME, which provides an independent assessment of joint medical capabilities, to validate individually-derived requirements. Further, Joint Staff officials stated that the military departments focus on their own medical requirements, which can lead to missed opportunities to integrate capabilities across the joint

force. According to military department officials, efforts are underway to address certain deficiencies, and they plan to use information from the current JME when updating requirements. Military department officials stated that they are also incorporating lessons learned from the COVID pandemic, for example.[69] Despite these efforts, according to a joint staff official, the JME risk assessment has not yet resulted in significant changes that would fundamentally drive the changes required to mitigate medical capability deficiencies. Moreover, according to senior joint staff officials, reductions to military medical personnel should not be made until requirements are sufficiently defined.

Standards for Internal Control in the Federal Government states that management should use quality information—information that is current, complete, accurate, accessible, and provided on a timely basis—to achieve an entity's objectives.[70] Applied to DOD in the context of making decisions about personnel reductions, this internal control principle would include DOD ensuring that it knows relevant information—specifically the medical personnel requirement— prior to making those decisions.

Without fully defined personnel requirements, DOD will not have all relevant information at its disposal to make decisions regarding the reduction of military medical personnel and risks exacerbating the issues it faces through decisions based on bad information. Additionally, without accurately defined requirements, DOD is unable to make a fully informed decision about where there is risk in reducing medical personnel requirements and how much of that risk it is willing to accept given budget constraints.

Conclusions

In fiscal year 2022, DOD spent over $55 billion on the MHS to provide medical care to active duty service members and other beneficiaries. Additionally, these funds provide training at MTFs to help ensure active duty medical personnel are ready to deploy for operational missions. Each military department has its own process to identify the number of active duty personnel needed to meet operational requirements. However, DOD has identified capability deficiencies in meeting joint wartime medical personnel requirements.

[69]For example, Air Force officials stated they may decide not to reduce staff at certain labs that not only support active duty care requirements but also provide pandemic response capabilities.

[70]GAO-14-704G.

Recently, DOD proposed reductions to thousands of active duty military personnel positions. While reducing active duty medical personnel may increase the number of operational billets for other capabilities, it may affect the MHS's ability to meet its medical missions and provide quality care to beneficiaries, according to DOD officials. The reductions may also affect the overall costs of health care provided at DOD. However, the department has not fully assessed the effect and cost these reductions will have on the MHS. Additionally, DOD has not assessed through defined measures whether it will be feasible to rely on the civilian provider networks to absorb additional patient workload that such reductions could cause. DOD should fully define military medical personnel requirements before determining personnel reductions. By taking steps to better address these issues, DOD would be better positioned to meet its MHS mission.

Recommendations for Executive Action

We are making the following nine recommendations to DOD:

The Secretary of Defense should ensure that the Assistant Secretary of Defense for Health Affairs, in coordination with the Surgeons General of the military departments and the Director of DHA, develops and implements department-wide guidance for assessing fully and consistently the potential effect of military medical personnel reductions on the MTFs, including procedures for documenting results of the assessments. Such guidance should provide clarity on assessing feasibility of using mitigation strategies for any identified reductions and conducting a risk analysis associated with the hiring, onboarding, and retention of civilian personnel. (Recommendation 1)

The Secretary of the Army, in coordination with the Surgeon General of the Army, should use the results of such assessments to inform the number of active duty medical personnel reductions. (Recommendation 2)

The Secretary of the Navy, in coordination with the Surgeon General of the Navy, should use the results of such assessments to inform the number of active duty medical personnel reductions. (Recommendation 3)

The Secretary of the Air Force, in coordination with the Surgeon General of the Air Force, should use the results of such assessments to inform the number of active duty medical personnel reductions. (Recommendation 4)

The Secretary of Defense should ensure that the Assistant Secretary of Defense for Health Affairs, in coordination with the Surgeons General of the military departments and the Director of the DHA, conducts a comprehensive assessment of the cost of any future proposed military medical personnel reductions on the unified medical budget and use that assessment to inform reduction decisions. (Recommendation 5)

The Secretary of Defense should ensure that the Assistant Secretary of Defense for Health Affairs, in coordination with the Surgeons General of the military departments, and the Director of DHA, develops guidance that translates the 719 Plan methodology into a process with measureable objectives that can facilitate consistent assessments of TRICARE networks' ability to absorb additional patient workload resulting from future reductions of military medical personnel. (Recommendation 6)

