Report No. DODIG-2017-066

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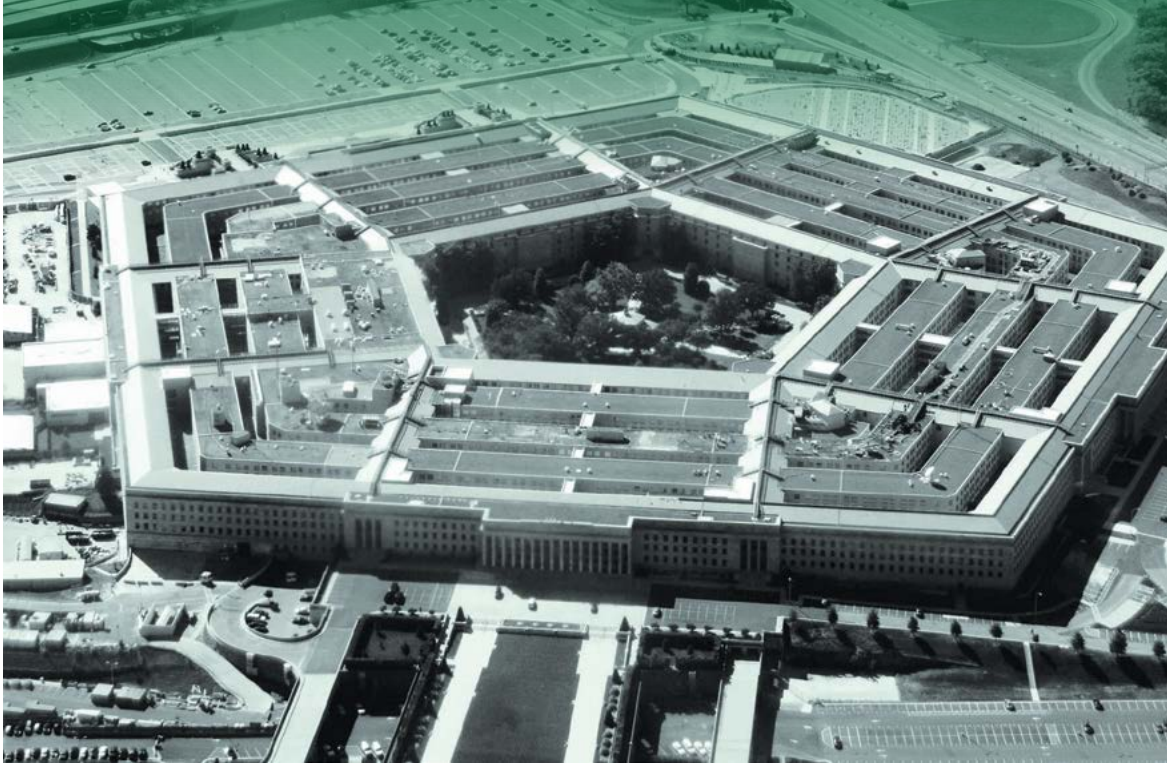
INSPECTOR GENERAL

U.S. Department of Defense

MARCH 14, 2017

Army Did Not Support Business Case Analysis Recommending Transition of Human Immunodeficiency Virus Testing



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Results in Brief

Army Did Not Support Business Case Analysis Recommending Transition of Human Immunodeficiency Virus Testing

March 14, 2017

Objective

We determined whether the Army supported its decision to transition Human Immunodeficiency Virus (HIV) testing from a contracted service to an in-house capability.[1] In addition, we reviewed the Navy's testing plans.

The House Committee on Appropriations requested that we review the Army's business case analysis to transition HIV testing from a contracted service to an in-house capability. In addition, House Report 114-577, to accompany the House Report 5293, "Department of Defense Appropriations Act, 2017," expressed concern with the decisions by the Army and Navy to transition HIV testing from a contracted service to an in-house capability. The report directed the DoD Office of Inspector General to examine the business case analyses and provide a report on its findings to the congressional defense committees.

Finding

We determined that Walter Reed Army Institute of Research personnel did not adequately support or document their business case analysis for bringing HIV testing in-house. This occurred because

[1] The Army considers in-house testing as testing performed at the HIV Diagnostics and Reference Laboratory.

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Finding (cont'd)

Walter Reed Army Institute of Research personnel did not follow DoD and Service guidance for preparing a business case analysis. Specifically they:

- developed the business case analysis around co-locating and moving the entire HIV Diagnostics and Reference Laboratory and other non-HIV testing elements to a leased facility. Specifically, WRAIR personnel included non-HIV testing elements in their analysis, which were not related to the problem statement;
- based the premise of the business case analysis on a research cooperative agreement that could not be used;
- did not consider three or more courses of action;
- did not consistently use total costs in their analysis; and
- used flawed selection criteria in the decision matrix analysis.

As a result, U.S. Army Medical Command personnel cannot ensure that they made the best decision transferring HIV testing from the contractor to the HIV Diagnostics and Reference Laboratory, and may increase costs by moving the laboratory and the other non-HIV mission elements into leased space.

However, we determined that the Navy's plans to transfer Navy HIV testing from a contractor to the Air Force appeared reasonable because using the Air Force for HIV testing instead of the Navy's current contractor could save the Navy approximately $3.58 million per year.[2]

[2] We calculated the $3.58 million in yearly savings by multiplying the number of planned tests by the difference in the cost per test charged by the contractor and the proposed cost per test charged by the Air Force.

Results in Brief

Army Did Not Support Business Case Analysis Recommending Transition of Human Immunodeficiency Virus Testing

Recommendations

We recommend that the Chief of Staff, U.S. Army Medical Command, re-perform the business case analysis for HIV testing and ensure the analysis:

- includes only the scope cited in the problem statement;
- uses accurate assumptions and current information and costs;
- includes three or more courses of actions and alternatives;
- consistently uses total costs associated with the project;
- uses well-defined and measurable alternative selection criteria; and
- is adequately documented and supported.

