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

PERSONNEL AND READINESS

NOV 1 8 2022

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

Dear Mr. Chairman:

The Department's response to House Report 117–118, pages 177-178, accompanying H.R. 4350, the National Defense Authorization Act for Fiscal Year 2022, which requests that the Secretary of Defense submit a review of mental health services within the Department, is enclosed.

This report includes an overview of behavioral health services and compensation within the Department. It provides an analysis of the feasibility of Health Professions Scholarship Program expansion; increasing use of Special and Incentive Pays to maximize the retention of active duty behavioral health providers; and increasing General Schedule paygrades for behavioral health providers working in military medical treatment facilities. The report also discusses a feasibility analysis of a pilot program using information technology-based human performance synthetic training systems capable of advanced biometric data collection and reporting in behavioral health.

Thank you for your continued strong support for the health and well-being of our Service members. I am sending a similar letter to the Committee on Armed Services of the Senate.

Sincerely,

Gilbert R. Cisneros, Jr.

cc:
The Honorable Mike D. Rogers
Ranking Member

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

PERSONNEL AND READINESS

NOV 1 8 2022

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

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Thank you for your continued strong support for the health and well-being of our Service members. I am sending a similar letter to the Committee on Armed Services of the House of Representatives.

Sincerely,

Gilbert R. Cisneros, Jr.

Enclosure:
As stated

cc:
The Honorable James M. Inhofe
Ranking Member

REPORT TO THE COMMITTEES ON ARMED SERVICES OF THE SENATE AND THE HOUSE OF REPRESENTATIVES

MENTAL HEALTH SERVICES AND COMPENSATION

November 2022

The estimated cost of report or study for the Department of Defense (DoD) is approximately $9,080 for the 2022 Fiscal Year. This includes $0 in expenses and $9,080 in DoD labor. Generated on 2022Jun29 RefID: 6-85CC2A4

EXECUTIVE SUMMARY

This report is in response to House Report 117–118, pages 177-178, accompanying H.R. 4350, the National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2022, which requests a review of expanding the Health Professions Scholarship Program (HPSP) to increase the number of behavioral health (BH)-related scholarships, a review of prioritizing an increase in Special and Incentive Pays to maximize the retention of active duty (AD) behavioral health providers (BHPs), a review on increasing General Schedule (GS) paygrades for BHPs working in military medical treatment facilities (MTFs), and a plan to establish a pilot program for advanced biometric data collection and reporting for use in behavioral health.

> *Mental Health Services*
>
> *The committee is concerned that the demand for mental health related services within the Department of Defense may be at a critical breaking point. The recently released Government Accountability Office Report 21–437R indicated that COVID–19 has further exacerbated mental health access challenges across the United States. The Centers for Disease Control and Prevention surveys found about 38 percent of respondents reported symptoms of anxiety or depression from April 2020 through February 2021, up from about 11 percent in 2019. Emergency department visits for overdoses and suicide attempts from mid-March to mid-October 2020 were up 36 percent and 26 percent, respectively, from 2019. Many behavioral health service providers reported increasing demand and decreasing staff sizes.*
>
> *Therefore, the committee directs the Secretary of Defense to submit a report to the Committees on Armed Services of the Senate and the House of Representatives, not later than February 1, 2022, that includes the following:*
>
> *(1) a review of how the Health Professions Scholarship Program can be expanded to increase the number of mental health-related scholarships granted, with the goal of increasing the pipeline of mental health providers.*
>
> *(2) a review of how the Department of Defense can prioritize an increase in Special and Incentive Pays to maximize the retention of Active Duty mental health providers.*
>
> *(3) a review of how the Department of Defense can increase General Schedule paygrades for mental health providers working in military treatment facilities.*
>
> *(4) a plan to establish a pilot program that uses information technology-based human performance synthetic training systems capable of advanced biometric data collection and reporting that can be used to: establish and monitor cognitive and physical baselines for service members throughout their careers and aid in forecasting, assessment, and diagnosis of mental health issues, including post-traumatic stress disorder (PTSD); explore the effectiveness of integrating PTSD resiliency skills with warfighter tactical training; and utilize data analytics to improve training protocols and effective mitigation strategies and tactics.*

Nationwide, demand for BH services is outpacing the supply of BHPs. This continued trend will result in increased difficulty recruiting and retaining BHPs, as members of these professions have more options and bargaining power. Further investigation into the cause of national shortages is necessary in order to determine effective national strategies for mitigation, which are likely beyond incentivizing via compensation.