The Secretary of Defense should ensure that the Assistant Secretary of Defense for Health Affairs, in coordination with the Surgeons General of the military departments and the Director of the DHA, prior to implementing its future military medical personnel reductions plans, assesses TRICARE networks with planned military medical personnel reductions using guidance developed from the 719 Plan methodology to determine the networks' ability to absorb additional patient workload. (Recommendation 7)

The Secretary of Defense should ensure that the Assistant Secretary of Defense for Health Affairs, in coordination with the Surgeons General of the military departments and the Director of the DHA, uses the guidance developed from the 719 Plan methodology and develops a plan that facilitates periodic monitoring of the ability of TRICARE networks to absorb additional patient workload resulting from any planned military medical personnel reductions. (Recommendation 8)

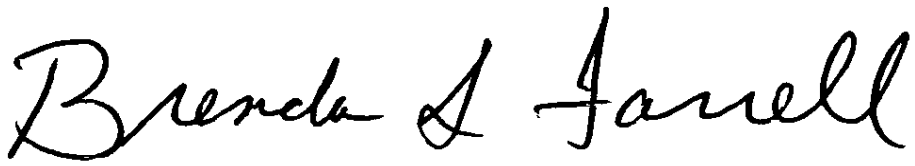
The Secretary of Defense, in coordination with the Chairman of the Joint Chiefs of Staff and the Secretaries of the military departments, should ensure that DOD fully defines military medical personnel requirements before making future decisions about how many military medical personnel to reduce and where to accept risk. (Recommendation 9)

Agency Comments

We provided a draft of this report to DOD for review and comment. In its written response, reproduced in appendix II, DOD concurred with our recommendations. DOD also provided technical comments on the draft report, which we incorporated as appropriate.

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 the Defense Health Agency, the Secretaries of the Army, the Navy, and the Air Force, and other interested parties. In addition, the report is available at no charge on the GAO website at http://www.gao.gov.

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



Brenda S. Farrell
Director, Defense Capabilities and Management

Appendix I: Objectives, Scope and Methodology

Section 731 of the National Defense Authorization Act (NDAA) for Fiscal Year 2022 included a provision for us to review the Department of Defense's (DOD's) analyses in support of reductions or realignment of military medical personnel, including any reduction or realignment of medical billets of the military departments.[1] DOD issued a report in July 2021 which included a plan (referred to as the 719 Plan) to reduce 12,801 military positions by the end of Fiscal Year 2027.[2] In this report, we evaluate the extent to which

1. DOD identified reductions or realignment of active duty medical personnel and strategies to mitigate any potential gaps in health care services at medical treatment facilities (MTFs), and assessed any effects, including overall costs, on the Military Health System (MHS) and DOD;
2. DOD assessed the ability of TRICARE networks to absorb the additional workload that may be caused by the reductions of active duty medical personnel; and
3. the military departments used wartime scenarios and identified medical capability deficiencies, if any, to determine active duty medical personnel requirements.

For objective one, we reviewed DOD's 719 Plan and supporting documents related to DOD's determination of reductions and documents of DOD's assessment on the effect reductions may have on the MHS. Moreover, to identify the total number of proposed military personnel reductions and realignments by specialty, location, and mitigation strategy, we reviewed DOD's 719 Plan and military department data. We used the military department data to identify the number of non-medical positions by MTF and mitigation strategy in order to exclude these from the total number of medical reductions reported in the 719 Plan. For the Navy, we used its data to identify positions that are marked for realignment in order to exclude these from the total number of medical reductions reported in the 719 Plan. We assessed the reliability of military department reduction data by (1) performing electronic testing for errors, such as missing or invalid data, (2) interviewing agency officials knowledgeable about the data, and (3) comparing data to what was reported in the 719 Plan where possible. We determined that in

[1]Pub. L. No. 117-81, § 731(a)(2) (2021), *amended by* Pub. L. No. 117-263, § 731 (2022).

[2]Department of Defense, *Report to the Congressional Armed Services Committees: Section 719 of the National Defense Authorization Act for Fiscal Year 2020 (Public Law 116-92)*, (Washington, D.C.: July 2021).

combination, these data are sufficiently reliable to report on the number of proposed reductions by military department, specialty, and mitigation strategy.

