



*Office of the Deputy Under Secretary of Defense*

# ***Installations***

**BRAC Knowledge Base**

**BRAC 1995**

**Joint Cross-Service Group For  
Medical Treatment Facilities and  
Graduate Medical Education**

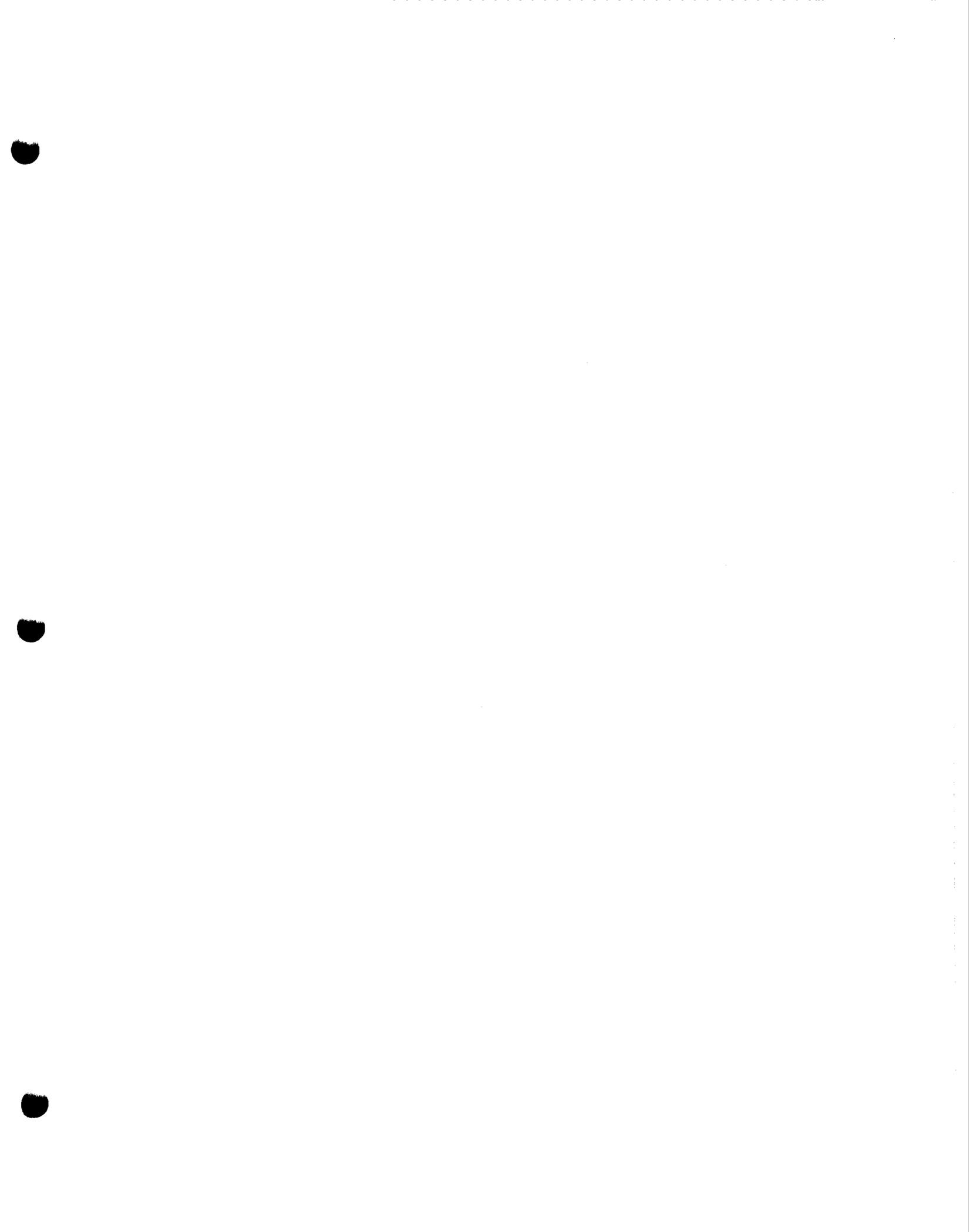
**Meeting Minutes**

**Volume I of III  
January to February 1994**

**BRAC Knowledge Base  
Room 3E1069, The Pentagon  
Point of Contact: Mike McAndrew (703) 614-5356**

**BRAC Knowledge Base No. MP951**





CLOSE HOLD

MINUTES OF THE  
MILITARY TREATMENT FACILITIES  
AND GRADUATE MEDICAL EDUCATION  
BRAC 95 JOINT CROSS SERVICE GROUP  
MEETING OF JANUARY 25, 1994

The first meeting of the Military Treatment Facilities and Graduate Medical Education (MTF/GME) BRAC 95 Joint Cross Service Group convened at 1515 hrs on January 25, 1994. The meeting was chaired by Dr. Edward D. Martin, Acting Assistant Secretary of Defense, Health Affairs.

The meeting began with each of the members introducing themselves to the group.

The Chairman then began an overview of BRAC 95 guidance, stressing that the guidance establishes an aggregate goal of a 15% reduction in Plant Replacement Value for the BRAC 95 round of closures and realignments. The Chairman also discussed the Department's lack of success in dealing with cross-Service issues in prior years. The Chairman did state, however, that the task of this group should be less troublesome since health care data was centrally available. Some concerns were expressed about potential reductions in health care manning levels. This generated a restatement of the objectives of the BRAC process; matching infrastructure to declining force structure. Notwithstanding the previously stated 15 % goal, the BRAC process does not bring with it specific reduction targets in facilities or personnel strength by committee or group.

Mr. Trevor Neve, Logistics Management Institute (LMI), gave a presentation on the "BRAC 95 Process for Joint Groups". LMI, a Federally Funded Research and Development Center available to support the Joint Cross Service Groups, has been involved in the three previous rounds of base closures and is familiar with both the BRAC process and analytical requirements.

The next items on the agenda were the proposed action plan and milestones for the development of policy guidance, assumptions, internal control plan, data collection and analysis, consideration of alternatives and submission of the final recommendations. These were reviewed by the group. The action plan and milestones, along with any emerging issues, were to be presented to the BRAC 95 Review Group on January 26, 1994.

At this point the group spent some time discussing where we were and where we wanted to go. The group also discussed how ongoing initiatives (potential closure of the USUHS, "733" study, GME study and the President's health care program) would impact or be impacted by the BRAC process.

CLOSE HOLD

**CLOSE HOLD**

The final item of the meeting was the distribution of the draft Military Health Services System Hospital Screening Criteria proposed for use in evaluating medical treatment facilities during the BRAC process. The group members were asked to review the draft criteria and be prepared to discuss them at the next meeting.

The meeting adjourned at 1645 hrs.

Approved Edward D. Martin  
Edward D. Martin, MD  
Acting ASD (HA)

Attachments

**CLOSE HOLD**

BRAC 95  
JOINT CROSS SERVICE GROUP  
FOR MILITARY TREATMENT FACILITIES AND  
GRADUATE MEDICAL EDUCATION

*JAN 25 Feb 3, 1994 Meeting*

<u>SERVICE/AGENCY</u>	<u>NAME</u>	<u>PHONE#</u>
CHAIR (AASD(HA))	Dr. Martin	703-697-2114
ASD(HA) (Designate)	Dr. Joseph	703-697-2144
TEAM LEADER	RADM Koenig	703-697-8973
ARMY	BG Zajtchuk	703-756-5680
NAVY	CAPT Golembieski	703-681-0461
NAVY	CDR Dilorenzo	703-681-0452
AIR FORCE	BG Hoffman	202-767-1894
JCS	COL Moore	703-697-4346
OASD (P&R)	Ms. St. Clair	703-696-8710
COMPT	Ms. Danko	703-697-9198
PA&E	Mr. Dickens	703-697-8050
ODASD (BRAC/ES)	Mr. Miglionico	703-697-8050
DOD IG	Mr. Hendricks	703-692-3414
DOD IG	Mr. Tomlin	804-766-3816
ODASD (HA)	Mr. Maddy	703-697-8979
ODASD (HA)	Dr. Mazzuchi	703-695-7116

## OTHER ATTENDEES

<u>SERVICE/AGENCY</u>	<u>NAME</u>	<u>PHONE #</u>
OASD (HA)	Ms. Watson	703-697-8973
OASD (HA)	Ms. Giese	703-614-4705
OASD (HA)	Col Garner	703-614-4705
OASD (HA)	CDR Bally	703-614-4705
OASD (HA)	LTC Ponatoski	703-614-4705
ARMY	COL Barton	703-756-8319
ARMY	COL Wilcox	703-756-5681
ARMY	LTC Powell	703-697-3877
ARMY	LTC McGaha	703-697-6388
ARMY	MAJ Dudevoir	703-756-0286
ARMY	MAJ Parker	703-756-8036
NAVY	CAPT Buzzell	703-681-0475
NAVY	Ms. Davis	703-602-2252
AIR FORCE	LtCol Silvernail	202-767-5550
AIR FORCE	Maj Costa	202-767-5066
AIR FORCE	Maj Pantaleo	202-767-5046
LMI	Mr. Neve	301-320-7287
LMI	Ms. Dahut	301-320-7408

**AGENDA**  
**JANUARY 25, 1994**

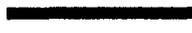
**BRAC 95 JOINT CROSS SERVICE GROUP  
FOR MILITARY TREATMENT FACILITIES AND  
GRADUATE MEDICAL EDUCATION**

- Introduction of Members Dr. Martin
- Overview of BRAC 95 DoD Guidance Dr. Martin
- Presentation by Logistics Management Institute Mr. Moore
  - History of BRAC
  - Overview of the Analytical Process
- Review of Draft Action Plan & Milestones Dr. Martin
- Hospital Screening Criteria RADM Koenig
- Air Force Screening Criteria BG Hoffman
- Administrative Issues Dr. Martin
  - Minutes (ODASD (ER) Mr. Miglianico
  - Meeting Frequency
- Adjournment

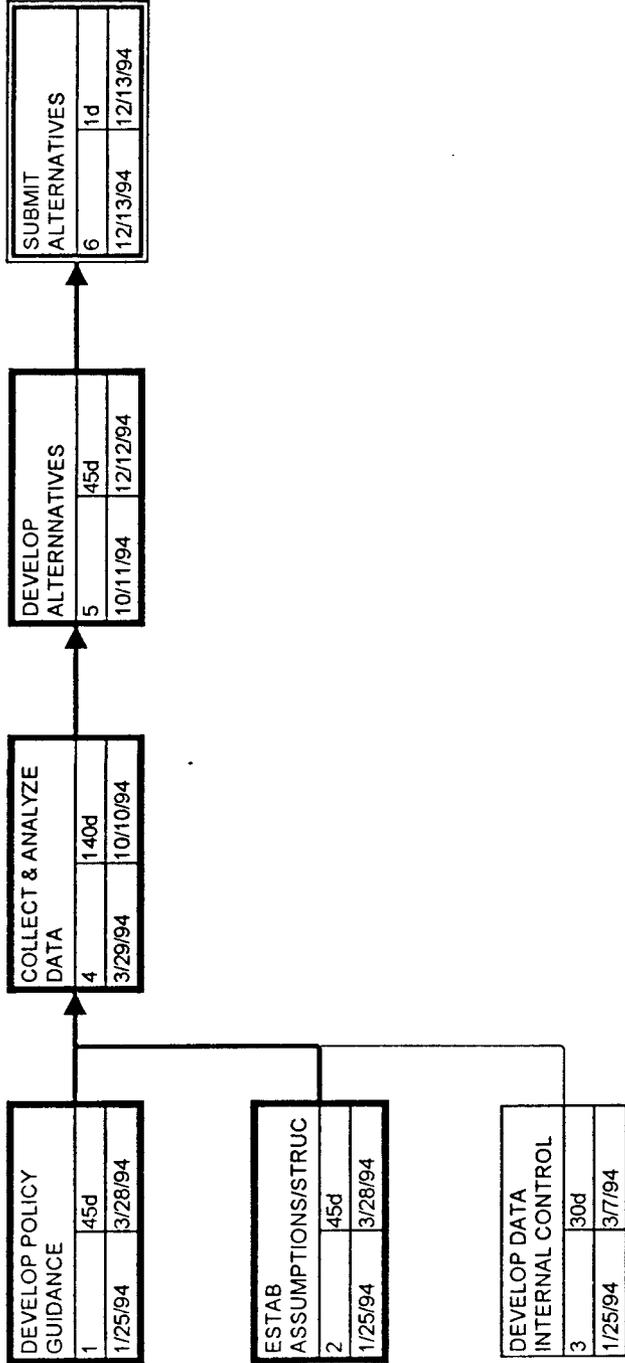
**BRAC 95 JOINT CROSS SERVICES  
GROUP FOR MTFs AND GME  
ACTION PLAN AND MILESTONES**

ID	Name	Qtr 1, 1994			Qtr 2, 1994			Qtr 3, 1994			Qtr 4, 1994			Qtr 1, 1995			Qtr 2, 1995			Qtr 3, 1995			Qtr 4, 1995
		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct
1	DEVELOP POLICY GUIDANCE		■	■																			
2	ESTAB ASSUMPTIONS/STRUCTURE/METHO		■	■																			
3	DEVELOP DATA INTERNAL CONTROL PLAN		■																				
4	COLLECT & ANALYZE DATA				■	■	■	■	■	■	■	■											
5	DEVELOP ALTERNNATIVES											■	■										
6	SUBMIT ALTERNATIVES																						◆

Project: BRAC 95 MED CROSS SER  
Date: 1/25/94

Critical  Progress  Summary   
 Noncritical  Milestone  Rolled Up 

BRAC 95 JOINT CROSS SERVICES GROUP  
PERT CHART



Project: BRAC 95 MED CROSS SER  
Date: 1/25/94

Name	
ID	Duration
Scheduled Start	Scheduled Finish

Subproject  
 Milestone  
 Critical  
 Noncritical  
 Summary  
 Marked

# BRAC 95



**Briefing for DoD BRAC Principals**

**November 30, 1993**

# **FY 95-99 Defense Guidance**

**Program to reduce base structure capacity commensurate with planned force and funded workload reductions. Base closures to date have reduced capacity by roughly 15 percent, while overall force reductions will exceed 30 percent. Components should prepare to use the BRAC 95 process to meet an additional 15 percent reduction to reach an overall goal of at least 30 percent.**

## **Logic Behind Guidance**

- ✧ **Military personnel stationed in the United States will decline by 30% from 1980's peak and the budget is down over 40%. Workload will decline accordingly**
- ✧ **BRAC's 88, 91 and 93 will reduce domestic base structure by 15% (measured by plant replacement value)**
- ✧ **BRAC 95 (the last round) should bring total domestic base structure reductions to about 30%, matching military personnel in U.S. reductions**

## **PDM Language**

### **Analyze BRAC 95 Process Options**

- **Develop alternative BRAC procedures to review and reduce base capacity**
  - ⊗ **Retain in only one Service militarily unique capability used by 2 or more Services**
  - ⊗ **Consolidate workload across Services to reduce capacity**
  - ⊗ **Assign operational units from more than one Service to a base**
- **Plan due to DepSecDef -- November 30, 1993**
- **DepSecDef BRAC 95 kick-off memo -- December 15, 1993**

# **PDM Language**

## **Analyze BRAC 95 Process Options**

- **Discuss and recommend**
  - ✧ **Process for establishing guidelines and standards for cross-service analysis**
  - ✧ **Functional areas (e.g. logistics facilities, hospitals, etc.) with cross-service opportunities for closure and realignment**
  - ✧ **Leadership and participation on cross-service functional area analyses**
  - ✧ **Who makes closure and realignment recommendations to SecDef for cross-service functional areas**
  - ✧ **Schedule for BRAC 95 process with emphasis on milestones for cross-service analyses**

# BRAC 93 Selection Criteria

In selecting military installations for closure or realignment, the Department of Defense, giving priority consideration to military value (the first four criteria below), will consider:

## *Military Value*

1. The current and future mission requirements and the impact on operational readiness of the Department of Defense's total force.
2. The availability and condition of land, facilities and associated airspace at both the existing and potential receiving locations.
3. The ability to accommodate contingency, mobilization, and future total force requirements at both the existing and potential receiving locations.
4. The cost and manpower implications.

## *Return on Investment*

5. The extent and timing of potential costs and savings, including the number of years, beginning with the date of completion of the closure or realignment, for the savings to exceed the costs.

## *Impacts*

6. The economic impact on communities.
7. The ability of both the existing and potential receiving communities' infrastructure to support forces, missions and personnel.
8. The environmental impact.

## **BRAC 93 Experiences**

- **What Worked -- Military Departments generally did good job in closing their operating force bases**
- **What Didn't -- All attempted cross-service analyses failed**
  - ✧ **Lack of common measures, common baselines, common databases**
  - ✧ **Differences in Service business practices**
  - ✧ **Lack of historical interservice cooperation**

## **External Policy Decisions Affecting BRAC Analyses**

- **Outsourcing of maintenance, R,D, T&E and other work**
- **Effect of health care initiative on hospital workload**

## **BRAC 95 Cross-Service Analysis Alternatives**

**Alternative One:**

**Military Departments Do Everything.**

Military Departments develop policies for conducting analyses, collect data and analyze data, i.e. no cross-service analyses.

**Alternative Two:**

**Executive Agents Do Everything.**

Executive Agents designated to control and conduct analyses of cross-service functional areas.

**Alternative Three:**

**OSD Lead Joint Groups Do Everything.**

Joint Groups designated to control and conduct analyses of cross-service functional areas.

**Alternative Four:**

**Shared Responsibility.**

Joint Groups develop policies for conducting analyses. Military Departments collect and analyze data.

## Cross-Service Functions Joint Group Leaders Group Players

<u>Function</u>	<u>Leader*</u>	<u>Group Players</u>
Depot Maintenance	DUSD(L)	Services, JCS, DLA
Laboratories	D, DR&E	Services
Test and Evaluation	D, OT&E and D, T&E	Services
Graduate Medical Education	ASD(HA)	Services
Undergraduate Pilot Training	ASD (P&R)	Services

\* Assumes Analysis Alternative Three or Four

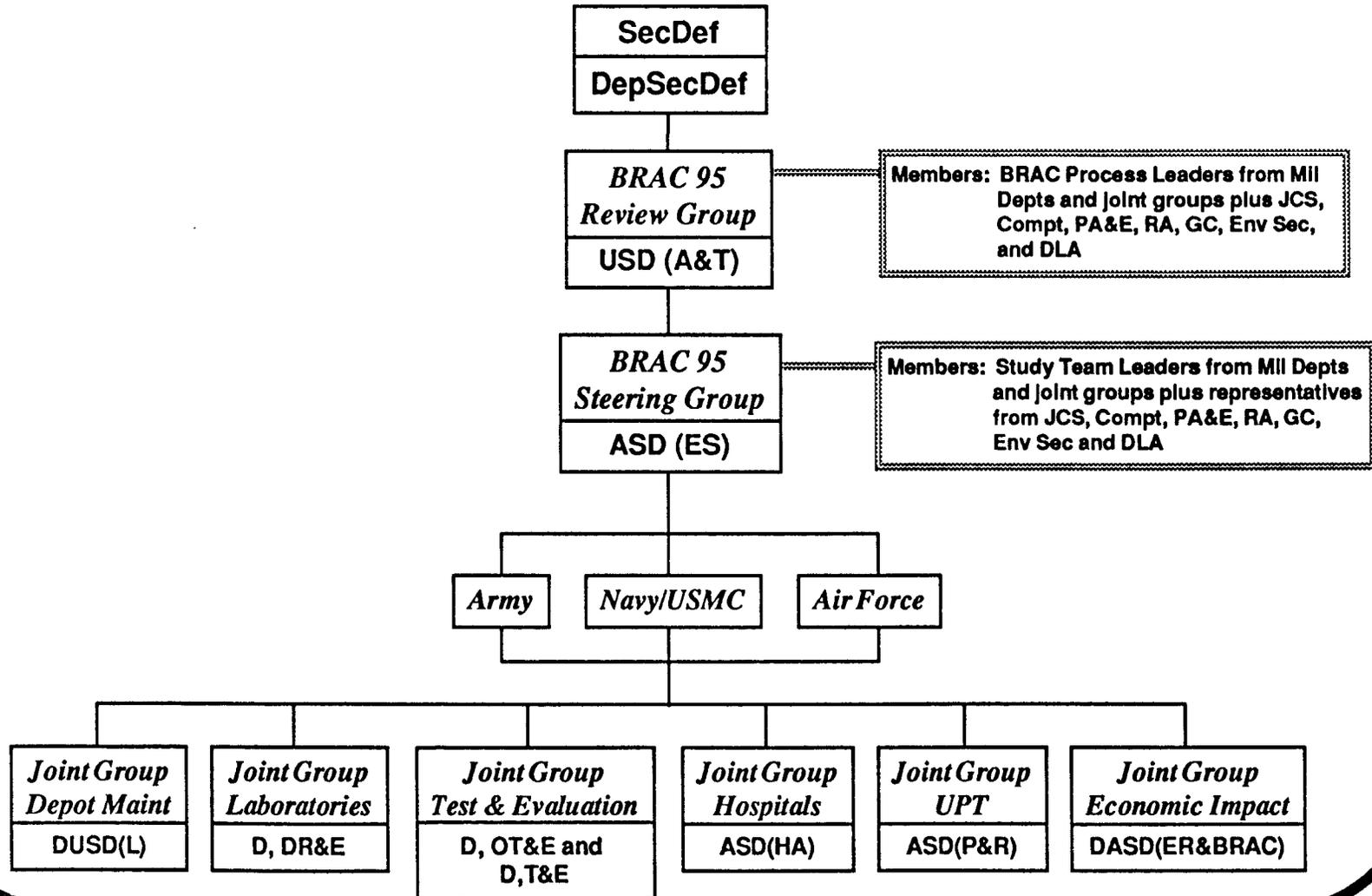
## **Options for Making Recommendations to SecDef**

- **Operating force bases -- Secretaries of the Military Departments**
- **Bases with cross-service potential**
  - ★ **Secretaries of the Military Departments**
  - ★ **Executive Agents**
  - ★ **OSD Lead Joint Groups**
  - ★ **JCS Leaders**

## **Proposed Plan - BRAC 95 Process**

- **Establish an outsourcing study team. Make critical outsourcing and other policy decisions early (Apr 94)**
- **Change internal DoD 1995 BRAC process**
  - ✧ **To address cross-service analysis problems to include control of data elements, measures of merit and milestone schedules**
  - ✧ **To ensure proper integration of all BRAC 95 recommendations**
- **Establish an overarching BRAC 95 Review Group led by USD(A) and a Steering Group led by DASD(ER&BRAC)**
- **Share Responsibility: Empower Joint Groups to influence analyses of cross-service functions but leave conduct of analyses to Services**
- **Focus cross-service analyses on best opportunities, not every opportunity**
- **Establish a cumulative economic impact working group**
- **Leave responsibility for making recommendations to SecDef with Secretaries of the Military Departments for all categories of bases**
- **Leave more time at end for the BRAC 95 Review Group to review Military Department recommendations and cumulative impact (8 weeks)**

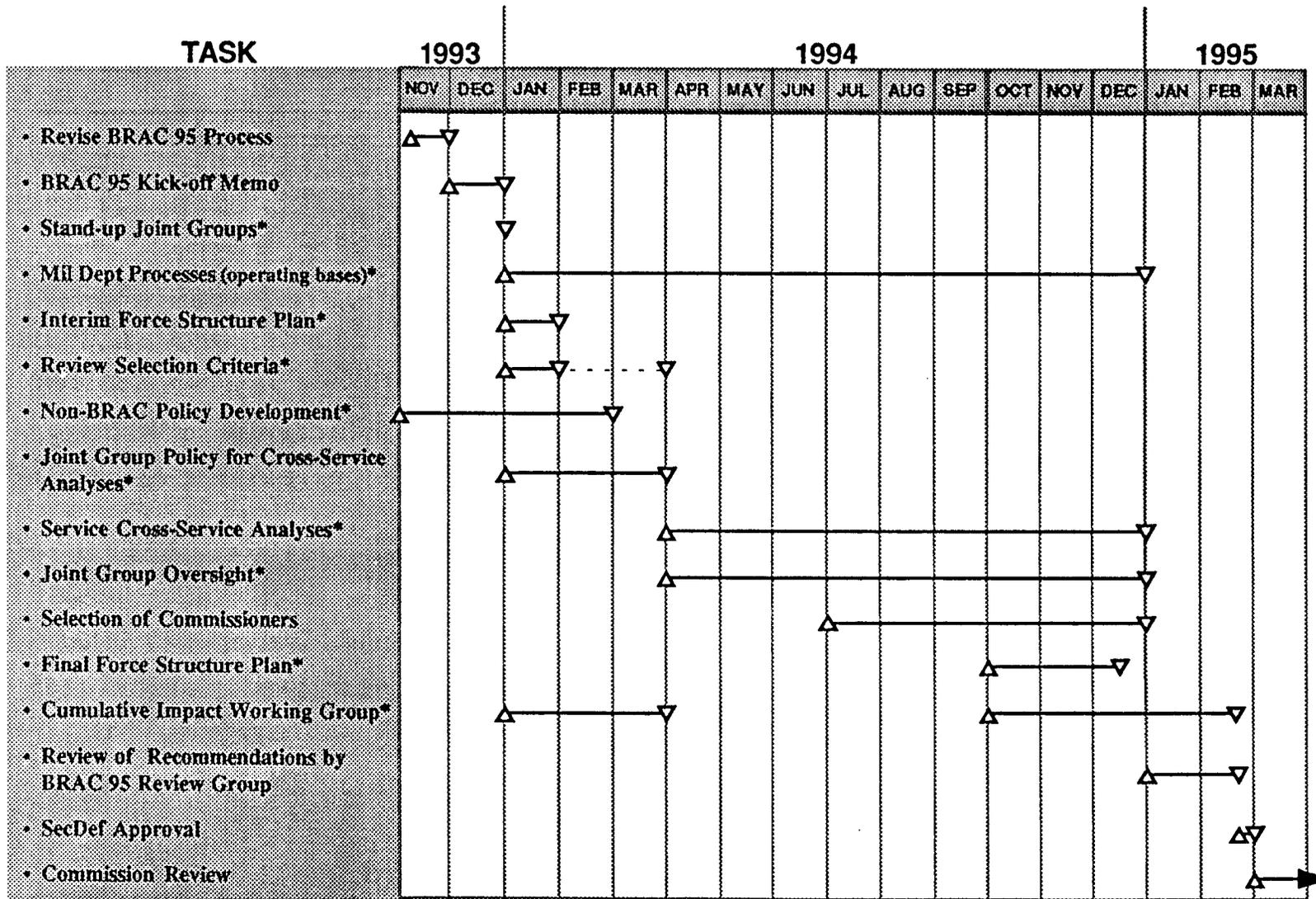
# BRAC 95 Organization for Analysis



# BRAC 95 Shared Responsibility

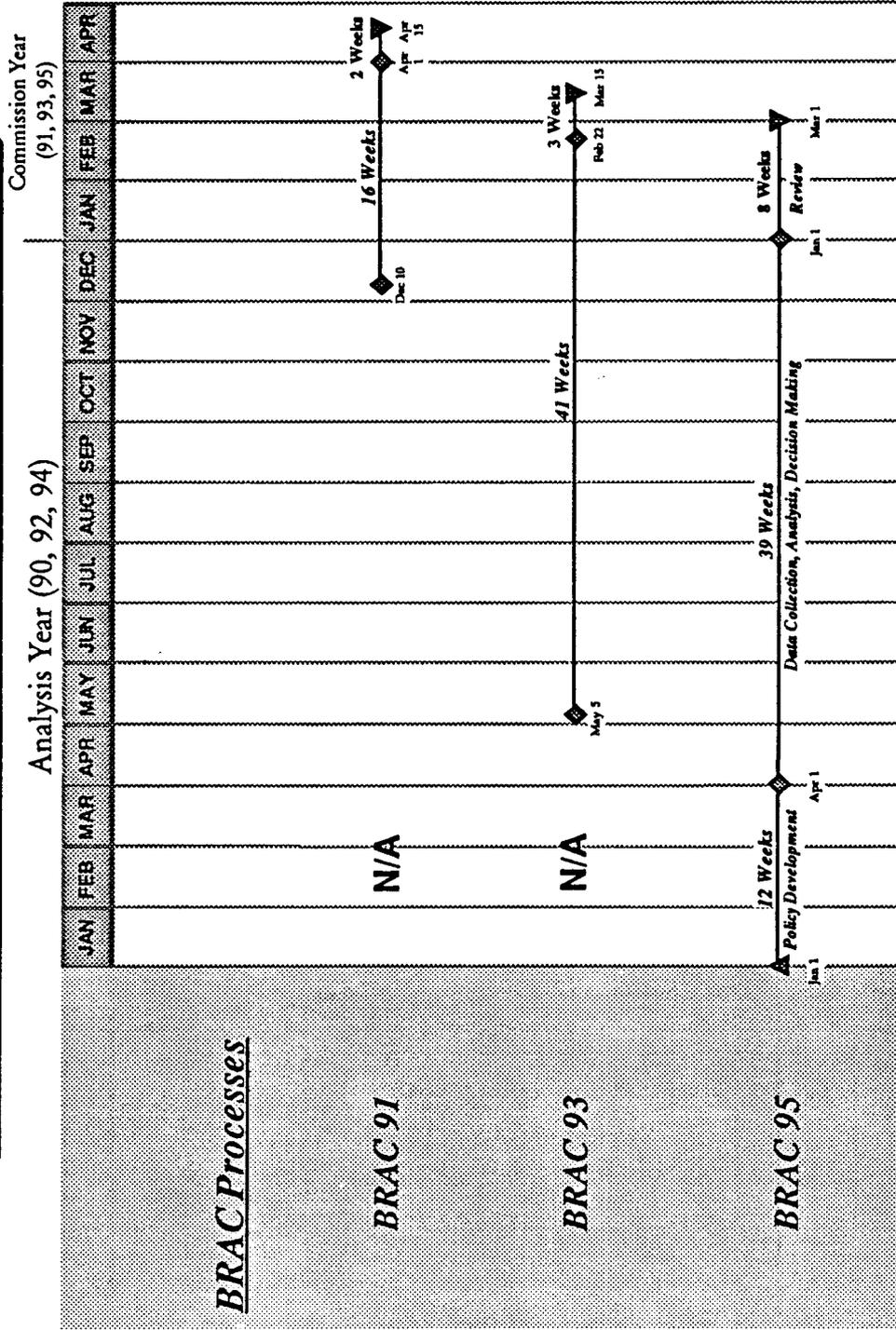
<u>Type of Base</u>	<u>Analysis Policy</u>	<u>Conduct of Analyses</u>	<u>Cross-Service Integration</u>	<u>Review of Recommend.</u>	<u>Review of Recommend.</u>
<b>Service Analysis</b>					
⊗ Operating Force Bases	Mil Deps	Mil Deps	0-6 Group	Mil Deps	Review Group
⊗ Command and Control	Mil Deps	Mil Deps	0-6 Group	Mil Deps	Review Group
⊗ Professional/Technical Training	Mil Deps	Mil Deps	0-6 Group	Mil Deps	Review Group
⊗ Guard and Reserve	Mil Deps	Mil Deps	0-6 Group	Mil Deps	Review Group
<b>Cross-Service Analysis</b>					
⊗ Depot Maintenance	Joint Groups	Mil Deps	Joint Groups	Mil Deps	Review Group
⊗ Laboratories					
⊗ Test and Evaluation					
⊗ Graduate Medical Education					
⊗ Undergraduate Pilot Training					

# BRAC 95 Timeline



\* Work products reviewed by BRAC 95 Review Group

# BRAC Timeline Comparison



## **What's Next - Thru End of 1993**

- **Principals Meeting -- Agree on:**
  - ★ **Cross-service analysis process**
  - ★ **Functional areas for cross-service analysis**
  - ★ **BRAC 95 Review Group and joint group leadership and participation**
  - ★ **Who makes recommendations to SecDef**
  - ★ **BRAC 95 schedule**
- **DepSecDef signs BRAC 95 kick-off memo -- Dec 15**
- **Stand-up BRAC 95 Review Group and joint groups**

**BRAC 95  
JOINT CROSS SERVICE GROUP  
FOR MILITARY TREATMENT FACILITIES AND  
GRADUATE MEDICAL EDUCATION**

<u>SERVICE/AGENCY</u>	<u>NAME</u>	<u>PHONE #</u>
CHAIR (ASD(HA))	Dr. Martin	703-697-2114
TEAM LEADER	RADM Koenig	703-697-8973
ARMY (Primary)	LTG LaNoue	703-756-0000
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AIR FORCE (Primary)	MG Buethe	202-767-4343
AIR FORCE (Alternate)	BG Hoffman	202-767-1894
JCS (Primary)	COL Moore	703-697-4346
JCS (Alternate)	COL Kim	703-697-4421
ASD (P&R) REP	Ms. St. Clair	703-696-8710
COMPR (Primary)	Ms. Danko	703-697-9198
COMPR (Alternate)	Mr. Smith	703-697-9198
PA&E (Primary)	Mr. Dickens	703-697-2999
PA&E (Alternate)	Mr. College	703-697-2999
DASD (ER) REP	Mr. Miglianico	703-697-8048
DOD IG REP	Mr. Million	703-692-2991
HA REP	Mr. Maddy	703-697-5185
HA REP	Dr. Mazzuchi	703-695-4964

# **BRAC 95 Process for Joint Groups**

Presentation to the  
Joint Cross-Service Group for  
MTF/GME

**LMI**

January 25, 1994



# Joint Cross-Service Groups...

## Dealing with a Tough Task

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The Objective: To promote effective analyses of joint- and cross-service functions in BRAC '95

The Challenges: To develop by March 31st the rules for guiding and structuring the analyses; action plans due by January 21st

Needed: a quick start and effective follow-through

# Some History of BRAC . . .

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- Early 1960s and 1970s
  - Many bases closed until Section 2687, Title 10 enacted
- 1988 Defense Commission on BRAC
  - Basis of the current analytical structure
  - Generally regarded as successful
  - Criticized for not being open enough



# Some History of BRAC . . .

## *(Continued)*

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- The Defense Base Closure & Realignment Commissions
  - 1991, 1993, and 1995
  - Have been using 8 selection criteria
  - Looking for "substantial deviation"
    - Methodology flawed or inconsistently applied
    - Inaccurate data



# BRAC 95 Process...

## Key Issues

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- Analytical frameworks -- Creating consistent, analytical frameworks for analyzing and studying joint- and cross-service matters
- Information management -- Supporting information management needs of the selection process
- Internal controls -- Conducting quality assurance and quality control



# Typical Analytical Structure...

## Four-Phased Approach

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- Categorize bases and facilities, and agree on reduction targets for each category
- Rate the bases and facilities in each category using some of the 8 criteria
- From the rated list of bases, develop BRAC alternatives
- Rate each BRAC alternative against all 8 criteria



# Phase One...

## Categorize the Bases and Facilities

- For example, by -
  - Missions (e.g., peacetime, operational)
  - Attributes (e.g., size, population served, staffing mix)
  - Capabilities (medical specialties, training programs)



# Phase Two...

## Initial Base Rating

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- Not all of the 8 criteria can be used in the initial base/facility rating
- For the criteria to be used in the initial rating, determine their most important measures
  - Determine the definitions and units of each measure
- Determine the weighting method for those measures
  - Color coding
  - Numerical
  - Structured expert opinion
- Calculate or determine the rating of each base/facility based on the weighted results of the measures

# Phase Three...

## Develop BRAC Alternatives

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- From each category's ranked list of bases, develop closure and realignment alternatives that meet the reduction targets



Include outsourcing

# Phase Four...

## Rate Each BRAC Alternative

- Use all 8 of the criteria -- Determine measures for those not yet used
- Determine the weighting method for the 8 criteria
  - Numerical, color coding, structured expert opinion
- Calculate or determine the rating of each BRAC alternative based on the weighted results of all 8 criteria
- Select the best alternative



# Approaches by the Services . . .

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- Army
  - Total Army Basing Study (TABS) Group
    - Used the most quantitative approach
- Navy
  - Base Structure Evaluation Committee (BSEC)
    - Base Structure Analysis Team (BSAT)
    - Computer modeling and military judgment
- Air Force
  - Base Closure Executive Group (BCEG)
    - Questionnaires to bases
    - Color-coded rating scale on 160 subelements
    - Voting by secret ballot



# Options for Organizing the Team . . .

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- Team organization before and after March 31st may not be the same
- Organize into subcommittees
  - By category (e.g., MTF, GME, etc.)
  - By criterion (e.g., military value, ROI, etc.)
  - Advantage: Specialization
  - Disadvantages: Control and standardization  
Takes time to organize group dynamics



# Options for Organizing the Team . . . (Continued)

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- Organize as a single committee
  - Advantage: Tight control and standard outputs
  - Disadvantages: Frequency of quorum meetings  
Can be unwieldy
- Use ad hoc subcommittees
  - Short duration, narrowly defined charters (e.g., research history of joint use in medical functions)
  - Advantage: Disperses the work load
  - Disadvantage: Minor issue of control



# Options for Organizing the Team . . .

## *(Continued)*

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- Use outside resources
  - Task to provide strawmen and recommended approaches
  - Advantages: Expands resources available
    - Brings in specific expertise and experience
    - Can use in combination with other options
  - Disadvantages: Minor issue of control
    - Must select competent outside support



# Helpful Tips...

## Some Do's & Don'ts

- Keep an open mind -- No preconceived ideas
- Define your goals/targets before the analysis begins
- Develop quantifiable measures and criteria, whenever possible
- Structure the analysis clearly before gathering and analyzing the data
- Structure the analysis so that your results are reproducible (using the same data and methodology)
- Do not change (refine) the methodology in the middle of the process (especially after the first results)
- Determine & challenge all assumptions; reject those that aren't supportable



# Helpful Tips...

**(Continued)**

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- Validate the data you use, or use "certified" data
- Keep good records: summarize meetings, describe recommendations, and record decisions -- Document but remember: everything is discoverable
- Maintain quality control to ensure accuracy of data collection and analyses
- Address all bases and activities equally
- Before changing the methodologies, consider the impacts
- Elevate seemingly irreconcilable differences to the Review Group



DRAFT—FOR COORDINATION ONLY

DASD (HSO)



**DEPARTMENT OF DEFENSE**

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**MILITARY HEALTH  
SERVICES SYSTEM**

**HOSPITAL SCREENING  
CRITERIA**

**CONTINENTAL  
UNITED STATES**

January 1994

Assistant Secretary of Defense (Health Affairs)

DRAFT—FOR COORDINATION ONLY

## INTRODUCTION

The criteria that are described here were designed for an initial screening of DoD military treatment facilities. Those facilities that were flagged by the criteria became candidates for further, more detailed analysis. "Yes" answers to the criteria are negative discriminators, an accumulation of which might indicate that: 1.) a particular medical treatment facility has more capability than is required for the catchment area, 2.) the MTF may not be cost effective as compared to either its peers or civilian (CHAMPUS) standards, 3.) the facility may be a liability in terms of its physical plant, 4.) a combination of all previously mentioned characteristics. It must be emphasized that the factors that each criterion measure cannot be taken alone as a measure of capability or lack thereof. The criteria have been crafted by working groups so that the factors work together to measure a facility's use and cost effectiveness. Mission criteria were not measured.

**RATIONALE FOR CRITERIA**  
for  
**Medical Facilities Operation Report of November 1992**  
**(Medical Centers)**

**CRITERION: DESCRIPTION:**

**POPULATION** *Population is a measure of requirements. Catchment area beneficiary population drives facility and staff size.*

1.1 TOTAL ELIGIBLE BENEFICIARIES IS LESS THAN 100,000

*rationale* This factor compares the broader service medical center to a large beneficiary population. Eligible beneficiaries include active duty, dependents of active duty, retirees, dependents of retirees and survivors. This measure for medical centers is twice the same criteria measure (50,000) for other hospitals. Many medical centers are in catchment areas with other MTFs, and their beneficiary population is reduced because of it. Although this is a negative discriminator, it's impact would be reversed if other MTFs in the medical center catchment area were to downsize to clinics or close. See criteria 1.8, 2.1, 2.2.

1.2 THE NUMBER OF ACTIVE DUTY AND DEPENDENTS OF ACTIVE DUTY BENEFICIARIES IS LESS THAN 50% OF TOTAL ELIGIBLE BENEFICIARIES POPULATION

*rationale* This criteria measures the majority of beneficiaries in the catchment area. If the majority of the beneficiaries are retirees, some will be MEDICARE eligible and some will have third party insurance. This indicates that the health care workload can be shifted from the DoD MTF to another provider, since DoD primary mission is health care to active duty beneficiaries.

1.3 THE NUMBER OF BENEFICIARIES AGE 65 AND OLDER IS GREATER THAN 15% OF TOTAL POPULATION

*rationale* This is a measure of MEDICARE eligible beneficiaries in the catchment area. It provides a more detailed look when combined with criteria 1.2.

1.4 NOT APPLICABLE TO MEDICAL CENTERS

**PHYSICAL PLANT** *The measure of the physical plant is a measure of both the short term and long term investment in operation and maintenance of the facility.*

1.5 CONDITION CODE IS LESS THAN 80.0

*rationale* The condition code is an indication of plant condition; a low score is a warning that maintenance and renovation costs will be higher than normal in the future, and may require a MILCON project to correct deficiencies.

1.6 GREATER THAN 25 YEARS SINCE LAST MAJOR MODIFICATION OR REHABILITATION

*rationale* This is a signal of higher than normal maintenance, operation, renovation, and construction costs in the future.

1.7 CONSTRUCTION REQUIREMENT IS GREATER THAN \$10M

*rationale* A large project may indicate long term neglect (or it may indicate critical need). This factor can be ignored if all other criteria indicate a critical requirement, but if beneficiary population is decreasing and cost effectiveness is poor then this criteria reinforces the need to further examine the facility for rightsizing.

**LOCATION** Location indicates overlap with other MTFs and the availability of civilian health care alternatives.

1.8 WITHIN FORTY-MILE OVERLAPPING CATCHMENT AREA WITH ANOTHER MEDICAL CENTER

*rationale* Taken by itself this criterion can indicate a geographic concentration of DoD facilities or isolation. Measured with the next two criteria and tempered by the detailed review of medical services that are available in the catchment area, it is a good survey of the catchment area's ability to absorb the MTF inpatient load if the MTF were downsized or closed.

1.9 NOT APPLICABLE TO MEDICAL CENTERS

1.10 NOT APPLICABLE TO MEDICAL CENTER

**OPERATING CHARACTERISTICS** These factors measure the effective use of both inpatient space and staffed beds.

2.1 PERCENT AVERAGE DAILY PATIENT LOAD TO BUILT BEDS IS LESS THAN 60%

*rationale* Although a hospital may have been built or configured for a certain number of beds, it is staffed based on workload (in this case ADPL). This measure compares the inpatient dispositions to the staffed operating beds. As a measure of efficiency, the work groups agreed that an ADPL to operating bed ratio of less than 60% indicated excess operating bed capacity.

2.2 PERCENT OPERATING BEDS TO BUILT BEDS IS 75% OR LESS

*rationale* This is a measure of excess capacity that has developed since the MTF was built, and indicates resources being maintained but not used for inpatients. The figure of 75% is a work group consensus.

**ADMISSIONS** *The inpatient factors associated with admissions allow measurement of usage, comparison to civilian norms and referral patterns from and to other MTFs.*

2.3 ACTIVE DUTY AND DEPENDENTS OF ACTIVE DUTY IS LESS THAN 50% OF TOTAL ADMISSIONS

*rationale* **Health care for active duty and dependents is the priority for MTFs. If the majority of admissions are other beneficiaries, the MTF resources might be better used at other DoD facilities where active duty and their dependents have difficult access.**

2.4 AVERAGE LENGTH OF STAY IS 1.25 (OR GREATER) TIMES THE NATIONAL NORMS

*rationale* **There is a presumption that national norms are more cost effective than MTF norms. If the MTF exceeds national norms, this indicates that cost effectiveness is slipping or even that the MTF has more capability or capacity than requirements. If either or both 2.1 and 2.2 are flagged "yes" for a facility, then one could expect 2.4 to be flagged also.**

2.5 CATEGORY III (IN REFERRALS) IS LESS THAN CATEGORY II (OUT REFERRALS)

*rationale* **If referrals out exceed referrals in, this indicates that: 1.) beneficiaries need more complex health care than the MTF can give, 2.)the MTF is understaffed, 3.) other MTFs and CHAMPUS providers can provide adequate inpatient health care.**

2.6 NOT APPLICABLE TO MEDICAL CENTERS

**COSTS** *The cost to operate a DoD inpatient facility can be compared to other MTFs and to local civilian facilities using information from the DMIS database and MEPRS. Cost comparisons help to weigh alternatives in a resource constrained environment. Such comparisons can also flag inefficiency and systemic problems. Detailed cost factors must be reviewed thoroughly in the functional economic analysis that would be executed for each downsizing candidate.*

2.7 AVERAGE UNIT COST OF DIRECT CARE INPATIENT WORK UNIT IS GREATER THAN THE AVERAGE UNIT COST OF CHAMPUS INPATIENT WORK UNIT

*rationale* **A "yes" answer to this criteria indicates that the MTF is spending more for inpatient health care than local civilian facilities. If the inpatient costs +10% for the MTF exceed CHAMPUS inpatient costs, then not only may the MTF be inefficient, but the net cost of inpatient care for beneficiaries clearly can be bought at less cost than it can be made available in the MTF. The +10% add on is a factor which takes into account the fact that MEPRS expenses are understated in depicting the total cost of operating an MTF. The expenses which are not in MEPRS include facility depreciation, cost of malpractice claims, personnel add-ons, corporate overhead and base operations.**

2.8 AVERAGE UNIT COST OF DIRECT CARE OUTPATIENT VISITS IS GREATER THAN THE AVERAGE UNIT COST OF CHAMPUS OUTPATIENT VISITS

*rationale* *Similar to the criteria above, a "yes" answer indicates that the outpatient service can be purchased from a civilian source for less than the MTF can provide it.*

2.9 THE DIFFERENCE BETWEEN THE MODEL AND THE OBSERVED AVERAGE COST PER INPATIENT WORK UNITS IS GREATER THAN +5% VARIATION

*rationale* *This measures the degree to which the small hospital is overspending or underspending in relation to the model-predicted costs for other hospitals of similar size. This is an indirect measure of overall resource use.*

2.10 NOT APPLICABLE TO MEDICAL CENTERS

**RATIONALE FOR CRITERIA**  
**for**  
**Medical Facilities Operation Report of November 1992**  
**(CONUS Hospitals Excluding Medical Centers)**

**CRITERION: DESCRIPTION:**

**POPULATION** *Population is a measure of requirements. Catchment area beneficiary population drives facility and staff size.*

1.1 TOTAL ELIGIBLE BENEFICIARIES IS LESS THAN 50,000

*rationale* **This factor compares the hospital to a proportionate beneficiary population. Eligible beneficiaries include active duty, dependents of active duty, retirees, dependents of retirees and survivors. This measure for hospitals is half the same criteria measure (100,000) for medical centers. See criteria 1.8, 2.1, 2.2.**

1.2 THE NUMBER OF ACTIVE DUTY AND DEPENDENTS OF ACTIVE DUTY BENEFICIARIES IS LESS THAN 50% OF TOTAL ELIGIBLE BENEFICIARIES POPULATION

*rationale* **This criteria measures the majority of beneficiaries in the catchment area. If the majority of the beneficiaries are retirees, some will be MEDICARE eligible and some will have third party insurance. This indicates that the health care workload can be shifted from the DoD MTF to another provider, since DoD primary mission is health care to active duty beneficiaries.**

1.3 THE NUMBER OF BENEFICIARIES AGE 65 AND OLDER IS GREATER THAN 15% OF TOTAL POPULATION

*rationale* **This is a measure of MEDICARE eligible beneficiaries in the catchment area. It provides a more detailed look when combined with criteria 1.2.**

**PHYSICAL PLANT** *The measure of the physical plant is a measure of both the short term and long term investment in operation and maintenance of the facility.*

1.4 LESS THAN 50 OPERATING BEDS

*rationale* **This factor separates out the small hospitals from larger hospitals and medical centers.**

1.5 CONDITION CODE IS LESS THAN 80.0

*rationale* **The condition code is an indication of plant condition; a low score is a warning that maintenance and renovation costs will be higher than normal in the future, and may require a MILCON project to correct deficiencies.**

1.6 GREATER THAN 25 YEARS SINCE LAST MAJOR MODIFICATION OR REHABILITATION

*rationale* This is a signal of higher than normal maintenance, operation, renovation, and construction costs in the future.

1.7 CONSTRUCTION REQUIREMENT IS GREATER THAN \$5M

*rationale* A large project may indicate long term neglect (or it may indicate critical need). This factor can be ignored if all other criteria indicate a critical requirement, but if beneficiary population is decreasing and cost effectiveness is poor then this criteria reinforces the need to further examine the facility for rightsizing.

**LOCATION** Location indicates overlap with other MTFs and the availability of civilian health care alternatives.

1.8 WITHIN 40-MILE OVERLAPPING CATCHMENT AREA WITH ANOTHER DoD INPATIENT MTF

*rationale* Taken by itself this criterion can indicate a geographic concentration of DoD facilities or isolation. Measured with the next two criteria and tempered by the detailed review of medical services that are available in the catchment area, it is a good survey of the catchment area's ability to absorb the MTF inpatient load if the MTF were downsized or closed.

1.9 PRIMARY PHYSICIAN TO POPULATION RATIO IS GREATER THAN 1 CIVILIAN PRIMARY PHYSICIAN TO 3500 INDIVIDUALS IN THE MTF CATCHMENT AREA

*rationale* In the original 1992 study this criterion stated that the "physician to population ration...was 1:1000." Since that time, better information has become available. This ratio is a measure of primary care physicians available in the catchment area. The AMA's 1993 publication "Physician Characteristics and Distribution in the US" displays physicians by specialty per 100,000 population. Their figures indicate that there is 1 office-based physician per 700 population in the United States. The National Association of Community Health Centers, Inc. Study (AMA News, Mar 16, 1992) indicates that 1 physician per 1800 is an underserved population. Standards published in the September, 1991 Federal Register establish a more meaningful primary care physician to people ratio of 1:3500. The work group felt that this ratio more accurately portrayed basic health care availability in a given population.

1.10 NUMBER OF NON-DoD HOSPITALS IS GREATER THAN 4 IN THE MTF CATCHMENT AREA

*rationale* This measure is founded on the conservative premise that at least four non-DoD hospitals in the catchment area provide sufficient competition to be accredited, sustain acceptable inpatient services, and have enough capacity to absorb the inpatient load from the realigned DoD small hospital. This factor would be examined in more detail during the functional economic analysis for each downsizing candidate.

**OPERATING CHARACTERISTICS**     *These factors measure the effective use of both inpatient space and staffed beds.*

2.1            PERCENT AVERAGE DAILY PATIENT LOAD TO BUILT BEDS IS LESS THAN 40%

*rationale*     *Although a hospital may have been built or configured for a certain number of beds, it is staffed based on workload (in this case ADPL). This measure compares the inpatient dispositions to the staffed operating beds. As a measure of efficiency, the work groups agreed that an ADPL to operating bed ratio of less than 40% indicated excess operating bed capacity in a hospital that is not a medical center.*

2.2            PERCENT OPERATING BEDS TO BUILT BEDS IS LESS THAN 50%

*rationale*     *This is a measure of excess capacity that has developed since the MTF was built, and indicates resources being maintained but not used for inpatients. The figure of 50% for non-medical center hospitals is a work group consensus.*

**ADMISSIONS**     *The inpatient factors associated with admissions allow measurement of usage, comparison to civilian norms and referral patterns from and to other MTFs.*

2.3            ACTIVE DUTY AND DEPENDENTS OF ACTIVE DUTY LESS THAN 50% OF TOTAL ADMISSIONS

*rationale*     *Health care for active duty and dependents is the priority for MTFs. If the majority of admissions are other beneficiaries, the MTF resources might be better used at other DoD facilities where active duty and their dependents have difficult access.*

2.4            AVERAGE LENGTH OF STAY IS 1.25 (OR GREATER) TIMES THE NATIONAL NORMS

*rationale*     *There is a presumption that national norms are more cost effective than MTF norms. If the MTF exceeds national norms, this indicates that cost effectiveness is slipping or even that the MTF has more capability or capacity than requirements. If either or both 2.1 and 2.2 are flagged "yes" for a facility, then one could expect 2.4 to be flagged also.*

2.5            NOT APPLICABLE TO CONUS HOSPITALS

2.6            CATEGORY I CARE (INPATIENT CARE PROVIDED TO CATCHMENT AREA BENEFICIARIES BY THE SAME MTF) IS LESS THAN 50% OF TOTAL CATCHMENT AREA CARE (CATEGORIES I + II + IV)

*rationale*     *A "yes" answer to this criterion indicates that the majority of inpatient care in this catchment area is provided by other facilities than the MTF whose catchment area it is.*

**COSTS**            *The cost to operate a DoD inpatient facility can be compared to other MTFs and to local civilian facilities using information from the DMIS database and MEPRS. Cost comparisons help to weigh alternatives in a resource constrained environment. Such comparisons can also flag inefficiency and systemic problems. Detailed cost factors must be reviewed thoroughly in the functional economic analysis that would be executed for each downsizing candidate.*

2.7 AVERAGE UNIT COST OF DIRECT CARE INPATIENT WORK UNIT IS GREATER THAN THE AVERAGE UNIT COST OF CHAMPUS INPATIENT WORK UNIT

*rationale* A "yes" answer to this criteria indicates that the MTF is spending more for inpatient health care than local civilian facilities. If the inpatient costs +10% for the MTF exceed CHAMPUS inpatient costs, then not only may the MTF be inefficient, but the net cost of inpatient care for beneficiaries clearly can be bought at less cost than it can be made available in the MTF. The +10% add on is a factor which takes into account the fact that MEPRS expenses are understated in depicting the total cost of operating an MTF. The expenses which are not in MEPRS include facility depreciation, cost of malpractice claims, personnel add-ons, corporate overhead and base operations.

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*rationale* Similar to the criteria above, a "yes" answer indicates that the outpatient service can be purchased from a civilian source for less than the MTF can provide it.

2.9 THE DIFFERENCE BETWEEN THE MODEL AND THE OBSERVED AVERAGE COST PER INPATIENT WORK UNIT IS GREATER THAN +20% VARIATION

*rationale* This measures the degree to which the small hospital is overspending or underspending in relation to the model-predicted costs for other hospitals of similar size. This is an indirect measure of overall resource use.

CATEGORY I: INPATIENT CARE PROVIDED TO MTF CATCHMENT AREA BENEFICIARIES BY THE SAME MTF.

CATEGORY II: INPATIENT CARE PROVIDED TO MTF CATCHMENT AREA BENEFICIARIES BY ANY OTHER MTF.

CATEGORY III: INPATIENT CARE PROVIDED TO BENEFICIARIES WHO RESIDE ANYWHERE OUTSIDE THE NAMED MTF'S CATCHMENT AREA.

