

Hospital bed figures. If your basel is not listed, then number is zero.

12/1/94

LINEAR PROGRAMMING MODEL DATASET

Sort by Service/DMIS ID - Final Consolidated Data Sheet

DMIS ID	SVC	FACILITY NAME	INSTALLATION	STATE	MTF OF BEDS	MTF AV BEDS	MTF EXP BEDS	# OF HOSP	AV CIV BEDS	CIV/MTF BED RATIO	PHYS. RATIO	AD + AD FAM	OTHERS	AC BED REQ	FUNCT VALUE	TYPE FAC	EAST/WEST
0001	A	FOX ACH	REDSTONE ARSENAL	AL	20	42	57	15	1,165	58.25	1420	8,566	21,080	21	4.86	CH	
0002	A	NOBLE ACH	FT. MCCLELLAN	AL	48	100	106	10	787	16.40	1892	10,927	13,679	19	4.90	CH	
0003	A	LYSTER ACH	FT. RUCKER	AL	42	69	77	8	515	12.26	1804	15,351	16,349	25	5.60	CH	
0005	A	BASSETT ACH	FT. WAINWRIGHT	AK	43	74	100	0	0	0.00	1456	14,790	3,243	17	5.02	CH	
0008	A	BLISS ACH	FT. HUACHUCA	AZ	30	103	107	3	110	3.67	2403	12,360	10,201	18	5.51	CH	
0031	A	FITZSIMONS AMC	DENVER	CO	174	335	375	20	1,976	11.36	867	13,022	41,878	37	6.35	MC	W
0032	A	EVANS ACH	FT. CARSON	CO	149	195	212	7	767	5.15	2208	54,150	27,367	71	7.62	CH	
0037	A	WALTER REED AMC	WASHINGTON DC	DC	694	718	847	27	2,108	3.04	572	19,260	24,836	34	7.72	MC	E
0047	A	EISENHOWER AMC	FT. GORDON	GA	346	757	757	6	487	1.41	878	28,710	27,486	45	8.25	MC	E
0048	A	MARTIN ACH	FT. BENNING	GA	172	282	380	8	875	5.09	1622	45,386	28,716	63	7.16	CH	
0049	A	WINN ACH	FT. STEWART	GA	114	148	165	5	241	2.11	1409	41,933	15,192	51	7.06	CH	
0052	A	TRIPLER AMC	FT. SHAFTER	HI	423	439	617	8	289	0.68	859	100,380	32,125	121	4.52	MC	W
0057	A	IRWIN ACH	FT. RILEY	KS	60	127	192	5	206	3.43	3175	49,615	8,747	55	7.62	CH	
0058	A	MUNSON ACH	FT. LEAVENWORTH	KS	20	65	65	27	2,904	145.20	821	18,320	21,414	31	4.49	CH	
0060	A	BLANCHFIELD ACH	FT. CAMPBELL	KY	146	241	350	6	504	3.45	2205	58,250	14,942	68	8.18	CH	
0061	A	IRELAND ACH	FT. KNOX	KY	84	172	333	16	2,081	24.77	1105	32,435	25,445	48	6.30	CH	
0064	A	BAYNE-JONES ACH	FT. POLK	LA	96	169	169	3	110	1.15	2405	26,021	7,760	31	5.83	CH	
0069	A	KIMBROUGH ACH	FT. MEADE	MD	36	68	170	28	2,173	60.36	687	40,659	35,721	62	6.76	CH	
0075	A	L. WOOD ACH	FT. LEONARD WOOD	MO	122	480	670	4	263	2.16	1928	34,541	9,866	41	7.51	CH	
0081	A	PATTERSON ACH	FT. MONMOUTH	NJ	15	67	67	69	9,464	630.93	820	10,476	16,979	20	4.76	CH	
0086	A	KELLER ACH	WEST POINT	NY	30	62	62	39	1,979	65.97	716	13,924	16,302	24	5.34	CH	
0089	A	WOMACK AMC	FT. BRAGG	NC	226	272	454	9	626	2.77	1542	113,185	44,498	141	8.52	CH	
0098	A	REYNOLDS ACH	FT. SILL	OK	100	157	264	5	406	4.06	1571	36,714	17,851	48	7.58	CH	
0105	A	MONCRIEF ACH	FT. JACKSON	SC	96	432	435	7	435	4.53	1130	33,276	25,915	49	7.55	CH	
0108	A	WILLIAM BEAUMONT AMC	FT. BLISS	TX	330	482	684	8	1,201	3.64	1689	30,999	31,765	50	5.91	MC	W
0109	A	BROOKE AMC	FT. SAM HOUSTON	TX	367	450	651	18	2,689	7.33	950	37,939	59,620	73	7.18	MC	W
0110	A	DARNALL ACH	FT. HOOD	TX	203	241	359	7	471	2.32	1014	91,766	33,486	113	8.36	CH	
0121	A	MCDONALD ACH	FT. EUSTIS	VA	42	116	116	7	1,414	33.67	1143	28,586	18,289	40	6.10	CH	
0122	A	KENNER ACH	FT. LEE	VA	49	67	87	17	1,467	29.94	865	14,800	22,600	28	5.43	CH	
0123	A	DEWITT ACH	FT. BELVOIR	VA	68	93	105	8	468	6.88	1593	59,530	63,814	97	7.49	CH	
0125	A	MADIGAN AMC	FT. LEWIS	WA	381	414	622	20	1,955	5.13	935	63,078	68,109	104	6.14	MC	W
0131	A	WEED ACH	FT. IRWIN	CA	25	27	27	1	66	2.64	2380	10,687	2,096	12	5.10	CH	
0004	F	502nd MEDICAL GROUP	MAXWELL AFB	AL	30	71	118	7	573	19.10	1092	14,410	23,209	28	3.83	CH	
0006	F	3rd MEDICAL CENTER	ELMENDORF AFB	AK	75	139	32	2	276	3.68	1389	25,834	12,942	34	6.03	CH	
0009	F	58th MEDICAL GROUP	LUKE AFB	AZ	40	60	100	20	1,537	38.43	1226	19,503	54,794	52	5.02	CH	
0010	F	355th MEDICAL GROUP	DAVIS MONTHAN AFB	AZ	30	70	112	9	782	26.07	833	18,327	31,846	37	5.22	CH	
0013	F	314th MEDICAL GROUP	LITTLE ROCK AFB	AR	20	39	68	9	1,221	61.05	1786	13,484	22,992	27	4.83	CH	