We also used data from DOD's Health Manpower Personnel Data System (HMPDS) report to calculate the extent to which the military departments met authorizations—that is, funded positions—by specialty for fiscal year 2022.[3] We analyzed data for fiscal year 2022 because it was the most recent year of available HMPDS data at the time of our review. We assessed the reliability of the HMPDS data by reviewing previous data reliability assessments on HMPDS, performing electronic testing for errors, such as missing or invalid data, and interviewing agency officials knowledgeable about the data. We found it to be sufficiently reliable for reporting authorization, end strength, and personnel gaps between end strength and authorization by specialty and military department.

Additionally, we reviewed relevant statutes and DOD guidance and compared them to DOD's assessments on the impact reductions have on the MHS.[4] We also determined that the control activities, information and communication, and monitoring components of internal control were significant to this objective, along with the underlying principles that management should design control activities to achieve objectives and respond to risks, use quality information, establish and operate monitoring activities, and remediate identified deficiencies on a timely basis.[5]

For objective two, we reviewed Defense Health Agency's (DHA) TRICARE network assessments that were reported in its 719 Plan and other supporting documentation. We compared the measure for network

[3]For purposes of this report, "authorizations" refers to the number of positions for which resources have been allocated to fulfill the departments' medical mission, as identified in *Health Manpower Personnel Data System* report for fiscal year 2022. End strength numbers represent the number of medical personnel fulfilling specific billet positions at the end of the fiscal year.

[4]Pub. L. No. 117-263, § 741 (2022); Pub. L. No. 116-92, § 719(b)(2) (2019) *amended by* Pub. L. No. 116-283, § 717 (2021) and Pub. L. No. 117-81, § 731 (2021) and Department of Defense Directive 5124.02, *Under Secretary of Defense for Personnel and Readiness (USD(P&R))* (June 23, 2008). According to DOD officials, the 719 Plan included guidance for identifying strategies to mitigate gaps caused by the reductions.

[5]GAO, *Standards for Internal Control in the Federal Government,* GAO-14-704G (Washington, D.C.: September 2014). Internal control is a process effected by an entity's oversight body, management, and other personnel that provides reasonable assurance that the objectives of an entity will be achieved.

adequacy, as defined in the 719 Plan to DHA's TRICARE network assessments that were reported to support the 719 Plan. We corroborated our understanding of the TRICARE network assessments by interviewing officials with knowledge of the Section 719 reductions assessment process. In addition, we reviewed our prior work on DOD's network assessment of MTFs.[6] We also determined that the risk assessment component of internal control was significant along with the underlying principle that management define objectives in measurable terms.[7]

For objective three, we compared military department efforts in planning military medical personnel requirements to section 719(b)(1) of the NDAA for Fiscal Year 2020 as well as DOD and military department guidance and documents. We reviewed the Joint Medical Estimate to identify any deficiencies in medical capabilities—gaps between capabilities needed to meet operational requirements and actual capabilities. We also reviewed a DOD report on its COVID-19 response and a Department of Health and Human Services assessment of the U.S. health care system to identify deficiencies in medical capabilities.[8] We determined that the information and communication component of internal control was significant to this objective, along with the underlying principle that management should use quality information to achieve the entity's objectives.[9]

To address all three reporting objectives, we reviewed DOD's 719 Plan and interviewed cognizant officials from the Office of the Under Secretary of Defense for Personnel and Readiness, Cost Assessment and Program Evaluation (CAPE), Health Affairs, DHA, Joint Staff, Northern Command, Indo-Pacific Command, and the military departments. We also met with officials from seven selected MTFs to understand their involvement in providing input on potential reductions and to obtain their perspective on

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

[7]GAO-14-704G.

[8]*See* Under Secretary of Defense for Personnel and Readiness, *Report to the Congressional Defense Committees, COVID-19 Military Health System Review Panel*, (Washington, D.C.: March 10, 2023); and Department of Health and Human Services, Assistant Secretary for Preparedness and Response Memorandum, *U.S. Healthcare System Capacity for Treatment of Military Casualties* (Jan. 14, 2020).

[9]GAO-14-704G.

the potential effect of reductions on the MTFs. We selected the MTFs to interview based on their military department affiliation, total planned reductions by military department, whether the MTF had a graduate medical education (GME) program, and whether the MTF is in a rural population.[10] We selected for each military department and DHA the MTF that has a GME program with the highest number of reductions. We also selected for each military department the MTF that is a hospital with the highest number of proposed reductions in a less populated area to obtain officials perspectives on the impact reductions may have on MTFs in rural locations.