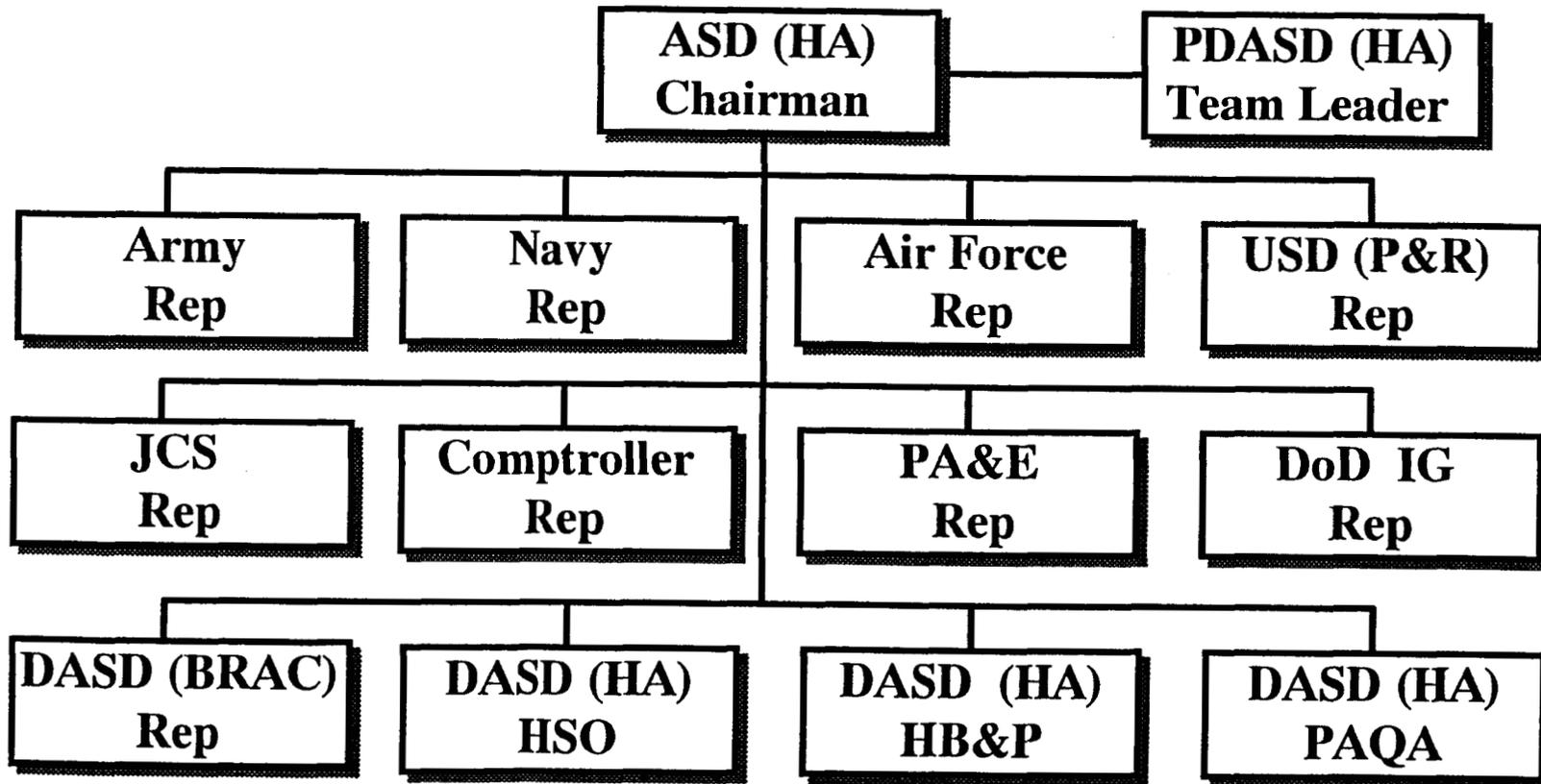
CATEGORY IV: INPATIENT CARE PROVIDED TO AN MTF'S ELIGIBLE CHAMPUS CATCHMENT AREA BENEFICIARIES BY ANY CIVILIAN MEDICAL FACILITY REIMBURSED THROUGH THE CHAMPUS PROGRAM.

# **JOINT CROSS SERVICE GROUP FOR MTFs AND GME**

- **Group Organization**
- **Process Development**
- **Current Issues**

# Organization

# Organization of MTF and GME Joint Cross Service Group



# Process Development

## **Major Analysis Assumptions**

- **MTF will close if base closes unless a sufficient active duty population remains**
- **Joint Group efforts will focus primarily on peacetime requirements**
- **Analysis will include facilities with < 300 civilian personnel**

# **Roles of Joint Group and Military Departments**

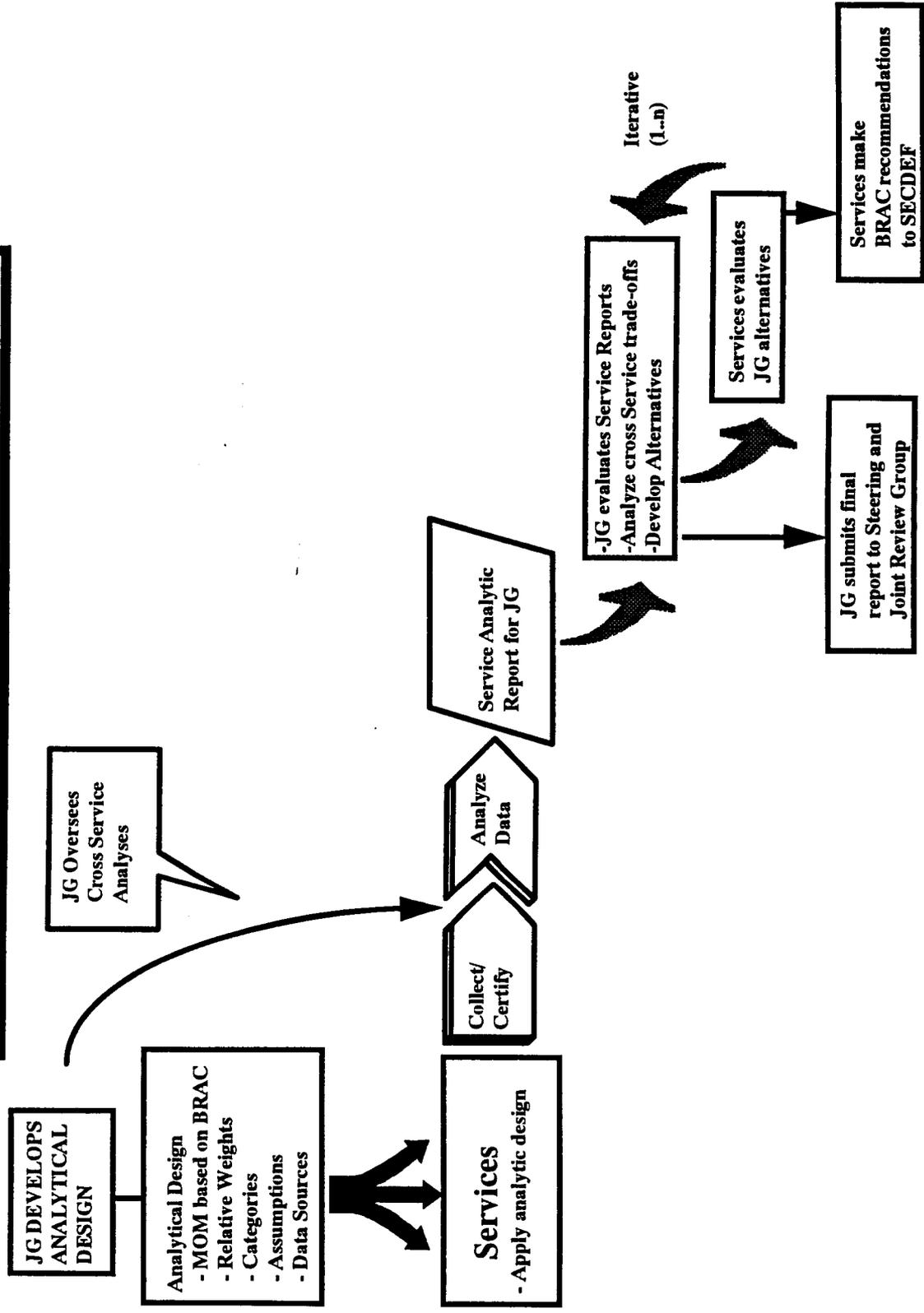
## ■ **Joint Group develops**

- Analysis assumptions
- General analytical approach and methodology
- Categories for study and their definitions
- Data definitions and measures of merit
- Relative weights for measures of merit

## ■ **Services**

- Collect and analyze data
- Present findings to Joint Cross Service Group
- Evaluate alternative options recommended by Joint Cross-Services Group

# GENERAL ANALYTICAL APPROACH



## **Categories for Study**

- **Stand Alone Health Clinics**
- **Community Hospitals**
- **Medical Centers**

## **Key Characteristics of Study Design**

- **Bases capacity on full DoD requirements**
- **New Costing Methodology for inpatient care**
- **Considers only Active Duty and Active Duty family members for population measure**
- **Focuses on downsizing/rightsizing facilities**

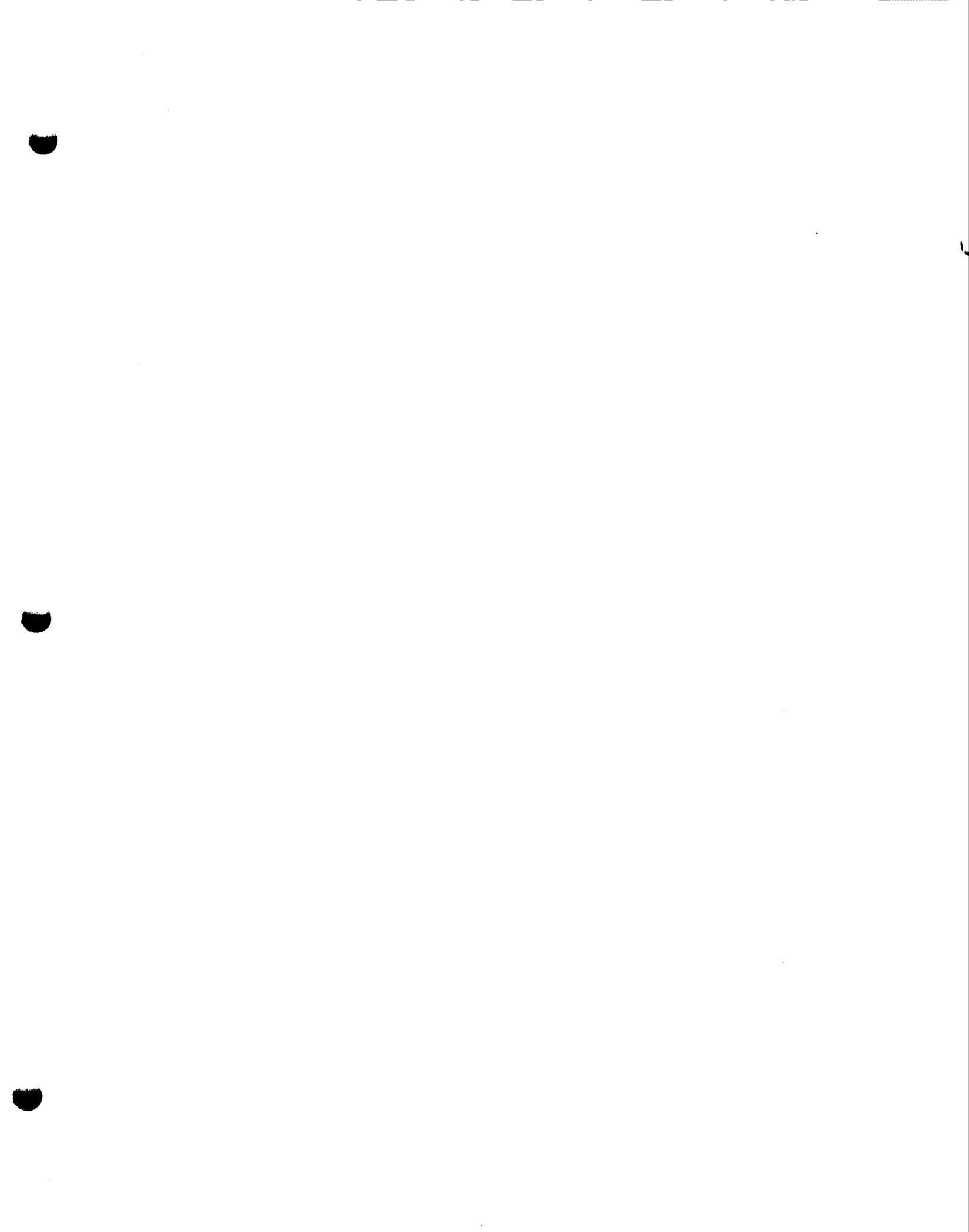
## **Other Rightsizing Opportunities**

- **Consolidation of Services'**
  - **Biostatistical Activities**
  - **Interservice Military Training Programs**
  - **Medical Labs and Research**
  - **Graduate Medical Education**

# Current Issues

# **Pending Policy Issues Related to BRAC 95 Efforts**

- **Final results of DoD 733 Study**
  
- **Legislative Issues relating to Health Care Reform**
  - **Medicare Subvention**
  
  - **Closed Enrollment**
  
  - **Third Party Reimbursement**



**MINUTES OF THE  
MILITARY TREATMENT FACILITIES  
AND GRADUATE MEDICAL EDUCATION  
BRAC 95 JOINT CROSS SERVICE GROUP  
MEETING OF FEBRUARY 3, 1994**

The second meeting of the Military Treatment Facilities and Graduate Medical Education (MTF/GME) BRAC 95 Joint Cross Service Group convened at 1400 hrs on February 3, 1994. The meeting was chaired by Dr. Edward D. Martin, Acting Assistant Secretary of Defense, Health Affairs.

The meeting opened with a review of the proceedings of the BRAC 95 Review Group meeting held on January 28, 1994. The only issue directly related to the MTF/GME group was that of the incorporation of the "733" and GME studies into the groups task at hand. The Chairman stated that the finalization of the GME study would be moved up to April 1 in order to coincide with the group's current tasking and that the "733" study already was planned for the proper time frame.

A discussion of "policy" vs "analysis" then began. The Chairman related the BRAC 95 Review Group guidance that policy proclivities or pre-conceived notions should not drive the BRAC analysis process.

The Chairman then asked each of the members to review the minutes from the previous meeting (a copy of the minutes was passed around the table).

A briefing package was provided to each of the members. The package included charts on near term actions, analysis assumptions, Joint Group and Service roles, administrative and group procedures, general analytical approach, categories for study, action plan and timelines and a Joint Hospital Group Declaration of Principles. The Chairman stated that the group's goal for today's meeting was to address the principles, roles of the group and Services, and analysis assumptions.

The Declaration of Principles was discussed and approved with a revision of principle number two that would replace "...eliminating unnecessary infrastructure.." with a statement addressing "right-sizing". During the discussion it was emphasized that the group must coordinate with the Services during the analysis process to ensure that the recommendations of each do not collectively eliminate all MTFs in a given area.

The roles of the joint groups and Services were addressed next. The question was raised as to whether or not the group should engage in its own analysis concurrent with that of the Services. The consensus was that the Services must perform the analyses and the MTF/GME group would evaluate the Service recommendations and suggest alternatives. It was decided that an

**CLOSE HOLD**

additional "bullet" be added to the roles of the Joint Group:  
"Prepare alternative recommendations, as appropriate, based on a review of the Service analyses".

The next item was the analysis assumptions of the group. The first assumption was whether or not an MTF would close if the installation it supported was identified for closure.

There was some discussion on whether a Service, having decided to close an installation, should be put in the position of operating an MTF to support a beneficiary population not necessarily its own. The Chairman reminded the group that its role was to ensure that the combined recommendations of the Services and the MTF/GME group provided for the health care needs of the remaining beneficiaries, regardless of Service affiliation. The group agreed on an analysis assumption that the MTF will close if an installation closes unless a significant active duty population is programmed to remain in that area.

The next assumption was whether the analysis would consider both peacetime and wartime missions. The Group agreed that the wartime mission requirements fell under the Service analyses and that the MTF/GME group would analyze the peacetime requirements.

The group also agreed that the third assumption would have the analyses include facilities with less than 300 civilian government employees.

The last assumption was that of establishing a quantitative goal. The group chose not to establish a quantitative goal at this time.

The meeting adjourned at 1535 hrs. The next meeting is scheduled for February 10, 1994 at 1400 hrs.

Approved Edward D. Martin  
Edward D. Martin, MD  
Acting ASD (HA)

Attachments

**CLOSE HOLD**

BRAC 95  
 JOINT CROSS SERVICE GROUP  
 FOR MILITARY TREATMENT FACILITIES AND  
 GRADUATE MEDICAL EDUCATION

<u>SERVICE/AGENCY</u>	<u>NAME</u>	<u>PHONE#</u>	<u>ATTENDING 3 Feb 94</u>
CHAIR (AASD(HA) ASD(HA) (Designate)	Dr. Martin	703-697-2114	<u>X</u>
	Dr. Joseph	703-697-2144	<u>X</u>
TEAM LEADER	RADM Koenig	703-697-8973	<u>X</u>
ARMY	BG Zajtchuk	703-756-5680	<u>COL Lyons</u>
NAVY NAVY	CAPT Golembieski	703-681-0461	<u>X</u>
	CDR Dilorenzo	703-681-0452	<u>X</u>
AIR FORCE	BG Hoffman	202-767-1894	<u>X</u>
JCS	COL Moore	703-697-4346	<u>X</u>
OASD (P&R)	Ms. St. Clair	703-696-8710	<u>X</u>
COMPT	Ms. Hiller	703-697-3101	<u>X</u>
PA&E	Mr. Dickens	703-697-8050	<u>X</u>
ODASD (BRAC/ES)	Mr. Miglionico	703-697-8050	<u>X</u>
DOD IG	Mr. Tomlin	804-766-3816	<u>X</u>
ODASD (HA)	Mr. Maddy	703-697-8979	<u>X</u>
ODASD (HA)	Dr. Mazzuchi	703-695-7116	<u>X</u>

OTHER ATTENDEES

<u>SERVICE/AGENCY</u>	<u>NAME</u>	<u>PHONE #</u>	<u>ATTENDING 3 Feb 94</u>
OASD (HA)	Ms. Watson	703-697-8973	<u>          X          </u>
OASD (HA)	Ms. Giese	703-614-4705	<u>          X          </u>
OASD (HA)	Col Garner	703-614-4705	<u>          X          </u>
OASD (HA)	CDR Bally	703-614-4705	<u>          X          </u>
OASD (HA)	LTC Ponatoski	703-614-4705	<u>          X          </u>
OASD (HA)	LTC McClinton	703-614-4705	<u>          X          </u>
ARMY	COL Barton	703-756-8319	<u>                          </u>
ARMY	COL Wilcox	703-756-5681	<u>                          </u>
ARMY	LTC Powell	703-697-3877	<u>                          </u>
ARMY	LTC McGaha	703-697-6388	<u>          X          </u>
ARMY	MAJ Dudevoir	703-756-0286	<u>          X          </u>
ARMY	MAJ Parker	703-756-8036	<u>          X          </u>
NAVY	CAPT Buzzell	703-681-0475	<u>                          </u>
NAVY	Ms. Davis	703-602-2252	<u>                          </u>
AIR FORCE	LtCol Silvernail	202-767-5550	<u>          X          </u>
AIR FORCE	Maj Costa	202-767-5066	<u>          X          </u>
AIR FORCE	Maj Pantaleo	202-767-5046	<u>          X          </u>
LMI	Mr. Neve	301-320-7287	<u>          X          </u>
LMI	Ms. Dahut	301-320-7408	<u>          X          </u>
JS	Lt Col Ferguson	703-697-4421	<u>          X          </u>
COMP	Ms. Kopperman	703-697-4517	<u>          X          </u>

**AGENDA  
FEBRUARY 3, 1994**

**BRAC 95 JOINT CROSS SERVICE GROUP  
FOR MILITARY TREATMENT FACILITIES AND  
GRADUATE MEDICAL EDUCATION**

- Review/approve minutes from previous meeting Dr. Martin
  - Discuss Analysis Assumptions/Roles/ and General Administrative Procedures Dr. Martin
  - Review/Discuss impact of 733 study, President's Health Care Plan, and PDM/PBDs Dr. Martin
  - Review/Discuss Hospital Screening Criteria used in previous analyses RADM Koenig
  - Review of revised Action Plan & Milestones Dr. Martin
  - Administrative Issues Dr. Martin
  - Adjournment
- 7

# BRAC 95 JOINT CROSS-SERVICE GROUP FOR MTFs AND GME

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## ■ Near Term Cross Service Group Actions (next 5-10 days)

- > Develop Analysis Assumptions
- > Define Role of Joint Group & Services
- > Define General Administrative and Group Procedures
- > Decide on General Analytical Approach
- > Determine Categories for Study
- > Revise Action Plan and Milestones

# BRAC 95 JOINT CROSS-SERVICE GROUP FOR MTFs AND GME

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## ■ Revised Action Plan & Timeline (thru 3/31/94)

- > Agree on Statement of Principles 2/4
- > Define role of Group & Services 2/4
- > Develop Analysis Assumptions 2/18
- > Determine Categories for Study 2/18
- > Determine General Analytical Approach 2/18
- > Review interim force structure plan 2/25
- > Submit list of irreconcilable differences to USD 2/28
- > Define Measures of Merit & Data Sources 3/4
- > Determine weights for Measures of Merit 3/11
- > Complete Measures of Merit Data Definitions 3/11
- > Establish Data Internal Control Plan 3/15

# BRAC 95 JOINT CROSS-SERVICE GROUP FOR MTFs AND GME

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## ■ Develop Analysis Assumptions

- MTF will/will not close if base closes
- Analysis will/ will not consider peacetime and wartime requirements
- Analysis will/will not consider functions with < 300 civilian personnel
- Quantitative goals will/will not be defined

# **BRAC 95 JOINT CROSS-SERVICE GROUP FOR MTFs AND GME**

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## **■ Define Roles for Joint Group and Service**

- > Joint Group will develop**
  - Analysis assumptions**
  - General analytical approach and methodology**
  - Internal Control Plan**
  - Categories for study and their definitions**
  - Data definitions and measures of merit**
  - Relative weights for measures of merit**
- > Services will**
  - Collect and analyze data**
  - Present findings to Joint Cross Service Group**
  - Evaluate alternative options recommended by Joint Cross-Services Group**

# **BRAC 95 JOINT CROSS-SERVICE GROUP FOR MTFs AND GME**

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## **■ General Administrative & Group Procedures**

- > Group to agree on Statement of Principles**
- > Best way to bring issues/items before group**
  - via a single committee**
  - via subcommittees**

# BRAC 95 JOINT CROSS-SERVICE GROUP FOR MTFs AND GME

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## ■ Determine General Analytical Approach

- > The eight BRAC selection criteria must be used for the analysis
- > Develop Measures of Merit (sub criteria) applicable to MTFs and GME (consider using previous measures)
- > Consider use of screening criteria to exclude specific categories or facilities
- > Develop process for individual Service analysis and tri-service integration of alternatives

# BRAC 95 JOINT CROSS-SERVICE GROUP FOR MTFs AND GME

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## ■ Determine Categories for Study

- > Consider stratification by
  - Size of MTF
  - Teaching vs Non-Teaching
  - Tricare Region
  - Location of MTFs (Urban....Rural)

## JOINT HOSPITAL GROUP DECLARATION OF PRINCIPLES

1. The Joint Cross Service Group on Medical Facilities and Graduate Medical Education seeks to identify measures of merit (subcategories of the 8 BRAC criteria) data elements, and methodologies that will allow the DoD components to apply the DoD criteria in a uniform, fair, reasonable, and consistent manner that complies with statutory and regulatory requirements and that adheres to the policy set forth in the January 7, 1994 DepSecDef memo, subject: 1995 Base Realignment and Closures (BRAC)
2. The Joint Cross Service Group on Medical Facilities and Graduate Medical Education recognizes the need for eliminating unnecessary infrastructure by seeking opportunities for cross-Service asset sharing and single military department support.
3. The measures of merit, data elements, and methodologies used to arrive at closure and realignment recommendations will be developed and approved by the Joint Cross Service Group on Medical Facilities and Graduate Medical Education by 31 March 1994. The approach developed should be easy to use, simple and straightforward, auditable, reproducible, and defensible.

# PDM EXTRACT

## FY95-99 PDM UPDATE

### 8. Defense Health Program

(U) Defense Wide. In FY 1995 add \$193M to the Defense Health Program in PE 0807712HP. Identify funds as Defense Health Program Operations and Maintenance TOA (Resource Identification Code 542).

### 12. Graduate Medical Education (GME)

(U) OSD. The Assistant Secretary of Defense (Health Affairs) (ASD(HA)) will, with the participation of the services, develop a plan for reducing Graduate Medical Education. This plan will provide quantitative reductions in the number of interns/residents/fellows, the number of programs, and the number of sites at which such programs are conducted. This plan will be provided by May 1, 1994 to the Deputy Secretary of Defense. The following principles shall be followed:

- Base the types and numbers of GME programs on the military departments' need for specialists and subspecialists (phase out redundant programs);
- Eliminate all duplicative residency programs in close geographical proximity by closure or merger of such programs (jointly staff merged programs);
- Disallow civilian interns/residents/fellows unless explicitly approved by the ASD(HA)

## NATIONAL HEALTH CARE REFORM

### BACKGROUND

On November 20, 1993, Mr. Gephardt introduced the President's "Health Security Act," a bill "To ensure individual and family security through health care coverage for all Americans in a manner that contains the rate of growth in health care costs and promotes responsible health insurance practices, to promote choice in health care, and to ensure and protect the health care of all Americans". The bill gives the Department an opportunity to bring military health care into harmony with the broader national reforms. In simplest terms, the framework of the Health Security Act promotes readiness, security, and choice:

- The President's plan maintains the unique readiness requirements of the military health care system through the continued staffing and management of military hospitals and clinics by uniformed health care providers. It makes no change in health care for active-duty personnel, nor overseas;
- The President's plan strengthens commitments to active-duty and retired military personnel and their family members by offering secure access, at low cost, to a comprehensive package of health care benefits through a Uniformed Services Health Plan; and
- The President's plan gives families of active-duty personnel and military retirees and their families a choice of enrolling in a military health plan or selecting from a range of other private sector plans, including at least one fee-for-service plan.

### KEY FEATURES

To achieve readiness, security, and choice, the Health Security Act gives the Secretary of Defense the authority to do the following:

- 1) Establish Uniformed Services Health Plans centered around military hospitals and clinics in the United States, supplemented by the use of civilian health care providers;
- 2) Automatically enroll active-duty members in a Uniformed Services Health Plan, and give family members of active-duty personnel and retired military personnel and their family members the choice of enrolling in a Uniformed Services Health Plan *as the exclusive source of health care services*. (This provision is key because, for the first time, it lets DoD serve a defined population.);
- 3) Provide persons enrolled in a Uniformed Services Health Plans at least the items and services in the President's proposed comprehensive benefit package;
- 4) Receive reimbursements from Medicare for persons enrolled in a Uniformed Services Health Plan who are eligible to receive Medicare benefits under part B;
- 5) Receive premium payments by private employers made in connection with persons enrolled in a Uniformed Services Health Plan;

- 6) Make premium payments on behalf of family members of active-duty personnel and retired military personnel and their family members so that they may enroll through a health alliance in a civilian health plan; and
- 7) Preempt conflicting state requirements as they might affect the Uniformed Services Health Plans.

In addition, the President's plan assures beneficiaries who enroll in a military health plan that they shall have, as a group, out-of-pocket costs no greater than on December 31, 1994. Until the Department is ready to carry out this plan, the current military health care benefits will stay in place.

### CURRENT ISSUES

As the Congress marks up the Health Security Act, DoD may be pressed for details on several unresolved issues, most of which concern the military health plan's package of benefits.

### **COST SHARING**

For civilian plans, the President has proposed detailed schedules of deductibles, copayments and coinsurance, some of which are shown below:

#### **EXAMPLES OF COST-SHARING UNDER THE HEALTH SECURITY ACT**

Service	Fee-for-Service Plans	Other Health Plans (e.g., HMOs, PPOs)
Inpatient hospital services	20 percent of payment rate	No copayment
Outpatient visits	20 percent of payment rate	\$10 per visit
Out-of-pocket limit	\$1,500 a person \$3,000 a family	\$1,500 a person \$3,000 a family
Deductible	\$200 a person \$400 a family	None

Independent of the Health Security Act, DoD has proposed that military health plans use a different schedule, based on the benefit approved for the Base Realignment and Closure (BRAC) sites. For example, retired families would pay a \$100 enrollment fee to join a military health plan, and then pay \$15 for a civilian visit (nothing for a military visit), \$135 a day for civilian hospital stays (less than \$10 a day for military hospital stays), and face a \$7,500 out-of-pocket limit. In light of these sorts of difference between the military health plan and civilian HMOs, DoD or the Congress may wish to revise the proposed benefit for the military health plan.

### **PREMIUM CONTRIBUTIONS**

When the members of a DoD family work at least 12 months full-time during the year, that family's employers must pay 80 percent of the average premium for the applicable rating pool. If that DoD family joins the military health plan, DoD receives the employers' contributions.

Some number of DoD families will have to pay all or part of that employer's share: these include families that lack 12 months of full-time work – either because they work part-time or because they do not work – and families in which one member is self-employed. DoD must decide whether or not it will cover the employer share of the premium for these families.

Joel Slackman  
January 26, 1994

**COMPREHENSIVE STUDY OF THE MILITARY  
HEALTH SERVICES SYSTEM  
(SECTION 733 STUDY)**

**BACKGROUND**

Section 733 of the National Defense Authorization Act for FY 1992/1993 directed that the Secretary of Defense conduct a comprehensive study of the military health services system, and report to the Congress by December 15, 1993. Specifically, the Congress called for DoD to study (1) the military medical care system required to support the Armed Force during war or other conflict; (2) any adjustments to the system required to provide cost-effective care in peacetime to covered beneficiaries; and (3) beneficiaries' attitudes, knowledge and utilization with respect to health care. DoD assigned the lead to Program Analysis and Evaluation (PA&E). This talking paper discusses the peacetime portion of the 733 Study.

A steering committee and several work groups were formed. An internal DoD working group examined the wartime requirements. A survey working group, with contractor support, conducted a survey of beneficiaries.

**KEY FEATURES**

The peacetime portion of the 733 study involved three analytic tasks. First, PA&E tasked the Institute for Defense Analysis (IDA) to estimate the total costs of providing medical care. IDA relied on the Medical Expense Performance Reporting System (MEPRS), adjusting those data as necessary for comparability with the civilian sector.

Second, IDA estimated the relationship between those costs and workload inside Military Treatment Facilities (MTFs). IDA's cost equations show that a MTF's inpatient costs are a function of the number of case-mix adjusted discharges, operating beds, GME, and hospital type.

Third, PA&E tasked the RAND Corporation to predict utilization of MTFs and the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) under a range of "scenarios":

- Current system with managed care – this "baseline" scenario assumes that beneficiaries nationwide may enroll in a managed care option that limits both their cost-sharing and their choice of providers;
- Maximize use of MTFs – this scenario assumes that DoD adds 1 hospital and increases resources at other facilities. It makes no direct assumptions about ambulatory capacity.

- Minimize use of MTFs – this scenario assumes that DoD runs only those hospitals to meet wartime bed requirements. Nonactive-duty beneficiaries enroll in civilian plans.
- Military-Civilian Competition – this scenario resembles the President's proposal in the Health Security Act. Beneficiaries will choose among a DoD-managed health plan, a private HMO, and a private PPO.

## CURRENT ISSUES

### FINDINGS TO DATE

IDA's costs analysis shows that DoD pays less for outpatient visits and hospital admissions produced inside MTFs than received under CHAMPUS. However, the RAND analysis shows that when access to MTFs increases, the volume of services increases by more than it decreases under CHAMPUS. This increase in volume swamps the effects of any relative efficiencies in production. Thus, total expenditures to DoD would rise if DoD moved from the current system with managed care to maximize use of MTFs.

What drives volume high in MTFs? First, MTFs offers a more generous health benefit than CHAMPUS: no deductibles, virtually no copayments, and wider scope of services. Second, the delivery system is subject to economic incentives (e.g., workload-based budgeting) as well as Service policies (e.g., hospital admissions for tooth extractions) that promote more rather than less health care. The 733 Study may emphasize the former over the latter.

These findings involve some degree of uncertainty. As a result, the 733 Study will likely stress the direction of change, rather than precise point estimates.

Joel Slackman  
January 31, 1994

PDM EXTRACT

FY 95-99

PDM UPDATE

8. Defense Health Program

(U) Defense Wide. In FY 1995 add \$193M to the Defense Health Program in PE 0807712HP. Identify funds as Defense Health Program Operations and Maintenance TOA (Resource Identification Code 542).

12. Graduate Medical Education (GME)

(U) OSD. The Assistant Secretary of Defense (Health Affairs) (ASD(HA)) will, with the participation of the services, develop a plan for reducing Graduate Medical Education. This plan will provide quantitative reductions in the number of interns/residents/fellows, the number of programs, and the number of sites at which such programs are conducted. This plan will be provided by May 1, 1994 to the Deputy Secretary of Defense. The following principles shall be followed:

- Base the types and numbers of GME programs on the military departments' need for specialists and subspecialists (phase out redundant programs);
- Eliminate all duplicative residency programs in close geographical proximity by closure or merger of such programs (jointly staff merged programs);

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**PROGRAM BUDGET DECISION**

029

No.

**SUBJECT:** Training, Recruiting, and Advertising

**DOD COMPONENTS:** Army, Navy, Air Force, OSD

**ISSUE:** What is the appropriate funding level for training, recruiting and advertising?

	<u>FY 1994</u>	<u>FY 1995</u>
<b><u>Service Estimate</u></b>		
TOA \$ Millions	6,338.5	6,563.1
Civilian End Strength	57,085	55,885
Active Military End Strength	178,234	170,406
<b><u>Alternative Estimate</u></b>		
TOA \$ Millions	-13.6	-56.9
Civilian End Strength	-45	+151
Active Military End Strength	-40	-259

**SUMMARY OF EVALUATION:** This PBD makes the following adjustments:

- Reduces U.S. Military Entrance Processing Command (MEPCOM) staffing and recruiting leases to reflect requirements (\$-1.5/\$-4.9 million; -45/-45 civilian and -40/-40 military end strength in FY 1994/FY 1995).
- Reduces Air Force Academy personnel in FY 1995 to align with audit findings (\$-1.2 million; +196 civilian end strength, -219 military end strength). Reduces Army ROTC to reflect officer requirements (\$-32.0 million in FY 1995).
- Reduces Army accession training, flight training, and Navy Bachelor Housing, to reflect supporting documentation (\$-10.6/\$-16.2 million).
- Reduces Air Force Flight Screening to reflect productivity improvements that should accrue (\$-1.5/\$-2.6 million in FY 1994/FY 1995).
- Directs Army to restore funds to Junior ROTC to fund increase approved in last year's PBD.

**ALTERNATIVE ESTIMATE:** Approve a decrease of \$13.6/\$56.9 million and 40/259 military end strength in FY 1994/FY 1995. Approve a decrease of 45 civilians in FY 1994 and an increase of 151 civilians in FY 1995.

THE DEPUTY SECRETARY APPROVED THE ALTERNATIVE ESTIMATE EXCEPT ACCESSION TRAINING (\$+7.2 MILLION) AND RECRUITING LEASES (\$+2.0 MILLION). DECISION DEFERRED ON FLIGHT TRAINING (\$4.7 MILLION) and ROTC (\$32.0 MILLION). **DECISION** \_\_\_\_\_ **Date** 12/13/93

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**DETAIL OF EVALUATION:** The following table shows the amounts funded in each Service for Training and for Recruiting and Advertising. The figures include Base Operations Support.

(TOA \$ in Millions)

	<u>FY 1993</u>	<u>Military Training</u>		<u>Delta</u>
		<u>FY 1994</u>	<u>FY 1995</u>	
Army	2,338.2	2,194.1	2,303.2	+109.1
Navy	1,311.2	1,395.2	1,410.5	+15.3
Marine Corps	187.4	197.1	193.2	-3.9
Air Force	1,100.7	1,329.6	1,404.1	+74.5
Defense Acquisition Univ.	-	104.5	110.1	+5.6
Defense Business Mgmt Univ.	2.9	3.8	3.9	+0.1
<b>Total</b>	<b>4,940.4</b>	<b>5,224.3</b>	<b>5,425.0</b>	<b>+200.7</b>

Recruiting, Advertising, and Other Support

Army	648.4	633.4	648.2	+14.8
Navy	191.3	198.2	196.6	-1.6
Marine Corps	78.5	76.7	81.0	+4.3
Air Force	200.7	205.9	212.3	+6.4
<b>Total</b>	<b>1,118.9</b>	<b>1,114.2</b>	<b>1,138.1</b>	<b>+23.9</b>

The increases in Army for both Training and Recruiting include price growth of \$62.9 million, transfers of \$34.2 million, and program growth of \$26.7 million. Increases are for a test program to provide \$2,000 stipends to non-scholarship ROTC students, enlisted advertising, flight training, environmental (which is addressed in another PBD) and restoration of funds for the Defense Business Operations Fund base support test.

The Navy increase is the result of cost growth and increases in real property maintenance which are addressed in another PBD. The Navy has reduced the cost of ROTC scholarships by establishing caps and providing scholarships to more senior students. Flight training increases slightly to reflect increases in Maritime and Strike pilot training.

The Marine Corps program reflects increases in the number of recruits and recruit training offset by reductions in contracted training, civilian personnel, and real property maintenance projects.

The Air Force increases in FY 1995 reflect the restructure of the training program and expansion of flight training to a two track system (one for Bomber/Fighter pilots and one for Tanker/Transport pilots). In addition, the Air Force increases the ROTC scholarship program to support an increased requirement for officers and the recruiting program to enhance awareness of opportunities in the Air Force.

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Defense Acquisition University (DAU) and Defense Business Management University are newly established programs. DAU program is increasing in order to reduce the backlog of career personnel needing mandatory training courses.

**U.S. Military Entrance Processing Command (MEPCOM) Manpower:**

USMEPCOM conducts medical examinations and qualification tests for Service applicants. The Department of Army is the executive agent for MEPCOM and funds the majority of the operation and maintenance costs. The MEPCOM's medical functions are now funded in the Defense Health Program and the drug testing is financed by transfer from the Drug Interdiction and Counter-Drug appropriation. Each Service provides military manpower in proportion to its share of the workload.

MEPCOM has recently completed a review of its manpower requirements in view of the force drawdown and indicated that the following reductions can be made. These reductions have not been reflected in the budget.

	<u>Current</u> FY 1994/FY 1995	<u>Revised</u> FY 1994	<u>Revised</u> FY 1995	<u>Delta</u> in 94	<u>Delta</u> in 95
Army					
Officers	135	132	132	-3	-3
Enlisted	605	586	586	-19	-19
Navy					
Officers	71	69	69	-2	-2
Enlisted	317	307	307	-10	-10
Marine Corps					
Officers	29	28	28	-1	-1
Enlisted	128	124	124	-4	-4
Air Force					
Officers	36	35	35	-1	-1
Enlisted	160	155	155	-5	-5
Civilians	1,442	1,397	1,397	-45	-45
Examining Program				(-26)	(-26)
Drug Program	-	-	-	(-7)	(-7)
Health Program	-	-	-	(-12)	(-12)

The alternative includes the end strength changes shown above (except for the Marine Corps whose end strength is fixed) and reduces FY 1994/FY 1995 by \$1.5/\$2.9 million. The changes are extended into the outyears.

**DoD Recruiting Facilities Lease Program:** The Joint Recruiting Facilities Committee has instituted a lease cost reduction program consistent with recruiting personnel changes. As a result, the lease program is reviewed each year and closures and consolidations are implemented where possible. The savings have not been fully reflected in the budget. Therefore, the alternative reduces FY 1995 by \$2.0 million and extends the reduction into the outyears.

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ARMY

Accession Training: The Army's FY 1994 budget estimate for Recruit Training and Officer Acquisition has increased by \$9.0 million from the FY 1994 President's budget. A portion of the increase (\$2.0 million) is for civilianization of military positions at the Military Academy. The remaining \$7.0 million is not justified. In addition, FY 1993 budget execution for the two programs was \$4.9 million below the budget plan and workload for recruit training has fallen from 12,370 recruits to 10,656. Based on the above, the alternative reduces FY 1994/FY 1995 by \$7.0/\$7.2 million and extends the reduction into the outyears.

Army Flight Training: The FY 1995 estimate includes an increase of \$4.7 million to train additional pilots. A comparison of authorized strength in the combat aviation units to on-board strength, indicates that the Army has excess pilots. In addition, the flight training workload shown in the budget justification decreases in FY 1995. Therefore, the increase in flight training does not appear to be warranted. The alternative includes a reduction of \$4.7 million and adjusts the outyears accordingly.

Junior ROTC (JROTC): In last year's PBD 033 on Recruiting, Advertising, and Other Personnel Activities, the Army was provided an additional \$45.1 million in O&M for a total of \$80.6 million to finance the stand-up and support of additional JROTC units. At the end of FY 1995, the Army was programmed to have 1,375 units. In the current FY 1995 budget submission, the Army has funded 1,322 units at a cost of \$70.1 million. The Army is directed to restore funding to JROTC in FY 1995 to stand-up the additional 53 JROTC units.

Senior ROTC: The Army allows anyone to enroll in ROTC even if they are ineligible for military service. Each year, approximately 10,000 students out of the 41,000 Army ROTC students are ineligible because of health problems or because they are non-U.S. residents. These students receive uniforms and some field training. Approximately 7,200 of these students are freshmen; the remainder are in the upper classes.

In addition, in FY 1992/FY 1993, the Army commissioned 1,103/936 ROTC graduates into the Individual Ready Reserve (IRR). This constitutes over twenty percent of the total number of ROTC graduates commissioned into the active, Guard, and Reserve components. The IRR officers attend a basic officer course funded in the Reserve Personnel, Army account and then are placed in an inactive status.

The Department is investing scarce resources in these two groups of students without obtaining optimum return. A policy change should be implemented so as to improve the screening process to eliminate these two groups from the ROTC program. Therefore, the alternative includes the following adjustments in FY 1995 and extends the reduction into the outyears:

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(TOA \$ in Millions)

	FY 1995
Reserve Personnel, Army	
Uniforms/Field Training	\$-1.7
Officer Basic Course	-18.7
Operation and Maintenance, Army	-11.6
Total	-32.0

**NAVY**

Bachelor Housing: The operating costs for Navy bachelor housing for accession, basic skills and advanced training are increasing as the number of facilities is decreasing. The following table compares the operating costs per facility (maintenance and repair and purchase of furnishings are excluded) for each year.

	FY 1993	FY 1994	FY 1995
Bachelor Housing Operations			
(\$ in Millions)	4.5	7.6	8.3
Number of Facilities	482	424	413
Cost per Facility	9,300	17,900	20,100

The alternative holds FY 1994 and FY 1995 to the FY 1993 unit cost plus inflation and reduces FY 1994/FY 1995 by \$3.6/\$4.3 million. The reduction is extended into the outyears.

**AIR FORCE**

Air Force Academy: The Office of the Inspector General conducted a review of the non instructional military positions at the Air Force Academy. Report 94-002, "Noninstructional Military Positions at the United States Air Force Academy," issued by the IG recommended that 23 military positions be eliminated and 196 positions be converted to civilian for a savings of \$2.5 million in FY 1994. The Air Force budget does not reflect the changes recommended by the IG. Because FY 1994 has already begun and the Air Force will have difficulty achieving the reductions in FY 1994, the alternative includes the following adjustments to implement the IG recommendations beginning in FY 1995:

	FY 1995	Outyears
O&M	2.9	24.2
Mil Pers	-4.1	-34.9
Net Savings	-1.2	-10.7
Personnel		
Civilian	196	196
Military	-219	-219

Flight Screening: Flight screening increases from \$7.7 million in FY 1993 to \$9.2/\$10.3 million in FY 1994/FY 1995 as the T-3A Enhanced Flight Screener is activated. Flight screening is provided to

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potential pilots in ROTC, the Air Force Academy, or Officer Training Schools in order to screen out students before they get into undergraduate pilot training (UPT). The purpose of the Enhanced Flight Screener is to wash-out pilot candidates early before they are in the more expensive undergraduate pilot training. The program should reduce attrition in UPT, however, attrition increases from 9.0 percent of students entering UPT to 15.4 percent in FY 1994/FY 1995. As a minimum, the additional cost of the Enhanced Flight Screener program should be offset by savings resulting from reduced attrition in UPT. Therefore, the alternative reduces FY 1994/FY 1995 by \$1.5/\$2.6 million and extends the reduction into the outyears.

**SUMMARY OF ADJUSTMENTS:**

(TOA, Dollars in Millions)

	<u>FY 1994</u>	<u>FY 1995</u>
Alternative Estimate		
Military Personnel, Army		
MEPCOM	-.4	-.7
Military Personnel, Navy		
MEPCOM	-.2	-.4
Military Personnel, Air Force		
MEPCOM	-.1	-.3
Air Force Academy	-	-4.1
Subtotal	-1.1	-4.4
Reserve Personnel, Army		
Senior ROTC	-	-20.4
Operation and Maintenance, Army		
MEPCOM Civilians	-.5	-.9
Recruiting Leases		-2.0
Accession Training	-7.0	-7.2
Flight Training	-	-4.7
Senior ROTC	-	-11.6
Subtotal	-7.5	-26.4
Operation and Maintenance, Navy		
Bachelor Housing	-3.6	-4.3
Operation and Maintenance, Air Force		
Air Force Academy	-	+2.9
Flight Screening	-1.5	-2.6
Subtotal	-1.5	+.3
Defense Health Program		
MEPCOM Civilians	-.2	-.4

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	<u>FY 1994</u>	<u>FY 1995</u>
Drug Interdiction MEPCOM Civilians	-.1	-.2
Total Reduction	-13.6	-56.9
 <u>Military End Strength</u>		
Military Personnel, Army MEPCOM	-22	-22
Military Personnel, Navy MEPCOM	-12	-12
Military Personnel, Air Force MEPCOM	-6	-6
Air Force Academy	-	<u>-219</u>
Subtotal	<u>-6</u>	<u>-225</u>
Total Military End Strength	-40	-259
 <u>Civilian End Strength</u>		
Operation and Maintenance, Army MEPCOM Civilians	-38	-38
Operation and Maintenance, Air Force Air Force Academy		+196
Drug Interdiction MEPCOM Civilians	-7	-7
Total Civilian End Strength	-45	+151

**OUTYEAR IMPACT:**

	<u>(TOA, Dollars in Millions)</u>			
	<u>FY 1996</u>	<u>FY 1997</u>	<u>FY 1998</u>	<u>FY 1999</u>
Service Estimate	6,531.2	6,552.6	6,528.6	6,677.7
Alternative Estimate				
Military Personnel, Army	-.7	-.7	-.7	-.8
Military Personnel, Navy	-.4	-.4	-.4	-.4
Military Personnel, Air Force	-8.9	-9.0	-9.2	-9.4
Reserve Personnel, Army	-20.9	-21.3	-21.8	-22.3
Operation and Maintenance, Army	-27.0	-27.6	-28.2	-28.8
Operation and Maintenance, Navy	-4.4	-4.5	-4.6	-4.7
Operation and Maintenance, AF	+3.2	+3.3	+3.4	+3.5
Defense Health Program	-.4	-.4	-.4	-.4
Drug Interdiction	<u>-.2</u>	<u>-.2</u>	<u>-.2</u>	<u>-.2</u>
Total Reduction	-59.7	-60.8	-62.1	-63.5

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	<u>FY 1996</u>	<u>FY 1997</u>	<u>FY 1998</u>	<u>FY 1999</u>
<b><u>Military End Strength</u></b>				
Service Estimate	166,660	163,718	164,248	164,064
<b>Alternative Estimate</b>				
Army	-22	-22	-22	-22
Navy	-12	-12	-12	-12
Air Force	<u>-225</u>	<u>-225</u>	<u>-225</u>	<u>-225</u>
Total Military End Strength	-259	-259	-259	-259
<b><u>Civilian End Strength</u></b>				
Service Estimate	55,420	54,887	54,669	54,355
<b>Alternative Estimate</b>				
Army	-38	-38	-38	-38
Air Force	+196	+196	+196	+196
Drug Interdiction	<u>-7</u>	<u>-7</u>	<u>-7</u>	<u>-7</u>
Total Civilian End Strength	+151	+151	+151	+151

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**PROGRAM BUDGET DECISION**

041

No.

**SUBJECT:** Defense Health Program (DHP)

**DOD COMPONENTS:** Army, Navy, Air Force, OSD, WHS

**ISSUE:** Should the DHP budget be realigned to fully fund CHAMPUS? Should Health Affairs address resource implications of options for the nationwide HMO benefit?

	<u>(TOA, Dollars in Millions)</u>	
	<u>FY 1994</u>	<u>FY 1995</u>
Service Estimate	9,080.5	9,485.5
Alternative Estimate	+272.8	-26.3*

\*In addition, the alternative resolves a \$507 million shortfall identified by Health Affairs.

**SUMMARY OF EVALUATION:** Health Affairs identified a \$700 million shortage (\$507 million after PDM add) which is allocated to the CHAMPUS program, while a \$641 million program increase is included for patient care activities. In addition to FY 1994 congressional action, this PBD reflects:

- Repricing and reduction of FY 1995 CHAMPUS requirement by \$238 million consistent with Bureau of Labor Statistics (BLS)/OMB medical inflation indices;
- Direction to Health Affairs to reevaluate CHAMPUS requirement and to resolve the newly priced CHAMPUS shortfall by transferring any required balance from direct patient care;
- Realignment of \$337 million of the \$641 million program increase for patient care to CHAMPUS, leaving \$303.7 million to fund FY 1995 cost of FY 1994 congressional add;
- Reductions in supplemental care, examining activities, and the health professions scholarship program due to pricing and policy reforms (-\$26.3 million);
- Direction to Health Affairs to present options for a less costly nationwide health benefit to the Deputy Secretary before any new regional managed care initiatives are undertaken; and,
- Direction to Health Affairs to realign and reprice FY 1994 and FY 1995 resources to comply with BLS/OMB inflation indices, and to manage the resources to remain within the total provided.

**ALTERNATIVE ESTIMATE:** Resolve FY 1995 shortfall with realignment/ repricing; net FY 1995 reduction of \$26.3 million and additional reduction of \$124.3 million from FY 1996-FY 1999. Health Affairs to complete analysis of options for Nationwide HMO benefit.

THE DEPUTY SECRETARY APPROVED THE ALTERNATIVE  
ESTIMATE EXCEPT \$4.0 MILLION FOR HEALTH CARE  
SCHOLARSHIP PROGRAM.

DECISION \_\_\_\_\_

Date DEC 18 1993

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## PBD Continuation Sheet

041

No.

### DETAIL OF EVALUATION:

This PBD addresses the following issues related to the Defense Health Program:

- FY 1994 Congressional Action
- Uniform Health Care Benefit
- CHAMPUS Shortfall
- Direct Patient Care
- Medical Examining Activities
- Care in Non-Defense Facilities
- Health Professions Scholarship Program
- Composite Health Care System
- Budget Activity Structure
- Technical Adjustments

### ADJUSTMENTS TO REFLECT FY 1994 CONGRESSIONAL ACTION

FY 1994 Congressional Action on the Defense Health Program: The alternative aligns the FY 1994 Defense Health Program budget estimates with the amounts appropriated. The extension of the congressional add in FY 1995 and the outyears is addressed later in this PBD. A summary of these adjustments follows:

<u>Congressional Adjustments:</u>	<u>(TOA, Dollars in Millions)</u>	
	<u>FY 1994</u>	<u>FY 1995</u>
<u>Operation and Maintenance (O&amp;M)</u>		
DBOF Test	-49.9	
Phys Asst/Rural Health Care	-1.0	
Head and Neck Injury	-6.0	
Funding "Shortfall"	+289.5	(+303.7)
Lab Technology Demo	+1.0	
Physicians Assistant/Rural Care	+1.3	
William Beaumont/Indigent Care	+2.5	
Medical Imaging	+3.0	
Head and Neck Injury	+7.0	
Composite Health Care System	+9.0	
Blood/Anatomic Pathology	+5.0	
Nursing Research	+3.0	
Nurse Practitioner Program	+2.0	
Pacific Island Referral	+2.5	
Brown Tree Snakes	+1.0	
Clinical Investigation	+.5	
National Museum of Health	+1.5	
Subtotal, O&M	+271.9	(+303.7)
<u>Procurement</u>		
Digital Mammography	+.9	
Total, Defense Health Program	+272.8	- (+303.7)

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No.

UNIFORM HEALTH CARE BENEFIT

The FY 1994 Defense Authorization Act requires the Secretary of Defense to prescribe and implement a uniform Health Maintenance Organization (HMO) benefit for nationwide implementation by February 1, 1994.

The statute requires that the cost to the Department of this health benefit option be no greater than the costs that would otherwise be incurred to provide health care to the covered beneficiaries who enroll in the option.

Health Affairs is proceeding with a plan to implement the same benefit structure nationwide as was implemented in three Base Realignment and Closure (BRAC) sites during FY 1993. Health Affairs states that national expansion of this revised CHAMPUS Reform Initiative (CRI) benefit would be budget neutral or would lower Department medical costs when examined on a nationwide basis. However, there is insufficient information and experience to establish that this benefit would be either cost neutral or generate savings. In addition, the Congressional Budget Office has issued a November 1993 report that questions the assumptions that Health Affairs has used in its cost certification analysis.

The following data provided by Health Affairs show the beneficiary and government shares of per capita CHAMPUS costs under standard CHAMPUS and the revised CRI benefit structure that Health Affairs proposes to expand nationwide.

<u>Benefit Structure</u>	<u>Active Duty Dependents</u>		<u>Retirees and Dependents</u>	
	<u>DoD</u>	<u>Benef.</u>	<u>DoD</u>	<u>Benef.</u>
Standard CHAMPUS	82%	18%	68%	32%
Revised CRI	89%	11%	80%	20%

This table demonstrates that under the revised CRI benefit the Department's share of health care costs is significantly more than under standard CHAMPUS.

Existing statute and legislation proposed in conjunction with the President's National Health Reform require that DoD not proliferate a health benefit structure that is more costly to beneficiaries than standard CHAMPUS. However, the figures above indicate that there is a range for discussion of the Department's appropriate share of the medical benefit, without approaching an erosion of benefits when compared to standard CHAMPUS.

With the Health Affairs budget submission describing a funding shortfall in FY 1994, and FY 1995, the Department needs to consider options and their resource implications before proceeding on a nationwide basis.

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The alternative requires that the ASD (Health Affairs) reevaluate the revised CRI benefit and propose at least two additional options that will be less costly to the Department while remaining consistent with existing statutory requirements and the President's National Health Reform proposal. The analysis of options should address the total health benefit package to be offered nationwide by incorporating:

- Any available findings of the congressionally directed Section 733 study of the military health care system;
- Plans to address cost and benefit concerns raised in this PBD related to the contract dental program, the Uniformed Services Treatment Facility (USTF) program and the PRIMUS/NAVCARE program;
- Plans and timeline for amending/recompeting existing managed care contracts and Requests for Proposals to ensure compatibility with the national plan and statutory cost effectiveness requirement (details discussed later in PBD);
- Issues that Health Affairs has indicated that it intends to pursue such as the issue of equity between the MTF costs to the beneficiary and the proposed nationwide benefit, e.g., the issue of MTF user fees;
- Any proposed legislation needed to effect or implement any of the proposed options; and,
- Use of BLS-OMB approved inflation indices for price assumptions, with any projected costs above these rates to be displayed as program increases with cost comparisons to include total military health system costs -- both direct care and CHAMPUS, as specified in the FY 1994 Authorization Act.

The report should be presented by Health Affairs to the Deputy Secretary for his decision after coordination with the Director, Program Analysis and Evaluation and Comptroller. Again, the report should clearly demonstrate that the options presented are cost beneficial to the Department as required in existing statute. Until the analysis is completed and a decision made by the Deputy Secretary, Health Affairs is directed not to take any action to expand the revised CRI benefit to new geographical areas, or to modify the benefits under discussion in connection with the national plan.

**ALLOCATION OF RESOURCES WITHIN THE DHP**

The budget submission from Health Affairs identifies a \$700 million funding shortage in the CHAMPUS program and a \$641 million program increase for medical care delivered in military medical facilities (direct patient care) in FY 1995.

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<u>Service Estimate</u>	<u>(Dollars in Millions)</u>		
	<u>FY 1993</u>	<u>FY 1994</u>	<u>FY 1995</u>
Direct Patient Care	\$3,334.0	\$2,820.1	\$3,535.8
CHAMPUS	<u>3,568.7</u>	<u>3,865.3</u>	<u>3,313.3*</u>
Total	6,902.7	6,685.4	6,849.1

\* The CHAMPUS requirement was cited in the DHP budget submission as \$4,013.3 million, but only \$3,313.3 million was applied to CHAMPUS. The submission identified the \$700 million difference as a CHAMPUS shortage.

The alternative addresses the CHAMPUS shortage by reevaluating its validity, and directing Health Affairs to conduct its own reevaluation of price and program requirements based on correct pricing assumptions. Health Affairs is then directed to resolve the newly priced shortfall by realigning a portion of the \$641 million program increase from direct patient care to the CHAMPUS program.

Several Defense Health Program programs are identified as requiring further cost and benefit analysis as part of Health Affairs' analysis of options for the nationwide health benefit. These programs are: the managed care support contracts and contract dental benefit currently funded out of the CHAMPUS total and the Uniformed Services Treatment Facilities and PRIMUS/NAVCARE programs funded out of the care in non-defense program activity.