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MIS ID	SVC	FACILITY NAME	INSTALLATION	STATE	MTF OI BEDS	MTF AV BEDS	MTF EXP BEDS	# OF HOSP	AV CIV BEDS	CIV/MTF BED RATIO	PHYS. RATIO	AD + AD FAM	OTHERS	AC BED REQ	FUNCT VALUE	TYPE FAC	EAST/WEST
014	F	DAVID GRANT USAF MED CTR	TRAVIS AFB	CA	195	408	388	22	1,721	8.83	1179	36,257	59,087	71	5.52	MC	W
015	F	9th MEDICAL GROUP	BEALE AFB	CA	9	14	14	6	288	32.00	548	9,488	10,896	16	3.76	CH	
016	F	323rd FTW HOSPITAL	MATHER AFB	CA	30	35	70	16	1,279	42.63	587	11,084	48,943	40	5.06	CH	
018	F	30th MEDICAL GROUP	VANDENBERG AFB	CA	20	48	46	3	126	6.30	1154	8,848	10,008	15	5.00	CH	
019	F	650th MEDICAL GROUP	EDWARDS AFB	CA	10	30	33	4	221	22.10	1098	13,152	7,581	18	3.82	CH	
033	F	USAF ACADEMY HOSPITAL	USAF ACADEMY	CO	55	80	157	2	361	6.56	1631	24,269	21,562	37	5.68	CH	
036	F	436th MEDICAL GROUP	DOVER AFB	DE	20	39	60	7	467	23.35	1183	13,663	13,421	22	4.69	CH	
042	F	646th MEDICAL GROUP	EGLIN AFB	FL	85	120	275	5	278	3.27	2276	39,369	32,757	59	6.62	CH	
043	F	325th MEDICAL GROUP	TYNDALL AFB	FL	25	57	79	2	155	6.20	3138	15,424	15,370	25	4.26	CH	
045	F	56th MEDICAL GROUP	MACDILL AFB	FL	50	69	142	24	2,884	57.68	831	15,542	79,529	62	5.35	CH	
046	F	45th MEDICAL GROUP	PATRICK AFB	FL	15	20	72	5	437	29.13	2696	10,556	33,023	30	4.82	CH	
050	F	347th MEDICAL GROUP	MOODY AFB	GA	10	47	47	4	292	29.20	794	9,611	7,381	14	3.81	CH	
051	F	653rd MEDICAL GROUP	ROBINS AFB	GA	15	31	32	11	560	37.33	1377	11,640	17,514	22	4.24	CH	
053	F	366th MEDICAL GROUP	MOUNTAIN HOME AFB	ID	20	31	31	0	0	0.00	2814	11,957	9,887	18	5.92	CH	
055	F	USAF MED CTR SCOTT	SCOTT AFB	IL	95	120	348	24	2,668	28.08	1125	24,566	33,977	45	5.48	CH	
062	F	2nd MEDICAL GROUP	BARKSDALE AFB	LA	25	46	70	7	700	28.00	538	15,532	18,199	26	5.04	CH	
066	F	MALCOLM GROW USAF MED CTR	ANDREWS AFB	MD	185	244	388	35	3,166	17.11	91	29,651	32,329	49	5.89	CH	
073	F	KEESLER USAF MED CTR	KEESLER AFB	MS	235	306	433	6	574	2.44	1408	38,690	23,112	53	5.06	MC	E
074	F	14th MEDICAL SQUADRON	COLUMBUS AFB	MS	5	17	17	7	438	87.60	1170	3,633	5,426	7	3.24	CH	
076	F	351st MEDICAL GROUP	WHITEMAN AFB	MO	15	26	29	4	165	11.00	2902	8,310	5,383	12	4.04	CH	
078	F	ELIHLING BERQUIST HOSPITAL	OFFUTT AFB	NE	50	107	123	10	989	19.78	866	26,703	23,276	41	5.85	CH	
079	F	554th MEDICAL GROUP	NELLIS AFB	NV	20	77	77	6	394	19.70	1331	20,071	34,967	41	5.90	CH	
083	F	542nd MEDICAL GROUP	KIRTLAND AFB	NM	25	40	40	9	965	38.60	1389	14,162	24,892	29	5.40	CH	
084	F	49th MEDICAL GROUP	HOLLOMAN AFB	NM	8	30	28	1	38	4.75	2733	14,414	11,976	22	4.68	CH	
085	F	27th MEDICAL GROUP	CANNON AFB	NM	15	29	36	1	37	2.47	1014	15,591	3,489	18	4.87	CH	
090	F	4th MEDICAL GROUP	SEYMOUR JOHNSON AFB	NC	15	44	48	6	382	25.47	1557	12,920	14,216	21	4.45	CH	
093	F	319th MEDICAL GROUP	GRAND FORKS AFB	ND	15	34	34	3	172	11.47	1106	12,545	2,821	14	3.82	CH	
094	F	5th MEDICAL GROUP	MINOT AFB	ND	25	47	75	2	176	7.04	1265	12,000	12,300	19	4.64	CH	
095	F	WRIGHT-PATTERSON USAF MED CTR	WRIGH-PATTERSON AFB	OH	160	175	433	19	1,917	11.98	1202	22,131	28,734	39	5.58	MC	E
096	F	654th MEDICAL GROUP	TINKER AFB	OK	25	65	90	17	1,325	53.00	1111	23,596	30,326	42	4.76	CH	
097	F	97th MEDICAL GROUP	ALTUS AFB	OK	7	39	39	3	77	11.00	2138	7,507	3,541	10	3.92	CH	
0101	F	363rd MEDICAL GROUP	SHAW AFB	SC	25	48	90	4	236	9.44	980	16,596	11,200	23	5.02	CH	
0106	F	28th MEDICAL GROUP	ELLSWORTH AFB	SD	15	35	58	3	242	16.13	1623	14,000	6,539	18	4.80	CH	
0111	F	64th MEDICAL SQUADRON	REESE AFB	TX	4	10	20	6	575	143.75	876	3,831	5,250	7	3.18	CH	
0112	F	96th MEDICAL GROUP	DYESS AFB	TX	15	35	100	2	45	3.00	1524	13,057	8,271	18	4.26	CH	
0113	F	396th MEDICAL GROUP	SHEPPARD AFB	TX	80	197	318	2	201	2.51	1300	12,420	9,050	18	5.00	CH	
0114	F	47th MEDICAL SQUADRON	LAUGHLIN AFB	TX	5	28	40	1	48	9.60	1919	3,009	2,159	4	3.72	CH	

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0117	F	WILFORD HALL MC	LACKLAND AFB	TX	585	1,006	1,033	14	2,430	4.15	870	43,110	47,424	71	6.74	MC	W
0119	F	649th MEDICAL GROUP	HILL AFB	UT	25	42	55	14	1,250	50.00	1827	15,002	21,608	28	5.88	CH	
0120	F	1st MEDICAL GROUP	LANGLEY AFB	VA	40	71	120	15	1,239	30.98	1815	31,455	22,299	45	5.68	CH	
0128	F	92nd MEDICAL GROUP	FAIRCHILD AFB	WA	30	61	90	5	547	18.23	1694	13,407	16,360	23	4.71	CH	
0129	F	90th MEDICAL GROUP	F.E. WARREN AFB	WY	15	24	43	2	160	10.67	1650	8,700	5,870	12	3.98	CH	
0326	F	438th MEDICAL GROUP	FT DIX	NJ	20	350	350	8	729	36.45	498	26,282	53,733	58	6.07	CH	
0024	N	NH CAMP PENDLETON	CAMP PENDLETON ✓	CA ✓	120	222	265	24	1,666	13.88	908	74,874	40,556	100	7.28	CH	
0028	N	NH LEMOORE	LEMOORE ✓	CA ✓	37	69	37	3	51	1.38	2686	22,516	12,030	30	5.12	CH	
0029	N	NH SAN DIEGO	SAN DIEGO ✓	CA ✓	422	617	583	20	1,941	4.60	956	188,255	116,441	259	7.84	MC	W
0030	N	NH TWENTYNINE PALMS	TWENTYNINE PALMS ✓	CA ✓	30	70	40	1	20	0.67	2627	23,000	5,250	26	7.58	CH	
0035	N	NH GROTON	GROTON	CT ✓	25	100	96	3	195	7.80	1217	20,151	17,369	31	5.41	CH	
0038	N	NH PENSACOLA	PENSACOLA	FL ✓	104	221	161	8	915	8.80	2112	47,769	38,494	71	7.19	CH	
0039	N	NH JACKSONVILLE	JACKSONVILLE	FL ✓	131	176	228	7	879	6.71	1252	64,858	56,262	98	6.98	CH	
0056	N	NH GREAT LAKES	GREAT LAKES	IL	136	228	718	67	7,100	52.21	469	37,555	28,945	55	6.48	CH	
0067	N	NATIONAL NAVY MC	BETHESDA	MD	342	459	779	53	4,048	11.84	725	42,361	47,076	70	7.40	MC	E
0068	N	NH PATUXENT RIVER	PATUXENT RIVER	MD	20	20	32	2	72	3.60	4231	8,985	6,106	13	3.74	CH	
0091	N	NH CAMP LEJEUNE	CAMP LEJEUNE	NC	176	224	238	2	83	0.47	1226	79,722	21,212	93	7.76	CH	
0092	N	NH CHERRY POINT	CHERRY POINT	NC	40	40	27	2	116	2.90	990	27,792	13,921	36	4.52	CH	
0103	N	NH CHARLESTON	CHARLESTON	SC	90	90	90	8	621	6.90	769	26,954	34,659	47	5.56	CH	
0104	N	NH BEAUFORT	BEAUFORT	SC	49	80	54	2	113	2.31	1105	17,078	8,303	22	4.70	CH	
0107	N	NH MILLINGTON	MILLINGTON	TN	66	102	106	15	1,737	26.32	3546	7,005	22,742	20	4.37	CH	
0118	N	NH CORPUS CHRISTI	CORPUS CHRISTI	TX	42	65	65	12	551	13.12	1384	8,433	9,560	14	4.26	CH	
0124	N	NH PORTSMOUTH	PORTSMOUTH	VA	431	437	176	17	1,538	3.57	1893	226,784	88,014	281	7.01	MC	E
0126	N	NH BREMERTON	BREMERTON ✓	WA	109	137	139	1	122	1.12	1259	35,678	19,965	48	6.98	CH	
0127	N	NH OAK HARBOR	OAK HARBOR ✓	WA	25	26	31	2	56	2.24	1104	18,918	9,378	25	5.38	CH	

MOBILIZATION BED REQUIREMENTS	
ARMY	6030
NAVY	2600
AIR FORCE	980
DOD	9610

	AD+ AD FAM	OTHERS	MEDCEN BED REQ
East Medical Centers	2,136,190	2,216,670	1,492
West Medical Centers	1,758,695	1,906,223	1,262

Document Separator

CONGRESSMAN

Joel Hefley

**2351 Rayburn H.O.B.
Washington, D.C. 20515-0605
(202) 225-4422**

FOR IMMEDIATE RELEASE

MEDIA ADVISORY

March 16, 1995

CONTACT: Leigh LaMora

(202) 225-4422

HEFLEY TO HOLD HEARINGS AT FITZSIMONS

(Washington D.C. - 3/16/95) Today, Representative Joel Hefley (R-CO) announced that the Subcommittee on Military Installations and Facilities will hold a field hearing at Fitzsimons Army Medical Center on Wednesday, April 12, 1995 at 9:00 a.m. Mr. Hefley is chairman of the Subcommittee.

The purpose of the hearing will be to review the future military health infrastructure requirements in the Rocky Mountain region. The hearing is open to the public. However, all witnesses will be pre-selected by the Committee.

DEFENSE BASE CLOSURE & REALIGNMENT COMMISSION
1700 NORTH MOORE STREET, SUITE 1425
ARLINGTON, VIRGINIA 22209
(703) 696-0504

MEMORANDUM OF MEETING

DATE: March 21, 1995

TIME: 10:30 a.m.