Additionally, we recommend that the Chief of Staff, U.S. Army Medical Command, not enter into any leases to move Army laboratories until the business case analysis is re-performed.

Management Comments and Our Response

The Chief of Staff, U.S. Army Medical Command, agreed with our recommendations and addressed all the specifics of the recommendations. The Chief of Staff agreed to revise the business case analysis to incorporate the elements in the recommendation. The Chief of Staff expects to complete the revised business case analysis by June 30, 2017. In addition, the Chief of Staff agreed not to enter into any new leases until the business case analysis is re-performed. Therefore, the recommendations are resolved but remain open. We will close the recommendations once we receive and analyze the revised business case analysis to ensure it contains all elements of our recommendation, and verify that the U.S. Army Medical Command has not entered into any new leases to move Army laboratories. Please see the Recommendations Table on the next page for status of recommendations.

Recommendations Table

Management	Recommendations Unresolved	Recommendations Resolved	Recommendations Closed
Chief of Staff, U.S. Army Medical Command	None	1.a.1, 1.a.2, 1.a.3, 1.a.4, 1.a.5, 1.a.6, 1.b	None

Note: The following categories are used to describe agency management's comments to individual recommendations.

- **Unresolved** – Management has not agreed to implement the recommendation or has not proposed actions that will address the recommendation.
- **Resolved** – Management agreed to implement the recommendation or has proposed actions that will address the underlying finding that generated the recommendation.
- **Closed** – OIG verified that the agreed upon corrective actions were implemented.


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March 14, 2017

MEMORANDUM FOR AUDITOR GENERAL, DEPARTMENT OF THE ARMY
NAVAL INSPECTOR GENERAL

SUBJECT: Army Did Not Support Business Case Analysis Recommending Transition of Human Immunodeficiency Virus Testing (Report No. DODIG-2017-066)

We are providing this report for your information and use. We performed the audit in response to a request from the House Committee on Appropriations. See Appendix B for a copy of the audit request. Walter Reed Army Institute of Research personnel did not adequately support or document their business case analysis for bringing Human Immunodeficiency Virus (HIV) testing in-house. As a result, U.S. Army Medical Command personnel cannot ensure that they made the best decision transferring HIV testing from the contractor to the HIV Diagnostics and Reference Laboratory, and may increase costs by moving the laboratory and the other non-HIV mission elements into leased space. We conducted this audit in accordance with generally accepted government auditing standards.

We considered management comments on a draft of this report when preparing the final report. Comments from the Chief of Staff, U.S. Army Medical Command, addressed all the specifics of the recommendations and conformed to the requirements of DoD Instruction 7650.03.

We appreciate the courtesies extended to the staff. Please direct questions to me at (703) 604-9187 (DSN 664-9187).

Michael J. Roark
Assistant Inspector General
Contract Management and Payments

Contents

Introduction

Objective

We determined whether the Army supported its decision to transition Human Immunodeficiency Virus (HIV) testing from a contracted service to an in-house capability,[3] in accordance with DoD and Service guidance. We also reviewed the Navy's plans for HIV testing.

Background

On March 2, 2016, the House Committee on Appropriations requested that the DoD Office of Inspector General review the business case analysis (BCA) that the Army approved in May 2014 to support the decision to perform HIV testing in-house. In addition, House Report 114-577, to accompany House Report 5293, "Department of Defense Appropriations Bill, 2017," expressed concern with the decisions by the Departments of the Army and Navy to transition HIV testing from a contracted service to an in-house capability. The report directed the DoD Office of Inspector General to examine the business case analyses undertaken by the Army and Navy, and provide a report on its findings to the congressional defense committees.

DoD HIV Testing Requirement

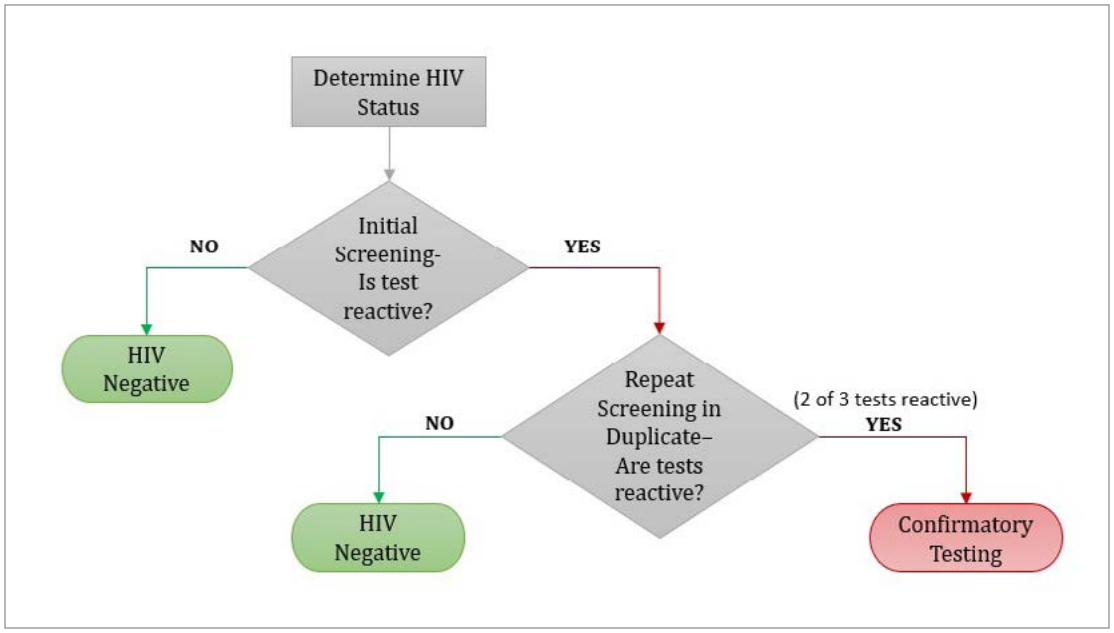
DoD Instruction 6485.01, "Human Immunodeficiency Virus (HIV) in Military Service Members," June 7, 2013, requires that all inductees into the Military Services be screened for HIV. Additionally, the Instruction requires that all service members be routinely screened every 2 years unless clinical symptoms indicate testing should be more frequent.