**CHAMPUS-OVERALL PER CAPITA ANALYSIS**

As displayed on the following page, the Service Estimate for the CHAMPUS requirement includes a per capita increase of 10.6 percent in FY 1994 and 7.7 percent in FY 1995. These rates exceed the Bureau of Labor Statistics (BLS)-based OMB inflation rates approved for use by all Federal health programs. The current rates prescribed by BLS/OMB are 5.1 percent and 4.9 percent in FY 1994 and FY 1995, respectively. These rates are based on recent trends in the medical consumer price index that reflects the variation in the price of drugs, medical equipment, professional services, and hospital services. The composite nature of the Bureau of Labor Statistics (BLS) price index accounts for price trends related to technology and intensity of care, as these are reflected in the professional services and hospital services cost components of the composite rate.

The alternative indicates that the FY 1995 unfunded requirement identified by Health Affairs for the CHAMPUS program is overstated by as much as \$238.2 million in FY 1995 when priced to comply with the prescribed BLS/OMB rates.

The alternative directs Health Affairs to reassess its CHAMPUS requirements using the BLS/OMB indices for price growth, with the balance of any "requirement" to be displayed as program growth. The alternative does not reduce the FY 1994 overestimate for CHAMPUS

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requirements because of the significant one-time costs that are budgeted in this year for transition of the California/Hawaii CRI contract to a new contractor and because of Health Affairs contention that the FY 1994 budget for the DHP is "underfunded."

**Per capita CHAMPUS Costs**

(Dollars in Millions)

	<u>FY 1993</u>	<u>FY 1994</u>	<u>FY 1995</u>
<b><u>Service Estimate</u></b>	<b>\$3,568.7</b>	<b>\$3,865.3</b>	<b>\$4,013.3</b>
CHAMPUS Eligibles	5,581,503	5,464,942	5,362,333
Per Capita Cost	\$639	\$707	\$748
Percentage Increase		+10.6%	+5.8%
<b><u>Alternative Estimate</u></b>	<b>\$3,568.7</b>	<b>\$3,672.4</b>	<b>\$3,775.1</b>
Per Capita Cost	\$639	\$672	\$704
Percentage Increase		<u>+5.1%</u>	<u>+4.9%</u>
<b>Difference from Service Estimate</b>		<b>-192.9</b>	<b>-238.2</b>

**CHAMPUS - ACTIONS TO ACHIEVE SAVINGS:** The CHAMPUS program funds several regional managed care initiatives in addition to standard CHAMPUS benefit claims. Recognizing that any reduction to total CHAMPUS requirements must be addressed on a program-by-program basis, the alternative recommends that Health Affairs conduct this reevaluation of CHAMPUS program requirements. Following is an analysis of standard CHAMPUS claims and the European benefit program -- both of which appear to be overstated. Health Affairs should consider applying these \$73.3 million savings identified below to the \$238.2 million reduction in CHAMPUS requirements.

	<u>FY 1995</u>
<b><u>Savings From Within the CHAMPUS Program</u></b>	<b><u>\$73.3</u></b>
Standard CHAMPUS Benefit	(60.3)
CHAMPUS Benefits in Europe	(13.0)

**Standard CHAMPUS Benefits**

Based on a per capita comparison similar to the one performed for CHAMPUS in total, the standard benefit portion of FY 1995 CHAMPUS requirements appears to be overstated, when compared to approved BLS/OMB medical inflation rates, by \$60.3 million in FY 1995. The potential savings is based on the number of total CHAMPUS eligibles nationwide declining. This decline should reduce standard-CHAMPUS benefit requirements.

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The number of CHAMPUS eligibles continuing to use and file standard CHAMPUS claims can be expected to further decline as managed care options are expanded. Health Affairs is requested to examine this data and the projected CHAMPUS eligibles in reassessing the appropriate funding level for standard CHAMPUS claims, with the \$60.3 million savings estimate viewed as a minimum savings.

CHAMPUS Benefits in Europe: The FY 1995 submission requests \$54.8 million for the payment of CHAMPUS claims for beneficiaries residing in Europe. This amount is a 25 percent increase over the \$43.5 million FY 1993 actual expenditure for this program. The FY 1995 overseas cost report indicates that total DoD medical care expenditures in Germany are declining by 65 percent over the same time period. Using the FY 1994 current estimate as a base, it appears that the FY 1995 request is overstated by approximately \$13 million. The alternative reduces the CHAMPUS requirement by this amount.

CHAMPUS Components to be addressed in Options for Nationwide Benefit

As part of the analysis of the CHAMPUS requirement, the budget submission for several large components of the CHAMPUS requirement were also examined. While the significant funding request for these programs is of concern, Health Affairs believes that the PBD is not the appropriate vehicle to make major policy decisions affecting the Department's health benefit or the cost sharing burden imposed on beneficiaries. Consequently, the benefit, policy, and cost effectiveness questions raised in this PBD on the following issues will be deferred for Health Affairs to address as part the analysis of options for a nationwide HMO benefit.

CHAMPUS Dental Contract  
CRI Contract in California and Hawaii  
Managed Care Contract in New Orleans  
Amendment of Region 6 RFP

CHAMPUS Dental Contract: In FY 1993 the program of contract dental care for active duty dependents was expanded, with \$50 million authorized and appropriated for the six month cost of the additional benefit. The FY 1993 actual cost for this program exceeded the \$50 million authorized and appropriated by nearly \$40 million. Costs related to the expanded program in FY 1994 are estimated at \$120 million, compared to \$105 million in the President's Budget. In FY 1995, \$162 million is estimated to be required versus the \$111 million that was included for FY 1995 in last year's PBD 041. In part, this unanticipated cost is due to a higher enrollment in the program than anticipated. Health Affairs also contends that the 10% reduction imposed on the direct care system's dental capacity as part of the FY 1994 Program Review has contributed to the increased enrollment in the expanded benefit. As part of the Uniform HMO benefit review, Health Affairs should include a redesign of the benefit and co-payment structure for the contract dental program

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within the latitude provided in the authorizing statute. Health Affairs' redesign should ensure that the expanded program remain within the \$100 million magnitude contemplated by Congress in authorizing the expanded benefit. If a modification to the restriction on direct care dental capacity is need to achieve this goal, the Uniform HMO benefit review should also address this requirement.

**CRI Contract in California and Hawaii:** Health Affairs has indicated to the Deputy Secretary that it plans to amend the CRI contract in California and Hawaii to implement the revised CRI benefit structure, that presumably would be less costly to the Department. Health Affairs has indicated that it could realize a 4 percent savings from a revised benefit structure. However, contract modifications to implement this structure can exceed the 4 percent savings. The fact that this contract modification requires the total savings that would accrue from adopting a revised benefit structure argues for more careful consideration of benefit options before proceeding with additional regional contracts. In designing its options for the Secretary, Health Affairs should use its five years of experience in operating the CRI contract and the documented reasons for the cost escalation experienced to ensure that the Uniform HMO benefit will not proliferate any potentially costly features nationwide.

**Managed Care Contract in New Orleans:** The budget submission includes \$187.6 million for the managed care contract based in New Orleans. If standard CHAMPUS had been continued in New Orleans and the three BRAC sites that were added to the contract in FY 1993, the cost to the Department would have been \$153.8 million in FY 1995 for the New Orleans area. One reason for the costly nature of the New Orleans contract is that it includes the original CRI benefit structure that was evaluated as costing the Department 11 percent more than standard CHAMPUS while it was being offered in California and Hawaii. In addition, the contract region has no large military medical facilities offering care as an alternative to the usually more costly civilian sector. However, the \$33.8 million or 22 percent higher cost of the contract when compared to standard CHAMPUS remains a concern. With 85 percent of the beneficiaries enrolled covered by the revised CRI benefit, this contract represents the only actual experience to-date in operation of the revised CRI/BRAC benefit advocated by Health Affairs for nationwide implementation. This experience with enrollment and the resulting cost increase should also be considered by Health Affairs in proposing more cost effective options for a nationwide benefit.

**Cost Certification for Region 6:** On November 1, 1993 Health Affairs informed the Deputy Secretary of the intent to issue a Request for Proposals (RFP) for a regional Managed Care Support Contract to be based in Texas. Once implemented, this Managed Care Support Contract for Region 6 will cover the states of Oklahoma, Arkansas, Texas, and Louisiana. Supporting documentation in the Health Affairs analysis included the following table displaying potential costs to the Department for Region 6:

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Military Health Services System Costs in Region 6

(Dollars in Millions)

	<u>Without Contract</u>	<u>Increase Past FY</u>	<u>With Contract</u>	<u>Diff.</u>
FY 1995	1,424		1,417	-7
FY 1996	1,520	+6.7%	1,513	-7
FY 1997	1,617	+6.4%	1,611	-6
FY 1998	1,728	+6.9%	1,722	-6
FY 1999	<u>1,847</u>	+6.9%	<u>1,842</u>	<u>-5</u>
<b>Health Affairs Total</b>	<b>8,136</b>		<b>8,105</b>	<b>-31</b>
<b>BLS/OMB-indexed Total</b>	<b>7,851</b>	<b>+4.9%</b> (annually)	<b>8,105</b>	<b>+254</b>

Health Affairs Projection: The above table indicates that, without implementation of the Managed Care Support Contract in the Texas Region, Health Affairs estimates that FY 1995-FY 1999 cumulative Military Health Services System costs in the region could be expected to total \$8.1 billion, based on inflation, and underlying trends in utilization per capita. With implementation of the contract and the revised CRI benefit, Health Affairs estimates that these total costs would be reduced by \$31 million from FY 1995-FY 1999, a savings of .4 percent.

BLS/OMB-indexed Projection: If the current costs in the Region (without contract) are inflated consistent with the Bureau of Labor Statistics-based OMB medical inflation index of 4.9% each year, the Region 6 contract will result in cumulative costs that are \$254 million higher, rather than the \$31 million in savings cited by Health Affairs. If the the FY 1995-FY 1999 programmed resources were reduced to ensure that they do not exceed the correctly priced program costs, a cumulative reduction of \$254 million would be required to Health Affairs' programmed resources.

The cost/savings analysis that the DHP provided for this managed care support contract is of concern because this was one of the regions of the country that was portrayed as having a potential for substantial cost savings. Health Affairs should not proceed with this acquisition until completion of the Department's review of the options for the Uniform HMO benefit.

DIRECT PATIENT CARE SUPPORT

Unsubstantiated \$641 Million Program Increase: This budget activity supports the delivery of patient care in DoD hospitals and clinics worldwide to eligible beneficiaries. The budget submission includes \$3.536 billion in FY 1995, an increase of 25 percent over the FY 1994

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current estimate of \$2.820 billion. This reflects a program increase of \$641.1 million.

Budget justification materials provide no details on the intended use for an increase of this magnitude. A request for details on the increase yielded no additional data.

The decline in the following statistics related to direct patient care raise additional questions about the need for an FY 1995 program increase in this activity:

Direct Patient Care

	<u>FY 1993</u>	<u>FY 1994</u>	<u>FY 1995</u>
Total Beneficiaries	8,722,714	8,544,531	8,322,093
Hospitals	147	140	133
Medical Clinics	551	520	504
Average Daily Patient Load	8,885	8,659	8,473
Ambulatory Visits (000s)	45,181	44,084	43,106

Based upon the lack of justification and the declining workload and infrastructure for direct medical care, the alternative recommends retaining a minimum of \$303.7 million of the \$641 million program increase in direct patient care to fund the FY 1995 impact of FY 1994 congressional action. The balance should be carefully evaluated by Health Affairs for its requirement after the CHAMPUS shortfall is resolved before applying it to the new patient care activity group as part of the FY 1995 President's Budget.

Capitation Budgeting: In allocating total Defense Health Program resources on a per capita basis, Health Affairs has stated that capitation is an important strategy to containing costs. However, the FY 1995 budget submission reflects no savings from implementation of the capitation methodology.

There is evidence that capitated budgeting will reduce resource requirements significantly. The Army Health Services Command experienced 1.4 and 2.0 percent savings in the first and second years of a demonstration project on capitation budgeting. As PA&E pointed out during the FY 1995 POM review, civilian health literature reports one time savings of 4.5 to 8 percent. Based on precautionary statements from Health Affairs and the Services, the alternative does not quantify a FY 1995 savings from the capitation methodology. However, these savings, that could approach \$100 million, will be reevaluated after FY 1994 actual experience with the capitated allocation to determine if the capitation methodology employed by Health Affairs should be modified.

Because capitation allocation is difficult to manage without knowing how many beneficiaries are planning to use the DoD system, Health Affairs is directed to include definitive plans for an enrollment system as part of its options for the Nationwide Benefit and in

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anticipation of enrollment requirements associated with National Health Reform.

**EXAMINING ACTIVITIES**

**Military Entrance Processing (MEP):** The Defense Health Program is responsible for funding the cost of the medical portion of entrance exams for new accessions into the Military Departments. The Army is executive agent for the MEP program. The DHP budget submission includes \$26.0 million for an estimated 393.6 thousand accession exams, an increase of 30.5 thousand exams over FY 1994. The alternative reduces the service estimate by \$2.3 million based on the Army Training and Recruiting budget estimate of only 359.1 thousand medical entrance exams to be required in FY 1995. The outyears have been adjusted accordingly.

**CARE IN NON-DEFENSE FACILITIES**

**Supplemental Care for Non-active duty Beneficiaries:** The supplemental care program was originally designed to fund the cost of civilian health care for active duty personnel when care is not available through military facilities, or when the active duty member, of necessity, is required to obtain emergency care from a civilian facility. The budget submission includes \$241.3 million for supplemental care compared to \$242.8 million in FY 1993 and \$208 million in FY 1994. A substantial portion of supplemental care is now used to support care for non-active duty beneficiaries, with Health Affairs estimating that as much as \$100 million or over 40% of the supplemental care budget was used to support non-active duty beneficiaries in FY 1993. This expanded use of supplemental care for non-active duty personnel could be viewed as a means to avoid CHAMPUS deductible and co-payment requirements, and/or to finance care obtained from the civilian sector for individuals not eligible for CHAMPUS. Based on the 20 to 25 percent CHAMPUS copayment requirement for non-active duty beneficiaries who are inappropriately using supplemental care, the alternative reduces the FY 1995 program estimate by \$20 million. The outyears have been adjusted accordingly.

**Uniformed Services Treatment Facilities:** The Department assumed responsibility for these 10 former Public Health Service hospitals in FY 1982, to provide them with an income base while they sought to obtain more patients from their communities and become less dependent on the income from the uniformed services patients. Since this time, the USTFs have operated under a series of agreements with the Department. This informal funding arrangement has proved so popular with the USTFs that they were successful in FY 1993 in obtaining an exemption from the Federal Acquisition Regulations in the Authorization Act. The request for FY 1995 of \$216.3 million represents a ten percent increase over the FY 1994 President's Budget. Subsequent to the budget submission, Health Affairs has pointed out that the current UTF program agreements provide for updating rates in FY 1995 at a level 3 percent higher than the change

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in the medical services component of the consumer price index. Consequently, Health Affairs concludes that an additional \$69 million is required for the program in FY 1995 -- a requirement that is unfunded in the budget submission. The alternative directs Health Affairs, in conjunction with General Counsel, to draft any legislation needed to remove these facilities' non-competitive status and to address the incorporation of the USTFs into plans for the Uniform HMO benefit. Management actions should be taken the necessary lead time away to ensure that the FY 1995 costs can be absorbed within total DHP requirements.

PRIMUS/NAVCARE Program: The budget submission requests \$105.6 million for the PRIMUS/NAVCARE program, a system of 22 clinics that provide outpatient care to DoD beneficiaries on a contractual basis. Through an interpretation of legislation authorizing the Department to conduct a variety of health care demonstration projects, these facilities have always been considered an extension of the Military Treatment Facilities. As such, these clinics have provided care to all categories of beneficiaries for no charge. During the past year, the Department has recognized that this affiliation with the military hospitals needs to be more clearly defined for the permanent PRIMUS/Navcare program. The alternative assumes that as the program is transitioned to a more permanent civilian contract status, that it will adopt the Uniform HMO benefit and any related co-pays and deductibles prescribed by the option selected by the Deputy Secretary.

EDUCATION AND TRAINING

Health Professions Scholarship Program: Armed Forces Health Professions Scholarships are awarded to eligible persons attending accredited educational institutions that provide training in approved health professions. Scholarship recipients receive a monthly stipend and payment of educational expenses such as tuition, fees, books, and laboratory expenses. Room, board, and non-academic expenses are excluded. The budget submission includes an increase of 10.5 percent per scholarship recipient from FY 1994 to FY 1995. The alternative reduces this increase to reflect the OMB medical inflationary allowance of 4.9 percent, reducing the \$77.9 million requested in FY 1995 by \$4.0 million. The outyears have been adjusted accordingly.

NEW BUDGET STRUCTURE FOR THE DEFENSE HEALTH PROGRAM: The alternative also establishes a new budget subactivity group structure for the Defense Health Program. This new structure will be used by Health Affairs in preparing the FY 1995 congressional justification material and subsequent budget submissions. These subactivities are not to be considered as 0-1 budget subdivisions.

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New Budget Structure:

Operation and Maintenance - Subactivities  
 Direct Patient Care  
 Standard CHAMPUS Benefits  
 Managed Care and other Contractual Support  
 Care in Non-Defense Facilities  
 Education and Training  
 Patient Care Support  
 Base Operations/Communications

**TECHNICAL ADJUSTMENTS:** Health Affairs has coordinated the following adjustments to the DHP with the Services. The net effect of these transfers and a brief description of the reason for the technical adjustment follow. (These adjustments do not reflect end strength adjustments related to these transfers. The Services are directed to make the appropriate shifts between DHP and non-DHP end strength to effect these transfers except as noted in the following.):

Navy/DHP: (TOA Dollars in Millions)

	<u>FY 95</u>	<u>FY 96</u>	<u>FY 97</u>	<u>FY 98</u>	<u>FY 99</u>
O&M, Navy	-4.0	-4.5	-3.6	-3.7	-3.7
O&M, DHP	+4.0	+4.5	+3.6	+3.7	+3.7

This transfer realigns funds between the Defense Health Program and the Navy for postal payment decentralization, public works center management, audio-visual support decentralization, branch medical clinic Yorktown base operations support, non-medical collateral equipment, environmental compliance projects, shipboard medical expense equipment, MMART block support, and medical department, Chinhae, Korea.

Marine Corps/DHP (TOA Dollars in Millions)

	<u>FY 95</u>	<u>FY 96</u>	<u>FY 97</u>	<u>FY 98</u>	<u>FY 99</u>
O&M, Marine Corps	-.2	-.2	-.2	-.2	-.2
O&M, DHP	+.2	+.2	+.2	+.2	+.2

This net transfer realigns funds for Naval Hospital Camp Pendleton fire protection.

Air Force/DHP (TOA Dollars in Millions)

	<u>FY 95</u>	<u>FY 96</u>	<u>FY 97</u>	<u>FY 98</u>	<u>FY 99</u>
O&M, Air Force	+5.2	+5.3	+5.4	+5.5	+5.6
O&M, DHP	-5.2	-5.3	-5.4	-5.5	-5.6

This net transfer realigns funds for the following functions: civilian authorizations transfer from Lowry AFB to Fitzsimmons Army Medical Center (transfer of 8 civilian end strength from Air Force to Army), Air Force base level printing services, and bioenvironmental engineering (environmental compliance).

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**ALIGNMENT RECOMMENDED IN THE ALTERNATIVE**

After repricing and reducing the projected FY 1995 CHAMPUS requirement, the alternative recommends a realignment of resources to fully fund CHAMPUS requirements with a portion of an unsubstantiated program increase for direct patient care. Health Affairs is directed to realign and reprice both FY 1994 and FY 1995 to comply with BLS/OMB inflation indices and to manage the resources to remain within the total provided. For future budget submissions, Health Affairs is directed not to align resources so as to create the perception of shortages in specific programs while providing large programmatic increases to other activities.

**SUMMARY OF ADJUSTMENTS:**

(TOA, Dollars in Millions)

<u>Alternative Estimate:</u>	<u>FY 1994</u>	<u>FY 1995</u>
<u>Defense Health Program (DHP):</u>		
<u>Congressional action:</u>		
O&M	+271.9	-*
Procurement	+.9	-
Supplemental Medical Care	-	-20.0
Medical Examining Activities	-	-2.3
Health Professions Scholarship	-	<u>-4.0</u>
Net Total, Alternative	+272.8	-26.3
<u>Technical Adjustments/Transfers:</u>		
O&M, Navy	-	-4.0
O&M, DHP	-	+4.0
O&M, Marine Corps	-	-.2
O&M, DHP	-	+.2
O&M, Air Force	-	+5.2
O&M, DHP	-	<u>-5.2</u>
Subtotal, Technical Transfers	-	-
<u>Net Adjustments by Appropriation:</u>		
<u>DHP, O&amp;M</u>	+271.9	-27.3
<u>DHP, Procurement</u>	+.9	-
<u>O&amp;M, Navy</u>	-	-4.0

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<u>O&amp;M, Marine Corps</u>	-	-.2
<u>O&amp;M, Air Force</u>	-	<u>+5.2</u>
Total, Alternative	+272.8	-26.3

Civilian End Strength (Technical Adjustment)  
(USDH)

Air Force	-	-8
Army	-	+8

\*FY 1995 cost of FY 1994 congressional action of \$303.7 million to be provided within the FY 1995 baseline for direct patient care.

OUTYEAR IMPACT:

(TOA, Dollars in Millions)

	<u>FY 1996</u>	<u>FY 1997</u>	<u>FY 1998</u>	<u>FY 1999</u>
Service Estimate	9,782.7	9,933.7	10,149.5	10,611.4
Alternative Estimate	-27.6	-28.9	-30.4	-31.8
<u>Technical Adjustments/Transfers:</u>				
O&M, Navy	-4.5	-3.6	-3.7	-3.7
O&M, DHP	+4.5	+3.6	+3.7	+3.7
O&M, Marine Corps	-.2	-.2	-.2	-.2
O&M, DHP	+.2	+.2	+.2	+.2
O&M, Air Force	+5.3	+5.4	+5.5	+5.6
O&M, DHP	<u>-5.3</u>	<u>-5.4</u>	<u>-5.5</u>	<u>-5.6</u>
Subtotal, Technical Adjustments	-	-	-	-
<u>Net Adjustments by Appropriation:</u>				
DHP, O&M	-28.2	-30.5	-32.0	-33.5
O&M, Navy	-4.5	-3.6	-3.7	-3.7
O&M, Marine Corps	-.2	-.2	-.2	-.2
O&M, Air Force	<u>+5.3</u>	<u>+5.4</u>	<u>+5.5</u>	<u>+5.6</u>
Total, Alternative	-27.6	-28.9	-30.4	-31.8

Civilian End Strength  
(USDH)

Air Force	-8	-8	-8
Army	+8	+8	+8

REISSUE

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No.

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**PROGRAM BUDGET DECISION**

SUBJECT: Uniformed Services University of the Health Sciences

DOD COMPONENTS: Army, Navy, Air Force, OSD

ISSUE: Should the Department accelerate the phase-out of USUHS?

<u>Service Estimate</u>	<u>FY 1994</u>	<u>FY 1995</u>
TOA \$ Millions	79.8	80.9
Civilian End Strength	651	651
Active Military End Strength	868	830
<u>Alternative Estimate</u>		
TOA \$ Millions	-	-10.5
Civilian End Strength	-	-127
Active Military End Strength	-	-156

SUMMARY OF EVALUATION: The Vice President's National Performance Review (NPR) proposed that the Department close the Uniformed Services University of the Health Sciences (USUHS). The NPR and accompanying supporting documents forwarded to the Congress from the Administration cite \$350 million in FY 1995-FY 1999 savings to be achieved from the phased closure.

The Defense Health Program (DHP) budget submission reflects the phased closure of USUHS with the last class to enter in the summer of FY 1994 and achieves net savings of \$50.4 million from FY 1995-FY 1999.

Based on the NPR the alternative recommends that the Assistant Secretary of Defense (Health Affairs) accelerate the phaseout of USUHS. The alternative reflects:

- cancellation of plans to select a new FY 1994 freshman class;
- no augmentation of the Health Professions Scholarship Program (HPSP) to offset the reduction in USUHS students (except for 20 students who have been given letters of acceptance from USUHS); and,
- elimination of military and civilian end strength and costs as the closure is accomplished.

ALTERNATIVE ESTIMATE: Reduce the DHP by \$10.5 million in FY 1995 and an additional \$214.9 million in FYs 1996-1999 incident to the acceleration of the closure of USUHS. The ASD (Health Affairs) should provide the Deputy Secretary of Defense a plan to accomplish the accelerated closure of USUHS no later than December 31, 1993.

THE DEPUTY SECRETARY APPROVED ALTERNATIVE EXCEPT THE HPSP IS AUGMENTED BY 624 SCHOLARSHIPS AND \$67.3 MILLION (FY 95-99). ASD(HA) IS DIRECTED TO TAKE ACTIONS NECESSARY TO MATRICULATE SECOND YEAR MEDICAL STUDENTS AT USUHS IN ORDER TO BE IN COMPLIANCE WITH TITLE 10, SECTION 2112 IN THE EVENT LEGISLATIVE RELIEF IS NOT APPROVED.

DECISION \_\_\_\_\_

Date 12/30/93

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**DETAIL OF EVALUATION:**

In 1972, the Congress enacted the Uniformed Services Health Professions Revitalization Act which established the Uniformed Services University of the Health Sciences (USUHS), a medical school operated by the Department of Defense to train physicians committed to long term military careers. In creating the University, the Congress hoped to alleviate difficulties experienced by the Military Departments in sustaining a medical corps large enough to support DoD health care needs.

Since the University was created, it has been the subject of much debate because of its relatively high cost to the Department. USUHS produces slightly less than 10 percent of the Services' physician accessions at a cost much higher than other programs to recruit and retain physicians. Based on figures from 1991, USUHS is the most expensive source of physicians at \$562 thousand per person. Military physicians who are trained under the Health Professions Scholarship Program (HPSP) cost the Department an average of \$111 thousand, and other sources of physician accessions such as the Financial Assistance Program and volunteers range in cost from \$14 to \$55 thousand each.

In recognition of the costly nature of the physician accessions produced by USUHS, the National Performance Review (NPR) recommended closing the facility and relying on the scholarship program and volunteers to meet DoD requirements for physicians. Supporting justification materials and legislative proposals submitted to the Congress in connection with the National Performance Review described total savings to the Defense Budget of \$350 million from FY 1995-FY 1999.

The FY 1995 Defense Health Program budget submission reflected the proposed closure of USUHS, but achieves net savings of only \$50.4 million from FY 1995-FY 1999. The Office of Management and Budget contends, and the Department agrees that the savings to be achieved in the FY 1995 President's Budget from closing the University should be approximately \$350 million from FY 1995-FY 1999. Based on data reflected in FY 1995 budget submission, the alternative reduces the Defense Health Program budget by an additional \$225.4 million from FY 1995-FY 1999, for direct savings to the Department totaling \$275.8 million.

The additional savings in the alternative are achieved in part by accelerating plans for USUHS closure by one year, with no new class to be accepted for entry in FY 1994. This assumption conflicts with the Defense Planning Guidance statement that the last class to enter the program as first year students will be in the summer of 1994. However, the Administration has decided to close the University. Any move to prolong this closure process -- such as proceeding with the application and selection process for a new class in 1994 -- detracts from what should be a concerted effort to effect this closure consistent with the Vice President's plan. To continue with the

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selection process in the summer of 1994 jeopardizes the Department's ability to achieve the savings projected by the National Performance Review and commits the Department to supporting yet another class of medical students through this comparatively expensive accession source.

Instead, the Department should demonstrate its support for the Administration's position by immediately developing a reasonable and detailed plan for the planned closure. As a minimum, this plan should include details on:

- the disposition of University assets (computers, vehicles, medical equipment, research facilities, and laboratory animals);
- a phase out of the University's host/tenant agreement with the National Naval Medical Center;
- the proposed use and/or transfer of the University facilities with related reimbursement/savings estimates;
- any plans for transferring students to private sector medical schools in the event the drawdown precludes the school from maintaining its accreditation until the final student is graduated;
- plans for effecting the drawdown of military and civilian staff; and,
- plans for smoothly phasing out ongoing programs (to include research grants and cooperative agreements) or transitioning them to other sources of support.

The Assistant Secretary of Defense, Health Affairs should develop and coordinate such a phase-out plan within the Department before providing it to the Congress as part of the FY 1995 President's Budget. This plan should be provided to the Deputy Secretary of Defense no later than December 31, 1993.

The alternative also assumes that the decrease in USUHS students and military and civilian staff will not be offset by increases to the Health Professions Scholarship Program and the Military Departments' medical end strength levels. The decrease in medical infrastructure and physician requirements as a result of the force drawdown argues against the need to continue to maintain medical accessions at current levels. An exception will be made for the 20 applicants who have already been given letters of acceptance for the freshman class scheduled to enter USUHS in FY 1994. The HPSP program has been increased by the approximately \$.5 million annually required to be able to offer these individuals scholarships as an alternative to attending USUHS.

The alternative eliminates all direct RDT&E funding for In-house Laboratory Independent Research at USUHS and phases out the related

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RDT&E civilian end strength. The plan to be developed by the ASD(HA) for USUHS closure should reflect input from Under Secretary of Defense (Acquisition) to ensure that this arrangement is viable.

The staffing and program resources associated with the Armed Forces Radiobiology Research Institute (AFRRI) are addressed in PBD 202 - Technology Base.

The service estimate and the alternative do not reflect an indirect savings in military construction requirements that result from the USUHS closure. The budget submission for the defense medical construction program reflects the decision to not pursue plans to construct a \$150 million new facility for the Armed Forces Institute of Pathology on the Walter Reed Army Medical Center complex. Instead, the Pathology Institute will be relocated on the USUHS campus once these facilities are vacated. The military construction requirement of \$72 million for rehabilitation of the USUHS facilities is less than half the cost of the new construction, resulting in indirect savings of \$78 million. When this indirect savings in military construction costs is added to the \$50.4 million in savings reflected in the DHP budget submission and the \$225.4 million in additional savings in the alternative, total savings (\$353.8 million) from the closure of USUHS exceeds the \$350 million cited by the National Performance Review.

**SUMMARY OF ADJUSTMENTS:**

	(Dollars in Millions)	
	<u>FY 1994</u>	<u>FY 1995</u>
Alternative Estimate		
RDT&E, Defensewide	-	-3.3
O&M, Defense Health Program	-	-1.0
Military Personnel, Army	-	-2.4
Military Personnel, Navy	-	-2.0
Military Personnel, Air Force	-	-1.8
Total	-	-10.5
	<u>End Strength</u>	
Army		
Officers	-	-60
Navy		
Officers	-	-48
Air Force		
Officers	-	-48
Defense Health Program		
Civilian, USDH	-	-76

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	<u>FY 1994</u>	<u>FY 1995</u>
RDT&E, Defensewide		
Civilian, USDH	-	-50
Civilian, FNDH	-	-1

**OUTYEAR IMPACT:**

	<u>(TOA, Dollars in Millions)</u>			
	<u>FY 1996</u>	<u>FY 1997</u>	<u>FY 1998</u>	<u>FY 1999</u>
Service Estimate	83.6	74.5	67.4	61.6
Alternative Estimate:	-36.4	-50.2	-66.7	-61.6
RDT&E, Defensewide	-3.3	-2.4	-2.4	-2.5
O&M, Defense Health Program	-16.5	-21.2	-26.4	-20.3
Military Personnel, Army	-6.8	-11.1	-14.9	-15.3
Military Personnel, Navy	-5.1	-8.0	-11.9	-12.1
Military Personnel, Air Force	-4.7	-7.5	-11.1	-11.4
Total	-36.4	-50.2	-66.7	-61.6

End Strength

Army				
Officers	-139	-218	-287	-287
Enlisted	-15	-22	-29	-29
(Students)	(-120)	(-180)	(-240)	(-240)
Navy				
Officers	-103	-157	-220	-220
Enlisted	-9	-14	-18	-18
(Students)	(-96)	(-144)	(-192)	(-192)
Air Force				
Officers	-103	-158	-221	-221
Enlisted	-12	-18	-23	-23
(Students)	(-96)	(-144)	(-192)	(-192)
Total, End Strength (Students)	-381 (-312)	-587 (-468)	-798 (-624)	-798 (-624)
Defense Health Program Civilian USDH	-348	-140	-87	-
RDT&E, Defensewide				
Civilian, USDH	-101	-151	-201	-201
Civilian, FNDH	-1	-1	-1	-1

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RDT&E APPENDIX (\$ in Thousands)				NUMBER 086	Alternative 1	
PROGRAM ELEMENT	Fiscal Year 1994	Fiscal Year 1995	Fiscal Year 1996	Fiscal Year 1997	Fiscal Year 1998	Fiscal Year 1999
601101 D		-3,345	-3,321	-2,348	-2,407	-2,464

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**PROGRAM BUDGET DECISION**

377

No.

**SUBJECT:** Military Construction, Defensewide

**DOD COMPONENTS:** Defense Medical Facilities Office (DMFO), US Special Operations Command (USSOCOM), Defense Logistics Agency (DLA), Defense Resources Management Institute (DRMI)

**ISSUE:** Should the Defensewide military construction program be adjusted based on reduced or uncertain requirements, phased funding of hospital projects, alternative financing, and pricing adjustments?

	<u>(TOA, Dollars in Millions)</u>	
	<u>FY 1994</u>	<u>FY 1995</u>
Service Estimate	1,013.5	739.5
Alternative No. 1	-	-220.7
Alternative No. 2		-340.7

**SUMMARY OF EVALUATION:** The Defensewide Military Construction program supports all of the Military Construction requirements of the Defense Agencies to include U.S. Special Operations Command and the DMFO. The request generally represents a reasonable approach to satisfy their facility requirements with the exceptions noted below.

**Alternative Nos. 1 and 2:**

- Adjusts a classified project based on reduced program manager's requirements. -191.0
- Deletes the Defense Resource Management Institute (DRMI) project due to a lack of justification. -20.0
- Adjusts 3 medical projects based on the ability to award contracts. +93.0
- Finances 1 medical project from available FY 1994 resources. -25.0
- Reprices 9 projects. -5.8

**Alternative No. 1:**

- Phases funding for Portsmouth Hospital project based on the ability to award contracts. -71.9

**Alternative No. 2:**

- Defers funding to FY 1996 for Portsmouth project based on audit recommendations. -191.9

**ALTERNATIVE ESTIMATE:** Alternative No. 1 approves TOA of \$518.8 million for FY 1995. Alternative No. 2 approves TOA of \$398.8 million for FY 1995.

THE DEPUTY SECRETARY APPROVED ALTERNATIVE  
DECISION NO. 1 EXCEPT FOR WRAIR (\$-50.0 MILLION).

Date 12/13/93

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DETAIL OF EVALUATION:

**CLASSIFIED PROJECTS**

(TOA, \$ in Millions)  
FY 1994      FY 1995

Defense Level Agencies      Classified Construction      -      -191.0

The FY 1995 budget requests \$191.0 million for classified projects in FY 1995. The classified project manager has determined that these funds are not required for FY 1995. Both alternatives reduce the request accordingly.

**UNCERTAINTY OF REQUIREMENTS**

Defense Resources      Admin Facility      -      -20.0  
Management Institute

The FY 1995 budget requests \$20.0 million for construction of an admin facility for the Defense Resources Management Institute in Monterey, CA. However, the requirement for this project cannot be validated because no budget justification material or other supporting documentation has been provided. Both alternatives reduce funding associated with this project.

**ALTERNATIVE FINANCING**

Fort Sam Houston, TX      Hospital Replacement      -      -25.0  
Phase VIII

Defense Medical Facilities Office (DMFO) requested \$25.0 million in FY 1995 for the final phase of construction of a Hospital Replacement project at Fort Sam Houston, TX. However, DMFO indicated that the funding requested in FY 1995 could actually be awarded during FY 1994, and if these funds are not provided in FY 1994, the agency would incur penalties totaling \$15.0 million. They propose using \$18.0 million which was appropriated for a project at March AFB, CA that has been canceled as a result of base closure and realignment actions, and an additional \$7.0 million from various other savings/cancellations of Defense Level programs has been identified for reprogramming to fund this requirement. Therefore, the \$25.0 million requested in FY 1995 for the Fort Sam Houston project is no longer required. Both alternatives reduce the request accordingly.

**PHASED FUNDING**

Elmendorf AFB, AK      Hospital Replacement      -      -32.0  
Phase III

DMFO requested \$98.0 million in FY 1995 to provide full funding for construction of the final phase of a new hospital at Elmendorf AFB, AK. The DMFO has indicated that they can only obligate \$66.0 million for Elmendorf during FY 1995. During the review of FY 1994 hospital

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construction funding, congressional committees indicated their support for phased funding of hospital projects based on the amount that could be awarded during the budget year and reduced funding accordingly. In addition, OMB has granted an exception to their Circular A-11 full-funding requirement for this project. Therefore, both alternatives reduce FY 1995 by \$32.0 million for the Elmendorf project to provide only the amount that can be obligated during FY 1995.

(TOA, \$ in Millions)  
FY 1994      FY 1995

Forest Glen, MD	Walter Reed Army Institute of Research	-	+50.0
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In FY 1993, construction of the Walter Reed Army Institute of Research (WRAIR) was authorized by Congress for \$147.3 million, and \$13.3 million was appropriated for construction of Phase I. In FY 1994, the Department requested \$48.1 million for Phase II construction but only \$15.0 million was appropriated. However, the appropriations committee conferees included report language reiterating their support for the project and directed that an award be made for a new WRAIR not later than December 25, 1993. The Department was also directed to include the next increment of funding in the FY 1995 budget and the balance, if required, in subsequent budgets. DMFO did not include funding for WRAIR in their FY 1995 budget, instead they fully funded Portsmouth, Elmendorf and Fort Sam Houston in accordance with OMB direction for full funding of these facilities. However, this method of financing puts resources at risk based on congressional action in FY 1994. Therefore, Alternative No. 1 proposes to phase fund the hospitals thereby freeing resources to fund WRAIR consistent with funds that can be obligated in FY 1995.

Fort Bragg, NC	Hospital Replacement Phase II	-	+75.0
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Construction of a replacement hospital at Fort Bragg, NC, was authorized in FY 1993 for \$250.0 million, and \$10.0 was appropriated. In FY 1994, \$195.0 million was requested for the final phases of construction, however, only \$35.0 million was appropriated. Although \$75.0 million could be obligated for the project in FY 1995, insufficient funds were available for the project as a result of the full funding policy. If the funds are not provided in FY 1995, project delays will occur. Accordingly, both alternatives provide \$75.0 million for the Fort Bragg Hospital Replacement consistent with the amount that can be obligated.

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**PRICING**

(TOA, \$ in Millions)  
FY 1994      FY 1995

Eglin Aux Field, FL      Various Projects      -      -3.3

The Tri-Service Committee on Cost Engineering has compiled a list of area cost factors and unit cost data for use in preparing and reviewing military construction budgets. This data indicates an area construction cost index of .73 for Eglin AFB, FL. SOCOM's FY 1995 budget request includes \$27.7 million associated with seven military construction projects at Eglin Aux Field 9, FL. According to the budget justification material, the estimates for these projects were developed using an area construction cost index of .83 rather than the approved index of .73. As a result, SOCOM's estimate has been overpriced by \$3.3 million. Both alternatives reduce the request accordingly.

Fort Bragg, NC      SOF Group Operations Complex      -      -1.5

SOCOM requested \$20.0 million for construction of a SOF Group Operations Complex. Applying the DoD pricing and area cost factor guidelines indicate that the cost for this facility should be \$18.5 million or \$1.5 million less than the SOCOM request. The higher construction costs requested by SOCOM are not supported by the justification material provided. Accordingly, both alternatives reprice this project consistent with DoD guidelines.

The justification material does indicate that the project includes a high support to primary facility cost ratio as a result of long utility runs commonly associated with the construction of facilities on sites where little or no infrastructure exists. Neither alternative makes any adjustment to these costs.

Naval Station, Guam      SOF-Naval Special Warfare Operations Facility      -      -1.0

SOCOM requested \$9.5 million for a SOF Group Operations Complex. Applying the DoD pricing and area cost factor guidelines indicate that the cost for this facility should be \$8.5 million or \$1.0 million less than the SOCOM request. The higher construction costs requested by SOCOM are not supported in the justification material provided. Accordingly, both alternatives reprice this project consistent with DoD guidelines.

**PORTSMOUTH NAVAL MEDICAL CENTER**

Alternative No. 1      -      -71.9  
Alternative No. 2      -      -191.9

DMFO requested \$191.9 million in FY 1995 to construct the final phase of a hospital at Portsmouth, VA. DMFO has indicated that they can only obligate \$120.0 million for Portsmouth during FY 1995. OMB has

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granted an exception to their Circular A-11 full-funding requirement for this project, and Congress has indicated their support for phased funding. However, the DoD IG recently completed an audit that recommended reducing the scope of the project and reducing the number of planned beds by 152. However, both the Navy and the ASD(HA) contend the size of the facility should not be rescoped on the basis that it may need to expand in the future. The DoD IG maintains that the currently planned scope of the project was not justified and that descoping the project and renovating existing facilities to meet essential needs could result in savings of \$49.9 million (construction cost savings of \$58.2 million less \$8.3 million in redesign costs). Descoping and redesigning the Portsmouth project would result in a delay of approximately 18 months; therefore, DFMO would not be able to award the \$191.9 million requested during FY 1995. DMFO already has been provided \$104.5 million to commence construction of the project and has an unobligated balance of \$41.1 million that is sufficient to cover the redesign costs. Alternative No. 1 reduces this project by \$71.9 million in FY 1995 to provide only the amount that can be obligated during FY 1995, while Alternative No. 2 defers the project to FY 1996 pending resolution of the audit recommendations.

SUMMARY OF ADJUSTMENTS:

	(TOA, Dollars in Millions)	
	<u>FY 1994</u>	<u>FY 1995</u>
Alternative No. 1:		
SOCOM		-5.8
DMFO		-3.9
Defense-Level		
Classified Programs		-191.0
DRMI		-20.0
Total	-	<u>-220.7</u>
Alternative No. 2:		
SOCOM		-5.8
DMFO		-123.9
Defense-Level		
Classified Programs		-191.0
DRMI		-20.0
Total	-	<u>-340.7</u>

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**PBD Continuation Sheet**

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No.

**OUTYEAR IMPACT:**

(TOA, Dollars in Millions)

	<u>FY 1996</u>	<u>FY 1997</u>	<u>FY 1998</u>	<u>FY 1999</u>
Alternative No. 1:				
DMFO				
Ft Bragg Hospital	+65.0	+20.0	-160.0	-
Elmendorf Hospital Phase IV	+32.0	-	-	-
Portsmouth Phase VII	+47.9	+24.0	-	-
WRAIR	+50.0	+19.0	-	-
Total	<u>+194.9</u>	<u>+63.0</u>	<u>-160.0</u>	-
Alternative No. 2:				
DMFO				
Ft Bragg Hospital	+65.0	+20.0	-160.0	-
Elmendorf Hospital Phase IV	+32.0	-	-	-
Portsmouth Hospital	+191.9	-	-	-
WRAIR	+50.0	+19.0	-	-
Total	<u>+338.9</u>	<u>+39.0</u>	<u>-160.0</u>	-

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CONSTRUCTION APPENDIX (\$ in Thousands)			NUMBER 377	Alternative 1		
APPN	BUD ACT	FAC ACT	LOCATION AND PROJECT	Fiscal Year 1993	Fiscal Year 1994	Fiscal Year 1995
MCDA	01	777	Elmendorf AFB, AK Hospital Replacement Phase III			-32,00
MCDA	01	777	Monterey, CA Defense Resource Mgmt Institute Admin Facility			-20,00
MCDA	01	777	Eglin Aux Field, FL SOF Aircraft Parking SOF Add to and Alter Simulator SOF Aquatic Training Facility SOF Armament System Maintenance Trainer SOF MC-130 Nose Dock/AMU SOF Benson Tank Storage Facility SOF Dormitory			-1,00 -70 -35 -15 -60 -5 -45
MCDA	01	777	Naval Station, Guam SOF-Naval Special Warfare Operations Facility			-1,00
MCDA	01	777	Forest Glen, MD Walter Reed Army Institute of Research			+75,00
MCDA	01	777	Fort Bragg, NC Hospital Replacement SOF Group Operations Complex			+50,00 -1,50
MCDA	01	777	Fort Sam Houston, TX Hospital Replacement Phase VIII			-25,00
MCDA	01	777	Portsmouth, VA Hospital Replacement Phase VI			-71,90
MCDA	01	777	Various Locations Classified Construction			-191,00

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CONSTRUCTION APPENDIX (\$ in Thousands)			NUMBER 377	Alternative 2		
APPN	BUD ACT	FAC ACT	LOCATION AND PROJECT	Fiscal Year 1993	Fiscal Year 1994	Fiscal Year 1995
MCDA	01	777	Elmendorf AFB, AK Hospital Replacement Phase III			-32,00
MCDA	01	777	Monterey, CA Defense Resource Mgmt Institute Admin Facility			-20,00
MCDA	01	777	Eglin Aux Field, FL SOF Aircraft Parking SOF Add to and Alter Simulator SOF Aquatic Training Facility SOF Armament System Maintenance Trainer SOF MC-130 Nose Dock/AMU SOF Benson Tank Storage Facility SOF Dormitory			-1,00 -70 -35 -15 -60 -5 -45
MCDA	01	777	Naval Station, Guam SOF-Naval Special Warfare Operations Facility			-1,00
A	01	777	Forest Glen, MD Walter Reed Army Institute of Research			+75,00
MCDA	01	777	Fort Bragg, NC Hospital Replacement SOF Group Operations Complex			+50,00 -1,50
MCDA	01	777	Fort Sam Houston, TX Hospital Replacement Phase VIII			-25,00
MCDA	01	777	Portsmouth, VA Hospital Replacement Phase VI			-191,90
MCDA	01	777	Various Locations Classified Construction			-191,00



**CLOSE HOLD**

**MINUTES OF THE  
MILITARY TREATMENT FACILITIES  
AND GRADUATE MEDICAL EDUCATION  
BRAC 95 JOINT CROSS SERVICE GROUP  
MEETING OF FEBRUARY 10, 1994**

The third meeting of the Military Treatment Facilities and Graduate Medical Education (MTF/GME) BRAC 95 Joint Cross Service Group convened at 1230 hrs on February 10, 1994. The meeting was chaired by Dr. Edward D. Martin, Acting Assistant Secretary of Defense, Health Affairs.

After calling the meeting to order the Chairman asked each of the members to review the minutes from the previous meeting (a copy of the minutes was passed around the table).

The first item on the agenda was a "Rightsizing" briefing presented by the Air Force. The briefing described a review of small hospitals previously undertaken by the Air Force. Lessons learned from the Air Force review included: civilian or other providers must be able and willing to absorb the workload, competition among civilian providers/Non Availability Statements control is required to contain costs and, communication between the MTFs and the public must take place.

The next item was a discussion of the proposed General Analytical Approach to be used during the BRAC 95 process. An OSD Health Affairs representative presented a graphic portrayal of the analysis process. The Chairman then explained the process for resolution of any differences between the recommendations of the Services and the MTF/GME Group. After minimal discussion the group accepted the proposed General Analytical Approach.

Next on the agenda was the determination of the categories for BRAC 95 study. The group agreed that the three categories under which the medical facilities will be placed for study are:

- o GME centers (In-patient care and Out-patient care and two or more graduate medical programs)
- o Hospitals (In-patient care and Out-patient care)
- o Stand-alone Clinics (Out-patient care)

The final item on the agenda was a discussion of the military service's comments on the screening criteria distributed during the first meeting of the MTF/GME Group. Each of the criterion and associated comments were discussed by the group. Following this, an organization of the Measures of Merit (MOMs) was presented for the group's consideration. Each of the MOMs and the key issues raised follow:

- o Population
  - Should be weighted
  - Need to rethink the 40 mile catchment area
  - MOMs for both active duty and dependents

**CLOSE HOLD**

**CLOSE HOLD**

- o Facility Condition
  - May need new data call
  - Do not limit to code <80 -- get all codes
- o Access
  - Drop "number of non-DoD hospitals is >4" -- just ask "how many" and what types of services available
- o Cost Effectiveness
  - Must be aware of unique active duty/military issues
  - Tri-Care Executive Committee working uniform cost measures

A suggestion was made that the criteria should include "utilization" measures, e.g., the number of times per year eligible beneficiaries use the emergency room. There was some question as to whether this data could be gathered within the time available. Another suggestion was the use of bed days per 1,000 category I beneficiaries. The discussion ended with no conclusions being made.

The meeting adjourned at 1435 hrs. The next meeting is scheduled for February 17, 1994 at 1400 hrs.

Approved Edward D. Martin  
Edward D. Martin, MD  
Acting ASD (HA)

Attachments

**CLOSE HOLD**



## OTHER ATTENDEES

<u>SERVICE/AGENCY</u>	<u>NAME</u>	<u>PHONE #</u>	<u>ATTENDING 10 Feb 94</u>
OASD (HA)	Ms. Watson	703-697-8973	X
OASD (HA)	Ms. Giese	703-614-4705	X
OASD (HA)	Col Garner	703-614-4705	X
OASD (HA)	CDR Bally	703-614-4705	X
OASD (HA)	LTC Ponatoski	703-614-4705	X
OASD (HA)	LTC McClinton	703-614-4705	
ARMY	COL Barton	703-756-8319	
ARMY	COL Wilcox	703-756-5681	
ARMY	LTC Powell	703-697-3877	
ARMY	LTC McGaha	703-697-6388	X
ARMY	MAJ Dudevoir	703-756-0286	X
ARMY	MAJ Parker	703-756-8036	X
ARMY	COL Lyons		X
NAVY	CAPT Buzzell	703-681-0475	
NAVY	Ms. Davis	703-602-2252	
AIR FORCE	LtCol Silvernail	202-767-5550	X
AIR FORCE	LtCol Bannick	202-767-5066	X
AIR FORCE	Maj Costa	202-767-5066	X
AIR FORCE	Maj Pantaleo	202-767-5046	X
LMI	Mr. Neve	301-320-7287	X
LMI	Ms. Dahut	301-320-7408	X
JS	LtCol Ferguson	703-697-4421	
COMP	Ms. Kopperman	703-697-4517	X

**BRAC 95 JOINT CROSS SERVICE GROUP  
FOR MILITARY TREATMENT FACILITIES AND  
GRADUATE MEDICAL EDUCATION**

**FEBRUARY 10, 1994  
Room 5D400, 12:30 pm**

- Review/approve minutes from previous meeting Dr. Martin
- Air Force "Rightsizing" Brief Maj Pantaleo
- Discuss General Analytical Approach LTC Ponatoski
- Review/Discuss Study Categories LTC Ponatoski
- Review/Discuss Service Comments to  
January 1994 Hospital Screening Criteria  
used in previous analyses RADM Koenig
- Actions for next meeting Dr. Martin
- Administrative Issues Dr. Martin

**NEXT MEETING FEBRUARY 17, 2:00pm  
ROOM 5D400**

- Adjournment

## RIGHT SIZING

- 1992 OASD(HA) EXPRESSED CONCERN - EFFICIENCY SMALL HOSPITALS
- USAF REVIEWED 34 CONUS HOSPITALS TO DETERMINE EFFICIENCY AND EVALUATE ALTERNATIVES
- BUILT ON PREVIOUS ANALYSIS OF SMALL HOSPITALS
  - "BLUE RIBBON PANEL"
  - VECTOR STUDY "PRELIMINARY STUDY ON COST EFFECTIVENESS OF SMALL MILITARY HOSPITALS"
  - PRIVATE SECTOR INFORMATION

## RIGHT SIZING

- USED HISTORICAL CRITERIA FOR INITIAL REVIEW
  - AVAILABILITY OF OTHER SOURCES CARE (CIV/MIL)
  - WORKLOAD
  - CHAMPUS/DIRECT CARE COSTS
  - 50 MOST COMMON MTF/CHAMPUS ADMISSIONS
  - MEPRS COST PER DISPOSITIONS
  - READINESS TASKINGS
  - FACILITY CONDITION AND MILCON REQUIREMENTS
  - CASE MIX INDEX

# RIGHT SIZING

- CRITERIA REVIEW ONLY AN INDICATOR OF NEED FOR ADDITIONAL STUDY
  - LOCAL AREA ANALYSIS REQUIRED
  - MUST UNDERSTAND EFFECT ON MHSS
- DETERMINE EFFECT AND REACTION OF BENEFICIARIES REMAINING IN THE AREA (MATHER/CHARLESTON/WALSON)

## RIGHT SIZING

- REPLACING HOSPITAL WITH AN AMBULATORY HEALTH CARE CENTER MAY REDUCE EXPENSES WITHOUT SIGNIFICANT NEGATIVE IMPACT ON PATIENTS:
- SOME INVESTMENT REQUIRED:
  - INCREASED CHAMPUS
  - PCS
  - FACILITY MODIFICATION (AMB. SURG)
- COST OFFSETS
  - REDUCED INPATIENT O&M
  - RECAPTURE OF CHAMPUS AND CONTRACTS AT OTHER LOCATIONS
  - POTENTIAL PERSONNEL REDUCTION
- ONE TIME MCP COST AVOIDANCE POSSIBLE

## RIGHT SIZING

- RESULTS OF CRITERIA REVIEW:
  - SITE VISITS TO 13 LOCATIONS
- RECOMMENDATIONS OF STUDY AND ANALYSIS:
- MEDICALLY REMOTE LOCATIONS (LOCAL AREA EFFECT)
  - ELLSWORTH
  - SEYMOUR-JOHNSON
  - F.E. WARREN
- NO SIGNIFICANT COST SAVINGS (SYSTEM WIDE EFFECT)
  - TINKER
  - MOODY
  - FAIRCHILD
  - MACDILL

## RIGHT SIZING

- USAF CANDIDATES FOR POSSIBLE RESTRUCTURING TO AMBULATORY HEALTH CARE CENTERS:
- PATRICK  
GRIFFISS  
LITTLE ROCK  
ROBINS  
BEALE  
REESE

## RIGHT SIZING

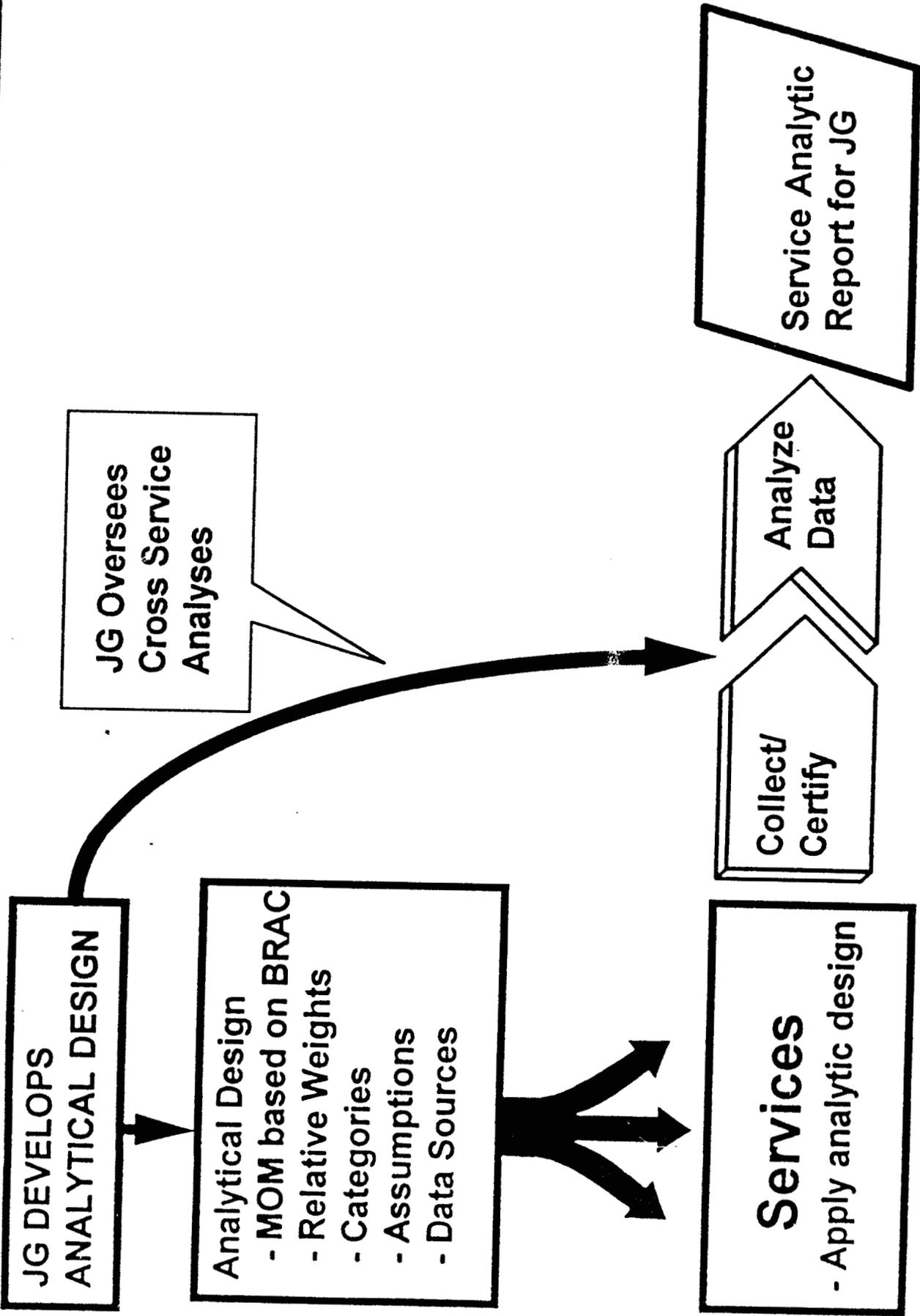
- REESE TEST (LESSONS LEARNED)
- CONGRESSIONAL/LINE SUPPORT VITAL
- OTHER PROVIDERS MUST BE ABLE AND WILLING TO ABSORB WORKLOAD
- COMPETITION AMONG CIVILIAN PROVIDERS/NAS CONTROL REQUIRED TO CONTAIN COSTS (MALMSTROM)
- COMMUNICATION BETWEEN MTF AND PUBLIC MUST OCCUR

MILITARY HOSPITALS DUE TO CLOSE UNDER BRAC  
GROSS SQUARE FEET & PLANT REPLACEMENT VALUE

Facility/BRAC	State	Service	GSP	PRV \$Millions
Pease AFB/I	NH	AF	128,354✓	27.416
Homestead AFB/III	FL	AF	154,528	27.713
Eaker AFB/II	AR	AF	60,514✓	10.365
England AFB/II	LA	AF	109,283✓	20.480
George AFB/I	CA	AF	148,002✓	37.578
Myrtle Beach AFB/II	SC	AF	77,314✓	12.308
Wurtsmith AFB/II	MI	AF	117,409✓	26.971
Williams AFB/II	AZ	AF	105,335✓	21.226
Chanute AFB/I	IL	AF	190,505	43.763
Bergstrom AFB/II	TX	AF	112,820✓	19.097
Carswell AFB/II	TX	AF	348,805	80.830
NH Long Beach/II	CA	N	407,488	86.300
Letterman AMC/I	CA	A	630,078	221.227
Fort Ord/II	CA	A	409,438	105.299
Fort Devens/II	MA	A	138,669✓	42.563
Loring AFB/II	ME	AF	146,264✓	23.284
Griffiss AFB/III	NY	AF	117,667✓	27.267
K.I. Sawyer AFB/III	MI	AF	122,671✓	26.449
Fort B. Harrison/II	IN	A	109,424✓	23.723
NH Orlando/III	FL	N	218,960	31.100
Castle AFB/II	CA	AF	128,800✓	29.588
NH Philadelphia/I	PA	N	293,633	49.146
March AFB/III	CA	AF	217,979	55.345
Plattsburgh AFB/III	NY	AF	100,635✓	22.307
NH Oakland/III	CA	N	520,759	128.500
GRAND TOTALS			5,115,334	1,199.845

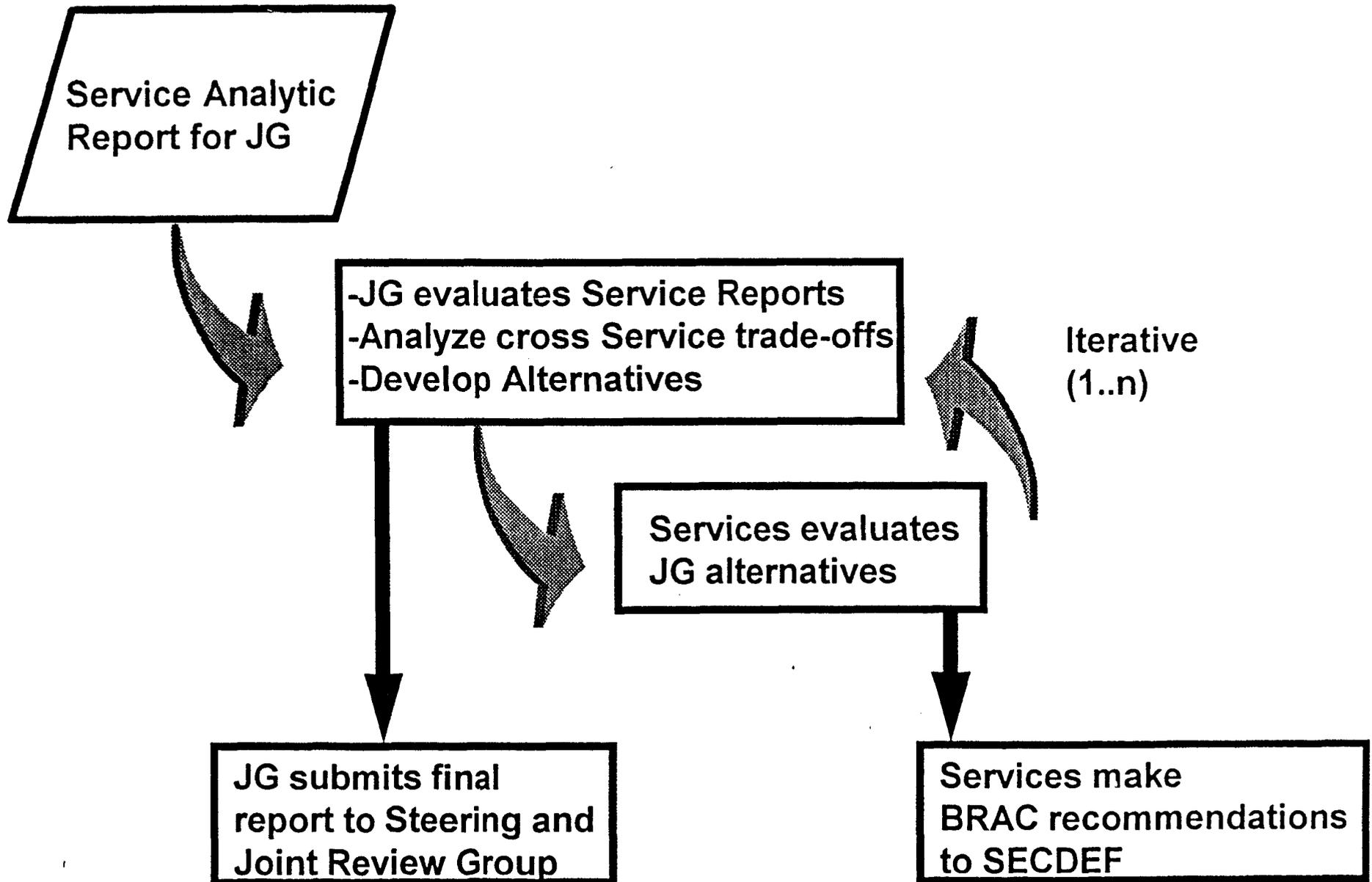
Note: Information received from: Captain O'Brien, HQ USAF/SCAFV at (302) 767-8554, for all Air Force medical installations; Major Bond, SCFF-PA at (703) 756-8229, for all Army medical installations; and LT Wilson, BUDG/MED-433 at (302) 653-1637, for all Navy medical installations.