MEETING WITH: Edward Martin, M.D., OASD(HA)

SUBJECT: Medical Joint Cross Service Group Results

PARTICIPANTS:

Name/Title/Phone Number:

**Edward Martin, M.D., Principal Deputy Assistant Secretary of Defense
(Health Affairs)**

LTC Ed Ponatoski, OASD(HA), JCSG Action Officer

LTC Rich Jones, OASD(HA), JCSG Action Officer

Commission Representatives:

Ben Borden, Director, Review & Analysis

Ed Brown, Army Team Leader

Bob Cook, Interagency Issues Team Leader

Frank Cirillo, Air Force Team Leader

Alex Yellin, Navy Team Leader

David Lewis, Army Team

Craig Hall, Air Force Team

Dave Epstein, Navy Team

Ralph Kaiser, Counsel

MEETING PURPOSE:

Dr. Martin and his staff said that the Medical Joint Cross Service Group alternatives represent the output of the linear programming model and the starting point for discussions with the services about what hospitals to close or realign. He discussed some of the service responses and noted that many of the JCSG alternatives are being implemented by DOD outside of BRAC through the budget process. He said that, through capitation, DOD now gives MTF commanders a budgetary incentive not to admit patients to hospitals when outpatient alternatives exist and that this is reflected in reduced demand for inpatient beds and the MHSS is downsizing accordingly.

Dr. Martin said that the wartime requirement for MTF beds is about 10,000 and that, based on utilization, about 14,000 beds are needed to meet all of the healthcare needs of the entire DOD beneficiary population.

He said that he would send a letter detailing the specific service responses and their rationale, including descriptions of action being implemented outside of BRAC. Copies of the briefing charts he used are attached.

(h:\lewis\doc\mmjcs2.doc)

David Lewis/Army Team/3/24/95



DEPARTMENT OF THE ARMY
OFFICE OF THE CHIEF OF STAFF
200 ARMY PENTAGON
WASHINGTON DC 20310-0200



REPLY TO
ATTENTION OF

30 MAR 1995

Mr. Edward A. Brown III
Defense Base Closure and
Realignment Commission
1700 North Moore Street
Suite 1425
Arlington, VA 22209

Please refer to this number
when responding 950.309-7R1

Dear Mr. Brown:

Enclosed is our response for record from questions asked at the Commission testimony on March 7, 1995.

If we may be of further assistance, please contact LTC Lamb, The Army Basing Study at (703) 697-6262.

Sincerely,

MICHAEL G. JONES
COL, GS
Director, TABS

Enclosures



QUESTIONS FROM BASE REALIGNMENT AND CLOSURE COMMISSION MEDICAL

1. The Army is recommending the closure of Fitzsimons Army Medical Center in Aurora, Colorado. In your analysis to determine which installation to close or realign, did you consider the needs of active duty and retired patient workload? Did you weight active duty and retirees differently? Were there any differences recognized between active duty and retiree beneficiaries?

Yes. The Joint Cross Service Working Group used a linear programming model to determine which medical treatment facilities (MTF) should close or downsize. 40% of the weight for determining an MTF's overall functional value was placed on active and family member populations supported within each region. Although retiree populations were not directly considered in the overall MTF functional value equation, they were one of the factors for determining a region's civilian primary care provider ratio. The Linear Programming Model was designed to ensure that the projected acute care and tertiary care requirements for our beneficiaries were met. All categories of the beneficiary population were considered, including active duty, family members of active duty, retirees, and family members of retirees.

The Army followed guidance from the Office of the Assistant Secretary of Defense for Health Affairs' capitation methodology for ensuring overall MTF cost efficiency. Although specific active duty and retiree patient workloads were not directly utilized for calculating an MTF's overall functional value, they were considered in determining the overall ratio of CHAMPUS costs to MTF costs for the specific region being studied.

HJCSG

3/17

comptonowski
ca. Jones

AF Gen Wyrek

Goal 15% PRV

capacity - def # beds

Functional value ~~same~~ ^{prox to} C9 air fld / strip
surge bed cap

measure functional value of all facilities

mil value assumed same for all - ie Liebit use Mil Val

alts
submitted
to AF

- AF Academy
- Scott
- Wright Patt
- Shaw
- Reese
- Lockland
- Sheppard
- Langley

AF response to alts?

Joseph 3/21
HJCSG chief

AF planning to downsize hosp ~~to~~ to super clinics thru budget/plan process
AF downsizing AF Academy hosp to dispensary (alt 2)
AF NOT JCSG assessed mil value

JCSG set criteria (ie algorithms) and submit alts to service
alts were intended to be overstatement (based on \$ + no care to returns)
LP model max > elim excess capacity
will provide - pos on alts, + budget actions

JCSG Recommendations

Close FAMC		Operating	Available	Expended	
		174	335	375	
Realign	Ft. McClellan	48	100	106	
	Ft. Rucker	42	69	77	
	Army	Ft. Meade	36	68	170
		Ft. Belvoir	68	93	105
		Ft. Lee	49	67	87
		417	732	920	
Navy	Beaufort	49	80	54	
	Corpus Christi	42	65	65	
		91	145	119	
Air Force	Air Force Academy	55	80	157	
	Scott AFB (MC)	95	120	348	
	Wright Patterson AFB (MC)	160	175	433	
	Shaw AFB	25	48	90	
	Reese AFB	4	10	20	
	Lackland AFB (all-fld-adj)(MC)	585	1006	1033	
	Sheppard AFB	80	197	318	
	Langley AFB	40	71	120	
	1044	1707	2519		
		<u>1552</u>	<u>2584</u>	<u>3,558</u>	

MHSS Infrastructure Reductions (FY 88 - FY 97)

- **Baseline - FY 88 Health Facility Planning Review**
- **Normal beds decreased by ~12,000, or 43%**
- **Expanded beds decreased by ~20,000, or 48%**
- **Number of hospitals decreased by 58 facilities, or 35%**

* Includes DHP Program Initiatives and BRAC 95

MHSS Infrastructure Reductions

1988 HEALTH FACILITY PLANNING REVIEW				
	# HOSP	OPER	NORMAL	EXPANDED
AIR FORCE	82	5,219	9,124	11,371
ARMY	50	7,781	11,647	19,231
NAVY	36	4,164	7,758	11,446
TOTALS	168	17,164	28,529	42,048

	# HOSP	OPER	NORMAL	EXPANDED
CURRENT INVENTORY	110	10,040	16,894	22,861
REDUCTIONS SINCE 1988	58	7,124	11,635	19,187
% DECREASE SINCE 1988	35%	42%	41%	46%

58 MTF REDUCTIONS - SINCE - 1988

CONUS (41)

BRAC-III (25)

Letterman AMC, CA
Ft. Ord, CA

NH Long Beach, CA
NH Orlando, FL

K.I. Sawyer AFB, MI
Pease AFB, NH
England AFB, LA
George AFB, CA
Williams AFB, AZ
Chanute AFB, IL
Carswell AFB, TX
Castle AFB, CA
March AFB, CA

OTHER Management Initiatives (6)

Naval Station, Adak, AK
Naval Home, Gulfport, MS
McConnell AFB, KS

Ft. Devens, Ma
Ft. B. Harrison, IN

NH Philadelphia, PA
NH Oakland, CA

Plattsburgh AFB, NY
Eaker AFB, AR
Myrtle Beach AFB, SC
Wurtsmith AFB, MI
Homestead AFB, FL
Bergstrom AFB, TX
Loring AFB, ME
Griffiss AFB, NY

BRAC 95 & DHP Program Reductions (10)

Fitzsimons AMC, CO
Ft. Lee, VA
NH Charleston, SC
NH Patuxent River, MD
NH Millington, TN

Ft. McClellan, AL
Ft. Meade, MD
NH Corpus Christi, TX
NH Groton, CT
—Reese AFB, TX

Kirtland AFB

OCONUS (17)

Hellenikon AB, GR
Augsburg, GE
Bad Cannstatt, GE
Bremerhaven, GE
Clark AB, PI
Hahn AB, GE
Torrejon AB, SP
NH Subic Bay, PI
SHAPE, BE
Weisbaden MC, GE
Frankfurt AMC, GE
Iraklion AS, GR
Nurnberg, GE
RAF Upper Heyford, UK
Vicenza, IT
Berlin, GE
Gorgus, PM

Document Separator

BRAC 1995: Military Medical Care Services

I. DoD Recommendations

A. Army

1. Close Noble Hospital (Ft. McClellan, AL)
2. Realign Kenner Hospital to Clinic (Ft. Lee, VA)
3. Realign Kimbrough Hospital to Clinic (Ft. Meade, MD)

~~Army~~ *Fitzsimons*

B. Navy - No closures or realignments recommended

C. Air Force

1. Close Clinic (Brooks AFB, TX)
2. Close Clinic (Reese AFB, TX)
3. Close Clinic (Onizuka AFB, CA)
4. Terminate shared activities with Veteran's Hospital (Kirtland AFB, NM)

D. Past BRAC Actions (1988, 91 & 93) - 28 Facilities Closed

II. DoD Military Health Services System (MHSS)

A. Mission - Maintain the health of military personnel so they can carry out their military missions, and to be prepared to deliver health care in time of war.

