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Report to Congressional Committees

May 2006

MILITARY PERSONNEL

Military Departments Need to Ensure That Full Costs of Converting Military Health Care Positions to Civilian Positions Are Reported to Congress

GAO-06-642

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Highlights

Highlights of GAO-06-642, a report to congressional committees

Why GAO Did This Study

Based on studies showing that many military members are performing tasks that are not considered military essential, the Air Force, Army, and Navy have plans to convert certain numbers of military health care positions to civilian positions. Questions have surfaced regarding the potential effects of these conversions on the Defense Health Program. The National Defense Authorization Act for Fiscal Year 2006 prohibits the military departments from performing any further conversions until the secretary of each department certifies to Congress that the conversions will not increase costs or decrease quality or access to care. The act also requires GAO to study the military departments' conversions and their potential effects. Specifically, GAO examined (1) the military departments' plans for and actions to date in converting military health care positions to civilian positions and the departments' experiences in filling the converted positions with civilians and (2) the potential effects of converting military health care positions to civilian positions on the Defense Health Program.

What GAO Recommends

GAO is making recommendations for the Department of Defense (DOD) to account for the full costs of military health care positions converted or planned for conversion. In reviewing a draft of this report, DOD agreed with GAO's recommendations.

www.gao.gov/cgi-bin/getrpt?GAO-06-642.

To view the full product, including the scope and methodology, click on the link above. For more information, contact Derek Stewart at (202) 512-5559 or stewartd@gao.gov.

What GAO Found

The Air Force, Army, and Navy have converted or have plans to convert several thousand military health care positions to civilian positions and have made progress in hiring civilian replacement personnel. From fiscal years 2005 through 2007, the Air Force, Army, and Navy collectively have converted or plan to convert a total of 5,507 military health care positions to civilian positions. Of the 5,507 military health care positions, the departments plan to convert 152 physician positions, 349 nurse positions, and 208 dental positions to civilian positions. In fiscal year 2006, there were a total of 10,352 military physicians, 9,138 nurses, and 3,020 dentists in the Air Force, Army, and Navy. The Navy is the most significantly affected of the three military departments, having converted or planning to convert a total of 2,676 military health care positions, representing 49 percent of the total 5,507 positions converted or planned for conversion. While the departments have been recruiting for about 4 to 7 months to hire civilian replacements for converted positions, to date, they have not experienced significant difficulties filling the civilian positions.

The military departments do not expect the conversions to affect medical readiness, quality of care, recruitment and retention of military health care personnel, or decrease beneficiaries' access to care. However, it is unknown whether the conversions will increase or decrease costs to DOD. At present, the military departments may not prepare their congressional certifications using cost data prepared by DOD's Office of Program Analysis and Evaluation, which is identifying the full costs for military health care positions. Instead, the military departments may use cost data that do not contain all the costs, like training, necessary to support a military medical position. Without accounting for the full costs in their methodologies, the military departments will not be able to make a true comparison of the total costs required to support military positions versus civilian positions. Moreover, Congress will be unable to judge the extent to which the departments' certifications are based on actual and anticipated compensation costs for civilian hires unless they include such delineations in their certifications.

Military to Civilian Health Care Position Conversions, Fiscal Years 2005–07

	Actual conversions		Planned conversions	All conversions, FY 2005-07	
Military department	FY 2005	FY 2006	FY 2007	Total	Percent
Air Force	0	401	813	**1,214**	22
Army	0	1,029	588	**1,617**	29
Navy	1,772	215	689	**2,676**	49
Total	**1,772**	**1,645**	**2,090**	**5,507**	
Percent of total conversions	**32**	**30**	**38**		**100**

Source: GAO analysis of Air Force, Army, and Navy data.

Contents

Abbreviations

DHP	Defense Health Program
DOD	Department of Defense
GS	General Schedule
MHS	Military Health System
MQA	Medical Quality Assurance
PA&E	Office of Program Analysis and Evaluation

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United States Government Accountability Office
Washington, DC 20548

May 1, 2006

The Honorable John Warner
Chairman
The Honorable Carl Levin
Ranking Minority Member
Committee on Armed Services
United States Senate

The Honorable Duncan L. Hunter
Chairman
The Honorable Ike Skelton
Ranking Minority Member
Committee on Armed Services
House of Representatives

Since September 11, 2001, the high pace of operations has created significant stress on the military's operating forces. In late 2003, the Department of Defense (DOD) reported that recent studies had found thousands of military personnel were being used to accomplish work tasks that were not military essential. DOD found that civilian or private sector contract employees could perform these tasks in a more efficient and cost-effective manner than military personnel. As a result, DOD directed the military departments to identify and convert certain targeted numbers of military positions to federal civilian or contract positions.[1] Along with other functional areas, the military departments identified military health care[2] positions that could be converted. Questions have surfaced, however, regarding the potential effects of these actual and planned conversions on the Defense Health Program (DHP), especially given that military health care personnel provide care to the families of servicemembers and to retirees in addition to active duty members.

[1] The military departments consist of the Air Force, Army, and Navy. The Navy is responsible for providing medical and dental support to the Marine Corps. Also, hereafter, we will refer to federal civilian or contract positions as "civilian positions."

[2] For the purpose of this report, military health care personnel includes medical, dental, and other personnel associated with the delivery of health care in the Defense Health Program.

The National Defense Authorization Act for Fiscal Year 2006[3] prohibits the military departments from performing any further conversions of military medical or dental positions to civilian positions until the secretary of each department submits, not before June 1, 2006, to the Committees on Armed Services of the Senate and the House of Representatives a certification that the conversions will not increase costs or decrease quality of care or access to care. The act also requires us to study the military departments' plans and progress, and the potential effects on the DHP of converting military health care positions to civilian positions. For this report, we examined (1) the military departments' plans for and actions to date in converting military health care positions to civilian positions and the departments' experiences in filling these converted positions with civilians and (2) the potential effects of converting military health care positions to civilian positions on the DHP.

To examine the military departments' completed and planned conversions of military health care positions, we obtained the number, type, and location of positions converted or planned for conversion from military health care positions to civilian positions during fiscal years 2005 through 2007 from the offices of the surgeon general of the Air Force, Army, and Navy. To examine the military departments' experience in filling the converted positions with federal civilian or contract employees, we requested that the offices of the surgeons general for the Air Force, Army, and Navy provide information on the extent to which the converted positions were filled, the time required to fill converted positions, and reasons for delays in filling the positions. To identify the potential effects of converting military health care positions on the DHP, we obtained and examined the offices of the surgeons general's assessments regarding how the conversions would affect medical readiness,[4] cost of the DHP, quality of care, beneficiaries' access to care, and recruitment and retention of military medical and dental personnel. In addition, we conducted focused analyses at the Naval Medical Center, Portsmouth. We chose this facility because it had the largest number of health care conversions of any Navy facility for fiscal year 2005 and represented the location with the largest number of conversions planned during fiscal year 2005 through fiscal year 2007. At the Naval Medical Center, Portsmouth, we examined data on

[3] Pub. L. No. 109-163, § 744 (2006).

[4] For the purposes of this report, medical readiness personnel requirements include those military health care personnel required to meet the demands of the operational scenarios in the national military strategy.

waiting times for appointments in selected departments before and after conversion of military physician positions. We determined that the data used in this report were sufficiently reliable for our purposes. We also discussed the potential effects on the DHP of converting military health care positions to civilian positions with officials from the TRICARE Management Activity in the Office of the Assistant Secretary of Defense for Health Affairs; from the offices of the surgeon general for the Air Force, Army, and Navy; from the Office of Program Analysis and Evaluation (PA&E); and from the Naval Medical Center, Portsmouth. For more detailed information on our scope and methodology, see appendix I. We performed our work from November 2005 through April 2006 in accordance with generally accepted government auditing standards.

