UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, D.C. 20301-4000

PERSONNEL AND
READINESS

AUG 2 3 2021

The Honorable Jack Reed
Chairman
Committee on Armed Services
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

The Department's response to the reporting requirements of section 719 of the National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2020 (Public Law 116-92), as amended, and section 721 of the NDAA for FY 2017 (Public Law 114-328), is enclosed. The report provides the Department's plan for the reduction of military medical personnel authorizations to better align with the Department's operational medical requirements. It also clearly outlines how the Department will implement changes using a conditions-based approach to ensure our beneficiaries continue to have access to quality health care.

The report represents the collaborative efforts of the Office of the Assistant Secretary of Defense for Health Affairs, Military Departments, Office of the Joint Chiefs of Staff, and Defense Health Agency, and provides a comprehensive explanation of the analyses and assessments the Department used to develop this plan. Our focus on the coronavirus disease 2019 (COVID-19) pandemic response prevented us from submitting the report to Congress earlier.

The Department is committed to adjusting the timing, location, and scope of these changes as necessary to address conditions in local health care provider networks, installation mission requirements, and operational plans. In addition, as the impacts of the COVID-19 response continue to be defined, the Department will adjust the plan to ensure continuity of care for affected military and local populations, and the continued ability of our medical force to meet its operational mission. The Department will complete all statutory requirements prior to taking actions to reduce or realign any military medical authorizations specified in this plan. These requirements include direct communication with affected Service members and beneficiaries, the provision of continuity of care transition plans, and the holding of public forums for beneficiaries to discuss their concerns regarding proposed personnel realignments. These particular efforts directed by section 719 of the NDAA for FY 2020 cannot commence until after the required 90-day period following the submission of this report, and conducted subject to COVID-19 pandemic response constraints.

Thank you for your continued strong support for our Service members, veterans, and families. I am sending a similar letter to the House Armed Services Committee. The Department will continue collaborating with you as we optimize the Military Health System.

Sincerely,

Virginia S. Penrod

Virginia S. Penrod
Acting

Enclosure:
As stated

cc:
The Honorable James M. Inhofe
Ranking Member

UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, D.C. 20301-4000

PERSONNEL AND
READINESS

AUG 23 2021

The Honorable Adam Smith
Chairman
Committee on Armed Services
U.S. House of Representatives
Washington, DC 20515

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Virginia S. Penrod

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Acting

Enclosure:
As stated

cc:
The Honorable Mike D. Rogers
Ranking Member


# 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**

The estimated cost of this report for the Department of Defense (DoD) is approximately $ 1,977,000. This includes $100,000 in expenses and $1,877,000 in DoD labor.

Report/Study Cost Estimate 5–B4F0AF2

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# Executive Summary

In response to section 717 of the William M. (Mac) Thornberry National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2021 (Public Law 116-283), section 719(c) of the NDAA for FY 2020 (Public Law 116-92) and sections 721 and 725 of the NDAA for FY 2017 (Public Law 114-328), the Department of Defense (DoD) submits this report on the plan for optimizing the military medical end strength to meet operational requirements. The various sections identified in the three NDAAs authorize the DoD to convert military medical or dental positions to civilian positions, if the Secretary of Defense determines that the military positions are not necessary to meet operational medical force readiness requirements. The legislation also provides specific limitations and exceptions for the realignment or reduction of military medical end strength authorizations. This report represents the collaborative efforts of the Office of the Assistant Secretary of Defense for Health Affairs (OASD(HA)), the Military Departments (MILDEPs), the Joint Chiefs of Staff, and the Defense Health Agency (DHA).

This document addresses the requirement to provide a report to Congress on the DoD's proposed military medical end strength reductions, as directed in the NDAA for FY 2020 section 719(c). Additionally, this report includes the necessary information to satisfy the remaining requirements of section 721(b) of the NDAA for FY 2017 to describe the process to define the military medical and dental personnel requirements necessary to meet operational medical force readiness requirements. Therefore, this report also serves as the final report to the congressional defense committees and meets the requirements of section 721 of the NDAA for FY 2017 for military medical authorizations aligned with the Defense Health Program (DHP).

The MILDEPs conducted a review and analysis to adjust the shape of the force to meet the National Security Strategy (NSS), the National Defense Strategy (NDS) and Defense Planning Guidance. The DoD applied the MILDEPs' analysis of operational requirements to determine the number of reductions. In FY 2020 the Department submitted a request to reduce military medical end strength by 17,005 for the MILDEPs to increase the number of operational billets needed for lethality. Due to the need to focus on the global pandemic, the DoD paused this effort. During this pause adjustments were made based on subsequent analysis against on-going mission updates and refinements. Additionally, in August 2020 the inaugural Joint Medical Estimate (JME) was finalized. Modifications to the military medical billets include decreasing some reductions and spreading the reductions over a longer period of time. Therefore, the DoD has changed the original amount of military medical reductions submitted in FY 2020 from 17,005 to 12,801, which include billets from the Army (2,948), Navy (5,169), and Air Force (4,684). This report only addresses military medical reductions aligned with the DHP.

The reductions include 3,765 officer, 7 warrant officer, and 9,029 enlisted medical billets. The changes affect 220 different units, which include hospitals, clinics, medical centers, research organizations, and educational facilities. The National Capital Region (NCR) market will take the largest portion of the reductions, as the ability to hire in this area is greater. The preponderance of reductions are planned for FY 2023 and will taper off through FY 2027.

The DHA and the MILDEPs collaboratively developed optimization strategies around impacts to military medical treatment facilities (MTFs) affected by the reductions. Optimization approaches include incrementally absorbing workload by balancing a deliberate transition for 3,266 positions, as well as hiring civilian or contractor replacements for 7,114 positions, moving care to the network for 163 positions, replacing 375 positions, and reshaping 684 positions. All MILDEPs allowed some flexibility in the location of the reductions to address situations where the network or ability to hire replacement personnel may not be optimal.

| Service | Absorb | Hire | Network | Replace | Reshape | Student | Grand Total |
|---|---|---|---|---|---|---|---|
| Army | 1,016 | 1,248 | -- | -- | 684 | -- | 2,948 |
| Navy | 1,043 | 3,250 | 97 | 375 | -- | 404 | 5,169 |
| Air Force | 1,207 | 2,616 | 66 | -- | -- | 795 | 4,684 |
| Grand Total | 3,266 | 7,114 | 163 | 375 | 684 | 1,199 | 12,801 |

The Department will accomplish military medical manpower reductions through attrition of personnel and other force shaping tools, to minimize impact on individuals, as well as maintain required delivery of quality health care to Service members and beneficiaries. The Secretary will ensure no military medical end strength authorizations are realigned or reduced until all requirements of section 719 of the NDAA for FY 2020 are met, unless the billet meets the exception criteria. Potential conversions of military authorizations to civilian authorizations will be executed in compliance with the requirements of section 721 and 725 of the NDAA for FY 2017 and Department of Defense Instruction (DoDI) 6000.19, "Military Medical Treatment Facility Support of Medical Readiness Skills of Health Care Providers," February 7, 2020.

The Department will continually reassess these requirements as strategies and plans change, ensuring the Department's military force structure, including military medical end strength, remains optimized to meet the operational requirements of the Department. The reductions beyond FY 2022 will be adjusted based on the ability to implement the optimization strategy and mission changes. As the Department embarks on this conditions-based, optimizing approach to military medical manpower, no eligible beneficiary will go without access to quality health care, which will continue to occur either in a MTF or through private sector care.

# 1.0 Introduction

This report addresses the requirement to provide a report to Congress on the Department of Defense's (DoD's) proposed military medical end strength reductions, as directed in the National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2020 Section 719(c). This report represents the collaborative efforts of the Office of the Assistant Secretary of Defense for Health Affairs (OASD(HA)), the Military Departments (MILDEPs), the Joint Chiefs of Staff, and the Defense Health Agency (DHA). Additionally, this report includes the necessary information to satisfy the remaining requirements of section 721(b) of the NDAA for FY 2017 for military medical authorizations aligned with the Defense Health Program (DHP) by describing the process to define the military medical and dental personnel requirements necessary to meet operational medical force readiness requirements.

## 1.1 Background

The Military Health System (MHS), through the MILDEPs and the DHA, ensures a medically ready force through the delivery of health care to active duty service members (ADSMs) through direct care at military medical treatment facilities (MTFs) and private sector care provided by the TRICARE Health Plan's (THP's) Managed Care Support Contractors (MCSCs). In addition, the MHS develops the readiness capabilities of the medical force by leveraging MTFs as the training and clinical currency platform for military medical personnel.

Section 721 of the NDAA for FY 2017 directed the Secretary of Defense, in collaboration with the Military Department Secretaries, to establish a process to define the military medical and dental personnel requirements necessary to meet operational medical force readiness requirements. This section also authorized the DoD to convert a medical or dental military position within the DoD to a civilian medical or dental position if the Secretary of Defense determines that the military position is not necessary to meet operational medical force readiness requirements. Section 725 of the NDAA for FY 2017 also authorizes the Secretary of Defense to make adjustments to military and civilian personnel authorized strengths throughout the MHS to maintain critical wartime medical readiness skills and ensure the medical readiness of the Armed Forces.

Section 719 of the NDAA for FY 2020 limits the Secretary of Defense and the MILDEP Secretaries from realigning or reducing military medical end strength authorizations until reviews and analyses are conducted, a network adequacy measurement is developed, and outreach is performed to covered beneficiaries impacted by the military medical end strength realignment or reduction. This outreach includes a transition plan for continuity of health services and a public forum to discuss the concerns of the beneficiaries. Section 719 also identifies exceptions to these limitations and military medical end strength realignments or reductions are authorized if the positions are (1) administrative billets of a military medical department that has remained unfilled since at least October 1, 2018, (2) identified as non-clinical in the President's budget for FY2020, but cannot exceed 1,700, and (3) medical headquarters billets of the MILDEPs not assigned or directly supporting operational commands. Section 717 of the William M. (Mac) Thornberry NDAA for FY 2021 amends the section 719 of

the NDAA for FY 2020 and does not allow any reductions or realignments of military medical end strength during 180 days following the date of the enactment of the NDAA for FY2021 and adds the homeland defense mission and pandemic influenza to the requirement to conduct a review of medical manpower requirements for all National Defense Strategy scenarios.

# 2.0 Military Department Review and Analysis

The MILDEPs conducted a review and analysis of the military medical personnel requirements needed to support the operational medical requirements to meet the National Security Strategy (NSS), the National Defense Strategy (NDS) and Defense Planning Guidance. The MILDEPs describe the methodology used to determine the military medical requirements needed to meet the operation mission in **Appendix B**: Methodology by Service. The DoD applied the MILDEPs' analyses of operational requirements to determine the number of reductions. The MILDEPs and the DHA also conducted an analysis of MTFs affected by the military medical manpower reductions and collaboratively developed strategies to address the impacts of the reductions. The strategies include absorb, hire, network, replace, reshape, and student, which are defined below.

- **Absorb** indicates remaining staff at a location is assumed to be sufficient to absorb the workload and cover current and future health care delivery demands.
- **Hire** refers to the replacement of active duty personnel with federal civilians or contractors in-house.
- **Network** is an option where input from the MTFs verified the feasibility of engaging the network (or purchased care) in place of civilian hires or uniformed personnel.
- **Replace** represents an internal secondary review of divested billets that cannot be optimized by hiring or leveraging the network. (Repurpose)
- **Reshape** the current force structure to support the current workload by leveraging existing civilian over-hires that were hired to replace historically unfilled military positions. (Army)
- **Student** indicates that the reduction is a student or trainee, and therefore does not require mitigation. Student billets are funded positions used to train and maintain appropriate throughput of medical personnel to support Force Generation (FG) requirements. (Navy/Air Force)

## 2.1 Army

### 2.1.1 Background

The NDAA for FY 2017 provided the Department the authority to convert military medical and dental authorizations to civilian positions when the position is not necessary to meet operational medical requirements. The Department of the Army conducted a comprehensive review of the operational medical requirements against the FY 2018 NDS. The Headquarters, Department of

the Army's (HQDA) Staff, Army Commands, and the Army Service Component Commands conducted an extensive analysis on the Army's military medical requirements. After defining the requirements, the Army conducted a military essentiality review of positions not required for the operating and generating force and prioritized 6,935 positions within the MTF and dental activities that could be converted from military personnel (MILPER) to civilian personnel (CIVPER).

The NDAA for FY 2020 directed the Department to limit the reductions of military medical personnel and review potential gaps in health care services. The Army conducted a detailed analysis at the MTF-level on the previous assumptions, such as ability to hire specific health care professionals, and reviewed local network adequacy with MTF Directors/Commanders. This assessment led to six options with increasing levels of impact. Army leaders had a low tolerance for mission impacts in Health Care Delivery (HCD) and decided to convert only 2,948 positions which were either:

(1) currently vacant military authorizations filled with civilian over-hires, or
(2) assessed with a high confidence to hire CIVPER in that health care market. The Army is not taking any additional military medical or dental conversions in FY 2021.[1] The Army manpower process includes iterative assessments of capabilities and capacity.

### 2.1.2 Billets Selected for Realignment

Army Military Medical Manpower Analysis Review Results. Based upon the additional analysis in FY20 with by-location impacts and possible optimization, the Secretary of the Army decided to adjust the military medical reductions from 6,935 to 2,948. The refined impact assessment demonstrated that 1,700 of the reductions would cause no impact to medical readiness or beneficiary care because the locations are over structured or the military position is vacant and a civilian is already in place. In addition, the refined impact assessment revealed a high level of confidence to hire civilian replacements for 1,248 of the reductions. In the updated assessment, the Army did not recommend any reductions that would cause MTF care to be transferred to the network or any reductions where it assessed difficulty in hiring a civilian replacement in that area. Additionally, the Army did not take any dental reductions unless there was no impact to medical readiness.

The table below shows the number of reductions by location and by Corps. The Army will adjust the numbers annually as it continuously evaluates impacts and optimizes available resources in accordance with changes in mission and requirements and as part of the Army's overall Total Army Analysis (TAA) process.

[1] Any conversion of military authorizations to civilian authorizations will be executed in compliance with the requirements of section 725 of the NDAA for FY 2017 and DoDI 6000.19, "Military Medical Treatment Facility Support of Medical Readiness Skills of Health Care Providers," February 7, 2020."

*Table 1 Army Military Medical Reductions by Location and Strategy*

| Location | MC | DC | AN | SP | MS | AI | AE | Total |
|---|---|---|---|---|---|---|---|---|
| BELVOIR | | 2 | 13 | 1 | 7 | | 285 | 308 |
| BAMC | 23 | 1 | 14 | 2 | 20 | | 191 | 251 |
| BENNING | 9 | 5 | 21 | 4 | 1 | | 185 | 225 |
| HOOD | | 2 | 13 | 4 | 19 | | 155 | 193 |
| CAMPBELL | 19 | 3 | 10 | 4 | 15 | | 131 | 182 |
| STEWART | 14 | | 24 | 2 | 12 | | 114 | 166 |
| WOMACK AMC | 1 | | 27 | | 15 | | 116 | 159 |
| KNOX | 12 | | 2 | 6 | 11 | | 104 | 135 |
| RILEY | 2 | 2 | 21 | 2 | 8 | | 97 | 132 |
| WALTER REED | 3 | | 4 | | | | 107 | 114 |
| CARSON | 16 | 1 | 7 | 2 | 9 | | 74 | 109 |
| SILL | 20 | 2 | 2 | 4 | 9 | | 66 | 103 |
| LEWIS (MADIGAN) | 7 | 1 | 3 | | 4 | 1 | 80 | 96 |
| EUSTIS | 9 | | 7 | | 8 | | 71 | 95 |
| LEONARD WOOD | | | 7 | 4 | 3 | | 75 | 89 |
| JACKSON | | 1 | 4 | 4 | 7 | | 58 | 74 |
| WEST POINT | 11 | 1 | 2 | | 5 | | 44 | 63 |
| MEADE | 2 | | 5 | | 6 | | 40 | 53 |
| LEAVENWORTH | | | 4 | | 3 | | 43 | 50 |
| TRIPLER AMC | 5 | | 13 | | 3 | | 29 | 50 |
| WBAMC | 1 | | 1 | | 6 | | 38 | 46 |
| DRUM | | | 4 | | 1 | | 35 | 40 |
| LANDSTUHL | | 1 | 8 | | 5 | | 26 | 40 |
| ALASKA | | | 4 | | 2 | | 21 | 27 |
| GORDON DDEAMC | | 1 | | | | | 24 | 25 |
| HUACHUCA | | | 4 | 2 | 2 | | 16 | 24 |
| POLK | | 2 | 2 | 2 | 2 | | 14 | 22 |
| RUCKER | | | 2 | | 4 | | 14 | 20 |
| ARMY DENTAL LABORATORY | | | | | | | 17 | 17 |
| KOREA | | | | | | | 16 | 16 |
| IRWIN | | | 2 | | 3 | | 4 | 9 |
| BAVARIA | | 1 | | | | | 3 | 4 |
| PHA BRAGG | | | | | | | 4 | 4 |
| JAPAN | | | | | | | 3 | 3 |
| PHC EUROPE | | | | | | | 1 | 1 |
| RDC ATLANTIC | | 1 | | | | | | 1 |
| RDC CENTRAL | | 1 | | | | | | 1 |
| USAARL | | | | | | | 1 | 1 |
| **Grand Total** | **154** | **28** | **230** | **43** | **190** | **1** | **2302** | **2948** |

| Location | Absorb | Hire | Total |
|---|---|---|---|
| BELVOIR | 45 | 263 | 308 |
| BAMC | 173 | 78 | 251 |
| BENNING | 179 | 46 | 225 |
| HOOD | 123 | 70 | 193 |
| CAMPBELL | 75 | 107 | 182 |
| STEWART | 67 | 99 | 166 |
| WOMACK AMC | 33 | 126 | 159 |
| KNOX | 135 | | 135 |
| RILEY | 79 | 53 | 132 |
| WALTER REED | 18 | 96 | 114 |
| CARSON | 75 | 34 | 109 |
| SILL | 87 | 16 | 103 |
| LEWIS (MADIGAN) | 67 | 29 | 96 |
| EUSTIS | 72 | 23 | 95 |
| LEONARD WOOD | 37 | 52 | 89 |
| JACKSON | 43 | 31 | 74 |
| WEST POINT | 56 | 7 | 63 |
| MEADE | 45 | 8 | 53 |
| LEAVENWORTH | 33 | 17 | 50 |
| TRIPLER AMC | 49 | 1 | 50 |
| WBAMC | 18 | 28 | 46 |
| DRUM | 13 | 27 | 40 |
| LANDSTUHL | 18 | 22 | 40 |
| ALASKA | 24 | 3 | 27 |
| GORDON DDEAMC | 25 | | 25 |
| HUACHUCA | 24 | | 24 |
| POLK | 20 | 2 | 22 |
| RUCKER | 14 | 6 | 20 |
| ARMY DENTAL LABORATORY | 17 | | 17 |
| KOREA | 16 | | 16 |
| IRWIN | 9 | | 9 |
| BAVARIA | 1 | 3 | 4 |
| PHA BRAGG | 4 | | 4 |
| JAPAN | 2 | 1 | 3 |
| RDC CENTRAL | 1 | | 1 |
| PHC EUROPE | 1 | | 1 |
| RDC ATLANTIC | 1 | | 1 |
| USAARL | 1 | | 1 |
| **Grand Total** | **1700** | **1248** | **2948** |

*The information in the table is subject to change.