For unified medical budget and Defense Health Program cost data provided in the background, we converted cost data to constant fiscal year 2022 dollars using appropriate deflators for costs for fiscal years 2017 through 2022 published in the DOD's *National Defense Budget Estimates for Fiscal Year 2022*. We expressed the costs in inflation-adjusted dollars to obtain a more accurate assessment of the change that occurred over the 6-year period. We have designated DOD's financial management area as high risk due to long-standing deficiencies in DOD's systems, processes, and internal controls. Since some of these systems provide the data used in the budgeting process, there are limitations to the use of DOD's budget data.[11] To assess the reliability of unified medical budget and Defense Health Program cost data, we checked the data for accuracy and completeness and compared the data with other data sources, and interviewed knowledgeable agency officials about the data. We determined that these data were sufficiently reliable for describing budget context in the background section.

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

[10]Our selection of seven MTFs represent 2,406 of the total 12,801 reductions and realignments. We selected the following MTFs: (1) 81st Medical Group, Keesler Air Force Base, Mississippi; (2) 96th Medical Group, Eglin Air Force Base, Florida; (3) Brooke Army Medical Center, Fort Sam Houston, Texas; (4) Walter Reed National Military Medical Center, Maryland; (5) Winn Army Community Hospital, Fort Stewart, Georgia; (6) Naval Medical Center Camp Lejeune, North Carolina; and (7) Naval Medical Center San Diego, California.

[11]GAO, *High-Risk Series: Efforts Made to Achieve Progress Need to Be Maintained and Expanded to Fully Address All Areas*, GAO-23-106203 (Washington, D.C.: Apr. 20, 2023).

the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix II: Comments from the Department of Defense

THE ASSISTANT SECRETARY OF DEFENSE

1200 DEFENSE PENTAGON
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

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

Dear Ms. Farrell:

This is the Department of Defense (DoD) response to the Government Accountability Office (GAO) draft report GAO-23-106094, "Defense Health Care: Additional Assessments Needed to Determine Effects of Active Duty Medical Personnel Reductions," dated May 25, 2023 (GAO Code 106094).

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

Sincerely,

MULLEN.SEILEEN.MARIE.1519853007 Digitally signed by MULLEN.SEILEEN.MARIE.1519853007 Date: 2023.06.28 11:21:59 -04'00'

Lester Martínez-López, M.D., M.P.H.

Attachment:
As stated

GAO DRAFT REPORT DATED MAY 25, 2023
GAO-23-106094 (GAO CODE 106094)

"DEFENSE HEALTH CARE: ADDITIONAL ASSESSMENTS NEEDED TO DETERMINE EFFECTS OF ACTIVE DUTY MEDICAL PERSONNEL REDUCTIONS"

DEPARTMENT OF DEFENSE COMMENTS TO THE GAO RECOMMENDATION

RECOMMENDATION 1: The Secretary of Defense should ensure that the Assistant Secretary of Defense for Health Affairs, in coordination with the Surgeons General of the military departments and the Director of Defense Health Agency (DHA), develops and implements department-wide guidance for assessing fully and consistently the potential effect of military medical personnel reductions on the military medical treatment facilities (MTFs), including procedures for documenting results of the assessments. Such guidance should provide clarity on assessing feasibility of using mitigation strategies for any identified reductions and conducting a risk analysis associated with the hiring, onboarding, and retention of civilian personnel.

DoD RESPONSE: Concur

RECOMMENDATION 2: The Secretary of the Army, in coordination with the Surgeon General of the Army, should use the results of such assessments to inform the number of active duty medical personnel reductions.

DoD RESPONSE: Concur

RECOMMENDATION 3: The Secretary of the Navy, in coordination with the Surgeon General of the Navy, should use the results of such assessments to inform the number of active duty medical personnel reductions.

DoD RESPONSE: Concur

RECOMMENDATION 4: The Secretary of the Air Force, in coordination with the Surgeon General of the Air Force, should use the results of such assessments to inform the number of active duty medical personnel reductions.

DoD RESPONSE: Concur

RECOMMENDATION 5: The Secretary of Defense should ensure that the Assistant Secretary of Defense for Health Affairs, in coordination with the Surgeons General of the military departments and the Director of the DHA, conducts a comprehensive assessment of the cost of any future proposed military medical personnel reductions on the unified medical budget and use that assessment to inform reduction decisions.