Performing HIV Tests

According to the Army and Navy HIV testing algorithms, when a patient is tested for HIV, an initial test is performed. If the initial screening test is nonreactive, the patient is determined as HIV negative. If the initial screening test is reactive (showing a response), the screening test is repeated two more times. If two of the three screening tests are reactive, a confirmatory test is performed to finalize a positive or negative result. Figure 1 illustrates the testing process to confirm a DoD member's HIV status.

[3] The Army considers in-house testing as HIV testing performed at the HIV Diagnostics and Reference Laboratory.

Figure 1. Testing Process to Confirm HIV Status



Source: DoD Testing Algorithm.

Army's HIV Research and Testing Program

The mission of U.S. Army Medical Command (MEDCOM) is to provide sustained health services and research in support of the Total Force to enable readiness and conserve the fighting strength while caring for the Soldier and their family. MEDCOM oversees the U.S. Army Medical Research and Materiel Command, which is responsible for medical research, development, and acquisition and medical logistics management. The Walter Reed Army Institute of Research (WRAIR), under the U.S. Army Medical Research and Material Command, conducts biomedical research that is responsive to the DoD and Army requirements.

According to an Army Report to Congress,[4] the Department of Laboratory Diagnostics and Monitoring within WRAIR was one of two departments authorized by Congress in 1986 to support the development, evaluation, and implementation of HIV diagnostic and monitoring technologies for the warfighter. The Army's HIV Diagnostics and Reference Laboratory (HDRL), at the WRAIR in Silver Spring, Maryland, was established within the Department of Laboratory Diagnostics and Monitoring, and has served as the DoD and Department of the Army's HIV Reference Laboratory since 1987. The Army performs HIV research and HIV testing at the HDRL.

[4] Department of the Army Report to Congress, Human Immunodeficiency Virus (HIV) Testing, 2016.

The Army administers its HIV testing program using a combination of in-house and contracted services, and according to WRAIR personnel, the Army performs approximately 1 million HIV tests per year.[5] A contracted laboratory in San Antonio, Texas, conducts the initial HIV screening tests of service members located in the continental United States at a cost of $10.4 million per year.[6] The HDRL conducts the initial HIV screening tests for U.S. Military Entrance Processing Command recruits and for service members located outside of the continental United States. The Army's HDRL conducts all Army confirmatory HIV testing.

According to an Army Report to Congress,[7] MEDCOM personnel considered conducting all HIV testing at the HDRL after September 2011 and would no longer use a contractor to perform the initial HIV screening test. However, the Army did not have the capacity to expand the laboratory space at the HDRL and planned to use leased space. Therefore, WRAIR personnel prepared a BCA to support transferring HIV testing from the current contractor, to testing in-house at the HDRL.

According to WRAIR personnel, the Army transitioned U.S. Military Entrance Processing Command's HIV testing, previously performed by the contractor, to the HDRL, in March 2016, increasing the HDRL's workload by approximately 300,000 tests per year. The contractor performed the rest of HIV testing for personnel in the continental United States. According to WRAIR personnel, the HDRL is over capacity because of physical space constraints, and the HDRL cannot conduct additional HIV testing without expanding the HDRL.

Navy HIV Testing

The Navy uses the same contractor as the Army for initial HIV screening tests. The contractor performs approximately 600,000 initial HIV tests per year. According to Navy personnel, if the results of the blood sample are reactive, the contractor sends the blood sample to the Army's HDRL for confirmatory testing.

Air Force HIV Testing

According to Air Force personnel, the Air Force performs approximately 350,000 HIV initial screening tests per year at the Air Force Public Health and Epidemiology Laboratory at Wright Patterson Air Force Base. Additionally, Air Force personnel stated that if the blood sample is reactive the Air Force sends it to the Army's HDRL for confirmatory testing.

[5] WRAIR personnel cited that they conducted approximately 58,000 HIV tests in 2015, and according to MEDCOM personnel, the contractor performed approximately 976,000 between March 2015 and February 2016.

[6] The $10.4 million cost for contractor-performed HIV testing from March 2015 through February 2016 included tests for both personnel in the continental United States and U.S. Military Entrance Processing Command recruits. According to WRAIR personnel, in March 2016, the HDRL assumed testing for U.S. Military Entrance Processing Command recruits.

[7] Department of the Army Report to Congress, Human Immunodeficiency Virus (HIV) Testing, 2016.

Business Case Analysis

According to the Army's Cost Benefit Analysis Guide (the CBA Guide), a BCA is a decision support tool that documents predicted effects of courses of action under consideration to solve a problem.[8] According to the CBA Guide, the BCA must be performed to support leadership decisions. The DoD's Product Support Business Case Analysis Guidebook, (the BCA Guidebook) states that the BCA is a structured methodology and document that aids decision-making by identifying and comparing alternatives and considers all benefits, including nonfinancial benefits.[9] The BCA provides an analytic, standardized, and objective foundation upon which credible decisions can be made and should be comprehensive, fair, and accurate for comparison and evaluation of the alternatives. The BCA should conclude with a recommendation to achieve organizational objectives and desired outcomes. According to the CBA Guide, it is important that the BCA preparer keep the document updated so that the decision maker can make a decision using the best available information.

WRAIR personnel prepared a BCA in May 2014 to support the decision to bring the portion of HIV testing performed by a contractor, in-house. According to WRAIR personnel, they updated the BCA, and MEDCOM personnel provided Congress with the updated BCA, dated February 2016. We reviewed the updated February 2016 BCA during the audit. According to Navy personnel, they did not prepare a BCA because they still plan to use a third party for the HIV testing.