The HPSP covers an individual's full tuition for an advanced medical degree while also providing a monthly stipend in exchange for future service in the military, and is accompanied with an active duty service obligation (ADO). Expanding HPSP for BH-related scholarships may not have the intended effect of increasing the pipeline of BHPs accessing into the military. Medical students are typically awarded the HPSP at the onset of medical school, prior to determining their future medical specialties. As a result, it is difficult to predict the specialty a student may choose during the HPSP recruitment process, creating significant challenges to use these programs to target certain specialties. Also, 10 U.S.C. § 523 sets AD commissioned officer end strength authorizations across each Service. Although medical officers (e.g., physicians) are excluded from its limitations, the exclusion is not extended to licensed BHPs (e.g., clinical psychologists, social workers, and mental health nurse practitioners (MHNPs).

Compensation for special and incentive pays for health professions officers (HPOs) is limited by 37 U.S.C. § 335(e)(1). The Office of the Assistant Secretary of Defense for Health Affairs (OASD(HA)) authorizes the "Health Professions Officer Special and Incentive Pay Plan," which sets the upper limit of the special pays for HPOs of the Active and Reserve Components. This guidance is used by the Military Departments to set Military Department-specific provider compensation. Each Military Department provides compensation at or approaching the maximum allowable limit set by the OASD(HA) pay plan. The Military Departments must satisfy requirements for all specialties so prioritizing special and incentive pays for mental health providers (MHPs) may negatively impact the ability for to bring on other high-demand medical specialties.

The Office of Personnel Management (OPM) sets the GS payscale. Consequently, the Department of Defense (DoD) leverages two broad compensation authorities for BHPs, which include title 38 authorities and Government-wide title 5 authorities. The MTFs are managed under the authority and control of the Defense Health Agency (DHA), which must consider requirements for all types of care, and authorization requirements for all specialties within its allocated budget.

Finally, a feasibility analysis was performed to assess whether to plan for a pilot using information technology-based human performance synthetic training systems capable of advanced biometric data collection and reporting to monitor, forecast, assess, diagnose, mitigate, and treat mental health issues. This analysis was conducted because of the continued concern associated with the reported rise in demand for mental health care within the Military Health System (MHS) and a concomitantly decreased capacity to meet demand for requested services. The feasibility analysis assessed whether using advanced biometric data would be technically feasible and economically justifiable. The feasibility analysis indicated a high probability of a false-positive rate for psychological distress that would likely result in a meaningful number of presumably unnecessary referrals for care. Consequently, the proposed intervention would not

have substantial impact on provider burden or access to care, and a plan for a pilot should not be further developed or implemented.

BACKGROUND

Nationwide, demand for behavioral health services is outpacing the supply of BHPs (Behavioral Health Workforce [BHW], 2018, BHW, 2020). This continued trend will result in increased difficulty recruiting and retaining BHPs, as members of these professions have more options and bargaining power. Further investigation into the cause of national shortages is necessary in order to determine effective national strategies for mitigation, which are likely beyond incentivizing via compensation.

Briefly, challenges associated with supply and demand include a competitive market that includes private sector care and other Federal agencies (e.g., Department of Veterans Affairs), increased compensation requirements, and non-compensation factors. Budget and statutory requirements impact compensation. BHPs weigh non-compensation factors into their decision-making, including the number and frequency of deployments, ability to function at full scope of practice for training, administrative requirements associated with service, family considerations associated with permanent change of station orders, inability to select residency of choice, non-selection for promotion, and retirement eligibility (GAO-20-165).