# GENERAL ANALYTICAL APPROACH



# GENERAL ANALYTICAL APPROACH

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# BRAC 95 JOINT CROSS-SERVICE GROUP FOR MTFs AND GME

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- Analysis Assumptions agreed on 2/3/94
  - > MTF will close if base closes unless a sufficient active duty population remains
  - > Joint Group efforts will focus on peacetime requirements
  - > Analysis will include facilities with < 300 civilian personnel
  - > Quantitative goals will not be initially defined
    - Revisit later if necessary

# BRAC 95 JOINT CROSS-SERVICE GROUP FOR MTFs AND GME

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## ■ Define Roles for Joint Group and Service

(Group consensus 2/3/94)

- Joint Group will develop
  - Analysis assumptions
  - Categories for study and their definitions
  - General analytical approach and methodology
  - Internal Control Plan
  - Data definitions and measures of merit
  - Relative weights for measures of merit
  - Prepare alternative options, as appropriate, based on review of the Services' analyses
  
- Services will
  - Collect and analyze data
  - Present findings to Joint Cross Service Group
  - Evaluate alternative options recommended by Joint Cross-Services Group

# BRAC 95 JOINT CROSS-SERVICE GROUP FOR MTFs AND GME

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## ■ General Administrative & Group Procedures

- Group agreed on Statement of Principles (2/3/94)
- Best way to bring issues/items before group
  - via a single committee
  - via subcommittees

# BRAC 95 JOINT CROSS-SERVICE GROUP FOR MTFs AND GME

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## ■ Determine General Analytical Approach

- The eight BRAC selection criteria must be used for the analysis
- Develop Measures of Merit (sub criteria) applicable to MTFs and GME (consider using previous measures)
- Consider use of screening criteria to exclude specific categories or facilities
- Develop process for individual Service analysis and tri-service integration of alternatives

# BRAC 95 JOINT CROSS-SERVICE GROUP FOR MTFs AND GME

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## ■ Determine Categories for Study

- Consider stratification by
  - Size of MTF
  - Teaching vs Non-Teaching
  - Tricare Region
  - Location of MTFs (Urban....Rural)

## JOINT HOSPITAL GROUP DECLARATION OF PRINCIPLES

1. The Joint Cross Service Group on Medical Facilities and Graduate Medical Education seeks to identify measures of merit (subcategories of the 8 BRAC criteria) data elements, and methodologies that will allow the DoD components to apply the DoD criteria in a uniform, fair, reasonable, and consistent manner that complies with statutory and regulatory requirements and that adheres to the policy set forth in the January 7, 1994, DepSecDef memo, subject: 1995 Base Realignment and Closures (BRAC)
2. The Joint Cross Service Group on Medical Facilities and Graduate Medical Education recognizes the need for right-sizing, seeking opportunities for cross-Service asset sharing, and /or single military department support.
3. The measures of merit, data elements, and methodologies used to arrive at closure and realignment recommendations will be developed and approved by the Joint Cross Service Group on Medical Facilities and Graduate Medical Education by 31 March 1994. The approach developed should be easy to use, simple and straightforward, auditable, reproducible, and defensible.

MEMORANDUM

08 February 1994

From: Captain M. Golembieski, MC, USN  
Base Structure Analysis Team  
To: Dr. Martin, Chairman Joint Service Working Group  
on Medical  
Via: Lieutenant Colonel E. Ponatoski  
Subj: HOSPITAL SCREENING CRITERIA

1. Review of the above criteria reveal the following concerns:
  - a. There is a definite sense that the outcome is already known by the designer of the criteria. This can lead to manipulation of the data by either the designer or the respondent to get the answer that is desired.
  - b. The tool does not consider the progress medicine has made, and that medicine is shifting from an inpatient practice to outpatient. Our health care facilities are truly centers of health care with a broad range of services being provided. This is true regardless of size. The tool only focuses on the inpatient aspects of care. It does not address the impact a shift to Same Day Surgery can have on hospitalizations or length of stays.
  - c. Use of built beds to operating beds only reflects older planning methods, and does not reflect that these spaces maybe currently providing outpatient care. Also, relating average daily patient load to built (possible typo) beds makes no sense. Review of the BRAC III criteria reveal the same wording was used.
  - d. Differences in cost accounting methods make any attempt to compare unit costs between the Army, Navy, and Air Force very difficult.
  - e. There is no readiness or mission factor considered.
  - f. The data required to support the criteria is undefined, and is crucial to ensuring the reproducibility of the process.

  
Michael E. Golembieski

DASG-RMP

MEMORANDUM FOR CHAIRMAN, BRAC 95 JOINT CROSS SERVICE GROUP FOR  
MEDICAL TREATMENT FACILITIES AND GRADUATE  
MEDICAL EDUCATION

SUBJECT: Proposed Hospital Screening Criteria for BRAC 95

1. The objectives of subject criteria should be to assess the ability of the hospitals to deliver accessible high quality care in the most efficient manner possible and the relative importance of that care to mission readiness. The criteria must also allow for differences in the manner in which the three services provide health care and for differences in the missions they support.

2. The criteria proposed need to be modified to accomplish the stated objectives and provide the required flexibility. General issues to be addressed are as follows:

a. Several criteria measure the same characteristic which results in ambiguous weighting and a skewed overall evaluation of the hospitals. This occurs with regards to the population mix, the condition of the physical plant and inpatient utilization measures. We need to identify the distinct (i.e. mutually exclusive) criteria that are important in achieving the objectives stated above and weight them appropriately.

b. The methodology for measurement associated with the criteria is absolute. The binary approach currently used results in minor differences having a large impact. For example a hospital with a catchment area population of 50,000 is awarded 100% of the criteria value while a hospital with a catchment area population of 49,000 is awarded 0% of the criteria value. This approach can radically skew the evaluation.

c. Some of the criteria reward the behavior "Coordinated Care" attempted to eliminate --workload churning-- and penalize innovation. Criteria 2.1 and 2.2 penalize activities that have reduced length of stay, increased the percentage of procedures being done on an outpatient basis and converted wards into ambulatory clinics in the process.

d. As noted in the "Introduction" mission criteria were not addressed. Although more difficult to measure than the other criteria, it is imperative that support of our respective military missions be incorporated in this evaluation at some juncture.

*Army p.1*

DASG-RMP

SUBJECT: Proposed Hospital Screening Criteria for BRAC 95

e. Although a separate set of criteria have been established for medical centers, these criteria do not allow for the unique missions associated with a military medical center: tertiary care, regional care and graduate medical education (GME). The criteria must be modified to address these distinct missions.

4. At enclosure we have proposed five criteria and related attributes that address the concerns we have noted above. We hope these can serve as a start point for the development of uniform criteria.

5. Our point of contact is MAJ Dudevoir, Resources Management Office, commercial (703)756-0286.

FOR THE SURGEON GENERAL:

Encl

JOSEPH F. LYONS  
Colonel, MS  
Chief, Resources Management  
Office

AMEDD PROPOSAL FOR:  
HOSPITAL SCREENING CRITERIA AND ASSOCIATED ATTRIBUTES

1. READINESS:
  - a. Bed expansion mission.
  - b. Support of active duty and their dependents.
  - c. GME by "Readiness Category."
2. CURRENT COST EFFICIENCY:
  - a. Cost per Relative Weighted Product (RWP) in comparison with same cost via CHAMPUS within the catchment area.
  - b. Cost per episode of ambulatory care in comparison with same cost via CHAMPUS within the catchment area.
3. CAPITAL INVESTMENT REQUIRED:
  - a. JCAHO Plant Technology and Safety scores.
  - b. Replacement value of equipment exceeding life expectancy.
4. AVAILABILITY OF CARE IN THE CATCHMENT AREA:
  - a. Proximity to other military hospitals.
  - b. Availability of care via CHAMPUS.
5. MEDCEN UNIQUE ATTRIBUTES:
  - a. Special Treatment Services provided.
  - b. GME by "Readiness Category" (see 1c above).



DEPARTMENT OF THE AIR FORCE  
HEADQUARTERS UNITED STATES AIR FORCE



2 FEB 1994

MEMORANDUM FOR ACTING ASSISTANT SECRETARY OF DEFENSE  
(HEALTH AFFAIRS)

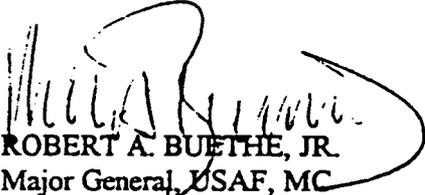
FROM: HQ USAF/SGH

SUBJECT: BRAC 95 Hospital Screening Criteria - ACTION MEMORANDUM

At the 25 January 1994 meeting of the BRAC 95 Joint Cross Service Group for Military Treatment Facilities and Graduate Medical Education, we were asked to review and comment on the OASD(HA) screening criteria for medical centers and CONUS hospitals. The comments at Attachment 1 express my concerns with the criteria as currently written. This input relies on the lessons learned from our own Right-Sizing efforts and the types of measures that provide the best indication of restructuring potential for United States Air Force medical facilities. No matter what measures are eventually used, however, they can only be considered as an initial screening mechanism. Any facility identified by these criteria as a potential restructuring candidate must have a detailed analysis that includes a site visit to determine local characteristics not readily discernible from the data.

I am concerned with incorporating our restructuring efforts into the BRAC process. Wing and base mission changes are the primary driver of BRAC, and as a result, base population and demographics can increase or decrease significantly. If screening criteria are applied before these mission decisions are made, detailed restructuring analyses will be conducted on the wrong facilities. In addition, the Air Force is well beyond the initial screening stage with our Right-Sizing initiative. We are testing our methodology and concept at Reese AFB over the next two years, and will incorporate the lessons learned into our future restructuring efforts. In his 12 October 1993 memorandum (Atch 2), AF/SG concurred with the selection of Davis-Monthan, Moody, Robins, Little Rock, Patrick, Fairchild, and McClellan AFBs as candidates for further detailed analyses.

My point of contact is Maj Costa, HQ USAF/SGHA, 170 Luke Avenue Suite 400, Bolling AFB, DC 20332-5113, (202) 767-5066.

  
ROBERT A. BUETHE, JR.  
Major General, USAF, MC  
Director, Medical Programs and Resources  
Office of the Surgeon General

Attachments:

1. AF/SG Comments
2. AF/SG Memo, 12 Oct 93

## HQ USAF/SG COMMENTS

ON

### OASD(HA) HOSPITAL SCREENING CRITERIA (JANUARY 1994)

#### GENERAL:

Wing/base mission changes are the primary drivers of the BRAC process. The application of any screening criteria to medical facilities prior to the development of the Line of the Air Force's recommendations will ignore significant changes in base population and demographics. The wrong USAF military treatment facilities (MTF) will be targeted for further detailed analyses.

The screening criteria, as currently written, appear biased against small hospitals that are the core of the USAF Medical Service. When applied during BRAC 93, five of these criteria flagged 75+% of USAF facilities. Any screening criteria that rule in that high a percentage of our facilities are of marginal value.

With the implementation of TRICARE, military treatment facilities (MTF) can no longer be viewed in isolation. The future of each MTF should be assessed in the context of the region's overall plan for its facilities. Previously underutilized facilities may be made more competitive by redirecting care to these facilities, and any criterion that appears to ignore or minimize the importance of a category of beneficiary should be reassessed.

While screening criteria may flag potential restructuring candidates, many details about a facility can only be determined by a site visit. For example, criterion 1.8 identifies medical centers or hospitals that have overlapping catchment areas. A site visit can identify any geographical barriers between the facilities and the extent of their overlap. Facilities that are 10-15 miles apart must be viewed somewhat differently than facilities that are 75 miles apart and separated by a mountain range.

#### SPECIFIC:

Criterion 1.1 Total eligible beneficiaries is less than 100,000 for medical centers and 50,000 for hospitals

The population served by medical centers is not accurately represented by the number of beneficiaries assigned in DMIS. Referrals and the typically larger geographical area (greater than 40 miles) served by a medical center are not addressed by this criterion. Since all USAF medical centers would fail this criterion, it has minimal value as a screening measure. Recommend the development of a weighted measure of beneficiary population (e.g., <50K, 50-70K, 70-90K, >90K) for medical centers and hospitals.

Criterion 1.2 The number of active duty and dependents of active duty beneficiaries is less than 50% of total eligible beneficiaries population

Delete criterion. This is not an appropriate screening measure given the direction of regionalization and capitation budgeting. The provision of cost-effective care should be the primary consideration, not the shifting of workload from DOD.

Criterion 1.3 The number of beneficiaries age 65 and older is greater than 15% of total population

Delete criterion. Same rationale as for criterion 1.2.

Criterion 1.4 Hospital is less than 50 operating beds

Delete criterion. In many USAF communities, the military treatment facility is the only source of care. If we can provide high quality, cost-effective care within a small hospital, there is nothing magical about any particular bed size.

Criterion 1.5 Condition code is less than 80.0

The condition code should only be used if it is less than two years old. This criterion should be changed to read: "Condition code is less than 80.0 and a major MILCON is not under construction". This will ensure that facilities currently being upgraded are not flagged.

Criterion 1.6 Greater than 25 years since last major modification or rehabilitation

Delete criterion. This criterion will generally flag the same facilities as criterion 1.5 and in essence is a duplication with no added value.

Criterion 1.7 Construction requirement is greater than \$10M for medical centers and \$5M for hospitals

Delete criterion. All medical centers will have construction requirements exceeding \$10M and almost all hospitals have construction requirements greater than \$5M. This criterion will also flag those facilities already highlighted by criterion 1.5.

Criterion 1.10 Number of non-DOD hospitals is greater than 4 in the MTF catchment area

Change criterion. This criterion should read: "Number of accredited, non-DOD community hospitals with the appropriate type/level of specialty care is greater than 4 in the MTF catchment area".

**Criterion 2.1** Percent average daily patient load to built beds is less than 60% for medical centers and 40% for hospitals

Delete criterion. The use of built beds tells nothing about the resource consumption or efficiency of a facility. Even the OASD(HA) rationale discusses an ADPL to operating bed ratio, not an ADPL to built bed ratio.

**Criterion 2.2** Percent operating beds to built beds is less than 75% for medical centers and 50% for hospitals

Change criterion. This criterion should read: "Percent operating beds to normal beds is 75% or less". Comparing operating beds to built beds gives no indication of whether a facility should be restructured. With the shift of health care from an inpatient to an outpatient setting, hospitals have converted built beds to outpatient space to accommodate the shift in workload. Excess capacity can only be determined by comparing operating to normal beds.

**Criterion 2.3** Active duty and dependents of active duty is less than 50% of total admissions

Delete criterion. This criterion appears to penalize a facility that is filling the needs of our retirees and their dependents. While this measure will identify who is the predominant user of your inpatient services, we should not discount the health care requirements of any particular category of beneficiary. During peacetime, we need to expose our providers to a wider variety of patients and acuity levels than found in the typically healthier active duty or active duty dependent patient.

**Criterion 2.4** Average length of stay is 1.25 (or greater) times the national norms

Criterion should ensure that facilities, particularly the medical centers, are compared to national norms that are developed from facilities with similar acuity levels, tertiary responsibilities, and training programs.

**Criterion 2.6** Category I care (inpatient care provided to catchment area beneficiaries by the same MTF) is less than 50% of total catchment area care (Categories I + II + IV)

Delete criterion. This criterion does not add any value to the screening process. The most important point is whether or not the care a small USAF facility provides is cost-effective.

**Criterion 2.7** Average unit cost of direct care inpatient work unit is greater than the average unit cost of CHAMPUS inpatient work unit

Criterion should ensure that facility costs are compared to CHAMPUS costs from facilities with similar acuity levels, responsibilities, and training programs. Readiness costs must be backed out of the direct care costs.

**Criterion 2.9** The difference between the model and the observed average cost per inpatient work units is greater than +5% variation for medical centers and +20% variation for hospitals

Criterion should be more specific on what cost model is to be used. To make accurate comparisons, the cost model should adjust for operational differences between facilities by adjusting for geographic location, demographics of population, readiness, end of the year fall-out funds, etc.



DEPARTMENT OF THE AIR FORCE  
HEADQUARTERS UNITED STATES AIR FORCE



12 OCT 1993

MEMORANDUM FOR ACTING ASSISTANT SECRETARY OF DEFENSE (HEALTH AFFAIRS)

SUBJECT: Small Hospital Analysis (Your Memo, 13 Aug 93) - ACTION MEMORANDUM

Thank you for the opportunity to provide input on your small hospital analysis. We identified the same concerns about the need for inpatient services at some of these locations and have already conducted additional analyses of all of the sites mentioned in your report. We would be happy to work with your staff and share our insights as part of a more in-depth analysis.

Although our initial research identified provider shortages and limited opportunities to achieve initial savings or avoid costs as a result of restructuring, we concur with your recommendation for further study at Davis-Monthan AFB, Moody AFB, Robins AFB, Little Rock AFB, Patrick AFB, Fairchild AFB, and McClellan AFB. Again, by working together on this analysis, our staffs can identify the proper size of facilities throughout the CONUS.

Further study of other locations is not recommended for the following reasons. Seymour Johnson and Columbus are located in areas where adequate health care is not available. Reese is already being restructured. The remaining bases are scheduled for closure under Base Realignment and Closure.

My point of contact for this matter is Col Shields, HQ USAF/SGHA,  
170 Luke Avenue Suite 400, Bolling AFB DC 20332-5113, (202) 767-5066.

  
ALEXANDER H. SLOAN  
Lieutenant General, USAF, MC  
Surgeon General

# BRAC 95 JOINT CROSS-SERVICE GROUP FOR MTFs AND GME

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- Determine Categories for Study
  - ▶ Concept of categorization
    - Must choose categories to enable like comparisons (apples to apples)
    - Must develop measures of merit for each category
    - May use all or some of one category's measures of merit as a subset of another category's

# **BRAC 95 JOINT CROSS-SERVICE GROUP FOR MTFs AND GME**

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- A "strawman" categorization for discussion
  1. GME centers to include MOMs\* for:
    - ▶ GME
    - ▶ In-patient care
    - ▶ Out-patient care
  2. Hospitals to include MOMs for:
    - ▶ In-patient care
    - ▶ Out-patient care
  3. Stand-alone clinics to include MOMs for:
    - ▶ Out-patient care

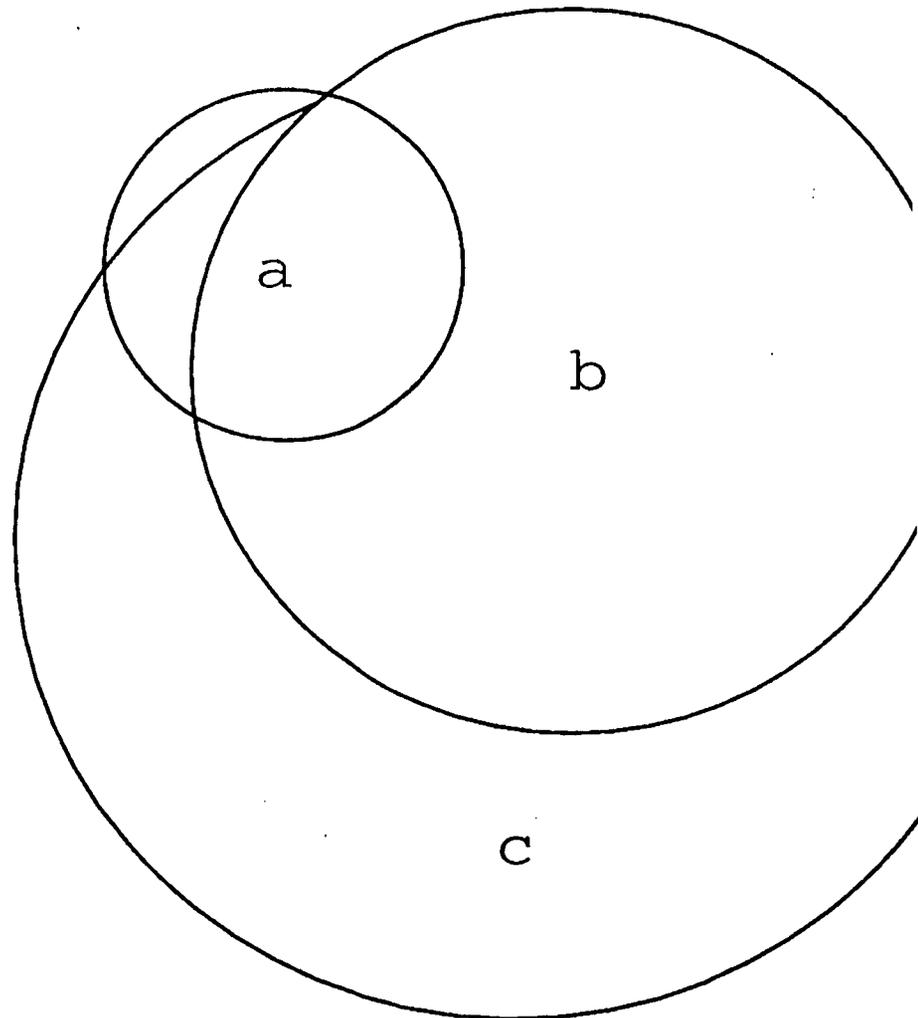
\*MOMs = Measures of Merit

# BRAC 95 JOINT CROSS-SERVICE GROUP FOR MTFs AND GME

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## The Three-Tiered Category Approach

- a. MOMs for stand-alone clinics
- b. MOMs for hospitals
- c. MOMs for GME centers



## CRITIQUE OF HOSPITAL MEASURES OF MERIT

### ARMY

In place of the present criteria have offered a different approach centering around five major concepts: 1) readiness, 2) current cost efficiency, 3) capital investment required, 4) availability of care in the catchment area, and 5) MEDCEN unique attributes.

Noted need to develop weighted scales of measure rather than a binary concept.

### NAVY

Had several general concerns regarding the present approach. 1) focused too heavily on inpatient aspects of care; 2) left out mission issue; 3) use of operating beds was built upon outdated planning methods; and 4) criteria were undefined.

### AIR FORCE

Believed that the data as presently structured are biased against smaller hospitals. Noted decisions had to be made in concert with the other Services. Critiqued the hospital criteria as noted in the following matrix.

MEASURE	ARMY	NAVY	AIR FORCE
1.1 Total eligible beneficiaries less than 100,000 (50,000 smaller hospitals).	CONCUR WITH WEIGHTING ON THIS AND OTHER MEASURES		DEVELOP A WEIGHTED MEASURE E.G. <50K, 50-70K, 70-90K
1.2 The number of active duty and dependents of active duty beneficiaries is less than 50% of total eligible beneficiaries population.	MUST CONSIDER AVAILABILITY OF CARE VIA CHAMPUS.		DELETE
1.3 The number of beneficiaries age 65 and older is greater than 15% of the population.			DELETE
1.4 small hospitals less than 50 operating beds.			DELETE
1.5 Condition code less than 80.	JCAHO PLANT TECHNOLOGY AND SAFETY SCORES		ADD "A MAJOR MILCON IS NOT UNDER CONSTRUCTION"
1.6 Greater than 25 years since last major modification or rehabilitation	CONSIDER REPLACEMENT VALUE OF EQUIPMENT EXCEEDING LIFE EXPECTANCY		DELETE - MEASURES THE SAME AS 1.5
1.7 Construction requirement is greater than \$10M. (\$5M smaller hospitals)			DELETE - MEASURES THE SAME AS 1.5
1.8 Within forty-mile catchment area with another medical center.	PROXIMITY TO OTHER MILITARY HOSPITALS.		
1.9 Primary physician population ratio is greater than 1 civilian primary physician to 3500 individuals in the MTF catchment area.			
1.10 Number of non-DoD hospitals is greater than 4 in the MTF catchment area.			CHANGE TO "NUMBER OF ACCREDITED NON-DoD COMMUNITY HOSPITALS WITH THE APPROPRIATE TYPE/LEVEL OF SPECIALTY CARE IS GREATER THAN 4 IN THE MTF CATCHMENT AREA"
2.1 Percent average daily patient load to built beds is less than 60%	DELETE RELATES TO WORK LOAD CHURNING	DELETE - OLDER PLANNING METHOD	DELETE

MEASURE	ARMY	NAVY	AIR FORCE
2.2 Percent operating beds is 75% or less.	DELETE RELATES TO WORK LOAD CHURNING	DELETE - OLDER PLANNING METHOD	DELETE
2.3 Active duty and dependents of active duty is less than 50% of total admissions.			DELETE
2.4 Average length of stay is 1.25 times the national norms.		TOO MUCH INPATIENT EMPHASIS - NO ACCOUNTING FOR SAME DAY SURGERY	ENSURE NORMS ARE FOR SIMILAR FACILITIES
2.5 Category III (in referrals) is less than category II (out referrals).			
2.6 Category I care (inpatient care provided to catchment area beneficiaries by the same MTF) is less than 50% of total catchment area care (CAT I+II+IV)			DELETE
2.7 Average unit cost of direct care inpatient work unit is greater than the average unit cost of CHAMPUS inpatient work unit.	USE COST PER RELATIVE WEIGHTED PRODUCT (RWP) WITH CHAMPUS IN SAME CATCHMENT AREA	CAN'T COMPARE UNIT COSTS AMONG THE SERVICES	ENSURE COSTS ARE FOR SIMILAR FACILITIES. READINESS BACKED OUT.
2.8 Average unit cost of direct care outpatient visits is greater than the average unit cost of CHAMPUS outpatient visits.	COST PER EPISODE OF CARE WITH CHAMPUS IN SAME CATCHMENT AREA	CAN'T COMPARE UNIT COSTS AMONG THE SERVICES	ENSURE COSTS ARE FOR SIMILAR FACILITIES. READINESS BACKED OUT.
2.9 The difference between the model and the observed average cost per inpatient work units is greater than +5% variation.			NEED MODEL SPECIFICS

# ORGANIZATION OF MEASURES OF MERIT

## CHARACTERISTICS

## CATEGORIES FOR STUDY

	CLINICS	HOSPITALS	GME CENTERS
POPULATION			
FACILITY CONDITION			
ACCESS			
COST EFFECTIVENESS			

# ORGANIZATION OF MEASURES OF MERIT

**POPULATION  
CHARACTERISTICS**

**CATEGORIES FOR STUDY**

	CLINICS	HOSPITALS	GME CENTERS	RECOMMENDATION
Beneficiary Population < X				Criteria should be weighted
AD + Dep of AD < 50% of total Population				Consider AD Population only + availability of civilian care
Beneficiaries > 65 yrs				Delete

# ORGANIZATION OF MEASURES OF MERIT

**FACILITY CONDITION  
CHARACTERISTICS**

**CATEGORIES FOR STUDY**

	CLINICS	HOSPITALS	GME CENTERS	RECOMMENDATION
Condition code < 80				Infrastructure data call consider alternative measures
> 25 years since last MILCON				Infrastructure data call consider alternative measures/subset of data call
Construction requirement > X million				Infrastructure data call consider alternative measures

# ORGANIZATION OF MEASURES OF MERIT

## ACCESS CHARACTERISTICS

## CATEGORIES FOR STUDY

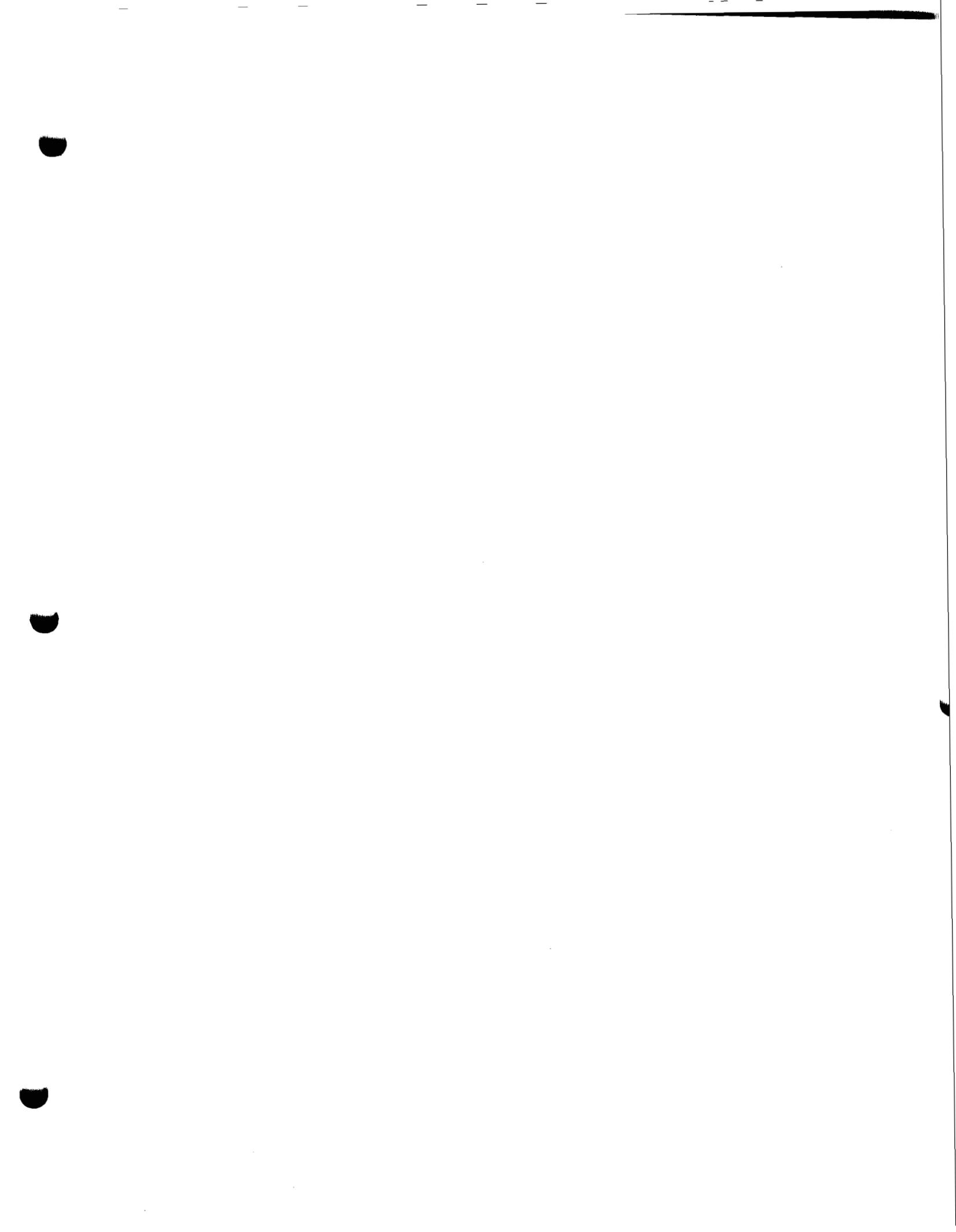
	CLINICS	HOSPITALS	GME CENTERS	RECOMMENDATION
Civilian Physician Primary Care Ratio > 1:3000				Retain
# of non DOD hosptials with capability/capacity is > 4				Retain
ADPL < 60% of built beds				Delete
% op beds to bult bed < 75%				Delete
AD/ADDEP < 50% of admissions				Delete

# ORGANIZATION OF MEASURES OF MERIT

**COST EFFECTIVENESS  
CHARACTERISTICS**

**CATEGORIES FOR STUDY**

	CLINICS	HOSPITALS	GME CENTERS	RECOMMENDATION
ALOS > 1.25 Nat norms				Address AD/Military unique issues
Referrals in < referrals out				Address order of magnitude/Type fac
Cat I care < 50 % of total catchment area care				Retain, but develop lower weighting
Inpatient Unit cost direct care > unit cost of CHAMPUS				
Outpatient Unit cost direct care > unit cost of CHAMPUS				
Variation of model and observed avg work units > 5%				



**CLOSE HOLD**

**MINUTES OF THE  
MILITARY TREATMENT FACILITIES  
AND GRADUATE MEDICAL EDUCATION  
BRAC 95 JOINT CROSS SERVICE GROUP  
MEETING OF FEBRUARY 17, 1994**

The fourth meeting of the Military Treatment Facilities and Graduate Medical Education (MTF/GME) BRAC 95 Joint Cross Service Group convened at 1400 hrs on February 17, 1994. The meeting was chaired by Dr. Edward D. Martin, Acting Assistant Secretary of Defense, Health Affairs.

After calling the meeting to order, the Chairman asked each of the members to review the minutes from the previous meeting (a copy of the minutes was passed around the table).

The Chairman informed the group that the policy considerations resulting from the "733" study will be presented at the next meeting. The Chairman pointed out that the policy conclusions of the report are important in that they will serve to guide the group's BRAC 95 process. The Chairman also made the group aware of two ongoing initiatives: a potential realignment of biomedical research functions, and consolidation of similar technical schools.

At this time the group was addressed by the Deputy Assistant Secretary of Defense for Economic Reinvestment and BRAC, Mr. Robert E. Bayer. Mr. Bayer told the members that their job was vitally important. He recognized that downsizing is a difficult task, but the Department must use its remaining resources, including its medical infrastructure, wisely.

The Chairman told Mr. Bayer that the group was on time with respect to its tasking and there were no irreconcilable differences that would prevent the group from meeting its objectives. He also noted that much of what the group is being asked to accomplish is already taking place under different initiatives.

The next item on the agenda was a discussion of the Measures of Merit (MoM) and the distribution of a draft MoM strawman. The Navy representative stated that we must clarify the differences between the analytical approaches taken by the Services and that of the Joint Cross-Service Group. After some discussion there was a general agreement that once the criteria are agreed upon by the group, the Military Departments will use them to evaluate their facilities. Mr. Bayer then provided an outline of how he perceived the group's BRAC 95 responsibilities. The group should:

- o Examine the Military Department's capacity vs requirements
- o Establish numerical reduction targets
- o Periodically review the Military Department's progress
- o Recommend alternatives as appropriate

**CLOSE HOLD**

CLOSE HOLD

The Secretaries of the Military Departments will make their recommendations to SECDEF. The Joint Cross-Service Groups will present their evaluations of the Service recommendations to the BRAC 95 Review Group.

The group then reviewed definitions and options for each of the MoMs:

- o Population (P.1): Number of active duty and active duty family members. Discussion ensued regarding the population thresholds necessary to justify a clinic, hospital and GME center. The group was asked to think about these thresholds and remember that they must include the total (tri-service) population. The group then agreed on using both options as the definition of population, with Option 2 being a fall-back option.

It was also emphasized that the above beneficiary population within a region will be counted for GME centers (GME centers were defined as Level III and IV facilities with other than family practice and emergency medicine residencies).

- o Population (P.2): Size of total beneficiary population. The Chairman noted that Option 1 was the same as that under P.1 and recommended that it be dropped. The group agreed. There was some discussion of the retired beneficiary population's impact.
- o Access (A.1): Civilian primary care physician ratio. The definition was accepted (it was noted that internal medicine was inadvertently left out of the definition).
- o Access (A.2): Option 1 was accepted. It was noted, however, that having more than one civilian hospital in the community is important and the occupancy, utilization rates and capacity of the civilian facilities must be known.
- o Facilities (F.1): Condition code. After some discussion of the difficulty in verifying Option 1, the group accepted Option 2.
- o Facilities (F.2): Age of facility. The group agreed to use Option 2.
- o Facilities (F.2) Cost of MILCON: The group agreed on Option 2, but only programmed costs could be included.
- o Cost Effectiveness. This Measure of Merit was tabled until a future meeting.

The meeting adjourned at 1540 hrs. The next meeting is scheduled for February 24, 1994 at 1400 hrs.

Approved Edward D. Martin  
Edward D. Martin, MD  
Acting ASD (HA)

Attachments

CLOSE HOLD



## OTHER ATTENDEES

<u>SERVICE/AGENCY</u>	<u>NAME</u>	<u>PHONE #</u>	<u>ATTENDING 17 Feb 94</u>
OASD (HA)	Ms. Watson	703-697-8973	X
OASD (HA)	Ms. Giese	703-614-4705	X
OASD (HA)	Col Garner	703-614-4705	X
OASD (HA)	CDR Bally	703-614-4705	X
OASD (HA)	LTC Ponatoski	703-614-4705	X
OASD (HA)	LTC McClinton	703-614-4705	
ARMY	COL Barton	703-756-8319	
ARMY	COL Wilcox	703-756-5681	
ARMY	LTC Powell	703-697-3877	X
ARMY	LTC McGaha	703-697-6388	X
ARMY	MAJ Dudevoir	703-756-0286	X
ARMY	MAJ Parker	703-756-8036	X
ARMY	COL Lyons		X
NAVY	CAPT Buzzell	703-681-0475	
NAVY	Ms. Davis	703-602-2252	X
NAVY	CDR DiLorenzo	703-602-0452	X
AIR FORCE	LtCol Silvernail	202-767-5550	X
AIR FORCE	LtCol Bannick	202-767-5066	X
AIR FORCE	Maj Costa	202-767-5066	X
AIR FORCE	Maj Pantaleo	202-767-5046	
LMI	Mr. Neve	301-320-7287	
LMI	Ms. Dahut	301-320-7408	
JS	LtCol Ferguson	703-697-4421	
COMP	Ms. Kopperman	703-697-4517	X
COMP	Mr. Joseph Smith	703-697-4133	X
OASD(P&R)	Mr. Monteleone	703-696-8710	X

**BRAC 95 JOINT CROSS SERVICE GROUP  
FOR MILITARY TREATMENT FACILITIES AND  
GRADUATE MEDICAL EDUCATION**

**FEBRUARY 17, 1994  
Room 4E327, 2:00 pm**

- Review/approve minutes from previous meeting Dr. Martin
- Comments by DASD (Economic Reinvestment and BRAC) Mr. Bayer
- Measures of Merit (MoM) Issues LTC Ponatoski
  - Draft MoM Strawman
- Consideration of adding Medical Labs and and Medical Training Facilities to Study Categories Dr. Martin
- Actions for next meeting Dr. Martin
- Administrative Issues Dr. Martin

**NEXT MEETING FEBRUARY 24, 2:00pm  
ROOM 4E327**

- Adjournment

# BRAC 95 JOINT CROSS-SERVICE GROUP FOR MTFs AND GME

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## ■ Revised Action Plan & Timeline (thru 3/31/94)

- |  |      |   |
|--|------|---|
| ➤ Agree on Statement of Principles   | 2/4  | ✓ |
| ➤ Define role of Group & Services  | 2/4  | ✓ |
| ➤ Develop Analysis Assumptions   | 2/11 | ✓ |
| ➤ Determine Categories for Study   | 2/18 | ✓ |
| ➤ Determine General Analytical Approach                                    | 2/18 | ✓ |
| ➤ Review interim force structure plan                                      | 2/25 |   |
| ➤ Submit list of irreconcilable differences,<br>if necessary, to USD (A&T) | 2/28 |   |
| ➤ Define Measures of Merit & Data Sources                                  | 3/4  |   |
| ➤ Determine weights for Measures of Merit                                  | 3/11 |   |
| ➤ Complete Data Definitions  | 3/11 |   |
| ➤ Establish Data Internal Control Plan                                     | 3/15 |   |

## PROPOSED MEASURES OF MERIT AND DEFINITIONS

**Population - Factors that will help identify the level of medical services required in a particular area.**

### **P1. Number of Active Duty and Active Duty Family Members :**

#### **CLINICS & HOSPITALS**

Option 1. Defined as the number of active duty personnel and their families within a defined catchment area. The catchment area is defined as sets of zip codes emanating from the center of the MTF with a radius of 40 miles.

Option 2. Defined as the number of active duty personnel and their families using a military treatment facility within the last six months. Possible source is the DoD Health Care User Survey. Results due March 31, 1994.

#### **GRADUATE MEDICAL EDUCATION CENTERS:**

Option 1. Defined as the number of active duty personnel and their families residing within the Lead Agent Region as defined by the July 93 Health Affairs Policy Guidance.

*rationale for BRAC criteria #1: A factor that helps determine if a treatment facility is necessary in a given area.*

### **P2. Size of Total Beneficiary Population:**

#### **CLINICS & HOSPITALS**

Option 1. Defined as the number of eligible beneficiaries within a defined catchment area. The catchment area is defined as sets of zip codes emanating from the center of the MTF with a radius of 40 miles.

Option 2. Defined as the number of eligible personnel using a military treatment facility within the last six months. Possible source is the DoD Health Care User Survey. Results due March 31, 1994.

#### **GRADUATE MEDICAL EDUCATION CENTERS:**

Option 1. Defined as the number of eligible beneficiaries within the defined forty mile catchment area plus the number of other beneficiaries residing within the Lead Agent Region as defined by the July 93 Health Affairs Policy Guidance.

*rationale for BRAC criterion #4: A factor that helps define the size and services necessary in a given area.*

## ACCESS

**Access to Care - Factors that will measure the availability and capability of the private sector healthcare system to meet the needs of the MHSS beneficiary population.**

**CLINICS, HOSPITALS, AND GME CENTERS:**

### **A1. CIVILIAN PRIMARY CARE PHYSICIAN RATIO:**

The mapping of civilian physicians and population to catchment area based on the January 1993 Catchment Area Directory (CAD) using ratios defined in the HHS Federal Register, Sept, 1991. Primary care physicians are defined as general practice, family practice, obstetrics, gynecology, and pediatric general and subspecialty physicians.

*rationale for BRAC criterion 7: An indicator of the availability of primary care physicians to provide services to the beneficiary population.*

### **A2. AVAILABILITY OF CIVILIAN INPATIENT ACUTE CARE RESOURCES IN CATCHMENT AREA:**

Option 1. The ability of local community acute care facilities to provide comprehensive health services to the eligible beneficiary population as defined in P1. Availability and ability is based projected health care demand - available resources (ie bed availability)

*rationale for BRAC criterion #7: A factor that measures inpatient capacity and its availability.*

## FACILITIES

**Facility Condition - Factors that will estimate condition of the physical plant and help make decisions regarding retention/closure of facility.**

**CLINICS, HOSPITALS, AND GME CENTERS:**

**F1 CONDITION CODE:**

Option 1. The commander's assessment of the physical condition of his/her facility based on its ability to meet mission requirements. Survey document used is the Defense Medical Facilities Office Facility Condition Assessment Document. This tool reflects the facility based on weighted engineering, life safety, and functional factors.

Option 2. Based on the DoD Real Property Inventory System. Normally rated on a 1-3 scale and performed by the installation engineer.

*rationale for BRAC criterion #2: The condition code is an indication of plant condition; low score is an indirect warning that maintenance and renovation costs will be higher than normal in the future, and may require significant resources to correct deficiencies.*

**F2. AGE OF FACILITY:**

Option 1. Chronological age of facility as reported on Real Property Inventory System

Option 2. Weighted age based on size of facility and age (area x age)/total area

*rationale for BRAC criterion #2: Provides an indication of the design efficiency of the physical plant.*

**F3. COST OF MILCON:**

Option 1. MTF total programmed MILCON resources spanning the Six Year Defense Program.

Option 2. MTF total programmed MILCON plus total programmed Major Repair and Minor Construction Resources spanning the Six Year Defense Program.

*rationale for BRAC criterion #2: An indicator that the physical plant is in a deteriorating state and requires renovation or major construction to operate within normal maintenance standards. This factor also helps determine the adequacy and appropriateness of the size of the facility.*

## COSTS

**Cost Effectiveness - Factors that measure the costs of providing services and compare those to the costs of buying the services from the private sector.**

### CLINICS, HOSPITALS, AND GME CENTERS

#### C1. REFERRALS IN VERSES REFERRALS OUT:

Defined as the number or ratio of inpatients receiving care at a specific MTF originating from anywhere outside the MTF's formal catchment area compared to the number or ratio of beneficiaries within the MTF catchment who receive inpatient care at an MTF outside the catchment area

#### **C2. Inpatient Direct Care Unit Cost verses Inpatient Champus Unit Cost**

Cost issues being addressed by AASD (HA) and Surgeon Generals.

*rationale for BRAC criterion #4: A factor that describes the most economic method on a per unit basis for providing health services.*

## Strawman Analytical Structure

### MILITARY VALUE

#### *Criterion 1- Mission/Impact on Readiness*

1. (P1) Size of active duty and dependents of active duty population.

#### *Criterion 2 - Availability/Condition of Facilities*

1. (F1) Condition codes of facilities at existing site
2. (F2) Age of facilities at existing site

#### *Criterion 3 - Contingency/Mobilization*

#### *Criterion 4- Cost/Manpower Implications*

1. (C1) Referrals In vs Referrals Out.
2. (C2) Unit Care Costs
3. (F3) Cost of construction pending at existing site
4. (P2) Size of total eligible beneficiary population in the defined catchment area.

### RETURN ON INVESTMENT

#### *Criterion 5- ROI*

1. Results from the COBRA analysis

### IMPACTS

#### *Criterion 6 - - Economic Impact on Communities*

#### *Criterion 7 )- (Partial) - Community Infrastructure*

1. (A1) Civilian Primary Care Physician Ratio
2. (A2) Availability of Civilian Inpatient Acute Care Resources in the Catchment Area.