Results in Brief

The Air Force, Army, and Navy have converted or have plans to convert military health care positions to civilian positions and have made progress in hiring civilian replacement personnel. From fiscal years 2005 through 2007, the Air Force, Army, and Navy collectively have converted or plan to convert a total of 5,507 military health care positions to civilian positions, representing 6.1 percent of the military departments' DHP military personnel. Specifically, the military departments converted 1,772 positions (32 percent of the total planned conversions) in fiscal year 2005[5] and 1,645 positions (30 percent of the total) in fiscal year 2006, and plan to convert 2,090 positions (38 percent of the total) in fiscal year 2007. The Navy is the most significantly affected of the three military departments. The Navy has converted or plans to convert 2,676 military health care positions, representing 49 percent of the total positions converted or planned for conversion. In contrast, the Air Force has converted or plans to convert 1,214 positions, or 22 percent of the total conversions and the Army has converted or plans to convert 1,617, or 29 percent of the total conversions. Of the total military health care positions converted or planned for conversion, the majority are enlisted positions, while about 20 percent are military officer positions. By the end of fiscal year 2007, the departments plan to have converted 152 physician positions, 349 nurse positions, and 208 dental positions to civilian positions. By comparison, in fiscal year 2006, there were a total of 10,352 military physicians, 9,138 nurses, and 3,020 dentists in the Air Force, Army, and Navy. The Navy, however, is the

[5] The Navy was the only military department to convert any military health care positions to civilian positions in fiscal year 2005. Also, the Navy made a staffing decision not to convert military health care positions to civilian positions on a one-for-one basis.

only department that plans to convert any physician positions. Regarding the hiring of replacements, the Navy has the most experience hiring civilians for the converted positions, but that experience is limited to 7 months. While the departments have been recruiting for a short time to hire civilian replacements for converted positions, they have each made varying degrees of progress and to date, have not experienced significant difficulties filling the civilian positions. In 7 months time, the Navy filled two-thirds of the positions it converted in fiscal year 2005, and the Air Force and Army have filled 37 percent and 30 percent of their fiscal year 2006 positions, respectively, within 4 months' time.

While the military departments do not expect the conversions to affect medical readiness, quality of care, recruitment and retention of military health care personnel, or to decrease beneficiaries' access to care, it is unknown whether the conversions will increase or decrease costs to DOD. Based on our examination of the military departments' application of the DOD medical readiness sizing model for determining which military health care positions are required for medical readiness, and our understanding of how the military departments determined which health care positions should be considered for conversion, it is unlikely that the conversions will affect medical readiness. Only military positions in excess of those required to meet the demands of the operational scenarios included in the national military strategy were considered candidates for conversion. Similarly, because each military department has maintained the same credentialing and privileging processes for civilian medical and dental care providers, quality of care is not expected to be affected by the conversions. In addition, given that many factors could affect a health care professional's decision to join or leave military service, it is difficult to isolate what potential effect the military-to-civilian conversions will have on recruitment and retention of military medical and dental personnel. However, it is unknown whether the military to civilian conversions will increase or decrease costs to DOD because (1) it is uncertain what actual compensation levels will be required to successfully hire replacement civilian personnel and (2) the methodologies each department is considering using in its certifications to Congress may not include the full costs for military personnel. Currently, the military departments may not prepare their certifications using cost data prepared by DOD's PA&E, which is currently identifying total costs for military health care positions. Without accounting for the full costs in their analyses, the military departments will not be able to make a true comparison of military positions to the costs to support civilian positions. Also, Congress will be unable to judge the extent to which the military departments' certifications are based on actual and anticipated compensation costs for completed and

future civilian hires unless the military departments include such delineations in their certifications to Congress.

We are making recommendations to ensure that the military departments account for the full costs of military health care positions converted or planned for conversion when they report to Congress. In written comments on a draft of this report, DOD generally concurred with our recommendations. DOD's comments are reprinted in appendix V.

Background

The Military Health System (MHS) provides health support for the full range of military operations and for military servicemembers and their families, military retirees, retiree family members, and survivors. The Defense Health Program (DHP) appropriation supports worldwide medical and dental services to eligible beneficiaries, veterinary services, medical command headquarters, graduate medical education and other training of medical personnel, and occupational and industrial health care. The DHP appropriation supports operations of 70 inpatient facilities, 409 medical clinics, 417 dental clinics and 259 veterinary clinics, and funds multiple TRICARE[6] contracts that augment health care delivery. Table 1 shows total DHP appropriations and budget estimates for fiscal years 2005 through 2007.

Table 1: Defense Health Program Appropriation, Fiscal Years 2005-07

Dollars in millions			
	FY 2005	**FY 2006**	**FY 2007**
Operation and maintenance[a]	$17,497.1	$19,386.9	$20,249.2
Procurement	368.3	403.9	396.4
Research, development, test and evaluation	523.1	536.9	130.6
Total	**$18,388.5**	**$20,327.7**	**$20,776.2**

Source: Department of Defense and President's Budget Position for Fiscal Year 2007.

[a]The military departments programmed $ 35.8 million in fiscal year 2005, $ 215.7 million in fiscal year 2006, and $135.4 million in fiscal year 2007 for the conversion of military health care positions to civilian positions.

[6] DOD provides health care through TRICARE, a regionally structured program that uses civilian contractors to maintain health care provider networks that complement health care provided at military treatment facilities.

In fiscal year 2005, the MHS employed approximately 42,400 federal civilian employee full-time equivalents whose costs were funded by the DHP. The MHS also employed about 90,000 military medical, dental, and support personnel. The cost of these military personnel who support DHP-funded activities is funded by each military department's military personnel appropriation.

In December 2003, DOD directed the military departments to convert certain targeted numbers of military positions, including some health care positions, to federal civilian or contract positions based on evaluations that showed many military personnel were being used to accomplish work tasks that were not military essential and could be performed more cost efficiently by civilians.[7] According to DOD officials, the conversion process began in late 2003/early 2004 with the creation of a task force, chaired by the Director of PA&E including members from offices of the Assistant Secretary of Defense for Health Affairs and the surgeons general for the Air Force, Army, and Navy, to identify military medical and dental positions that could be converted to federal civilian or contract positions. The task force examined 121 occupational medical and dental specialties for potential conversion. It applied a DOD medical readiness personnel sizing model to identify the baseline medical readiness personnel requirements for each military department, taking into consideration only those positions that members believed would not be required for medical readiness, would not degrade clinical capabilities, would not reduce access to medical or dental care to beneficiaries, or would not increase costs to DOD.

As the military departments began to implement the conversions, each military department reassessed the availability and affordability of civilian replacement personnel in the geographical areas where conversions were planned. Adjustments were then made to the military departments' plans to reflect local medical commanders' assessments. According to officials with the offices of the surgeons general for the Air Force and Army, conversions of military health care positions in their military departments are planned to be replaced on a one-for-one basis with civilian or personnel. However, according to a Navy official, the Navy decided to link a reassessment of appropriate medical and dental staffing levels in its medical centers to the conversion process. This reassessment, among other things, reviewed the number and type of staffing required to meet

[7] Program Budget Decision 712, December 24, 2003.

clinical productivity goals and quality standards. Applying the results of the staffing reassessments resulted in the Navy concluding that there was no need to hire civilian personnel replacements for 345 of the 1,772 positions converted for fiscal year 2005.