Review of Internal Controls

DoD Instruction 5010.40 requires DoD organizations to implement a comprehensive system of internal controls that provides reasonable assurance that programs are operating as intended and to evaluate the effectiveness of the controls.[10] We identified an internal control weakness within the Army's development of the BCA. Specifically, WRAIR personnel did not adequately develop or support their BCA. We will provide a copy of the report to the senior official responsible for internal controls within MEDCOM.

[8] U.S. Army Cost Benefit Analysis Guide, 3rd Edition, April 24, 2013.

[9] DoD Product Support Business Case Analysis Guidebook, 2011.

[10] DoD Instruction 5010.40, "Managers' Internal Control Program Procedures," May 30, 2013.

Finding

Army BCA for HIV Testing Was Flawed and Lacked Support

WRAIR personnel did not adequately support or document their BCA for bringing HIV testing in-house. This occurred because WRAIR personnel did not follow DoD and Army guidance for preparing a BCA. Specifically they:

- developed the BCA around co-locating and moving the entire HDRL and other non-HIV testing elements to a leased facility. Specifically, WRAIR personnel included non-HIV testing elements in their analysis, which were not related to the problem statement;
- based the premise of the BCA on a research cooperative agreement that could not be used;
- did not consider three or more courses of action;
- did not consistently use total costs in their analysis; and
- used flawed selection criteria in the decision matrix analysis.

As a result, MEDCOM personnel cannot ensure that they made the best decision transferring HIV testing from the contractor to the HDRL, and may increase costs by moving the HDRL and the other non-HIV mission elements into leased space.

The Army BCA Analysis Was Not Consistent With Defined Scope and Problem Statement

WRAIR personnel developed the BCA around co-locating and moving the entire HDRL and other non-HIV testing elements to a leased facility. Specifically, WRAIR personnel included non-HIV testing elements in their analysis, which were not related to the problem statement. The Army's CBA Guide states that defining the scope of the analysis is critical because it keeps the BCA focused, and a well-scoped BCA should reinforce the problem statement.

The BCA cited that the Army planned to move 37,410 square feet of laboratory space to a leased facility, but documentation provided by WRAIR personnel did not adequately support the need for the 37,410 square footage estimate requested in the BCA. WRAIR personnel included in the BCA plans to move the Army's Leishmania Diagnostic Laboratory, and the U.S. Military HIV Research Program's

Biorepository, which are not related to HIV testing. Specifically, the Leishmania Diagnostic Laboratory specializes in the full spectrum of leishmaniasis[11] diagnostics, and the biorepository is part of the U.S. Military HIV Research Program but does not perform HIV screening tests. The Leishmania Diagnostic Laboratory and the U.S. Military HIV Research Program's Biorepository account for 13,680 square feet of the 37,410 square feet the WRAIR personnel requested in their BCA.

If MEDCOM personnel want to co-locate their laboratories and other elements outside of the HIV testing mission, they should include the non-HIV functions in the BCA scope. Additionally, if MEDCOM personnel determine the focus of the BCA should be only HIV testing as the scope states, the BCA analysis should include only the HIV testing mission, instead of including HIV research and other elements. Therefore, MEDCOM should re-perform the BCA and ensure the analysis includes only scope cited in the problem statement.

If MEDCOM personnel want to co-locate their laboratories and other elements outside of the HIV testing mission, they should include the non-HIV functions in the BCA scope.

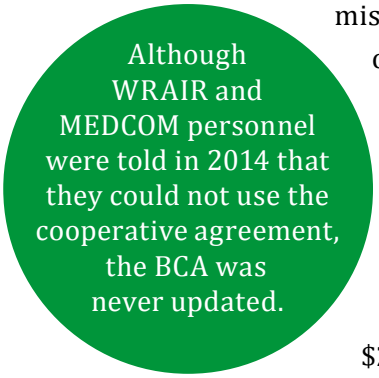
BCA Was Based on a Research Cooperative Agreement That Could Not Be Used

WRAIR personnel based the premise of the BCA on a research cooperative agreement that could not be used. The Army's CBA Guide states that it is important for the preparer to keep the BCA updated so that the decision maker can make the best decision. Furthermore, the CBA Guide states that cost estimates should be accurate, and updated to reflect changes in technical or program assumptions.

Section 178, title 10, United States Code, established the Foundation for the Advancement of Military Medicine, a private, not-for-profit corporation. The Foundation's core functions are to support research and education at the Uniformed Services University of the Health Sciences and throughout the military medical community and to serve as a link between military researchers and the private medical sector. In September 2011, the Army awarded a research cooperative agreement to the Henry Jackson Foundation, valued at $817 million, to conduct a program of basic and applied infectious disease research and associated care and treatment of HIV.

[11] Leishmania is a vector-borne disease transmitted by sand flies.

WRAIR personnel included in the BCA a lease cost of $20 per square foot and $970,000 in renovation costs that were based on the research cooperative agreement. In July 2014, U.S. Army Medical Research and Materiel Command personnel informed WRAIR and MEDCOM personnel that they could not use the research cooperative agreement to execute the HIV testing mission. Additionally, MEDCOM personnel received a legal opinion from General Counsels at the U.S. Army Medical Research and Materiel Command and MEDCOM that supported that the Army could not use the research cooperative agreement to conduct HIV testing. Although WRAIR and MEDCOM personnel were told in 2014 that they could not use the cooperative agreement, the BCA was never updated and still reflected costs of $20 per square foot to lease laboratory and administrative space. However, costs for leased space in the Maryland to Washington, D.C., area could range from $35 to $45 per square foot, based on General Services Administration leases sought by other Federal entities. If WRAIR used these lease costs, it could almost double the costs cited in the BCA.



In addition, WRAIR personnel included renovation costs of $970,000 in the BCA associated with laboratory space that the Henry Jackson Foundation planned to lease on behalf of the Army under the cooperative agreement. However, the Army cannot use the location, and renovation costs may be more expensive. Additionally, Defense Health Agency personnel stated that if renovation costs fall between $1 million and $3 million, the Army must use military construction funds, and those funds require approval from the Assistant Secretary of Defense for Health Affairs and from Congress. MEDCOM should re-perform the BCA and ensure the analysis uses accurate assumptions and current information and costs.