#### *Criterion 8 - - Environmental Impact*

# P1: TOTAL POPULATION MEASURE OF MERIT EXAMPLE OF SCORING SYSTEM

POPULATION: not real data- for example only

## POPULATION AREA DEFINITIONS

- CLINIC = DMIS DEFINED AREA (20MI)
- HOSPITAL = DMIS DEFINED AREA (40MI)
- GME FAC = LEAD AGENT REGION POPULATION

## CRITERIA MEASUREMENT POINT

- CLINIC POPULATION RANGE OF EXISTING FACILITIES = 2000 - 20000      MEAN = 10000
- HOSP POPULATION RANGE OF EXISTING FACILITIES = 20000- 60000      MEAN = 40000
- GME POPULATION RANGE OF EXISTING FACILITIES = 60000 - 120000      MEAN = 90000

### SCORING BASED ON TENS

	1	2	3	4	5	6	7	8	9	10
CLINIC	2000	4000	6000	8000	10000	12000	14000	16000	18000	20000
HOSPITAL	20000	24000	30000	36000	40000	44000	48000	52000	56000	60000
GME CENTER	61000	72000	78000	84000	90000	96000	102000	108000	114000	120000

## P2 ACTIVE DUTY RATIO MEASURE OF MERIT EXAMPLE OF SCORING SYSTEM

POPULATION AREA DEFINITIONS: Based on DMIS Catchment Area Population Data

CRITERIA MEASUREMENT POINT: Percent of Active Duty to total population. Range is from 6% to 55%

### SCORING BASED ON TENS

	1	2	3	4	5	6	7	8	9	10
CLINIC	5.5	11	16.5	22	27.5	33	38.5	44	49.5	55
HOSPITAL	5.5	11	16.5	22	27.5	33	38.5	44	49.5	55
GME CENTER	5.5	11	16.5	22	27.5	33	38.5	44	49.5	55

**F1: CONDITION OF FACILITY**  
**EXAMPLE OF SCORING SYSTEM**

**FACILITY CONDITION: Based on either DMFO Facility Condition Assessment Document  
or Real Property Inventory System. FCAD used in example**

**CRITERIA MEASUREMENT POINT: Condition as reported by Commander**

**SCORING BASED ON TENS**

<b>SCORE</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>	<b>8</b>	<b>9</b>	<b>10</b>
<b>CLINICS</b>	0-10	11-20	21-30	31-40	41-50	51-60	61-70	71-80	81-90	91-100
<b>HOSPITAL</b>	0-10	11-20	21-30	31-40	41-50	51-60	61-70	71-80	81-90	91-100
<b>GME CENTER</b>	0-10	11-20	21-30	31-40	41-50	51-60	61-70	71-80	81-90	91-100

**F2: AGE OF FACILITY**  
**EXAMPLE OF SCORING SYSTEM**

**FACILITY CONDITION: Based on either DMFO Facility Condition Assessment Document  
or Real Property Inventory System. FCAD used in example**

**CRITERIA MEASUREMENT POINT: Age as reported by Commander and or Real  
Property Inventory System**

**SCORING BASED ON TENS - NO JUDGMENT MADE BETWEEN CATEGORIES**

<b>SCORE</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>	<b>8</b>	<b>9</b>	<b>10</b>
<b>CLINICS</b>	46-55	37-45	29-36	22-28	16-21	11-15	7-10	4-6	2-3	1
<b>HOSPITAL</b>	46-55	37-45	29-36	22-28	16-21	11-15	7-10	4-6	2-3	1
<b>GME CENTER</b>	46-55	37-45	29-36	22-28	16-21	11-15	7-10	4-6	2-3	1

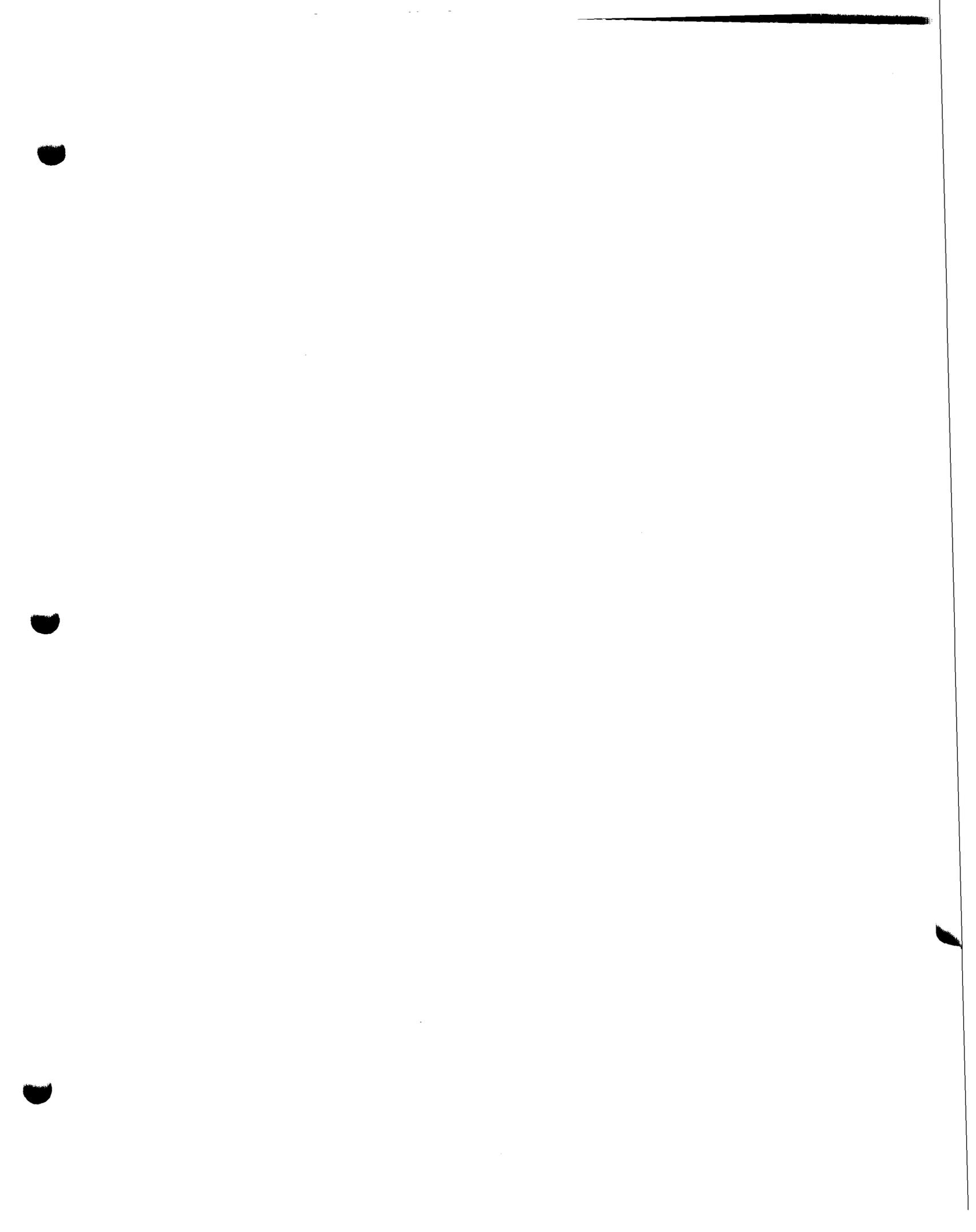
**F3: COST OF MILCON**  
**EXAMPLE OF SCORING SYSTEM**

**FACILITY CONDITION: Based on range of projects within the six year DoD MILCON Program- \$300,000 TO \$330,000,000**

**CRITERIA MEASUREMENT POINT: Cost as described in DoD Medical MILCON Program**

**SCORING BASED ON TENS/DATA IN MILLIONS**

<b>SCORE</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>	<b>8</b>	<b>9</b>	<b>10</b>
<b>AD/TOTAL</b>	>37	33-36	29-32	25-28	21-24	17-20	13-16	9-12	5-8	<4
<b>HOSPITAL</b>	>37	33-36	29-32	25-28	21-24	17-20	13-16	9-12	5-8	<4
<b>GME CENTER</b>	>37	33-36	29-32	25-28	21-24	17-20	13-16	9-12	5-8	<4



POLICY GUIDELINES FOR  
IMPLEMENTING MANAGED CARE REFORMS  
IN THE  
MILITARY HEALTH SERVICES SYSTEM

February 18, 1994

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## OVERVIEW

The mission of the Military Health Services System (MHSS) is to provide medical services and support to the armed forces during military operations, and to provide continuous medical services to members of the armed forces, their dependents, and others entitled to Department of Defense (DoD) medical care. Military medical treatment facilities (MTF) are the heart of the military health care delivery system, providing about three-fourths of all care. Civilian care, financed through the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) comprises a much smaller portion and is designed primarily to supplement care available in military facilities.

Consistent with National Health Care Reform, the military health care system is embarking on a major program of health care reform, to be known as TRICARE. TRICARE is designed to ensure the most effective execution of the military health care mission, recognizing the need to ensure access to a secure, quality health care benefit, control costs, and respond to changing national military and health care priorities.

The Department is also identifying future medical readiness objectives in a strategic plan for achieving and maintaining medical readiness, the DoD Medical Readiness Objectives 2001, developed jointly by the Office of the Secretary of Defense, the Military Departments and the Joint Staff.

The DoD began its transition to managed care on October 1, 1993, adding several major features to its health care program that provide commanders the tools, authority and flexibility to manage better in an era of health care reform. They are the following:

1. Division of the United States-based MHSS into twelve Health Services Regions; each headed by a medical center commander designated as a lead agent, who has broad new responsibilities for health care management throughout the region. A DoD Instruction formalizing the lead agent's authorities will be issued this Spring.

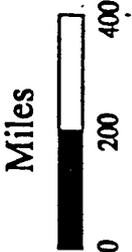
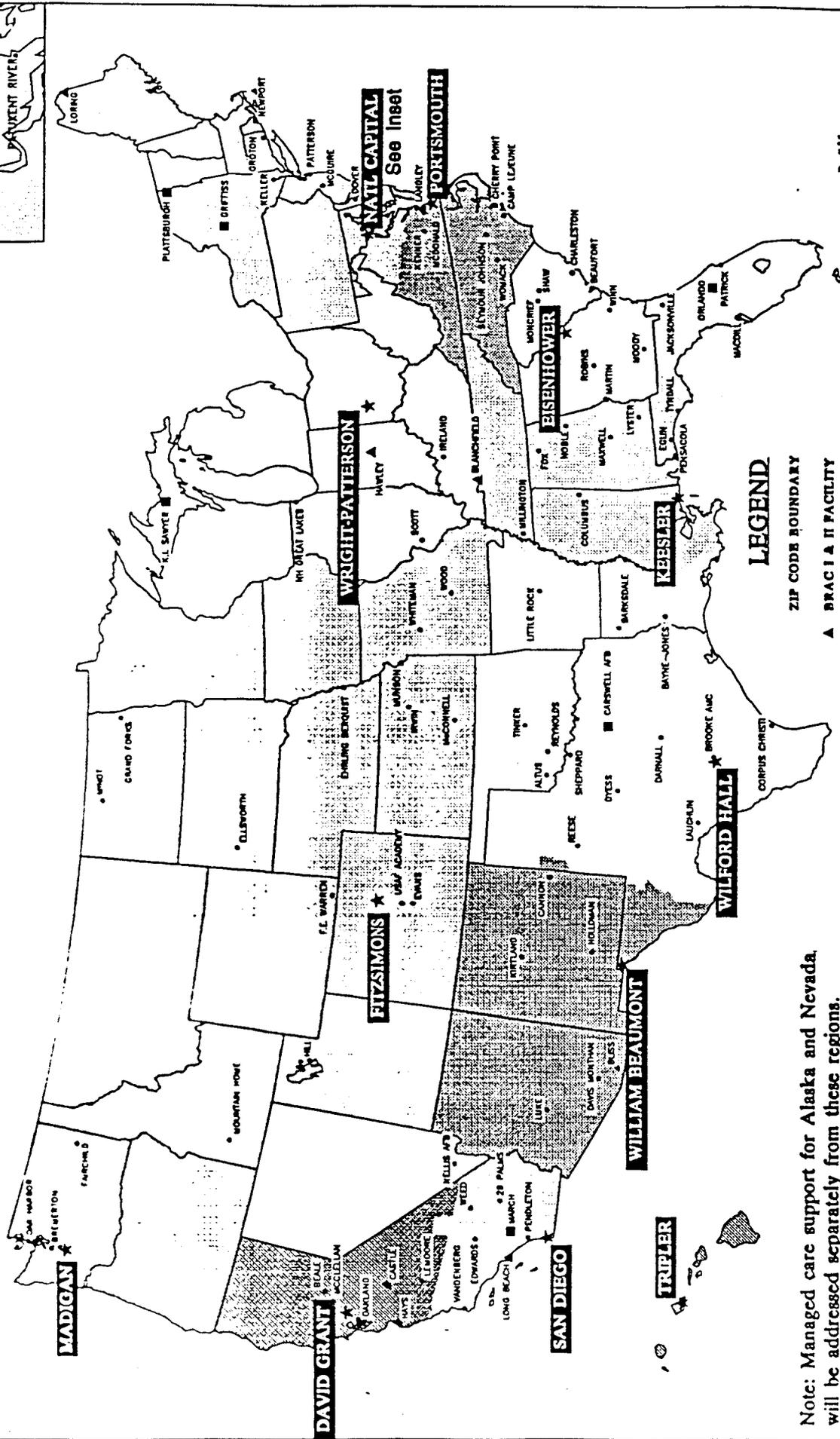
2. Development of proposed standard managed care options for CHAMPUS-eligible beneficiaries: a health maintenance organization type option known as TRICARE Prime and a preferred provider option known as TRICARE Extra; both alternatives to standard CHAMPUS, or TRICARE Standard. CHAMPUS beneficiaries retain their freedom to choose among several health care alternatives, and the opportunity to elect enrollment in an option that lowers their out-of-pocket costs. Implementation of these options is the subject of rule making proceedings now underway.

3. Transition to a capitation-based method of allocating health care resources to the Military Departments, which provides financial incentives for effective health care management; and

4. Transition to the establishment of a fixed price, at-risk TRICARE Support contract to operate in each MHSS region, offering fiscal and administrative support to lead agents for care purchased from networks of civilian health care providers.

These policy guidelines describe the principles and design of the DoD TRICARE Program. They describe the key features of the program, including strategies for the delivery, organization and financing of care, and improved accountability. This policy guidance incorporates by reference the DoD Medical Readiness Objectives 2001, and replaces the Department's Coordinated Care Guidance memoranda dated August 14, 1992.

# MEDICAL TREATMENT FACILITIES



## LEGEND

- ZIP CODE BOUNDARY
- ▲ BRAC I & II FACILITY
- BRAC III FACILITY
- ★ LEAD AGENT MTP
- MEDICAL TREATMENT FACILITY

Note: Managed care support for Alaska and Nevada will be addressed separately from these regions.

Sources: DMIS and Defense Base Closure and Realignment Commission, 1993 Report to the President

## TRICARE PROGRAM GOALS AND GUIDING PRINCIPLES

The TRICARE Program is based on the following goals:

- Improving beneficiary access to care;
- Assuring the security of a high quality, consistent health care benefit for all MHSS beneficiaries, at low cost;
- Preserving choice for all non-active duty participants; and
- Containing overall DoD health care costs.

### PRINCIPLES

The principles that guide the design and implementation of the TRICARE Program are as follows:

- **Serve those on active duty so that we maintain a combat-ready force.**  
Enable the DoD to retain a force capable of meeting its broad-ranging mission requirements
- **Improve access to health care for all DoD beneficiaries.** Each regional military health care plan, composed of military and civilian provider networks, must have attributes of size, composition, mix of providers and geographical distribution that together will adequately address the healthcare needs of all DoD beneficiaries with emphasis on those who choose to enroll. Specific access standards will be prescribed and monitored in every DoD Health Services Region.

- **Achieve greater equity.** TRICARE will ensure a secure, high quality, cost-effective and uniform benefit for all beneficiary categories in the MHSS.

Achieving greater equity in the areas of access, quality, and cost of the military health care benefit will be continuously pursued.

- **Ensure choice for all other DoD beneficiaries for selection of health care options which minimize out-of-pocket costs.** Consistent with National Health Care Reform, military beneficiaries retain choice among several health care options. This enables non-active duty beneficiaries to consider selecting a managed health care plan as an alternative to standard CHAMPUS, allowing MTF commanders to identify beneficiaries as their responsibility and direct resources accordingly. By voluntarily choosing modest enrollment fees, CHAMPUS-eligible participants can keep their out-of-pocket costs low.

- **Make the most efficient use of MHSS resources.** Military MTFs are the heart of the military health care delivery system, providing about seventy-five percent of all care, system-wide. Primary care managers and health care finders, new cornerstones in the military health care system, will direct enrolled patients to the military MTF, or when care is not available there; to civilian providers under contract to the Department in a TRICARE Support contract. This will optimize the use of military health system direct care resources and minimize out-of-pocket costs for beneficiaries.

- **Achieve a uniform standard of quality.** The DoD is striving for uniform standards of quality, which will apply equally to health care in the direct care system and any care purchased from civilian providers under managed care support contracts.

- **Designate regional health service areas and lead agents.** The TRICARE Program incorporates the MHSS into a fundamental restructuring, creating twelve Health Services Regions. These regions were established to ensure an adequate beneficiary population base to support cost-effective volumes of care under TRICARE Support contracts, and regional access to tertiary care provided primarily by military medical centers. A lead agent, corresponding to a

regional medical center, is designated for each of the Health Services Regions, and functions as the focal point for health services planning within the region.

- **TRICARE Support Contracts.** A fixed price, at-risk managed care support contract, combining civilian managed care networks with fiscal and administrative support, will support each lead agent, and complement the majority of services that are provided in the MTFs. The Department will perform economic analyses required by statute, before implementing any regional, at-risk, managed care support program based on the combined cost of health care in the direct care system and CHAMPUS.
  
- **Provide specialized treatment services.** Specialized Treatment Services (STS), such as those clinical services involving high technology and high cost procedures, will be available to DoD beneficiaries at designated facilities, both within and among Health Services Regions. The STS program will operate in accordance with CHAMPUS regulatory requirements, issued November 5, 1993, and a DoD Instruction soon to be issued.
  
- **Central oversight; local accountability and execution.** Health care is delivered locally, therefore it must be managed locally. Consequently, MTF commanders will have the tools, flexibility, and authority to make appropriate decisions about the delivery of care. Lead agents and MTF commanders will be accountable for the health care costs, quality and access in their delivery areas for all beneficiaries, in both the civilian networks and the direct care system. The system's performance will be monitored centrally by the Military Departments and the Office of the Secretary of Defense for Health Affairs.
  
- **Consistent with the President's National Health Care Reform Plan.** The TRICARE Program will remain in harmony with National Health Care Reform. TRICARE will significantly expand managed care in the MHSS, and emphasize a secure, consistent benefit. It will ensure accountability for health care spending and provide beneficiaries access to high quality care. For other than active duty beneficiaries, the program will preserve the freedom to choose among alternative sources of health care.

- **Achieve effective use of information systems.** One key to the success of the TRICARE Program is the effective use of information systems; both the integration of present systems and the rapid fielding of new integrated, open systems. Without timely information on access, utilization, and cost, the maximum benefits of TRICARE cannot be realized. Working groups composed of representatives from Health Affairs and the Military Departments are meeting to provide more guidance on this topic.

## THE TRICARE PROGRAM BENEFIT OPTIONS

Under the current MHSS, covered beneficiaries as defined by Title 10, United States Code, are eligible to receive care in the direct care system provided in military hospitals or clinics. Non-active duty beneficiaries may also seek care from civilian health providers; the government shares in the cost of such civilian care for most beneficiaries who are not eligible for Medicare under the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). The majority of care for military beneficiaries is provided within catchment areas of inpatient MTFs, an area roughly defined as a 40 mile radius around the facility.

Sound management of the MHSS requires a great degree of coordination between the direct care system and CHAMPUS-funded civilian care. The TRICARE Program recognizes that "step one" of any management improving process is to identify the beneficiaries for who the health program is responsible.

TRICARE moves toward the establishment of a basic structure of health care enrollment for the MHSS. Enrollment of beneficiaries in their respective health care plans is an essential element in most private sector health plans as well as within the context of the President's Health Care Reform Program.

A major feature of the TRICARE program will be local health care delivery networks based on arrangements between military and civilian health care providers and organizations. The civilian preferred provider portion of this network will be composed of a wide array of CHAMPUS-authorized health care providers, who agree to follow certain rules and procedures for sound utilization management; maintain close coordination with the MTF; and provide

affordable care, easy administration, and a comprehensive quality management program. They will also accept the CHAMPUS, or lower negotiated fees for provided services.

CHAMPUS-eligible beneficiaries will be offered three options: 1) they may enroll to receive health care in this military-civilian health care system, called "TRICARE Prime;" 2) they may use the civilian preferred provider network, on a case-by-case basis, under "TRICARE Extra"; or 3) they may remain in the standard CHAMPUS benefit plan, called "TRICARE Standard". Enrollees in TRICARE Prime will generally obtain all their care within the network and pay reduced CHAMPUS cost shares for care received from civilian providers. A point-of-service option will be provided under TRICARE Prime, allowing enrollees to go outside the provider network, but cost-sharing requirements under this option will be higher. Beneficiaries who choose not to enroll in TRICARE Prime, will preserve their freedom of choice of provider, for the most part, by remaining in TRICARE Standard. These beneficiaries will face standard CHAMPUS cost-sharing requirements. Whenever beneficiaries, who are not enrolled in TRICARE Prime, use the network, they will benefit from reduced cost-sharing under TRICARE Extra. The operation of this triple option will be governed by the TRICARE Program regulation, which is presently in the rule making process.

Other features of the TRICARE Program are the primary care management process and the Health Care Finder. TRICARE Prime enrollees will have a primary care manager as a regular point of service for most health care needs. The primary care manager will refer patients for needed care at the MTF or in the civilian network. In this aspect the primary care manager will be complemented by the Health Care Finder, an administrative office that supports the referral process. TRICARE Standard participants can also use the services of the Health Care Finder (See last section of this document for detailed charts outlining options).

## LEAD AGENT RESPONSIBILITIES

Lead agents, working in concert with MTF commanders and staffs from all Services in the region, are responsible for developing a Tri-Service, Regional Health Services Plan for all beneficiaries--including the care provided by military facilities and clinics as well as the care the MTFs do not provide. A TRICARE Support contract, procured centrally by the Office of the Assistant Secretary of Defense for Health Affairs, will develop and maintain an integrated network of civilian providers to complement direct care system capabilities according to regional priorities.

Military MTFs within the Health Services Region retain their Service designated chain-of-command regardless of their lead agent. Authority to make decisions regarding direct care funds, facility maintenance, and personnel actions within the MTF is also retained by the parent Service. All monies collected through the Third Party Collection Program are retained by the MTF that provided the care.

The National Capital Region will functionally carry out the lead agent policy through a Tri-Service board with annual rotation of the chairperson. The TRICARE Support contract responsibility for the board will be carried out by Walter Reed Army Medical Center.

### **Major Responsibilities of the Lead Agents:**

- Developing, in coordination with the other commanders in the region, a Regional Health Services Plan and producing an annual update of this plan.

- Developing, in concert with medical facilities, reserve units, and the TRICARE Support contractor, plans for increasing clinical support, if required, during contingencies.
  
- Ensuring that the plan for delivery of health care services provides continuous quality improvement in pursuit of the goals of managed care.
  
- Developing regional TRICARE Support contract requirements within the framework of overall DoD policy. A prototype statement of work for the TRICARE Support contract will be developed jointly between the Office of the Assistant Secretary of Defense (Health Affairs) and the Military Departments. The lead agent 1) is responsible to recommend or make modifications to the contract requirements (depending on the nature of the modification) based upon the Regional Health Services Plan and unique regional needs; 2) will work with the contractor to determine the size and configuration of the network, to complement the MTF capabilities; 3) will ensure that the network will meet the health needs of, and DoD access standards for, beneficiaries in the region; and 4) will be fully involved in the development, procurement, transition and operation of the TRICARE Support contract through an administrative contracting officer and a regional TRICARE Support program manager.
  
- Developing procedures for coordinating health care delivery between military and civilian health care providers in the region.
  
- Monitoring the CHAMPUS budget targets.
  
- Coordinating utilization management and quality assurance activities.
  
- Working with commanders in the region to establish priorities for routing beneficiaries to the direct care system.
  
- Determining the level and cost of resource sharing between military MTFs and the TRICARE Support contractor throughout the region.

- Developing, in accordance with DoD policy, regional policy for coordinating patient referrals and issuance of non-availability statements. The lead agent will develop overall policy in concert with the regional MTF on non-availability statement issuance and management of Specialized Treatment Services, and may choose to transfer part of this function to the TRICARE Support contractor. Determinations of exclusion from CHAMPUS on the grounds of medical necessity must be made by qualified medical personnel and subject to reconsideration and appeal procedures. At a minimum, prior to the issuance of a non-availability statement, a determination will be made, in accordance with all substantive and procedural requirements of the CHAMPUS regulation, as to the medical necessity of the care sought. To assure compliance with the CHAMPUS regulation and achieve necessary integration with CHAMPUS procedures, applicable requirements will be established in revised DoD Instruction 6015.19, "Issuance of Nonavailability Statements" (Nov 26, 1984), to be issued this Spring.
- Designating and maintaining the regional Specialized Treatment Services program for certain resource intensive clinical services within the region, in accordance with applicable provisions of the CHAMPUS regulation and STS program DoD Instruction.
- Coordinating, in concert with regional military MTFs, the development of an annual regional capitalization, maintenance and repair and renovation plan for all military MTFs within the Health Services Region.
- Overseeing efforts to disseminate information about the TRICARE Program to beneficiaries and direct care and contractor staff.
- Conducting ongoing evaluations of resource utilization, clinical services, and access throughout the Health Services Region and coordinating corrective actions through the direct care or civilian support systems as appropriate.
- Coordinating the development of a region-wide information systems modernization plan for all military MTFs within the Health Services Region.

## Access Standards

Another responsibility of the lead agent is to ensure timely access to health care services for all military plan participants. Before offering any enrollment option to DoD beneficiaries, the lead agent and MTF commanders within the region, must ensure that the capabilities of the military MTF plus the TRICARE civilian provider network will meet the following access standards:

- Emergency and urgent care services shall be available and accessible within the service area, 24 hours a day, seven-days a week.
- The drive time of the military health plan enrollee should not generally exceed 30 minutes from home to the site of primary care delivery. Non-availability of providers in the area may justify longer travel time.
- The drive time to obtain specialty care, except in cases of Specialized Treatment Services, should normally not exceed one-hour. If a longer drive time is required based on availability of specialists, the beneficiary will be informed of these circumstances.
- Maximum wait times for primary care appointments are as follows:
  - four weeks for a well visit (health maintenance and prevention--non-urgent)
  - one week for a routine visit (intervention required, but non-urgent); and
  - one day for acute illness care (early intervention required--urgent).

*However, a healthcare provider using professional standards and clinical judgment, may determine more appropriate appointments based on the needs of the beneficiary.*

- Maximum wait times for specialty care appointments will be:

*--four weeks for a routine visit; and*

*--one day for urgent care.*

*The appropriate wait time for specialty care appointments shall be determined by the primary care manager making the referral, based on the nature of care required, but; in general, shall be no longer than four weeks.*

### Summary

To carry out these responsibilities, the lead agent will work cooperatively with each of the regional military MTFs (including free standing clinics) in accomplishing the goal of maximizing the most effective use of the direct care system. Knowledge of the regional capacity for the provision of direct care services will enable the lead agent to develop regional policies for referrals, non-availability statement issuance, and specialized treatment services. The Regional Health Services Plan will then be enhanced by the TRICARE Support contract that will both complement health services provided by the direct care system, and provide additional support to the facilities and lead agent as required. However, before awarding any TRICARE Support contract, the DoD will perform economic and other analyses required by law to certify that the costs of the contract do not exceed current costs of standard CHAMPUS. Such certification will take into account any impact on the cost of health care in the direct care system attributable to the TRICARE Support contract.

The success of the TRICARE Program relies to a great extent on inter-Service cooperation and the administrative skills lead agents can bring to bear in the development and execution of the regional health service plans. Thus, the TRICARE Program will foster

teamwork and decentralized, regional execution across Service lines. Achievement of DoD performance standards will be monitored jointly by the Office of the Secretary of Defense for Health Affairs and the Military Departments.

When instituting changes necessitated by the transition to regionally-based health service plans, lead agents will seek concurrence by the Military Departments and MTF commanders. In the event of a disagreement, resolution will be sought first at the regional level by the medical treatment facility commanders and the lead agent. If agreement cannot be reached at the regional level, then the MTF commanders will initiate an appeals process, elevating the open issue for further action through their respective Military Department chains-of-command. Lead agents will elevate unresolved disputes within ten working days to their parent Service Surgeon General for coordination and resolution with the affected Military Departments. In the case of the National Capital Region, disputes will be forwarded through the parent Service of the chairperson. Unresolved disputes at the Surgeon General level will be forwarded for final disposition within ten days, to the Assistant Secretary of Defense for Health Affairs through the Assistant Service Secretaries for Personnel, Readiness and Reserve Affairs. The final decision regarding the issue under dispute will be provided within ten working days by the Assistant Secretary of Defense for Health Affairs.

Because of the scope, magnitude and complexity of the MHSS, the extensive nature of TRICARE Program reforms, and the need to minimize any unforeseen effects to readiness or beneficiary care, the TRICARE Program will be phased-in over a three-year period that began October 1, 1993. The Office of the Assistant Secretary of Defense for Health Affairs will promulgate, by regulation, the scope of services, including cost shares, for a uniform military health care benefit. That benefit will be incorporated into all DoD managed care programs

including Uniformed Services Treatment Facilities, and will move toward conformance with the national health care benefit as such a benefit is defined.

Although the transition to regional managed care will take approximately three years to complete, many aspects of the TRICARE Program have already been put in place with the establishment of lead agents, health services regions, and a capitation-based resource allocation methodology.

Lead agents should begin to develop a regional management structure immediately. While the Services must resource these operations out of their existing budgets, Health Affairs will make every effort to support the regional health services planning needs identified by the Services. The composition of the regional office will be determined by the lead agent in coordination with other military medical treatment facilities in the region, and will include Tri-Service staffing.

## REGIONAL LEAD AGENTS AND SUPPORTED POPULATIONS

### MEDICAL TREATMENT FACILITIES

LEAD AGENT/HSR	POPULATION	ARMY	NAVY	AIR FORCE	TOTAL
National Capital <sup>1</sup>	1,093,918	5	6	4	15
Portsmouth	872,011	3	3	2	8
Eisenhower	1,063,770	4	4	5	13
Keesler	595,024	3	2	5	10
Wright-Patterson	653,328	2	1	3	6
Wilford Hall	949,778	4	1	9	14
William Beaumont	323,058	2	0	5	7
Fitzsimons	732,821	5	0	9	14
San Diego	710,461	1	3	3	7
David Grant	382,590	1	2	4	7
Madigan <sup>2</sup>	350,439	1	2	1	4
Tripler	151,750	1	0	0	1
<b>TOTAL</b>	<b>7,878,948</b>	<b>31</b>	<b>23</b>	<b>53</b>	<b>106</b>

<sup>1</sup> The National Capital Region will functionally carry out this policy through a Tri-Service board with annual rotation of the chair person. The contract responsibility for the board will be carried out by Walter Reed Army Medical Center.

<sup>2</sup> Alaska and Nevada will be free-standing entities and will develop referral patterns with appropriate medical centers.

## **CAPITATION-BASED RESOURCE ALLOCATION**

One of the guiding principles of the TRICARE Program is to optimize the use of MHSS resources. Resource allocation and financing mechanisms have been designed to encourage improved efficiency and effectiveness. The MHSS resources are allocated based on a capitation-based methodology that allocates operation and maintenance dollars for direct care and CHAMPUS, as well as military personnel resources. These funds are allocated from the central Defense Health Program that was established to improve overall management of the military health services program.

### **WHAT IS CAPITATION?**

The concept of capitation is recognized nationally as an important strategy for containing the cost of health care. Under the MHSS capitation system, the commander of each MTF assumes responsibility for providing health services to a defined population for a fixed amount per beneficiary. Regardless of the amount of health services used, there is no financial incentive under a capitation methodology to inappropriately increase the number of services or to provide more costly care than is clinically appropriate. Because a capitated allocation system makes the MTF commander responsible for providing all health services, there are built-in incentives for care to be provided in the most cost-effective setting; the use of preventive services, the efficient delivery of each episode of care, and the careful monitoring of the volume of provided services. Capitation discourages inappropriate hospital admissions, excessive lengths of stay, and unnecessary services. And, because the MHSS will set the capitation amount prospectively, the health care provider cannot influence the funding received for beneficiaries' care within the period of the allocation. Quality assurance and utilization

management programs will monitor appropriate utilization of medically necessary services to ensure that budgetary controls do not erode the provision of needed care.

#### **Basic Resource Allocation Plan:**

Resource allocations are based upon a two-step process that reflects each Service's individual requirements, yet is consistent with the overall Defense Health Program resource allocation framework. Health Affairs allocates CHAMPUS and direct care operation and maintenance dollars and military personnel resources to the three Services, using a financially-based modified capitation methodology. The Military Departments allocate resources to each of their MTFs based on a modified capitation methodology, designed by the Services to meet their unique requirements as approved by Health Affairs. The Military Departments will identify all CHAMPUS resources for the lead agent's management oversight at each of the twelve regions. The method for further allocating the CHAMPUS resources will be dependent on the Service affiliation of the regional lead agent and the existence of a fixed price, at-risk TRICARE Support contract. Calculation of the allocation of CHAMPUS resources to MTFs in regions with such contracts will be done by Health Affairs and provided to the Military Departments.

#### **Operation and Maintenance, Direct Care and Military Personnel Resources**

Under the regionalization concept, the direct care and military personnel resources will continue to flow through the Military Departments to the MTFs without change. The MTF commander will continue to have control over the allocated operation and maintenance direct care and military personnel resources. The non-interchangability of military personnel and

operation and maintenance resources during the budget development and execution phases of the Planning, Programming, Budgeting System create a problem that will need new, more flexible budgeting. Including military manpower in the resource equation will drive a more integrated planning approach at the Service and the MTF level.

Although the first year, FY94, is realistically the most difficult, it is expected that this problem will be minimized as commanders and their staffs make manpower decisions early enough to affect military assignments and balance their overall staffing levels. In the short term, excess military resources can be directed on a temporary basis to provide needed health care services in lieu of contracts or CHAMPUS at other MTFs. Service-specific command and control of the MTFs and legal liability for over-obligation of operation and maintenance direct care resources will also continue without change.

#### CHAMPUS Resources

All CHAMPUS resources will be allocated by Health Affairs to the Military Departments based on the capitation methodology. Until TRICARE Support contracts are established for all regions, the Military Departments will calculate both catchment area and non catchment area costs for their beneficiaries in each of the regions.

In regions that do not have a TRICARE Support contract in place, the operation and maintenance CHAMPUS funds will be included in the initial budget allocation of the Military Departments. The Military Departments will hold their Services' share of the CHAMPUS budget at the Service headquarters level. The Military Departments will identify the beneficiaries' share of the CHAMPUS requirement for each region, and will report the

amount held for each region to the lead agent's parent Service. Or, in the case of the National Capital Region, to ensure continuity of CHAMPUS fiscal operations and planning, the Military Departments will identify their beneficiaries' share of the CHAMPUS requirement and will report the amount held for the National Capital Region to Walter Reed Army Medical Center. Each of the lead agents will receive information and fiscal guidance through their parent Service's chain-of-command that identifies their total CHAMPUS budget with Service-specific and catchment area-specific subtotals. (For example, the Air Force has lead agent responsibility in the Wright-Patterson Region. At the Surgeons General level, the Army and Navy will notify the Air Force of the total funds they are holding for their Service's beneficiaries in the Wright-Patterson Region. The Air Force will then be responsible for providing the necessary financial information and fiscal guidance to the lead agent, who is the Commander, USAF Medical Center Wright-Patterson).

Lead agents will assume administrative responsibility for coordinating the management of the CHAMPUS program within their specified area of responsibility. Based on the regional health services plan, developed by the lead agent and coordinated with each of the Services represented in the region, the lead agent will recommend to the Services that CHAMPUS resources be released to the appropriate MTF for direct care projects designed to reduce overall costs. The expenditure of CHAMPUS resources by the Military Departments will be monitored by catchment area and region.

In regions with TRICARE Support contracts, the MTFs' CHAMPUS allocations will be retained by the parent Services and pooled among the Services to fund the lead agent's execution of the support contract. Health Affairs will calculate both catchment area and out-of-catchment area CHAMPUS allocations and provide them to the Military Departments.

Under this methodology, each Service remains jointly accountable for the TRICARE Support contract.

### **CHAMPUS Budget Savings/Overruns**

If an MTF commander generates identifiable CHAMPUS savings, then the parent Service will retain the savings. The commander, with guidance from the designated lead agent, will develop cooperative management initiatives to invest funds to recapture CHAMPUS costs. The management initiatives will be reflected in the jointly developed regional health services plan and approved by the affected Military Departments. As an incentive for the local commanders, the lead agent, with the approval of the MTFs' parent Service, will project in advance the estimated overall CHAMPUS net savings--the local military medical treatment facility/parent Service will then be authorized to retain 100 percent of the actual earned savings. If the CHAMPUS claims of the MTF, exceed or overrun the authorized budget, then the MTF, or parent Service, must make up the difference.

### **Transfer Payments**

With a capitation based allocation system, reducing workload can result in increasing a commander's discretionary funds. This establishes an incentive to shift necessary workload to other military MTFs. In addition, transferring workload that traditionally was covered by CHAMPUS to tertiary care military medical centers within a region, requires a transfer of funds from the catchment area in which the patient resides, to the medical center. The policy is currently in draft for identifying and transferring appropriate funding to cover the additional

costs to be incurred at the medical centers. Without transfer payments the medical centers would be unable to expand their capabilities to provide Specialized Treatment Services.

### **Shared Resource Information**

This resource allocation framework is targeted toward the managed care environment that features direct care services augmented by at-risk contractor support. To achieve the goals embodied by the TRICARE Program, particular emphasis must be placed on coordination of resources and responsibilities during the transition of CHAMPUS contractor support from the historical fee-for-service system to one in which the contractor is at-risk. Prior to the establishment of TRICARE Support contracts, the regional CHAMPUS resources will be coordinated and monitored by the lead agent to achieve savings through the development of negotiated discounts, provider networks, and utilization management options under established CHAMPUS regulations, DoD Instructions, and existing CHAMPUS Fiscal Intermediary and Utilization Management contracts. To implement successfully the TRICARE Program, the lead agents and MTF commanders must know the full cost of the assets employed to deliver health care services. The Military Departments will develop and publicize their capitation methodology for allocating all applicable operating resources to each catchment area to include military personnel, operation and maintenance direct care, and operations and maintenance CHAMPUS. Sharing of resource management information among MTF commanders, lead agents, Military Departments and Health Affairs staff is required to preclude inappropriate intra- and inter-regional resource shifting. Timely access on a "need to know" basis to available plans and resource information--financial, workload, manpower and beneficiary population--must be assured at all organizational levels. To this end, CHAMPUS claims data posting will be expedited by reducing the allowed beneficiary claims filing period

from 24 to 12 months, thereby bringing this period into greater alignment with civilian healthcare plans.

### **Resource Management Plans**

A detailed resource management plan that includes the areas of resource allocation and execution will be developed locally and provided by each MTF commander - first to the next level of command and control and then to the designated lead agent for review and approval. With the lead agent's approval, the resource management plan will become an integral part of the overall Regional Health Services Plan. Significant changes instituted by lead agents will be coordinated with affected commanders. Disagreements over regional resources are to be first addressed at the regional level by the MTF commanders and the lead agent. If concurrence is not reached at the regional level, then the MTF commander will elevate the open issue for resolution through the appeals process specified earlier in this policy guidance.

## TRICARE SUPPORT CONTRACTS

To implement the TRICARE Program in the most effective way possible, the DoD has begun the transition from standard fee-for-service financing of care purchased from civilian providers under CHAMPUS to large TRICARE Support contracts for each of the twelve Health Service Regions. These TRICARE Support contracts, procured centrally by the Office of CHAMPUS, will assist lead agents and MTFs in meeting their responsibilities to improve access to quality health care, while containing costs. They are fixed price, at-risk contracts intended to provide substantial incentives for the civilian managed care contractors to develop innovative programs and linkages with the MTFs.

The primary functions of the TRICARE Support contract are the following:

- Development of civilian provider networks in support of both the TRICARE Prime and TRICARE Extra benefits;
- Claims processing and data collection;
- Utilization management and quality assurance;
- Patient routing and referral, and beneficiary services;
- TRICARE Prime program enrollment;
- Provider and beneficiary education; and
- Marketing.

The transition to TRICARE Support contracts for lead agents will occur over a three-year period. Prior to the implementation of a TRICARE Support contract, local MTFs and their respective Services are totally responsible for the direct care system and CHAMPUS costs. In those regions where a regional TRICARE Support contract is not yet in place and economic analyses demonstrate savings, the lead agent and MTF commanders may choose to develop a contract to manage portions of CHAMPUS care; such as a contract for certain clinical services. These locally managed contracts must be consistent with the design of the TRICARE Extra option. Any such contract must conform with all rights and obligations under the CHAMPUS regulation and other legal requirements. There must also be coordination with OCHAMPUS to permit corresponding revisions, if necessary, to existing Fiscal Intermediary or Utilization Management contracts. In addition, such contracts must be integrated to the extent feasible into the TRICARE Support contract when it is awarded. Once procured, the TRICARE Support contractor and the Services will share the financial risk for the CHAMPUS benefit program.

#### **Development of Civilian Provider Networks**

The TRICARE Support contractor, based upon the regional plan developed by the lead agents, shall establish a preferred provider network wherever feasible and desirable. These networks will support the TRICARE Prime, a health maintenance organization-type model for those beneficiaries who chose the enrollment option as well as the TRICARE Extra, a managed care option similar to a preferred provider organization for eligible beneficiaries. The contractor will work with the lead agent and local MTF commanders to determine the optimal configuration of the network as subordinate and complementary to the direct care system capabilities of the region, where the majority of the care is delivered. The lead agent will

assist in determining the adequacy of the network based on the availability of direct care services, the availability of civilian providers, and the size, distribution, and health care needs of the beneficiary population. In determining the adequacy of the network, the contractor must meet the standards centrally developed by DoD, with input from the lead agents. Requirements will accommodate differences in managed care markets and in the supply of health care providers across geographic areas. According to Federal law, state or local government laws or regulations for health care contracts can be pre-empted to the extent that the Department determines that such laws or regulations are inconsistent with specific provisions in the contract.

The MTFs will be integral parts of the regional provider network and will serve as primary care sites. To make the most efficient use of military resources, direct care providers shall be treated by the contractor as the providers of first choice in accordance with the routing and referral protocols established by the lead agent.

### **Primary Care Managers**

The contractor shall assist in the selection of a primary care manager who will be responsible for the provision of virtually all primary care to the patient and for referring the patient for any necessary specialty services. The primary care manager may be an MTF or a civilian network provider. Civilian network providers who agree to be primary care managers must follow all of the rules and procedures identified in the provider agreements. Providers who agree to be primary care managers shall sign agreements that identify the rules and procedures for specialty referrals and their responsibilities as primary care managers. In the event the assigned primary care manager cannot provide the necessary, full range of primary

care functions, this manager will ensure access to necessary health care services as well as any specialty requirements. The contractor will work with the MTF commanders, under the guidance of the lead agent, in establishing priorities for routing beneficiaries to the direct care system, determining the capacity of the MTFs regarding direct care primary care manager patient load, and establishing goals for supplementing in-house capacity through resource sharing arrangements. The MTF providers must follow the same referral protocols for the civilian providers as established by the lead agents.

The contractor will assist the lead agent in determining the optimal manner to supplement direct care capacity through civilian contracting or resource sharing and working with each involved MTF. The lead agent can arrange with the contractor and the MTF commanders for the provision of contracted services within the military facilities. With the implementation of the TRICARE Support contracts, prior contracts or agreements including partnership providers, PRIMUS/NAVCARE, Base Realignment and Closure benefits, and Catchment Area Management demonstrations, may be phased into the new contract.

For those areas in which health maintenance organization or preferred provider organization options are not feasible, the TRICARE Support contractor will be required to develop the CHAMPUS Participating Provider Program to the extent possible, thus enhancing access to TRICARE Standard. While the expansion of participating providers will be a requirement in all areas, the areas that offer no other choice to CHAMPUS beneficiaries will receive priority attention if a significant number of beneficiaries reside there.

## **Utilization Management/Quality Monitoring**

The TRICARE Support contractor will be required to establish utilization management (UM) and quality monitoring programs in a manner consistent with policy requirements established by DoD, ensuring uniformity of standards across regions. To promote greatest efficiency, comprehension and consistency, the TRICARE Support contractor in each region may be requested by the MTFs to perform UM, covering all network and non-network care. This UM screening may be extended to care provided in the MTFs, using the Department's standard quality and utilization review criteria and the TRICARE program regulation that is currently under development. In his or her respective facility, the MTF commander is the final authority regarding quality and UM decisions. However, there will be a need to integrate the utilization review mechanisms applicable to military facility and CHAMPUS care, which will be achieved pursuant to the TRICARE regulation and a DoD Instruction. This process will assure beneficiaries that they can expect the same standards of care regardless of where or by whom that care is delivered.

## **Patient Routing and Referral**

The patient routing and referral procedures must be carefully developed to assure the optimal use of the direct care system and the civilian provider network, and at the same time provide beneficiaries with the greatest freedom of choice possible. The TRICARE Support contractor will work closely with the lead agent to assure the most cost-effective delivery of services. The contractor and lead agent will develop a memorandum of understanding to ensure balanced workloads between the MTFs and the civilian network. Each MTF, under the guidance of the lead agent, will establish a balanced workload agreement with the contractor

that establishes the required routing and referral specifications with regard to primary, specialty, emergency and urgent, and inpatient care, diagnostic services, and any other services specified by the MTF or lead agent. These specifications will be coordinated with the contractor's internal protocols for routing beneficiaries to network providers. Civilian primary care managers must use the health care finder established by the contractor for referring patients for specialty care. The MTF primary care managers who refer patients to civilian providers must also comply with the health care finder protocols. The lead agents must establish overall policies for the management and referral of patients within each region. Flexibility will be given to the lead agents to determine when it is prudent to allow the local MTF to perform these functions. If an MTF has the resources and capacity, there is no need to task the contractor to perform these functions.

### Claims Processing

The TRICARE Support contractor will be responsible for claims processing. Claims will be processed according to the requirements set by DoD; however, the Services and lead agents will have an opportunity to review the procedures and propose changes. The existing fiscal intermediary will continue to process claims prior to the procurement of the regional TRICARE Support contractor. Health Affairs will assign an administrative program manager for direct oversight of the contractor's claims processing responsibilities. The Services and lead agents, through this program manager, will review the procedures and propose changes to the claims processing operations.

## **Provider and Beneficiary Education**

The contractor will be responsible for developing and implementing programs for provider and beneficiary education that comply with guidance provided by the lead agent. The lead agent will be responsible for reviewing and approving the contractor's proposed plan for provider and beneficiary education and ensuring that the plan is adequate and complies with the policies of the TRICARE Program and objectives of the lead agent. The lead agent is ultimately responsible for the education of the direct care providers with regard to this program and will determine the extent to which the contractor's provider education efforts shall incorporate an educational effort for MTF providers.

The lead agent will oversee the contractor's beneficiary education efforts and coordinate the distribution of beneficiary education materials with the contractor. Beneficiaries must receive detailed information on available health care options and any limitations imposed on their freedom of choice and access to specialty care. They will also be fully informed of the differences in cost sharing requirements among health care options.

## **Beneficiary Services**

The contractor shall be responsible for providing health care finders located at each of the TRICARE Support Service Centers. TRICARE Support Service Centers will be the focal point for smooth and effective operation of the integrated military and civilian network of providers. Contractors shall consult with lead agents to determine the ideal location of the service centers, including placing them within the MTFs. The centers will facilitate referrals of patients to the most appropriate military and civilian health care services. The objectives of

the service centers are to establish appropriate referral mechanisms, maintain continuity of care for patients, ensure optimal use of military MTFs, foster effective coordination of care delivered in the civilian sector, and establish educational systems to inform beneficiaries of access mechanisms and referral procedures. When requested by the MTF, the contractor shall perform Health Benefits Advisor functions. To the extent feasible, government systems to support the health care finder functions will be used. The lead agents will determine the capabilities of the military MTF to fully support these functions.

### **Enrollment and Primary Care Manager Assignment**

The contractor will be responsible for performing the enrollment function for the TRICARE Prime option using the policies established by the lead agents in conjunction with Health Affairs. This function includes collecting enrollment fees, tracking enrollment information, participating in the disenrollment process, and entering appropriate information into DEERS. The lead agent will provide the contractor with the enrollment plan that includes specific priorities in the assignment of primary care managers. Military MTFs will participate as primary care sites in the assignment of primary care managers. The lead agent and regional military MTFs will determine if there are sufficient military MTF primary care providers to support the enrollment option. The contractor will augment the MTFs when providers are needed and ensure that network providers accept Medicare assignments to enable those beneficiaries access to care through health care finder services.

## ROLES AND RESPONSIBILITIES

The Office of the Assistant Secretary of Defense for Health Affairs and the Military Departments will work jointly to develop a uniform statement of requirements for the TRICARE Support contract. Lead agents are responsible to propose or make modifications to these requirements (depending on the nature of the modification), via their regional plans and as part of acquisition planning. The incentives system developed for the conduct of good business practices, including bid-price adjustment methodologies, will also be developed jointly by Health Affairs and the Military Departments.

The TRICARE Support contractor will work closely with the lead agent's program managers regarding beneficiary education, routing and referral, and other issues directly related to the provision of services. The contractor will also communicate with designated Health Affairs representatives regarding both managed care and claims processing functions. When problems are identified in the execution of these functional areas, lead agents will be consulted. Health Affairs, the Services, and the lead agents will work jointly to ensure the problems are properly solved in a timely manner. Lead agents and Health Affairs may communicate directly on technical matters. In matters of policy, the appropriate Service channels will be employed. The TRICARE Support contractor will be responsible for providing timely information required to support the lead agents. These information requirements will be identified in the regional health plans and incorporated into the procurement documents.

The development, procurement, transition and operation of the TRICARE Support contracts will be a joint effort on the part of the military MTFs, lead agents, Services and

Health Affairs. The procurement and oversight of the TRICARE Support contracts will be provided through Health Affairs in cooperation with the lead agents. The point of contact at the Office of the Assistant Secretary of Defense for Health Affairs for oversight of TRICARE Support Contract procurement is the Director, Managed Care Operations, Health Services Financing. The lead agents will have responsibility for oversight of the health care requirements of the contracts. Each lead agent will participate directly in the contract operations concerning health care issues through a program manager and an administrative contracting officer assigned to the lead agent's staff. Health Affairs will be responsible for the business process requirements of the contract such as claims processing and data collection; however, lead agents will have the opportunity to review claims processing rules and propose changes to Health Affairs.

Health Affairs will have responsibility for the procurement of the contracts, transition of the contracts, and for oversight of the contract management. The procurement contracting officer will have the final responsibility for contract administration, management of national policy changes that are ordered in the contract, management of the bid price adjustment process, and overview of the prime contractor's subcontractor administration system. Additionally, the lead agents and the Services will actively participate and evaluate the bid price adjustment process.

Each lead agent will assign a contracting specialist to his or her respective TRICARE Support contract. These individuals will have a contracting officer's warrant and function as an administrative contracting officer, reporting to the lead agents. Relatively broad contract administration authority is to be delegated to the administrative contracting officer from the procurement contracting officer. These duties will include but are not limited to controlling

the development of local changes, including technical evaluations by the program manager; negotiating contract changes in concert with the procurement contracting officer; reviewing and approving subcontracts; and overseeing property administration.

A program manager on the lead agent's staff will serve as the technical representative for the contract for health care issues. Specifically, the program manager will be responsible for assisting the lead agent in the definition of new requirements applicable to the region that require contract modification, performing technical evaluations of change-order proposals, assisting in resolving contractual issues of concern to the lead agent, evaluating contractor-proposed resource sharing agreements, proposing resource sharing agreements to the contractor, evaluating the development of provider networks with respect to MTF requirements, and administration of the enrollment process. The program manager will coordinate issues and proposals with the procurement contracting officer's representative to ensure that there is no conflict with the general policy of the MHSS or with the business processes for the region, such as claims processing and data collection. The program manager will also approve all marketing and informational materials produced by the contractor.

## DEVELOPMENT OF REGIONAL HEALTH SERVICES PLANS

Lead agents in coordination with the military MTF commanders within the region, will develop the regional health services plan. Each lead agent will provide an annual update of its Regional Health Services Plan the Assistant Secretary of Defense for Health Affairs. This plan will be submitted formally through the proper Service chain-of-command.

Planning will cover a broad range of the program aspects of managed care. These planning elements must each be addressed to assure effective integration with regional health care operations and regional TRICARE Support contracts. In keeping with the principle of decentralized execution, the Office of the Assistant Secretary of Defense for Health Affairs will prescribe general topics to be addressed in the plan. Health Affairs will appoint a joint-Service working group to facilitate the development and evaluation of the regional health services plans and the business plans that they include.

## REGIONAL HEALTH SERVICES PLAN OUTLINE

Planning elements to be addressed:

- I. Health Services Region Managed Care Goals
- II. Medical Readiness
- III. Resource Management
  - A. Direct Care, CHAMPUS and Military Personnel Funds
  - B. Investment Strategy for CHAMPUS
  - C. Capitation Methodology
  - D. Third Party Collection Program
- IV. Network Development
  - A. Primary Care Network
  - B. Specialty Network
  - C. Referral Policies
- V. Enrollment
- VI. Utilization Management and Quality Monitoring
- VII. Benefit Structure
- VIII. Clinical Preventive Services/Health Promotion
- IX. Information Systems
- X. Marketing/Education
- XI. Evaluation Plan
- XII. Specialized Treatment Services
- XIII. Graduate Medical Education

## **DISCUSSION OF PLANNING TOPICS**

Following are a series of discussions on topics related to the Regional Health Services Plan. The discussions are intended to shed light on current and planned initiatives in the topical area and to assist the lead agent in developing a general framework for detailed health care planning at the operational level.

### **Medical Readiness**

Lead agents should address efficiencies that would be obtained through joint development of requirements in a number of contingency areas. These areas include Military Support to Civil Authorities, the National Disaster Medical System, and the Department of Veterans Affairs - Department of Defense Contingency System. The plan should address shifting of resources, coordination of resource sharing and contracting for additional local facilities and health care providers due to training or deployment in support of contingency operations. Although responsibility for readiness training is clearly retained by the Services, lead agents should encourage and MTF commanders should take advantage of every opportunity to conduct joint medical readiness training.

### **Resource Management**

Lead agents will be responsible for and have the authority to oversee CHAMPUS dollars for their regions following the award of the TRICARE Support contract. Each of the hospitals within the regions will be funded directly for direct care and military personnel dollars; however, CHAMPUS funds will be managed on a regional basis. Although the

capitated budget of the MTF includes its CHAMPUS target, these targets are rolled up to the regional level for lead agent oversight. Thus, a balance will have to be achieved between direct care and CHAMPUS operations. The effective management of referrals between direct care and CHAMPUS providers coupled with strong utilization management efforts within both systems will be essential to the financial success of regional health care operations.

Resource Management Plans will be developed by the lead agents the MTF commanders will become key components of regional health services plans. Lead agents will include, as a component of these plans, regional coordinating requirements relative to the maintenance, renovation, and replacement of facilities. The plan will further address the requirements of the draft Joint Regulation on Review Procedures for High Cost Medical Equipment (AR 40-65/NAVMEDCOM INST 6700.4/AFR 167-13) relative to the purchase and maintenance of high-cost medical equipment. Third Party Collection Program procedures should be addressed in the resource management plan.

### **Network Development**

A thorough analysis is necessary to determine the requirements for provider networks needed to support given beneficiary populations. Attention must be given to assuring access to sufficient primary care providers located in direct care facilities and supplemented by primary care providers in the external network. The determination of the "right-sized" primary care network for the population is essential to the overall concept of managed care and healthcare reform. The primary care system is the base from which lead agents build additional network needs, referral policy, and from which access standards are measured. Also, consideration must be given to assuring providers a reasonable volume of patients. In doing so, the number

of providers in a network will be limited. Thus, determining the number of providers required can best be done only after a thorough review of the demographics of the served beneficiary population. Following the award of a regional TRICARE Support contract, the contractor will adjust the size and composition of the network based on input from the lead agent as identified in the regional health services plan. The challenge for the lead agent is to determine the appropriate military MTF medical care and capacity so the contractor can obtain the proper number of network providers to augment MTF capabilities.

Enrollment of all TRICARE military health program participants will simplify this process in overlapping catchment areas. Assignment of a primary care manager is part of the enrollment process. Beneficiaries routinely will be scheduled for care with their primary care manager. Enrollment and primary care managers ensure that beneficiaries do not seek care simultaneously from several different military MTFs that could result in inappropriate treatment. Additionally, enrollment assists the military MTF to reliably plan for healthcare expenditures.

### **Enrollment**

A key element in managing a health care beneficiary population is knowing the enrollees for whom a managed care program is committed to provide care. During start-up operations, phased enrollment will allow for the smooth assignment of beneficiaries to panels of providers. CHAMPUS-eligible beneficiaries who enroll in TRICARE Prime, the health maintenance organization-like option, will obtain enhanced preventive care benefits and a reduced cost-sharing structure in return for choosing from a specified group of providers. Eventually, under national health care reform, it is anticipated that MHSS beneficiaries will

have an even broader range of choices among health plans, and beneficiary entitlement to duplicate healthcare coverage will be eliminated.

To enroll in the TRICARE Program, MHSS beneficiaries must be registered in the Defense Enrollment Eligibility Reporting System (DEERS). Under a TRICARE Support contract, the contractor will be responsible for entering this information in DEERS. The lead agent will provide input to the contractor on its enrollment plan and specify priorities for assignment of military MTF primary care managers. Prior to the implementation of the TRICARE Support contract, it will be the lead agent's responsibility to develop procedures for TRICARE Prime enrollment. These enrollment procedures must be specified in the lead agent's plan, conform with the TRICARE program regulation, and be approved by Health Affairs.

The lead agent must have the approval of Health Affairs to start an enrollment plan prior to the implementation of the TRICARE Support contract. To obtain approval, the lead agent must submit a plan consistent with the TRICARE program regulation (32 CFR 199.18), detailing the adequacy of the network established for the health maintenance organization type option, the enrollment targets, the utilization management and quality assurance processes to be established, and other characteristics of the program necessary to assure the delivery of high quality, accessible and cost-effective care. If the proposed enrollment program includes the Uniform HMO Benefit, established in the CHAMPUS regulation, approval by Health Affairs also requires a determination, established by Congress, that government cost under the proposed interim enrollment program are no greater than the costs that would otherwise be incurred to provide health care to the beneficiaries who enroll (Pub.L. 103-160, sec 731). Upon implementation of the TRICARE Support contract, any existing health maintenance

organization program operated by the lead agent or designee must either be incorporated into the regional TRICARE Support contract, on the basis of better cost-containment, or else be discontinued.

Similarly, lead agents or MTF commanders may choose to develop broad preferred provider networks prior to the initiation of regional TRICARE Support contracts. These programs must be consistent with provisions of the TRICARE program regulations (32 CFR 199.18), identified in the regional health services plan and approved by Health Affairs prior to implementation to offer the reduced cost shares provided by the TRICARE Extra benefit. Still another approach is the local implementation of the Participating Provider Program under DoD Instruction 6010.18, "CHAMPUS Health Care Finder and Participating Provider Program" (Nov 9, 1989).

The use of a preferred provider network or the standard CHAMPUS benefit package will not require registration beyond that required of DEERS. Beneficiaries may use the preferred provider organization on a point-of-service basis as a TRICARE Extra benefit. In addition, Medicare-eligible beneficiaries and active duty members will be registered in DEERS as they are now and the local MTF will be responsible for managing their care. Eligible beneficiaries who do not choose one of these CHAMPUS-funded care options will continue to have access to direct care at the military MTF on a space-available basis.

#### **Utilization Management and Quality Monitoring**

While utilization management and quality monitoring are not synonymous, their goals and the mechanisms frequently employed to attain them overlap. Utilization management is,

ideally, a function of a health care system that ensures eligible beneficiaries receive care necessary and appropriate to their clinical needs. Quality monitoring seeks to provide assurance that the care delivered is high quality and consistent with general clinical practices for the diagnosis and the patient. In most venues, the term quality monitoring, as opposed to quality assurance, also carries the implication that continuous quality improvement is incorporated into the program. Cost containment initiatives must not emphasize lower costs at the expense of the medical needs of the patient.