EXPANDING THE HPSP FOR MENTAL HEALTH-RELATED SCHOLARSHIPS

The HPSP covers an individual's full tuition for an advanced medical degree while also providing a monthly stipend in exchange for future service in the military. General requirements for the HPSP are provided in Department of Defense Instruction (DoDI) 6000.13, "Accession and Retention Policies, Programs, and Incentives for Military Health Professions Officers (HPOs)" (DoD, 2015). Benefits of the HPSP may include full tuition for up to 4 years, funding for books, equipment, and other school fees, a monthly stipend, a sign-on bonus, officer's pay during AD tours, and cost-of-living adjustments. While benefits are similar across the DoD, the HPSP is offered and operated individually by the Army, Navy, and Air Force.

HPSP scholarship approval is accompanied with an ADO. Medical school HPSP recipients incur an ADO of one-half year for each half year or portion thereof; however, the minimum ADO is two years (DoD, 2015). Per DoDI 6000.13, "A participant may not serve any part of a military obligation incurred by participation in the AFHPSP [Armed Forces HPSP] or FAP [Financial Assistance Program] concurrently with any other military obligation, unless specified otherwise."

Expanding HPSP for behavioral health-related scholarships may not have the intended effect of increasing the pipeline of psychiatrists accessing into the military. Students are typically awarded the HPSP at the onset of medical school, prior to determining their future medical specialties. Although the benefits and impact of choosing a particular specialty can be highlighted throughout the individual's tenure in medical school, a student's decision-making process is very personal and complex, and includes many different factors. As a result, it is

difficult to predict the specialty a student may choose during the HPSP recruitment process, creating significant challenges to use these programs to target certain specialties (GAO-18-77).

Section 523 of title 10, U.S. Code., sets AD commissioned officer end strength authorizations across each Service. Although medical officers (e.g., physicians) are excluded from its limitations, the exclusion is not extended to licensed BHPs (e.g., clinical psychologists, social workers, and MHNPs). As a result, recruitment, accessions, and retention efforts for these HPOs are subject to the limitation on billets available under 10 U.S.C. § 523. This results in a "zero-sum game," where providing an advantage to one type of officer, in this case behavioral health, would necessitate an equivalent loss for another, such as biomedical engineering or pharmacy.

Additional challenges present themselves during the ADO. Students who participate in the HPSP may have difficulty fulfilling service obligations, affecting the likelihood that the individual is retained following completion of the ADO. By comparison, students who apply and are accepted to medical school within the Uniformed Services University have been reported as serving longer, deploying for more days, and more likely to have attained board certification and complete a greater number of operationally relevant trainings then their HPSP counterparts (John, et al., 2019).

Alternatively, the DoD could leverage available annual accession and retention programs, such as the Health Professions Loan Repayment Program (HPLRP), which repays educational loans in return for an ADO (GAO-18-77). Eligibility for the HPLRP includes possessing professional qualifications, or being enrolled in a program of education leading to professional qualifications. As a result, BHP HPLRP applicants are typically fully trained in their specialty upon accessing into the military.

PRIORITIZING AN INCREASE IN SPECIAL AND INCENTIVE PAYS

Previous reports discussed military health professional compensation as generally less than the mean compensation for their civilian counterparts, which includes BHPs (GAO-20-165). Compensation for special and incentive pays is subject to the limits in 37 U.S.C. § 335(e)(1). Section 612 of the William M. (Mac) Thornberry NDAA for FY 2021 increased the limits for Accession Bonus (AB) to $100k, for Critically Short Wartime Specialties Accession Bonus (CSWSAB) to $200k, Retention Bonus (RB) to $150k, Incentive Pay for medical and dental officers and other health professionals to $200k and $50k, respectively, and Board Certification Pay (BCP) to $15k.