Army Did Not Consider Three or More Courses of Action

WRAIR personnel did not consider three or more courses of action in the BCA. Specifically, WRAIR personnel only considered two alternatives, the status quo (testing performed by a contractor) and bringing the HIV testing mission in-house to the Army, while other alternatives could have been considered.

According to the Army's CBA Guide, a BCA ideally should consider three or more alternatives. Furthermore, the CBA Guide states that the reasons for eliminating potential alternatives should be included in documentation supporting the BCA. Additionally, the DoD's BCA Guidebook states the BCA team should document the process used to determine which alternatives would be analyzed and considered in

the BCA. Finally, according to a 2011 inter-service support agreement, it is in the best interest of the Defense Health Program and the individual Services that they evaluate available clinical laboratory resources to reduce duplication of capabilities and capture efficiencies both within and between the Services.

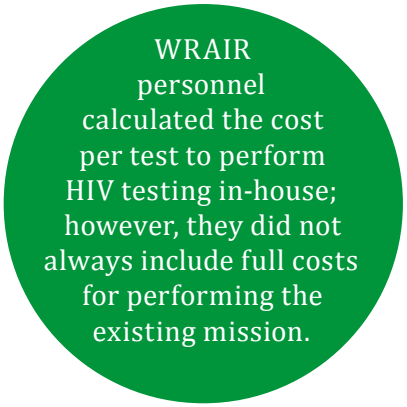
WRAIR personnel did not present other alternatives in the BCA for bringing the testing in-house, such as using another DoD laboratory, using another Service for testing, or renovating the existing HDRL. WRAIR personnel stated that they did not analyze additional alternatives in the BCA because they were directed by MEDCOM personnel to include only the "status quo," the contractor providing HIV testing, and bringing the testing in-house. Additionally, WRAIR personnel stated that they did not provide alternatives to renovate their existing laboratory to expand capacity or look for alternate Federal or DoD laboratory sites within the National Capital Region because leasing space would be the quickest alternative to implement and provide flexibility if the Army was to take on the entire DoD testing mission.

MEDCOM personnel cannot ensure that they selected the best HIV testing option if they did not consider all viable options for HIV testing and did not document the decisions to remove options from consideration. MEDCOM should re-perform the BCA and ensure the analysis includes three or more courses of actions and alternatives.

Costs Were Applied Inconsistently

WRAIR personnel were not consistent when they cited costs in the BCA analysis. According to the Army's CBA Guide, the cost estimate should capture the total cost of each alternative over its entire life cycle, and the estimate should be a summation of all relevant cost elements. Additionally, the CBA Guide states that when developing a cost estimate, much of an analyst's time will be spent obtaining data and it is important to capture all of the costs related to the initiative for which the BCA is being developed to ensure the cost estimate is well documented, comprehensive, accurate, and credible.

WRAIR personnel calculated the cost per test to perform HIV testing in-house; however, they did not always include full costs for performing the existing mission and sometimes included only the increased operating costs, or incremental costs, to perform the additional testing. For example, WRAIR personnel presented incremental labor costs in the BCA as $836,406 for 2016 that included only the additional personnel



required to bring the HIV testing mission in-house. However, when WRAIR personnel calculated blood draw material costs for collection tubes and packaging materials for the performance of 1 million HIV tests, they calculated costs for the full mission. Additionally, WRAIR personnel stated that the costs discussed in the BCA for additional laboratory personnel to perform the in-house HIV test mission were supported by a sole-source contract awarded in 2015. However, this contract provided only a total monetary amount of $770,498, citing a quantity of one job, with no breakdown of costs for the specific jobs included in the BCA necessary for performing in-house HIV testing.

Additionally, the BCA did not include full costs for decappers, which are laboratory equipment that manage sample tubes and automate the inspection, identification, decapping, validation, and recapping of test tube samples. The BCA cited that six new decappers, costing $261,258 per year, were required to handle HIV testing if the mission was brought in-house. However, the Army already leased four decappers through a contract at an annual cost of $228,883, which was not included in the costs cited in the BCA. WRAIR personnel should have included full costs for the four decappers already in use and the additional six cited in the BCA. Additionally, the costing support provided by WRAIR personnel did not agree with the costs for the decappers cited in the BCA. Figure 2 shows blood specimen samples at the HDRL, as they are decapped before testing.

Figure 2. Decapping Blood Samples at the HDRL
Source: DoD OIG.

For WRAIR personnel to determine the price per test for in-house HIV testing to compare to the contractor's price, MEDCOM personnel should use full costs when citing the cost of an element in the HIV testing process. MEDCOM could not ensure that the costs cited in the BCA captured the full cost of performing the entire in-house HIV test mission. MEDCOM should re-perform the BCA and ensure the analysis consistently uses total costs associated with the project and costs are adequately documented and supported.

Decision Matrix Analysis Used Flawed Alternative Selection Criteria

WRAIR personnel used flawed alternative selection criteria when evaluating alternatives in the decision matrix. For example, WRAIR personnel included "performance" in the selection criteria, but WRAIR personnel did not define "performance" as a factor in the problem statement and did not apply rankings consistently.

According to the Army's CBA Guide, a decision matrix is a tool for comparing and prioritizing a list of alternatives, including quantitative and non-quantitative costs and benefits. Furthermore, the CBA Guide states that the BCA must contain documentation that defines decision criteria and their impact in making the recommendation of the preferred alternative. Finally, the DoD's BCA Guidebook states that the BCA team will establish evaluation criteria and that the BCA problem statement, requirements, and desired outcomes should drive the evaluation criteria. Table 1 shows the comparison of alternatives and selection criteria WRAIR personnel presented in the BCA.