Early experience with a broad utilization management program for beneficiaries in the Military Health Services System indicates that focus on patient need does not result in exorbitant costs or runaway utilization. The National Mental Health Utilization Management Program, initiated in January 1990, is administered under a fixed cost contract, so that the contractor does not have a financial incentive to deny care. Clinical criteria for evaluating preauthorization, concurrent review and waiver consideration requests have been evaluated and found to be consistent with good clinical practice. In three years experience, acute psychiatric and residential treatment center admissions were reduced by 12.1 percent, with a reduction in inpatient days of 32.8 percent. The cost per admission has gone down 12.2 percent. The DoD's present average length of stay for acute psychiatric inpatient care is twenty percent below the average in a survey conducted by the National Association of Psychiatric Healthcare Organizations. Overall costs for this care began to slow early on and were actually slightly reduced in the third year of the program.

The use of diagnosis related groups in determining lengths of stay in medical/surgical and obstetrical admissions has already had an impact on bed days in those areas. Nonetheless, moving to a utilization management model that focuses on patient condition as an additional

criterion in authorizing admissions and continued stay has the potential of further reducing bed days and assuring that care delivered is necessary and consistent with the needs of the patient.

The decision to organize the MHSS along regional lines provided an opportunity to initiate a uniform set of guidelines regarding utilization management and quality monitoring across the entire system. The advantages of such an approach include: (1) a single standard of care regardless of care setting (i.e., direct or purchased and contracted care); (2) consistent and uniform clinical criteria determining setting and length of stay; (3) a basis for monitoring the system as to utilization patterns, quality of care, and adequacy of clinical decision-making process as reflected in documentation; (4) the means to examine and evaluate providers, both individual and institutional, as to the appropriateness and quality of the care provided to DoD beneficiaries; and (5) a vehicle for evaluating and comparing regions against themselves, one another and the system at large, as well as against national data for civilian populations.

To implement such a plan, it is necessary to develop a number of elements intrinsic to the discrete but related functions of utilization management and quality monitoring. As a principle of any such undertaking, it is important to recognize the needs and functions peculiar to each component of the system. These include the patient, the lead agent, the military MTF, the TRICARE Support contractor, and the network and non-network providers, as well as the Services and Health Affairs. Many of these functions involve the gathering and the analysis of data. To promote greater efficiency and consistency, the TRICARE Support contractor may be requested by the military MTF to perform utilization management functions, such as preauthorization, concurrent and retrospective reviews, and waiver considerations, for all types of care in all settings. Regardless of who actually performs these activities, they will be carried out based on a uniform set of criteria determined by the DoD. At present, the criteria

designated for use are the Interqual criteria for medical/surgical and obstetrics care, and Health Management System criteria for mental health care. As the MHSS gains more experience and sophistication in managed care, these criteria may be refined or changed but will remain consistent across the system.

The quality monitoring program will consist of elements that collectively give reasonable assurance that care rendered was consistent with the needs of the patient, delivered by providers acting within the scope of their training and credentialing, and of a high quality. As an adjunct to these assurances, the quality monitoring program ascertains that care is adequately documented to provide the above assurances. Activities will include the retrospective review of a sample of cases to determine if they meet Department criteria; the monitoring of provider qualifications, such as, licensing, credentialing and adverse actions. The Department is currently working with the Joint Service Quality Management Committee and the Joint Commission on Accreditation of Healthcare Organizations to develop a centralized credentialing process. The guidance for this activity will be found in the new Clinical Quality Management Directive to be published in December 1993.

Further objectives of utilization management and quality monitoring programs are:

- Creating a network of educators and acquiring software to facilitate statistical process control networks.
- Developing a process or system to capture outcomes, codify findings, and make them available to educate clinicians, change behaviors, and modify clinical practice guidelines to ensure that medically necessary services are not eroded by budgetary control mechanisms.

- Developing guidance on accreditation requirements for the various components of the regional managed care system including inpatient facilities (direct care and civilian) and managed care entities (TRICARE Support contractors, contracted health maintenance organizations, etc.)
- Continuing to work on the development of a common set of standards for utilization management and quality assurance which will apply to health care regardless of whether it is provided within the direct care system or through contractor provided support. The regions will be evaluated for quality of care using common standards that include measures from the Joint Commission for Accreditation of Healthcare Organizations, Healthy People 2000, and the National Committee for Quality Assurance.
- Smoothing the introduction of utilization management into military medical MTF through well-organized provider education programs and through the use of commonly available programs if possible.
- Developing further access criteria and integrating measures for these criteria into the utilization management and quality assurance processes.
- Ensuring the maximum possible use is made of existing information systems in assessing the performance of the health plan as more refined systems are being developed
- Developing an integrated case management process and including these provisions in the TRICARE Support contract to ensure an effective case management liaison between direct care and contractor provided care.

A comprehensive policy on quality assurance and utilization management is currently under development and will be incorporated by reference into policy guidelines for the TRICARE Program.

Oversight of both utilization management and quality monitoring activities will be provided by the National Quality Monitoring Contract. As the lead agents implement the regional plans, the National Mental Health Utilization Management Contract and the Regional Review Centers will be phased out.

## **Benefit Structure**

The benefit structure for TRICARE Prime is a function of the Uniform HMO Benefit, required by section 731 of the National Defense Authorization Act for Fiscal Year 1994. The Uniform HMO Benefit will be promulgated in the CHAMPUS regulation. As now being developed, there are two components of the benefit structure:

### 1) Scope of Covered Services

There are currently differences in health care services between CHAMPUS and the direct care system. The services covered throughout the continental United States, including Hawaii and Alaska, should be as consistent as possible, so that all beneficiaries are treated uniformly. It is a principle objective of the TRICARE Program that beneficiaries assigned to a civilian primary care manager have the same benefit as those assigned to a military medical treatment facility primary care manager. CHAMPUS-eligible beneficiaries who do not have access to the TRICARE Prime or TRICARE Extra options will continue to have access to the basic CHAMPUS program, known as TRICARE Standard.

Under the TRICARE Prime option, enrolled beneficiaries will be offered enhanced benefits including free immunizations, periodic physical examinations, eye examinations (expanded to survivors, retirees and their dependents), health promotion programs, and case management. Otherwise, the basic CHAMPUS program (TRICARE Standard) will define the scope of services available to those beneficiaries choosing the health maintenance organization, preferred provider organization, or basic options. The Department will determine the uniform set of benefits that will be available to the various categories of beneficiaries eligible for care in the MHSS. The TRICARE Benefit Structure is described in the next section.

## 2) Cost Sharing

The existing cost sharing requirements in the direct care system and in the standard CHAMPUS benefit package will continue to be in effect for military medical treatment facility care and basic CHAMPUS care, respectively. The cost sharing requirements for TRICARE Extra will be similar to basic CHAMPUS requirements, except that the beneficiary's co-insurance percentage will be reduced by five percentage points to serve as an inducement to beneficiaries to use network providers. TRICARE Prime will require an annual enrollment fee combined with nominal co-payments per unit of service. The cost sharing structure for the options available to CHAMPUS beneficiaries will reflect an incentive for beneficiaries to choose the most highly managed delivery option. For example, if the beneficiary chooses to enroll in the health maintenance organization option arrangement, which limits choice of providers, the expected out-of-pocket expenditures would be less than under either TRICARE Extra or TRICARE Standard. The cost sharing requirements are calculated to be budget neutral on a national basis. No cost sharing differences will be allowed across regions. The Department will perform the economic analysis required by statute before implementing any regional managed care support program.

### **Clinical Preventive Services/Health Promotion**

Department of Defense beneficiaries and the health care providers who serve them have substantial interests in activities that prevent disease and promote health. Accomplishment of these activities will be facilitated through focused patient education about the availability and desirability of obtaining specified clinical preventive services. The TRICARE Program goals for preventive services and health promotion embrace the recommendations of the Department of Health and Human Services Preventive Health Services Task Force.

As an incentive for beneficiaries to enroll in TRICARE Prime, enhanced clinical and preventive services selected on the basis of established scientific evidence, risk benefit and cost analysis of implementation, will be included. These services will be provided without an

expected co-payment. The establishment of clinical preventive services such as mammography, pap smears, eye exams, immunizations, serologic screening for hepatitis, rubella antibodies, non-fasting cholesterol levels, and screening blood lead levels, are considered part of the standard of care for primary care services within the DoD.

An important aspect of compliance with practice guidelines for preventive clinical services is patient and provider education. Patients need to be informed about specific services they need. Providers need to know the age, gender and special risk group indications for the specific services that are needed by their beneficiary population. Lead agents and TRICARE Support contractors share the responsibility to inform beneficiaries about ways to promote wellness and good health.

### Information Systems

Key to the lead agent's ability to identify managed care beneficiaries, assign them to primary care providers, and provide them quick access to health care is an effective information management system that integrates these various aspects of health care management into a well-organized database. Without timely access to information on network utilization, cost and quality, lead agents will not be able to effectively manage regional health services. To support the lead agents' information systems needs, the Department, with the support of the Services, has developed software to support enrollment, network development, and health care finder operations. Further, the Department is accelerating the fielding of the Composite Health Care System, an integrated clinical system, with this managed care software to assist lead agents in their regional health care operations.

Other information essential to managed care operations will be provided through contractor operated information systems, such as information relative to claims processing and utilization management. Planning for the integration of these systems with government-operated systems are key to providing lead agents the information required to make the daily management decisions necessary in a managed care environment. One of the requirements for information systems planning will be standard interoperability between the TRICARE Support contractors' systems and the systems developed by the government for the Military Health Services System. To fully achieve this requirement, standard data elements comparable to those used by the civilian health care provider community must be integrated into the direct care system. Health Affairs, working with the Military Departments, will take the lead in developing the required data standardization.

Health Affairs has undertaken a number of initiatives to assist the military MTFs and the Services in their healthcare planning. Among these is the recent inventory of information systems available to support TRICARE planning. This inventory has been published and circulated to the Surgeons General and is also available from Health Affairs. Another initiative currently being pursued is the development of an electronic "bulletin board" on managed care issues. This medium will enhance communications and information sharing among lead agents, the Services, and Health Affairs.

A number of information systems planning objectives was developed by the Services and endorsed by Health Affairs. These objectives are as follows :

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\* OASD(HA) Memorandum dated November 4, 1993, subject: "Systems Inventory for TRICARE Support".

- Developing regional information systems requirements to support lead agents' needs for managed care operations support, to include the completion of the development of the Composite Health Care System Divided Work Center to support lead agents' need to monitor and evaluate multiple military medical treatment facilities.
- Determining ambulatory data requirements and developing systems to support the collection and analysis of this data.
- Establishing minimum case-mix adjusted data requirements for inpatient and outpatient care and developing systems to support collection and analysis.
- Establishing standards for the interoperability of information systems between and within the Services, Health Affairs and TRICARE Support contractors, and providing required software as government furnished equipment if appropriate. This would necessitate the need to establish data flow parameters, integration support, and enhanced data quality to ensure lead agents have access to timely, accurate and complete data to measure and monitor regional costs, quality and access including unmet demand.
- Developing training support for the proper use and analysis of data derived from information systems.
- Establishing information systems requirements which support medical readiness planning.
- Establishing a means to determine whether it is more cost-effective to develop our own systems to support future regional information needs or contract for this support.

- Developing an information system to support the collection of essential clinical performance and accreditation data, including the Health Plan Employees Data Information System, the Joint Commission on the Accreditation of Healthcare Organizations, and the Indicator Monitoring System.

It is the policy of the DoD to acquire open systems information support, based on common terms and tri-Service business practices. To that end, many standard information capabilities exist. When standard capabilities exist, such as clinical support, they will be used unless a more cost-effective alternative can be identified and approved by the Office of the Assistant Secretary of Defense for Health Affairs.

#### **Marketing/Education**

Marketing and education are necessary to develop and maintain an enrollment base for the health care plan. Marketing may also be required to generate the necessary interest from providers to ensure a sufficiently large panel of providers to care for the anticipated number of enrollees. The staff of the direct care facilities must also be fully educated on the aspects of the managed care plan. Planning for this range of marketing and education activities requires intensive effort. Marketing, in particular, is an activity which will benefit from contractor support.

To ensure uniformity of benefit and consistency of perception of the benefit structure, Health Affairs will work with the Services in the development of TRICARE marketing materials. The materials developed will allow for local and regional supplementation.

## Evaluation Plan

The TRICARE Program fundamentally shifts the orientation of the managed health care portion of the MHSS, away from a focus on performance of facilities to a focus on managing the health care needs of people. Lead agents and MTF commanders will make decisions regarding: (1) the volume of health services used by their health service region's population; (2) the referral of that region's patients between direct care and civilian alternatives; and (3) the patterns of clinical treatment inside the MTF.

The quality of decisions made by the lead agents and the MTF commanders can be described by the beneficiaries' access to health care, the quality of their health care outcomes, and the cost of achieving those outcomes. Thus, the DoD health care evaluation strategy will look at differences in the cost, quality and accessibility of health care across regions and catchment areas. Health Affairs identified several global indicators that serve as proxies for cost. For example, total admissions per 1,000 active-duty family members living in a region (adjusted for that population's age and sex) indicate the relative cost of providing health services to a population; and inpatient lengths of stay (adjusted for patients' age, sex, and diagnosis) indicate the relative cost of treating patients within a military MTF. A DoD Tri-Service Medical Outcomes Working Group is developing indicators for quality and access, which shall be consistent with standards developed for utilization management and quality assurance.

The DOD's current health care information systems leave gaps in the Department's ability to evaluate quality and access. Hence, Health Affairs, in coordination with the Services, is developing an annual standardized survey to each region covering access, health

care satisfaction, utilization and health status. Specific items will address waiting times for appointments, access to preventive care, satisfaction with specific clinic services, perceived quality of care, use of military and civilian providers, and physical, emotional and social health. Reports will be compiled by catchment area or region by Service, and for the Department of Defense as a whole. Current plans are for mailing out the survey during the Spring of 1994 with results available in late Summer.

Health Affairs plans to refine the indicators of cost, quality, and access relative to a set of common health issues that reflect the way consumers receive health care. When consumers experience the health care system, they think about their health care needs in terms such as "having a baby," "living with heart disease," or "preventing depression." These common health issues also reflect the way a health care system manages the "production" of health. By organizing the evaluation strategy around such common health issues, or product lines, such evaluations will help providers judge and improve the care they give. Obstetrics care has been identified as the first product line, largely because of its high volume and relatively specialized requirements for staff and capacity. Health Affairs is developing specific indicators that relate to the volume of obstetrical health services, such as, the rate of Cesarean-section per 1,000 deliveries as a proxy for cost and percent low weight babies as a proxy for quality, and to patterns of clinical treatment. The DoD Medical Outcomes Working Group will develop subsequent product lines.

The TRICARE Program evaluation strategy lends itself to a two-tiered structure of implementation. First, Health Affairs has the responsibility for evaluating performance among the various regions. Lead agents are responsible for monitoring performance within their regions. It is critical that Health Affairs and the lead agents use the same conceptual

constructs, measures, and data sources. Lead agents may add new indicators, as long as they maintain consistency with the core evaluation strategy. Health Affairs will work with the lead agents on methodological issues and facilitate the lead agents' participation in developing measures through the Tri-Service Outcomes Work Group. Lead agents will then administer the evaluation plan within the region.

The evaluation strategy will assist Health Affairs develop report cards to assess cost, quality and access across regional and, as required, in site-specific MHSS health delivery systems. Managers and policy makers will be asked to interpret indicators in these report cards to assess the appropriateness of care and how effectively "best clinical practices" are being provided. To meet consumer needs, report cards will inform enrollees about how well the TRICARE Program delivers care. They will borrow certain data elements, such as immunization and cholesterol screening rates, from the Health Plan Employer Data and Information Set. The Fiscal Year 1990, MHSS Outcomes Report serves as a useful guide on conducting such evaluations. A copy of this report can be obtained from the Program Review and Evaluation Directorate under the Deputy Assistant Secretary of Defense for Health Budgets and Programs, Office of the Assistant Secretary of Defense (Health Affairs).

#### **Specialized Treatment Services (STS)**

For certain high technology or high cost procedures, Health Affairs will establish STS on a multi-regional or national level. These centers may be designated military or civilian facilities. The designation of an STS will be based on readiness, access, quality and cost considerations. Lead agents may, pursuant to a DoD Instruction to be issued this Spring, designate regional STS' as a component of their Regional Health Services Plan. Using

provisions of the CHAMPUS regulation and in accordance with its procedures, an MTF commander can withhold a non-availability statement based on the availability of care at designated STS facilities. Should a beneficiary choose not to use a specialized service when one is designated and available, the beneficiary will be responsible for the full cost of the care. Waivers may be granted in consideration of medical appropriateness or personal hardship. However, for all other beneficiary services, the 40-mile catchment area rule remains in effect, even in overlapping catchment areas.

Additional costs may arise from access to specialized treatment programs, such as the costs of transportation and lodging for non-medical attendants. These costs and others associated with this program will be incorporated in the computed cost of the STS Diagnosis Related Group in accordance with policy derived from the recommendation of a Tri-Service Work Group on Transfer Payments. To attenuate the need for excessive transfer payments on an intra-regional basis, lead agents may choose to develop local ground transportation, such as shuttle buses, within the region to support the regional referral patterns that are developed.

### **Graduate Medical Education (GME)**

Health Affairs will cooperate closely with the Services to forecast future specialty needs that will determine GME requirements. Health Affairs and the Services will develop a plan for the 1996 GME requirements. The plan will incorporate the following principles:

- Adjust the size of individual programs (within accreditation constraints) to recognize the decline in required numbers of interns, residents, and fellows.

- Base the types and numbers of graduate medical education programs on the Services' readiness needs for medical specialists and sub specialists (phasing out programs where the need is not clearly demonstrated).
- Eliminate all duplicative residency programs in close geographical proximity (except primary care) unless both (a) the patient population clearly supports multiple programs and the Services can demonstrate requirements for the types and numbers of specialists to be trained.
- Disallow civilian interns, residents, and fellows unless under exceptional circumstances.
- Staff combined graduate medical education programs with Tri-Service personnel.

## TRICARE PROGRAM BENEFITS AND BENEFICIARY PAYMENTS

(PROPOSED)

### TRICARE PRIME

Outpatient Services (See Note 1)

ENROLLMENT FEE	TRICARE Prime
Applies to all outpatient services	Dependents of E-4 and below - \$0 Dependents of E-5 and above - \$35 Retirees and others - \$50 (double above amounts for family enrollment)

Standard CHAMPUS Benefits	Beneficiary Cost Sharing
<i>Type of Service</i>	
<b>PHYSICIAN SERVICES</b> Office visits; outpatient office-based medical and surgical care; consultation, diagnosis and treatment by a specialist; allergy tests and treatments; osteopathic manipulation; medical supplies used within the office including casts, dressings and splints	Dependents of E-4 and below - \$5 copay per visit Dependents of E-5 and above - \$10 copay per visit Retirees and others - \$15 copay per visit
<b>LABORATORY AND X-RAY SERVICES</b> (No copayment if included in provider's office visit)	Dependents of E-4 and below - \$5 copay per visit Dependents of E-5 and above - \$10 copay per visit Retirees and others - \$10 copay per visit
<b>AMBULANCE SERVICES</b> When medically necessary as defined by the CHAMPUS Policy Manual and the service is a covered benefit.	Dependents of E-4 and below - \$5 per occurrence Dependents of E-5 and above - \$10 per occurrence Retirees and others - \$15 per occurrence

Standard CHAMPUS Benefits	Beneficiary Cost Sharing
<i>Type of Service</i>	
<p><b>AMBULATORY SURGERY (SAME DAY)</b>            Authorized hospital-based or free-standing ambulatory surgical center that is CHAMPUS certified (not performed in a physician's office).</p>	<p>Dependents of E-4 and below - \$15 copay            Dependents of E-5 and above - \$25 copay            Retirees and others - \$75 copay</p>
<p><b>IMMUNIZATIONS</b>            Immunizations required for active duty family members whose sponsors have permanent change of station orders to overseas locations.</p>	<p>Dependents of E-4 and below - No cost            Dependents of E-5 and above - No cost</p>
<p><b>EMERGENCY SERVICES</b>            Emergency and urgently needed care obtained on an outpatient basis, both network and non-network and in and out of service area.</p>	<p>Dependents of E-4 and below - \$35 per ER visit            Dependents of E-5 and above - \$50 per ER visit            Retirees and others - \$60 per ER visit</p>
<p><b>DURABLE MEDICAL EQUIPMENT, PROSTHETIC DEVICES, AND MEDICAL SUPPLIES PRESCRIBED BY AN AUTHORIZED PROVIDER WHICH ARE COVERED SERVICES</b>            If dispensed for use outside of the office or after the home visit.</p>	<p>Dependents of E-4 and below - 10%            Dependents of E-5 and above - 15%            Retirees and others - 20%            (of the negotiated reimbursement rate)</p>
<p><b>HOME HEALTH CARE</b>            Part-time skilled nursing care, physical, speech and occupational therapy, when medically necessary and which are covered benefits</p>	<p>Dependents of E-4 and below - \$5 copay per visit            Dependents of E-5 and above - \$10 copay per visit            Retirees and others - \$10 copay per visit</p>
<p><b>FAMILY HEALTH SERVICES</b>            Family planning and well baby care (up to 24 months of age). The exclusions in the CHAMPUS Policy Manual will apply.</p>	<p>Dependents of E-4 and below - \$5 copay per visit            Dependents of E-5 and above - \$10 copay per visit            Retirees and others - \$15 copay per visit</p>
<p><b>PRESCRIPTION DRUGS</b></p>	<p>Dependents of E-4 and below - \$4 per Rx            Dependents of E-5 and above - \$4 per Rx            Retirees and others - \$8 per Rx            (up to 30 day supply)</p>

Standard CHAMPUS Benefits	Beneficiary Cost Sharing
<i>Type of Service</i>	
<p><b>OUTPATIENT MENTAL HEALTH</b> One hour of therapy no more than two times per week when medically necessary.</p>	<p><i>Individual Visits:</i> Dependents of E-4 and below - \$10 copay per visit Dependents of E-5 and above - \$20 copay per visit</p>
<p><b>PARTIAL HOSPITALIZATION FOR ALCOHOLISM TREATMENT</b> Up to 21 days for rehabilitation on a limited hour per day basis. Does not count toward the limits for days of mental health inpatient care.</p>	<p>Retirees and others - \$25 copay per visit <i>Group Visits:</i> Dependents of E-4 and below - \$5 copay per visit Dependents of E-5 and above - \$10 copay per visit Retirees and others - \$10 copay per visit</p>

**Inpatient Services (See Note 2)**

Standard CHAMPUS Benefits	Beneficiary Cost Sharing
<i>Type of Service</i>	
<p><b>HOSPITALIZATION</b>                      Semiprivate room (and when medically necessary, special care units), general nursing, and hospital service. Includes inpatient physician and their surgical services; meals including special diets; drugs and medications while an inpatient; operating and recovery room; anesthesia; laboratory tests; x-rays and other radiology services; necessary medical supplies and appliances; blood and blood products services. Unlimited services with authorization, as medically necessary.</p>	<p>Dependents of active duty - \$9.30 per day or \$25 (whichever is more)                      Retirees and others - \$125 per day or 25% of the hospital's billed charges (whichever is less) with a 10-day cap on inpatient cost sharing per episode, plus 20% of separately billed professional charges</p>
<p><b>MATERNITY</b>                      Hospital and professional services (prenatal and post natal). Unlimited services with authorization, as medically necessary.</p>	
<p><b>SKILLED NURSING FACILITY CARE</b>                      Semiprivate room; regular nursing services; meals including special diets; physical, occupational and speech therapy; drugs furnished by the facility; necessary medical supplies, and appliances. Unlimited services with authorization, as medically necessary</p>	

Standard CHAMPUS Benefits	Beneficiary Cost Sharing
<i>Type of Service</i>	
<p><b>MENTAL ILLNESS</b>            With authorization, up to 30 days per fiscal year for adults (age 19+); up to 45 days per fiscal year for children under age 19. For Residential Treatment Facilities (RTC) care, up to the 150 day limit per year. (See CHAMPUS policy manual for further restrictions.)</p>	<p>Dependents of active duty - \$9.30 per day or \$25 (whichever is more)            Retirees and others - \$100 per day copay or 20% cost share of total charges (based on the negotiated rate), whichever is less, for institutional services plus 15% copay or cost share on professional charges</p>
<p><b>PARTIAL HOSPITALIZATION FOR MENTAL HEALTH</b>            With authorization, up to 60 days per fiscal year or per admission.</p>	
<p><b>ALCOHOLISM</b>            With authorization, 7 days for detoxification and 21 days for rehabilitation per 365 days. Maximum of one rehabilitation program per year and three per lifetime. Detoxification and rehabilitation days count toward limit for mental health benefits.</p>	

**TRICARE EXTRA**

**Outpatient Services**

<b>ANNUAL DEDUCTIBLE</b>	<b>TRICARE Extra</b>
Applies to all outpatient services	Standard CHAMPUS deductibles apply as defined by the CHAMPUS Policy Manual.

<b>Standard CHAMPUS Benefits</b>	<b>Beneficiary Cost Sharing</b>
<i>Type of Service</i>	
<b>PHYSICIAN SERVICES</b> Office visits; outpatient office-based medical and surgical care; consultation, diagnosis and treatment by a specialist; allergy tests and treatments; osteopathic manipulation; medical supplies used within the office including casts, dressings and splints.	Dependents of active duty members - 15% Retirees and others - 20% (of the negotiated reimbursement rate)
<b>LABORATORY AND X-RAY SERVICES</b>	
<b>AMBULANCE SERVICES</b> When medically necessary as defined by the CHAMPUS Policy Manual and the service is a covered benefit.	
<b>EMERGENCY SERVICES</b> Emergency and urgently needed care obtained on an outpatient basis, both network and non-network and in and out of service area.	
<b>ROUTINE PAP SMEARS</b> Frequency to depend on physician recommendations based on the published guidelines of the American College of Obstetrics and Gynecology.	

Standard CHAMPUS Benefits	Beneficiary Cost Sharing
<i>Type of Service</i>	
<p><b>DURABLE MEDICAL EQUIPMENT, PROSTHETIC DEVICES, AND MEDICAL SUPPLIES PRESCRIBED BY AN AUTHORIZED PROVIDER WHICH ARE COVERED SERVICES</b> If dispensed for use outside of the office or after the home visit.</p>	<p>Dependents of active duty members - <b>15%</b> Retirees and others - <b>20%</b> (of the negotiated reimbursement rate)</p>
<p><b>HOME HEALTH CARE</b> Part-time skilled nursing care, physical, speech and occupational therapy, when medically necessary and which are covered benefits.</p>	
<p><b>FAMILY HEALTH SERVICES</b> Family planning and well baby care (up to 24 months of age). The exclusions in the CHAMPUS Policy Manual will apply.</p>	
<p><b>PRESCRIPTION DRUGS</b> (Deductibles are waived when network pharmacies are used.)</p>	
<p><b>EYE EXAMINATIONS</b> One routine examination per year covered for family members of active duty sponsors</p>	<p><b>15%</b> of the negotiated reimbursement rate</p>
<p><b>IMMUNIZATIONS</b> Immunization required for active duty family member whose sponsors have permanent change of station orders to overseas locations</p>	
<p><b>AMBULATORY SURGERY (SAME DAY)</b> Authorized hospital-based or free-standing ambulatory surgical center that is CHAMPUS certified (not performed in a physician's office).</p>	<p>Dependents of active duty members - <b>\$25</b> copay per visit Retirees and others - <b>20%</b> of the negotiated rate per visit</p>

Standard CHAMPUS Benefits	Beneficiary Cost Sharing
<i>Type of Service</i>	
<p><b>OUTPATIENT MENTAL HEALTH</b>            One hour of therapy no more than two times per week when medically necessary.</p>	<p>Dependents of active duty members - 15% cost share            Retirees and others - 20% cost share (of the negotiated reimbursement rate)</p>
<p><b>PARTIAL HOSPITALIZATION FOR ALCOHOLISM TREATMENT</b>            Up to 21 days for rehabilitation on a limited hour per day basis. Does not count toward the limits for days of mental health inpatient care.</p>	

**Inpatient Services**

Standard CHAMPUS Benefits	Beneficiary Cost Sharing
<i>Type of Service</i>	
<p><b>HOSPITALIZATION</b>                      Semiprivate room (and when medically necessary, special care units), general nursing, and hospital service. Includes inpatient physician and their surgical services; meals including special diets; drugs and medications while an inpatient; operating and recovery room; anesthesia; laboratory tests; x-rays and other radiology services; necessary medical supplies and appliances; blood and blood products services. Unlimited services with authorization, as medically necessary.</p>	<p>Dependents of active duty - \$9.30 per day or \$25 (whichever is more)</p> <p>Retirees and others - \$200 per day or 25% of the hospital's billed charges (whichever is less), plus 20% cost share of separately billed professional charges (of the negotiated rate)</p> <p>(See Notes 1 and 2)</p>
<p><b>MATERNITY</b>                      Hospital and professional services (prenatal and post natal). Unlimited services with authorization, as medically necessary.</p>	
<p><b>SKILLED NURSING FACILITY CARE</b>                      Semiprivate room; regular nursing services; meals including special diets; physical, occupational and speech therapy; drugs furnished by the facility; necessary medical supplies, and appliances. Unlimited services with authorization, as medically necessary</p>	

Standard CHAMPUS Benefits	Beneficiary Cost Sharing
<i>Type of Service</i>	
<p><b>MENTAL ILLNESS</b>            With authorization, up to 30 days per fiscal year for adults (age 19+); up to 45 days per fiscal year for children under age 19. For Residential Treatment Facilities (RTC) care, up to the 150 day limit per year. (See CHAMPUS policy manual for further restrictions.)</p>	<p>Dependents of active duty - \$9.30 per day or \$25 (whichever is more)</p> <p>Retirees and others - 20% cost share of total charges (based on the negotiated rate) for institutional services, plus 20% cost share on separately billed professional charges (based on the negotiated rate)</p>
<p><b>PARTIAL HOSPITALIZATION FOR MENTAL HEALTH</b>            With authorization, up to 60 days per fiscal year or per admission.</p>	
<p><b>ALCOHOLISM</b>            With authorization, 7 days for detoxification and 21 days for rehabilitation per 365 days. Maximum of one rehabilitation program per year and three per lifetime. Detoxification and rehabilitation days count toward limit for mental health benefits.</p>	

**NOTES**

1. The beneficiary copayments (i.e., beneficiary payments expressed as a specified amount) in this chart are effective for FY 1993 and will be updated for inflation each fiscal year by the national CPI-U medical index (the medical component of the Urban Consumer Price Index). Beneficiary cost shares (i.e., beneficiary payments as expressed as a percentage of the providers' fees) will not be similarly updated. CHAMPUS annual deductibles under standard CHAMPUS will not be similarly updated. The beneficiary is responsible for the full cost of non-covered services and non-emergency services obtained outside the network without prior authorization.
2. The beneficiary cost sharing for inpatient care for active duty dependents will be adjusted periodically to reflect the cost of an inpatient stay in an MTF.

## ENHANCED BENEFITS

There is no preauthorization required for the following services. The following services are expected of good comprehensive clinical practice. There is no co-payment expected nor is the provider expected to unbundle the services for an additional fee or inconvenience the patient by rescheduling these services unnecessarily.

Routine history and physical examinations are no longer recommended for health promotion disease prevention in individuals who are not being monitored as a part of a therapeutic plan for chronic disease. In counterdistinction, the Preventive Services Task Force recommends that a variety of age and sex specific services be combined into periodic health promotion disease prevention surveillance examinations. These services are reflected below.

SERVICES	FREQUENCY OR AGE INTERVAL
<b>Lab, X-ray, Mammography</b>	
Screening blood lead level	Once age 12 months - 6 years
Rubella antibodies	Females, once age 12-18
Non-fasting total blood cholesterol	Every five years over age 18
Fecal occult blood testing	Annually age 50 and over
Mammogram	Baseline age 40; every two years age 40-50; annually age 50 and over
<b>Pap Smears</b>	Annually over age 18, or younger if sexually active

### Eye Exams/Refractions

Red reflex, corneal light reflex, inspection (by primary care provider)

Newborn - 3 months

Red reflex, corneal light reflex, inspection, differential occlusion, fixed and follow with each eye (by primary care provider)

6-12 months

Baseline optometric examination for amblyopia and/or strabismus

Age 3-4 years

Annual eye exams age 5-17; every three years over age 18

### Immunizations

DPT

2 months; 4 months; 6 months

DTaP (acellular)

15-18 months; once age 4-6 years

OPV

2 months; 4 months; 15-18 months; once age 4-6 years

MMR

Age 15 months; once age 4-6 or 11-12 years; once after age 19 unless evidence of immunity

Td

Once age 14-16; every 10 years thereafter

Pneumococcal vaccine

Persons at increased risk due to other medical condition

HIB

Age 2, 4, 6, and 15 months

PPD

12 months; after close contact with person with suspected TB

Hepatitis B

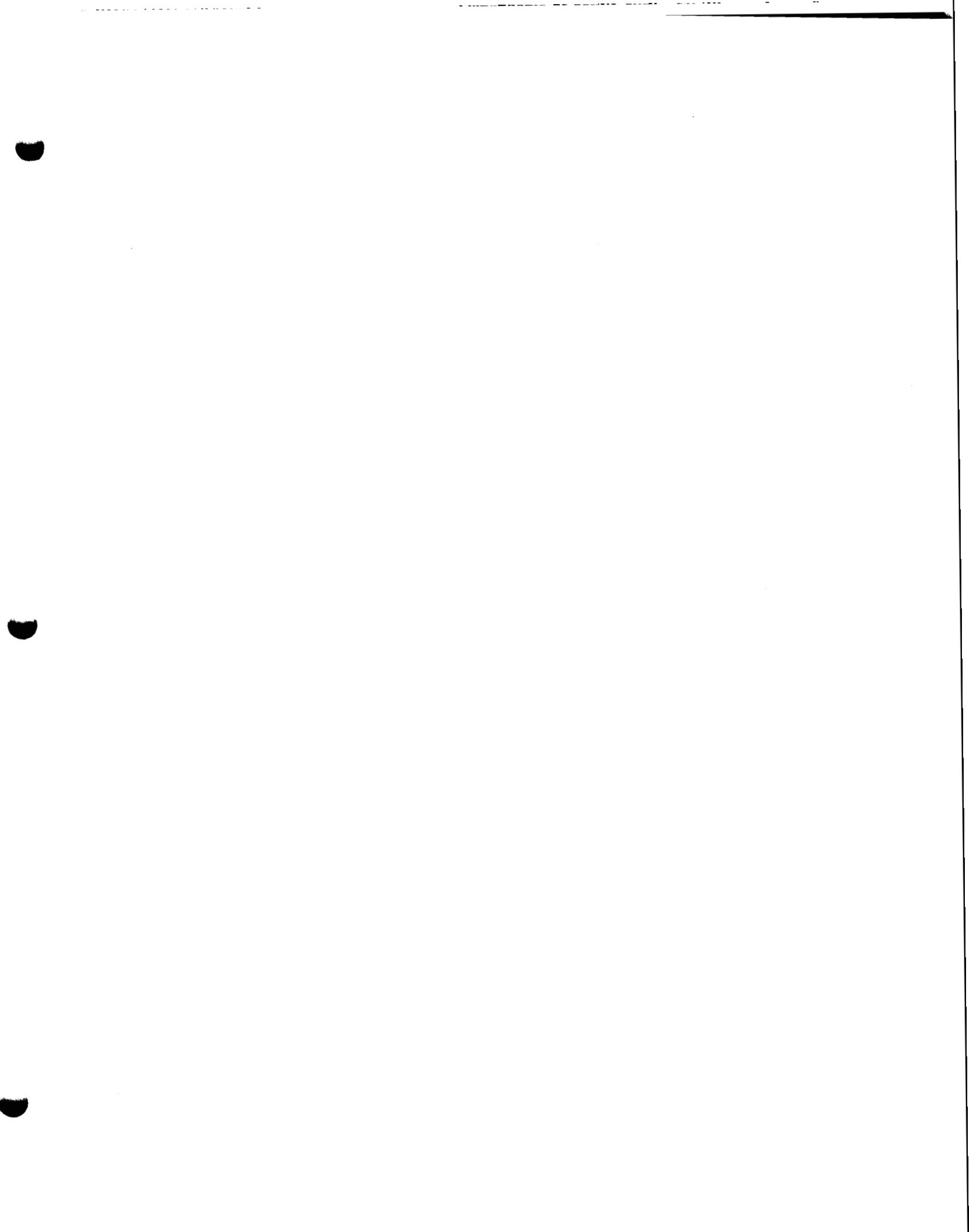
See schedule below for infants; once age 11-19 years if not immunized as an infant

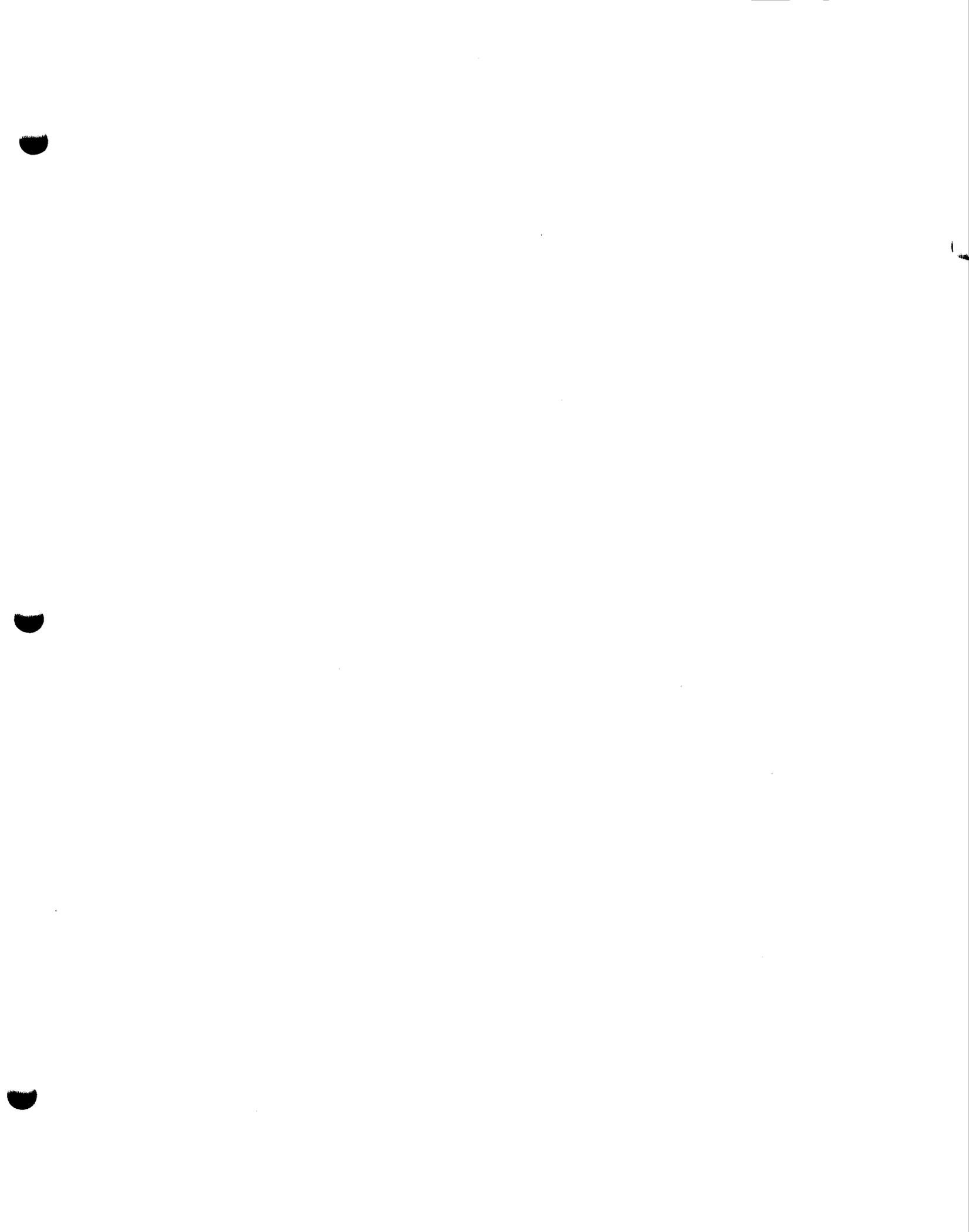
<b>Periodic Health Promotion Disease Prevention Exams Over Age 24 Months</b>	One evaluation and follow up during following age intervals: 2-4; 5-11; 12-17; 18-39; 40-64
Blood pressure	During above exams
Clinical breast exam	Annually age 40 and above
Clinical testicular exam	Annually age 18 and over
Rectal prostate exam	Annually age 18 and over
<b>Blood Pressure</b>	Every two years age 18 and over
<b>Hearing Screening</b>	
Otacoustic emissions (OAE) screening	Infant (before leaving hospital); once age 2-5; once age 6-10; once age 12-17; once age 40-59; once age 60-65
<b>Sigmoidoscopy or Colonoscopy</b>	Once every 3-5 years over age 50
<b>Serologic Screening of All Pregnant Women for HBsAg (Hepatitis B Surface Antigen)</b>	<p>Infants born to HBsAg-negative mothers receive HBG vaccine before discharge; second dose at 1-2 months; third dose at 6-18 months</p> <p>Infants born to HBsAg-positive mothers immunize with HBIG preferably within 12 hours of birth; second and third doses at 1 and 6 months. Serologic status should be checked at 9 months and fourth dose administered to infants who are HBsAg-negative with titers of anti-HBs &lt; 10 mIU/mL. Re-test one month later for anti-HBs. Up to two additional doses may be considered for those who fail to respond.</p>

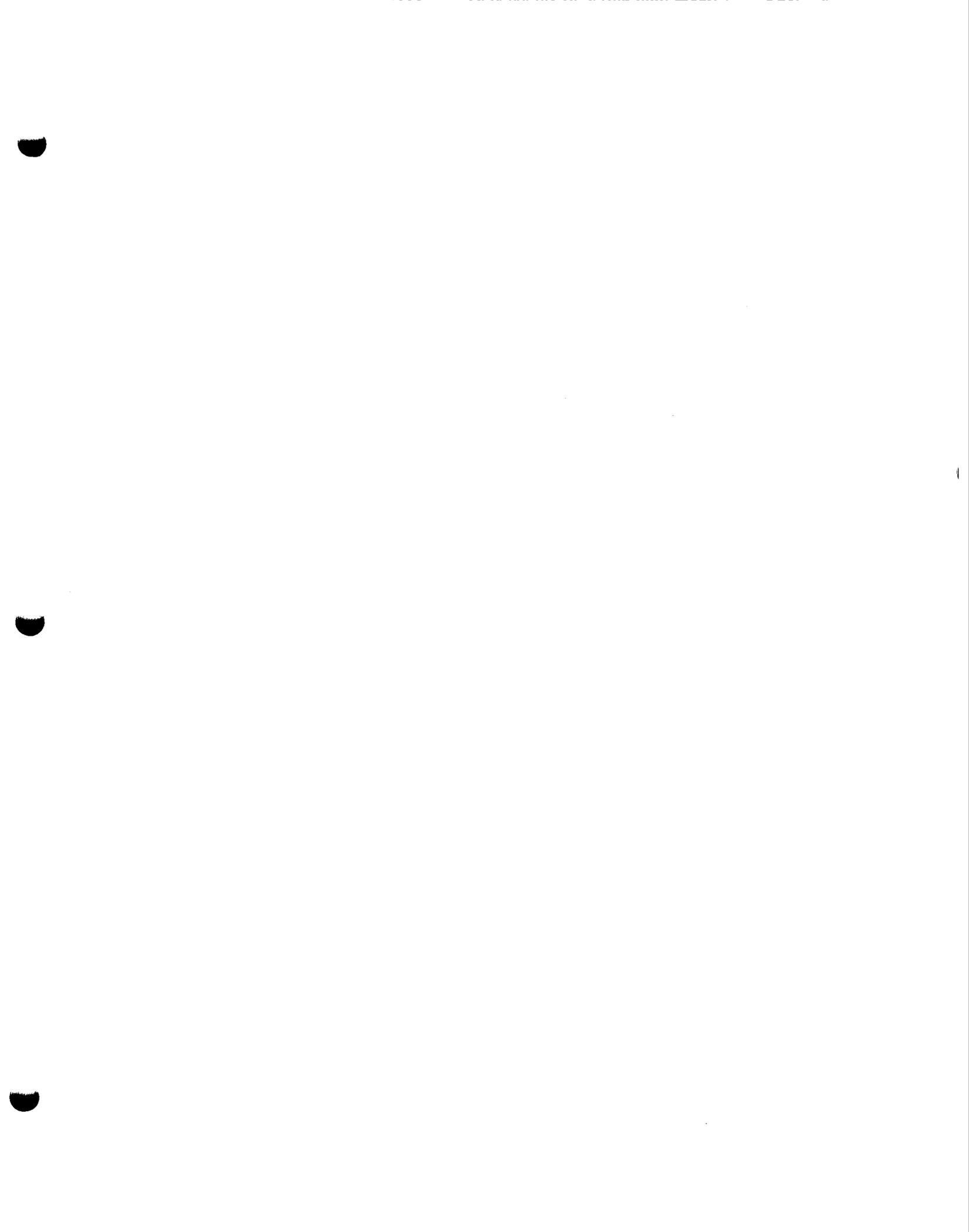
**Patient and Parent Education and Counseling**

These services are expected components of good clinical practice that are integrated into the office visit at no additional charge.

- Dietary assessment and nutrition
- Physical activity and exercise
- Cancer surveillance
- Sexual practices
- Substance abuse
- Injury prevention
- Promoting dental health
- Stress and bereavement







**CLOSE HOLD**

MINUTES OF THE  
MILITARY TREATMENT FACILITIES  
AND GRADUATE MEDICAL EDUCATION  
BRAC 95 JOINT CROSS SERVICE GROUP  
MEETING OF FEBRUARY 24, 1994

**CLOSE HOLD**

The fifth meeting of the Military Treatment Facilities and Graduate Medical Education (MTF/GME) BRAC 95 Joint Cross Service Group convened at 1400 hrs on February 24, 1994. The meeting was chaired by Dr. Edward D. Martin, Acting Assistant Secretary of Defense, Health Affairs.

After calling the meeting to order, the Chairman asked each of the members to review the minutes from the previous meeting (a copy of the minutes was passed around the table).

Each member of the group was then provided a copy of the updated TRICARE policy guidelines. The Chairman remarked that the guidelines will give the members an idea of the system for which the group is trying to develop criteria.

At this point the Chairman asked the members if they had reviewed the interim force structure plan. The Chairman asked that copies be provided for those members that had not yet reviewed the plan.

The Chairman then reviewed ongoing actions regarding consolidation of biomedical laboratories, training, and data centers.

The next item on the agenda was an overview of the Region Population Realignment or Lead Agent Initiative. This initiative establishes twelve Defense Health Regions with designated Service Medical Centers as Lead Agents. The Lead Agents will oversee direct care and CHAMPUS services for all beneficiaries within their respective regions. The objectives of the initiative are to:

- o Control cost growth through expansion of managed care and greater accountability for performance at the regional level.
- o Assure beneficiaries of accessible health care.
- o Maintaining and improving the quality of care.
- o Assure consistency with the National Health Care Reform efforts.
- o Improve efficiency of the direct care system.

The group was then briefed on the "733" study, a comprehensive study of the military medical care system. The study attempts to answer two basic questions: what are our wartime medical requirements and what are the cost effective additions for peacetime care? Three of the points briefed that most directly relate to the group's BRAC analysis were:

- o On average, direct care is not more expensive than CHAMPUS.

**CLOSE HOLD**

PLEASE HOLD

PLEASE HOLD

- o The Bottom-Up Review's scenario of two concurrent major regional conflicts will result in excess medical capacity.
- o For non-active duty beneficiaries, the preservation of some excess capacity should be considered if direct care does prove to be less costly than CHAMPUS (This depends on DoD's ability to control the demand for care).

The report is due to Congress in late March/early April.

The Chairman reported that the GME study is going to the Flag Group this week, the Surgeons General the following week, and will be presented to the group the week after that.

The next item on the agenda was a review of the previously agreed upon measures of merit (MoMs). The Chairman emphasized that the Services must ensure that all life safety projects are identified and programmed in the Future Years Defense Plan (Facilities MoM (F.2) Cost of MILCON).

A proposed methodology to measure Cost Effectiveness will be presented at the next meeting.

A discussion of the measurement of utilization ensued. The following points summarize the discussion:

- o Patient care is moving from inpatient to ambulatory.
- o Bed days per 1000 active duty members dropped by approximately 20% since FY 89.
  - oo Not as many patients are being admitted.
  - oo The average length of stay has been reduced.
  - oo Technology advances have helped reduce the number of admissions/length of stay.
- o The overall number of outpatient visits has remained constant.
- o We can reduce the bed days ratio below the current 513 per 1000 active duty beneficiaries.
  - oo We can use the data in the "733" study to develop the methodology.

At the next meeting the group will review the draft report to the BRAC 95 Review Group and the proposed data elements and definitions.

The meeting adjourned at 1520 hrs. The next meeting is scheduled for March 4, 1994 at 1000 hrs.

Approved Edward D. Martin  
 Edward D. Martin, MD  
 Acting ASD (HA)

PLEASE HOLD

**BRAC 95  
JOINT CROSS SERVICE GROUP  
FOR MILITARY TREATMENT FACILITIES AND  
GRADUATE MEDICAL EDUCATION**

<u>SERVICE/AGENCY</u>	<u>NAME</u>	<u>PHONE #</u>	<u>ATTENDING 24 FEB 94</u>
CHAIR AASD (HA)	Dr. Martin	703-697-2114	_____X_____
ASD (HA) (Designate)	Dr. Joseph	703-697-2111	_____no_____
DASD (ER/BRAC)			
TEAM LEADER	RADM Koenig	703-697-8973	_____X_____
ARMY	BG Zajchuk	703-756-5680	_____(COL Lyons)_____
NAVY	CAPT Golembieski	703-681-0461	_____X_____
NAVY	CDR DiLorenzo	703-681-0452	_____no_____
AIR FORCE	MG Buethe		_____X_____
AIR FORCE	BG Hoffman	202-767-1894	_____no_____
JCS	COL Moore	703-697-4346	_____X_____
OASD (P&R)	Ms. St. Clair	703-696-8710	_____(Mr. Monteleone)_____
COMPT	Ms. Hiller	703-697-3101	_____no_____
PA&E	Mr. Dickens	703-697-8050	_____X_____
ODASD (ER/BRAC)	Mr. Miglionico	703-697-8050	_____X_____
DOD IG	Mr. Tomlin	804-766-3816	_____X_____
ODASD (HA)	Mr. Maddy	703-697-8979	_____X_____
ODASD (HA)	Dr. Mazzuchi	703-695-7116	_____X_____

## OTHER ATTENDEES

<u>SERVICE/AGENCY</u>	<u>NAME</u>	<u>PHONE #</u>	<u>ATTENDING 24 FEB 94</u>
OASD (HA)	Ms. Watson	703-697-8973	X
OASD (HA)	Ms. Giese	703-614-4705	X
OASD (HA)	Col Garner	703-614-4705	no
OASD (HA)	CDR Bally	703-614-4705	no
OASD (HA)	LTC Ponatoski	703-614-4705	X
OASD (HA)	LTC McClinton	703-614-4705	no
OASD (HA)	LTC Guerin	703-756-2081	X
OASD (HA)	Ms. Spurlin	703-614-4705	X
OASD (HA)	COL Burkhalter	703-695-6800	X
ARMY	COL Barton	703-756-8319	no
ARMY	COL Wilcox	703-756-5681	no
ARMY	LTC Powell	703-697-3887	X
ARMY	LTC McGaha	703-697-6388	no
ARMY	MAJ Dudevoir	703-756-0286	X
ARMY	MAJ Parker	703-756-8036	X
ARMY	COL Lyons		X
NAVY	CAPT Buzzell	703-681-0475	no
NAVY	Ms. Davis	703-602-2252	no
NAVY	CDR DiLorenzo	703-681-0452	no
AIR FORCE	LtCol Silvernail	202-767-5550	no
AIR FORCE	LtCol Bannick	202-767-5066	no
AIR FORCE	Maj Costa	202-767-5066	X
AIR FORCE	Maj Pantaleo	202-767-5046	no
LMI	Mr. Neve	301-320-7287	X
LMI	Ms. Dahut	301-320-7408	no
JS	LtCol Ferguson	703-697-4421	no
COMP	Ms. Kopperman	703-697-4517	no
COMP	Mr. Smith	703-697-4133	no
OASDLP	Mr. Monteleone	703-696-8710	X

**BRAC 95 JOINT CROSS SERVICE GROUP  
FOR MILITARY TREATMENT FACILITIES AND  
GRADUATE MEDICAL EDUCATION**

**FEBRUARY 24, 1994  
Room 4E327, 2:00 PM**

- Review/approve minutes from previous meeting Dr. Martin
- TRICARE Policy Guidelines (Handout)
- Interim Force Structure Plan (verification) Dr. Martin
- Consolidation of Services' Health Data Centers Dr. Martin  
RADM Koenig
- Inclusion of Medical Labs and Medical Training Facilities in BRAC 95 Dr. Martin
- Region Population Realignment RADM Koenig
- Overview of 733 study Mr. Dickens
- Measures of Merit (Mom) Issues RADM Koenig  
LTC Ponatoski
- Action items for next meeting LTC Ponatoski
- Administrative Issues Dr. Martin

**NEXT MEETING MARCH 3, 2:00 PM**

**PENTAGON 4E327**

- Adjournment

# BRAC 95 JOINT CROSS-SERVICE GROUP FOR MTFs AND GME

## ■ Revised Action Plan & Timeline (thru 3/31/94)

- |  |      |   |
|--|------|---|
| ➤ Agree on Statement of Principles   | 2/4  | ✓ |
| ➤ Define role of Group & Services  | 2/4  | ✓ |
| ➤ Develop Analysis Assumptions   | 2/11 | ✓ |
| ➤ Determine Categories for Study   | 2/18 | ✓ |
| ➤ Determine General Analytical Approach                                    | 2/18 | ✓ |
| ➤ Review interim force structure plan                                      | 2/25 |   |
| ➤ Submit list of irreconcilable differences,<br>if necessary, to USD (A&T) | 2/28 |   |
| ➤ Define Measures of Merit & Data Sources                                  | 3/4  |   |
| ➤ Determine weights for Measures of Merit                                  | 3/11 |   |
| ➤ Complete Data Definitions  | 3/11 |   |
| ➤ Establish Data Internal Control Plan                                     | 3/17 |   |
| ➤ Draft report to Joint Group for review                                   | 3/17 |   |
| ➤ Final report to Steering Group   | 3/31 |   |

new  
items →

## **PROPOSED MEASURES OF MERIT**

**P1. Number of Active Duty Family Members**

**A1. Civilian Primary Care Physician Ratio**

**A2. Availability of Civilian and other Federal Inpatient Acute  
Care Resources in the Catchment Area**

**F1. Condition Code**

**F2. Age of Facility**

**F3. Cost of MILCON**

**Cn. Costs of Direct Care System Versus CHAMPUS**

# PROPOSED MEASURES OF MERIT AND DEFINITIONS

## POPULATION

**Factors that will help identify the level of medical services required in a particular area (BRAC CRITERION #1)**

- P1. Number of Active Duty and Active Duty Family Members.** Contains two data sets;
- 1) *eligible population as defined by catchment area or region; and*
  - 2) *population as defined by who uses the facility.*

### CLINICS

1. Defined as the number of active duty personnel and their families within a defined catchment area. The catchment area is defined as sets of zip codes emanating from the center of the MTF with a radius of 40 miles.
2. Defined as the number of active duty personnel and their families using a military treatment facility within the last six months. Possible source is the DoD Health Care User Survey. Results due March 31, 1994.

### HOSPITALS

1. Defined as the number of active duty personnel and their families within a defined catchment area. The catchment area is defined as sets of zip codes emanating from the center of the MTF with a radius of 40 miles.
2. Defined as the number of active duty personnel and their families using a military treatment facility within the last six months. Possible source is the DoD Health Care User Survey. Results due March 31, 1994.