MC = Medical Corps
DC = Dental Corps
AN = Army Nurse Corps
SP = Specialty Corps
MS = Medical Service Corps
AI = Medical Immaterial
AE = Enlisted Corps

The Army conducted a comprehensive assessment of the operational requirements, as mandated in the NDAA for FY 2017, and completed additional analysis, as directed in the NDAA for FY 2020, to review potential gaps in health care services. The initial assessment determined 6,935 military medical personnel authorizations were available for conversion to CIVPER. After a detailed review of the ability to convert positions and health care network adequacy, as well as additional collaboration with the other MILDEPs, Joint Staff, and DHA, the Secretary of the

Army decided on 2,948 military medical positions for conversion. These positions were either already vacant military positions filled with civilian over-hires, or there was a high degree of confidence to hire CIVPER in the local health care market. Any such hiring actions will be conducted in accordance with all applicable statutory and policy requirements.[2]

The authorizations are planned for reinvestment in capabilities that will better enable the Army to provide ready and lethal capabilities to the Joint force. These include investments in long-range fires, mobile air and missile defenses, cyber, electronic warfare capabilities, and holistic health and fitness programs.

The Army is not converting any military medical or dental authorizations in FY 2021. The Army process includes iterative reassessment of capabilities and capacity, which will include the lessons learned from the COVID-19 response.

## 2.2 Navy/Marine Corps

### 2.2.1 Background

Section 719 of the NDAA for FY 2020: "Limitation on the Realignment or Reduction of Military Medical Manning End Strength" requires the Department to provide a Report to Congress (RTC) detailing the impact of the proposed reductions to include the potential impacts and optimization plans. The FY 2020 President's Budget request to reduce Active Component (AC) end strength because of reduction in Naval Expeditionary Health Service Support (NEHSS) capabilities is delayed, pending submission and review of the RTC. This report builds off methodologies outlined in the section 721 of the NDAA for FY 2017 interim reports provided on March 30, 2017; November 14, 2017; and March 26, 2018. The analytical processes used by the Navy are described in detail in the interim reports. Additionally, section 703 of the NDAA for FY 2017 Final RTC information was used to guide location feasibility of the proposed divestitures.

***Table 2 Navy Optimization Strategies***

| Fiscal Year | Student[1] | Absorb | Hire | Network | Replace | Divestiture[2] |
|---|---|---|---|---|---|---|
| FY21 | 298 (11%) | 769 (29%) | 1,232 (47%) | 11 (0.4%) | 319 (12%) | 2,629 |
| FY22 | 106 (20%) | 137 (26%) | 270 (52%) | 0 (0%) | 6 (1%) | 519 |
| FY23 | N/A | 100(6%) | 1,392 (87%) | 75 (5%) | 28 (2%) | 1,595 |
| FY24 | N/A | 21 (8%) | 202 (80%) | 9 (4%) | 21 (8%) | 253 |
| FY25 | N/A | 16 (9%) | 154 (89%) | 2 (1%) | 1 (1%) | 173 |
| **Total** | **404 (8%)** | **1,043 (20%)** | **3,250 (63%)** | **97 (2%)** | **375 (7%)** | **5,169** |

*1 Optimization is not needed for Students. Students are in training and not included in the calculation to determine how to mitigate divestitures.*

[2] Any conversion of military authorizations to civilian authorizations will be executed in compliance with the requirements of section 725 of the NDAA for FY 2017 and DoDI 6000.19, "Military Medical Treatment Facility Support of Medical Readiness Skills of Health Care Providers," February 7, 2020

*2 *The Navy divestiture of 5,169 reflected in this table represents Navy military medical billets aligned with the Defense Health Program only.*

### 2.2.2 Optimization Strategies

Navy analysis considered the directed capability divested, operational platform placement/realignment, and the support required to meet and maintain readiness missions. DHA general planning guidance, in accordance with DoDI 6000.19, involves the shift of family member and retiree care to the network unless it directly supports the following:

(1) Graduate Medical Education (GME)/Graduate Health Professional Education (GHPE), or
(2) Military medical force readiness (ready medical force); and HCD where the network has no capability or additional capacity.

The Navy exercised four optimization options in the review and analysis of the divestitures and absorbed some divestiture impacts through a realignment of operational platforms. The realignment of platforms created an economy of scale which subsequently led to the ability to absorb some of the divestitures. "Absorb" also became an option where a facility was impacted by section 703 of the NDAA for FY 2017 implementation planning.

The Navy prefers hiring to maintain military MTF capabilities and capacity, and to minimize disruption of the medical readiness of the forces and medical training pipelines. Positions were identified for hire in areas that could not be absorbed utilizing the remaining assets at each MTF. Identifying the estimated cost of hiring personnel is vital to informing the DHP future budget requests. There are anticipated risks associated with hiring. These risks include, a potential lengthy civilian hiring process, which is highly dependent on the specialty skill and market availability that is being 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 (ATC) issues.

Early in the divestiture process, Navy Medicine determined that some of the originally identified billets required a reassessment. Approximately 375 billet divestitures were identified and optimized by repurposing and realigning billets from other locations. These were replaced for various reasons, primarily in cases where the loss of military staff could not be optimized by hiring or using the network. Replacements were also utilized when there was an identified need to support GME/GHPE, operational platforms, or the Navy and Marine Corps accession and training sites. Billets utilized for this purpose (repurposed and used as replacements) were identified through additional analysis that included a prioritization evaluation to identify alternate, lower impact billets for divestment, as well as those identified as a result of section 703 of the NDAA for FY 2017 sites decreasing scope of care. Through these efforts, the Navy was able to eliminate impacts to GME/GHPE, as well as replace critical positions identified as "hard to hire" in certain locations. As part of the reassessment effort, adjusting specialty/skill mix to support operational medical requirements was done to bolster needed critical war time specialties that were previously under-resourced to meet readiness requirements.

The Network optimization strategy was used sparingly based on current, limited network adequacy information. Some examples of services identified that could be sent to the Network include Pediatrics, Radiology, and Physical Therapy Services in San Diego. Network was also utilized for non-readiness related positions as part of the implementation planning for the section 703 of the NDAA for FY 2017 report.

Optimization of Navy GME/GHPE was a priority in Navy Medicine's strategy. The Bureau of Medicine and Surgery (BUMED) made every effort to align operational platform unit locations to coincide with GME/GHPE locations. Navy will be partnering with the DHA to identify and recruit for civilian positions to ensure Accreditation Council for Graduate Medical Education (ACGME) program requirements are satisfied. Through a separate, military manpower effort, specialty/skill types were changed to support operational medical requirements, optimizing most of the GME/GHPE program requirements. In circumstances where GME required a specialty skill that does not align to operational requirements, it will require the hiring of civilians or a network solution.

Congruent to this effort, Navy has joined Army, Air Force, and DHA to conduct a comprehensive GME/GHPE program review. Consistent with section 749 of the NDAA for FY 2017, there is already a process formalized practices in place and two oversight entities: The Oversight Advisory Council (OAC) and the Integration Advisory Board (IAB), chartered in 2018 to report to the Director, DHA. While the OAC reviews the MILDEPs training plans to ensure plans are joint, the council assists the DHA with optimizing military GME programs to improve readiness. The IAB ensures collaboration, ensures programs support readiness, assesses programs for unwarranted duplication, and ensures MTFs remain the primary training platform for GME. This will be essential as the Navy navigates through the challenges of mitigating GME gaps in certain specialty areas and locations.

A review of all GME programs is ongoing, in collaboration with all the MILDEPs and DHA, to identify post-divestiture requirements. The divestitures may require adjustments to program throughput and/or locations. This could include combining or consolidating currently dispersed program sites. However, downsizing of programs will take time and require a phased approach to achieve the desired end state, while meeting ACGME guidelines.

The Navy will continue analysis of the medical community's non-operational uniform essential requirement to include the force generation requirement. Navy Medicine will mitigate graduate education and readiness impacts, including loss of faculty, to preserve the training pipelines/accreditation status essential to force generation where it can. Consistent with DoDI 6015.24, "DoD Graduate Medical Education Program," April 9, 2021, in most cases the DHA will be required to provide personnel in order to maintain GME program accreditation or certification.

### 2.2.3 Remaining Optimizations

The Navy has identified several potential challenges that will be addressed during execution;

(1) With realignments within the Program of Record, which includes the 5,169 reduction, and a reassessment of the role of the Navy Reserve in the provision of medical care, the Navy can mitigate impact on our highest priority, Operational Medical Care.
(2) The Navy will use available tools to shape specialty communities to meet operational requirements.
(3) Availability of funds to hire civilians or contractors will need to be executed through comprehensive planning so there are no disruptions to the MTFs service lines and ATC capability.
(4) The Navy will continue to work with DHA to mitigate reductions of Navy uniformed personnel at the MTFs. Mitigations will include military to civilian conversions, shifting care to the network, and improved efficiency of the direct care system.

Based on the rigor of the analysis done, the Department of the Navy stands behind the proposed medical end strength reductions. The Navy also recognizes that minor changes to the divestiture plan may be required. Reviews of operational plans, the Joint Medical Estimate, legacy surge layer medical capabilities, and evolving concepts such as Distributed Maritime Operations, and Expeditionary Advanced Base Operations are ongoing. Insights and lessons learned from the COVID-19 pandemic and its impact on the global strategic operating environment, and updated planning factors for the employment of Active and Reserve forces in operational plans and peacetime operations are being considered as well.

**Table 3** shows the number of reductions by location, by Corps, and mitigation strategy. The Navy will adjust divesture specialty mix/location to mitigate wartime specialty gaps, keep infrastructure to maintain readiness and core competencies to meet military essential current/future demands, and sustain a combat ready force.

## *Table 3 Navy Military Medical Reductions by Location and Strategy*

| DMIS Location | DC | MC | MSC | NC | HM | NON MED OFF | NON MED ENL | Total | Absorb | Hire | Network | Replace | Student | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| BMC INDIAN ISLAND | | | | | 1 | | | 1 | | 1 | | | | 1 |
| BUMED HQ | | | 2 | | | | | 2 | 2 | | | | | 2 |
| NAVAL MEDICAL FORCES ATLANTIC | | | 2 | | | | | 2 | 2 | | | | | 2 |
| NAVSUBMED RESEARCH LAB | | | | | | | 1 | 1 | 1 | | | | | 1 |
| NDC CAMP LEJEUNE | 2 | | 1 | | 7 | | | 10 | 1 | 9 | | | | 10 |
| NDC OKINAWA | 3 | | 2 | | | | | 5 | | 5 | | | | 5 |
| NMRTC CAMP PENDLETON | 6 | 16 | 21 | 31 | 71 | 2 | 30 | 177 | 56 | 103 | 8 | 10 | | 177 |
| NMCPHC | | | 2 | | | | | 2 | | 2 | | | | 2 |
| NMLPDC - BETHESDA | | | 1 | | | | | 1 | 1 | | | | | 1 |
| NMRC | | | 2 | | | | | 2 | 1 | 1 | | | | 2 |
| NMRTC 29 PALMS DET BRIDGEPORT | | | | | 2 | | | 2 | | 2 | | | | 2 |
| NMRTC ANNAPOLIS | 1 | 1 | 4 | 1 | 9 | | 6 | 22 | 6 | 16 | | | | 22 |
| NMRTC BEAUFORT | 2 | 6 | 15 | 30 | 81 | 1 | 14 | 149 | 49 | 100 | | | | 149 |
| NMRTC BREM DET NSY PUGET SND | | | | | 8 | | | 8 | 4 | 4 | | | | 8 |
| NMRTC BREMERTON | 3 | 30 | 20 | 45 | 181 | 5 | 51 | 335 | 126 | 190 | 19 | | | 335 |
| NMRTC CAMP LEJEUNE | 3 | 27 | 29 | 32 | 50 | 2 | 2 | 145 | 8 | 98 | | 39 | | 145 |
| NMRTC CHARLESTON | 1 | | 8 | 10 | 7 | | 8 | 34 | 14 | 19 | | 1 | | 34 |
| NMRTC CHERRY POINT | | 4 | 7 | 7 | 29 | | | 47 | 6 | 41 | | | | 47 |
| NMRTC CORPUS CHRISTI | 2 | 4 | 2 | 1 | 25 | | 10 | 44 | 20 | 20 | 4 | | | 44 |
| NMRTC GREAT LAKES | 1 | 13 | 14 | 13 | 42 | 2 | 29 | 114 | 38 | 76 | | | | 114 |
| NMRTC GUAM-AGANA | | | 2 | 2 | 12 | | | 16 | | 16 | | | | 16 |
| NMRTC HAWAII | 7 | 8 | 14 | 7 | 84 | | 2 | 122 | 4 | 117 | | 1 | | 122 |
| NMRTC JACKSONVILLE | 13 | 33 | 17 | 45 | 157 | 1 | 61 | 327 | 43 | 214 | | 70 | | 327 |
| NMRTC LEMOORE | | 2 | 7 | 7 | 15 | | 4 | 35 | 12 | 22 | 1 | | | 35 |
| NMRTC NAPLES | | | 1 | | 3 | | | 4 | | 4 | | | | 4 |
| NMRTC NEW ENG DET SARA SPRINGS | 1 | | | | 6 | | | 7 | 1 | 6 | | | | 7 |
| NMRTC NEW ENGLAND | 4 | 4 | 5 | 7 | 42 | 1 | 10 | 73 | 38 | 32 | 3 | | | 73 |
| NMRTC OAK HARBOR | 6 | 4 | 7 | 13 | 26 | | 9 | 65 | 5 | 60 | | | | 65 |
| NMRTC PATUXENT | 2 | 4 | 6 | 5 | 20 | | | 37 | 20 | 10 | 7 | | | 37 |
| NMRTC PAX DET INDIAN HEAD MD | 1 | | 1 | 1 | 6 | | | 9 | 4 | 4 | 1 | | | 9 |
| NMRTC PAX DET M GROW ANDREWS | | | | 1 | | | | 1 | | 1 | | | | 1 |
| NMRTC PCOLA DET CRANE IN | | 1 | | | | | | 1 | | 1 | | | | 1 |
| NMRTC PCOLA DET PANAMA CITY FL | | | | | 1 | | | 1 | | 1 | | | | 1 |
| NMRTC PEARL HARBOR DET CSMITH | | | | 1 | 7 | | | 8 | 3 | 5 | | | | 8 |
| NMRTC PENSACOLA | 10 | 35 | 28 | 57 | 233 | 2 | 38 | 403 | 98 | 305 | | | | 403 |
| NMRTC PORTS DET DAM NECK VA | 1 | | | | 5 | | | 6 | | 6 | | | | 6 |
| NMRTC PORTS DET NSY NORFOLK V | | | | | 4 | | | 4 | 1 | 3 | | | | 4 |
| NMRTC PORTS DET YORKTOWN VA | | | | | 2 | | | 2 | | 2 | | | | 2 |
| NMRTC PORTSMOUTH | 17 | 86 | 28 | 81 | 252 | 2 | 18 | 484 | 81 | 303 | | 100 | | 484 |
| NMRTC QUANTICO | 7 | 3 | 8 | 3 | 20 | | 2 | 43 | 3 | 40 | | | | 43 |
| NMRTC QUANTICO DET WNY WASH | 1 | | 1 | 1 | 16 | | | 19 | 2 | 17 | | | | 19 |
| NMRTC ROTA | | | 1 | | 4 | | | 5 | | 5 | | | | 5 |
| NMRTC SAN DIEGO | 10 | 86 | 27 | 94 | 276 | 6 | 19 | 518 | 132 | 312 | 23 | 51 | | 518 |
| NMRTC SAN DIEGO DET CORONADO | 4 | | | | 5 | | | 9 | 1 | 4 | 4 | | | 9 |
| NMRTC SAN DIEGO DET EL CENTRO | | | | | 3 | | | 3 | | 3 | | | | 3 |
| NMRTC SAN DIEGO DET K MESA | | | | | 1 | | | 1 | 1 | | | | | 1 |
| NMRTC SAN DIEGO DET MIRAMAR | | | 2 | 1 | 8 | | | 11 | 2 | 9 | | | | 11 |
| NMRTC SAN DIEGO DET SCLEMENTE | | | | | 1 | | | 1 | 1 | | | | | 1 |
| NMRTC SIGONELLA | | | 1 | | 2 | | | 3 | | 3 | | | | 3 |
| NMRTC TWENTYNINE PALMS | | 2 | 9 | 19 | 22 | 1 | 15 | 68 | 10 | 57 | 1 | | | 68 |
| NMRTC WRNMMC | 6 | 69 | 27 | 78 | 327 | 7 | 95 | 609 | 63 | 444 | | 102 | | 609 |
| NMRTC YOKOSUKA | | | 1 | | 9 | | | 10 | | 10 | | | | 10 |
| NMRTU ALBANY GA | 1 | 1 | | | 2 | | 1 | 5 | 1 | 3 | 1 | | | 5 |
| NMRTU BANGOR WA | 5 | 3 | 2 | | 26 | | | 36 | 12 | 20 | 4 | | | 36 |
| NMRTU BELLE CHASSE LA | 2 | 2 | 2 | 1 | 13 | | 2 | 22 | 7 | 12 | 3 | | | 22 |
| NMRTU CHINA LAKE CA | | | | | 2 | | | 2 | | 2 | | | | 2 |
| NMRTU DAHLGREN VA | | 1 | | | 3 | | | 4 | 2 | 1 | 1 | | | 4 |
| NMRTU EARLE NJ | | 1 | | | 3 | | | 4 | 2 | 1 | 1 | | | 4 |
| NMRTU EVERETT WA | 2 | 1 | 4 | | 14 | | 1 | 22 | 4 | 18 | | | | 22 |
| NMRTU FALLON NV | 1 | | 1 | | 2 | | | 4 | | 4 | | | | 4 |
| NMRTU FT BELVOIR VA | 3 | 20 | 13 | 45 | 82 | 4 | 11 | 178 | 15 | 162 | | 1 | | 178 |
| NMRTU GROTON CT | 6 | 3 | 4 | 6 | 57 | | 4 | 80 | 37 | 39 | 4 | | | 80 |
| NMRTU GULFPORT MS | 1 | 1 | 2 | 1 | 11 | | | 16 | 5 | 11 | | | | 16 |
| NMRTU KEY WEST FL | 1 | 1 | 2 | 1 | 3 | | 1 | 9 | 5 | 4 | | | | 9 |
| NMRTU KINGS BAY GA | 4 | 4 | 2 | 2 | 11 | | | 23 | 1 | 22 | | | | 23 |
| NMRTU KINGSVILLE TX | | 1 | | | 3 | | 1 | 5 | 3 | 2 | | | | 5 |
| NMRTU LITTLE CREEK VA | 2 | | 2 | 2 | 16 | | | 22 | 9 | 13 | | | | 22 |
| NMRTU MAYPORT FL | 4 | 3 | 4 | 5 | 9 | | 1 | 26 | 7 | 19 | | | | 26 |
| NMRTU MCRD PARRIS ISLAND SC | | 1 | | | | | | 1 | | 1 | | | | 1 |
| NMRTU MEMPHIS TN | 1 | 1 | 2 | 1 | 10 | | 2 | 17 | 7 | 8 | 2 | | | 17 |
| NMRTU MERIDIAN MS | 1 | | 1 | | 13 | | | 15 | 8 | 7 | | | | 15 |
| NMRTU NAVBASE SAN DIEGO CA | 14 | 1 | 3 | 1 | 23 | | | 42 | 1 | 39 | 2 | | | 42 |
| NMRTU NAVSTA NORFOLK VA | 20 | | 5 | 1 | 20 | | | 46 | 8 | 38 | | | | 46 |
| NMRTU NORTH ISLAND CA | 1 | 3 | 3 | | 19 | | | 26 | 3 | 21 | 2 | | | 26 |
| NMRTU OCEANA VA | 2 | | 3 | 1 | 20 | | | 26 | 8 | 18 | | | | 26 |
| NMRTU POINT LOMA CA | | 1 | 3 | | 4 | | | 8 | 3 | 3 | 2 | | | 8 |
| NMRTU PORT HUENEME CA | 3 | | 2 | | 20 | | 5 | 30 | 11 | 19 | | | | 30 |
| NMRTU PORTSMOUTH NH | 1 | | 2 | | 11 | | 1 | 15 | 8 | 6 | 1 | | | 15 |
| NMRTU WHITING FIELD FL | | 1 | 1 | 2 | 19 | | | 23 | 2 | 21 | | | | 23 |
| NMRTU WORTH TX | 1 | 1 | | 2 | 3 | | | 7 | 2 | 5 | | | | 7 |
| NMRTU YUMA AZ | | | | | 3 | | | 3 | | 3 | | | | 3 |
| NMTSC-SAN ANTONIO | 1 | 1 | 2 | 1 | 3 | | | 8 | 2 | 3 | 3 | | | 8 |
| NOSTRA | | | 1 | | 9 | | | 10 | 10 | | | | | 10 |
| U.S. NMRTC OKINAWA | | | 3 | | 14 | | | 17 | | 17 | | | | 17 |
| US NMRTU ATSUGI JA | | | | | 1 | | | 1 | | 1 | | | | 1 |
| US NMRTU IWAKUNI JA | | | | | 3 | | | 3 | | 3 | | | | 3 |
| US NMRTU SASEBO JA | | | | | 1 | | | 1 | | 1 | | | | 1 |
| IA MEDICAL DEPT TRAINING | 9 | 18 | 21 | 40 | 316 | | | 404 | | | | | 404 | 404 |
| **Total** | **200** | **508** | **415** | **705** | **2851** | **36** | **454** | **5169** | **1043** | **3250** | **97** | **375** | **404** | **5169** |