~~(FOUO)~~ Table 1. Alternative Comparison Decision Matrix Presented in the BCA

~~(FOUO)~~		Status Quo: Contract Out Initial HIV Screening			Alternative: HDRL Execution of HIV Screening at Common New Lab Space		
Selection Criteria	Criteria Weight	Data/Rating	Rank	Score	Data/Rating	Rank	Score
Force Readiness	25%	Average	1	0.25	Excellent	3	0.75
Performance	20%	Unknown	2	0.40	Excellent	3	0.60
Flexibility/ Scalability	15%	Poor	1	0.15	Excellent	3	0.45
Cost	15%	$28M (5 years): [redacted]	3	0.45	$30.8M (5 years): [redacted]	3	0.45
Schedule	15%	18 hours for initial screen	3	0.45	18 hours for initial screen	3	0.45

~~(FOUO)~~

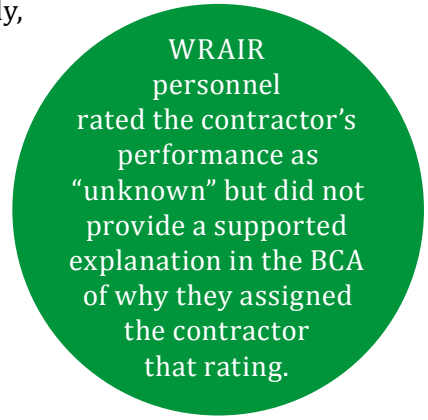
~~(FOUO)~~ Table 1. Alternative Comparison Decision Matrix Presented in the BCA (cont'd)

~~(FOUO)~~		Status Quo: Contract Out Initial HIV Screening			Alternative: HDRL Execution of HIV Screening at Common New Lab Space		
Selection Criteria	Criteria Weight	Data/Rating	Rank	Score	Data/Rating	Rank	Score
Subject Matter Expertise	5%	Unknown	2	0.10	Excellent	3	0.15
Risk	5%	Average	2	0.10	Average/Low	2	0.10
Total	**100%**			**1.90**			**2.95**

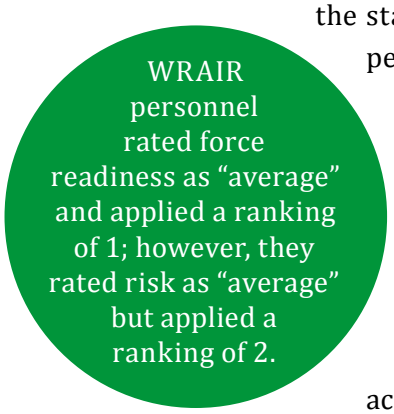
~~(FOUO)~~

Source: U.S. Army HIV Force Test Business Case Analysis, February 5, 2016.

WRAIR personnel cited "performance" as the second-highest weighted selection criteria in the BCA; however, WRAIR personnel did not document or define, in the problem statement, this selection criteria as one of the factors for wanting to transfer HIV testing in-house. Additionally, WRAIR personnel rated the contractor's performance as "unknown" but did not provide a supported explanation in the BCA of why they assigned the contractor that rating. However, in the annual contractor performance assessment reports, MEDCOM personnel stated the contractor met contractual requirements successfully, relative to their performance requirements, and rated the contractor at satisfactory or very good.



WRAIR personnel also did not consistently apply the appropriate rank to their ratings in the BCA decision matrix. For example, for the status quo, or work completed by the contractor, WRAIR personnel rated force readiness as "average" and applied a ranking of 1; however, they rated risk as "average" but applied a ranking of 2. If both ratings were considered "average," the rankings should have been consistent or as defined in the DoD's BCA Guidebook, personnel should have defined why they ranked one alternative higher than the other. As a result, the total calculations for the alternatives were not accurate. The total calculations from the decision matrix of each alternative should be used in recommending the preferred solution. MEDCOM should re-perform the BCA and ensure the analysis uses well-defined and measurable alternative selection criteria, and is adequately documented and supported.



MEDCOM Should Not Sign a Lease Until a New BCA is Complete

In April 2016, MEDCOM personnel forwarded a lease package through Installation Management Command to pursue leased space to accommodate the HDRL and other laboratories at the WRAIR. According to MEDCOM personnel, as of December 2016, the lease package was forwarded through Washington Headquarters Services to the General Services Administration. MEDCOM personnel should not enter into any leases to move Army laboratories until the BCA is re-performed.

Conclusion

WRAIR personnel did not adequately support or document their decision to bring HIV testing in-house because they did not follow DoD and Service guidance. Therefore, MEDCOM personnel cannot ensure that they made the best decision transferring HIV testing from the contractor to the HDRL and may increase costs by moving the HDRL and other non-HIV mission elements into leased space.

Other Matters of Interest on Navy Plans to Transfer HIV Testing

We determined plans to transfer Navy HIV testing from a contractor to the Air Force appeared reasonable because using the Air Force for HIV testing instead of the Navy's current contractor could save the Navy approximately $3.58 million per year.[12]

Using the Air Force for HIV testing instead of the Navy's current contractor could save the Navy approximately $3.58 million per year.

~~(FOUO)~~ The Navy did not prepare a BCA because it does not plan to expand its mission or resources, but instead plans to transfer the HIV initial screening tests performed by a contractor to the Air Force. The Air Force conducts all HIV initial screening tests at the U.S. Air Force School of Aerospace Medicine on Wright-Patterson Air Force Base, Ohio. Air Force personnel stated on November 14, 2016, that a simulation modeled after the Air Force laboratory demonstrated that the laboratory could accommodate the current Navy HIV testing workload, and Air Force personnel stated that they would charge the Navy [redacted]. The Navy plans to transfer approximately 600,000 tests from the contractor to the Air Force, which should result in a cost savings of approximately $3.58 million per year.

[12] We calculated the $3.58 million in yearly savings by multiplying the number of planned tests by the difference in the cost per test charged by the contractor and the proposed cost per test charged by the Air Force.