B. Structure

1. **Facilities:** 135 Hospitals; 500 Medical Clinics (300 Dental Clinics)
2. **Personnel:** 54,000 Civilians; 107,000 AD Personnel

C. Budget - \$15.3 billion, FY95 (CHAMPUS \$3.9 billion or 25.5%)

D. Assistant Secretary of Defense for Health Affairs - Dr. Stephen C. Joseph

III. Base Medical Care and Alternatives

A. Military Health Care Facilities

B. Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)

C. MediCare

IV. Medical Care "Entitlements" and Access

A. Active Duty (AD) - entitled to health care in military medical facilities (10 U.S.C. 1074)

B. Dependents of AD - entitled upon request on a space-available basis (10 U.S.C. 1076)

C. Retirees and their Dependents - may be given medical care on space-available basis after AD personnel and their families; no entitlement (P.L. 85-861, 2 Sept 1958)

V. Costs

A. Users

1. **Military Facilities** - free of charge except for small per diem to cover meals (< \$10)
2. **CHAMPUS** - yearly deductible for family, \$300, afterwards 20% of all approved care

B. DoD - FY95 \$15.3 billion or 5.9% of DoD budget (CHAMPUS, \$3.9 billion or 1.5% of DoD budget)

VI. Reforms

A. CHAMPUS Reform Initiative (CRI)

B. TRICARE

C. Catchment Area Management (CAM)

D. Clinton Health Care Plan

**Ralph Kaiser
Counsel**

Document Separator

April 21, 1995

Mr. Robert E. Bayer
Deputy Assistant Secretary (Installations)
Office of the Assistant Secretary of Defense for Economic Security
3300 Defense Pentagon
Room 3E808
Washington, D.C. 20301-3300

Dear Mr. Bayer:

Request that the Department of Defense provide detailed descriptions of current actions or future plans for realignment or "right-sizing" of the following military treatment facilities:

- Blanchfield Army Community Hospital, Fort Campbell, KY
- Ireland Army Community Hospital, Fort Knox, KY

- Madigan Army Medical Center, Fort Lewis, WA
- NH Bremerton, WA
- NH Oak Harbor, WA

- Walter Reed Army Medical Center, DC
- DeWitt Army Community Hospital, Fort Belvoir, VA
- National Navy Medical Center, MD
- NH Patuxent River, MD
- Malcolm Grow USAF Medical Center, Andrews AFB, MD

- McDonald Army Community Hospital, Fort Eustis, VA
- NH Portsmouth, VA
- 1st Medical Group, Langley AFB, VA
- Munson Army Community Hospital, Fort Leavenworth, KS
- Irwin Army Community Hospital, Fort Riley, KS
- 351st Medical Group, Whiteman AFB, MO
- Womack Army Medical Center, Fort Bragg, NC
- NH Cherry Point, NC
- NH Camp Lejeune, NC
- 4th Medical Group, Seymour Johnson AFB, NC

- NH Camp Pendleton, CA
- NH San Diego, CA

- Evans Army Community Hospital, Fort Carson, CO
- USAF Academy Hospital, CO

- Bliss Army Community Hospital, Fort Huachuca, AZ
- 355th Medical Group, Davis-Monthan AFB, AZ

- NH Pensacola, FL
- 646th Medical Group, Eglin AFB, FL
- 325th Medical Group, Tyndall AFB, FL
- Keesler USAF Medical Center, Keesler AFB, MS

- Martin Army Community Hospital, Fort Benning, GA
- Lyster Army Community Hospital, Fort Rucker, AL
- 502nd Medical Group, Maxwell AFB, AL
- 653rd Medical Group, Robins AFB, GA

- Reynolds Army Community Hospital, Fort Sill, OK
- 97th Medical Group, Altus AFB, OK
- 654th Medical Group, Tinker AFB, OK
- 396th Medical Group, Sheppard AFB, TX

- Moncrief Army Community Hospital, Fort Jackson, SC
- 363rd Medical Group, Shaw AFB, SC

- Winn Army Community Hospital, Fort Stewart, GA
- NH Beaufort, SC

In regards to planned actions, please be specific about the status of those plans in Defense Health Program budgeting.

Also, please describe in detail the status of current plans to realign NH Charleston, SC; 9th Medical Group, Beale AFB, CA; 323rd FTW Hospital, Mather AFB, CA; and 438th Medical Group, Fort Dix, NJ.

Thank you for your assistance. I appreciate your time and cooperation.

Sincerely,

Alan J. Dixon
Chairman

Document Separator

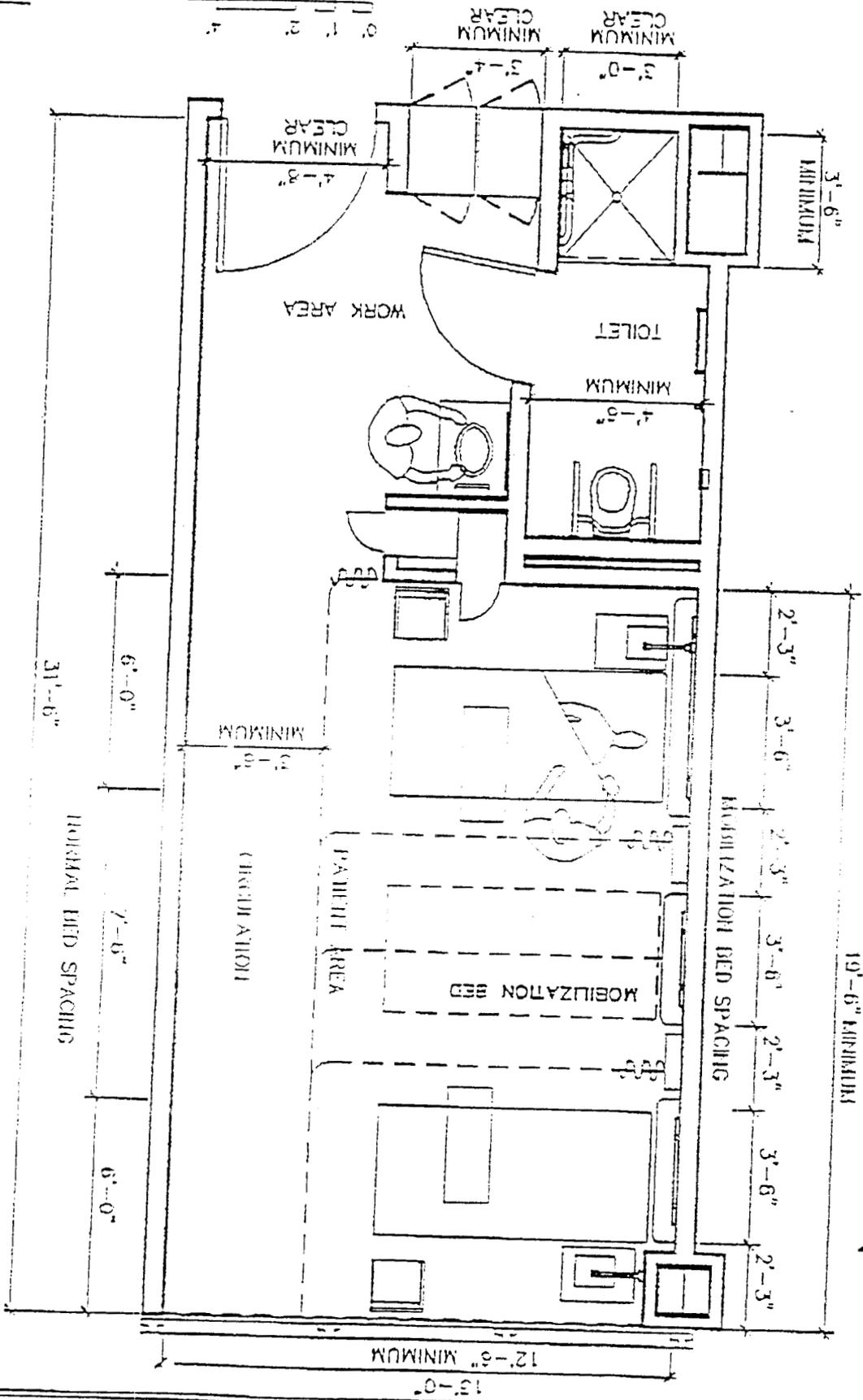
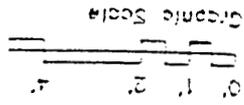
Policy Constraints Dependent upon Model Function

- **Maintain by Service and MHSS the aggregate number of expanded beds to meet wartime requirements + current direct care peacetime demand**
- **Maintain average functional value within the aggregate MHSS for the sets of Community Hospitals and Medical Centers**

Model Policy Constraints

- **Maintain MTF if considered underserved primary care area (unless base closes) 1:3000**
- **Maintain MTF if < 2 accredited community facilities (unless base closes)**
- **Maintain MTF if MTF bed demand $>$ civilian acute care available beds**
- **Maintain MTF if Active Duty and Family Members $> 25,000$**