*The information in the table is subject to change.

DC = Dental Corps MC = Medical Corps MSC = Medical Service Corps NC = Nurse Corps
HM = Hospital Corpsman Non-Med Off = Non-medical Officer Non-Med Enl = Non-medical Enlisted

## 2.3 Air Force

### 2.3.1 Background

In 2017, the Air Force Medical Service (AFMS) conducted an analysis to determine the optimal use of its available military end-strength to ensure sufficient resources are available to support NDS requirements. The AFMS uses the Critical Operational Readiness Requirements (CORR) Model to identify medical and dental operational requirements. The Air Force Surgeon General approved the model output of 25,863 as the low-end AD medical force requirement, consisting of 20,118 for the operational requirement and an additional 5,745 for sustainment if the Air Force is fully deployed. The approved CORR requirement of 25,863 resulted in a MILPER excess of 4,684 medical military billets. The Air Force intends to use this excess military end-strength to support NDS priorities. However, Air Force leadership is committed to reforming its force structure at a pace that does not result in ATC gaps for its beneficiary populations.

### 2.3.2 Optimization Strategies

The 4,684 medical reductions will result in fewer military authorizations for administrative, non-clinical and non-deployable specialty care services. Additionally, the reductions will include other billets identified as career fields having over and above their operational requirements. The 866 vacant billets can be reduced and not cause any gap (workload is already covered by remaining licensed providers at the maximum capacity or purchased care). Reductions in uniformed medical personnel will be phased in over time, first taking vacant positions off the manning document, followed by attrition and retraining, and finally force management actions. Approximately 73 percent of Air Force proposed reductions were from enlisted specialties. Of the officers, only 2.5 percent were physicians and three percent were nurses. DHA analysis supports these reductions. The Air Force is working on a coordinated process with DHA for moving the MILPER out of the MTFs to minimize any access impacts. Military billets will not be reduced until the DHA can ensure that workload can be covered by the remaining military and civilian backfill or by increased utilization of the TRICARE network.

The reduction of the MILPER "faces" was coordinated with the Directorate of Manpower and Personnel (A1) community and was initially planned to take place gradually between FY 2021 and FY 2023. However, due to COVID-19 response efforts and the uncertainty moving forward on what medical capability will need to be maintained to combat the virus, the Air Force has decided to pause medical MILPER reductions until FY 2022. In addition, the Air Force is reviewing lessons learned from COVID-19 which may change the overall CORR requirement and subsequent overall reduction. The programmed ramp in **Table 3** will stay the same. However, the start of the faces reduction will be delayed one year. This will allow the Air Force to proceed with starting to hire civilian backfills and ensure network adequacy for future reductions. The plan calls for using existing force management authorities to reach Air Force medical requirements. The Air Force Surgeon General's office is working in coordination with the Air Force Deputy Chief of Staff, Manpower, Personnel, & Services to ensure any drawdown of military clinical personnel inventories supports both the AFMS and DHA reform efforts,

minimizing the impact to the HCD mission as much as possible. The Air Force still plans on beginning the hiring process for the civilian backfills in FY 2021 by classifying position descriptions and posturing for fills when funds become available, once all requirements of section 719 are met.[3]

***Table 4*** shows the current programmed ramp for both officer and enlisted billets in the FYDP profile. Encumbered positions may contain both officer and enlisted Student Man Years (SMYs). An SMY is based on the number of student entries and course length days; the student entries requirement is driven by medical skills retention rates and projected AD medical end strength. The future state of 25,863 will require adjusting student entries and AD accessions each year so as not require involuntary force management actions when the CORR reduction is completed in FY 2027. Proportions of SMY and fully qualified encumbered reductions will be determined to ensure force sustainment of all operational medical readiness requirements during the period of the drawdown.

***Table 4 AFMS Military Medical Reduction Programming Ramp***

| Reductions | Officers | Enlisted | Total |
|---|---|---|---|
| **Reductions** | **1,262** | **3,422** | **4,684** |
| FY20 Vacancies | -30 | -183 | -213 |
| FY21 Vacancies | -117 | -536 | -653 |
| FY22 Encumbered | -7 | -288 | -295 |
| FY23 Encumbered | -587 | -423 | -1,010 |
| FY24 Encumbered | -159 | -1,546 | -1,705 |
| FY25 Encumbered | -334 | -73 | -407 |
| **Total** | **0** | **0** | **0** |

***Table 5***, on the next page shows the number of Air Force military medical reductions by location, by Corps, and mitigation strategy. The information in the table is subject to change pending further validation

[3] Any conversion of military authorizations to civilian authorizations will be executed in compliance with the requirements of section 725 of the NDAA for FY 2017 and DoDI 6000.19, "Military Medical Treatment Facility Support of Medical Readiness Skills of Health Care Providers," February 7, 2020."

## *Table 5 AFMS Military Medical Reduction by Location and Strategy*

| Location | BSC | DC | MC | MSC | NC | ME | SMY | TOTAL |
|---|---|---|---|---|---|---|---|---|
| Altus | 1 | | | | | 7 | | 8 |
| Andersen | 1 | | | | | 3 | | 4 |
| Aviano | 2 | | | | | 1 | | 3 |
| Barksdale | 6 | 1 | 2 | 4 | 3 | 83 | | 99 |
| Beale | 2 | 2 | 1 | | 2 | 16 | | 23 |
| Buckley | | 1 | 1 | | | 17 | | 19 |
| Cannon | 1 | 2 | | | | 11 | | 14 |
| Columbus | 1 | | | | | 5 | | 6 |
| Creech | | | | | | 1 | | 1 |
| Davis-Monthan | 5 | 3 | 1 | | 4 | 43 | | 56 |
| Dover | 6 | | 2 | 4 | 2 | 50 | | 64 |
| Dyess | 2 | | 2 | 3 | 2 | 39 | | 48 |
| Edwards | 2 | 1 | | | 1 | 12 | | 16 |
| Eglin | 7 | 1 | 1 | | 2 | 98 | | 109 |
| Eielson | | | | | | 2 | | 2 |
| Ellsworth | | 2 | | | 1 | 11 | | 14 |
| Fairchild | 3 | 2 | 3 | 2 | 3 | 57 | | 70 |
| FE Warren | | 1 | 1 | | 2 | 15 | | 19 |
| Ft Sam Houston | 1 | | | | | 243 | | 244 |
| Goodfellow | 3 | 2 | 1 | 2 | | 29 | | 37 |
| Grand Forks | 1 | 1 | | | 1 | 8 | | 11 |
| Hanscom | 2 | 1 | 1 | 1 | 1 | 28 | | 34 |
| Hill | 5 | 1 | 1 | 3 | 6 | 63 | | 79 |
| Holloman | | | | | 2 | 10 | | 12 |
| Hurlburt Field | | 4 | 1 | | | 37 | | 42 |
| Incirlik | | | | | | 1 | | 1 |
| JB Andrews | 9 | 4 | 20 | 5 | 10 | 225 | | 273 |
| JB Bolling | 5 | 1 | 1 | 2 | 1 | 26 | | 36 |
| JB Charleston | 2 | 2 | 1 | | | 29 | | 34 |
| JB Elmendorf-Richardson | 1 | 3 | | | 1 | 25 | | 30 |
| JB Langley-Eustis | 4 | 5 | 7 | 1 | 2 | 128 | | 147 |
| JB PRL HBR-Hickam | | 1 | | | | 5 | | 6 |
| JBCM McChord | 1 | | | | | 6 | | 7 |
| JBMDL MCGuire | 8 | 1 | 3 | 2 | 3 | 65 | | 82 |
| JBSA Lackland | 8 | 3 | | 6 | 8 | 164 | | 189 |
| JBSA Randolph | 5 | 3 | 2 | | 3 | 35 | | 48 |
| Kadena | | | | | | 4 | | 4 |
| Keesler | 7 | 11 | 21 | 5 | 7 | 221 | | 272 |
| Kirtland | 2 | 2 | | | 2 | 26 | | 32 |
| Kunsan | | | | | | 1 | | 1 |
| Lakenheath | 3 | 1 | | | | 10 | | 14 |
| Landstuhl | | | | | | 5 | | 5 |
| Laughlin | 2 | | | | | 5 | | 7 |
| Little Rock | 2 | | 1 | | 2 | 18 | | 23 |
| Los Angeles | 2 | 1 | 1 | | | 23 | | 27 |
| Luke | 8 | 2 | 5 | 4 | 9 | 109 | | 137 |
| MacDill | 12 | 8 | 14 | 4 | 7 | 189 | | 234 |
| Malmstrom | | 1 | | | | 8 | | 9 |
| Maxwell | 6 | 2 | 3 | 4 | 5 | 52 | | 72 |
| McConnell | 6 | 1 | 1 | 2 | 4 | 50 | | 64 |
| Minot | 2 | | | | | 7 | | 9 |
| Misawa | | | | | | 3 | | 3 |
| Moody | 1 | 2 | | | | 18 | | 21 |
| Mountain Home | 1 | | | 1 | | 11 | | 13 |
| Nellis | 2 | 5 | | | 3 | 81 | | 91 |
| Offutt | 3 | 2 | 2 | | 3 | 48 | | 58 |
| Osan | | | | | | 1 | | 1 |
| Patrick | 8 | | 1 | 4 | 4 | 56 | | 73 |
| Peterson | | | 1 | 1 | 4 | 45 | | 51 |
| Pope | 1 | 1 | | | | 6 | | 8 |
| Ramstein | 2 | 1 | | | | 4 | | 7 |
| Robins | 5 | 2 | 3 | 3 | 4 | 52 | | 69 |
| Schriever | | | | | | 2 | | 2 |
| Scott | 1 | 7 | | | 3 | 51 | | 62 |
| Seymour Johnson | 3 | | | | | 22 | | 25 |
| Shaw | 3 | 1 | 1 | 1 | 1 | 25 | | 32 |
| Sheppard | 3 | 2 | | | 2 | 22 | | 29 |
| Spangdahlem | 3 | | | | | 2 | | 5 |
| Tinker | 6 | 1 | 1 | 3 | 1 | 51 | | 63 |
| Travis | 6 | 4 | 3 | 1 | 5 | 98 | | 117 |
| Tyndall | 6 | | 1 | 6 | 9 | 63 | | 85 |
| USAF Academy | 7 | 6 | 3 | 2 | 2 | 79 | | 99 |
| Vance | | | | | | 4 | | 4 |
| Vandenberg | 1 | | | | | 6 | | 7 |
| Whiteman | 1 | 1 | | | 2 | 15 | | 19 |
| Wright-Patterson | 3 | 5 | 3 | | 7 | 127 | | 145 |
| Yokota | | | | | | 3 | | 3 |
| SMY | | | | | | | 795 | 795 |
| Total | | | | | | | | 4684 |

| Row Labels | Absorb | Hire | Networl | TOTAL |
|---|---|---|---|---|
| Altus | 2 | 6 | | 8 |
| Andersen | 1 | 3 | | 4 |
| Aviano | | 3 | | 3 |
| Barksdale | 69 | 26 | 4 | 99 |
| Beale | 3 | 20 | | 23 |
| Buckley | 2 | 17 | | 19 |
| Cannon | 2 | 12 | | 14 |
| Columbus | | 6 | | 6 |
| Creech | 1 | | | 1 |
| Davis-Monthan | 14 | 42 | | 56 |
| Dover | 39 | 19 | 6 | 64 |
| Dyess | 30 | 16 | 2 | 48 |
| Edwards | 2 | 14 | | 16 |
| Eglin | 39 | 70 | | 109 |
| Eielson | 1 | 1 | | 2 |
| Ellsworth | 1 | 13 | | 14 |
| Fairchild | 7 | 63 | | 70 |
| FE Warren | 1 | 18 | | 19 |
| Ft Sam Houston | 3 | 241 | | 244 |
| Goodfellow | 15 | 20 | 2 | 37 |
| Grand Forks | 3 | 8 | | 11 |
| Hanscom | 21 | 10 | 3 | 34 |
| Hill | 14 | 65 | | 79 |
| Holloman | 5 | 7 | | 12 |
| Hurlburt Field | 9 | 33 | | 42 |
| Incirlik | | 1 | | 1 |
| JB Andrews | 54 | 219 | | 273 |
| JB Bolling | 11 | 25 | | 36 |
| JB Charleston | 5 | 29 | | 34 |
| JB Elmendorf-Richardson | 17 | 13 | | 30 |
| JB Langley-Eustis | 34 | 113 | | 147 |
| JB PRL HBR-Hickam | 4 | 2 | | 6 |
| JBCM McChord | 1 | 6 | | 7 |
| JBMDL MCGuire | 39 | 35 | 8 | 82 |
| JBSA Lackland | 62 | 127 | | 189 |
| JBSA Randolph | 11 | 37 | | 48 |
| Kadena | 1 | 3 | | 4 |
| Keesler | 32 | 240 | | 272 |
| Kirtland | 8 | 24 | | 32 |
| Kunsan | | 1 | | 1 |
| Lakenheath | 9 | 5 | | 14 |
| Landstuhl | | 5 | | 5 |
| Laughlin | 3 | 4 | | 7 |
| Little Rock | 8 | 15 | | 23 |
| Los Angeles | 5 | 22 | | 27 |
| Luke | 17 | 120 | | 137 |
| MacDill | 155 | 56 | 23 | 234 |
| Malmstrom | 2 | 7 | | 9 |
| Maxwell | 50 | 14 | 8 | 72 |
| McConnell | 8 | 56 | | 64 |
| Minot | 4 | 5 | | 9 |
| Misawa | 2 | 1 | | 3 |
| Moody | 4 | 17 | | 21 |
| Mountain Home | 1 | 12 | | 13 |
| Nellis | 15 | 76 | | 91 |
| Offutt | 13 | 45 | | 58 |
| Osan | | 1 | | 1 |
| Patrick | 52 | 12 | 9 | 73 |
| Peterson | 15 | 36 | | 51 |
| Pope | 4 | 4 | | 8 |
| Ramstein | 3 | 4 | | 7 |
| Robins | 47 | 16 | 6 | 69 |
| Schriever | 1 | 1 | | 2 |
| Scott | 26 | 36 | | 62 |
| Seymour Johnson | 8 | 17 | | 25 |
| Shaw | 11 | 21 | | 32 |
| Sheppard | 4 | 25 | | 29 |
| Spangdahlem | | 5 | | 5 |
| Tinker | 14 | 49 | | 63 |
| Travis | 30 | 87 | | 117 |
| Tyndall | 70 | 15 | | 85 |
| USAF Academy | 14 | 85 | | 99 |
| Vance | 2 | 2 | | 4 |
| Vandenberg | 2 | 5 | | 7 |
| Whiteman | 2 | 17 | | 19 |
| Wright-Patterson | 36 | 109 | | 145 |
| Yokota | 2 | 1 | | 3 |
| Various | 795 | | | 795 |
| Total | | | | 4684 |

*The information in the table is subject to change pending further validation.