DoD RESPONSE: Concur

RECOMMENDATION 6: The Secretary of Defense should ensure that the Assistant Secretary of Defense for Health Affairs, in coordination with the Surgeons General of the military

departments, Director of Cost Assessment and Program Evaluation, and the Director of DHA, develops guidance that translates the 719 Plan methodology into a process with measurable objectives that can facilitate consistent assessments of TRICARE networks' ability to absorb additional patient workload resulting from future reductions of military medical personnel.

DoD RESPONSE: Concur

RECOMMENDATION 7: Secretary of Defense should ensure that the Assistant Secretary of Defense for Health Affairs, in coordination with the Surgeons General of the military departments and the Director of the DHA, prior to implementing its future military medical personnel reductions plans, assesses TRICARE networks with planned military medical personnel reductions using guidance developed from the 719 Plan methodology to determine the networks' ability to absorb additional patient workload.

DoD RESPONSE: Concur

RECOMMENDATION 8: The Secretary of Defense should ensure that the Assistant Secretary of Defense for Health Affairs, in coordination with the Surgeons General of the military departments and the Director of the DHA, uses the guidance developed from the 719 Plan methodology and develops a plan that facilitates periodic monitoring of the ability of TRICARE networks to absorb additional patient workload resulting from any planned military medical personnel reductions.

DoD RESPONSE: Concur

RECOMMENDATION 9: The Secretary of Defense, in coordination with the Chairman of the Joint Chiefs of Staff and the Secretaries of the military departments, should ensure that the military medical personnel requirements are fully defined before making future decisions about how many military medical personnel to reduce and where to accept risk.

DoD RESPONSE: Concur

2

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), Stephanie Santoso (Analyst in Charge), Christopher Gezon, Jackson Gode, Alexandra Gonzalez, Amber Sinclair, William Tedrick, Sean Worobec, and Lillian Moyano Yob made key contributions to this report.

Related GAO Products

Defense Health Care: Actions Needed to Improve Billing and Collection of Debt for Civilian Emergency Care. GAO-22-104770. Washington, D.C.: July 7, 2022.

Defense Health Care: DOD Expanded Telehealth for Mental Health Care during the COVID-19 Pandemic. GAO-22-105149. Washington, D.C.: Feb. 3, 2022.

Defense Health Care: Actions Needed to Define and Sustain Wartime Medical Skills for Enlisted Personnel. GAO-21-337. Washington, D.C.: June 17, 2021.

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

Defense Health Care: Plans Needed to Ensure Implementation of Required Elements for TRICARE's Managed Care Support Contracts. GAO-20-197. Washington, D.C.: February 7, 2020.

Defense Health Care: DOD Should Collect and Use Key Information to Make Decisions about Incentives for Physicians and Dentists. GAO-20-165. Washington, D.C.: January 15, 2020.

Defense Health Care: Opportunities to Improve Future TRICARE Managed Care Support Contract Transitions. GAO-20-39. Washington, D.C.: Nov. 21, 2019.

Defense Health Care: DOD's Proposed Plan for Oversight of Graduate Medical Education Programs. GAO-19-338. Washington, D.C.: March 28, 2019.

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

Military Personnel: DOD Needs to Improve Dental Clinic Staffing Models and Evaluate Recruitment and Retention Programs. GAO-19-50. Washington, D.C.: December 13, 2018.

Defense Health Care: Additional Assessments Needed to Better Ensure an Efficient Total Workforce. GAO-19-102. Washington, D.C.: November 27, 2018.

Defense Health Care: DOD Should Demonstrate How Its Plan to Transfer the Administration of Military Treatment Facilities Will Improve Efficiency. GAO-19-53. Washington, D.C.: October 30, 2018.

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

Defense Health Care: TRICARE Surveys Indicate Nonenrolled Beneficiaries' Access to Care Has Generally Improved. GAO-18-361. Washington, D.C.: March 29, 2018.

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.

Defense Health Care Reform: Actions Needed to Help Ensure Defense Health Agency Maintains Implementation Progress. GAO-15-759. Washington, D.C. September 10, 2015.

Defense Health Care Reform: Actions Needed to Help Realize Potential Cost Savings from Medical Education and Training. GAO-14-630. Washington, D.C.: July 31, 2014.

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.

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

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

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.

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