Military Departments Converting Military Health Care Positions to Civilian Positions and Making Progress Filling Civilian Positions

The Air Force, Army, and Navy have each begun implementing plans to convert non-military essential health care positions to civilian positions and have made progress in hiring civilians to fill the converted positions. During fiscal years 2005 through 2007, the military departments have converted or plan to convert about 5,500 military health care positions to civilian positions, including certain numbers of physician, nurse, and dental positions. While the departments have been recruiting for a short time to hire civilian replacements for converted positions, they have each made varying degrees of progress and to date, have not experienced significant difficulties filling the civilian positions.

Air Force, Army, and Navy Have Converted or Plan to Convert Military Health Care Positions to Civilian Positions

The Air Force, Army, and Navy have each made plans and begun converting military health care positions to civilian positions. During fiscal years 2005 through 2007, the departments have converted or plan to convert a total of 5,507 military health care positions to civilian positions, representing 6.1 percent of the total DHP military personnel. Specifically, the departments converted 1,772 positions (32 percent of the total planned conversions) in fiscal year 2005, 1,645 positions (30 percent) in fiscal year 2006, and plan to convert 2,090 positions (38 percent) in fiscal year 2007. Table 2 summarizes the number of planned/converted positions by military department.

Table 2: Number of Military Health Care Positions Converted or Planned for Conversion to Civilian Positions, Fiscal Years 2005-07

	Actual conversions		Planned conversions	All conversions, FY 2005-07	
Military department	FY 2005	FY 2006	FY 2007	Total	Percent
Air Force	0	401	813	**1,214**	22
Army	0	1,029	588	**1,617**	29
Navy	1,772	215	689	**2,676**	49
Total	**1,772**	**1,645**	**2,090**	**5,507**	
Percent of total conversions	**32**	**30**	**38**		**100**

Source: GAO analysis Air Force, Army, and Navy data.

Conversion by military department: The Navy is the most significantly affected of the three military departments by the military to civilian conversions. The Navy has converted or plans to convert 2,676 military health care positions, representing 49 percent of the total positions converted or planned for conversion in DOD. In addition, as table 2 shows, the Navy was the only department that converted positions in fiscal year 2005, converting a total of 1,772 positions—32 percent of the total number of planned/converted positions. By contrast, the Air Force has converted or plans to convert 1,214 positions, or 22 percent of the total conversions and the Army has converted or plans to convert 1,617, or 29 percent of the total conversions.

Conversion by type of position and grade: While each of the departments plans to convert both enlisted and officer health care positions to civilian positions, the majority of positions planned for conversion are enlisted positions (80 percent), while military officer positions account for about 20 percent of the conversions. Military health care positions consist of (1) medical—including not only health care providers who directly interact with patients, but also a variety of support positions whose functions directly relate to medical care, such as laboratory, radiology and dietary technicians; (2) dental—including dentists and dental technicians and assistants; and (3) other—including a variety of positions that are part the DHP but which do not directly affect the provision of medical or dental care to patients, such as administrators and public affairs officers. Table 3 shows the breakdown of types of health care positions converted or planned for conversion by each military department.

Table 3: Military Health Care Positions Converted or Planned for Conversion to Civilian Positions by Type of Position and Grade, Fiscal Years 2005-07

Type of position	Air Force	Army	Navy	Total	Percent
Medical					
Officers	228	128	412	**768**	
Enlisted	589	794	1,622	**3,005**	
Subtotal	**817**	**922**	**2,034**	**3,773**	**69**
Dental					
Officers	0	32	176	**208**	
Enlisted	132	59	388	**579**	
Subtotal	**132**	**91**	**564**	**787**	**14**
Other DHP					
Officers	15	44	67	**126**	
Enlisted	250	560	11	**821**	
Subtotal	**265**	**604**	**78**	**947**	**17**
Total	**1,214**	**1,617**	**2,676**	**5,507**	**100**

Source: GAO analysis of Air Force, Army, and Navy data.

As table 3 shows, the majority of the health care positions that have been or are scheduled for conversion fall into the medical category (69 percent). Dental positions account for 14 percent of the total conversions, while other positions represent 17 percent of the total conversions.

Of all health care positions, the type of position most affected by the conversions for fiscal years 2005 through 2007 is the position categorized by the Navy as enlisted corpsman, by the Army as an enlisted medic, and by the Air Force as enlisted aerospace medical services personnel.[8] Within the medical category, the three positions with high rates of conversion are physician, nurse, and dentist. By the end of fiscal year 2007, the departments plan to have converted 152 physician positions, 349 nurse positions, and 208 dental positions to civilian positions. In fiscal year 2006, there were a total of 10,352 military physicians, 9,138 nurses, and 3,020

[8] Navy corpsmen serve in various hospital departments such as radiology, laboratory, and clinics and also perform administrative duties such as patient records management and appointment scheduling. Army medics provide emergency and routine outpatient and inpatient medical care and also perform administrative duties. Aerospace medical services personnel serve in various capacities such as licensed practical nurses, occupational health specialists, and emergency medical technicians and perform other administrative functions.

dentists in the Air Force, Army, and Navy. The Navy, however, is the only department that plans to convert any physician positions—neither the Army nor the Air Force plans to convert any military physician positions to civilian positions. Appendix II shows the military physician positions by specialty converted by the Navy in fiscal year 2005 and fiscal year 2006.

Table 4 provides a detailed breakdown of military health care positions converted or planned for conversion to civilian positions by type of position and grade.

Table 4: Military Health Care Positions Converted or Planned for Conversion to Civilian Positions by Type of Position and Grade, Fiscal Years 2005-07 (Detailed)

Type of position/grade	Air Force	Army	Navy	Total	Percent
Officers					
Physicians	0	0	152	152	3
Physician assistants	3	0	39	42	0.8
Nurses[a]	177	75	97	349	6
Dentists	0	32	176	208	4
Pharmacists	6	13	29	48	0.9
Optometrists	5	11	3	19	0.3
Psychologists	2	8	1	11	0.2
Social workers	11	6	0	17	0.3
Other medical positions[b]	24	21	91	136	2
Other DHP positions[c]	15	38	67	120	2
Total officers[d]	**243**	**204**	**655**	**1102**	**20**
Enlisted					
Corpsmen, medics, aerospace medical services	47	482	1620	2149	39
Dental assistants/technicians	132	59	388	579	11
Other Medical Positions	542	312	2	856	16
Other DHP positions	250	560	11	821	15
Total enlisted	**971**	**1413**	**2021**	**4405**	**80**
Total	**1214**	**1617**	**2676**	**5507**	**100**

Source: GAO analysis of Air Force, Army, and Navy data.

[a]Nurses includes eight nurse practitioners scheduled for conversion by the Air Force, five in fiscal year 2006 and three in fiscal year 2007.
[b]Other military medical officer positions include dieticians, physical therapists, speech pathologists, radiation health/radiation specialists, microbiologists, and biochemists.
[c]Other DHP military officer positions include administrative positions.
[d]Includes Army warrant officers.

Appendix III provides information regarding the military departments' military to civilian conversions by geographical region.

Military Departments Making Progress Hiring Civilian Replacements

Each of the military departments has made varying degrees of progress in hiring civilian personnel to fill military health care positions that have been converted to civilian positions. According to military department officials, the Air Force ceased hiring actions to fill its fiscal year 2006 converted positions in January 2006 and the Army in February 2006 after enactment of the National Defense Authorization Act for Fiscal Year 2006. However, their experiences to date suggest they have not encountered significant difficulties hiring civilian personnel to fill converted positions.