1/4" = 1'-0"
12



op / normal

Functional Diagram

3.02.02 B
Two Bedroom (Mob)

Capacity Definitions

- **Operating Beds - Beds that are set up, staffed, and equipped for patient care**
- **Expanded Beds - Spaced on 6 foot centers with embedded electrical and gas utility support**



Office of the Assistant Secretary of Defense (Health Affairs)
Contingency Operations Policy

ADMISSION RATES

WOUNDED IN ACTION

- EXPRESSED AS ADMISSIONS/1000 PAR/DAY
- CALCULATED BY WARFIGHTERS, NOT MEDICS
 - HISTORICAL DATA
 - WAR GAMING
- INFLUENCED BY:
 - WEAPONS USED
 - ORDER OF BATTLE
 - INTENSITY OF BATTLE
 - DURATIONS OF ENGAGEMENTS
 - STRATEGY/TACTICS



Office of the Assistant Secretary of Defense (Health Affairs)
Contingency Operations Policy

ADMISSION RATES

DISEASE AND NON-BATTLE INJURY

- EXPRESSED AS ADMISSIONS/1000 PAR/DAY
- CALCULATED BY MEDICS
 - HISTORICAL DATA
 - PANELS
- INFLUENCED BY:
 - CLIMATE
 - ENDEMIC DISEASES
 - NATURE OF OPERATION
 - CONDITION OF FORCES
 - DURATION OF OPERATION
 - COMMAND DISCIPLINE
 - PREVENTIVE MEDICINE ACTIVITIES



Office of the Assistant Secretary of Defense (Health Affairs)
Contingency Operations Policy

JOINT MEDICAL SUPPORT PLANNING REQUIREMENTS CALCULATION

ACROSS TIME....

(TODAY'S REMAINING PATIENTS + PREVIOUS DAYS'
REMAINING PATIENTS) X DISPERSION =
BED REQUIREMENT

WHERE,
DISPERSION = ALLOWANCE FOR LESS THAN
PERFECT ACCESS TO ALL UNOCCUPIED BEDS



Office of the Assistant Secretary of Defense (Health Affairs)
Contingency Operations Policy

EVACUEES

- EVACUATION POLICY - THE PERIOD OF NON-EFFECTIVE TIME (DAYS) THAT PATIENTS MAY BE HELD FOR IN-PATIENT CARE
- PER CENT EVACUEES BY ADMISSION TYPE DECREASE WITH INCREASED EVACUATION POLICY - YIELDS:
 - HIGHER BED REQUIREMENT
 - MORE RETURNS TO DUTY
 - LESS EVAC TRANSPORTATION REQUIREMENT
- EVACUATION DELAY - THE PERIOD BETWEEN DECISION TO EVACUATE AND MOVEMENT - INCLUDES STABILIZATION AND WAIT FOR TRANSPORTATION



Office of the Assistant Secretary of Defense (Health Affairs)
Contingency Operations Policy

REQUIREMENTS CALCULATION

BASICALLY

**(PAR X ADM RATE) - RTD'S - EVACUEES - DIH =
PATIENTS REMAINING (OCCUPYING BEDS)**

WHERE,

PAR = POPULATION AT RISK

RTD = RETURNS TO DUTY

DIH = DIED IN HOSPITAL

CALCULATING MEDICAL REQUIREMENTS

CONOPS

WIA
RATES

KCMIA
RATES



DNBI
RATES

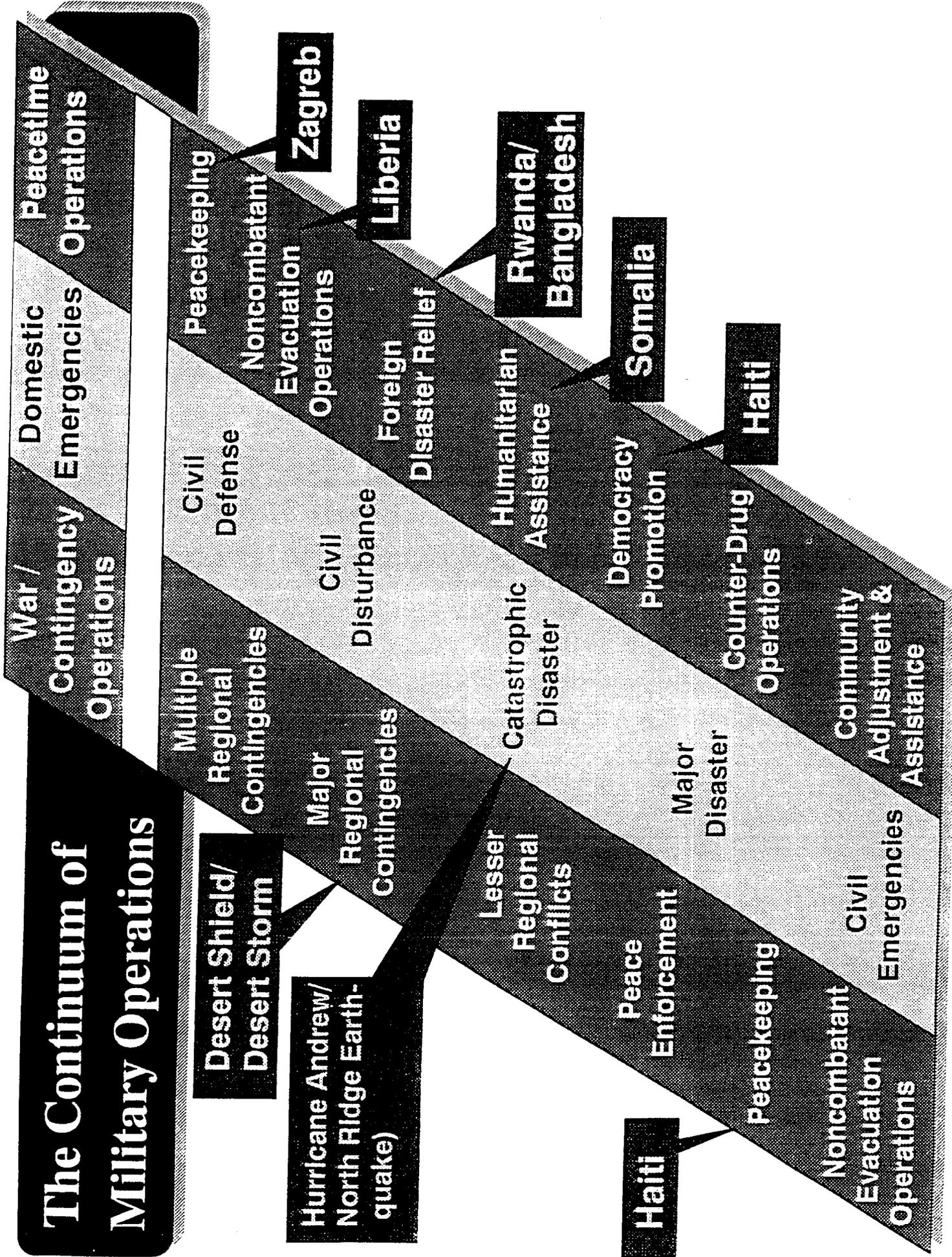
AVG
STAY

EVAC
DELAY

EVAC
POLICY

DETERMINE NUMBER 3 / 4 / 5 ECHELON BEDS

The Continuum of Military Operations



Briefing Outline

- **Introductory Remarks** **MajGen Anderson**
- **Developing Military Medical
Wartime Requirements** **CAPT Hanrahan**
- **Incorporation of Wartime
Requirements into Medical Joint
Cross Service Group** **LTC Ponatoski**
- **Closing Remarks** **MajGen Anderson**

Issues

ANG
4

- 1 Given FS decline why not deactivate units - esp in light of AF Times piece ^{expected cuts}
- 2 AF HQ forcing decisions on ANG, spreading AF Olt to ANG
- 3 price tag (ie rent) to ANG units & state ↑ ?
- 4 ANG units on big AF bases, ≠ hometown unit, visibility, & security

28M
Rosumy
Ind
fed owned

1 - downsizing in place

OPTEMPTO high now - worse if cut + active ↑ optempo
Flexible at minimal \$

to GET: = ANG 101
= OPTEMPTO

2

Medicine
Brief

Wilford Hall - Grad Med Educ

biggest

Trans AFB

big

Keesler AFB

prognostic actions to downsize w/b provided

Plan

- Cobra run to close Wilford Hall (implete close)
 - prognostic plan
 - what they've done / where going
- downsize to comm hosp

→ SEC AF from Dixon



DEPARTMENT OF THE AIR FORCE
HEADQUARTERS UNITED STATES AIR FORCE
WASHINGTON DC

1995

MEMORANDU

FROM: HQ U
1670.
Washi

SUBJECT: Re

We receive
and other appropria
the overall feasibilit
evaluation of each o

- 1. Will AF do COBRA - if find platform - or does this bring issue to closure?
- 2. Could we scale down the scope of realignment to facilitate AF performing COBRA
- 3. Can we pick on another area w/ many MTFs

(BRA) -
ted that

The Air Force is the premier Air Force medical facility known internationally for its medical services and GME teaching programs. It has a long and distinguished history in delivering health care to a population spanning the globe and in its medical research and technology development. Any decrease in capability along the lines of the two options will impact negatively on the Air Force's wartime readiness mission and operational healthcare costs.