BSC = Biomedical Science Corps DC = Dental Corps MC = Medical Corps
MSC = Medical Service Corps NC = Nurse Corps ME = Medical Enlisted SMY = Student Man Years

## 2.4 Joint Staff Surgeon

The Military Health System faces unprecedented stresses and challenges as it supports ongoing military operations and health care delivery during the COVID-19 pandemic, deploys a new enterprise electronic health record, grapples with financial shortfalls, and implements multiple changes in roles and responsibilities of key system stakeholders. Balancing current and future operational requirements is forcing difficult choices across the DoD.

In order to improve senior leader visibility of the readiness of current medical force elements, the Joint Staff has partnered with key stakeholders to enhance operational medical readiness reporting through Defense Readiness Reporting System Strategic (DRRS-S). In addition, for the first time ever, the Joint Staff has begun incorporating medical reviews into long-standing processes like the Annual Joint Assessment (AJA), in order to obtain Combatant Command insights into operational medical gaps and challenges. The Joint Staff is also completing the second Combat Support Agency Review Team (CSART) assessment of the Defense Health Agency. And, as medical care for increasing numbers of Service members transition from military to non-military providers in multiple locations, the Joint Staff continues to advocate for commanders receiving the same visibility of timeliness and quality of care provided off base as is currently available for care provided in MTFs.

Recurring Joint Staff-led Readiness Reviews focused on key Operational Plans (OPLANS) have identified gaps and risks to the force and to DoD missions. Furthermore, the OSD-Joint Staff Strategic Review of COVID-19 Response and the Joint Staff In-Stride Review of COVID-19 Response identified multiple opportunities for the MHS to improve operational medical support.

Section 732 of the John S. McCain NDAA for FY 2019 required the DoD to report on the process to "establish required joint force medical capabilities for members of the Armed Forces that meet the operational planning requirements of the Combatant Commands." The initial report was submitted in August 2019 and included the DoD's commitment to produce an annual Joint Medical Estimate (JME). The initial JME, completed in Aug 2020, consolidated some operational medical requirements and a risk assessment using the Chairman of the Joint Chief of Staff's risk assessment framework and is currently available for review. In addition to summarizing key findings from the above products, the FY 2021 JME provides a more detailed assessment of operational medical requirements, gaps and wide-ranging risks to force and mission based on detailed analysis of key OPLANs, using a new methodology which has been endorsed by the Services and Combatant Command operational leadership.

As part of the development of the Joint Warfighting Concept and in coordination with the OASD(HA), MILDEPs and the DHA, the Joint Staff is updating the 2015 Joint Concept for Health Services (JCHS) to describe the medical capabilities needed for future conflicts. New chemical and biological threats, coupled with hypersonic and directed energy weapons, will present military medics with a very different casualty mix then seen over the past twenty years. The challenges created in supporting warfighting operations in a cyber-degraded environment in which resupply and patient movement occur intermittently and potential adversaries engage the US globally will drive significant changes in medical force development and design, especially

in support of maritime operations. Key observations from the JME, AJA, JCHS, CSART and other products are also being used to inform future Globally Integrated Wargames and Exercises and the Defense Planning Guidance.

The evolving national security environment and multitude of changes affecting the MHS will continue to create risk to the ability of the MHS to provide required operational medical support. The Joint Staff will continue to work with the OASD(HA), MILDEPs, and DHA to update globally integrated operational requirements, assess current and future capabilities and provide objective assessments of risk to force and mission.

# 3.0 Results

The results of the effort are provided on the next page in Tables 5-7**,** which demonstrate MILPER reductions by year, strategy, and occupational code. This report only addresses military medical reductions aligned with the DHP. The DoD has plans to reduce the military medical end strength by 12,801 billets, which include positions from the Army (2,948), Navy (5,169), and Air Force (4,684). The reductions include 3,765 officer, 7 warrant officer, and 9,029 enlisted medical billets. The changes affect 220 different units, which include hospitals, clinics, medical centers, research organizations, and educational facilities. The National Capital Region (NCR) market will take the largest portion of the reductions, as the ability to hire in this area is greater. The preponderance of reductions are planned for FY 2023, and will taper off through FY 2027.

The DHA and the MILDEPs collaboratively developed optimization strategies around impacts to MTFs affected by the reductions. Optimization approaches include incrementally absorbing workload by balancing a deliberate transition for 3,266 positions, as well as hiring civilian or contractor replacements for 7,114 positions, moving care to the network for 163 positions, replacing 375 positions, and reshaping 684 positions. All MILDEPs allowed some flexibility in the location of the reductions to address situations where the network or ability to hire replacement personnel may not be optimal. The Department will accomplish military medical manpower reductions through attrition of personnel and other force shaping tools, to minimize impact on individuals, as well as maintain required delivery of quality health care to Service members and beneficiaries.

The Department will continually update the plan to reduce military end strength through the implementation period based on network capacity, ability to hire, and career decisions made by affected staff. For these reasons, reductions have increasing uncertainty through the implementation years. The Department will continue to reassess this plan throughout the execution period and adjust, as necessary. The Department will also continue to use the National Security Strategy, National Defense Strategy, and Defense Planning Guidance to direct the future force shaping efforts and adjustments to this plan will be made, if necessary. The reductions beyond FY 2022 will be adjusted based on the ability to implement the optimization strategy and mission changes. As the Department embarks on this conditions-based, optimizing approach to military medical manpower, no eligible beneficiary will go without access to quality health care, which will continue to occur either in a MTF or through private sector care.

*Table 6 Reductions by Year*

| Year | Army | | | Navy | | Air Force* | | Total |
|---|---|---|---|---|---|---|---|---|
| | Enlisted | Officer | Warrant | Enlisted | Officer | Enlisted | Officer | |
| **FY20** | 98 | - | - | - | - | 183 | 30 | 311 |
| **FY21** | - | - | - | 2,392 | 237 | 536 | 117 | 3,282 |
| **FY22** | 1,235 | 339 | 4 | 397 | 122 | 288 | 7 | 2,392 |
| **FY23** | 969 | 300 | 3 | 516 | 1,079 | 423 | 587 | 3,877 |
| **FY24** | - | - | - | - | 253 | 1,546 | 159 | 1,958 |
| **FY25** | - | - | - | - | 173 | 73 | 334 | 580 |
| **FY26** | - | - | - | - | - | 246 | 28 | 274 |
| **FY27** | - | - | - | - | - | 127 | - | 127 |
| **Total** | **2,302** | **639** | **7** | **3,305** | **1,864** | **3,422** | **1,262** | **12,801** |

**Air Force's vacant positions are all included in FY20*

*Table 7 Reductions by Fiscal Year, Strategy*

| Year | Strategy | Army | | Navy | | Air Force* | | Total |
|---|---|---|---|---|---|---|---|---|
| | | Enlisted | Officer / Warrant | Enlisted | Officer | Enlisted | Officer | |
| **FY20** | **Absorb** | 55 | - | - | - | 183 | 30 | **268** |
| | **Hire** | 21 | - | - | - | - | - | **21** |
| | **Reshape** | 22 | - | - | - | - | - | **22** |
| **FY21** | **Absorb** | - | - | 703 | 66 | 536 | 91 | **1,396** |
| | **Hire** | - | - | 1,080 | 152 | | 26 | **1,258** |
| | **Network** | - | - | - | 11 | - | - | **11** |
| | **Student/No Impact** | - | - | 298 | - | - | - | **298** |
| | **Replace** | - | - | 311 | 8 | - | - | **319** |
| **FY22** | **Absorb** | 601 | 126 | 125 | 12 | - | - | **864** |
| | **Hire** | 299 | 76 | 250 | 20 | 288 | 7 | **940** |
| | **Network** | - | - | - | - | - | - | **0** |
| | **Replace** | - | - | 4 | 2 | - | - | **6** |
| | **Student/No Impact** | - | - | 18 | 88 | - | - | **106** |
| | **Reshape** | 335 | 141 | - | - | - | - | **476** |
| **FY23** | **Absorb** | 165 | 69 | 19 | 81 | 1 | - | **335** |
| | **Hire** | 688 | 164 | 487 | 905 | 422 | 370 | **3,036** |
| | **Network** | - | - | - | 75 | | 2 | **77** |
| | **Replace** | - | - | 10 | 18 | - | - | **28** |
| | **Reshape** | 116 | 70 | - | - | - | - | **186** |
| | **Student** | - | - | - | - | - | 215 | **215** |
| **FY24** | **Absorb** | - | - | - | 21 | 66 | 8 | **95** |
| | **Hire** | - | - | - | 202 | 1,314 | 5 | **1,521** |
| | **Network** | - | - | - | 9 | - | 5 | **14** |
| | **Replace** | - | - | - | 21 | - | - | **21** |
| | **Student** | - | - | - | - | 166 | 141 | **307** |

| Year | Strategy | Army | | Navy | | Air Force* | | Total |
|---|---|---|---|---|---|---|---|---|
| | | Enlisted | Officer / Warrant | Enlisted | Officer | Enlisted | Officer | |
| **FY25** | **Absorb** | - | - | - | 16 | - | 30 | **46** |
| | **Hire** | - | - | - | 154 | 73 | 7 | **234** |
| | **Network** | - | - | - | 2 | - | 59 | **61** |
| | **Replace** | - | - | - | 1 | - | - | **1** |
| | **Student** | - | - | - | - | - | 238 | **238** |
| **FY26** | **Absorb** | - | - | - | - | 208 | 6 | **214** |
| | **Hire** | - | - | - | - | 3 | 22 | **25** |
| | **Student** | - | - | - | - | 35 | - | **35** |
| **FY27** | **Absorb** | - | - | - | - | 48 | - | **48** |
| | **Hire** | - | - | - | - | 79 | - | **79** |
| **Total** | | **2,302** | **646** | **3,305** | **1,864** | **3,422** | **1,262** | **12,801** |

**Air Force's vacant positions are all included in FY20*

*Table 8 Reductions by Occupational Code, All Years*

| Occ. Code | Occupational Code Description | Army | Navy | Air Force | Total |
|---|---|---|---|---|---|
| 151000 | Administration, General | - | 14 | - | 14 |
| 270100 | Administrators, General | - | 1 | - | 1 |
| 115000 | ADP Computers, General | - | 20 | - | 20 |
| 260102 | Allergy/Immunology | 2 | 6 | 3 | 11 |
| 260104 | Anesthesiology | 7 | 13 | - | 20 |
| 260801 | Audiology and Speech | 7 | 9 | 6 | 22 |
| 260101 | Aviation/Aerospace Medicine, Residency Trained Aerospace | 9 | - | - | 9 |
| 130200 | Behavioral Sciences/Mental Health Services | - | 22 | 48 | 70 |
| 132800 | Bioenvironmental Engineering | - | - | 43 | 43 |
| 260815 | Bioenvironmental Engineering | - | - | 34 | 34 |
| 260817 | Biomedical Equipment Maintenance and Repair | 7 | - | - | 7 |
| 132600 | Biomedical Equipment Maintenance and Repair Services | 45 | 53 | 38 | 136 |
| 131100 | Biomedical Laboratory Services | 112 | 79 | 370 | 561 |
| 260812 | Biomedical Sciences And Allied Health Officers | - | - | 9 | 9 |
| 106000 | Boatswains | - | 1 | - | 1 |
| 260142 | Cardiology | 3 | 10 | - | 13 |
| 250700 | Chaplains | - | 23 | - | 23 |
| 156100 | Chaplain's Assistants | - | 12 | - | 12 |
| 260818 | Clinical Laboratory | 12 | 18 | 12 | 42 |
| 152000 | Combined Personnel and Administration, General | - | 30 | - | 30 |
| 260520 | Community Health Nurse | 9 | 4 | - | 13 |
| 260310 | Comprehensive Dentistry | 14 | 40 | 38 | 92 |
| 270400 | Comptrollers and Fiscal | 12 | 20 | - | 32 |
| 240100 | Construction and Utilities | - | 5 | - | 5 |
| 260510 | Critical Care Nurse | 9 | 31 | - | 40 |
| 260147 | Critical Care/Trauma, Medicine | - | 5 | - | 5 |
| 133000 | Dental Care, General | 61 | 123 | 434 | 618 |
| 133200 | Dental Hygiene | - | 10 | - | 10 |

| Occ. Code | Occupational Code Description | Army | Navy | Air Force | Total |
|---|---|---|---|---|---|
| 133100 | Dental Laboratory | - | 12 | 7 | 19 |
| 260107 | Dermatology | 2 | 18 | 3 | 23 |
| 132500 | Diet Therapy | 47 | - | 33 | 80 |
| 260810 | Dietician | 6 | 7 | 3 | 16 |
| 143300 | Divers | - | 1 | - | 1 |
| 172100 | Electricians | - | 1 | - | 1 |
| 119800 | Electronic Instruments, N.E.C. | - | 1 | - | 1 |
| 260103 | Emergency Medicine | - | 8 | - | 8 |
| 260517 | Emergency/Trauma Nurse | 2 | 35 | - | 37 |
| 260145 | Endocrinology | - | 3 | 2 | 5 |
| 260302 | Endodontics | 2 | 9 | 3 | 14 |
| 260803 | Environmental Health Services | - | 4 | 1 | 5 |
| 132200 | Environmental Health/Preventive Medicine Services | 30 | 28 | - | 58 |
| 260301 | Executive Dentistry | 2 | - | - | 2 |
| 260105 | Executive Medicine | 4 | - | - | 4 |
| 130800 | Expeditionary Medical Services | - | 279 | - | 279 |
| 260511 | Family Nurse Practitioner | 34 | 29 | 17 | 80 |
| 260111 | Family Practice | 47 | 91 | 12 | 150 |
| 180000 | Food Service, General | - | 145 | - | 145 |
| 260141 | Gastroenterology | 9 | 13 | 1 | 23 |
| 260311 | General Dentistry | 3 | 96 | 40 | 139 |
| 260109 | General Medicine | - | 2 | - | 2 |
| 260509 | General Nursing | 37 | 86 | - | 123 |
| 260180 | Graduate Medical Education Post Grad Year 1 | - | 12 | - | 12 |
| 260181 | Graduate Medical Education Post Grad Year 2 and Above | - | 18 | - | 18 |
| 260900 | Health Services Administration | 91 | 84 | 79 | 254 |
| 260144 | Hematology and Oncology | - | 8 | 3 | 11 |
| 130900 | Independent Duty Hospital Services | - | 11 | 4 | 15 |
| 260823 | Industrial Hygiene | - | 7 | - | 7 |
| 260149 | Infectious Disease | 1 | 5 | 1 | 7 |