### GRADUATE MEDICAL EDUCATION CENTERS

1. Defined as the number of active duty personnel and their families residing within the Lead Agent Region as defined by the July 93 Health Affairs Policy Guidance.
2. Defined as the number of active duty personnel and their families using a military treatment facility within the last six months. Possible source is the DoD Health Care User Survey. Results due March 31, 1994.

*rationale: A factor that helps determine if a treatment facility is necessary in a given area. Looking at excess capacity.*

## ACCESS

**Factors that will measure the availability and capability of the private sector healthcare system to meet the needs of the MHSS beneficiary population (BRAC Criterion #7).**

### **CLINICS, HOSPITALS, AND GME CENTERS:**

#### **A1. Civilian Primary Care Physician Ratio: ratio = 1/3500**

The mapping of civilian physicians and population to catchment area based on the January 1993 Catchment Area Directory (CAD) using ratios defined in the HHS Federal Register, Sept, 1991. Primary care physicians are defined as general practice, family practice, internal medicine, obstetrics, gynecology, and pediatric general and subspecialty physicians.

*rationale: An indicator of the availability of primary care physicians to provide services to the beneficiary population.*

#### **A2. Availability of Civilian and Department of Veterans Affairs Inpatient Acute Care Resources in the Catchment Area:**

1. The ability of local community acute care facilities to provide comprehensive health services to the eligible beneficiary population. Availability, capacity, and capability are based on DoD projected health care demand compared to available community healthcare resources (ie bed availability). Due to competition issues, this measure is viable only if there is more than one local community hospital.

*rationale: A factor that measures inpatient capacity, capability and availability.*

## FACILITIES

Factors that will estimate condition of the physical plant and facilitate decisions regarding retention/closure of a facility (BRAC Criteria # 2,4).

### CLINICS, HOSPITALS, AND GME CENTERS:

#### F1. CONDITION CODE:

1. Based on the DoD Real Property Inventory System. Normally rated on a 1-3 scale and performed by the installation engineer.

*rationale: The condition code is an indication of plant condition; low score is an indication of high maintenance and renovation costs and may require significant resources to correct deficiencies.*

#### F2. AGE OF FACILITY:

1. Weighted age based on size of facility and age.

*rationale: Provides an indication of the design efficiency of the physical plant.*

#### F3. COST OF MILCON:

1. MTF total programmed MILCON plus total programmed Major Repair and Minor Construction Resources spanning the Future Years Defense Program.
2. Life Safety Scores from the most recent Joint Commission on Accreditation of Healthcare Organizations.

*rationale: An indicator that the physical plant is in a deteriorating state and requires renovation or major construction to operate within acceptable maintenance standards. This factor also helps determine the adequacy and appropriateness of the size of the facility.*

## COSTS

**Factors that measure the costs of providing services in the direct care system and compare those to the costs of buying the services from the private sector (BRAC Criterion # 4).**

### **CLINICS, HOSPITALS, AND GME CENTERS**

AASD(HA) is coordinating the methodology with the Surgeons General.

# STRAWMAN ANALYTICAL STRUCTURE

## MILITARY VALUE

### *Criterion 1 - Mission/Impact on Readiness*

1. (P1) Size of active duty and dependents of active duty population.

### *Criterion 2 - Availability/Condition of Facilities*

1. (F1) Condition codes of facilities based on DoD Real Property Inventory System.
2. (F2) Age of facilities at existing site

### *Criterion 3 - Contingency/Mobilization*

### *Criterion 4 - Cost/Manpower Implications*

1. Costing mechanism with SGs.
2. (F3) Total programmed MILCON plus total programmed Major Repair and Minor Construction.

## RETURN ON INVESTMENT

### *Criterion 5 - ROI*

1. Results from the COBRA analysis

## IMPACTS

### *Criterion 6 - Economic Impact on Communities*

### *Criterion 7 - Community Infrastructure*

1. (A1) Civilian Primary Care Physician Ratio (1/3500 ratio).
2. (A2) Availability of Civilian and other Federal Inpatient Acute Care Resources in the Catchment Area (capacity and capability).

### *Criterion 8 - Environmental Impact*

## OVERVIEW OF LEAD AGENT INITIATIVE

- Designated Service Medical Centers Act as Lead Agent for Twelve New Defense Health Regions
- MHSS Funding Allocated on Capitated Basis to the Services' Medical Department
- Lead Agents Oversee Direct Care Services and CHAMPUS Services; Local Commanders Have Active Role in Designing Patient Routing and Referral Priorities, Resource Sharing Configurations, and Managed Care Responsibilities
- Civilian At-Risk Contractor Procured for Each Region to Provide Managed Care Services for CHAMPUS, with Lead Agent-Designated Contracting Officer's Representative (COR) Overseeing Contractor
- CHAMPUS Benefits Distinguish Between Levels of Managed Care, With Reduced Cost Sharing for Beneficiaries Choosing Program with more Managed Care Elements

## OBJECTIVES OF THE LEAD AGENT INITIATIVE

- Controlling Cost Growth through Expansion of Managed Care and Greater Accountability for Performance at the Region Level
- Assuring Beneficiaries of Accessible Health Care
- Maintaining and Improving the Quality of Care
- Assuring Consistency with the National Healthcare Reform Efforts
- Improving the Efficiency of the Direct Care System

## REGIONAL LEAD AGENTS AND SUPPORTED POPULATIONS<sup>1</sup>

LEAD AGENT	POPULATION	MEDICAL TREATMENT FACILITIES			TOTAL
		ARMY	NAVY	AIR FORCE	
National Capital <sup>2</sup>	1,093,918	5	6	4	15
Portsmouth	872,011	3	3	2	8
Eisenhower	1,063,770	4	4	5	13
Keesler	595,024	3	2	5	10
Wright-Patterson	653,328	2	1	3	6
Wiford Hall	949,778	4	1	9	14
William Beaumont	323,058	2	0	5	7
Fitzsimons	805,376	5	0	10	15
San Diego	710,461	1	3	3	7
David Grant	382,590	1	2	4	7
Madigan <sup>3</sup>	350,439	1	2	1	4
Tripler	151,750	1	0	0	1
<b><u>TOTAL</u></b>	<b><u>7,951,503</u></b>	<b><u>31</u></b>	<b><u>23</u></b>	<b><u>54</u></b>	<b><u>107</u></b>

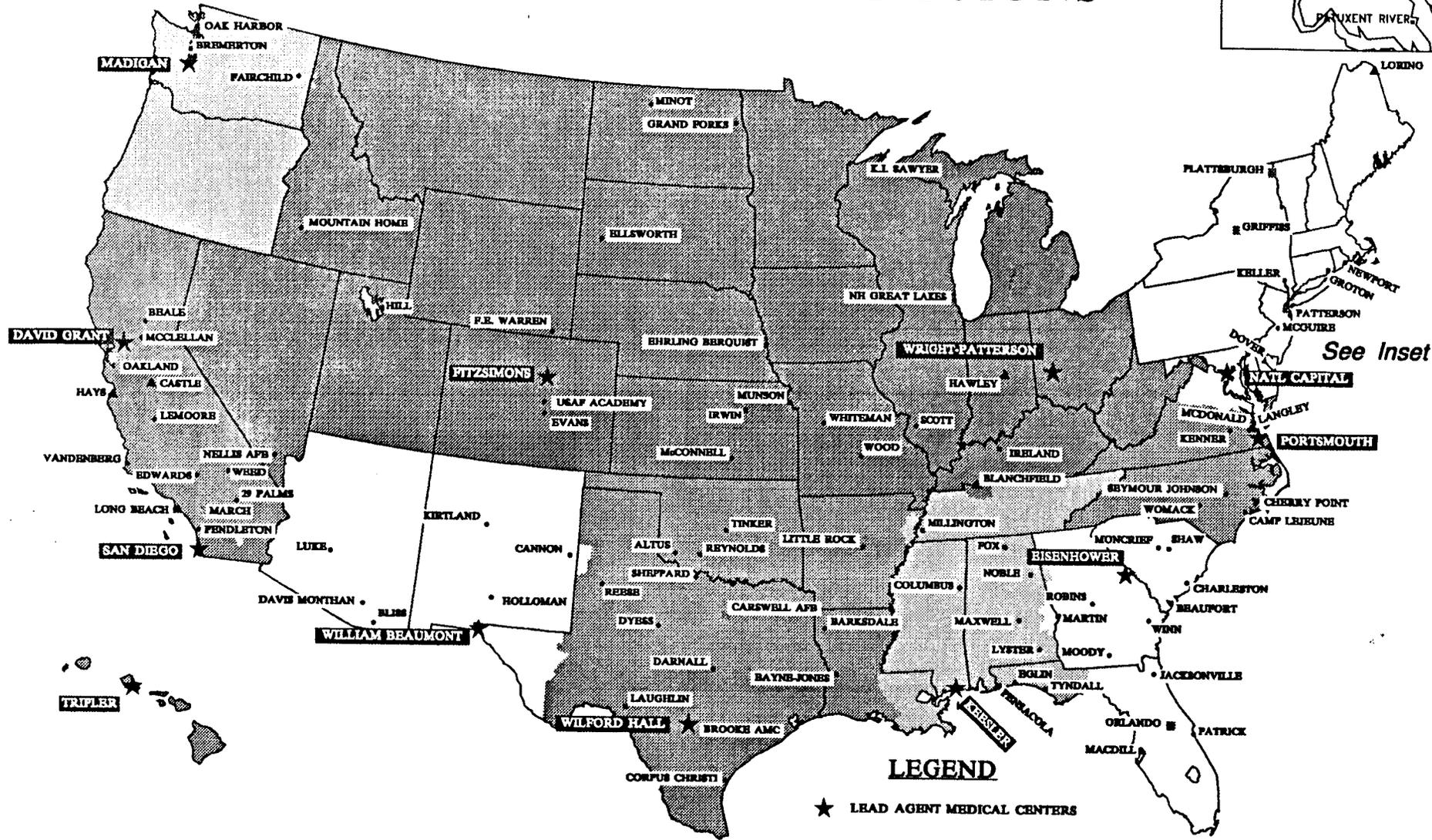
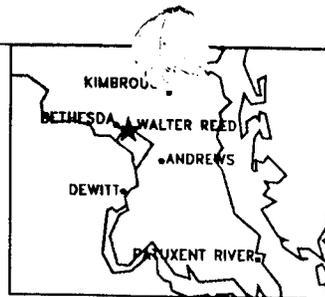
<sup>1</sup> Population numbers are estimates based on FY 93 DMIS data.

<sup>2</sup> The National Capital Region will functionally carry out this policy through a tri-Service board with annual rotation of the chair person. The contract responsibility for the board will be carried out by Walter Reed Army Medical Center.

<sup>3</sup> Alaska will be a free-standing entity and will develop referral patterns with appropriate medical centers.

22 FEB 1994

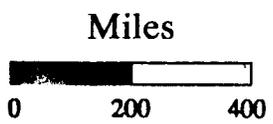
# TRICARE LEAD AGENTS AND HEALTH SERVICE REGIONS



See Inset

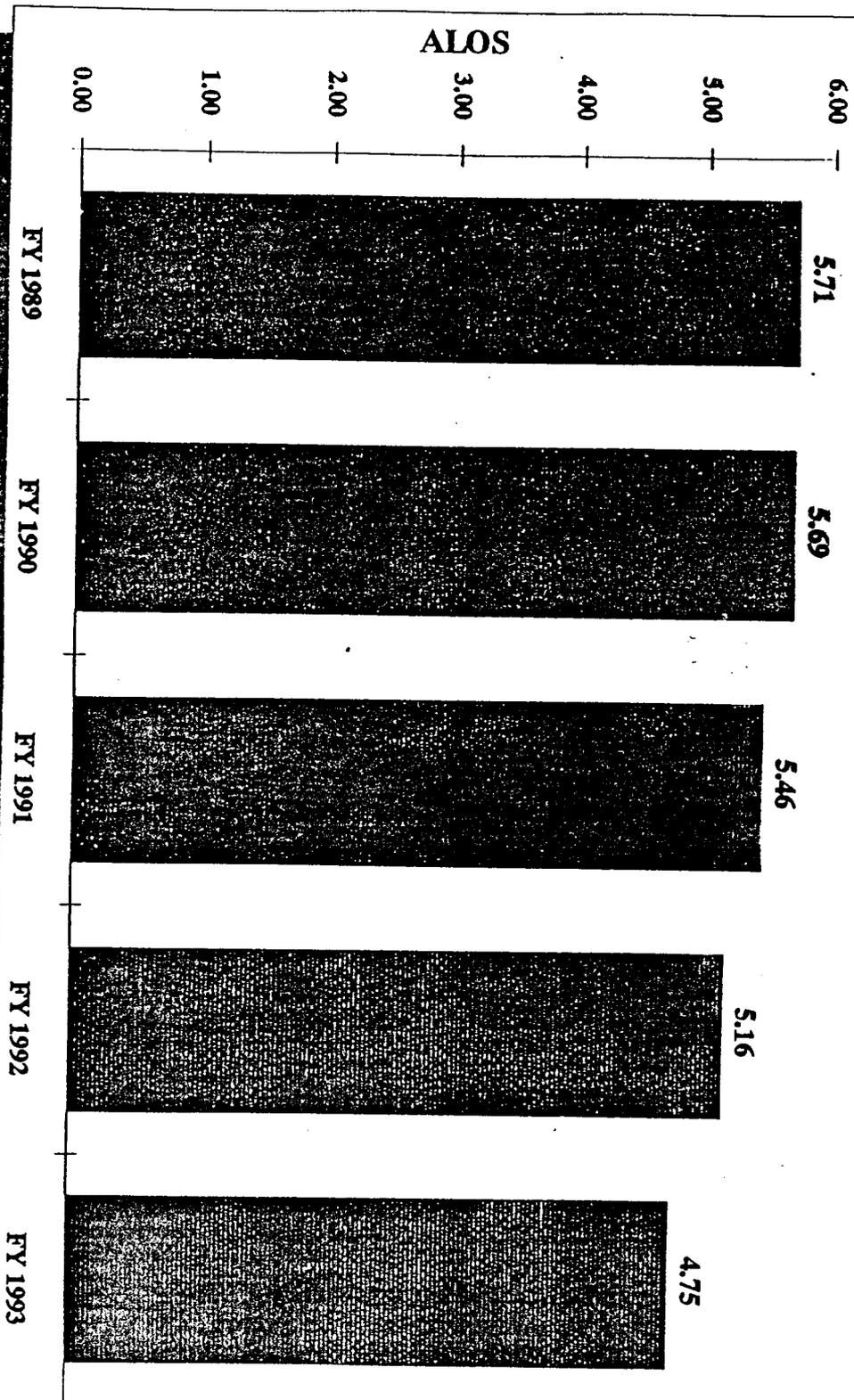
## LEGEND

- ★ LEAD AGENT MEDICAL CENTERS
- MEDICAL TREATMENT FACILITY
- ▲ BRAC I AND II FACILITY
- BRAC III FACILITY



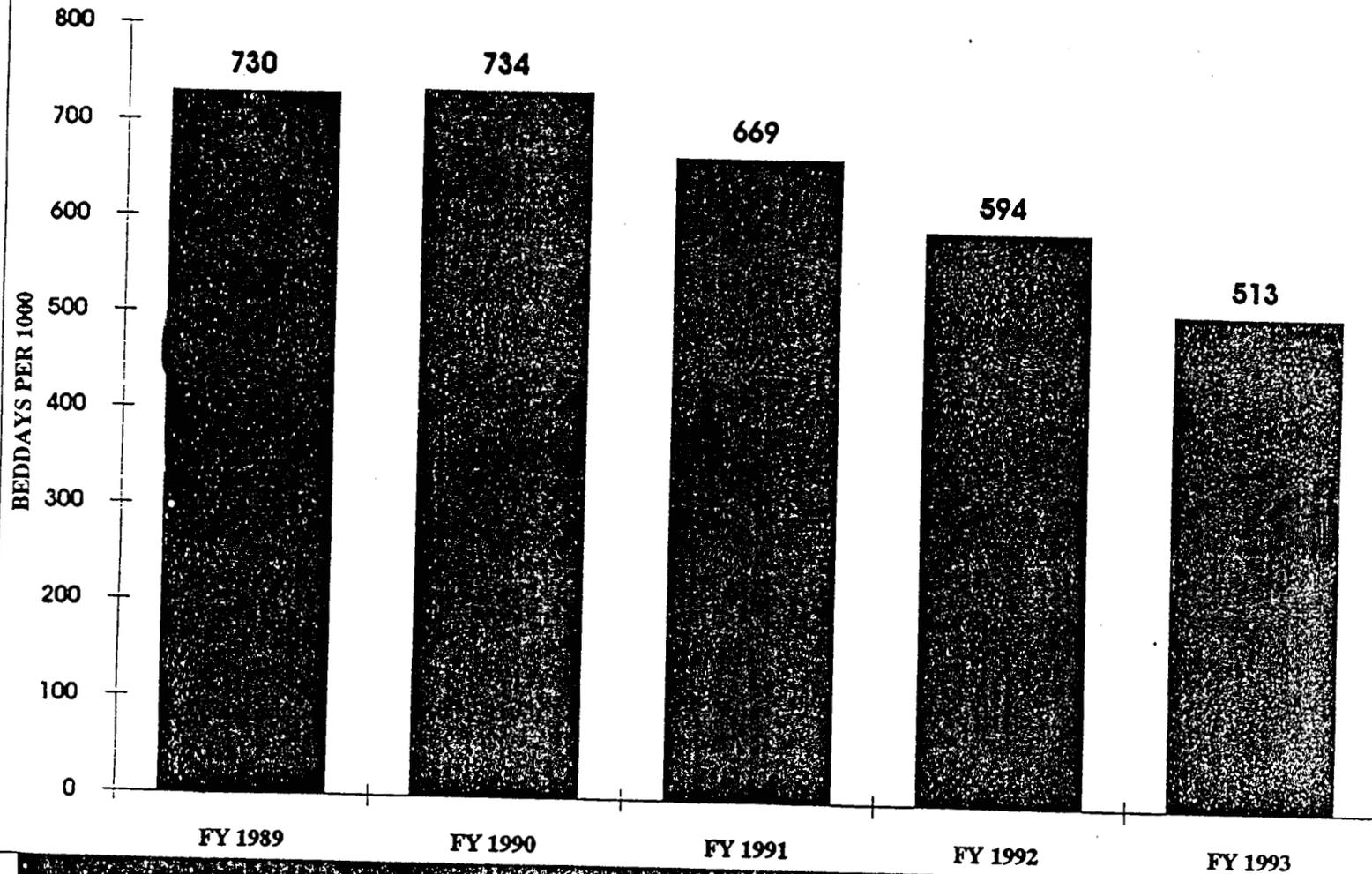
Sources: DMIS and Defense Base Closure and Realignment Commission, 1993 Report to the President

# MHSS CONUS Performance Review ACTIVE DUTY AVERAGE LENGTH OF STAY



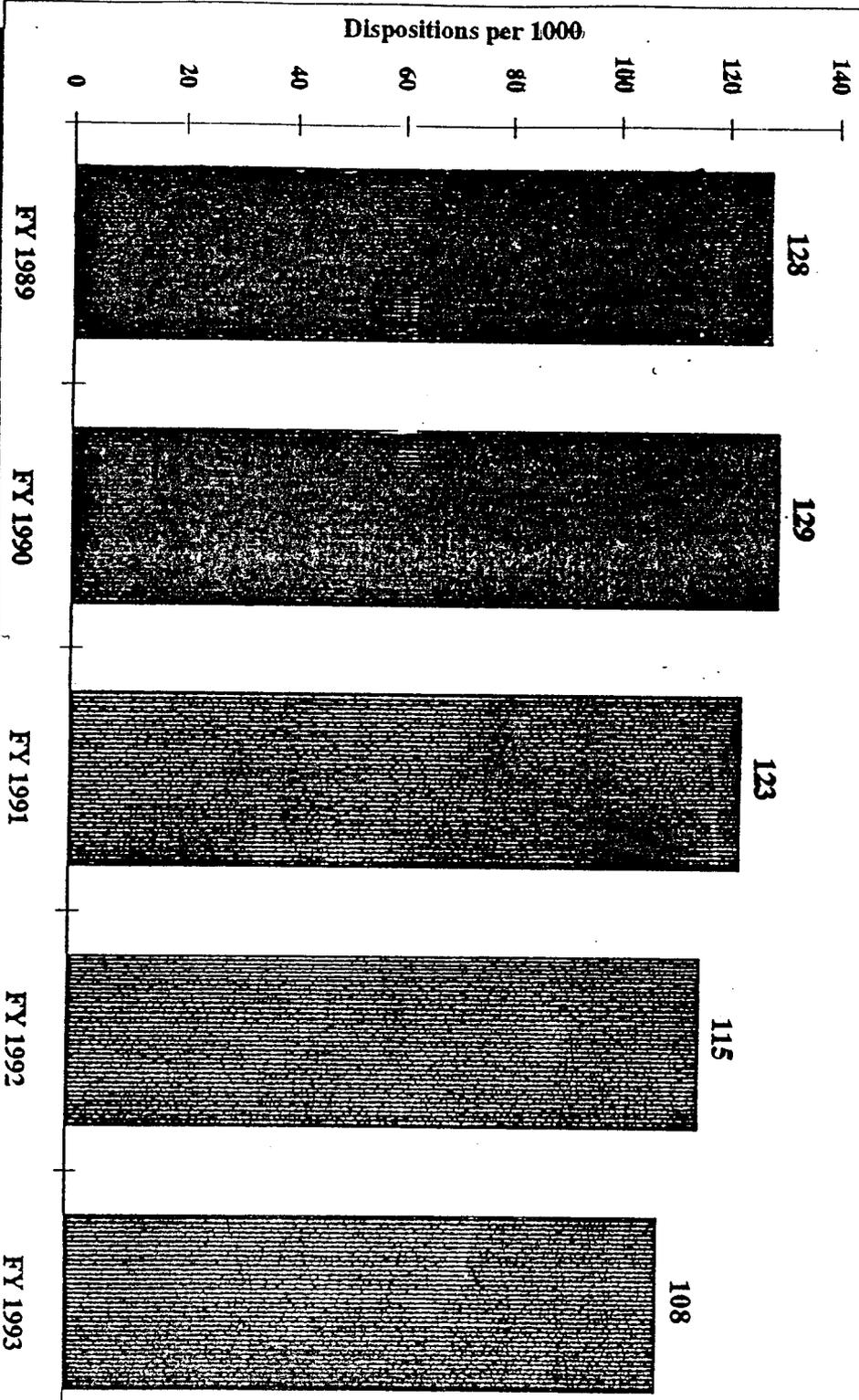
SOURCES: DMIS BIOMETRICS, RCMAS CENTRAL, HB and P ELIGIBLE POPULATION PROGRAM  
NOV-93 JUN-SEP FY 93 Navy Inpatient workload data was estimated using validated forecasting.

**MHSS CONUS Performance Review**  
**Active Duty Bed Days per 1000 Active Duty**



SOURCES: DMIS BIOMETRICS, RCMAS CENTRAL, HB and P ELIGIBLE POPULATION PROGRAM  
NOTE: JUN-SEP FY 93 Navy Inpatient workload data was estimated using seasonalized forecasting.

### MHSS CONUS Performance Review Active Duty Dispositions per 1000 Active Duty



SOURCES: DMIS BIOMETRICS, RCMAS CENTRAL, HB and P ELIGIBLE POPULATION PROGRAM  
NOTE: JUN-SEP FY 93 Navy Inpatient workload data was estimated using annualized forecasting.

## Military Hospitals Under Proposed DoD Regionalization

### Region 1 - TRISERVE Lead Agent

#### ARMY (MTF's - 6)

Kimbrough AH - Ft Meade  
 Walter Reed AMC  
 Keller AH - West Point  
 Cutler AH - Ft Devens (10/93) \*  
 Patterson AH - Ft Monmouth  
 Dewitt AH - Ft Belvoir

#### NAVY (MTF's - 4)

NH Bethesda  
 NH Patuxent River  
 NH Groton  
 NH Newport

#### Closed Sites

NH Philadelphia (10/91) \*

#### AIR FORCE (MTF's - 6)

Malcolm Grow USAF Medical Center - Andrews AFB  
 42nd Strategic Hospital - Loring AFB (1/94) \*  
 380th Strategic Hospital - Plattsburgh AFB (BRAC III) \*  
 416th Strategic Hospital - Griffiss AFB (BRAC III) \*  
 USAF Hospital - Dover AFB  
 438th Medical Group - McGuire AFB

#### Closed Sites

509th Strategic Hospital - Pease AFB (9/90) \*

#### OTHER (MTF's - 4)

USTF Baltimore  
 USTF Boston  
 USTF Staten Island  
 USTF Portland

### Region 2 - NRMC Portsmouth Lead Agent

#### ARMY (MTF's - 3)

Kenner AH - Ft Lee  
 McDonald AH - Ft Eustis  
 Womack AH - Ft Bragg

#### NAVY (MTF's - 3)

NRMC Portsmouth  
 NH Cherry Point  
 NH Camp Lejeune

#### AIR FORCE (MTF's - 2)

1st Medical Group - Langley AFB  
 4th Medical Group - Seymour Johnson AFB

#### OTHER (MTF's - 0)

### Region 3 - Eisenhower AMC Lead Agent

#### ARMY (MTF's - 4)

Moncrief AH - Ft Jackson  
 Eisenhower AMC - Ft Gordon  
 Winn AH - Ft Stewart  
 Martin AH - Ft Benning

#### NAVY (MTF's - 4)

NH Charleston  
 NH Beaufort  
 NH Jacksonville  
 NH Orlando (BRAC III) \*

#### AIR FORCE (MTF's - 5)

363rd Medical Group - Shaw AFB  
 USAF Hospital - Robins AFB  
 347th Medical Group - Moody AFB  
 56th Medical Group - MacDill AFB  
 USAF Hospital - Patrick AFB

#### OTHER (MTF's - 0)

#### Closed Sites

31st Medical Group - Homestead AFB (8/92) \*  
 354th Medical Group - Myrtle Beach AFB (12/92) \*

\* ( ) Indicates Hospital Closure Date/BRAC consideration

## Military Hospitals Under Proposed DOD Regionalization (Continued)

### Region 4 - USAF Med Ctr Keesler Lead Agent

ARMY (MTF's - 3)  Lyster AH - Ft Rucker Fox AH - Redstone Arsenal Noble AH - Ft McClellan	NAVY (MTF's - 2)  NH Pensacola NH Millington	AIR FORCE (MTF's - 5)  325th Medical Group - Tyndall AFB USAF Regional Hospital - Eglin AFB USAF Medical Center - Keesler AFB Air University Regional Hospital - Maxwell AFB USAF Hospital - Columbus AFB	OTHER (MTF's - 0)
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### Region 5 - AF Med Ctr Wright Patterson Lead Agent

ARMY (MTF's - 3)  Ireland AH - Ft Knox Hawley AH - Ft Ben Harrison (10/93) * Blanchfield ACH - Ft Campbell	NAVY (MTF's - 1)  NH Great Lakes	AIR FORCE (MTF's - 3)  USAF Medical Center - Scott AFB AF Medical Center - Wright Patterson AFB 410th Strategic Hospital - K I Sawyer AFB (BRAC III) *  Closed Sites 379th Strategic Hospital - Wurtsmith AFB (7/92) * Chanute TTC Hospital - Chanute AFB (12/92) *	OTHER (MTF's - 1)  USTF Cleveland
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### Region 6 - Wilford Hall USAF Med Ctr Lead Agent

ARMY (MTF's - 4)  Bayne-Jones AH - Ft Polk Darnall AH - Ft Hood Reynolds AH - Ft Sill Brooke AMC - Ft Sam Houston	NAVY (MTF's - 1)  NH Corpus Christi	AIR FORCE (MTF's - 9)  USAF Hospital - Little Rock AFB 2nd Strategic Hospital - Barksdale AFB Wilford Hall USAF Medical Center - Lackland AFB USAF Hospital - Laughlin AFB 96th Strategic Hospital - Dyess AFB USAF Regional Hospital - Sheppard AFB USAF Hospital - Reese AFB USAF Hospital - Altus AFB USAF Hospital - Tinker AFB	OTHER (MTF's - 4)  USTF Nassau Bay USTF Galveston USTF Houston USTF Port Arthur
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Closed Sites

- 97th Strategic Hospital - Eaker AFB (7/92) \*
- 23rd Medical Group - England AFB (9/92) \*
- 67th Medical Group - Bergstrom AFB (2/93) \*
- Hempson Strategic Hospital - Carswell AFB (6/93) \*

) Indicates Hospital Closure Date/BRAC consideration

**Military Hospitals Under Proposed DoD Regionalization  
(Continued)**

**Region 7 - William Beaumont AMC Lead Agent**

<u>ARMY (MTF's - 2)</u>	<u>NAVY (MTF's - 0)</u>	<u>AIR FORCE (MTF's - 5)</u>	<u>OTHER (MTF's - 0)</u>
William Beaumont AMC - Ft Bliss Bliss AH - Ft Huachuca		833rd Medical Group - Holloman AFB 27th Medical Group - Cannon AFB USAF Hospital - Kirtland AFB 836th Medical Group - Davis Monthan AFB 832nd Medical Group - Luke AFB  Closed Sites USAF Hospital - Williams AFB (7/92) *	

**Region 8 - Fitzsimons AMC Lead Agent**

<u>ARMY (MTF's - 5)</u>	<u>NAVY (MTF's - 0)</u>	<u>AIR FORCE (MTF's - 9)</u>	<u>OTHER (MTF's - 0)</u>
Wood AH - Ft Leonard Wood Munson AH - Ft Leavenworth Irwin AH - Ft Riley Evans AH - Ft Carson Fitzsimons AMC		351st Strategic Hospital - Whiteman AFB USAF Academy Hospital Ehring Berquist Regional Hospital - Offutt AFB USAF Hospital - Hill AFB 90th Strategic Hospital - F E Warren AFB 44th Strategic Hospital - Ellsworth AFB 321st Strategic Hospital - Grand Forks AFB 91st Strategic Hospital - Minot AFB 366th Medical Group - Mountain Home AFB 554th Medical Group - Nellis AFB	

**Region 9 - NH San Diego Lead Agent**

<u>ARMY (MTF's - 1)</u>	<u>NAVY (MTF's - 4)</u>	<u>AIR FORCE (MTF's - 4)</u>	<u>OTHER (MTF's - 0)</u>
Weed AH - Ft Irwin	BRH Twenty Nine Palms NH Camp Pendleton NH San Diego NH Long Beach (12/93) *	22nd Strategic Hospital - March AFB (BRAC III) * USAF Hospital - Edwards AFB 1st Strategic Hospital - Vandenberg AFB  Closed Sites 831st Medical Group - George AFB (7/92) *	

\* ( ) Indicates Hospital Closure Date/BRAC consideration

**Military Hospitals Under Proposed DoD Regionalization  
(Concluded)**

**Region 10 - David Grant USAF Hospital Lead Agent**

<u>ARMY (MTF's - 2)</u>	<u>NAVY (MTF's - 2)</u>	<u>AIR FORCE (MTF's - 4)</u>	<u>OTHER (MTF's - 0)</u>
Hays AH - Ft Ord (9/93) * Letterman AMC Presidio (9/93) *	NH Oakland (BRAC III) * NH Lemoore	David Grant USAF Hospital - Travis AFB 9th Strategic Hospital - Beale AFB USAF Hospital - McClellan AFB 93rd Strategic Hospital - Castle AFB (9/95) *	

**Region 11 - Madigan AMC Lead Agent**

<u>ARMY (MTF's - 1)</u>	<u>NAVY (MTF's - 2)</u>	<u>AIR FORCE (MTF's - 1)</u>	<u>OTHER (MTF's - 1)</u>
Madigan AMC - Ft Lewis	NH Bremerton NH Oak Harbor	92nd Strategic Hospital - Fairchild AFB	USTF Seattle

**Region 12 - Tripler AMC Lead Agent**

<u>ARMY (MTF's - 1)</u>	<u>NAVY (MTF's - 0)</u>	<u>AIR FORCE (MTF's - 0)</u>	<u>OTHER (MTF's - 0)</u>
Tripler AMC			

\* ( ) Indicates Hospital Closure Date/BRAC consideration

CONUS Medical Centers

DMIS ID	Facility	40 mile Catchment Area				Region less Catchment Area				Region				Region
		Active Duty	FM of AD	All Others	Total	Active Duty	FM of AD	All Others	Total	Active Duty	FM of AD	All Others	Total	
0004	502nd MEDICAL GROUP	5,857	10,885	20,127	36,869	92,771	146,989	318,395	558,155	98,628	157,874	338,522	595,024	4
0047	EISENHOWER AMC	8,168	15,239	26,997	50,404	190,990	272,632	549,744	1,013,366	199,158	287,871	576,741	1,063,770	3
0014	DAVID GRANT	8,224	15,425	29,482	53,131	54,044	92,356	183,059	329,459	62,268	107,781	212,541	382,590	10
0031	FITZSIMONS AMC	8,719	12,650	40,371	61,740	140,253	211,054	319,774	671,081	148,972	223,704	360,145	732,821	8
0095	WRIGHT-PATTERSON	9,463	18,656	27,959	56,078	98,672	158,410	340,168	597,250	108,135	177,066	368,127	653,328	5
0055	USAF MED CTR SCOTT	9,540	19,798	30,687	60,025	98,595	157,268	337,440	593,303	108,135	177,066	368,127	653,328	5
0066	MALCOLM GROW	14,270	19,709	29,398	63,377	182,286	291,065	557,190	1,030,541	196,556	310,774	586,588	1,093,918	1
0108	WILLIAM BEAUMONT	14,333	20,877	30,465	65,675	38,834	71,037	147,512	257,383	53,167	91,914	177,977	323,058	7
0037	WALTER REED AMC	14,919	9,683	22,953	47,555	181,637	301,091	563,635	1,046,363	196,556	310,774	586,588	1,093,918	1
0073	KEESLER	15,397	17,510	22,215	55,122	83,231	140,364	316,307	539,902	98,628	157,874	338,522	595,024	4
0109	BROOKE AMC	15,645	25,555	56,643	97,843	146,381	230,925	474,629	851,935	162,026	256,480	531,272	949,778	6
0117	WILFORD HALL	21,945	22,841	45,397	90,183	140,081	233,639	485,875	859,595	162,026	256,480	531,272	949,778	6
0027	NH OAKLAND	23,276	26,800	45,789	95,865	38,992	80,981	166,752	286,725	62,268	107,781	212,541	382,590	10
0125	MADIGAN AMC	24,294	39,162	58,160	121,616	29,703	60,064	139,056	228,823	53,997	99,226	197,216	350,439	11
0067	NNMC BETHESDA	24,515	21,875	39,554	85,944	172,041	288,899	547,034	1,007,974	196,556	310,774	586,588	1,093,918	1
0052	TRIPLER AMC	51,563	64,338	30,527	146,428	556	715	4,051	5,322	52,119	65,053	34,578	151,750	12
0029	NH SAN DIEGO	86,867	94,091	104,257	285,215	94,675	132,450	198,121	425,246	181,542	226,541	302,378	710,461	9
0124	NH PORTSMOUTH	95,865	136,495	80,377	312,737	127,796	202,098	229,380	559,274	223,661	338,593	309,757	872,011	2

25th PERCENTILE = 9,482  
 MEDIAN = 15,158  
 75th PERCENTILE = 24,040

FY 93 POPULATION DATA

CONUS Community Hospitals

DMIS ID	Facility	40 mile Catchment Area				Region less Catchment Area				Region				Region
		Active Duty	FM of AD	All Others	Total	Active Duty	FM of AD	All Others	Total	Active Duty	FM of AD	All Others	Total	
0114	47th MEDICAL SQUADRON	1,228	1,796	2,135	5,159	160,798	254,684	529,137	944,619	162,026	256,480	531,272	949,778	6
0111	64th MEDICAL SQUADRON	1,333	2,911	5,025	9,269	160,693	253,569	526,247	940,509	162,026	256,480	531,272	949,778	6
0074	14th MEDICAL SQUADRON	1,528	2,745	4,933	9,206	97,100	155,129	333,589	585,818	98,628	157,874	338,522	595,024	4
0087	380th MEDICAL GROUP	2,376	3,807	3,754	9,937	194,180	306,967	582,834	1,083,981	196,556	310,774	586,588	1,093,918	1
0001	FOX ACH	2,709	7,001	20,932	30,642	95,919	150,873	317,590	564,382	98,628	157,874	338,522	595,024	4
0072	410th MEDICAL GROUP	2,940	5,223	2,995	11,158	105,195	171,843	365,132	642,170	108,135	177,066	368,127	653,328	5
0097	97th MEDICAL GROUP	3,117	4,895	3,557	11,569	158,909	251,585	527,715	938,209	162,026	256,480	531,272	949,778	6
0018	30th MEDICAL GROUP	3,283	6,371	9,554	19,208	178,259	220,170	292,824	691,253	181,542	226,541	302,378	710,461	9
0068	NH PATUXENT RIVER	3,378	5,443	5,995	14,816	193,178	305,331	580,593	1,079,102	196,556	310,774	586,588	1,093,918	1
0053	366th MEDICAL GROUP	3,472	6,096	4,670	14,238	145,500	217,608	355,475	718,583	148,972	223,704	360,145	732,821	8
0015	9th MEDICAL GROUP	3,554	5,232	10,430	19,216	58,714	102,549	202,111	363,374	62,268	107,781	212,541	382,590	10
0046	45th MEDICAL GROUP	3,577	7,949	30,703	42,229	195,581	279,922	546,038	1,021,541	199,158	287,871	576,741	1,063,770	3
0129	90th MEDICAL GROUP	3,722	5,921	5,314	14,957	145,250	217,783	354,831	717,864	148,972	223,704	360,145	732,821	8
0076	351st MEDICAL GROUP	3,830	5,405	5,112	14,347	145,142	218,299	355,033	718,474	148,972	223,704	360,145	732,821	8
0017	93rd MEDICAL GROUP	3,995	8,060	12,347	24,402	58,273	99,721	200,194	358,188	62,268	107,781	212,541	382,590	10
0050	347th MEDICAL GROUP	4,018	6,492	7,220	17,730	195,140	281,379	569,521	1,046,040	199,158	287,871	576,741	1,063,770	3
0118	NH CORPUS CHRISTI	4,301	7,878	11,590	23,769	157,725	248,602	519,682	926,009	162,026	256,480	531,272	949,778	6
0051	653rd MEDICAL GROUP	4,475	8,848	16,556	29,879	194,683	279,023	560,185	1,033,891	199,158	287,871	576,741	1,063,770	3
0019	650th MEDICAL GROUP	4,552	7,529	7,683	19,764	176,990	219,012	294,695	690,697	181,542	226,541	302,378	710,461	9
0128	92nd MEDICAL GROUP	4,573	8,773	15,432	28,778	49,424	90,453	181,784	321,661	53,997	99,226	197,216	350,439	11
0088	416th MEDICAL GROUP	4,605	7,506	8,909	21,020	191,951	303,268	577,679	1,072,898	196,556	310,774	586,588	1,093,918	1
0250	652nd MEDICAL GROUP	4,736	10,295	46,728	61,759	57,532	97,486	165,813	320,831	62,268	107,781	212,541	382,590	10
0093	319th MEDICAL GROUP	4,822	7,852	2,723	15,397	144,150	215,852	357,422	717,424	148,972	223,704	360,145	732,821	8
0036	436th MEDICAL GROUP	4,883	8,234	14,108	27,225	191,673	302,540	572,480	1,066,693	196,556	310,774	586,588	1,093,918	1
0021	22nd MEDICAL GROUP	4,952	14,160	45,048	64,160	176,590	212,381	257,330	646,301	181,542	226,541	302,378	710,461	9
0094	5th MEDICAL GROUP	5,030	7,128	2,185	14,343	143,942	216,576	357,960	718,478	148,972	223,704	360,145	732,821	8
0028	NH LEMOORE	5,037	9,423	10,193	24,653	57,231	98,358	202,348	357,937	62,268	107,781	212,541	382,590	10
0090	4th MEDICAL GROUP	5,085	9,503	13,518	28,106	218,576	329,090	296,239	843,905	223,661	338,593	309,757	872,011	2
0131	WEED ACH	5,210	6,906	2,156	14,272	176,332	219,635	300,222	696,189	181,542	226,541	302,378	710,461	9
0112	96th MEDICAL GROUP	5,213	8,836	8,121	22,170	156,813	247,644	523,151	927,608	162,026	256,480	531,272	949,778	6

FY 93 POPULATION DATA

CONUS Community Hospitals (continued)

DMIS ID	Facility	40 mile Catchment Area				Region less Catchment Area				Region				Region
		Active Duty	FM of AD	All Others	Total	Active Duty	FM of AD	All Others	Total	Active Duty	FM of AD	All Others	Total	
0085	27th MEDICAL GROUP	5,217	7,938	3,465	16,620	47,950	83,976	174,512	306,438	53,167	91,914	177,977	323,058	7
0083	542nd MEDICAL GROUP	5,236	10,522	23,711	39,469	47,931	81,392	154,266	283,589	53,167	91,914	177,977	323,058	7
0106	28th MEDICAL GROUP	5,364	10,255	5,745	21,364	143,608	213,449	354,400	711,457	148,972	223,704	360,145	732,821	8
0081	PATTERSON ACH	5,408	7,361	16,356	29,125	191,148	303,413	570,232	1,064,793	196,556	310,774	586,588	1,093,918	1
0010	355th MEDICAL GROUP	5,517	11,645	26,452	43,614	47,650	80,269	151,525	279,444	53,167	91,914	177,977	323,058	7
0002	NOBLE ACH	5,520	6,888	13,540	25,948	93,108	150,986	324,982	569,076	98,628	157,874	338,522	595,024	4
0013	314th MEDICAL GROUP	5,603	10,909	20,604	37,116	156,423	245,571	510,668	912,662	162,026	256,480	531,272	949,778	6
0084	49th MEDICAL GROUP	5,633	9,893	6,075	21,601	47,534	82,021	171,902	301,457	53,167	91,914	177,977	323,058	7
0003	LYSTER ACH	5,704	11,578	16,239	33,521	92,924	146,296	322,283	561,503	98,628	157,874	338,522	595,024	4
0100	NH NEWPORT	5,772	9,660	17,575	33,007	190,784	301,114	569,013	1,060,911	196,556	310,774	586,588	1,093,918	1
0043	325th MEDICAL GROUP	5,783	10,809	14,924	31,516	92,845	147,065	323,598	563,508	98,628	157,874	338,522	595,024	4
0008	BLISS ACH	5,819	8,192	10,241	24,252	47,348	83,722	167,736	298,806	53,167	91,914	177,977	323,058	7
0062	2nd MEDICAL GROUP	5,906	10,537	17,033	33,476	156,120	245,943	514,239	916,302	162,026	256,480	531,272	949,778	6
0113	396th MEDICAL GROUP	6,217	7,291	8,774	22,282	155,809	249,189	522,498	927,496	162,026	256,480	531,272	949,778	6
0119	649th MEDICAL GROUP	6,262	11,777	18,996	37,035	142,710	211,927	341,149	695,786	148,972	223,704	360,145	732,821	8
0101	363rd MEDICAL GROUP	6,329	11,063	10,751	28,143	192,829	276,808	565,990	1,035,627	199,158	287,871	576,741	1,063,770	3
0009	58th MEDICAL GROUP	6,429	14,009	46,412	66,850	46,738	77,905	131,565	256,208	53,167	91,914	177,977	323,058	7
0045	56th MEDICAL GROUP	6,485	15,873	71,653	94,011	192,673	271,998	505,088	969,759	199,158	287,871	576,741	1,063,770	3
0086	KELLER ACH	6,633	7,699	15,663	29,995	189,923	303,075	570,925	1,063,923	196,556	310,774	586,588	1,093,918	1
0122	KENNER ACH	6,969	9,348	21,927	38,244	216,692	329,245	287,830	833,767	223,661	338,593	309,757	872,011	2
0079	554th MEDICAL GROUP	7,293	14,333	34,986	56,612	181,542	226,541	302,378	710,461	188,835	240,874	337,364	767,073	9
0127	NH OAK HARBOR	8,041	11,428	8,224	27,693	45,956	87,798	188,992	322,746	53,997	99,226	197,216	350,439	11
0107	NH MILLINGTON	8,254	11,912	20,611	40,777	90,374	145,962	317,911	554,247	98,628	157,874	338,522	595,024	4
0121	MCDONALD ACH	8,688	20,222	17,991	46,901	214,973	318,371	291,766	825,110	223,661	338,593	309,757	872,011	2
0023	HAYS ACH	8,796	22,283	17,595	48,674	53,472	85,498	194,946	333,916	62,268	107,781	212,541	382,590	10
0058	MUNSON ACH	9,118	11,604	20,754	41,476	139,854	212,100	339,391	691,345	148,972	223,704	360,145	732,821	8
0092	NH CHERRY POINT	9,199	13,269	9,226	31,694	214,462	325,324	300,531	840,317	223,661	338,593	309,757	872,011	2
0035	NH GROTON	9,225	14,450	15,773	39,448	187,331	296,324	570,815	1,054,470	196,556	310,774	586,588	1,093,918	1
0096	654th MEDICAL GROUP	9,246	16,790	28,410	54,446	152,780	239,690	502,862	895,332	162,026	256,480	531,272	949,778	6
0030	NH TWENTYNINE PALMS	9,253	7,971	2,948	20,172	172,289	218,570	299,430	690,289	181,542	226,541	302,378	710,461	9

CONUS Community Hospitals (continued)

DMIS ID	Facility	40 mile Catchment Area						Region less Catchment Area						Region			Region	
		Active		FM of		All		Active		FM of		All		Active	FM of AD	All Others		Total
		Duty	AD	AD	AD	AD	AD	Duty	AD	AD	AD	AD	AD					
0126	NH BREMERTON	9,690	23,286	19,560	52,336	44,307	73,940	177,656	297,903	53,997	99,226	197,216	350,439	11				
0120	1st MEDICAL GROUP	9,714	24,588	21,556	55,858	213,947	314,005	288,201	816,153	223,661	338,593	309,757	872,011	2				
0078	EHLING BERQUIST HOSP	10,114	18,885	22,152	51,151	138,858	204,819	337,993	681,670	148,972	223,704	360,145	732,821	8				
0038	NH PENSACOLA	10,300	18,767	36,360	65,427	88,328	139,107	302,162	529,597	98,628	157,874	338,522	595,024	4				
0075	L. WOOD ACH	12,732	11,616	9,794	34,142	136,240	212,088	350,351	698,679	148,972	223,704	360,145	732,821	8				
0326	438th MEDICAL GROUP	13,004	21,944	45,436	80,384	183,552	288,830	541,152	1,013,534	196,556	310,774	586,588	1,093,918	1				
0123	DEWITT ACH	13,225	56,508	65,047	134,780	183,331	254,266	521,541	959,138	196,556	310,774	586,588	1,093,918	1				
0033	USAF ACADEMY HOSPITAL	13,316	12,835	21,043	47,194	135,656	210,869	339,102	685,627	148,972	223,704	360,145	732,821	8				
0104	NH BEAUFORT	13,910	10,158	7,726	31,794	185,248	277,713	569,015	1,031,976	199,158	287,871	576,741	1,063,770	3				
0064	BAYNE-JONES ACH	14,057	15,352	7,829	37,238	147,969	241,128	523,443	912,540	162,026	256,480	531,272	949,778	6				
0069	KIMBROUGH ACH	14,609	22,029	25,996	62,634	181,947	288,745	560,592	1,031,284	196,556	310,774	586,588	1,093,918	1				
0057	IRWIN ACH	14,839	20,870	8,687	44,396	134,133	202,834	351,458	688,425	148,972	223,704	360,145	732,821	8				
0042	646th MEDICAL GROUP	15,012	26,843	32,068	73,923	83,616	131,031	306,454	521,101	98,628	157,874	338,522	595,024	4				
0061	IRELAND ACH	15,543	19,820	25,146	60,509	92,592	157,246	342,981	592,819	108,135	177,066	368,127	653,328	5				
0040	NH ORLANDO	17,082	11,164	51,568	79,814	182,076	276,707	525,173	983,956	199,158	287,871	576,741	1,063,770	3				
0032	EVANS ACH	17,427	32,728	29,206	79,361	131,545	190,976	330,939	653,460	148,972	223,704	360,145	732,821	8				
0098	REYNOLDS ACH	17,428	24,190	17,719	59,337	144,598	232,290	513,553	890,441	162,026	256,480	531,272	949,778	6				
0105	MONCRIEF ACH	18,426	11,467	25,190	55,083	180,732	276,404	551,551	1,008,687	199,158	287,871	576,741	1,063,770	3				
0060	BLANCHFIELD ACH	19,197	31,051	18,446	68,694	88,938	146,015	349,681	584,634	108,135	177,066	368,127	653,328	5				
0049	WINN ACH	19,391	27,949	15,117	62,457	179,767	259,922	561,624	1,001,313	199,158	287,871	576,741	1,063,770	3				
0048	MARTIN ACH	23,184	28,208	28,091	79,483	175,974	259,663	548,650	984,287	199,158	287,871	576,741	1,063,770	3				
0103	NH CHARLESTON	23,285	40,431	33,192	96,908	175,873	247,440	543,549	966,862	199,158	287,871	576,741	1,063,770	3				
0056	NH GREAT LAKES	25,771	19,121	23,658	68,550	82,364	157,945	344,469	584,778	108,135	177,066	368,127	653,328	5				
0039	NH JACKSONVILLE	26,981	48,057	55,127	130,165	172,177	239,814	521,614	933,605	199,158	287,871	576,741	1,063,770	3				
0110	DARNALL ACH	34,587	46,600	33,833	115,020	127,439	209,880	497,439	834,758	162,026	256,480	531,272	949,778	6				
0024	NH CAMP PENDLETON	35,852	40,936	29,741	106,529	145,690	185,605	272,637	603,932	181,542	226,541	302,378	710,461	9				
0091	NH CAMP LEJEUNE	36,331	41,129	15,478	92,938	187,330	297,464	294,279	779,073	223,661	338,593	309,757	872,011	2				
0089	WOMACK AMC	45,887	70,107	44,384	160,378	177,774	268,486	265,373	711,633	223,661	338,593	309,757	872,011	2				

CONUS Community Hospitals (continued)

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25th Percentile = 4,801  
Median = 6,240  
75th Percentile = 13,059

FY 93 POPULATION DATA

REGION 1

Community Hospitals

DMIS ID	Name	40 mile Catchment				Region less Catchment Pop				Region			
		Active Duty	FM of AD	All Others	Total	Active Duty	FM of AD	All Others	Total	Active Duty	FM of AD	All Others	Total
65	42nd MEDICAL GROUP	1,728	3,487	1,774	6,989	194,828	307,287	584,814	1,086,929	196,556	310,774	586,588	1,093,918
87	380th MEDICAL GROUP	2,376	3,807	3,754	9,937	194,180	306,967	582,834	1,083,981	196,556	310,774	586,588	1,093,918
68	NH PATUXENT RIVER	3,378	5,443	5,995	14,816	193,178	305,331	580,593	1,079,102	196,556	310,774	586,588	1,093,918
88	416th MEDICAL GROUP	4,605	7,506	8,909	21,020	191,951	303,268	577,679	1,072,898	196,556	310,774	586,588	1,093,918
36	436th MEDICAL GROUP	4,883	8,234	14,108	27,225	191,673	302,540	572,480	1,066,693	196,556	310,774	586,588	1,093,918
81	PATTERSON ACH	5,408	7,361	16,356	29,125	191,148	303,413	570,232	1,064,793	196,556	310,774	586,588	1,093,918
100	NH NEWPORT	5,772	9,660	17,575	33,007	190,784	301,114	569,013	1,060,911	196,556	310,774	586,588	1,093,918
86	KELLER ACH	6,633	7,699	15,663	29,995	189,923	303,075	570,925	1,063,923	196,556	310,774	586,588	1,093,918
70	CUTLER ACH	7,481	13,495	33,578	54,554	189,075	297,279	553,010	1,039,364	196,556	310,774	586,588	1,093,918
35	NH GROTON	9,225	14,450	15,773	39,448	187,331	296,324	570,815	1,054,470	196,556	310,774	586,588	1,093,918
326	438th MEDICAL GROUP	13,004	21,944	45,436	80,384	183,552	288,830	541,152	1,013,534	196,556	310,774	586,588	1,093,918
123	DEWITT ACH	13,225	56,508	65,047	134,780	183,331	254,266	521,541	959,138	196,556	310,774	586,588	1,093,918
69	KIMBROUGH ACH	14,609	22,029	25,996	62,634	181,947	288,745	560,592	1,031,284	196,556	310,774	586,588	1,093,918

MEDIAN = 5,772

Medical Centers

DMIS ID	Name	40 mile Catchment				Region less Catchment Pop				Region			
		Active Duty	FM of AD	All Others	Total	Active Duty	FM of AD	All Others	Total	Active Duty	FM of AD	All Others	Total
66	MALCOLM GROW	14,270	19,709	29,398	63,377	182,286	291,065	557,190	1,030,541	196,556	310,774	586,588	1,093,918
37	WALTER REED AMC	14,919	9,683	22,953	47,555	181,637	301,091	563,635	1,046,363	196,556	310,774	586,588	1,093,918
67	NNMC BETHESDA	24,515	21,875	39,554	85,944	172,041	288,899	547,034	1,007,974	196,556	310,774	586,588	1,093,918

MEDIAN = 14,919

REGION 1 (continued)

Non Catchment Areas

DMIS ID	Name	Non Catchment Area				Region less Non Catchment Area				Region			
		Active Duty	FM of AD	All Others	Total	Active Duty	FM of AD	All Others	Total	Active Duty	FM of AD	All Others	Total
940	RHODE ISLAND	0	775	118	893	196,556	309,999	586,470	1,093,025	196,556	310,774	586,588	1,093,918
908	DELAWARE	10	636	1,589	2,235	196,546	310,138	584,999	1,091,683	196,556	310,774	586,588	1,093,918
946	VERMONT	482	1,042	5,525	7,049	196,074	309,732	581,063	1,086,869	196,556	310,774	586,588	1,093,918
907	CONNECTICUT	603	1,416	6,646	8,665	195,953	309,358	579,942	1,085,253	196,556	310,774	586,588	1,093,918
995	NORTHERN VIRGINIA	1,241	1,315	7,943	10,499	195,315	309,459	578,645	1,083,419	196,556	310,774	586,588	1,093,918
921	MARYLAND	1,359	2,349	5,886	9,594	195,197	308,425	580,702	1,084,324	196,556	310,774	586,588	1,093,918
922	MASSACHUSETTS	2,430	4,742	14,946	22,118	194,126	306,032	571,642	1,071,800	196,556	310,774	586,588	1,093,918
931	NEW JERSEY	2,544	2,254	5,954	10,752	194,012	308,520	580,634	1,083,166	196,556	310,774	586,588	1,093,918
930	NEW HAMPSHIRE	3,922	1,569	11,914	17,405	192,634	309,205	574,674	1,076,513	196,556	310,774	586,588	1,093,918
920	MAINE	5,198	8,258	23,767	37,223	191,358	302,516	562,821	1,056,695	196,556	310,774	586,588	1,093,918
939	PENNSYLVANIA	6,876	14,635	70,651	92,162	189,680	296,139	515,937	1,001,756	196,556	310,774	586,588	1,093,918
933	NEW YORK	20,520	29,162	52,362	102,044	176,036	281,612	534,226	991,874	196,556	310,774	586,588	1,093,918

MEDIAN = 1,895

USTF

DMIS ID	Name	40 mile Catchment				Region less 40 mile				Region			
		Active Duty	FM of AD	All Others	Total	Active Duty	FM of AD	All Others	Total	Active Duty	FM of AD	All Others	Total
190	WYMAN PARK Baltimore	5,340	9,731	17,418	32,489	191,216	301,043	569,170	1,061,429	196,556	310,774	586,588	1,093,918

**REGION 2**

**Community Hospitals**

DMIS ID	Name	40 mile Catchment				Region less Catchment Pop				Region			
		Active Duty	FM of AD	All Others	Total	Active Duty	FM of AD	All Others	Total	Active Duty	FM of AD	All Others	Total
0090	4th MEDICAL GROUP	5,085	9,503	13,518	28,106	218,576	329,090	296,239	843,905	223,661	338,593	309,757	872,011
0122	KENNER ACH	6,969	9,348	21,927	38,244	216,692	329,245	287,830	833,767	223,661	338,593	309,757	872,011
0121	MCDONALD ACH	8,688	20,222	17,991	46,901	214,973	318,371	291,766	825,110	223,661	338,593	309,757	872,011
0092	NH CHERRY POINT	9,199	13,269	9,226	31,694	214,462	325,324	300,531	840,317	223,661	338,593	309,757	872,011
0120	1st MEDICAL GROUP	9,714	24,588	21,556	55,858	213,947	314,005	288,201	816,153	223,661	338,593	309,757	872,011
0091	NH CAMP LEJEUNE	36,331	41,129	15,478	92,938	187,330	297,464	294,279	779,073	223,661	338,593	309,757	872,011
0089	WOMACK AMC	45,887	70,107	44,384	160,378	177,774	268,486	265,373	711,633	223,661	338,593	309,757	872,011