Navy HIV Systems

The Navy uses the HIV Management System to track service members identified with HIV infection. According to a Navy Report to Congress,[13] the primary technical challenge of using the Air Force laboratory is electronic connectivity with the HIV Management System. The Navy and Defense Health Agency Health Information Technology group are developing a solution to resolve the challenge. According to Navy personnel, the solution is in the design phase but they were unable to provide an estimated completion date.

Path Forward for Navy HIV Testing

~~(FOUO)~~ To fulfill the Navy's HIV testing requirement while it develops and implements the system solution, the Navy awarded a $36.1 million contract, a base and four option years that began in January 2017, for HIV testing with the same contractor the Army is using. The contract charges the Navy approximately [redacted], for a maximum of 650,000 initial screening tests.

Management Actions Taken

We discussed the preliminary findings with the Chief of Staff, MEDCOM, on October 6, 2016, to enable MEDCOM officials to take action. The Chief of Staff agreed that there were problems with the BCA prepared by MEDCOM and agreed to re-perform a BCA on the project. He also agreed not to commit funds on the lease package until MEDCOM re-performs the BCA.

Since the meeting in October 2016, MEDCOM personnel have begun to revise the BCA. Specifically, according to MEDCOM personnel, they have developed a template and are re-defining the problem statement, reviewing courses of action, and considering related costs.

[13] "Report to Congress on Human Immunodeficiency Virus Testing: Transition Plans for the Department of the Navy Contracted Commercial Versus Department of Defense Facility Laboratory Testing," December 2015.

Recommendations, Management Comments, and Our Response

Recommendation 1

We recommend that the Chief of Staff, U.S. Army Medical Command:

a. Re-perform the business case analysis for HIV testing and ensure the analysis:

1. **includes only scope cited in the problem statement;**
2. **uses accurate assumptions and current information and costs;**
3. **includes three or more courses of actions and alternatives;**
4. **consistently uses total costs associated with the project;**
5. **uses well-defined and measurable alternative selection criteria; and**
6. **is adequately documented and supported.**

U.S. Army Medical Command Comments

The Chief of Staff, MEDCOM, agreed, stating that MEDCOM personnel initiated a new BCA to incorporate the elements in the recommendation. Specifically, the Chief of Staff stated that MEDCOM personnel are refining the problem statement to only address the Army's HIV Force testing requirements. Additionally, the Chief of Staff stated that personnel will update and validate costs related to the testing mission, and will develop the BCA to meet current requirements in Army and MEDCOM guidance. Furthermore, the Chief of Staff stated that the new BCA will be coordinated to ensure it includes the most accurate and up-to-date information in the cost analysis, and will include at least three courses of action. The estimated completion date for the revised BCA is June 30, 2017.

Our Response

Comments from the Chief of Staff addressed the specifics of the recommendation; therefore, this recommendation is resolved. We will close this recommendation once we receive and analyze the revised BCA and verify that it addresses all of the elements of the recommendation.

b. Not enter into any leases to move Army laboratories until the business case analysis is re-performed.

U.S. Army Medical Command Comments

The Chief of Staff, MEDCOM, agreed, stating that MEDCOM will not enter into any leases to move the HDRL and other WRAIR laboratories until the BCA is re-performed. The target completion date for the revised BCA is June 30, 2017.

Our Response

Comments from the Chief of Staff addressed the specifics of the recommendation; therefore, the recommendation is resolved. We will close this recommendation once we receive the revised BCA and verify that MEDCOM did not enter any leases to the move the HDRL.

Appendix A

Scope and Methodology

We conducted this performance audit from May 2016 to January 2017 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

We interviewed personnel from the following organizations to determine the Services' current HIV testing processes and plans for future HIV testing.

- Defense Health Agency
- Office of the Surgeon General, U.S. Army Medical Command
- U.S. Army Medical Research Acquisition Activity
- U.S. Army Medical Research and Materiel Command
- Walter Reed Army Institute of Research
- Navy Bloodborne Infection Management Center
- U.S. Air Force School of Aerospace Medicine, Public Health and Preventive Medicine Department, Public Health and Epidemiology Laboratory

To determine whether the Army met requirements for development of a BCA we reviewed the following guidance.

- DoD Product Support Business Case Analysis Guidebook, 2011
- U.S. Army Cost Benefit Analysis Guide, 3rd Edition, updated as of April 24, 2013

To determine the Services' HIV test program requirements and processes we reviewed the following guidance.

- DoD Instruction 6485.01, "Human Immunodeficiency Virus (HIV) in Military Service Members," June 7, 2013
- Assistant Secretary of Defense (Health Affairs) Policy Memorandum: 04-007, "Human Immunodeficiency Virus Interval Testing," March 29, 2004
- Army Regulation 600-110, "Identification, Surveillance, and Administration of Personnel Infected with Human Immunodeficiency Virus," April 22, 2014

- Department of the Navy, Office of the Secretary, SECNAVINST 5300.30E, "Management of Human Immunodeficiency Virus, Hepatitis B and Hepatitis C Virus Infection in the Navy and Marine Corps," August 13, 2012
- Air Force Instruction 44-178, "Human Immunodeficiency Virus Program," March 4, 2014, certified current November 30, 2015

We reviewed the contracts that provide requirements the contractor must meet when performing HIV testing for the Services. We also reviewed contracts over the procurement of supplies and services over U.S. Military Entrance Processing Command's HIV testing process. Additionally, we reviewed reports submitted to Congress about the Army and Navy's HIV testing programs and plans, cost estimates for bringing HIV testing into the HDRL, HIV test algorithms, HIV test program briefings to command, contractor quarterly site visit reports, the contractor's annual performance evaluation, the BCAs, and the Army's lease and stationing packet.

Use of Computer-Processed Data

We did not use computer-processed data to perform this audit.

Prior Coverage

No prior coverage has been conducted on Military Service HIV testing programs during the last 5 years.