| Occ. Code | Occupational Code Description | Army | Navy | Air Force | Total |
|---|---|---|---|---|---|
| 157000 | Information and Education, General | - | 2 | 6 | 8 |
| 162300 | Interior Communications | - | 6 | - | 6 |
| 260148 | Internal Medicine | 12 | 21 | - | 33 |
| 183000 | Law Enforcement, General | - | 57 | - | 57 |
| 151200 | Legal | - | 2 | - | 2 |
| 250600 | Legal | - | 5 | - | 5 |
| 130600 | Licensed Practical Nurse | 136 | - | - | 136 |
| 280100 | Logistics, General | - | 2 | - | 2 |
| 165100 | Main Propulsion | - | 8 | - | 8 |
| 270300 | Manpower and Personnel | 17 | 3 | - | 20 |
| 134000 | Medical Administration | 86 | - | 447 | 533 |
| 130000 | Medical Care and Treatment, General | 1,252 | 1,417 | 909 | 3,578 |
| 134100 | Medical Logistics | 60 | 63 | 96 | 219 |
| 260518 | Medical/Surgical Nurse | 51 | 304 | 48 | 403 |
| 260507 | Mental Health Nurse | - | 10 | - | 10 |
| 260519 | Mental Health Nurse Practitioner | - | 12 | - | 12 |
| 260824 | Microbiology | 1 | 2 | - | 3 |
| 101200 | Military Training Instructor | - | 7 | - | 7 |
| 260512 | Neonatal Intensive Care Unit Nurse | - | 4 | - | 4 |
| 260143 | Nephrology | - | 3 | 2 | 5 |
| 260113 | Neurology | 3 | 12 | 1 | 16 |
| 260825 | Nuclear Medical Science | 1 | 4 | 10 | 15 |
| 260128 | Nuclear Medicine | 1 | - | - | 1 |
| 260502 | Nurse Anesthetist | 2 | 25 | - | 27 |
| 260505 | Nurse Midwife | 7 | 7 | 2 | 16 |
| 260508 | Nursing Education | - | 6 | 32 | 38 |
| 260513 | Obstetrics Nurse | 37 | 39 | 1 | 77 |
| 260115 | Obstetrics/Gynecology | 6 | 41 | 7 | 54 |
| 260116 | Occupational Medicine | 1 | 6 | - | 7 |
| 260826 | Occupational Therapy | 7 | 10 | 2 | 19 |

| Occ. Code | Occupational Code Description | Army | Navy | Air Force | Total |
|---|---|---|---|---|---|
| 260503 | Operating Room Nurse | 42 | 64 | - | 106 |
| 130100 | Operating Room Services | 92 | 197 | 83 | 372 |
| 260117 | Ophthalmology | 3 | 16 | 9 | 28 |
| 132300 | Ophthalmology/Optometry | 63 | 23 | 79 | 165 |
| 260804 | Optometry | 9 | 47 | 22 | 78 |
| 260304 | Oral Maxillofacial Surgery | - | 1 | 6 | 7 |
| 260303 | Oral Pathology | 1 | 9 | - | 10 |
| 260305 | Orthodontics | 2 | 7 | 8 | 17 |
| 130400 | Orthopedic Services | 44 | 26 | 34 | 104 |
| 260132 | Orthopedic Surgery | - | 12 | 3 | 15 |
| 179000 | Other Crafts Workers, N.E.C., General | - | 1 | - | 1 |
| 260119 | Otorhinolaryngology | 2 | 20 | 4 | 26 |
| 260120 | Pathology | 7 | 18 | 8 | 33 |
| 260514 | Pediatric Nurse Practitioner | - | 6 | 20 | 26 |
| 260121 | Pediatrics, General | 18 | 14 | 41 | 73 |
| 260118 | Pediatrics, Subspecialties | - | 27 | 2 | 29 |
| 260306 | Pedodontics | 1 | 3 | 2 | 6 |
| 260307 | Periodontics | - | 11 | 12 | 23 |
| 131200 | Pharmacy | 93 | 101 | 325 | 519 |
| 260805 | Pharmacy | 31 | 54 | 40 | 125 |
| 260828 | Physical Therapy | 15 | 32 | 2 | 49 |
| 130300 | Physical/Occupational Therapy Services | 39 | 27 | 50 | 116 |
| 260122 | Physical/Rehabilitation Medicine | 2 | 1 | - | 3 |
| 260811 | Physician Assistant | 15 | 38 | 63 | 116 |
| 260133 | Plastic Surgery | 1 | - | - | 1 |
| 260809 | Podiatry | 2 | 14 | 4 | 20 |
| 260123 | Preventive Medicine | 6 | 9 | - | 15 |
| 260308 | Prosthodontics | 3 | 14 | 8 | 25 |
| 260125 | Psychiatry | - | 5 | - | 5 |
| 260829 | Psychology, Clinical | - | 6 | 3 | 9 |

| Occ. Code | Occupational Code Description | Army | Navy | Air Force | Total |
|---|---|---|---|---|---|
| 260309 | Public Health Dentistry | - | 1 | - | 1 |
| 260140 | Pulmonary Disease | 2 | - | - | 2 |
| 126000 | Radio/Radar, General | - | 4 | - | 4 |
| 131300 | Radiology | 106 | 101 | 215 | 422 |
| 260127 | Radiology, Diagnostic | 6 | 47 | 7 | 60 |
| 260139 | Radiology, Therapeutic | - | 7 | - | 7 |
| 150100 | Recruiting and Counseling | - | 2 | - | 2 |
| 130700 | Respiratory Therapy Services | 33 | 19 | - | 52 |
| 260146 | Rheumatology | - | 3 | 1 | 4 |
| 182300 | Sales Store | - | 72 | - | 72 |
| 107000 | Security Guards | - | 4 | - | 4 |
| 164100 | Small Arms Repair | - | 2 | - | 2 |
| 260833 | Social Work | - | 36 | 1 | 37 |
| 191200 | Students | - | 316 | 201 | 517 |
| 290200 | Students | - | 88 | 594 | 682 |
| 270200 | Training Administrators | - | 2 | - | 2 |
| 130500 | Undersea/Aviation Medicine | - | 6 | - | 6 |
| 260136 | Urology | 1 | 16 | 4 | 21 |
| 132100 | Veterinary Medicine | 3 | - | - | 3 |
| 260516 | Women's Health Nurse Practitioner | - | - | 26 | 26 |
| **Grand Total** | | **2,948** | **5,169** | **4,684** | **12,801** |

# 4.0 Standard Measurement of Network Adequacy

## 4.1 Network Adequacy Measure

As directed in the NDAA for FY 2020 section 719(b)(3), the Department established a specific measurement for network adequacy to determine the capacity of the local health care network to provide care for covered beneficiaries in areas where MTFs would be impacted by a reduction. In determining the proposed reductions, the Department assessed the impact to network adequacy. Of the 12,801 planned military medical personnel reductions, 163 or 1.3% have an optimization strategy of utilizing the network.

Network adequacy is defined as a network with a sufficient number of providers to meet ATC standards for Prime enrollees as defined in Title 32, Code of Federal Regulations (CFR) part 199.17(p)(5) (unless there is an absence of providers in the area). Preferred Provider Networks (PPNs) will have attributes of size composition, mix of providers, and geographical distribution so that the networks, coupled with the MTF capabilities, can adequately address the health care needs of the enrollees. Before offering enrollment in Prime to a beneficiary group, the MTF Directors/Commanders or Market Directors (or other authorized persons) will assure that the capabilities of the MTF, plus PPN, will meet the following access standards with respect to the needs of the expected number of enrollees from the beneficiary group being offered enrollment:

(1) Under normal circumstances, enrollee travel time may not exceed 30 minutes from home to primary care delivery site unless a longer time is necessary because of the absence of providers (including providers not part of the network) in the area.
(2) The wait time for an appointment for a well-patient visit or a specialty care referral shall not exceed 4 weeks; for a routine visit, the wait time for an appointment shall not exceed 1 week; and for an urgent care visit the wait time for an appointment shall generally not exceed 24 hours.
(3) Emergency services shall be available and accessible to handle emergencies (and urgent care visits) if not available from other primary care providers within the service area 24 hours a day, 7 days a week.
(4) The network shall include a sufficient number and mix of board-certified specialists to meet reasonably the anticipated needs of enrollees. Travel time for specialty care shall not exceed 1 hour under normal circumstances, unless a longer time is necessary because of the absence of providers (including providers not part of the network) in the area. This requirement does not apply under the Specialized Treatment Services Program.
(5) Office waiting times in nonemergency circumstances shall not exceed 30 minutes, except when emergency care is being provided to patients, and the normal schedule is disrupted.

Network adequacy is a product of the number of providers contracted – known as Network Status Report (NSR) – by the MCSC and their ability to see TRICARE beneficiaries within the ATC standards listed above. The MCSCs are contractually obligated to provide a variety of ATC reports that detail the number of providers contracted, the time from authorization of a referral to date of service (Days-to-Care Reports), drive times from beneficiary residence to

provider (Drive Time Reports), percentage of referrals sent to network providers and MTFs versus non-network providers, claims paid to network versus non-network providers, and referrals sent to non-network providers due to network inadequacy reports. DHA uses the information from these reports as an initial evaluation of the potential impact of proposed military medical end strength realignment or reductions. Additionally, DHA screens for reductions in primary and specialty care using the methodologies describe below.

### 4.1.1 Primary Care Adequacy Screen

When evaluating proposals to reduce MTF primary care capacity, DHA assumes that existing network Primary Care Managers (PCMs) maintain nearly full panels and have limited capacity for new patients. According to the Medical Group Management Association, the average civilian PCP maintains a panel of approximately 2,000 patients. The DHA assesses the degree of difficulty in implementing the network optimization strategy based on the excess network capacity and new beneficiaries per PCM. Following this initial screening, DHA coordinates with the MCSC to conduct further analysis prior to implementation planning.

- **Low:** >60% excess network capacity and/or each PCMs would have to accept <50 new patients/beneficiaries
- **Medium:** 50-59% excess network capacity and/or each PCMs would have to accept 50-79 new patients/beneficiaries
- **Moderate:** 40-49% excess network capacity and/or each PCMs would have to accept 80-100 new patients/beneficiaries
- **High:** 30-39% excess network capacity and/or each PCMs would have to accept 101-199 new patients/beneficiaries
- **Very high:** <30% excess network capacity and/or each PCMs would have to accept >200 new patients/beneficiaries

### 4.1.2 Specialty Care Adequacy Screen

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, 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 to conduct further analysis prior to implementation planning.

### 4.1.3 Urgent Care

When evaluating proposals to reduce MTF urgent care capacity, DHA uses the ATC report, urgent care claims data, utilization, location, facility hours, and appointment wait times.

### 4.1.4 Emergent Care

When evaluating proposals to reduce MTF emergent care capacity, DHA assumes the network is adequate for emergent care if it is readily available and beneficiaries can access any emergency room.

### 4.1.5 Inpatient Care

Although the CFR does not define inpatient access standards, inpatient network adequacy is directly related to the inpatient bed capacity and capabilities of nearby network hospitals. Facilities should have at least the minimum number of Medicare-certified hospital beds based on population and specialty care utilization ratios. The minimum number criteria for acute inpatient hospitals is calculated based on the number of beds rather than the number of facilities to reflect the varying capacity of acute inpatient hospitals.

### 4.1.6 MCSC Contractual Requirements

By contract, the MCSC is required to "…adjust 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." Analysis of network capability can only be complete with direct MCSC input due to the direct relationship and provider agreements negotiated with providers in the community. Actual panel sizes, ability to expand panels, percentage of panels dedicated to TRICARE beneficiaries, availability of non-network providers that could be networked, new providers/provider groups moving into a community, and near-term plans of providers/provider groups to leave a community are integral to any analysis of network capability/capacity.

# 5.0 Implementation

As directed in section 719 (b)(4) of the NDAA for FY 2020, the Department will provide each affected beneficiary a transition plan for the continuity of health care services and establish a public forum to discuss beneficiary concerns in areas that would be impacted by realignment reductions. The Department commits to not realigning or reauthorizing any military medical end strength authorizations until these actions are completed, unless the billet meets the exception criteria described in section 719 of the NDAA for FY 2020. In some locations, the reduction of medical military billets will be optimized by transitioning non-readiness-generating specialty and primary care to the local TRICARE network. Regarding specialty care, DHA will closely monitor network adequacy to ensure patients receive quality care within established access standards. Regarding primary care, DHA will ensure maximum transparency of enrollment changes by collaborating with the MCSC, MTFs, impacted communities, Military Service Organizations/Veterans Service Organizations, and beneficiaries. 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.

As patients shift to civilian primary care providers, the DHA will monitor network performance and slow or halt transitions as necessary to ensure continued ATC. For patients, as the result of these changes they will continue to enjoy quality ATC, though the location at which they receive care will change to a civilian-sector provider. Primary care transition will be based on conditions, tailored by MTF, and timed according to the network's ability to accept more patients. Some MTFs will complete the transition within a year, but others may require five or more years, depending on the timing of staff attrition and the ability of the network to meet the new demand. The pace of the transition will be determined as a part of an implementation planning process outlined below. A deliberate transition will prevent saturating the network and will also allow beneficiaries an opportunity to be involved in their Primary Care Manager (PCM) assignment. In most locations, local civilian markets should be able to absorb additional TRICARE patients, and affected patients should be able to get an appointment just as quickly, or more quickly. Many patients may find care closer to their homes. Some patients – especially those who live on-base – may have to travel farther for their care, though travel times will remain within TRICARE standards.

DHA is responsible for executing the transition and developing detailed, coordinated market/MTF implementation plans. Implementation planning will be based on the timing of military staff attrition, ability to hire civilians, and the adequacy of the network, with the following major milestones:

- Six months prior to implementation (D-6 months): MILDEP informs DHA of military provider attrition with intent to send care to the network.
- D-6 months: MCSC begins real time network analysis and builds additional network capacity if available in the community.
- D-6 months: MTF collaborates with the MCSC to establish stop date for empaneling new non-AD beneficiaries to MTF PCMs.
- D-3 months: MTF establishes a Beneficiary Transition Cell (BTC) to specifically manage the MTF-enrolled beneficiaries being transitioned to the network.
- D-3 months: MTF will schedule first Town Hall to discuss the transition with affected beneficiaries.
- D-2 months: MCSC and BTC compile data on transitioning beneficiaries in order to assign a network PCM.
- D-2 months: BTC and MCSC initiate synchronized staff and beneficiary attrition plan.
- D-2 months: First round of dis-empanelment letters to transition beneficiaries to the network.
- D-1 month: MCSC in collaboration with BTC assign beneficiary to a network provider and book first appointment.
- D-Day: Military staff attrition.
- Iterative: DHA sends surveys to transitioned beneficiaries to ensure satisfaction with the transition, their new network PCM, and access to their PCM.

BTC staff will serve as a bridge between the MTF and the local civilian health care network and ensure access to quality care during transition. The BTC will be responsible for helping to identify a PCM, assisting in transferring medical records, and answering any beneficiary questions.

The BTC will manage all beneficiary categories to include retirees, retiree family members and active duty family members. Beneficiaries that are currently case managed will be identified and transitioned in accordance with established procedures. In addition, TRICARE Plus beneficiaries that are empaneled to the MTF will receive assistance with checking Medicare eligibility and locating a Medicare provider at www.medicare.gov/sign-up, get Medicare Enrollment Forms at https://www.cms.gov/Medicare/CMS-Forms/ and TRICARE for Life information at https://tricare.mil/tfl.

The MCSC, as a member of the BTC, will determine individual PCM capacity based on provider call-outs and driving distance to ensure each beneficiary is appropriately assigned to the right PCM to the greatest extent possible. Additionally, the MCSC will remain in constant communication to ensure provider status is updated regarding willingness to accept new TRICARE patients and capacity.

If a civilian market cannot provide required access to primary care for beneficiaries, the Department will pause disenrollment and reassess its plans.

The MTF Leadership will establish regular Town Hall events, which the members of the BTC will support and attend in order to ensure clear and consistent communication, coordination, and cooperation.

## 5.1 Key Considerations for Implementation

Utilizing the previously detailed network adequacy measures in addition to reviewing the entire community population, geographical challenges, MTF capabilities, and known shortfalls in the local medical communities, the DHA identified several locations where the MILDEPs' intent to shift care to the network will require close monitoring to ensure the availability of timely care. First and foremost, behavioral health is a community shortfall in most Prime Service Areas and these types of providers should not be reduced at MTFs. Overall, there were a total of 122 medical communities/ TRICARE networks/MTFs evaluated with the following results:

- There are 28 MTFs that show little – no risk and the network can absorb additional workload
- There are 26 MTFs that show little – medium risk and the network should be able to absorb additional workload with some minor impact
- There are 35 MTFs that show high risk and the network will have major issues trying to absorb additional workload

- There are 33 MTFs that show extreme risk and the network cannot absorb additional workload

Additionally, 10 U.S.C. § 129c stipulates that DoD may "not make a reduction in the number of medical personnel of" DoD greater than 5 percent per year or 10 percent over 3 years unless a certification is made that, among other things, the reduction will not cause an increase in purchased care costs. The following tables shows percentage reduction by year, demonstrating compliance with the relevant statutory requirements.

***Table 9 10 USC § 129c Compliance Matrix***

| Fiscal Year | Authorizations | Reductions | % Annual | % Over 3 Years |
|---|---|---|---|---|
| FY20 | 212,366 | 311 | 0.15% | N/A |
| FY21 | 209,084 | 3,282 | 1.57% | N/A |
| FY22 | 206,692 | 2,392 | 1.16% | 2.9% |
| FY23 | 202,815 | 3,877 | 1.91% | 4.7% |
| FY24 | 200,857 | 1,958 | 0.97% | 4.1% |
| FY25 | 200,277 | 580 | 0.29% | 3.2% |
| FY26 | 200,003 | 274 | 0.14% | 1.4% |
| FY27 | 199,876 | 127 | 0.06% | 0.5% |

# 6.0 Key Considerations

As the Department transitions its MTFs to a lesser reliance on military personnel (MILPER), close monitoring the ability of local networks of providers to absorb additional workload, as well as the ability to hire or contract replacement staff, will be key to a successful transition. The Department will closely monitor these aspects of the transition and will adjust its plans as implementation continues.

The DHA labeled 110 of the Navy specialty physician cuts as "hard to hire" because it is unlikely that the MTFs could hire a quality candidate for less than $400K. The DHA and Navy will develop options in the event that transition of these 110 authorizations is not possible.

Current hiring times to replace military staff extend up to 180 days to complete. These hiring times will require careful planning to ensure that care is not affected by a transition.