Of the three departments, the Navy has the most experience hiring civilian replacements, filling two-thirds of the positions it converted in fiscal year 2005. As table 2 shows, the Navy converted a total of 1,772 military health care positions to civilian positions in fiscal year 2005. According to a Navy official, while these conversions took place on October 1, 2004, the first day of fiscal year 2005, the Navy did not begin recruiting civilians to fill the converted positions until July 2005 to allow for (1) Navy military treatment facilities to assess their staffing needs, (2) military personnel to vacate the converted positions, and (3) consultations with human resource offices to develop federal civilian job announcements. Also, the Navy decided not to fill all of the military health care positions it converted. After reassessments of medical and dental staffing levels at its facilities, the Navy decided to fill only 1,361, or 77 percent, of the 1,772 converted military positions. Over a 7-month period for these 1,361 positions, the Navy had successfully recruited 907, or 67 percent, of the civilians needed, as of January 31, 2006. Appendix IV provides more detailed information about the Navy's experience in hiring civilian personnel by type of position. Before enactment of the National Defense Authorization Act for Fiscal Year 2006, Navy officials indicated that they had planned to begin hiring civilian personnel in April 2006 to fill the 215 military health care positions converted at the beginning of fiscal year 2006.[9]

[9] According to DOD officials, the military departments remove military positions from authorized military endstrength for conversion to civilian positions on October 1, the first day of the fiscal year. Hiring of civilian or contract personnel to fill converted positions is a separate action which may occur later. In the case of the Navy, funding for hiring civilian replacement personnel becomes available at the midpoint of the fiscal year in the first year of conversion.

A Navy official told us that there have been no significant difficulties in filling such a large number of federal civilian positions within a short period of time. However, public and private employers report a limited supply of certain types of medical and dental personnel both on a national level and in certain geographical areas. In 2005, the Bureau of Labor Statistics reported that nurses were considered difficult to hire and retain by non-military employers and forecast that employers will continue to compete for nursing services. In addition, in December 2005, the Health Resources and Services Administration, an agency of the Department of Health and Human Services, reported that about 20 percent of the U.S. population lives in a primary medical care health professional shortage area.[10] According to a Navy official, based on this information, the Navy is recruiting on a national level to hire four types of personnel—physicians, dentists, pharmacists, and laboratory officers—at its various facilities. For its other types of medical and dental positions, the Navy is seeking to hire civilian personnel by targeting local markets. Also, the Navy is using various special pay provisions to allow it to compete with other employers, such as Department of Veterans Affairs' medical centers in selected geographical areas.

Because the Air Force and Army only began converting military health care positions to civilian positions in fiscal year 2006, their experiences hiring civilians to fill converted positions are more limited than the Navy's experience. However, as of January 2006, the Air Force had successfully recruited 149, or 37 percent, of the 401 positions converted within 4 months. The Army recruited 305, or 30 percent, of the 1,029 military health care positions converted within 4 months. Air Force and Army officials told us that they have not experienced significant difficulties in hiring civilian replacement personnel.

[10] This designation is based on the number of physicians in a geographic area, per unit of population. A separate designation is based on the number of dentists.

Conversions Not Expected to Alter Medical Readiness, Quality of Care, Recruitment and Retention, or Access to Care, but Effects on Cost to DOD Unknown

The military departments do not expect conversion of military health care positions to civilian positions to have any effect on medical readiness, the quality of care, recruitment and retention of military health care personnel, and beneficiaries' access to care. However, it is unknown what effect the conversions will have on the cost to DOD.

Medical Readiness

Based on our examination of the military departments' application of the DOD medical readiness sizing model for determining which military health care positions are required for medical readiness, and our understanding of how the military departments determined which health care positions should be considered for conversion, it is unlikely that the conversions will affect medical readiness. Incorporating scenarios that reflected operational plans, each military department applied DOD's medical readiness sizing model to identify the number of military health care personnel required for medical readiness. In determining which specific military health care positions would be converted, each department, in consultation with military health care facilities, then assessed the impact of conversions on medical readiness. Senior medical officials told us that the military departments' plans for converting military health care positions to civilian positions are not expected to have any effect on medical readiness because only military positions in excess of those needed for medical readiness were candidates for conversion. In defining medical readiness personnel requirements, the military departments included those military health care personnel required to meet the demands of the operational scenarios included in the National Military Strategy. Moreover, while not generalizable to all facilities and all military departments, our examination of military health care positions converted at Naval Medical Center, Portsmouth showed that the conversions did not affect medical readiness.

According to DOD officials, in 2004, the Air Force, Army, and Navy, in identifying which military health care positions were candidates for conversion, initially determined the military positions that would be required for medical readiness, incorporating scenarios that reflected

operational plans. The operational plans incorporated joint medical requirements, and the military departments then used these requirements to define medical requirements to respond to anticipated casualties, including those wounded in action and those with disease and nonbattle injuries. In defining medical readiness requirements for the military-to-civilian conversion process, each military department used the national military strategy that was current at that time. Using a DOD-approved medical readiness personnel sizing model,[11] the military departments identified the number of military medical and dental personnel that was required for medical readiness. Table 5 shows the number of positions the departments determined to be required for medical readiness compared to the military medical and dental endstrength for the Air Force, Army, and Navy for fiscal year 2004.

Table 5: Combined Air Force, Army, and Navy Military Medical Readiness Requirements Compared to Combined Military Departments' Medical and Dental Personnel End-strength, Fiscal Year 2004

	Number of positions required for medical readiness	Military medical/dental endstrength, FY 2004	Non-medical readiness end-strength, FY 2004
Medical corps	10,557	12,067	1,510
Nursing corps	9,652	10,412	760
Dental corps	2,735	3,532	797
Other medical service	10,587	11,709	1,122
Total officers	**33,531**	**37,720**	**4,189**
Enlisted medical	65,162	74,388	9,226
Enlisted dental	4,706	6,816	2,110
Total enlisted	**69,868**	**81,204**	**11,336**
Total	**103,399**	**118,924**	**15,525**

Source: Office of Assistant Secretary of Defense for Health Affairs.

Only those military positions in excess of those positions required for medical readiness were considered for possible conversion to federal civilian or contract positions.

[11] We did not assess the validity of the DOD medical readiness personnel sizing model or the reasonableness of the assumptions and data used in applying the model.

According to a DOD official, in 2005, the military departments again used the DOD-approved medical readiness personnel sizing model to identify their medical readiness requirements for the purpose of setting end-strength requirements for the fiscal years 2006-2011 time frame. Medical officials for the Air Force, Army, and Navy told us that they again used the national military strategy, which was current at that time, in applying the medical readiness sizing model. Officials from the Air Force, Army, and Navy told us the model produced results showing that the services' medical/dental personnel endstrength exceeded medical readiness personnel requirements.

Our review of military positions converted at Naval Medical Center, Portsmouth showed no apparent effect on medical readiness requirements. To test the assertion that none of the positions converted at the Naval Medical Center, Portsmouth, had a mobilization/readiness mission, we examined the 352 military health care positions that were converted to federal civilian positions on October 1, 2004, for fiscal year 2005. Of the 352 military positions examined, we found 349 positions did not have mobilization/readiness missions. Although three of the 352 military positions had mobilization/readiness missions, a Navy medical official explained that they transferred the mobilization requirement for the converted military positions to other positions that were not scheduled for conversion to avoid any effect on medical readiness. We verified that the mobilization missions for the converted military positions were transferred to other military positions not scheduled for conversion.

Quality of Care

Because the military services have maintained the same processes and requirements for delivery of health care by civilian employees and considering the results of our limited testing of the credentialing and privileging process at Naval Medical Center, Portsmouth, the military departments' plans for military-to-civilian conversions are not expected to adversely affect the quality of care. Officials in the offices of the surgeon general for the Air Force, Army, and Navy told us that converting military health care positions to civilian positions will not result in decreased quality of care because each department has maintained the same

credentialing and privileging requirements[12] for civilian personnel. Also, in developing civilian position descriptions for converted military health care positions, officials told us that they give close attention to appropriately identifying the required education, training, and professional qualifications of applicants. Officials also stated that before civilian applicants are hired, their compliance with the educational and other minimum qualification requirements for the civilian positions will be verified. Our examination of the credentialing and privileging documentation for selected civilian personnel hired to fill converted military health care positions at the Naval Medical Center, Portsmouth, found that required queries of national health care databases were performed for each civilian employee and the results of the queries revealed no adverse information about the civilian employees hired.