Appendix B

House Committee on Appropriations Audit Request

KEN CALVERT
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ENERGY AND WATER DEVELOPMENT

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March 2, 2016

[redacted]
Inspector General
U.S. Department of Defense
4800 Mark Center Drive
Alexandria, VA 22350

Inspector General Rymer:

It has been brought to my attention that the Army's HIV Diagnostics and Reference Laboratory (HDRL) plans to conduct all HIV testing in-house. I am concerned that the decision has disregarded projected increased costs and does not take into account current efficiencies, which could result in more errors in testing for military personnel.

HDRL's initial plan was to transfer all HIV testing in-house by March 2015 based upon a Business Case Analysis (BCA) approved by the Office of the Surgeon General (Army) in May 2014. Since the assumptions and conclusions in the BCA are the basis of the decision, I have requested a copy of the BCA to review. Unfortunately, I have been told that the details of the BCA cannot be shared as they contain Source Selection information which is protected by the Procurement Integrity Act FAR 3.104.

Since I am unable to view the BCA, I would request that you and your staff conduct an analysis to ensure that the correct course of action has been chosen. I would ask that you pay particular attention to the BCA's assumptions regarding facilities and personnel requirements and the associated costs. I also request that you evaluate whether any consideration was given to the considerable administrative and management challenge and associated costs of dramatically expanding HDRL's in-house testing.

In addition, the Army was left without an in-house capability to assume testing at the conclusion of the existing HIV testing contract because they were unable to meet the March 2015 deadline. As a result, the Army issued a last-minute sole source contract to continue testing. Due to the hurried nature of this contract, it resulted in significantly higher costs given the contractor's short depreciation timeline dictated by a potentially immediate transition to HDRL in-house testing. As a result of the new contract, a new BCA was issued that used the higher costs from the new sole source contract to justify transferring HIV testing in-house. I

House Committee on Appropriations Audit Request (cont'd)

would appreciate your attention to ensure that cost comparisons were not based on the higher costs associated with a last-minute contract.

Again, I would appreciate your full attention to this matter and respectfully request a report on whether the assumptions made in the original Business Case Analysis truly justify the transfer of HIV testing in-house. If you have any questions, please do not hesitate to call me at [redacted] or have your staff contact my Legislative Director [redacted].

Sincerely,

KEN CALVERT
Member of Congress

Management Comments

U.S. Army Medical Command

DEPARTMENT OF THE ARMY
HEADQUARTERS, UNITED STATES ARMY MEDICAL COMMAND
2748 WORTH ROAD
JBSA FORT SAM HOUSTON, TEXAS 78234-6000

REPLY TO ATTENTION OF

MCIR

23 FEB 2017

MEMORANDUM FOR Department of Defense Inspector General, Contract Management and Payments, ATTN: [redacted] 4800 Mark Center Drive, Alexandria, VA 22350-1500

SUBJECT: Reply to Draft Report Army Did Not Support Business Case Analysis Recommending Transition of Human Immunodeficiency Virus Testing (Project Code D2016-D000CJ-0159.000)

1. Thank you for the opportunity to review the draft report. Enclosed are the US Army Medical Command's comments regarding the subject draft report.

2. Our point of contact is [redacted].

FOR THE COMMANDER:

ROBERT L. GOODMAN
Chief of Staff

Encl

U.S. Army Medical Command (cont'd)

U.S. Army Medical Command (MEDCOM) and
Office of the Surgeon General (OTSG)

Comments on DODIG Draft Report
Army Did Not Support Business Case Analysis Recommending Transition of Human Immunodeficiency Virus Testing
(Project No. D2016-D000CJ-0159.000)

RECOMMENDATION 1: DODIG recommends the Chief of Staff, US Army Medical Command:

a. Re-perform the business case analysis for HIV testing and ensure the analysis:
   1. Includes only scope cited in the problem statement.
   2. Uses accurate assumptions and current information and costs.
   3. Includes three or more courses of actions and alternatives.
   4. Consistently uses total costs associated with the project.
   5. Uses well-defined and measurable alternative selection criteria.
   6. Is adequately documented and supported.

b. Not enter into any leases to move Army laboratories until the business case analysis is re-performed.

RESPONSE: Concur. US Army Medical Command (MEDCOM) has initiated a new business case analysis (BCA) for HIV testing and will incorporate the elements referenced in recommendations 1a.

Specifically, MEDCOM personnel are currently refining the problem statement to only address the Army's HIV Force Testing requirements, and the new BCA will be limited in scope to strictly those mission requirements. In addition, personnel are reviewing cost information and estimates to separate the HIV Diagnostics and Reference Laboratory HIV Force Testing mission from research mission requirements. Costs related to the HIV Force Testing mission will be updated and validated. The new BCA will be based upon current requirements, objectives and costs and developed in accordance with current Army and MEDCOM guidance.

As of November 2015 information regarding existing external General Services Administration inventory for Region 11 of the Washington, D.C. and Maryland area show current lease costs in Maryland averaged about $27 a square foot. Facility lease and renovation cost estimates in the new BCA will be coordinated to ensure the most accurate and up-to-date information is used in the cost analysis.

Encl

U.S. Army Medical Command (cont'd)

The U.S. Army Cost Benefit Analysis Guide, 3rd Edition, updated April 24, 2013 includes no explicit requirements for the use of three or more courses of action. Consistent with DODIG's report, the Guide states, "*Ideally, a CBA should consider three or more COAs (one of which may be the Status Quo).*" However, to ensure the best HIV testing option is selected, the new BCA will include at least three courses of action.

Finally, in accordance with recommendation 1b, MEDCOM will not enter into any leases to move the HIV Diagnostics and Reference Laboratory and other WRAIR laboratories until the BCA is re-performed.

The anticipated completion date for the new BCA is 30 June 2017.

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Acronyms and Abbreviations

BCA	Business Case Analysis
CBA	Cost Benefit Analysis
HIV	Human Immunodeficiency Virus
HDRL	HIV Diagnostics and Reference Laboratory
MEDCOM	U.S. Army Medical Command
WRAIR	Walter Reed Army Institute of Research


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