# 7.0 Appendix A: Acronym Glossary

***Table 10 Acronym Glossary***

| Acronym | Term |
|---|---|
| **AC** | Active Component |
| **ACGME** | Accreditation Council for Graduate Medical Education |
| **AD** | Active Duty |
| **AFMS** | Air Force Medical Service |
| **ARSTRUC** | Army Structure Memorandum |
| **ATC** | Access to Care |
| **BCT** | Brigade Combat Team |
| **BTC** | Beneficiary Transition Cell |
| **BSO** | Budget Submitting Office |
| **BUMED** | Bureau of Medicine and Surgery |
| **BUR** | bottom-up review |
| **CAA** | Center for Army Analysis |
| **CAPE** | Cost Assessment and Program Evaluation |
| **CCMD** | Combatant Command |
| **CFR** | Code of Federal Regulations |
| **CIVPER** | civilian personnel |
| **CONUS** | continental United States |
| **CORR** | Critical Operational Readiness Requirements |
| **COVID-19** | coronavirus disease 2019 |
| **DHA** | Defense Health Agency |
| **DHP** | Defense Health Program |
| **DoD** | Department of Defense |
| **DoDI** | Department of Defense Instruction |
| **DPG** | Defense Planning Guidance |
| **DRRS** | Defense Readiness Reporting System |
| **DTF** | dental treatment facility |
| **FORSCOM** | Forces Command |
| **FY** | Fiscal Year |
| **FYDP** | Future Years Defense Program |
| **GAO** | Government Accountability Office |
| **GDE** | Graduate Dental Education |
| **GIBP** | Global Integrated Base Plans |
| **GME** | Graduate Medical Education |
| **GHPE** | Graduate Health Professional Education |
| **H2F** | Holistic Health and Fitness |
| **HCD** | Health Care Delivery |
| **HQDA** | Headquarters, Department of the Army |
| **IAB** | Integration Advisory Board |
| **MCSC** | Managed Care Support Contractor |

| Acronym | Term |
|---|---|
| **MDO** | multi-domain operations |
| **MHS** | Military Health System |
| **MILDEP** | Military Department |
| **MILPER** | military personnel |
| **MTF** | military medical treatment facility |
| **NCR** | National Capital Region |
| **NDAA** | National Defense Authorization Act |
| **NDS** | National Defense Strategy |
| **NEHSS** | Naval Expeditionary Health Service Support |
| **NSR** | Network Status Report |
| **OAC** | Oversight Advisory Council |
| **OASD(HA)** | Office of the Assistant Secretary of Defense for Health Affairs |
| **OCONUS** | Outside the Continental United States |
| **OPNAV** | Office of the Chief of Naval Operations |
| **OSD** | Office of the Secretary of Defense |
| **PB** | President's Budget |
| **PCM** | Primary Care Manager |
| **PCP** | Primary Care Provider |
| **POM** | Program Objective Memorandum |
| **PPN** | Preferred Provider Network |
| **RDT&E** | Research, Development, Test, and Evaluation |
| **RTC** | Report to Congress |
| **SECDEF** | Secretary of Defense |
| **SMY** | Student Man Year |
| **TAA** | Total Army Analysis |
| **THP** | TRICARE Health Plan |
| **TPPH** | Transient, Patient, Prisoner, and Holdee |

***Table 11 Key Definitions***

| Term | Description |
|---|---|
| **Civilian Medical or Dental Position.** | A position for the performance of health care functions within the Department held by an employee of the Department or of a contractor of the Department. |
| **Conversion.** | A change of a military medical or dental position to a civilian medical or dental position, effective as of the date of the manning authorization document of the MILDEP making the change (through a change in designation from military to civilian in the document, the elimination of the position as a military position in the document, or through any other means indicating the change in the document or otherwise). |
| **Direct Care** | Health care delivered in MTFs. |
| **Manpower and Organization** | Determine organizations and manpower requirements for MTF clinical operations, shared-services activities for medical forces, foundational activities (e.g., validating requirements, establishing priorities for requirements). |
| **Medically Ready Force** | Armed Force or Armed Forces units that have met all medical requirements for deployment. |
| **Military Medical or Dental Position.** | A position for the performance of health care functions within the armed forces held by a member of the armed forces. |
| **MTF** | Facility dedicated to providing health care to DoD-eligible beneficiaries, staffed and run by Department of Defense (DoD) personnel. For the purposes of the Plan, MTFs are divided into three categories (Inpatient Facility, Outpatient Facility, Active Duty Only Clinic), utilizing Title 10, U.S.C. §1073d facility criteria. |
| **Parent/Child MTF** | The MHS identifies its main MTFs, which perform billing and activities, as "parent MTFs." A parent MTF may have one or more subordinate clinics, which are referred to as "child MTFs." |
| **Private Sector Care** | Health care delivered in the civilian private sector system through THP MCSCs. |
| **Proposed Military Medical End Strength Realignment or Reduction** | A realignment or reduction of military medical end strength authorizations, as proposed by the budget of the FY 2020 PB submitted to Congress pursuant to 31 U.S.C. § 1105. |
| **Ready Medical Force** | Deployable uniformed medical or dental teams able to perform the essential capabilities, functions, activities, and tasks necessary to sustain all medical elements of all operating forces in theater and at all levels of war. |
| **TRICARE Health Plan** | The health care program for uniformed service members, retirees, and their families around the world. |

# 8.0 Appendix B: Methodology by Service

## 8.1 Army

### 8.1.1 Medical Requirements Determination

When the SECDEF published the FY 2018 NDS, the Army undertook a holistic effort to modernize the force. To address competition from near-peer adversaries, the Army needs to equip its formations with, among other things, more lethal, survivable systems; enhanced cyber, information, and electronic warfare capabilities; and advanced capabilities for long-range fires, as well as air and missile defense. The Army also recognized a need to modernize its medical capabilities, including a need for more combat medics in operational units, enhanced health and fitness capabilities for Soldiers in units, and medical support to training units. As part of the Army's approach to modernization, the Army conducted the analysis and impact assessments that are described below. Throughout the analysis, the Army recognized that it must maintain a military end-strength that complies with the NDAA and, as such, must "pay" for any increases in military authorizations with commensurate decreases.

As part of the Army's modernization effort, the Secretary of the Army, under the direction of Congress, led a comprehensive review and analysis of military medical manpower that fully supports the FY 2018 NDS. The review included an original assessment of an 8 percent reinvestment from the medical generating force and realignment of military medical end-strength at low to moderate impact to mission and force. Further analysis in FY 2020 resulted in an endorsement of a 3 percent reinvested and realignment of 2,948 spaces at no to low impact to the mission and force. The full scope of the NDS requirement accounts for the simultaneous requirement to defeat a near-peer adversary, deter aggression in a second theater, disrupt violent extremist organizations, and defend the homeland, as well as the requirement to maintain a joint (medically) integrated force, disaster and bio-disaster response, and capacity to support humanitarian assistance. The Army's end-to-end review is comprised of capabilities to support Soldiers and the joint force from point-of-injury to and within the continental United States (CONUS) MTFs, as we transition patients back to the force or to the Department of Veterans Affairs. The Army's methodology centered on HQDA's annual Total Army Analysis (TAA) and was augmented by a Forces Command (FORSCOM) bottom-up review (BUR) and other emerging requirements to achieve the Army's objective force to execute large scale combat and multi-domain operations (MDO). Key examples of emerging and continued military medical requirements assessed in this review include: home-station HCD, the Army Recovery Care Program, the Holistic Health and Fitness (H2F) Program, preserving a strategic medical reserve, and sustainment of behavior health programs. Furthermore, the Army conducted prudent impact analysis of the conversion of home-station health care military authorizations to civilian authorizations or network-supported capabilities, in order to identify optimization options that would preserve health care services while reinvesting in the home-station generating force structure. The military medical manpower conversions plan was not designed to reduce health

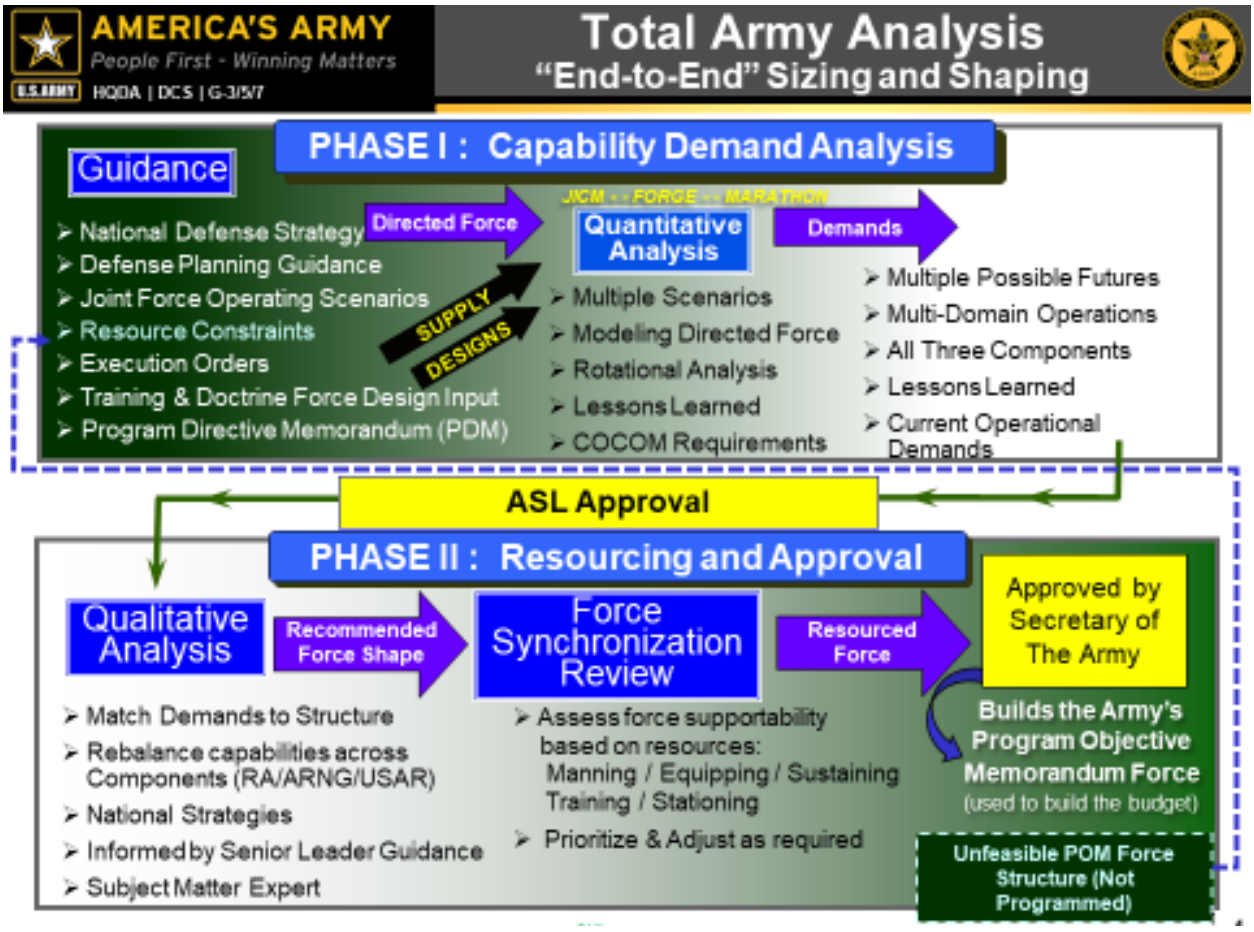
care capabilities but change who is providing the care in some instances (from military medical personnel to civilian medical personnel) or where beneficiaries receive the care (e.g., TRICARE Network). Please note that all medical; dental; veterinary; medical research, development, test, and evaluation (RDT&E); medical logistics; patient evacuation; medical education and training; and behavioral health capabilities will all be termed "medical" unless purposefully indicated in this service report.

**Army Review Methodology – TAA.** TAA serves as the Army's proven, reliable annual process to determine all capabilities and requirements needed to execute the NDS, including the total military medical requirement. (Note: The Army's TAA process has undergone periodic review by the Government Accountability Office (GAO), including most recently in 2016[4] and 2019[5]). The full scope of the Army's military medical requirements account for the simultaneous requirement to defeat a near-peer adversary, deter aggression in a second theater, disrupt violent extremist organizations, and defend the homeland, as well as the requirement to maintain a joint (medically) integrated force, disaster or bio-disaster response and capacity to support humanitarian assistance. TAA determines comprehensive medical requirements from point-of-injury to and within CONUS MTFs – for all components (i.e., Regular Army, Army National Guard, and the U.S. Army Reserve). TAA also determines both the deployable operating force and the home-stationed generating force. The medical generating force involves organizations that conduct medical recruiting, training, sustaining (i.e., sustaining a medically ready force and a ready medical force), education, reconstitution, transition, and RDT&E in support of the operating force. This review is a product of an enterprise-wide effort executed by the Army Staff, Army medical experts, all Army commands, and the Center for Army Analysis (CAA).

CAA's analysis included employment of physics-based combat models (e.g., casualty streams are generated from potential force-on-force actions that would occur over the course of a battle and be dispersed across the geography of battlespace), a model that employ rules of allocation to address preparedness for other casualties (e.g., to dispersed logistics personnel), and a model of force generation (i.e., to address the ability to sustain forces over time). By definition, TAA is a strategy-based, resource-informed process that uses both quantitative and qualitative analyses to shape structure and determine the ideal complement of medical organizations and personnel required to achieve a balanced and affordable force**.** **Figure 1** outlines the TAA process.

[4] GAO-16-327 addressed the Army's analysis of combat and enabler force structure.
[5] GAO-19-570 addressed the Army's analysis of cyber and electronic warfare units.

*Figure 1 TAA Process*




TAA "shapes" the Army's medical force structure via an iterative, cost/benefit, and trade-off process. The outcome is a set of medical organizations to support the Joint force, and considers: capability functions (e.g., hospitalization, evacuation, and medical logistics), operating and generating force capacity, component balance, and military/civilian composition. TAA concludes with the publication of the Army Structure Memorandum (ARSTRUC) that codifies the Secretary of Army's decisions regarding the force structure to meet the demands of the NDS. The ARSTRUC serves as a direction to change the force as well as an input to the Army's Program Objective Memorandum (POM). Prior to executing the Medical Manpower Review to assess opportunities for reinvestment, the Army's senior leaders directed a full review of medical requirements for the Army's operational (deployable) and generating forces. The paragraphs below describe that analysis.

*Table 12 Army Medical Unit Types*

| | | | |
|---|---|---|---|
| 1 | Battalion Aid Station / Treatment Team | 14 | Optometry Team |
| 2 | Brigade Support Medical Company | 15 | Area Medical Laboratory |
| 3 | Area Support Medical Company | 16 | Preventive Medicine detachment |
| 4 | Forward Resuscitative & Surgical Team | 17 | Area Dental Support Company |
| 5 | Air MEDEVAC Company | 18 | Combat Operational Stress Control |
| 6 | Ground Ambulance Company | 19 | Veterinary Service Detachment |
| 7 | Hospital Center (Hospital C2) | 20 | Medical Logistics Company |
| 8 | Field Hospital | 21 | Blood Support Detachment |
| 9 | Hospital Aug, Surgical | 22 | Medical Log Management Center |
| 10 | Hospital Aug, Medical | 23 | Medical Battalion (Multi-Functional) |
| 11 | Hospital Aug, ICW 60 Bed | 24 | Medical Brigade |
| 12 | Hospital Aug, Head and Neck | 25 | Medical Command (DS) |
| 13 | Minimal Care Ward | | |

*Table 13 Army Medical Functions*

| | 10 Army Medical Functions |
|---|---|
| 1 | Medical Treatment (Role 1, 2) |
| 2 | Medical Evacuation |
| 3 | Hospitalization |
| 4 | Medical Laboratory/Diagnostics |
| 5 | Preventive Medicine |
| 6 | Dental Services |
| 7 | Combat Stress Control |
| 8 | Veterinary Services |
| 9 | Medical Logistics and Blood Mgt |
| 10 | Medical Mission Command (C2) |

**Determining the Army's Medical Operating Force Requirement.** The Army's deployable medical structure (i.e., operating force) is a set of capabilities that supports the full range of military operations and is comprised of approximately 535 units, 49,500 medical personnel, with over 120 skillsets to deliver expeditionary medicine. The continuum of care links point-of-injury to the sustaining base. The Army's deployable medical operating force is comprised of 25 distinct capability-based unit types across 10 interdependent medical functions. **Table** and **Table 13** identify the Army's operating force medical functions and their associated medical unit capability types. The Army modeled its medical operating force in TAA to identify how many Army medical units and personnel are required to execute the NDS. The application of medical doctrine to rules of allocation, including scenario-driven casualty streams, quantifies the demand for each capability in the model. For a large-scale force-on-force battle (i.e., the NDS requirement to defeat a near-peer adversary), CAA employs a physics-based, data-driven, and accredited combat model. The model replicates direct and indirect fire engagements to calculate casualty streams over time and across the geographical dispersion of the battlefield. These casualty streams drive the calculations for ground and air evacuation demand, bed-space requirements, operating room hours, blood supply usage, short-tons of medical supplies, etc. These requirements, in turn, determine the Army requirements for medical units and personnel for the "defeat" element of the NDS. The NDS requires the Army to simultaneously deter aggression in a second theater, disrupt violent extremist organizations, and defend the homeland. These requirements are not expected to generate casualty streams, so the Army calculates the medical requirements through application of rules of allocation. (For example, an infantry Brigade Combat Team (BCT) might be required to protect critical infrastructure in the United States. That BCT has medical personnel just as if they were in combat, and those personnel would be available to support that BCT regardless of any casualties it might suffer, including if it were further directed to move to reinforce "surge" operations elsewhere in the world). Lastly, CAA models the Army's force generation process to calculate the requirements to sustain operations over time. In sum, the TAA process determines the deployable medical capability requirements and its resource- informed recommendation in support of the Army and the joint force.