In May 2002, the Assistant Secretary of Defense for Health Affairs defined quality in health care in responding to the Healthcare Quality Initiative Review Panel's recommendation to promulgate a definition of quality concerning healthcare and related services within the Military Health System to orient current and future measurement initiatives. Quality in health care was defined as "the degree to which health care services for individuals and population increase the likelihood of desired health outcomes and are consistent with current professional knowledge."[13] In conjunction with the promulgation of this definition, the Assistant Secretary of Defense for Health Affairs required that the quality of health care be assessed by performance measures addressing three specific questions: (1) Is the foundation for the provision of high-quality care in place and is this foundation robust? (2) How well does our health care system perform with respect to measurable processes and outcomes of care and other comparable data? and (3) How is our health care delivery

[12] Credentialing of health care personnel refers to the process of inspecting and verifying the credentials of health care practitioners. The credentials process is conducted before the granting of clinical privileges and is repeated at the time of reappointment and renewal of privileges. Clinical privileging refers to the granting of permission and responsibility of a health care provider to provide specified health care within the scope of a provider's license, certification, or registration. Clinical privileges define the scope and limits of practice for individual providers and are based on the capability of the health care facility, licensure, training, experience, health status, judgment, and peer and department head recommendations.

[13] Department of Defense, Office of the Assistant Secretary of Defense for Health Affairs, *Military Health System Definition of Quality in Health Care*, HA-Policy: 02-016, May 9, 2002.

system and quality of health care provided viewed by our beneficiaries, military leadership, and Congress?

Officials in the offices of the surgeon general for the Air Force, Army, and Navy told us that they have many processes and performance measures within the MHS to ensure the delivery of quality health care. Each military department already employs many civilian employees who work in military treatment facilities. Officials told us that these civilian employees are subject to the same quality of care assessments and processes as military medical and dental personnel. The civilian personnel who will be hired to replace converted military positions will also be subject to the same quality of care processes and performance assessments.

To test the credentialing and privileging processes for the civilian replacement personnel hired at the Naval Medical Center, Portsmouth, we examined the credentialing and privileging files for 27 civilian employees: 5 physicians, 8 dentists, 3 pharmacists, and 11 other types of personnel hired to replace converted military positions in fiscal year 2005. All five civilian physicians hired were board certified in their respective specialty. As part of our examination, we also reviewed the files for documentation that officials had queried health care practitioner databases, as required by DOD.[14] We found documentation in the credentialing and privileging files from the National Practitioner Data Bank[15] and the Healthcare Integrity and Protection Data Bank[16] showing that both data banks were queried, as required, for all of these civilian employees. The query results revealed no adverse information about the civilian employees hired.

[14] Department of Defense Directive 6025.13, Medical Quality Assurance (MQA) in the Military Health System (MHS), signed by the Deputy Secretary of Defense, May 4, 2004.

[15] The National Practitioner Data Bank was established under the Health Care Quality Improvement Act of 1986, Pub. L. No. 99-660 (1986), as an information clearinghouse to improve the quality of health care by collecting and releasing information related to the professional competence and conduct of physicians, dentists, and other health care practitioners.

[16] The Healthcare Integrity and Protection Data Bank was established by the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191 (1996), as a means to prevent fraud and abuse in health insurance and health care delivery and to improve the quality of care.

Recruitment and Retention of Military Health Care Personnel

Given the multitude of factors that may influence an individual health care professional's decision to join or leave military service, it is difficult to isolate the potential effect of converting military health care positions to civilian positions on the recruitment and retention of military health care personnel. Officials in the offices of the surgeons general for the Air Force, Army, and Navy told us that the military-to-civilian conversions will not have any impact on recruiting and retention of military health care personnel. For example, Navy officials commented that while the Navy is experiencing difficulties in recruiting and retaining certain types of health care personnel, factors other than planned military-to-civilian conversions, such as military pay levels and the Global War on Terrorism, are responsible. Army officials commented that they recognize the importance of viable medical career fields and will perform career progression analyses to ensure that the medical career fields are viable. Air Force officials commented that conversions will be accomplished through normal attrition, and no individuals will be forced to retire or separate from the military as a result of the conversions.

Access to Care

Officials in the offices of the surgeon general for the Air Force and Army stated that converting military health care positions to civilian positions will not result in any degradation in the availability of medical or dental care to servicemembers, their families, or retirees because converted military medical and dental positions are being replaced on a one-to-one basis. So for every converted military health care position, there will be a civilian personnel replacement. Moreover, neither the Air Force nor the Army plans to convert any physician positions during fiscal years 2006 and 2007. While the Air Force and Army's decision not to convert any military physician positions will probably decrease the likelihood for significant reductions in the availability of medical care, it is important to note that delays in filling the civilian positions after the military positions have been removed may result in decreased military medical capacity. Air Force and Army medical officials pointed out that they have the option of purchasing medical or dental care from the managed care network of health care providers, if necessary, to avoid any decreases in servicemembers' or beneficiaries' access to care.

Officials in the office of the surgeon general of the Navy told us that they do not expect any decreases in servicemembers' or beneficiaries' access to care attributable to the conversions even though, in many instances, military health care positions were not replaced on a one-for-one basis. With the new staffing levels, Naval Medical Center, Portsmouth, officials believe that the mix of current staffing for departments is more efficient

and will not result in longer waiting times for appointments. Also, Naval Medical Center, Portsmouth, officials pointed out that the purchased care system (managed care network of health care providers) is available if capacity within the medical center becomes temporarily limited.

At the Naval Medical Center, Portsmouth, we examined data on waiting times for appointments before and after the conversion in two departments and a family practice clinic that had military physician positions converted for fiscal year 2005 and found that for the most part, waiting times did not increase after the conversions. On October 1, 2004, military physician positions were converted in the departments of internal medicine and physical therapy and in the family practice clinic at the Naval Medical Center, Portsmouth. Naval Medical Center, Portsmouth, officials told us that it is difficult to attribute changes in appointment waiting times to the military-to-civilian conversions because several factors, such as the deployment of military physicians or the arrival or departure of ships, may affect the departments' capacity or demand for appointments. Data that we obtained from the two departments and a family practice clinic at the Naval Medical Center, Portsmouth, showed for the most part that waiting times were within standards for appointment waiting times for varying types of appointments.

Cost of Conversions to DOD

It is unknown whether the conversion of military health care positions to civilian positions will ultimately increase or decrease costs for DOD because:

- it is uncertain what actual compensation levels will be required to successfully hire most civilian replacement personnel and
- the programming rates the departments are considering using in their certifications to Congress about the cost of the conversions to DOD do not include the full compensation costs for military personnel.

While officials in the offices of the surgeons general for the Air Force, Army, and Navy believe that the military-to-civilian conversions will not increase costs, we believe it is uncertain how much it will cost to hire civilian replacement personnel for recent and planned conversions of military health care positions and whether this cost will exceed the cost for the military positions. While the military departments have made progress in hiring civilian personnel within a short time, many civilian personnel remain to be hired. As of January 31, 2006, the Navy had recruited 67 percent of the personnel it plans to hire for the conversions made in fiscal year 2005, and the Air Force and Army had recruited 37

percent and 30 percent, respectively, of the positions they converted in fiscal year 2006. However, according to DOD officials, as of March 6, 2006, the Air Force, Army, and Navy had not compared the actual costs to hire these federal civilian employees with what it had cost them to employ military personnel in these positions.