MEDIAN = 9,199

**Medical Centers**

DMIS ID	Name	40 mile Catchment				Region less Catchment Pop				Region			
		Active Duty	FM of AD	All Others	Total	Active Duty	FM of AD	All Others	Total	Active Duty	FM of AD	All Others	Total
0124	NH PORTSMOUTH	95,865	136,495	80,377	312,737	127,796	202,098	229,380	559,274	223,661	338,593	309,757	872,011

**Non Catchment Areas**

DMIS ID	Name	Non Catchment Area				Region less Non Catchment Area				Region			
		Active Duty	FM of AD	All Others	Total	Active Duty	FM of AD	All Others	Total	Active Duty	FM of AD	All Others	Total
0996	SOUTHERN VIRGINIA	1,894	3,185	22,373	27,452	221,767	335,408	287,384	844,559	223,661	338,593	309,757	872,011
0934	NORTH CAROLINA	4,029	10,747	62,927	77,703	219,632	327,846	246,830	794,308	223,661	338,593	309,757	872,011

MEDIAN = 2,962

FY 93 POPULATION DATA

**REGION 2**

**Community Hospitals**

DMIS ID	Name	40 mile Catchment				Region less Catchment Pop				Region			
		Active Duty	FM of AD	All Others	Total	Active Duty	FM of AD	All Others	Total	Active Duty	FM of AD	All Others	Total
0090	4th MEDICAL GROUP	5,085	9,503	13,518	28,106	218,576	329,090	296,239	843,905	223,661	338,593	309,757	872,011
0122	KENNER ACH	6,969	9,348	21,927	38,244	216,692	329,245	287,830	833,767	223,661	338,593	309,757	872,011
0121	MCDONALD ACH	8,688	20,222	17,991	46,901	214,973	318,371	291,766	825,110	223,661	338,593	309,757	872,011
0092	NH CHERRY POINT	9,199	13,269	9,226	31,694	214,462	325,324	300,531	840,317	223,661	338,593	309,757	872,011
0120	1st MEDICAL GROUP	9,714	24,588	21,556	55,858	213,947	314,005	288,201	816,153	223,661	338,593	309,757	872,011
0091	NH CAMP LEJEUNE	36,331	41,129	15,478	92,938	187,330	297,464	294,279	779,073	223,661	338,593	309,757	872,011
0089	WOMACK AMC	45,887	70,107	44,384	160,378	177,774	268,486	265,373	711,633	223,661	338,593	309,757	872,011

MEDIAN = 9,199

**Medical Centers**

DMIS ID	Name	40 mile Catchment				Region less Catchment Pop				Region			
		Active Duty	FM of AD	All Others	Total	Active Duty	FM of AD	All Others	Total	Active Duty	FM of AD	All Others	Total
0124	NH PORTSMOUTH	95,865	136,495	80,377	312,737	127,796	202,098	229,380	559,274	223,661	338,593	309,757	872,011

**Non Catchment Areas**

DMIS ID	Name	Non Catchment Area				Region less Non Catchment Area				Region			
		Active Duty	FM of AD	All Others	Total	Active Duty	FM of AD	All Others	Total	Active Duty	FM of AD	All Others	Total
0996	SOUTHERN VIRGINIA	1,894	3,185	22,373	27,452	221,767	335,408	287,384	844,559	223,661	338,593	309,757	872,011
0934	NORTH CAROLINA	4,029	10,747	62,927	77,703	219,632	327,846	246,830	794,308	223,661	338,593	309,757	872,011

MEDIAN = 2,962

FY 93 POPULATION DATA

REGION 3

Community Hospitals

DMIS ID	Name	40 mile Catchment				Region less Catchment Pop				Region			
		Active Duty	FM of AD	All Others	Total	Active Duty	FM of AD	All Others	Total	Active Duty	FM of AD	All Others	Total
0046	45th MEDICAL GROUP	3,577	7,949	30,703	42,229	195,581	279,922	546,038	1,021,541	199,158	287,871	576,741	1,063,770
0050	347th MEDICAL GROUP	4,018	6,492	7,220	17,730	195,140	281,379	569,521	1,046,040	199,158	287,871	576,741	1,063,770
0051	653rd MEDICAL GROUP	4,475	8,848	16,556	29,879	194,683	279,023	560,185	1,033,891	199,158	287,871	576,741	1,063,770
0101	363rd MEDICAL GROUP	6,329	11,063	10,751	28,143	192,829	276,808	565,990	1,035,627	199,158	287,871	576,741	1,063,770
0045	56th MEDICAL GROUP	6,485	15,873	71,653	94,011	192,673	271,998	505,088	969,759	199,158	287,871	576,741	1,063,770
0104	NH BEAUFORT	13,910	10,158	7,726	31,794	185,248	277,713	569,015	1,031,976	199,158	287,871	576,741	1,063,770
0040	NH ORLANDO	17,082	11,164	51,568	79,814	182,076	276,707	525,173	983,956	199,158	287,871	576,741	1,063,770
0105	MONCRIEF ACH	18,426	11,467	25,190	55,083	180,732	276,404	551,551	1,008,687	199,158	287,871	576,741	1,063,770
0049	WINN ACH	19,391	27,949	15,117	62,457	179,767	259,922	561,624	1,001,313	199,158	287,871	576,741	1,063,770
0048	MARTIN ACH	23,184	28,208	28,091	79,483	175,974	259,663	548,650	984,287	199,158	287,871	576,741	1,063,770
0103	NH CHARLESTON	23,285	40,431	33,192	96,908	175,873	247,440	543,549	966,862	199,158	287,871	576,741	1,063,770
0039	NH JACKSONVILLE	26,981	48,057	55,127	130,165	172,177	239,814	521,614	933,605	199,158	287,871	576,741	1,063,770

MEDIAN = 15,496

Medical Centers

DMIS ID	Name	40 mile Catchment				Region less Catchment Pop				Region			
		Active Duty	FM of AD	All Others	Total	Active Duty	FM of AD	All Others	Total	Active Duty	FM of AD	All Others	Total
0047	EISENHOWER AMC	8,168	15,239	26,997	50,404	190,990	272,632	549,744	1,013,366	199,158	287,871	576,741	1,063,770

Non Catchment Areas

DMIS ID	Name	Non Catchment Area				Region less Non Catchment Area				Region			
		Active Duty	FM of AD	All Others	Total	Active Duty	FM of AD	All Others	Total	Active Duty	FM of AD	All Others	Total
0941	SOUTH CAROLINA	898	5,092	31,205	37,195	198,260	282,779	545,536	1,026,575	199,158	287,871	576,741	1,063,770
0987	EASTERN FLORIDA	9,171	14,591	89,219	112,981	189,987	273,280	487,522	950,789	199,158	287,871	576,741	1,063,770
0911	GEORGIA	13,778	25,290	76,426	115,494	185,380	262,581	500,315	948,276	199,158	287,871	576,741	1,063,770

MEDIAN = 9,171

FY 93 POPULATION DATA

REGION 4

Community Hospitals

DMIS ID	Name	40 mile Catchment				Region less Catchment Pop				Region			
		Active Duty	FM of AD	All Others	Total	Active Duty	FM of AD	All Others	Total	Active Duty	FM of AD	All Others	Total
0074	14th MEDICAL SQUADRON	1,528	2,745	4,933	9,206	97,100	155,129	333,589	585,818	98,628	157,874	338,522	595,024
0001	FOX ACH	2,709	7,001	20,932	30,642	95,919	150,873	317,590	564,382	98,628	157,874	338,522	595,024
0002	NOBLE ACH	5,520	6,888	13,540	25,948	93,108	150,986	324,982	569,076	98,628	157,874	338,522	595,024
0003	LYSTER ACH	5,704	11,578	16,239	33,521	92,924	146,296	322,283	561,503	98,628	157,874	338,522	595,024
0043	325th MEDICAL GROUP	5,783	10,809	14,924	31,516	92,845	147,065	323,598	563,508	98,628	157,874	338,522	595,024
0107	NH MILLINGTON	8,254	11,912	20,611	40,777	90,374	145,962	317,911	554,247	98,628	157,874	338,522	595,024
0038	NH PENSACOLA	10,300	18,767	36,360	65,427	88,328	139,107	302,162	529,597	98,628	157,874	338,522	595,024
0042	646th MEDICAL GROUP	15,012	26,843	32,068	73,923	83,616	131,031	306,454	521,101	98,628	157,874	338,522	595,024

MEDIAN = 5,744

Medical Centers

DMIS ID	Name	40 mile Catchment				Region less Catchment Pop				Region			
		Active Duty	FM of AD	All Others	Total	Active Duty	FM of AD	All Others	Total	Active Duty	FM of AD	All Others	Total
0004	502nd MEDICAL GROUP	5,857	10,885	20,127	36,869	92,771	146,989	318,395	558,155	98,628	157,874	338,522	595,024
0073	KEESLER MED CTR	15,397	17,510	22,215	55,122	83,231	140,364	316,307	539,902	98,628	157,874	338,522	595,024

MEDIAN = 10,627

Non Catchment Areas

DMIS ID	Name	Non Catchment Area				Region less Non Catchment Area				Region			
		Active Duty	FM of AD	All Others	Total	Active Duty	FM of AD	All Others	Total	Active Duty	FM of AD	All Others	Total
0988	WESTERN FLORIDA	256	951	7,013	8,220	98,372	156,923	331,509	586,804	98,628	157,874	338,522	595,024
0925	MISSISSIPPI	4,458	6,978	24,499	35,935	94,170	150,896	314,023	559,089	98,628	157,874	338,522	595,024
0943	TENNESSEE	5,212	6,389	52,100	63,701	93,416	151,485	286,422	531,323	98,628	157,874	338,522	595,024
0901	ALABAMA	5,461	7,414	30,669	43,544	93,167	150,460	307,853	551,480	98,628	157,874	338,522	595,024
0989	EASTERN LOUISIANA	7,177	11,204	22,292	40,673	91,451	146,670	316,230	554,351	98,628	157,874	338,522	595,024

MEDIAN = 5,212

**REGION 5**

**Community Hospitals**

DMIS ID	Name	40 mile Catchment				Region less Catchment Pop				Region			
		Active Duty	FM of AD	All Others	Total	Active Duty	FM of AD	All Others	Total	Active Duty	FM of AD	All Others	Total
0072	410th MEDICAL GROUP	2,940	5,223	2,995	11,158	105,195	171,843	365,132	642,170	108,135	177,066	368,127	653,328
0061	IRELAND ACH	15,543	19,820	25,146	60,509	92,592	157,246	342,981	592,819	108,135	177,066	368,127	653,328
0060	BLANCHFIELD ACH	19,197	31,051	18,446	68,694	88,938	146,015	349,681	584,634	108,135	177,066	368,127	653,328
0056	NH GREAT LAKES	25,771	19,121	23,658	68,550	82,364	157,945	344,469	584,778	108,135	177,066	368,127	653,328

MEDIAN = 17,370

**Medical Centers**

DMIS ID	Name	40 mile Catchment				Region less Catchment Pop				Region			
		Active Duty	FM of AD	All Others	Total	Active Duty	FM of AD	All Others	Total	Active Duty	FM of AD	All Others	Total
0095	WRIGHT-PATTERSON	9,463	18,656	27,959	56,078	98,672	158,410	340,168	597,250	108,135	177,066	368,127	653,328
0055	SCOTT	9,540	19,798	30,687	60,025	98,595	157,268	337,440	593,303	108,135	177,066	368,127	653,328

MEDIAN = 9,502

**Non Catchment Areas**

DMIS ID	Name	Non Catchment Area				Region less Non Catchment Area				Region			
		Active Duty	FM of AD	All Others	Total	Active Duty	FM of AD	All Others	Total	Active Duty	FM of AD	All Others	Total
0918	KENTUCKY	1,345	4,103	23,533	28,981	106,790	172,963	344,594	624,347	108,135	177,066	368,127	653,328
0949	WEST VIRGINIA	1,611	3,618	18,933	24,162	106,524	173,448	349,194	629,166	108,135	177,066	368,127	653,328
0914	ILLINOIS	2,173	8,781	31,111	42,065	105,962	168,285	337,016	611,263	108,135	177,066	368,127	653,328
0950	WISCONSIN	4,232	5,757	26,683	36,672	103,903	171,309	341,444	616,656	108,135	177,066	368,127	653,328
0936	OHIO	4,812	12,862	53,057	70,731	103,323	164,204	315,070	582,597	108,135	177,066	368,127	653,328
0923	MICHIGAN	5,192	14,264	44,719	64,175	102,943	162,802	323,408	589,153	108,135	177,066	368,127	653,328
0915	INDIANA	6,316	14,012	41,200	61,528	101,819	163,054	326,927	591,800	108,135	177,066	368,127	653,328

MEDIAN = 4,232

FY 93 POPULATION DATA

REGION 6

Community Hospitals

DMIS ID	Name	40 mile Catchment				Region less Catchment Pop				Region			
		Active Duty	FM of AD	All Others	Total	Active Duty	FM of AD	All Others	Total	Active Duty	FM of AD	All Others	Total
0114	47th MEDICAL SQUADRON	1,228	1,796	2,135	5,159	160,798	254,684	529,137	944,619	162,026	256,480	531,272	949,778
0111	64th MEDICAL SQUADRON	1,333	2,911	5,025	9,269	160,693	253,569	526,247	940,509	162,026	256,480	531,272	949,778
0097	97th MEDICAL GROUP	3,117	4,895	3,557	11,569	158,909	251,585	527,715	938,209	162,026	256,480	531,272	949,778
0118	NH CORPUS CHRISTI	4,301	7,878	11,590	23,769	157,725	248,602	519,682	926,009	162,026	256,480	531,272	949,778
0112	96th MEDICAL GROUP	5,213	8,836	8,121	22,170	156,813	247,644	523,151	927,608	162,026	256,480	531,272	949,778
0013	314th MEDICAL GROUP	5,603	10,909	20,604	37,116	156,423	245,571	510,668	912,662	162,026	256,480	531,272	949,778
0062	2nd MEDICAL GROUP	5,906	10,537	17,033	33,476	156,120	245,943	514,239	916,302	162,026	256,480	531,272	949,778
0113	396th MEDICAL GROUP	6,217	7,291	8,774	22,282	155,809	249,189	522,498	927,496	162,026	256,480	531,272	949,778
0096	654th MEDICAL GROUP	9,246	16,790	28,410	54,446	152,780	239,690	502,862	895,332	162,026	256,480	531,272	949,778
0064	BAYNE-JONES ACH	14,057	15,352	7,829	37,238	147,969	241,128	523,443	912,540	162,026	256,480	531,272	949,778
0098	REYNOLDS ACH	17,428	24,190	17,719	59,337	144,598	232,290	513,553	890,441	162,026	256,480	531,272	949,778
0110	DARNALL ACH	34,587	46,600	33,833	115,020	127,439	209,880	497,439	834,758	162,026	256,480	531,272	949,778

MEDIAN = 5,755

Medical Centers

DMIS ID	Name	40 mile Catchment				Region less Catchment Pop				Region			
		Active Duty	FM of AD	All Others	Total	Active Duty	FM of AD	All Others	Total	Active Duty	FM of AD	All Others	Total
0109	BROOKE AMC	15,645	25,555	56,643	97,843	146,381	230,925	474,629	851,935	162,026	256,480	531,272	949,778
0117	WILFORD HALL	21,945	22,841	45,397	90,183	140,081	233,639	485,875	859,595	162,026	256,480	531,272	949,778

MEDIAN = 18,795

FY 93 POPULATION DATA

REGION 6 (continued)

Non Catchment Areas

DMIS ID	Name	Non Catchment Area				Region less Non Catchment Area				Region			
		Active Duty	FM of AD	All Others	Total	Active Duty	FM of AD	All Others	Total	Active Duty	FM of AD	All Others	Total
0990	WESTERN LOUISIANA	894	4,496	18,099	23,489	161,132	251,984	513,173	926,289	162,026	256,480	531,272	949,778
0904	ARKANSAS	1,286	4,524	30,973	36,783	160,740	251,956	500,299	912,995	162,026	256,480	531,272	949,778
0937	OKLAHOMA	2,334	5,034	25,697	33,065	159,692	251,446	505,575	916,713	162,026	256,480	531,272	949,778
0993	EASTERN TEXAS	9,877	30,251	165,916	206,044	152,149	226,229	365,356	743,734	162,026	256,480	531,272	949,778

MEDIAN = 1,810

USTF

DMIS ID	Name	40 mile Catchment				Region less Catchment Pop				Region			
		Active Duty	FM of AD	All Others	Total	Active Duty	FM of AD	All Others	Total	Active Duty	FM of AD	All Others	Total
0192	ST JOHNS - NASSAU BAY	1,809	5,794	23,917	31,520	160,217	250,686	507,355	918,258	162,026	256,480	531,272	949,778

FY 93 POPULATION DATA

**REGION 7**

**Community Hospitals**

DMIS ID	Name	40 mile Catchment				Region less Catchment Pop				Region			
		Active Duty	FM of AD	All Others	Total	Active Duty	FM of AD	All Others	Total	Active Duty	FM of AD	All Others	Total
0085	27th MEDICAL GROUP	5,217	7,938	3,465	16,620	47,950	83,976	174,512	306,438	53,167	91,914	177,977	323,058
0083	542nd MEDICAL GROUP	5,236	10,522	23,711	39,469	47,931	81,392	154,266	283,589	53,167	91,914	177,977	323,058
0010	355th MEDICAL GROUP	5,517	11,645	26,452	43,614	47,650	80,269	151,525	279,444	53,167	91,914	177,977	323,058
0084	49th MEDICAL GROUP	5,633	9,893	6,075	21,601	47,534	82,021	171,902	301,457	53,167	91,914	177,977	323,058
0008	BLISS ACH	5,819	8,192	10,241	24,252	47,348	83,722	167,736	298,806	53,167	91,914	177,977	323,058
0009	58th MEDICAL GROUP	6,429	14,009	46,412	66,850	46,738	77,905	131,565	256,208	53,167	91,914	177,977	323,058

MEDIAN = 5,575

**Medical Centers**

DMIS ID	Name	40 mile Catchment				Region less Catchment Pop				Region			
		Active Duty	FM of AD	All Others	Total	Active Duty	FM of AD	All Others	Total	Active Duty	FM of AD	All Others	Total
0108	WILLIAM BEAUMONT	14,333	20,877	30,465	65,675	38,834	71,037	147,512	257,383	53,167	91,914	177,977	323,058

**Non Catchment Areas**

DMIS ID	Name	Non Catchment Area				Region less Non Catchment Area				Region			
		Active Duty	FM of AD	All Others	Total	Active Duty	FM of AD	All Others	Total	Active Duty	FM of AD	All Others	Total
0994	WESTERN TEXAS	16	31	215	262	53,151	91,883	177,762	322,796	53,167	91,914	177,977	323,058
0932	NEW MEXICO	384	1,986	11,595	13,965	52,783	89,928	166,382	309,093	53,167	91,914	177,977	323,058
0903	ARIZONA	4,583	6,821	19,346	30,750	48,584	85,093	158,631	292,308	53,167	91,914	177,977	323,058

MEDIAN = 384

**REGION 8**

**Community Hospitals**

DMIS ID	Name	40 mile Catchment				Region less Catchment Pop				Region			
		Active Duty	FM of AD	All Others	Total	Active Duty	FM of AD	All Others	Total	Active Duty	FM of AD	All Others	Total
0053	366th MEDICAL GROUP	3,472	6,096	4,670	14,238	154,215	234,550	402,371	791,136	157,687	240,646	407,041	805,374
0129	90th MEDICAL GROUP	3,722	5,921	5,314	14,957	153,965	234,725	401,727	790,417	157,687	240,646	407,041	805,374
0076	351st MEDICAL GROUP	3,830	5,405	5,112	14,347	153,857	235,241	401,929	791,027	157,687	240,646	407,041	805,374
0093	319th MEDICAL GROUP	4,822	7,852	2,723	15,397	152,865	232,794	404,318	789,977	157,687	240,646	407,041	805,374
0094	5th MEDICAL GROUP	5,030	7,128	2,185	14,343	152,657	233,518	404,856	791,031	157,687	240,646	407,041	805,374
0106	28th MEDICAL GROUP	5,364	10,255	5,745	21,364	152,323	230,391	401,296	784,010	157,687	240,646	407,041	805,374
0119	649th MEDICAL GROUP	6,262	11,777	18,996	37,035	151,425	228,869	388,045	768,339	157,687	240,646	407,041	805,374
0079	554th MEDICAL GROUP	7,293	14,333	34,986	56,612	150,394	226,313	372,055	748,762	157,687	240,646	407,041	805,374
0058	MUNSON ACH	9,118	11,604	20,754	41,476	148,569	229,042	386,287	763,898	157,687	240,646	407,041	805,374
0078	EHRLING BERQUIST	10,114	18,885	22,152	51,151	147,573	221,761	384,889	754,223	157,687	240,646	407,041	805,374
0075	L. WOOD ACH	12,732	11,616	9,794	34,142	144,955	229,030	397,247	771,232	157,687	240,646	407,041	805,374
0033	USAF ACADEMY	13,316	12,835	21,043	47,194	144,371	227,811	385,998	758,180	157,687	240,646	407,041	805,374
0057	IRWIN ACH	14,839	20,870	8,687	44,396	142,848	219,776	398,354	760,978	157,687	240,646	407,041	805,374
0032	EVANS ACH	17,427	32,728	29,206	79,361	140,260	207,918	377,835	726,013	157,687	240,646	407,041	805,374

MEDIAN = 6,778

**Medical Centers**

DMIS ID	Name	40 mile Catchment				Region less Catchment Pop				Region			
		Active Duty	FM of AD	All Others	Total	Active Duty	FM of AD	All Others	Total	Active Duty	FM of AD	All Others	Total
0031	FITZSIMONS	8,719	12,650	40,371	61,740	148,968	227,996	366,670	743,634	157,687	240,646	407,041	805,374

FY 93 POPULATION DATA

REGION 8 (continued)

Non Catchment Areas

DMIS ID	Name	Non Catchment Area				Region less Non Catchment Area				Region			
		Active Duty	FM of AD	All Others	Total	Active Duty	FM of AD	All Others	Total	Active Duty	FM of AD	All Others	Total
0951	WYOMING	246	770	3,697	4,713	157,441	239,876	403,344	800,661	157,687	240,646	407,041	805,374
0906	COLORADO	489	1,199	9,958	11,646	157,198	239,447	397,083	793,728	157,687	240,646	407,041	805,374
0942	SOUTH DAKOTA	617	1,507	4,859	6,983	157,070	239,139	402,182	798,391	157,687	240,646	407,041	805,374
0928	NEBRASKA	646	1,437	7,788	9,871	157,041	239,209	399,253	795,503	157,687	240,646	407,041	805,374
0935	NORTH DAKOTA	661	1,128	3,161	4,950	157,026	239,518	403,880	800,424	157,687	240,646	407,041	805,374
0945	UTAH	1,061	1,778	6,176	9,015	156,626	238,868	400,865	796,359	157,687	240,646	407,041	805,374
0929	NEVADA	1,422	2,609	11,910	15,941	156,265	238,037	395,131	789,433	157,687	240,646	407,041	805,374
0913	IDAHO	2,379	3,868	15,122	21,369	155,308	236,778	391,919	784,005	157,687	240,646	407,041	805,374
0924	MINNESOTA	2,762	5,465	26,766	34,993	154,925	235,181	380,275	770,381	157,687	240,646	407,041	805,374
0917	KANSAS	4,439	12,678	22,810	39,927	153,248	227,968	384,231	765,447	157,687	240,646	407,041	805,374
0926	MISSOURI	4,450	5,288	32,641	42,379	153,237	235,358	374,400	762,995	157,687	240,646	407,041	805,374
0927	MONTANA	5,247	8,852	13,823	27,922	152,440	231,794	393,218	777,452	157,687	240,646	407,041	805,374
0916	IOWA	7,208	4,112	16,592	27,912	150,479	236,534	390,449	777,462	157,687	240,646	407,041	805,374

MEDIAN = 1,422

FY 93 POPULATION DATA

REGION 9

Community Hospitals

DMIS ID	Name	40 mile Catchment				Region less Catchment Pop				Region			
		Active Duty	FM of AD	All Others	Total	Active Duty	FM of AD	All Others	Total	Active Duty	FM of AD	All Others	Total
0018	30th MED GROUP	3,283	6,371	9,554	19,208	178,259	220,170	292,824	691,253	181,542	226,541	302,378	710,461
0019	650th MED GROUP	4,552	7,529	7,683	19,764	176,990	219,012	294,695	690,697	181,542	226,541	302,378	710,461
0021	22nd MED GROUP	4,952	14,160	45,048	64,160	176,590	212,381	257,330	646,301	181,542	226,541	302,378	710,461
0131	WEED ACH	5,210	6,906	2,156	14,272	176,332	219,635	300,222	696,189	181,542	226,541	302,378	710,461
0030	TWENTYNINE PALMS	9,253	7,971	2,948	20,172	172,289	218,570	299,430	690,289	181,542	226,541	302,378	710,461
0025	NH LONG BEACH	23,181	35,998	67,345	126,524	158,361	190,543	235,033	583,937	181,542	226,541	302,378	710,461
0024	CAMP PENDLETON	35,852	40,936	29,741	106,529	145,690	185,605	272,637	603,932	181,542	226,541	302,378	710,461

MEDIAN = 5,210

Medical Centers

DMIS ID	Name	40 mile Catchment				Region less Catchment Pop				Region			
		Active Duty	FM of AD	All Others	Total	Active Duty	FM of AD	All Others	Total	Active Duty	FM of AD	All Others	Total
0029	NH SAN DIEGO	86,867	94,091	104,257	285,215	94,675	132,450	198,121	425,246	181,542	226,541	302,378	710,461

Non Catchment Areas

DMIS ID	Name	Non Catchment Area				Region less Non Catchment Area				Region			
		Active Duty	FM of AD	All Others	Total	Active Duty	FM of AD	All Others	Total	Active Duty	FM of AD	All Others	Total
0986	SOUTHERN CALIF	8,392	12,579	33,646	54,617	173,150	213,962	268,732	655,844	181,542	226,541	302,378	710,461

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REGION 10

Community Hospitals

DMIS ID	Name	40 mile Catchment				Region less Catchment Pop				Region			
		Active Duty	FM of AD	All Others	Total	Active Duty	FM of AD	All Others	Total	Active Duty	FM of AD	All Others	Total
0022	LETTERMAN	2,435	6,869	20,463	29,767	59,833	100,912	192,078	352,823	62,268	107,781	212,541	382,590
0015	9th MEDICAL GROUP	3,554	5,232	10,430	19,216	58,714	102,549	202,111	363,374	62,268	107,781	212,541	382,590
0017	93rd MEDICAL GROUP	3,995	8,060	12,347	24,402	58,273	99,721	200,194	358,188	62,268	107,781	212,541	382,590
0250	652nd MEDICAL GROUP	4,736	10,295	46,728	61,759	57,532	97,486	165,813	320,831	62,268	107,781	212,541	382,590
0028	NH LEMOORE	5,037	9,423	10,193	24,653	57,231	98,358	202,348	357,937	62,268	107,781	212,541	382,590
0023	HAYS ACH	8,796	22,283	17,595	48,674	53,472	85,498	194,946	333,916	62,268	107,781	212,541	382,590

MEDIAN = 4,366

Medical Centers

DMIS ID	Name	40 mile Catchment				Region less Catchment Pop				Region			
		Active Duty	FM of AD	All Others	Total	Active Duty	FM of AD	All Others	Total	Active Duty	FM of AD	All Others	Total
0014	DAVID GRANT	8,224	15,425	29,482	53,131	54,044	92,356	183,059	329,459	62,268	107,781	212,541	382,590
0027	NH OAKLAND	23,276	26,800	45,789	95,865	38,992	80,981	166,752	286,725	62,268	107,781	212,541	382,590

MEDIAN = 15,750

Non Catchment Areas

DMIS ID	Name	Non Catchment Area				Region less Non Catchment Area				Region			
		Active Duty	FM of AD	All Others	Total	Active Duty	FM of AD	All Others	Total	Active Duty	FM of AD	All Others	Total
0985	NORTHERN CALIFORNIA	2,215	3,394	19,514	25,123	60,053	104,387	193,027	357,467	62,268	107,781	212,541	382,590

**REGION 11**

**Community Hospitals**

DMIS ID	Name	40 mile Catchment				Region less Catchment Pop				Region			
		Active Duty	FM of AD	All Others	Total	Active Duty	FM of AD	All Others	Total	Active Duty	FM of AD	All Others	Total
0128	92nd MEDICAL GROUP	4,573	8,773	15,432	28,778	49,424	90,453	181,784	321,661	53,997	99,226	197,216	350,439
0127	NH OAK HARBOR	8,041	11,428	8,224	27,693	45,956	87,798	188,992	322,746	53,997	99,226	197,216	350,439
0126	NH BREMERTON	9,690	23,286	19,560	52,536	44,307	75,940	177,656	297,903	53,997	99,226	197,216	350,439

MEDIAN = 8,041

**Medical Centers**

DMIS ID	Name	40 mile Catchment				Region less Catchment Pop				Region			
		Active Duty	FM of AD	All Others	Total	Active Duty	FM of AD	All Others	Total	Active Duty	FM of AD	All Others	Total
0125	MADIGAN	24,294	39,162	58,160	121,616	29,703	60,064	139,056	228,823	53,997	99,226	197,216	350,439

**Non Catchment Areas**

DMIS ID	Name	Non Catchment Area				Region less Non Catchment Area				Region			
		Active Duty	FM of AD	All Others	Total	Active Duty	FM of AD	All Others	Total	Active Duty	FM of AD	All Others	Total
0948	WASHINGTON	1,325	4,000	25,127	30,452	52,672	95,226	172,089	319,987	53,997	99,226	197,216	350,439
0938	OREGON	3,077	6,256	41,384	50,717	50,920	92,970	155,832	299,722	53,997	99,226	197,216	350,439

MEDIAN = 2,201

**USTF**

DMIS ID	Name	40 mile Catchment				Region less 40 mile				Region			
		Active Duty	FM of AD	All Others	Total	Active Duty	FM of AD	All Others	Total	Active Duty	FM of AD	All Others	Total
0194	PACIFIC MEDICAL	2,997	6,321	29,329	38,647	51,000	92,905	167,887	311,792	53,997	99,226	197,216	350,439

FY 93 POPULATION DATA

**REGION 12**

**Medical Centers**

DMIS ID	Name	40 mile Catchment				Region less Catchment Pop				Region			
		Active Duty	FM of AD	All Others	Total	Active Duty	FM of AD	All Others	Total	Active Duty	FM of AD	All Others	Total
0052	TRIPLER AMC	51,563	64,338	30,527	146,428	556	715	4,051	5,322	52,119	65,053	34,578	151,750

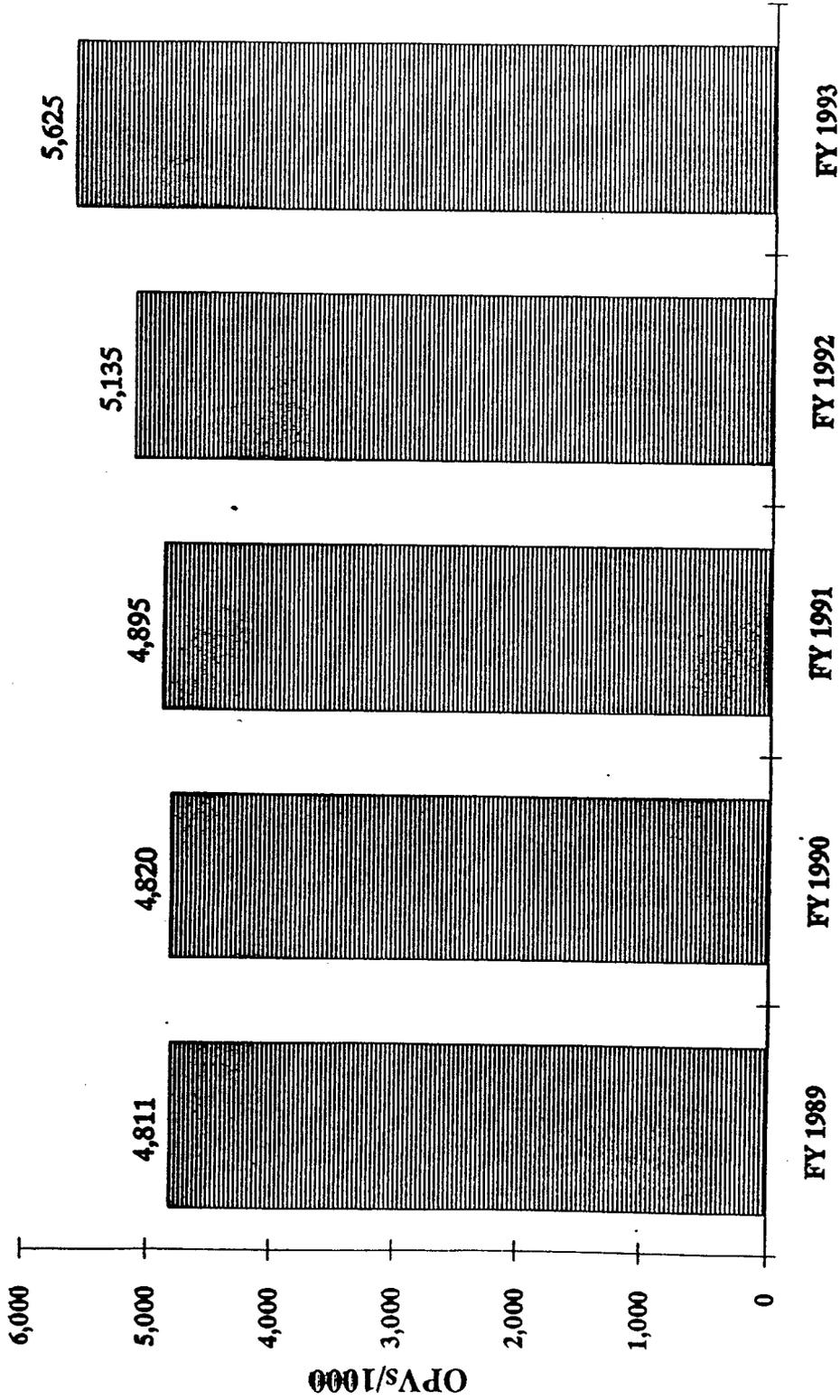
**Non Catchment Areas**

DMIS ID	Name	Non Catchment Area				Region less Non Catchment Area				Region			
		Active Duty	FM of AD	All Others	Total	Active Duty	FM of AD	All Others	Total	Active Duty	FM of AD	All Others	Total
0912	HAWAII	556	715	4,051	5,322	51,563	64,338	30,527	146,428	52,119	65,053	34,578	151,750

## Bed Days/1000 for Active Duty and Their Family Members

	1989	1990	1991	1992	1993
ACDU	730	734	669	594	513
ACDU Family Direct Care	359	346	312	314	286
ACDU Family CHAMPUS	423	443	418	329	279
<b>ACDU Family Total</b>	<b>782</b>	<b>788</b>	<b>730</b>	<b>643</b>	<b>565</b>
<b>ACDU &amp; ACDU Family Direct Care</b>	<b>1089</b>	<b>1080</b>	<b>980</b>	<b>908</b>	<b>799</b>
<b>ACDU &amp; ACDU Family Total</b>	<b>1512</b>	<b>1523</b>	<b>1398</b>	<b>1237</b>	<b>1078</b>
<b>Bed Requirements/10,000 ACDU Using Dispersion Factor of 0.8</b>					
ACDU	25	25	23	20	18
ACDU Family Direct Care	12	12	11	11	10
ACDU Family CHAMPUS	14	15	14	11	10
<b>ACDU Family Total</b>	<b>27</b>	<b>27</b>	<b>25</b>	<b>22</b>	<b>19</b>
<b>ACDU &amp; ACDU Family Direct Care</b>	<b>37</b>	<b>37</b>	<b>34</b>	<b>31</b>	<b>27</b>
<b>ACDU &amp; ACDU Family Total</b>	<b>52</b>	<b>52</b>	<b>48</b>	<b>42</b>	<b>37</b>

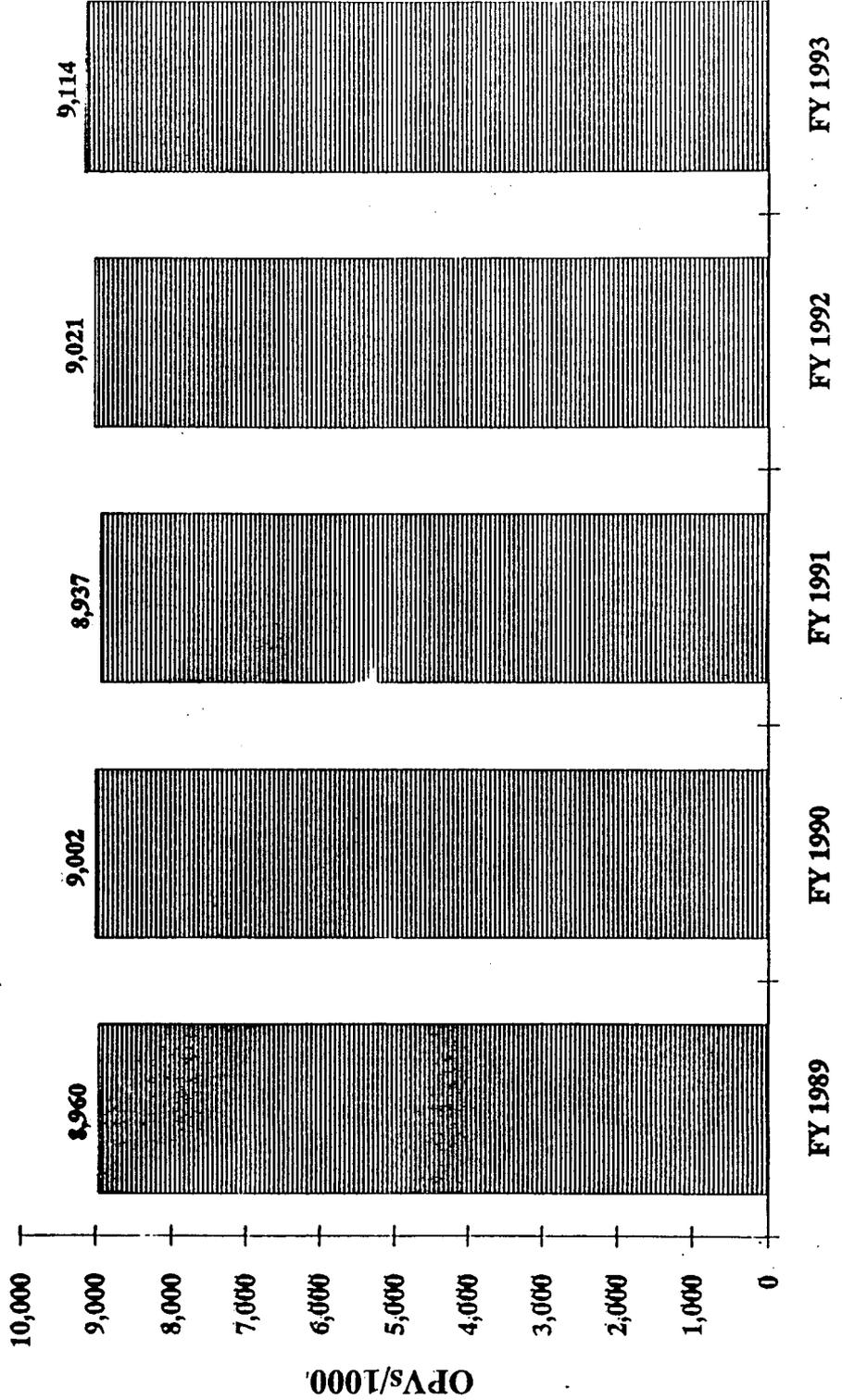
# Family of Active Duty OPVs/1000



JUL-SEP FY 93 OPVs were projected using seasonalized forecasting.

SOURCES: DMIS BIOMETRICS, RCMAS CENTRAL, MDMIS, HB and P ELIGIBLE POPULATION PROGRAM

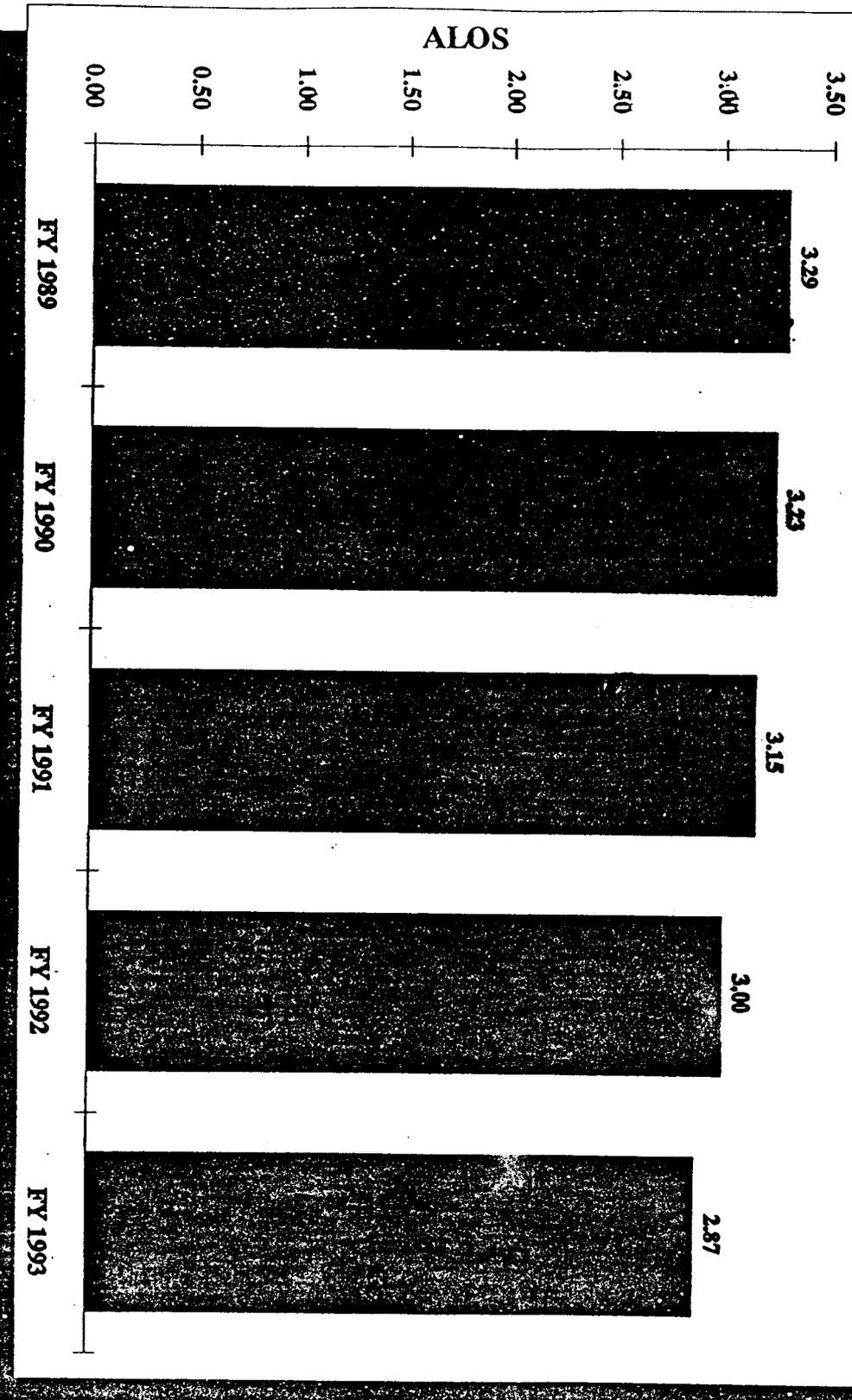
# Active Duty OPVs/1000



JUL-SEP FY 93 OPVs were projected using seasonalized forecasting.

# MHSS CONUS PERFORMANCE REVIEW

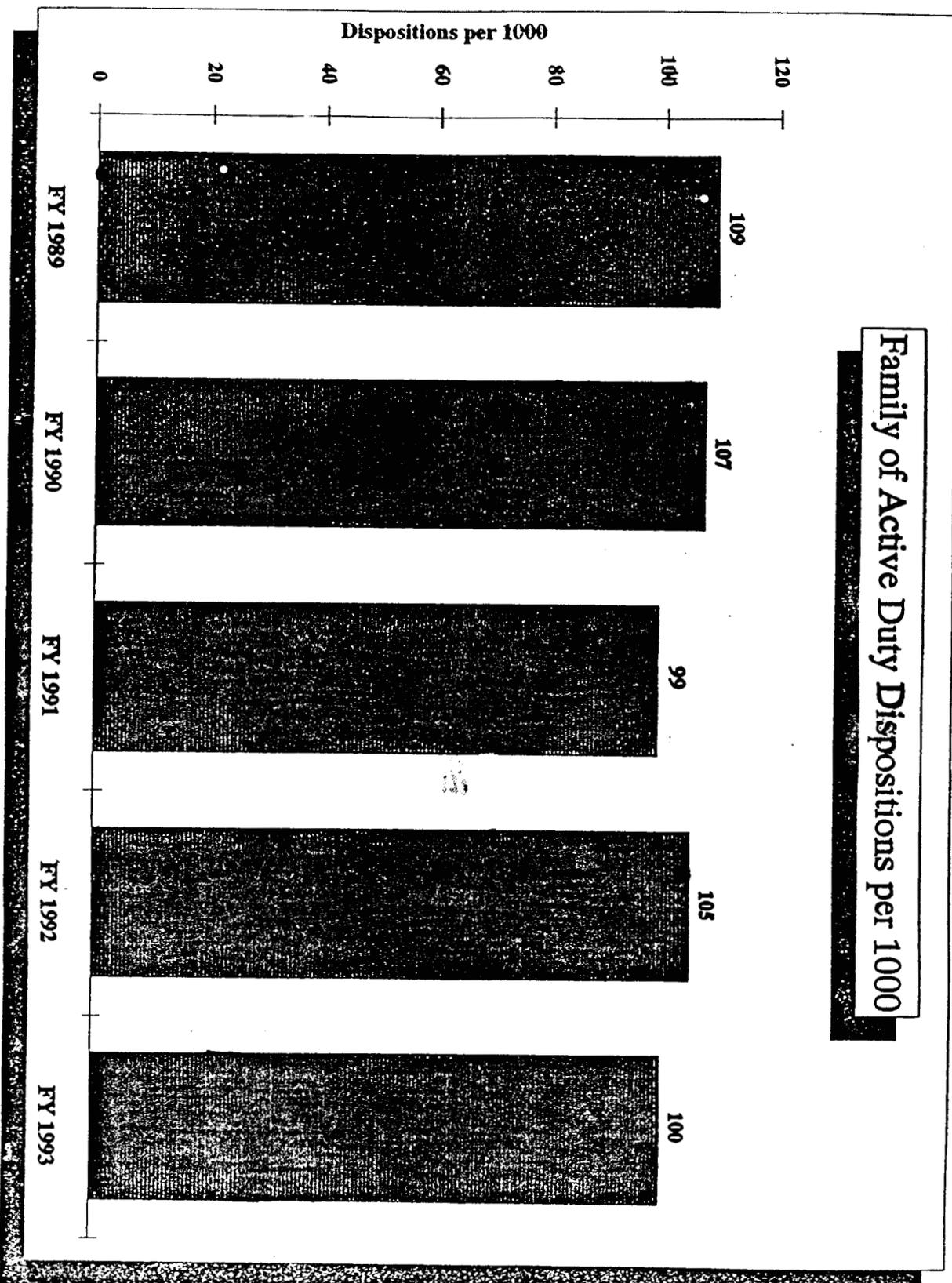
## Family of Active Duty Average Length of Stay



SOURCES: DMIS BIOMETRICS DATA, RCMAS CENTRAL, HB and P ELIGIBLE POPULATION PROGRAM  
NOTE: TIN-SEP FY93 Navy Inpatient workload data was estimated using season-tized forecasting.

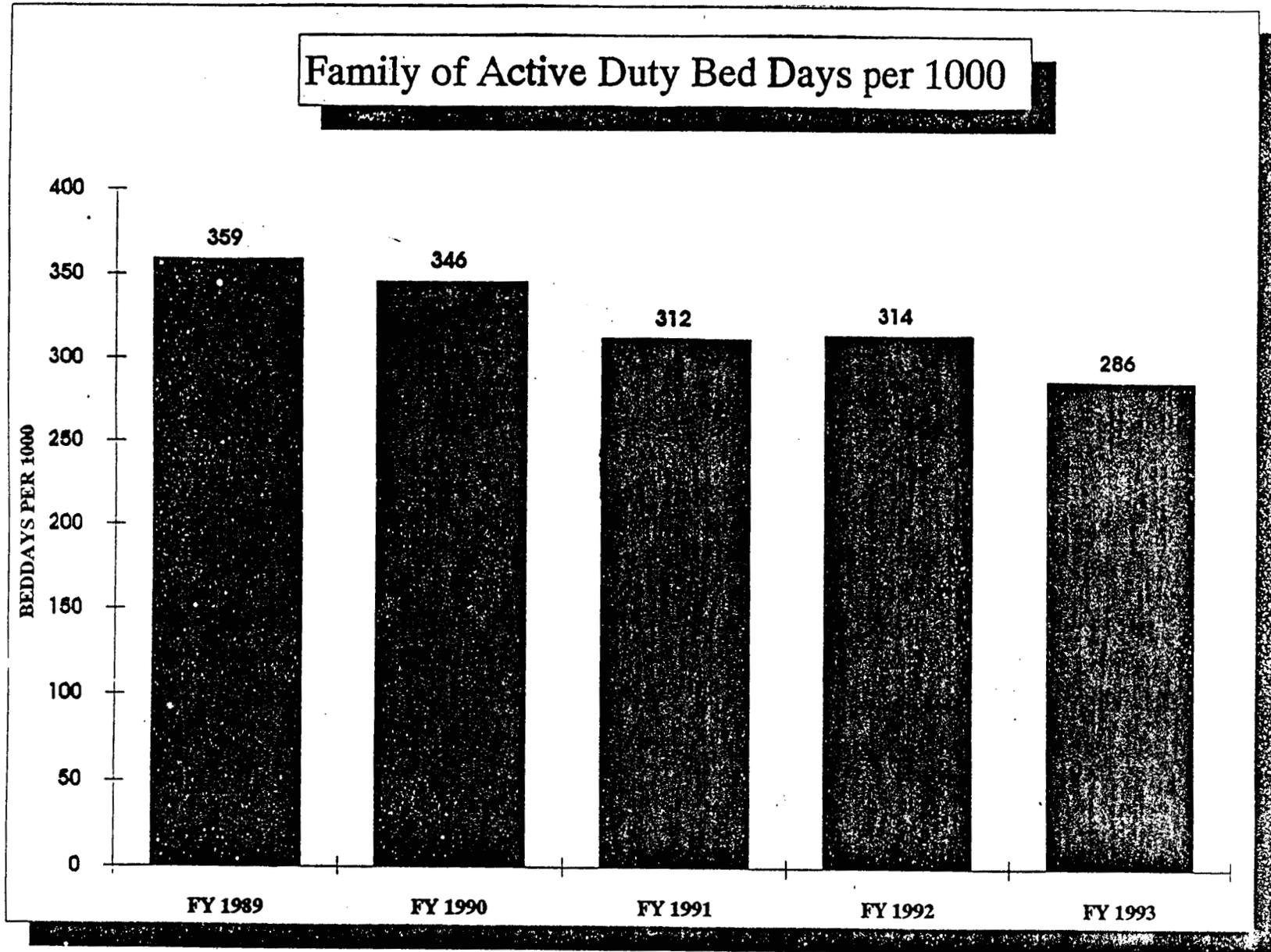
# MHSS CONUS PERFORMANCE REVIEW

## Family of Active Duty Dispositions per 1000



SOURCES: DMIS BIOMETRICS DATA, RCMAS CENTRAL, HB and P ELIGIBLE POPULATION PROGRAM  
NOTED: IN-SEP FY93 Navy Inpatient workload data was estimated using scars and forecasting.

# MISS CONUS PERFORMANCE REVIEW



SOURCES: DMIS BIOMETRICS DATA, RCMAS CENTRAL, HB and P ELIGIBLE POPULATION PROGRAM  
NOTE: JUN-SEP FY93 Navy Inpatient workload data was estimated using normalized forecasting.



HEALTH AFFAIRS

THE ASSISTANT SECRETARY OF DEFENSE

WASHINGTON, D. C. 20301-1200

FEB 22 1994

MEMORANDUM FOR ASSISTANT SECRETARY OF THE ARMY (M&RA)  
ASSISTANT SECRETARY OF THE NAVY (M&RA)  
ASSISTANT SECRETARY OF THE AIR FORCE (MRAI&E)

SUBJECT: Updated TRICARE Policy Guidelines

This memorandum transmits TRICARE guidance for the Lead Agents and Medical Treatment Facility (MTF) commanders. The guidelines are for their use in the development of their TRICARE plan and program. Although major changes are not anticipated, the document will continue to be refined to reflect our experiences and "lessons learned" as we progress in the implementation of managed care.

The point of contact for this action is my TRICARE Coordinator, Colonel Susan McMarlin, AN, USA. (703) 697-8979.

*Edward D. Martin*

Edward D. Martin, M.D.

Acting Assistant Secretary of Defense

Attachment  
As stated

cc  
Surgeon General of the Army  
Surgeon General of the Navy  
Surgeon General of the Air Force



HEALTH AFFAIRS

THE ASSISTANT SECRETARY OF DEFENSE

WASHINGTON, D. C. 20301-1200

FEB 22 1994

MEMORANDUM FOR TRICARE LEAD AGENTS  
THROUGH: SURGEONS GENERAL

SUBJECT: Updated TRICARE Policy Guidelines

This memorandum transmits TRICARE guidance for Lead Agents and Medical Treatment Facility (MTF) commanders. We are working on the necessary regulations and instructions to fully implement the various aspects of the TRICARE Managed Care Program. As soon as these documents are finalized they will also be provided to you.

The guidelines are for your use in the development of your TRICARE plan and ultimately, your program. Although major changes are not anticipated, we will continue to refine the document to reflect our experiences and "lessons learned" as we progress in the implementation of managed care. The Congress strongly supports our approach, and efforts should be made to address planning and implementing activities and programs reflecting the major areas covered in the policy guidelines.

An area that will require additional clarification concerns systems interoperability. An information system annex is currently being prepared to supplement the guidelines. We expect our TRICARE support contractors to have systems interoperability with the Lead Agents and MTFs when these systems are available to contractors. Enrollment, appointments, referrals, exchange of demographic information, and third party billing will need to be easily accessed by all participants. We have identified as a priority, the work necessary to assure seamless automated information systems and data compatibility.

You have asked questions regarding expectations prior to the implementation of a regional TRICARE support contract. At this time, you should be in the process of developing your regional plans, to include information about referrals and other MTF relationships. An important element of the regional plan is the development of the specialized treatment services system and the appropriate referral mechanism. When these plans are developed, authority can be provided to the region through the MTFs and the fiscal intermediary to initiate the requirement for non-availability statements in much broader geographic areas to support regional specialized treatment services.

As you are aware, the basic financial foundation for transition into managed care is capitation. This approach is a major change from the way we once obtained resources and will require a philosophical change in the attitude of many of our health care providers. The military

MTF commanders are now accountable for all resources used within their catchment areas to provide services for their beneficiaries. This method of financing will encourage more effective utilization management and delivery of appropriate and cost-effective, medical care.

Other activities will require considerable effort prior to the award of regional contracts. These include the implementation of improved utilization management strategies, MTF systems and information exchange, assessment of improved purchase of services through CHAMPUS recapture efforts and the development of requirements for network provider systems.

The point of contact for this action is my TRICARE Coordinator, Colonel Susan McMarlin, AN, USA. (703) 697-8979.

*Edward D. Martin*

Edward D. Martin, M.D.

Acting Assistant Secretary of Defense

Attachment  
As stated