**Determining the Army's Generating Force.** The Army's medical generating force performs vital functions specified in title 10 and is comprised of organizations that remain home-stationed to conduct medical recruiting, training and educating, equipping, modernizing, organizing, deploying, sustaining (i.e., sustaining a medically ready force and a ready medical force), reconstituting, and transitioning, as well as conducting RDT&E in support of the operating force. These capabilities deliver operational depth to the operating force by providing real-time reach-back support and by deploying individuals, teams, or entire units to provide specific medical capabilities and functions for employment by or in direct support of joint force commanders and the operating force. The MTFs provide force generation platforms that support the readiness of deploying medical capabilities and bed space in the event of large numbers of medical evacuations.

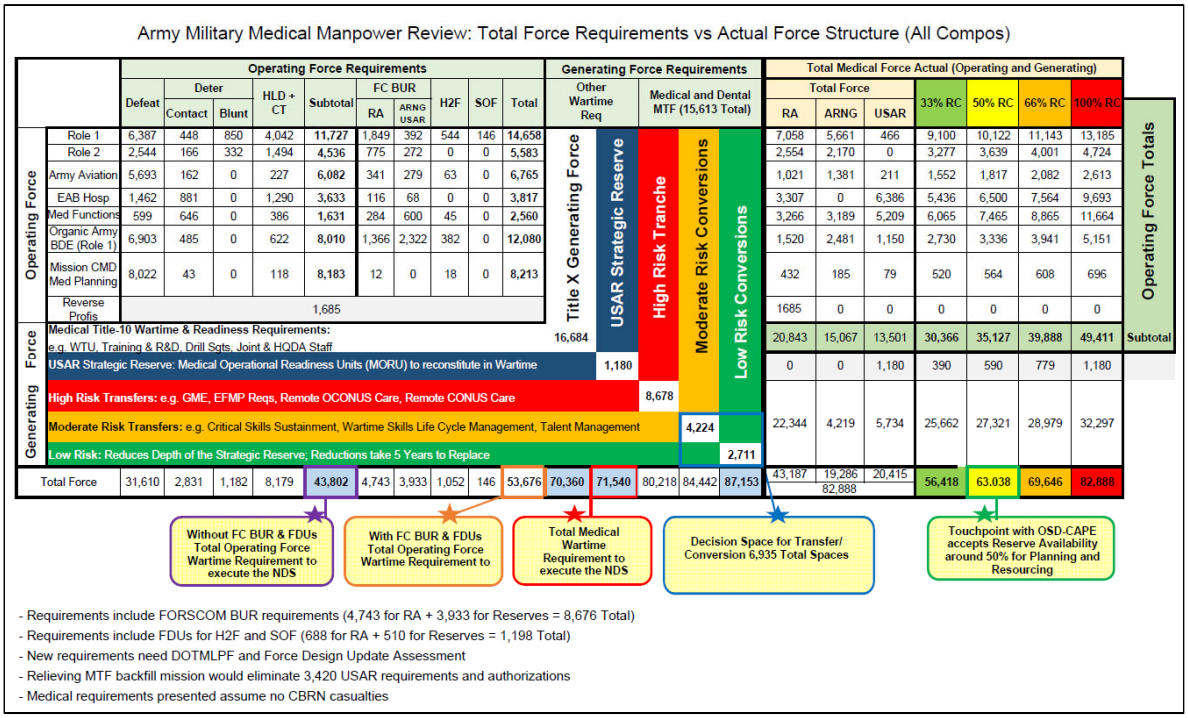
The Army's generating force manpower requirements are derived from manpower models that are validated within the Army's manpower management process and approved by the U.S. Army Manpower Analysis Agency and HQDA G-3/5/7 Force Management Directorate. The models include algorithms and formulas that quantify the relationship between workload and manpower resource requirements essential to performing each mission. Model examples include nursing, professional services, dental, logistics, and administrative services. The Army Medical Command performs manpower studies to determine manpower requirements for subordinate organizations or functional areas not amenable to, or not covered by, approved manpower models. For these manpower studies, only HQDA-approved manpower requirements determination procedures are used.

**The Army's Total Military Medical Force Balance.** Per statutory mandate, the Army's total force is comprised of capabilities and capacities from the Regular Army, Army National Guard, and the U.S. Army Reserves. Currently, the Army's military medical force structure is comprised of 50 percent Regular Army, 23 percent Army National Guard, and 27 percent U.S. Army Reserves. **Figure 3** depicts the total force balance of the Army's military medical structure. Notably within the operating force, the Army relies heavily on U.S. Army Reserves to support military medical requirements to execute the NDS – about 70 percent of the Army's deployable medical force structure is in the Reserves.

**Army Military Medical Manpower Review Results.** As directed by the NDAA for FY 2017, the Army conducted a comprehensive review of military medical manpower that fully supports the FY 2018 NDS. The Army's end-to-end analysis reviews the requirements for all capabilities to support Soldiers and the joint force from point-of-injury to and within CONUS MTFs. In addition to the TAA process discussed earlier, the Army's review was augmented by a FORSCOM BUR, a health care manpower analysis, and other continued and emerging requirements to achieve the Army's objective force. Primary examples of continued and emerging military medical requirements in this review include: home-station HCD, the Army Recover Care Program, the H2F Program, preserving a strategic medical reserve, sustaining behavior health programs, and other essential title 10 generating force requirements. The Army planned for more than 1,000 conversions as reinvestment into Regular Army medical authorizations in operational and training units. **Figure 2** illustrates the comprehensive approach

of this review. All numbers in the table were applicable to the Army's analysis in support of the FY18 NDS, in preparation for POM 22-26. Even if the NDS remains unchanged, the Army is continually conducting analysis and particular numbers are subject to change as formations evolve over time.

***Figure 2 Army's Military Medical Manpower Review***




In the top left quadrant, **Figure 2** delineates the requirements of each NDS element and mission-set (columns), grouped by medical functions at each echelon (rows). The functions that are grouped by echelon include: roles 1 and 2 medical treatment, aeromedical evacuation, hospitalization and medical mission command. The Army's operating force subtotal requirement to meet wartime demands in accordance with the NDS, equates to 43,802 military medical personnel requirements (see purple identifier at the bottom of **Figure 2*).*** The Army's review of the operating force also addressed emerging requirements in support of lethality, survivability and readiness priorities that enable large scale combat and MDO. Army leaders validated these new requirements, which support maneuver brigades in MDO (i.e., finding of the FORSCOM BUR) and increase capabilities in all Army brigades with H2F enablers and sustaining embedded behavioral health.[6] As a result, the total medical operating force requirement for the Army was reviewed at 53,676 MILPER requirements (see orange identifier at the bottom of **Figure 2**). The emerging requirements require additional analysis and refinement. In ARSTRUC 22-26, the Secretary of the Army directed that the Army invest authorizations to meet the full H2F requirement, the full Special Operations Force requirement, and more than 500 additional medical personnel in operational units.

[6] H2F is an Army program to improve Soldier readiness by providing direct access to health professionals who enhance individual training.

As part of the Army's medical force review, the leadership assessed a portion of generating force as a wartime requirement in support of the NDS. The military medical generating force includes capabilities that meet title 10 requirements regarding medical recruiting, training, readiness, education, reconstitution, transition, planning, and RDT&E in support of the operating force. (This portion of the generating force review does not include direct HCD within MTFs.) Example of these requirements include:

- The Army Recovery Care Program;
- Medical Center of Excellence (i.e., the Army's medical training base, which includes medical drill sergeants, initial trainee instructors and other functions that sustain a ready medical force for the Army);
- Medical logistics management;
- Medical Research, Development and Acquisition;
- Medical Operational Readiness Units (i.e., U.S. Army Reserves' strategic medical reserve utilized to augment and reconstitute medical operating force in time of war); and
- Strategic medical integration, planning and assessment within HQDA and the joint staff.

This allocation of generating force personnel was exempt from reinvestment consideration and brings the Army's total wartime demand to 71,540 military medical personnel requirements (see red identifier at the bottom of **Figure 2**).

The balance of the military generating force under review is the structure that serves inside the medical and dental treatment facilities (DTFs) (i.e., the Army's military positions in the MTFs). The Army has approximately 45,000 personnel in this category. About two-thirds of those personnel are CIVPER and will continue to provide their services as the MTFs and dental activities transition from the Army to the DHA. The remaining 15,613 military medical authorizations were the focus of the Army's comprehensive review that is under consideration for conversion to civilian authorizations or network-supported capabilities (note the vertical high, moderate and low impact bands on **Figure 2**). With section 721 of the NDAA for FY 2017 rescinding the prohibition on military medical and dental conversions to civilian status, the Army, in coordination with the DHA, performed a detailed analysis of the Defense Health Program (DHP) military and civilian workforce mix. The goal of the workforce mix analysis was to determine if additional military authorizations could be converted to civilian positions while meeting mission and force health protection requirements, thereby enabling the Army to reinvest its military end-strength to other priorities (including operating force medical requirements).

**Army Military Medical Manpower Analysis Methodology.** Per 10 U.S.C. § 129, the Generating Force is based on workload and within available funding. As outlined in DoDI 1100.22, "Policy and Procedures for Determining Workforce Mix," manpower shall be designated as civilian except when one or more of the following conditions apply: (1) Military-unique knowledge and skills are required for performance of the duties; (2) military incumbency is required by law, Executive Order, treaty, or International Agreement; (3) military performance is required for command and control, optimization, or esprit de corps; (4) military manpower is needed to provide for overseas and sea-to-shore rotation, career development, or wartime

assignments; or (5) unusual working conditions or costs are not conducive to civilian employment.

***Figure 3 Army Medical Generation Force***

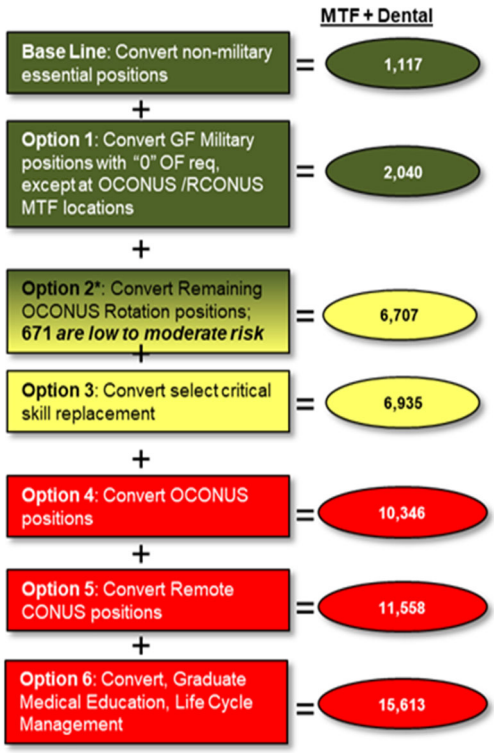
| Generating Force Element* | RA | NG | AR | CIV |
|---|---|---|---|---|
| MTFs | 14,050 | | | 30,858 |
| Dental | 1,563 | | | 2,370 |
| Public Health | 1,874 | | | 2,899 |
| MEDCOM HQ | 374 | | | 1,247 |
| Stand Alone Units | 79 | | | |
| Training & Education | 1,342 | | | 987 |
| Research & Development | 900 | | | 1,854 |
| Warrior Transition Units | 207 | | | 570 |
| Army Reserve MEDCOM | | | 6,737 | |
| PROFIS | 1,685 | | | |
| Other Missions | 1,955 | 4,219 | 2,417 | |
| **Total** | **24,029** | **4,219** | **9,154** | **40,785** |

*Based on FY19 TDAs

These PROFIS authorizations were assigned back to Operating Force Units ("Reverse PROFIS", MAP) that reduces the total RA military positions to 22,344

In August through September 2018, the Army conducted an assessment of the military essentiality for all Regular Army 24,029 military positions within the Generating Force; see **Figure 3.** With section 721 of the NDAA for FY 2017 authorizing the SECDEF to convert military medical and dental positions to civilian status, the 15,613 military medical authorizations within MTFs and DTFs were the focus of the Army's comprehensive review. The military positions comprise one-third of the total force structure within MTF and DTFs.

***Figure 4 Risk Assessment (FY 2018)***




The Army assessed 1,117 of the 15,613 as non-military essential. The remaining force structure was prioritized based on impacts to operational mission and HCD. Two assumptions factored into the assessment. First, work performed in the MTF/DTF was valid and required a civilian replacement. Second, a civilian would be available to replace the military position. The impact assessment placed the 14,496 positions into six separate options and categorized as low, medium or high impact, as shown in **Figure 4**. Option 1 (Low Impact) called to convert military positions with "0" operating force requirements, except at outside the continental United States (OCONUS)/remote CONUS locations. Option 2 (Low to Moderate Impact) called to convert remaining OCONUS rotation positions. Option 3 (Moderate Impact) called to convert select critical skill replacement positions. Option 4 (High Impact) called to convert OCONUS positions. Option 5 (High Impact) called to convert remote CONUS positions. Option 6 (High Impact) called to convert GME. The Army initially opted to convert the 1,117 non-military essential and options 1-3 positions, for a total of 6,935 military positions, to civilian positions phased over 4 years.

Army reviewed the reductions and optimized the remaining 8,678 High Impact positions within the MTF/DTFs. Army's impact assessment was conducted using a model with rules of allocation for the following essential factors: Graduate Health Professional Education (GHPE) Instructors (GME, Graduate Dental Education (GDE) and other hospital-based training), GHPE

residents, remote OCONUS locations, OCONUS locations, initial assessment for hard to hire positions, critical skills, military leadership positions and finally adjustments to enlisted reductions to account for leadership and developmental positions. The model (**Figure 5**) assumed all reduced positions would be replaced with civilian force structure and was spread over four FYs.

***Figure 5 Model Summary***

| Corps | OF Reqs | PROFIS (for reference only - included in OF Reqs #) | GF Except MTF/DTF | GHE Instructors | GHE Residents | RCONUS | OCONUS | Hard to Hire | Critical Skills | CDR/CSM/ 1SG | Deputies | XOs | Adjustments | Reduction | Grand Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| AE | 15,117 | 343 | 3,730 | 96 | 0 | 500 | 1,555 | 164 | 0 | 30 | 0 | 0 | 2,176 | 4,868 | 28,236 |
| AI | 101 | 2 | 175 | 0 | 0 | 11 | 27 | 4 | 0 | 58 | 1 | 0 | 0 | 7 | 384 |
| AN | 971 | 663 | 265 | 93 | 0 | 92 | 399 | 0 | 562 | 0 | 21 | 0 | 50 | 498 | 2,951 |
| BI | 0 | 0 | 73 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 73 |
| DC | 191 | 109 | 26 | 85 | 75 | 62 | 126 | 94 | 46 | 19 | 1 | 0 | 0 | 173 | 898 |
| GO | 0 | 0 | 12 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 12 |
| MC | 816 | 396 | 307 | 82 | 934 | 115 | 415 | 230 | 318 | 1 | 21 | 0 | 0 | 827 | 4,066 |
| MS | 1,607 | 109 | 1,144 | 4 | 0 | 93 | 186 | 26 | 66 | 3 | 18 | 3 | 0 | 478 | 3,628 |
| SP | 639 | 56 | 155 | 64 | 0 | 35 | 48 | 17 | 43 | 0 | 1 | 0 | 50 | 84 | 1,136 |
| VC | 102 | 7 | 382 | 5 | 10 | 0 | 1 | 0 | 4 | 0 | 0 | 0 | 0 | 0 | 504 |
| **Grand Total** | **19,544** | **1,685** | **6,269** | **429** | **1,019** | **908** | **2,757** | **535** | **1,039** | **111** | **63** | **3** | **2,276** | **6,935** | **41,888** |

AE = Enlisted Corps, AI = Medical Immaterial, AN = Nurse Corps, BI = Branch Immaterial, DC = Dental Corps, GO = General Officer, MC = Medical Corps, MS = Medical Service Corps, SP = Specialists Corps, VC = Veterinary Corps

After ongoing analysis and input from MTF Directors/Commanders, the Army determined that hiring CIVPER for every military position of the 6,935 either was not necessary (due to Army's ability to absorb positions) or was not achievable based on three factors: (1) the lack of available civilian medical specialties in every location; (2) the ability to offer a competitive salary to successfully recruit civilians in some locations; and (3) the availability of enduring funding to procure the full number of civilians necessary to replace the military reductions.

***Figure 6 Mitigation Measures Considered***

1. **ABSORB**, current force structure can absorb the workload
2. **RESHAPE FORCE STRUCTURE**, currently hired overhires can replace military reductions due to vacancies, program civilian authorizations
3. **HIRE A CIVILIAN**, a civilian hire can replace the military reduction
4. **SEND TO NETWORK**, the workload can be pushed to the network, private sector care
5. **UNABLE TO MITIGATE**, military reduction cannot be mitigated and recommend restoral of reduction

In response, the Army developed and considered five optimization measures for the lack of ability to hire; see **Figure 6**. First, absorb the workload with the current force structure where possible based on existing underutilization in a given MTF. Second, reshape the current force structure to support the current workload by leveraging existing civilian over-hires that were hired to replace historically unfilled military positions. Third, hire additional civilians to

replace the military position targeted for conversion.[7] Fourth, transfer the care to the network. Finally, if none of the previous four measures can be implemented, request the military position be restored.

The Army conducted a further assessment to determine the impact of the reductions at each location. Impacts are grouped into four major categories, as outlined below and in **Figure 7**.

1. The military reduction would have no impact on the operational mission or to the beneficiary population. This group included the optimization measures of absorb and reshape the workforce and was resource neutral.
2. The military reduction requires replacement by a civilian hire. This group was broken into three categories: (a) those having a high level of confidence to hire; (b) those having a low level of confidence to hire; and (c) those within the dental community that would require hiring civilians in an untested market with which the Army has no previous experience. (Army DTFs serve a primarily AD population with limited use of the Private Sector dental network to support AD dental care).