The OASD(HA) authorizes the "Health Professions Officer Special and Incentive Pay Plan," which sets the upper limit of the special pays for HPO of the Active and Reserve Components within the statutory limits. This guidance is used by the Military Departments to set Military Department-specific provider compensation. Due to the discretionary nature of the special pays, Military Departments provide cash compensation, as appropriate, at or below the limit established by the OASD(HA) pay plan guidance. The FY 2022 pay plan special and incentive pays for psychiatry are provided in Table 1, and special pays for MHNPs, social workers, and psychologists are provided in Table 2.

Table 1. FY 2022 Psychiatry Special and Incentive Pays.

Pay	335(e)(1)	FY2022 Pay Plan
CSWSAB	$200k	$75k*
RB	$150k	$75k**
Incentive Pay	$200k	$43k
BCP	$15k	$6k

*$300k per 4 year contract
**6 year rate

Table 2. FY 2022 Special Pays for MHNP, Social Workers, and Psychologists.

Pay	MHNP	Social Worker	Psychologist
Specialty AB*	$30k	$30k	-
CSWSAB*	-	-	$65k
RB	$40k**	$10k*	$65k**

*4-year rate
**6-year rate

Each Military Department provides compensation at or approaching the maximum allowable limit set by the OASD(HA) pay plan. The Military Departments must satisfy requirements for all specialties (e.g., psychiatrists, anesthesiologists, surgeons, social workers) within their allocated budgets. Thus, DoD must consider alternatives to maximize the retention of AD BHPs. Such alternatives include non-compensation factors that BHPs consider during their retention decision-making process. Previous reports indicate that health professionals consider number and frequency of deployments, ability to function at full scope of practice for training, administrative requirements associated with service, family considerations, or non-selection for promotion during the retention process (GAO-20-165).

INCREASING GENERAL SCHEDULE PAYGRADES

OPM sets the GS payscale. As a result, DoD will continue to use all existing hiring and compensation authorities available for medical positions, including MHPs.

DoD leverages two broad compensation authorities for BHPs: title 38 authorities and Government-wide title 5 authorities. Title 38 authorities, which are available to DoD pursuant to 10 U.S.C. § 1599c, include, but are not limited to, Special Salary Rate (SSR) authority, allowing the DoD to increase rates of basic pay to amounts competitive within the local labor market; Physicians and Dentists Pay Plan; Nurse Locality Pay System; Head Nurse Pay; and premium pay. Government-wide title 5 authorities include, but are not limited to, the Superior Qualifications and Special Needs Pay-Setting Authority; recruitment, relocation, and retention incentives; Student Loan Repayment Program; service credit for leave accrual; and SSR authority, which allows OPM to increase pay to address existing or likely significant difficulties in recruiting or retaining well-qualified employees due to factors such as significantly higher non-Federal pay rates than those payable by the Federal Government within the area, location, or occupational group involved.

The report to Congress, "Behavioral Health Requirements of the DoD," reported that the civilian psychiatrist cost basis for a contract psychiatrist is $300k annually, based on the median for the Physicians and Dentists Pay Plan and locality pay of the MTF with benefits included. The report also indicated that contract social workers and contract psychologists both cost $130k annually. Civilian social worker cost basis is calculated using the GS-12, step 5 rate, and civilian psychologist cost basis is calculated using the GS-13, step 5 rate (DoD, 2022).

Use of these tools will improve employee recruitment and retention and assist MTFs in successfully meeting mission requirements. There may be minor improvements in manpower recruitment and sustainment, but, historically, pay increases may not be enough to compensate for the other perceived drawbacks of serving as a civilian BHP in the DoD (GAO, 2015).

EVALUATING A PILOT PLAN FOR ADVANCED BIOMETRIC DATA FOR USE IN BEHAVIORAL HEALTH

The Committees on Armed Services of the Senate and the House of Representatives have expressed concern related to a reported rise in mental health care seeking within the MHS and a concomitantly decreased capacity to meet demand for requested services. Consequently, the Committees requested a plan to establish a pilot program that uses information technology-based human performance synthetic training systems capable of advanced biometric data collection and reporting. DHA performed a feasibility analysis to determine the viability of a pilot program, and whether a pilot program would be technically feasible and economically justifiable. At the present time, the use of biometric markers for the screening or diagnosis of all behavioral health conditions is not sufficiently mature to aid in current difficulties related to access to behavioral health services.