The methodologies the military departments may use to certify conversion costs in their reports to Congress may understate savings associated with the elimination of military medical and dental positions, according to PA&E officials. While the Air Force, Army, and Navy had not finalized the methodologies they plan to use in the certification process, at the time of our review, representatives from the offices of the surgeons general for the Air Force, Army, and Navy discussed the possibility of using military department-specific programming rates. These rates are calculated by dividing the military personnel budgets by the number of military personnel currently employed by the Air Force, Army, and Navy. However, according PA&E officials, this calculation omits several significant costs (such as training, recruitment, educational assistance, and health benefit costs) incurred by military medical personnel which may lead to understated cost projections for the converted military positions.

PA&E officials told us that at this time they lack complete information on all of the costs that are associated with compensating military medical and dental personnel. Officials told us that PA&E is completing a project designed to determine true military medical and dental personnel costs, but the project is not expected to be completed until summer 2006, which is after the June 1, 2006 date when the military departments may submit certifications to the House and Senate Committees on Armed Services that their planned conversions of military medical or dental positions will not increase costs. In the meantime, PA&E has completed preliminary estimates, which officials believe are far more complete in estimating the cost of military medical and dental positions than the programming rates that may be used by the Air Force, Army, and Navy. These preliminary estimates show that the programming rates considerably understate military medical and dental personnel costs when compared to the PA&E estimates. Currently, the military departments are not required to coordinate the development of their cost comparisons for the congressional certifications with PA&E. By not coordinating their cost analyses efforts with PA&E to ensure that they are considering the full costs of the military medical and dental positions they have converted or plan to convert to civilian positions, the Air Force, Army, and Navy will be unable to determine the true cost implications for defense health care.

Conclusions

While the Air Force, Army, and Navy are already well under way in converting about 5,500 military health care positions to civilian positions, they are not currently in the position to know how the conversions will affect the cost to DOD. Because none of the military departments has plans to use cost data prepared by the DOD's PA&E, they risk using methodologies to certify program costs that omit several significant factors, such as training, recruitment, and educational assistance. Without ensuring that they are accounting for the full costs—both direct and indirect—of converting the military health care positions to civilian positions, the military departments will be unable to provide Congress with accurate comparative costs for their conversions. Further, Congress will be unable to judge the extent to which the military departments' certifications are based on anticipated compensation costs for completed and future civilian hires unless the military departments include such delineations in their congressional certifications.

Recommendations for Executive Action

To ensure that the military departments account for the full costs of military health care positions converted or planned for conversion when they report to Congress, we recommend that the Secretary of Defense direct the Secretaries of the Air Force, Army, and Navy to take the following two actions:

- Coordinate the development of their congressional certifications for military health care conversions with the Office of Program Analysis and Evaluation in order to consider the full cost for military personnel and for federal civilian or contract replacement personnel in assessing whether anticipated costs to hire civilian replacement personnel will increase costs to DOD for defense health care.
- Address in their congressional certifications for military health care conversions the extent to which total projected costs for hiring federal civilian or contract personnel include actual compensation costs for completed hires and anticipated compensation costs for future hires.

Agency Comments and Our Evaluation

DOD provided written comments on a draft of this report and generally concurred with our recommendations.

In commenting on our recommendation that the secretaries of the military departments coordinate with DOD's PA&E in developing their congressional cost certifications, DOD noted that PA&E's effort to identify the total cost for military health care positions is not yet complete and that it is unlikely that these data will be available in a final format for use by

June 1, 2006, the date DOD stated the military departments are required to provide their cost certifications to Congress. We note, however, that the National Defense Authorization Act for Fiscal Year 2006 does not require the secretary of each military department to submit such certifications by June 1, 2006. Instead, the act requires the department secretaries to submit their certifications not before June 1, 2006. DOD also commented that the PA&E data add several personnel cost items that are not included in the military departments' programming rates, and that these additional costs will generate a higher average cost per military member than that reflected by the programming rates. While it is indeed possible that using PA&E data—which include costs such as training, recruitment, educational assistance, and health benefits—will provide higher average costs for military members than the military departments' programming rates that do not include these additional costs, we believe it is important that the military departments provide Congress with the most accurate comparative costs of converting the military health care positions to civilian positions.

In commenting on our recommendation that the military departments certifications address the extent to which total projected costs for hiring civilian personnel include actual compensation costs for completed hires and anticipated compensation costs for future hires, DOD stated that our recommendation appears to be unnecessary because in order to make a certification that the conversions will not increase costs, each secretary will review actual civilian employee and contract employee costs for conversions already completed, as well as estimated costs for pending conversions. It is important to note that while the military departments have made progress in hiring civilian replacement personnel, 74 percent of the civilian replacement personnel for military health care positions converted and planned for conversions during fiscal years 2005 through 2007 had not been hired as of January 31, 2006. So, the military departments' certifications on the total projected costs of the conversions are likely to be based more on anticipated rather than actual compensation costs. Consequently, we believe that it is important for Congress to understand the extent to which the military departments' certifications are based on actual compensation costs for completed hires versus projected compensation costs for future hires.

DOD's comments are reprinted in appendix V. DOD also provided technical comments, which we have incorporated in the final report where appropriate.

We are sending copies of this report to the Secretary of Defense and other interested parties. We will provide copies of this report to others upon request. In addition, the report is available at no charge on the GAO Web site at http://www.gao.gov.

If you or your staffs have any questions about this report, please contact me at (202) 512-5559 or stewartd@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 VI.

Derek B. Stewart
Director, Defense Capabilities and Management

Appendix I: Scope and Methodology

To meet our objectives, we reviewed pertinent documents, reports, and other information, as available, that related to the conversion of military health care positions to federal civilian or contract positions. We also interviewed cognizant officials in the TRICARE Management Activity within the Office of the Assistant Secretary of Defense for Health Affairs, the offices of the surgeons general of the Air Force, Army, and Navy, the Office of Program Analysis and Evaluation, and the office of the Undersecretary of Defense for Personnel and Readiness. We also performed additional work at the Naval Medical Center in Portsmouth, Virginia.

To examine the extent to which the military departments have developed and implemented plans to convert military health care positions to civilian positions, we obtained data on Defense Health Program positions that have been converted since October 1, 2004, and those planned for conversion through fiscal year 2007 from the offices of the surgeon general for the Air Force, Army, and Navy. For each position converted or planned for conversion, we requested that the offices of the surgeons general to provide the geographic location, type of position, and the grade (either officer or enlisted position). We analyzed the data obtained from each military department to identify the characteristics of the positions converted for fiscal year 2005 and fiscal year 2006 and planned for conversion in fiscal year 2007. We also obtained information regarding the process used by the military departments in selecting the number and types of positions converted and planned for conversion from discussions with officials within the offices of the surgeons general and reviews of documentation.

To identify the experiences of the military departments in filling the converted military positions with civilian personnel, we requested that the military departments identify for each converted position the following information as of January 31, 2006:

- Location
- Former military position title
- Date converted
- Billet occupied on date of conversion
- Current civilian position title
- Programmed as General Schedule (GS) or contract position
- Date recruitment initiated
- Date civilian or contract employee reported for duty
- Whether civilian position was filled as of January 31, 2006
- Whether the civilian position was filled by a GS or contract employee

- If civilian position was not filled, status of recruitment efforts
- If civilian position was not being recruited, reasons why

We analyzed the data obtained from the military departments to identify the characteristics of their experiences in filling the federal civilian or contract positions by type of position and by geographical area and to identify reasons for difficulties in filling positions, if any. We also reviewed information from the Bureau of Labor Statistics and the Health Resources and Services Administration to identify the types of health professional positions that are considered to be difficult to fill.