The Air Force performed no COBRAs on WHMC during the Service's review or in the Medical Joint Cross-Service Group's study. The Air Force prefers to facilitate medical mission changes programmatically rather than through BRAC law in order to maintain a degree of flexibility in sculpting its future medical force. Flexibility is important in implementing TRICARE initiatives and delivery of healthcare to all beneficiaries. The Air Force advocates aggressive efforts in rightsizing its medical facilities based on its readiness mission, along with TRICARE, through a strategic resourcing methodology. This methodology forges the results of a population-based, demand projection, business case analysis with capitated based resource allocation and incorporates best business practices to culminate in the most effective and efficient use of healthcare resources. Using these tools will methodically and purposely eliminate duplication of services and provide for an optimum product-line and personnel mix.

We are unable to complete the requested COBRA analysis within the time constraints of your request. The Air Force has serious operational concerns with these proposed actions and believes COBRA analysis, even if available, should not be a decisive factor. Please contact Col Mayfield, HQ USAF/RTR, at DSN 225-6766 if you have any questions.

Jay D. Blume Jr.
 JAY D. BLUME JR., Major General, USAF
 Special Assistant to Chief of Staff for Realignment
 and Transition

Attachment:
As Stated

cc:
OASD/HA
HQ USAF/SG

Response To Base Realignment And Closure (BRAC) Commission's Options

For

WHMC USAF Medical Center (WHMC)

Introduction

The Air Force does not support any BRAC initiative that eliminates a major Air Force medical presence in the San Antonio region. By any standard, the Air Force is the major Service component represented in the San Antonio area. Operationally, it is home to the only Air Force induction and basic military training center. It contains four major Air Force installations, including two major commands, with WHMC representing the total Air Force bed capacity. Air Force beneficiaries outnumber other service beneficiaries by an overwhelming margin. Medically, WHMC is the flagship of the Air Force Medical Service. It is the largest, single contributor to our readiness capability, houses 34 percent of our GME training programs of which 27 are unique to WHMC, and accounts for 41% of the total physician training man-years, is the only designated Specialty Treatment Center in the Air Force, as well as its only operating Level 1 Trauma Center.

A large patient population and teaching infrastructure is absolutely essential to generate the volume and types of patients required to support graduate medical education and other specialty training programs. The Air Force has only one such hospital in their system and depends on WHMC as the foundation on which the remainder of the Air Force and DoD regional healthcare system is designed. The other three graduate medical education sites are very limited in their scope, capability, demand and capacity.

Evaluation of both options proposed for WHMC involve a review of three major functions: 1) medical readiness; 2) clinical capability (to include graduate medical education); and 3) managed care. Each of these topics' impact on cost, quality, access, and feasibility are discussed in detail below. It is impossible to separate any of these issues and fully understand the significance of WHMC's status as the "flagship" for Air Force medicine. Any dramatic change in the operational capability of WHMC threatens the viability of the entire Air Force Medical Service (AFMS) structure. It is not just the Air Force structure that is threatened by the options. The Air Force's substantial DoD mission is magnified by support of the entire San Antonio community. This total demand forced establishment of a consolidated WHMC/BAMC operating Level 1 Trauma training center. This unique mission is integral to the support of the 56 training programs and four organ transplant missions and the entire DoD medical readiness mission. In addition, a portion of the civilian indigent health care in San Antonio is supported through Congressional appropriations. In essence, the total demand generated by Lackland AFB and its external forces continue to support the requirement for WHMC. Brooke Army Medical Center (BAMC) has practically no physical capacity to support this demand. In addition, the

worldwide referral pattern also focuses on WHMC's tertiary and quaternary care capabilities and any reduction in capability, as it exists today, will degrade the overall AFMS mission effectiveness. Most critically, relocating our readiness missions, training programs and redesigning the entire DoD and AFMS referral process will raise costs and lower access to specialty and subspecialty healthcare and the quality of this care.

The Military Health Service System (MHSS) is sensitive to structuring itself to the needs of the world-wide community it serves, and is aggressively addressing this issue outside the BRAC process. In San Antonio, the new Army Medical Center at Ft Sam Houston is built recognizing the size and capability of WHMC, eliminating duplication of services and creating economies of scale. In pursuing our local GME and services realignment in San Antonio, the designated operating capacity of WHMC has been judiciously decreased from 1,000 beds to its present level of 530. Additional economies in this community may be warranted; however, it is the position of the Air Force and DoD that such actions be incorporated through careful and programmatic analyses of all pertinent factors. Weaknesses in the Joint Cross-Service Group (JCSG) model were evident in its handling of referral flow patterns, neglect of BRAC closure nominees, and an inordinate reliance on the age of facilities without regard to overall operational considerations. By any measure of merit, other than facility age, the major medical player in San Antonio is the Air Force. WHMC, despite its relatively age, is a modern, extremely well-equipped, and efficient facility.

Medical Readiness

WHMC has the largest single medical deployment mission in the Air Force. It consists of the following personnel and equipment packages: a 750-bed contingency hospital, an air transportable hospital, three 40-bed hospital surgical expansion teams, and various other taskings totaling 1360 personnel and involving 26 Unit Type Codes (UTC's).

Transfer of these taskings is impossible without moving existing medical subspecialties. Certain medical specialties are nearly 100% utilized throughout the AFMS. These include surgery, urology, aerospace medicine, anesthesiology, nephrology, pulmonary/critical care, and associated ancillary support which must be retained and relocated to other medical centers. With WHMC deployable specialty capability representing 20-30% of the total AFMS readiness mission, these taskings then could be relocated, but not without substantial medical military construction (MILCON) costs and redistribution of referral workload. Again, the demand for these critical subspecialties already exists in the greater San Antonio area and is increased by the existing AFMS referrals. These subspecialties are also integral to meeting the American College of Surgeon's Level I trauma center requirements as well as the national accreditation requirements for the 33 medical residencies and fellowships currently located at WHMC. To challenge the need for WHMC is to challenge the very essence of the AFMS delivery system and compromises our readiness mission creating a shortfall in critical specialty areas.

World events challenged the personnel assigned to this facility. During, Operation Desert Storm (ODS) tasked 1047 personnel from WHMC. Similarly, taskings for operations other than war (OOTW) locations such as Haitian/Cuban support (424 personnel) have been supported by deployments from WHMC. The Air Force's most effectively trained trauma personnel either are based at WHMC or have rotated through its Level I Trauma center. Deployment requirements tasked to smaller AFMS medical facilities often force a degradation of beneficiary care. WHMC must experience a very large tasking before this would occur.

The Air Force blood program receives 25-30% of its total annual support from WHMC. This is achievable since Lackland AFB is the induction and basic military training site for the entire Air Force. WHMC also has the casualty reception center for the entire San Antonio area. This 50-bed aeromedical staging facility (expandable to 250-beds) supports casualty reception in peace and war. Casualties returning from Just Cause, Operation Desert Storm, and other humanitarian peacetime operations are sent to San Antonio for care and most frequently to WHMC for treatment. WHMC is unique in its ability to provide all levels of casualty healthcare. In addition, the proximity of WHMC to a major airhead at Kelly AFB, precludes transport delays in receiving intensive care in a medical center environment. These capabilities must continue in the San Antonio area.

WHMC's extensive medical capabilities and leadership places them at the forefront in deployable specialty care. An example is the development of the Mobile Field Surgical Team (MFST) and Critical Care Transport (CCT) Teams. These unique capabilities are designed to deliver highly mobile, subspecialty care far forward. As a result, more critical casualties can be treated at the point of injury and then transported safely to more definitive sources of care. Both the MFST and CCT have been deployed to support of White House and Special Operations taskings. Again, this is an innovative by-product of WHMC's clinical capabilities.

WHMC and medical readiness and the AFMS cannot be separated. The vast capabilities demanded by the local community and base mission support the worldwide casualties transferred to this hospital. The entire AFMS is predicated on use of this "flagship" as the focal point for our operational readiness. Use of this focal point ensures that its graduate medical education programs turn out medical personnel who are the best qualified personnel in the world to respond to trauma in contingency situations. Diffusing this health care delivery system based upon either option proposed would drastically reduce our patient care capability and greatly increase the cost of obtaining this same capability at other locations.

Clinical Capability

WHMC represents a unique entity which would be extremely expensive to disperse or replicate anywhere in the MHSS. Located in San Antonio, it has one of the largest local beneficiary populations in the world. Over the years many military beneficiaries have relocated to San Antonio because of the vast and often unique medical services available. These include

services for many children with complex medical needs and specialties for retired groups with increasing needs for medical and surgical care. Located in southwest San Antonio, the civilian community generates over 800 cases of very serious trauma per year treated at WHMC (representing 25-33% of all cases in San Antonio). The large community combined with the large referral workload have justified the development of highly specialized services, many of which are unique in DoD.