The feasibility analysis included scoping definitions according to current state of the science and evidence-based best practices, such as: information technology-based human performance synthetic training systems; biometric; biometric marker; cognitive and physical baselines; and resiliency skills. Further, critical assumptions underlying the execution of a pilot program and key planning elements associated with the proposed pilot were defined to assess viability, technical feasibility, and economic justification. If any of the critical assumptions were determined to be invalid, the feasibility analysis indicated that findings from a pilot project would be of limited value, require substantial acquisition activities prior to pilot launch, or not be feasible or advisable to complete.

Initial simulation modeling (assuming good sensitivity [proportion of true cases detected at 0.7] and specificity [proportion of non-cases correctly classified as such at 0.8]) of the performance of biometric data as an indicator of psychological distress suggests that, as the true prevalence of distress in the population approaches 20 percent, that only 46 percent (90 percent confidence interval: 30-70 percent) of those identified by biometric indicators as being at risk would actually be at risk. This is a substantial false-positive rate that is likely to result in a meaningful number of presumably unnecessary referrals for care. At the same time (and under the same assumptions), biometric indicators are expected to miss roughly 30 percent of true positive cases.

In a hypothetical population of 1,000 Service members where the true prevalence of psychological distress is 20 percent, biometric indicators (under the assumptions outlined above) would (on average) correctly identify 140 cases as being at risk, would misidentify 164 cases as being at risk, and would fail to identify 60 cases that were actually at risk. As a result, it seems unlikely that the proposed pilot program intervention would have substantial impact on provider burden or access to care.

Thus, the feasibility analysis for the pilot indicates a high probability of a false-positive rate that is likely to result in a meaningful number of presumably unnecessary referrals for care. Consequently, the proposed intervention would not have substantial impact on provider burden or access to care, and a plan for a pilot should not be further developed or implemented.

CONCLUSION

Nationwide, demand for behavioral health services is outpacing the supply of BHPs, resulting in more competition and increased bargaining power for these professionals. Additional studies are necessary to determine effective recruitment and retention strategies, which are likely beyond incentivizing via compensation. For example, challenges exist with expanding the HPSP for psychiatrists, as these scholarships are awarded well in advance of a specialty selection by recipients. Further, compensation via special and incentive pays or increasing GS paygrades for BHPs are limited by statutory requirements for compensation and authorizations as well as budgetary considerations.

A feasibility analysis was performed to assess whether to plan for a pilot using information technology-based human performance synthetic training systems capable of advanced biometric data collection and reporting to monitor, forecast, assess, diagnose, mitigate, and treat mental health issues. The feasibility analysis indicated a high probability of a false-positive rate for psychological distress that is likely to result in a meaningful number of presumably unnecessary referrals for care. Consequently, the proposed intervention would not have substantial impact on provider burden or access to care, and a plan for a pilot should not be further developed or implemented.

REFERENCES

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APPENDIX A: LIST OF ACRONYMS

ACRONYM	DESCRIPTION
AB	Accession Bonus
AD	active duty
ADO	active duty obligation
BCP	Board Certified Pay
BH	behavioral health
BHP	behavioral health provider
DHA	Defense Health Agency
DoD	Department of Defense
DoDI	Department of Defense Instruction
CSWSAB	Critically Short Wartime Specialties Accession Bonus
FAP	Financial Assistance Program
FY	Fiscal Year
GS	General Service
HPLRP	Health Professions Loan Repayment Program
HPO	health professions officer
HPSP	Health Professional Scholarship Program
MHP	mental health provider
MHNP	mental health nurse practitioner
MHS	Military Health System
MTF	military medical treatment facility
NDAA	National Defense Authorization Act
OASD(HA)	Office of the Assistant Secretary of Defense for Health Affairs
OPM	Office of Personnel Management
PTSD	post-traumatic stress disorder
RB	Retention Bonus
SSR	Special Salary Rates