We took steps to ensure the reliability of the data we used in our review. We provided an Excel spreadsheet and specification of data elements to the Army, Air Force, and Navy. The spreadsheet had 16 defined variables in which we requested data for military health care positions converted to a civilian position since October 1, 2004. Several of the data elements were restricted to drop-down menu choices to minimize error and clearly convey the type of response we were seeking. The military departments returned the Excel spreadsheet to us in electronic format. To assess the reliability of these data, we reviewed the data for obvious inconsistency errors and completeness and compared the total number of positions converted with official numbers we were given in interviews with officials. In addition, we reviewed any related accompanying documentation and worked closely with agency officials to identify any data problems. When we found discrepancies (such as nonpopulated fields or data inconsistencies), we brought them to our points of contact's attention and worked with them to correct the discrepancies before conducting our analyses. In addition, we sent an electronic questionnaire with questions regarding the data to our points of contact and followed up on any issues we felt pertinent regarding the reliability of the data. Based on these efforts, we determined that the data were sufficiently reliable for the purposes of our report.

In regard to the potential effects of conversions, we focused on potential impacts on medical readiness, cost, quality of care, access to care, and recruitment and retention of military medical and dental personnel. For each of these potential effects, we requested that the military departments provide their assessments and the basis for their views. To obtain detailed information regarding the effects of conversions, we selected the Naval Medical Center, Portsmouth, for focused analyses because it had the largest number of health care conversions of any Navy facility for fiscal year 2005 and represented the location with the largest number of conversions planned from fiscal year 2005 through fiscal year 2007.

Regarding potential effects of the conversions on medical readiness, we obtained and examined information regarding the process used by the military departments in determining the medical readiness personnel requirements. We did not assess the validity of the DOD medical readiness personnel sizing model or the reasonableness of the assumptions and data used in applying the model. Also, we examined whether each of the 352 positions converted for fiscal year 2005 at the Naval Medical Center, Portsmouth, had a mobilization/readiness mission and, if so, whether the mission was transferred to another position that was not converted.

Regarding the potential effects of the conversions on the quality of care, we obtained information on the processes that the military departments will use to ensure quality of care delivery by civilian replacement personnel. We examined the credentialing and privileging documentation and assessed whether queries were made, as required, to the National Practitioner Data Bank and the Healthcare Integrity and Protection Data Bank as part of the credentialing and privileging process in hiring the civilian replacement employees at Naval Medical Center, Portsmouth.

Regarding access to care, we obtained and examined military department representatives' assessments of the potential effect of conversions on servicemember and beneficiary access to care. We also requested and analyzed data from the Naval Medical Center, Portsmouth, on the extent to which TRICARE access to care standards were being met in those departments where military physician positions were converted.

Regarding the potential effect of the conversions on the cost of defense health care to DOD, we discussed with officials in the offices of the surgeons general, the methodology that they planned to use in certifying to Congress that planned conversions would not increase costs. We also discussed the extent to which military department-specific programming rates include the full costs for military personnel with representatives from the Office of Program Analysis and Evaluation and from the Office of the Undersecretary of Defense for Personnel and Readiness.

We performed our work from November 2005 through April 2006 in accordance with generally accepted government auditing standards.

Appendix II: Conversion of Navy Military Physician Positions by Specialty

The Navy is the only military department that has converted any military physician positions since October 1, 2004—converting 148 physicians during fiscal year 2005 and 4 physicians during fiscal year 2006. Of the 152 military physician positions converted by the Navy, 41, or 27 percent, were family practice physicians; 37, or 24 percent, were pediatric physicians; 21, or 14 percent, were general medical officers; and 17, or 11 percent, were internal medicine physicians, as shown in table 6. There are no military physicians scheduled for conversions in fiscal year 2007.

Table 6: Navy Military Physician Positions Converted by Specialty, Fiscal Years 2005 and 2006

Type of Specialty	Fiscal Year 2005	Fiscal Year 2006	Total
Family practice	41	0	**41**
General surgeon	1	0	**1**
General medical officer[a]	21	0	**21**
Internal medicine[b]	17	0	**17**
Neurology	2	0	**2**
Nuclear medicine	2	0	**2**
Obstetrics/gynecology	6	0	**6**
Ophthalmology	2	0	**2**
Pathology	9	0	**9**
Pediatrics[c]	34	3	**37**
Physical medicine	3	0	**3**
Psychiatry	8	1	**9**
Radiology	1	0	**1**
Urology	1	0	**1**
Total	**148**	**4**	**152**

Source: GAO analysis of Navy data.

[a]A general medical officer has completed medical school, including a 1-year internship but has not completed specialty residency training.

[b]Internal medicine conversions include internal medicine physicians with specialties in cardiology, gastroenterology, and pulmonary disease as well as general internal medicine physicians.

[c]Pediatrics conversions include pediatric physicians with specialties in adolescence, cardiology, genetics and sexual abuse in addition to general pediatric physicians.

Appendix III: Conversion of Military Health Care Positions to Civilian Positions by Geographic Region

The military departments' plans for converting military health care positions to civilian positions are widely dispersed among many locations within each military department. The Navy's actual and planned conversions of military health care positions to federal civilian positions are occurring at 39 different locations, both in the United States and overseas. Of these locations, the majority—34, or 87 percent—have fewer than 200 positions scheduled for conversion. Table 7 shows the locations of the largest numbers of military health care positions to civilian positions.

Table 7: Military Installations, by Military Department, with the Largest Cumulative Numbers of Military Health Care Positions Converted or Planned for Conversion to Civilian Positions, Fiscal Years 2005-07

Location	FY 2005	FY 2006	FY 2007	Total
Army				
William Beaumont Army Medical Center, Fort Sam Houston, San Antonio, Texas	0	170	51	**221**
Walter Reed Army Medical Center, Washington, D.C.	0	125	56	**181**
Madigan Army Medical Center, Fort Lewis, Washington	0	13	98	**111**
Tripler Army Medical Center, Hawaii	0	54	27	**81**
Brooke Army Medical Center, Fort Bliss, Texas	0	48	26	**74**
Navy				
Naval Medical Center, Portsmouth, Virginia	347	34	111	**492**
Naval Medical Center, San Diego, California	208	52	78	**338**
Naval Hospital, Great Lakes, Illinois	224	40	65	**329**
National Naval Medical Center, Bethesda, Maryland	158	33	72	**263**
Naval Health Care-New England, Newport, Rhode Island	120	7	83	**210**
Air Force				
Lackland Air Force Base, San Antonio, Texas	0	46	61	**107**
Keesler Air Force Base, Biloxi, Mississippi	0	33	68	**101**
Travis Air Force Base, Fairfield, California	0	27	38	**65**
Wright Patterson Air Force Base, Dayton, Ohio	0	17	39	**56**
Langley Air Force Base, Hampton, Virginia	0	19	34	**53**

Source: GAO analysis Air Force, Army, and Navy data.

The military-to-civilian conversions of Air Force health care positions are occurring at 62 locations in the United States. The majority of these

locations, 57, or 92 percent, are scheduled for fewer than 50 conversions for fiscal years 2006 and 2007. At 5 Air Force locations the number of conversions planned exceeds 50, including Lackland Air Force Base, Keesler Air Force Base, Travis Air Force Base, Wright-Patterson Air Force Base and Langley Air Force Base. Lackland and Keesler are the most significantly affected with 107 and 101 conversions, respectively.