There is limited capacity in the San Antonio area to absorb the care now being provided at WHMC particularly as it applies to quaternary services. Furthermore, there is little capacity in the MHSS to absorb the clinical training now being conducted at WHMC. Because of the national climate to reduce specialty residency programs, it would be impossible to obtain Residency Review Committee approval to reestablish military GME programs elsewhere once a WHMC program has been closed. Finally, there are both clinical services and clinical training that are unique to WHMC that could not be provided in a community hospital. These services would be difficult to defend or establish in other DoD facilities, and extremely expensive to access in the civilian community.

Realignment of WHMC as a clinic or community hospital would result in significant decrements in clinical services as well as clinical training. Providing these clinical services and clinical training in other locations would be costlier in many cases and unfeasible in many others. The overall impact on cost, quality and access to the widest range of general and highly specialized services would be severe if WHMC was realigned as a community hospital. The effects are worsened substantially if WHMC is realigned as a clinic. In both options, WHMC would be unable to provide the following services now offered by the medical center:

a. Specialized Treatment Service for autologous and allogeneic bone marrow transplantation. This requires additional clinical specialties and laboratory services not justifiable in a community hospital. This service would have to be relocated to another appropriate facility along with its vast support structure in both specialty and ancillary services. This transfer would be at great expense to the DoD.

b. Level I Trauma Services. A community hospital would not have the requisite specialty services, critical care units, patient acuity, or volume to support a full service trauma facility. WHMC has the only Air Force military trauma center which qualifies for Level I Trauma Center Certification providing this service in peacetime. This trauma center supports Mobile Surgical Team (MST) training and the Trauma and Critical Care Course for Surgeons which provides intensive refresher training for dozens of Air Force surgeons annually. The trauma center also provides the training opportunity for many Army, Navy and Air Force special forces paramedics. CBO recently lauded WHMC's trauma operation for its support of both the local community and its contribution to wartime skills preparedness of the assigned medical staff.

c. Critical Care Units. Critical care units are seldom provided in community hospitals. These units currently provide essential clinical services and a major training environment for numerous medical personnel as well as the newly established Critical Care Transport Teams.

d. Emergency Services. An estimated two thousand Code III emergency patients would be diverted or retransported to other facilities due to limited hospital capability. This introduces additional risk and morbidity to these patients and legal exposure for the Air Force.

e. Organ Donation. Participation in the San Antonio Emergency Medical System as a Level I Trauma Center has produced the majority of organ donors for the DoD Liver Transplant STS and the only DoD Eye Bank and it has also produced a substantial number of donors as a substantial community service. WHMC also provides a substantial number of the organs for the San Antonio donor bank.

f. Solid organ transplant services include the DoD Liver Transplant STS, and kidney and pancreas transplant programs. A community hospital lacks the requisite specialty services, critical care units, patient acuity or volume to support a solid organ transplant program.

g. Specialty medical and surgical services. No community hospitals can justify the full range of medical and surgical subspecialties. The patients generated by these subspecialties would exceed Brooke's planned capability and would be seen at substantial expense in the community. An ambulatory surgery facility would not be justified in a free standing clinic serving the military population alone.

h. Clinical outreach services. WHMC currently provides specialty services at outlying military facilities in DoD Region VI. These would be unsupportable as a community hospital.

i. Reference laboratory services and specialized laboratory services to support HIV and transplant services would no longer be required. This requirement would continue to exist and need to be transferred.

j. A unique DoD stereotactic radiation therapy and neurosurgery capability would no longer be justified but its requirement would continue.

k. Inpatient mental health currently serving Region 6 could not be justified in a community hospital. Absence of an inpatient mental health unit in the clinic scenario would seriously degrade support for the military training center at Lackland. No inpatient mental health unit is planned for BAMC.

i. Pediatric Intensive Care Unit (PICU). This is the only PICU in DoD (400 admissions per year). BAMC will not have a PICU. Local civilian facilities are frequently closed to PICU patients.

m. Extensive services for multiple handicapped children are available. These services are at WHMC principally because they serve a worldwide population. However, many active and retired personnel have relocated to the WHMC catchment area because of the availability of these specialized capabilities.

n. Neonatal Intensive Care. The 34 bed NICU supports critical neonates from a worldwide referral base. Military and civilian NICUs are often saturated; civilian NICU care is extremely expensive and very limited in capacity. Specialized services like extracorporeal membrane oxygenation (ECMO) and high frequency oxygenation would have to be sought elsewhere at great expense from one of the few such services that are available in the country. WHMC is the only in-transport ECMO in the country.

o. Dental. WHMC hosts 84% of the Air Force's dental GME program.

Both discussions on medical readiness and clinical capabilities have documented a substantial demand base supporting the population in the San Antonio area. Referrals from Region 6 in addition to the worldwide focus on WHMC as a source of many unique sources of care within the DoD compound the need for the health delivery system that WHMC represents. Clearly, immense costs would be driven to shift these services to other locations. Quality of patient care and access to the complete range of services currently offered by WHMC would not be possible. As documented earlier, removing the nucleus of the AFMS delivery system by changing the structure of WHMC threatens to severely limit the capability of the entire system resulting in shifted workload to much more costly civilian sources of care.

Similarly, clinical education for Air Force physicians, dentists, nurses, scientists and numerous other disciplines would be severely decremented in either scenario. The large San Antonio patient base, substantial worldwide referral patient demand, and designation as the only Level I Trauma training center have fostered the establishment of 56 graduate medical education programs including 33 medical residencies and fellowships. This demand has created a highly centralized Air Force Graduate Medical, Advanced Medical Education and Dental programs at WHMC.

AFMS personnel train in 119 different graduate programs. WHMC operates 40 of these training programs (34%); 27 of these programs are unique to WHMC. WHMC's training programs represent 471 of 1489 training years for all corps (32%) and 398 of 965 medical corps training years (41%).

The Air Force already has the leanest in-house GME program of the 3 Services relying upon sponsorship of trainees in civilian and military training programs and deferment of trainees in civilian programs. As a result of having only one major medical center, AF makes greatest use of civilian deferred status. Historical data show that physicians trained in civilian deferred status have poorer retention than those trained in military programs (20% vs. 40%). Having a greater proportion of physicians in civilian training requires AF to have more total physicians in GME training than either the Army or Navy.

Maintaining the current level of military GME programs is vital to our readiness mission. Instructors/staff actually deploy to operations or contingencies, bringing back levels of experience not available by any other means (contingency operations, utilization of military-unique equipment and apparatus). Trainees who study under these instructors gain from this experience (obviating the need to gain the experience "on-the-ground" at the time of deployment).

WHMC, by virtue of its size and location, provides a "critical mass" of organic patient population, referral patients, experienced staff, and support programs to support the training of combat critical specialties. Residency Review Committees (RRC) of Accreditation Council for Graduate Medical Education (ACGME) requires presence of supporting training programs to maintain accreditation of numerous militarily critical specialties. National healthcare economics and certain specialty RRC decisions are leading to downsizing or **elimination of civilian training programs** in these critical specialties, making it more difficult to defer trainees to these programs or to establish new programs at other DoD medical centers. Training programs in these specialties in other Services cannot produce the combined output required by their own Services and the Air Force. Therefore, WHMC's programs would have to be relocated to another medical center (none of which is large enough or has the patient base to support them or their attendant specialty programs) if WHMC was downsized. To transfer GME programs, the gaining medical center would require additional catchment area population sufficient to support the additional training requirements, akin to transfer of the Air Force beneficiary population from the San Antonio catchment area. Relocation or changes in existing GME programs require accreditation by the RRC as new programs, a process that is neither simple nor guaranteed.

STSs provide highly specialized, cost effective alternatives to civilian referral. Many would not be possible or would be much more expensive without support of GME residents and fellows. STS services must be provided in larger medical centers since smaller centers cannot provide the ancillary support or supporting specialty services necessary to make the STS effective.

Elimination of all GME programs at WHMC will deprive the Air Force of critical medical, dental, and ancillary support specialists. WHMC presently provides clinical training to over 450 officers and enlisted professionals over and above the medical and dental GME. Transfer of GME programs from WHMC will dilute the specialty training program mix necessary to provide the highly specialized medical specialists necessary to meet the healthcare needs of TRICARE beneficiaries into the next century.

In conclusion, the medical readiness, clinical capabilities and graduate medical education programs are inextricably combined. Either option would force a dilution of medical capabilities within the entire spectrum of the AFMS to a point that the AFMS may not be able to regain. Certainly, any such change would be far more costly than the continued existence of WHMC.

Managed Care

WHMC is the keystone to the DoD's managed care program called TRICARE for Health Service Region (HSR) 6. TRICARE represents a system that integrates quality, cost, and accessibility in the delivery of healthcare to our patient population. It also expands the lead agency concept from management of overlapping catchment areas to oversight of entire, considerably larger regions. HSR 6 is the second largest of the twelve regions with a total population of 1,031,513 and 17 military medical treatment facilities, of which 14 are Air Force.

Any significant realignment or reduction of WHMC's capability will significantly impact its awarded TRICARE managed care support contract. The recently awarded \$1.82 billion TRICARE managed care support contract was based on existing DoD health care resources and capacities, CHAMPUS utilization rates, and estimated future workload and physical plant capacities. By 1997, all DoD HSRs will have a single, private TRICARE support contractor responsible for developing civilian health care networks and managing the DoD health benefit in support of the Services. The contractor is "hired" to supplement the DoD direct care system based on known capacities and demand at the time of awarding the contract. Any changes to the baseline will require major revisions to the contract creating the potential for a tremendous escalation in the cost of the contract through extensive bid-price adjustments. Changing the capacity of WHMC does not negate the population's need for health care, either within the San Antonio catchment area, or within the entire region for which the contract and regional planning are based.