***Figure 7 Impact Categories***

- **NO IMPACT**, reduction will cause no impact to beneficiaries or decrease capability to generate AOC/MOS
- **BENEFICARY CARE REPLACED BY CIVILIAN HIRE**, broken into three categories low and high confidence to hire, Dental
- **BENEFICARY CARE SENT TO NETWORK**, broken into four categories Sec. 703 locations, GPHE* locations, Dental, Remaining
- **LOSS OF HEALTHCARE CAPABILITY**, reduction will cause a decrease in the availability of healthcare provided

3. Transfer workload to the network. A portion of these reductions were considered with the section 703 of the NDAA for FY 2017 MTF re-scoping changes; some of the workload was from places where GHPE programs existed, and some were reductions whose workload would be sent to an untested dental network.
4. Part of the originally planned military reductions would result in the loss of health care capability. Two factors influenced this assessment: the inability to hire civilian replacements and insufficient local network capabilities or capacity.

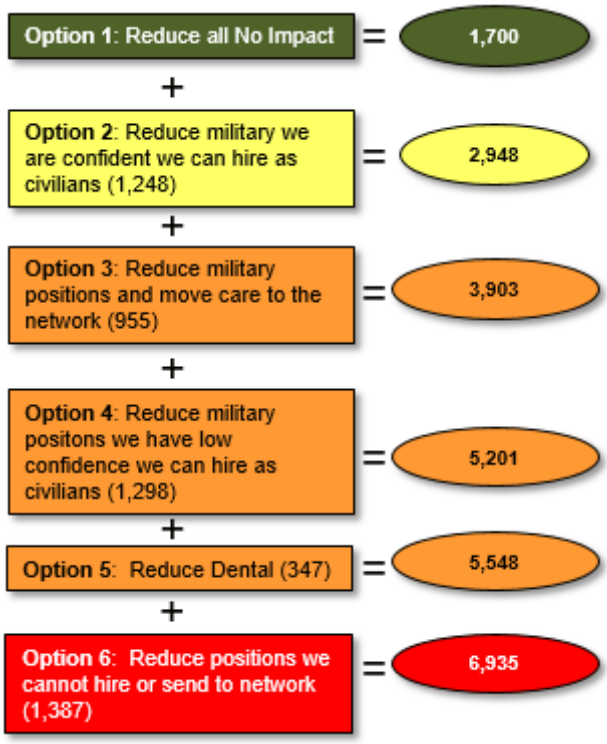
Of note, MTFs provide a training platform for medical specialties; some of these platforms produce medical specialties that Army cannot produce in the school house (i.e., GME, GDE, and Clinical Phase II training).

[7] Any conversion of military authorizations to civilian authorizations will be executed in compliance with the requirements of section 725 of the NDAA for FY 2017 and DoDI 6000.19, "Military Medical Treatment Facility Support of Medical Readiness Skills of Health Care Providers," February 7, 2020."

### 8.1.2 Billets Selected for Realignment

**Army Military Medical Manpower Analysis Review Results**. Based upon additional analysis in FY 2020 with by-location impacts and possible optimization, the Secretary of the Army decided to adjust the military medical reductions from 6,935 to 2,948. The refined impact assessment demonstrated that 1,700 of the reductions will cause no impact to medical readiness or beneficiary care because the locations are over structured or the military position is vacant and a civilian is already in place, Figure 9. In addition, the refined impact assessment revealed a high level of confidence to hire civilian replacements for 1,248 of the reductions. In the updated assessment, the Army did not recommend any reductions that would cause MTF care to be transferred to the local network or any reductions in areas which it assessed difficulty in hiring a civilian replacement. Additionally, the Army did not take any dental reductions unless there was no impact to medical readiness.

***Figure 8 Risk Assessment (FY20)***




The Army conducted a comprehensive assessment of the operational requirements, as mandated in the NDAA for FY 2017, and completed additional analysis, as directed in the NDAA for FY 2020, to review potential gaps in health care services. The initial assessment determined 6,935 military medical personnel authorizations were available for conversion to CIVPER. After a detailed review of the ability to convert positions and health care network adequacy, as well as additional collaboration with the other Services, Joint Staff, and DHA, the Secretary of the Army decided on 2,948 military medical positions for conversion. These positions were either already vacant military positions filled with civilian over-hires, or there was a high degree of confidence to hire CIVPER in the local health care market. Any such hiring actions will be conducted in accordance with all applicable statutory and policy requirements. [8]

The Army is not converting any military medical or dental authorizations in FY 2021. The Army process includes iterative reassessment of capabilities and capacity, which will include the lessons learned from the COVID-19 response.

[8] Any conversion of military authorizations to civilian authorizations will be executed in compliance with the requirements of section 725 of the NDAA for FY 2017 and DoDI 6000.19, "Military Medical Treatment Facility Support of Medical Readiness Skills of Health Care Providers," February 7, 2020

## 8.2 Navy/Marine Corps

### 8.2.1 Medical Requirements Determination

The Navy Medicine's force structure determination process is based on providing operational mission support and delivering capabilities approved by the Chief of Naval Operations in support of two Services – the United States Navy and the United States Marine Corps. Navy Medicine protects, promotes, and restores the health of Sailors and Marines around the world, ashore and afloat, in all warfare domains.

In February 2018, the Deputy Secretary of Defense directed a review of the requirement for organic and surge medical forces to directly meet the wartime casualty treatment mission, including Military Medical Occupational Specialties required for future military operations. To provide an estimate of the total force requirement, the Navy assessed operational force demands to meet a single most stressing operational plan and the associated generating force to reflect the most stressing threats consistent with the FY 2018 Defense Planning Guidance (DPG) and the FY 2018 NDS.

The OSD, Director of Cost Assessment and Program Evaluation (CAPE), and the Office of the Chief of Naval Operations (OPNAV) initiated a medical manpower requirement review in the summer of 2018 for POM 2020 (POM-20).

Navy POM-20 analysis resulted in decreased AC NEHSS capabilities and the accompanying generating force to include Student/Training billets and Transient, Patient, Prisoner, and Holdee (TPPH) status authorizations. As a result of Navy's review of the NEHSS, Navy medical billet divestitures will be reinvested in other Navy operational priorities that support a more lethal and resilient force ready to operate seamlessly across all domains.

The NDAA for FY 2020 directed the MILDEPs review medical manpower requirements to account for all NDS scenarios. Navy review indicated the assumptions used for earlier reviews is sufficient to meet NDS scenarios. However, given that operational requirement and priorities are dynamic, the requirements are continuously reviewed to optimize use of finite resources.

**Navy Medicine Focus.** Navy Medicine will provide well-trained medical experts, operating as a high-performance, ready medical force to project medical power in support of Naval superiority. Navy Medicine will continue to focus on the readiness mission, enhancing medical capabilities required in operational settings and ensuring that the Navy and Marine Corps forces are medically ready. The POM-20 billet divestitures will continue to require ongoing thorough analysis of the medical force structure. Focus areas include the following:

- Specialty mix alignment to operational requirements, to provide sustainable readiness platforms leading to optimized warfighter performance, increased medical force agility and responsiveness, and adequately maintained core health care competencies.
- GME/GHPE Programs, to include faculty and supporting clinical services.
- Support to isolated/remote and OCONUS locations where network, contractor, or federal civilian hires are unavailable to support the mission, function, and tasks of a facility.
- Military unique installation support requirements.

- Accession and Service/Training site support for Navy and Marine Corps recruits/Service members.

### 8.2.2 Billets Selected for Realignment

Navy Medicine carefully reviewed the divestitures and developed "Business Rules" to minimize the impact on operational support sites, remaining operational platforms, military unique or essential billets, and accession or MILDEPs' training locations. Additionally, remote locations with limited network availability, overseas locations, and support for GME were also reviewed to limit potential negative effects.

Navy and OSD CAPE included a phased reduction across the Future Years Defense Program (FYDP) to allow for appropriate time to reduce both personnel inventory through voluntary levers and impacts to HCD and readiness for the warfighter and their families. Voluntary force shaping measures appear to be adequate for the enlisted divestitures to occur within the FYDP. The resourcing profile in **Table 14** supports the following: additional time to reduce the medical department through voluntary levers, better enable the transition of beneficiary care to the DHA, and provide consistency with current training and deployment cycles to maintain readiness for planned/unplanned operations and the steady state security posture. The DHA requires time to determine HCD requirements to support beneficiaries and analyze markets for network capabilities and hiring capacities, and to transfer current Department of Navy Federal civilians to the OASD(HA)/DHA.

***Table 14 New Navy FY 2021-2025 Divestiture Profile***

| Manpower Type | FY21 | FY22 | FY23 | FY24 | FY25 | Total* |
|---|---|---|---|---|---|---|
| Officer | -237 | -122[b] | -1,079 | -253 | -173 | -1,864 |
| Enlisted | -2,392 | -397 | -516 | 0 | 0 | -3,305 |
| **Total** | **-2,629[a]** | **-519** | **-1,595** | **-253** | **-173** | **-5,169** |

**The Navy divestiture of 5,169 reflected in this table represents Navy military medical billets aligned with the Defense Health Program only.*

### 8.2.3 Optimization Planning Assumptions

**Realignment Optimization Options.** The Navy considered optimization options per DHA guidance that included "Absorb," "Hire," "Network," or "Replace." The guidelines are described below, and data is provided in **Table 2.**

**Absorb** indicates remaining staff at a location is assumed to be sufficient to cover future HCD demands. This optimization referenced positions that, if removed, would be at the minimum levels not to degrade overall capability of that HCD service. This applied to line items where additional billets did not equate to increased efficiencies. Specialist and/or trained technicians were not able to be absorbed utilizing current MTF assets. Planned losses, if required for mission, but could not be absorbed, were moved to hire or network.

**Hire** refers to the replacement of active duty personnel with federal civilians or contractors in-house. Hire was applied to cases where a Shore Manpower Requirement Determination showed validated workload, and positions were necessary to accomplish HCD functions (i.e., Dentists,

Dental Technicians must be hired to keep a required 1:2 ratio; hiring essential clinical/administrative functions in support of patient care operations). As Markets become certified and transfer to DHA, hiring authority will also transfer from the MILDEPs to DHA. DHA and the MILDEPs will ensure MTFs know projected departures and status of funds for coordination with respective hiring authority to prioritize hiring actions.[9]

**Network** is an option where input from the MTFs verified the feasibility of engaging the network, in place of civilian hires or uniformed personnel (i.e., Prosthodontic work sent to network in order to preserve available billets for mission essential tasks such as Flight Physicians, Submarine/Surface Force Independent Duty Corpsmen, or other Navy/military unique functions). Network deferrals will be driven by market availability, or civilian providers' willingness to accept TRICARE payments. Additional DHA coordination and assessment of Network adequacy will be iterative in most market areas.

**Replace** represents an internal secondary review of divested billets that cannot be optimized by hiring or leveraging the network. Navy Medicine's optimization strategy included the internal "re-assessment" of billets originally identified to be divested within Budget Submitting Office (BSO)-18 – Bureau of Medicine and Surgery (BUMED) and replacing them by realigning and repurposing other clinical billets to meet health care demand. These repurposed billets were identified through analysis that remaining staff at a location were sufficient to cover HCD demand. Consistent with POM-20 guidance and subsequent to this assessment, BUMED adjusted the divestiture to better align with medical mission sets and enhances medical readiness in operational settings.

## 8.3 Air Force

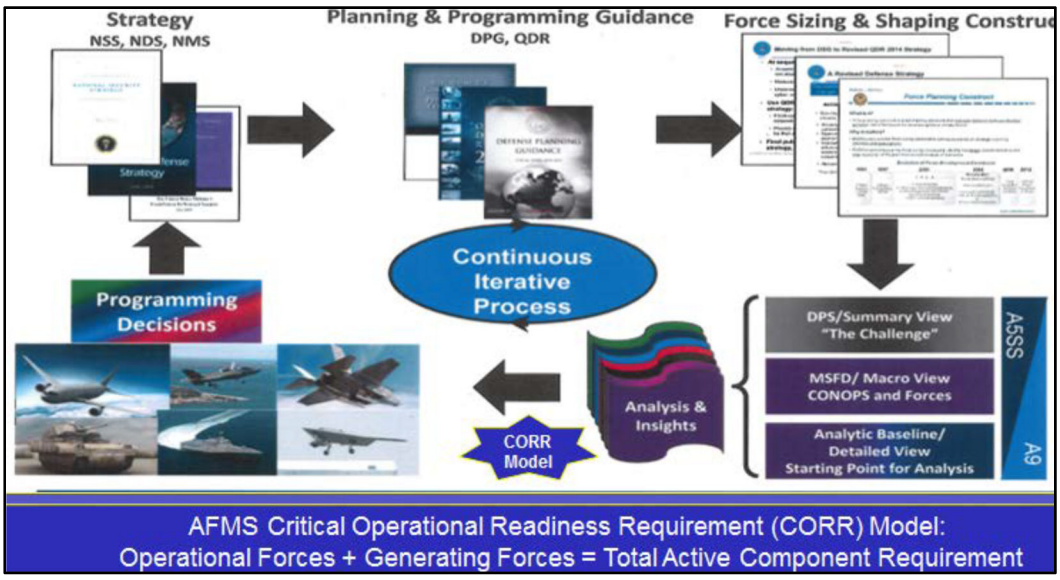
### 8.3.1 Medical Requirements Determination

The AFMS assesses capabilities and develops a POM capable of supporting national objectives and Combatant Commands' (CCMDs) operational needs. The Air Force operating force requirements are the uniformed military forces required to execute DPG-prescribed scenarios, or "Operational Plans." The AFMS used the CORR force-sizing model to determine the minimum military essential AD manpower, including DHP and non-DHP requirements, for Air Force medical career fields. The CORR does not model the Total Force requirements. All reserve component medical forces are modeled separately but are fully integrated into all operational planning requirements. The Total Force requirements include capabilities and capacity from the Active, National Guard, and Reserve Components. In general, the Active Air Force component is best suited for unpredictable and frequent Air Expeditionary Force deployments that deal with complex operational environments and unexpected contingencies. The Reserve Component is best suited for predictable and infrequent deployments, meeting strategic surge capability (e.g.,

[9] Any conversion of military authorizations to civilian authorizations will be executed in compliance with the requirements of section 725 of the NDAA for FY 2017 and DoDI 6000.19, "Military Medical Treatment Facility Support of Medical Readiness Skills of Health Care Providers," February 7, 2020.

aeromedical and patient staging), and providing title 32 support to State and local authorities including chemical, biological, radiological, and nuclear response elements for homeland scenarios. The presumptive Reserve Component operational requirements are included in the Air Force total medical force requirements. The AFMS AD requirements determination model is shown in **Figure 9**.

***Figure 9 AFMS Operational Requirements Development Model***




The CORR was developed as a response to section 733 of the NDAA for FY 1992 and NDAA for FY 1993 that required the Department to reassess the appropriate size and mix of its medical force based on post-Cold War scenarios. Congress required the Department identify ways to provide high-quality, cost-effective medical care delivered during peacetime. Congress instructed the Department to determine the size and composition of the military medical system needed to support a war or other conflict.

A CORR for each medical specialty is calculated using a computer program with data inputs such as unit manning documents, expeditionary force packages, and medical support authorizations for in-place missions. These data are derived from the operational requirements analysis of the National Military Strategy, DPG, and Defense Planning Scenarios. Other inputs into the model include institutional force structure requirements such as leadership positions, headquarters staff functions, medical specialty training infrastructure, and platforms used to maintain deployable readiness skills such as the Center for Sustainment of Trauma and Readiness Skills. Additional additives include authorizations for GME and force development activities, positions for OCONUS rotations base and casualty replacement, forces that manage sustainment and modernization programs and conduct RDT&E.

### 8.3.2 Optimization Planning Assumptions

In accordance with section 719 of the NDAA for FY 2020, the Air Force review of the FY 2020 medical manpower requirements accounted for all NDS scenarios. An office outside the AFMS conducted the review using a common framework to categorize military medical capabilities

similar to the review done prior in the readiness review of operational squadrons. The review used different assumptions to produce a range for medical operational requirements based on distributed or robust operational platform laydown. The review found the CORR output of 20,118 accounted for all NDS scenarios under current operating concepts, and when incorporated with the 5,745 sustainment force the model results are sufficient. Note: The Air Force will continue to assess the impacts of the COVID-19 pandemic response, which may change the requirements in the CORR model in the future. The following assumptions were used to determine both the FY 2020 medical operational requirement and optimization of access gaps:

Inclusion of all Air Force determined medical manpower requirements in the baseline; excluded requirements authorized for Joint Staff, U.S. CCMD, OSD, and Defense-wide activities and their direct reports (e.g., U.S. Military Entrance Examination Activity).

- Core operational requirements are medical Unit Type Codes reported in the Defense Readiness Reporting System (DRRS), in-place OCONUS hospitals, and Air Force operational headquarters that are Supporting HQ to a U.S. CCMD in Forces for Document. Additive manpower (above what the Air Force has postured in DRRS) if Air Force is fully deployed.
- Air Force is the lead MILDEP for aeromedical evacuation and should be able to continually swap out casualty care crews at theater embarkation points and CONUS or theater debarkation points in the same manner as commercial airline flight crews.
- Assume deployment period with an NDS scenario involving a near-peer competitor will be as they were in World War II, for the duration of the conflict, thus do not adjust for deploy-to-dwell but instead adjust for the Department's target for personnel availability/non-deployable rates.
- Assume that Congress will accept all 703 proposals. Therefore, the AFMS may reduce the military footprint of 12 Air Force facilities soon after the DHA has transferred beneficiaries to the network.

This assessment was an initial external assessment to review the previous CORR model assertions. It validated the Air Force's position that reducing the medical force structure would have limited impact on the AFMS' ability to meet its operational mission requirements.