The military-to-civilian conversions of Army military health care positions are occurring at 124 locations in the United States and overseas. Of these 124 locations, 59 are Army installations, 20 are for Army personnel at other service installations, and 45 are at military entrance processing commands. The majority of these locations, 116, or 94 percent, are scheduled for fewer than 50 conversions for fiscal years 2006 and 2007. At 8 locations, the number of Army conversions planned exceeds 50 including Fort Sam Houston, Walter Reed Army Medical Center, Fort Lewis, Tripler Army Medical Center, Fort Bliss, Fort Bragg, Fort Rucker, and Fort Gordon. Fort Sam Houston and Walter Reed Army Medical Center are the most significantly affected with 221 and 181 conversions, respectively.

Appendix IV: Navy's Experience in Recruiting Civilians for Converted Military Health Care Positions, Fiscal Year 2005

As of March 16, 2006, the Navy had hired exclusively federal civilians as replacement personnel under the General Schedule but had also approved the hiring of 14 physicians as contract employees because of concerns that higher compensation levels than are available under the General Schedule system would be necessary to hire these physicians. The Navy's experience in successfully recruiting federal civilian health care personnel to replace military health care positions converted in fiscal year 2005 varied by type of position, as shown in table 8.

Table 8: Navy Experience in Recruiting Federal Civilian Health Care Personnel to Fill Converted Military Positions in Fiscal Year 2005 by Type of Position, as of January 31, 2006

Type of Position	Number who are on board/accepted job offers	Number being recruited	Percentage of converted positions
Physicians	49	77	64
Physician assistants	13	25	52
Nurses	92	122	75
Dentists	60	89	67
Pharmacists	27	31	87
Optometrists	1	1	100
Psychologists	0	1	0
Social workers	5	6	83
Dental assistants/hygienists	126	199	63
Other medical or DHP positions	534	810	66
Total	**907**	**1,361**	**67**

Source: GAO analysis of office of the surgeon general of the Navy data.

Appendix V: Comments from the Department of Defense

THE ASSISTANT SECRETARY OF DEFENSE

1200 DEFENSE PENTAGON
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

APR 20 2006

Derek B. Stewart
Director, Defense Capabilities and Management
U.S. Government Accountability Office
441 G. Street, N.W.
Washington, DC 20548

Dear Mr. Stewart,

This is the Department of Defense (DoD) response to the Government Accountability Office (GAO) Draft Report entitled "MILITARY PERSONNEL: Military Departments Need to Assure that Full Costs of Converting Military Health Care Positions to Civilian Positions Are Reported to Congress," dated April 7, 2006 (GAO Code 350754/GAO-06-642).

Thank you for the opportunity to review and comment on the draft report. First, let me say that I appreciate the collaborative, insightful and thorough approach that your team has taken with this important issue. Successful implementation of these conversions is critical to the accomplishment of the missions assigned to the Military Health System.

I agree with your assessment that the planned conversions of military health care positions to civilian health care positions will not have a detrimental impact on medical readiness, the quality of health care delivered in military health care facilities, military recruitment and retention, or access to health care. However, I do have some concerns with the draft report's "Recommendations for Executive Action." These concerns, as well as several suggested technical corrections, are included in the attached formal response.

Again, thank you for the opportunity to provide these comments. My points of contact for additional information are Mr. Jack Thornburg and Mr. Mark Yow (Functional) at (703) 681-3518 and Mr. Gunther Zimmerman (Audit Liaison) at (703) 681-3492.

Sincerely,

William Winkenwerder, Jr., MD

Enclosure:
As stated

GAO DRAFT REPORT DATED APRIL 7, 2006
GAO-06-642 (GAO CODE 350754)

"MILITARY PERSONNEL: MILITARY DEPARTMENTS NEED TO ASSURE THAT FULL COSTS OF CONVERTING MILITARY HEALTH CARE POSITIONS TO CIVILIAN POSITIONS ARE REPORTED TO CONGRESS"

DEPARTMENT OF DEFENSE COMMENTS TO THE RECOMMENDATION

To assure that the military departments account for the full costs of military health care positions converted or planned for conversion are reported to Congress, we recommend that the Secretary of Defense direct the Secretaries of the Air Force , Army, and Navy to take the following two actions:

RECOMMENDATION 1: Coordinate the development of their Congressional certifications for military health care conversions with the Office of Program Analysis, and Evaluation in order to consider the full cost for military personnel and for federal civilian or contract replacement personnel in assessing whether anticipated costs to hire federal civilian or contract replacement personnel will increase costs to DoD for defense health care.

DOD RESPONSE:

Concur with comment. The Office of Program Analysis and Evaluation (PA&E) leads the working group, consisting of both Offices of the Secretary of Defense and Military Department representatives, that determined the cost of conversion of the positions identified by the Military Departments as excess to their readiness requirements and selected for conversion. This working group also estimated the cost of the government civilian or contract personnel that will replace the military personnel being converted, and PA&E concurred with that estimated cost. A principal factor in the determination of the positions selected for conversion was that the resulting civilian and contractor cost, in total, would not exceed the military programming rate cost.

As stated on page 4 of the draft report, PA&E "is currently identifying total costs for military health care positions." This effort is not yet complete, nor has it been reviewed by the Department's senior leadership. It is unlikely that this data will be available in a final format for use by the Secretaries of the Military Departments in time for them to provide their required certifications by June 1, 2006, in accordance with the FY 2006 National Defense Authorization Act (P.L. 109-163).

Furthermore, the PA&E data adds several items of personnel cost that are not included in the programming rates. It is apparent that the end result of this analysis will generate a higher average cost per military member than that reflected by the programming rates. It

would be highly unlikely if additional civilian cost factors would result in a "total cost" which would exceed the higher and more accurate rendering of military costs that the Department's analysis is revealing. Therefore, if the Secretaries of the Military Departments are able to certify by comparing the projected civilian and contractor costs to the programming rates, certification based upon comparison to the PA&E data would seem to be assured.

Finally, although the PA&E approach may result in more accurate portrayal of the full cost of military personnel, that does not guarantee that additional funds would be made available to the Defense Health Program (DHP) Operation and Maintenance budget to pay for civilian and contractor personnel. The Military Personnel Appropriation programming rates represent the amount of budgetary authority allocated to the Assistant Secretary of Defense (Health Affairs) to fund military personnel, and these conversions must remain within the upper bound of that budgetary authority to be deemed cost effective to the DHP.

RECOMMENDATION 2: Address in their Congressional certifications for military health care conversions the extent to which total projected costs for hiring Federal civilian or contract personnel include actual compensation costs for completed hires and anticipated compensation costs for future hires.

DOD RESPONSE:

Concur with comment. This recommendation appears to be unnecessary. Section 744 of the 2006 National Defense Authorization Act (P.L. 109-163) requires the Secretaries of the Military Departments to certify that the conversions within their department will not increase costs. In order to make such a certification, each Military Department Secretary must review actual civilian employee and contract employee costs for conversions already completed, as well as estimated costs for pending conversion actions.

Additionally, requiring the Secretary of Defense to provide direction to the Secretaries of the Military Departments provides an additional administrative step that may jeopardize the ability of the Military Department Secretaries to provide certification by June 1, 2006. Further, Section 744(a)(2)(A) requires the certification to include "the methodology used by the Secretary in making the determinations necessary for the certification, including the extent to which the Secretary took into consideration the findings of the Comptroller General in the report under subsection (b)(3)." Therefore, this requirement appears to be unnecessary.

Appendix VI: GAO Contact and Staff Acknowledgments

GAO Contact

Derek B. Stewart (202) 512-5559 or stewartd@gao.gov

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In addition to the individual named above, Sandra Bell, Assistant Director; Steve Fox; Benjamin Bolitzer; Alissa Czyz; Dawn Godfrey; Jennifer Jebo; Lynn Johnson; William Mathers; Julia Matta; and Terry Richardson made key contributions to this report.

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