While government direct care savings may initially accrue from resizing WHMC, the potential savings generated will in all probability be greatly offset by the increased contract costs. Using the assumptions in the Section 733 Study, government costs could increase 10% to 24% on a per-unit basis for the same care provided in the civilian network.

TRICARE support contracts. Changing the contract-provided capacities of either WHMC or any other bedded military medical treatment facility, such as BAMC will have the following affects:

a. Affect on local catchment DoD and beneficiary costs and access. Overall, DoD and beneficiary-shared costs will increase to the extent direct care workload (inpatient and outpatient) is shifted to civilian providers. The trade-off factors identified in the CHAMPUS Reform Initiative studies may be too conservative for WHMC, given the higher demand for non-elective specialty care services, and the fact a significant portion is based on referral. Although the contractor's civilian network will be held to the same access standards as the MTF, retirees over the age of 65 (who are ineligible for TRICARE and CHAMPUS) will face both increased costs and greater difficulty accessing providers.

b. Affect on DoD Region 6 costs and beneficiary access. Because about half of WHMC's inpatient workload originates from outside the catchment area, it is probable that bid-price adjustments will occur in other regional managed care support contracts as well as Region 6's. There is extremely limited capacity at BAMC to absorb any additional inpatient workload in Region 6. Other MTFs will refer care to their local civilian network, increasing the number of non-availability statements issued, causing an unfavorable bid-price adjustment. Again, as previously mentioned, retirees over the age of 65 will face both increased costs and greater difficulty accessing providers. Increased wait times may occur for patients with elective cases which would have to remain in their local area for care.

c. Affect on DoD HSRs other than Region 6. Depending on the extent of reductions to services at WHMC affecting its reception of patients from outside Region 6, the extremely limited ability of BAMC to absorb the difference, and concomitant reduction in overall San Antonio direct care system capacity to absorb referral workload, outlying catchment areas will either have to increase direct care service capability, or increase reliance on civilian provider network workload. While this may have minimal impact on primary and secondary care, it will greatly impact tertiary and quaternary care services (e.g., bone marrow transplant, liver transplant), especially in smaller metropolitan areas (e.g., Laughlin, Reese, etc.) Limitation of WHMC's capabilities may drive increased demand for care in the local community and local MHSS facilities with resultant increase in queuing.

d. Outreach Care capability. Eliminating the WHMC capability would either show a reduction in outlying MTF workload or would have to increase local MTF resources accordingly. Given the smaller size of most other MTF populations in the region, to compensate for the loss of just one surgeon in the WHMC's Outreach program would require more than a one-to-one surgeon elsewhere in the region due to lower economies of scale at smaller MTFs. That is, if several or all MTFs attempted to continue the same level of surgical services provided currently through the Outreach program each MTF would have to procure

the services of at least one surgeon. This phenomenon is due to the ability of WHMC to use its marginal available capability to assist other MTFs (at an overall savings to the Air Force, as well as to the beneficiaries, who would otherwise use CHAMPUS). Reduction to the Outreach program would increase other MTF costs to the extent additional manpower were added to the MTFs to maintain the same capability. Without re-deploying those assets, at a greater than one-for-one basis, local CHAMPUS and beneficiary costs will increase.

Temporary deployment of clinical assets from WHMC under the Outreach program to outlying smaller MTFs provides several quality opportunities.

(a) Beneficiaries receive an enhanced direct care medical benefit than might otherwise be provided locally, and may continue receiving their care in the same institution, rather than being referred to local, off-base civilian providers.

(b) The local MTF providers receive enriched clinical opportunities as they participate in clinical practice with WHMC experts, and receive continuing medical education.

Beneficiaries currently receiving care via these TDY resources, if discontinued, would be disengaged from the direct care system, and required to access these services in the local community.

e. Impact of reduction on DoD national and regional STSs. WHMC has two of only three DoD-designated National DoD STSs: liver transplants (since 2 Dec 93) and allogenic/autologous adult bone marrow transplant (since Dec 94). WHMC's STS programs are nationally acclaimed resources serving the DoD that required years of development and system maturation. They are predicated, as are the other GME-related services, on a core local population requirement supporting an appropriate mix of diversity in patient condition, chronicity, and clinic need.

Reduction in WHMC capability and inability of BAMC to absorb these critical STS programs will require transfer and maturation of the programs elsewhere in DoD (thus MILPERS, equipment and time-related costs), or transfer of these programs to the civilian community (at increased TRICARE contractual costs), and loss of a benefit for those patients 65 years of age or older. In addition, it would affect the continuity of treatment currently provided to patients, and the critical loss of GME and clinical treatment synergies arising from multi-disciplinary and highly specialized services. Access, of course, would diminish for patients required to transfer to the civilian network, if eligible, or to fee-for-service or private HMOs if Medicare eligible.

f. Impact on AFMS quality standards. WHMC compares very favorably, or exceeds, national indicators of quality health as follows:

JCAHO Grid Scores:

AF Average- 90

Civilian Average- 83

WHMC- 98

JCAHO Accreditation With Commendation:

AF- 22%

Civilian- 10%

WHMC- All major categories received "1s" (highest score possible), no "Type 1" recommendations

MHA Quality Indicators:

AF Better than National Average on 11 of 14 Indicators

WHMC - better than the median in 19 of 23 indicators

Physician Specialty Board Completion (pass rate, first testing):

AF - 92-100%, depending on specialty

- All of our physicians (non resident) are Board Certified

Civilian- 83-92%

WHMC- The five year first time pass rates are as follows: 100% in 19 of 27 medical specialties, 95% or better in four, 90% or better in three, and one at 81%.

g. Physical plant. The new BAMC facility was planned, budgeted, and approved by Congress based on WHMC's capabilities to avoid unnecessary duplication of services. The new BAMC will not have the capacity to absorb both the inpatient and outpatient medical requirements of the local community, let alone GME/tertiary care and referral requirements, without substantial MILCON and O&M funded enhancements.

h. Reduction of services. Reduction of WHMC capabilities will degrade its Level I Trauma Center capabilities. Loss of this vital military and civilian community emergency asset will reduce access to exigent care services. A significant amount of uncompensated emergency care is also provided to the community by WHMC on an annual basis. Trauma care is usually associated with catchment and near catchment populations, and could not realistically support that population's trauma needs if transferred to another major DoD medical center (e.g. Keesler or Travis).

The new BAMC was not planned or designed to accommodate WHMC's trauma workload, but, rather, to supplement WHMC's capability. MILCON and O&M funds will be required at BAMC to maintain the same DoD capability in the community. Otherwise, the TRICARE support contract will require modification, at increased costs, since true trauma care is a local requirement, and not elective, hence, not subject to the "trade-off" factors.

Emergent patients will have to seek care elsewhere, potentially at lower level emergency medicine departments with fewer specialties immediately available. Medical staff, especially specialists, will suffer reduced opportunities for practicing wartime trauma skills. These staff could practice emergency skills in a local civilian emergency medicine department, but would then be unavailable for more routine care, consultation and continuing provider education.

Summary

This document substantiates two key points:

a. WHMC is a unique platform in the AFMS providing world-class training and medical capabilities whose continuation are critical to the entire Air Force Medical Service. No other platform exists that can accommodate the infrastructure required to support many of the medicine and surgical subspecialty training programs that are required. Diffusion of the graduate medical education program to other locations would not replace the capability that WHMC represents nationally today.

b. No COBRA has been done. If a platform could be found to accommodate this vast mission, the cost of transferring the programs and associated infrastructure would be staggering.

It is therefore critical that WHMC be maintained at its existing operational capability. Any changes to the structure of WHMC should be made programmatically and not through the BRAC process.

Document Separator

Purpose: To discuss Wilford Hall

COMM. KLING
DR MARTIN
LT Gen Habiger / AF

5/9

page 6 TX, OK, LA, MW

lead agent - Wilford Hall

merge WH + Brooke (obstetrics for ex)

merge $\left\{ \begin{array}{l} S.A \\ Henderson \\ DC \end{array} \right.$

GME big driver in merger

one set of residency in geographic area

1 major med ctr in multiple facilities merged by 2 SVCS

end of
by '97 all " "

1 residencies consolidated now

retention of med officers

CDR 59th med wing works for AETC

20% to 40% when GME provided in house
retention

try by type only @ 1 location (WH or Bke)



OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
 3300 DEFENSE PENTAGON
 WASHINGTON, DC 20301-3300



25 MAY 1995

NUCLEAR SECURITY

Honorable Alan J. Dixon
 Chairman, Defense Base Closure
 and Realignment Commission
 1700 N. Moore Street, Suite 1425
 Arlington, Virginia 22209

Dear Mr. Chairman:

This is in response to your April 27, 1995, letter requesting that the Department of Defense provide responses to questions for the record resulting from the April 17, 1995 hearing. On May 9, 1995, we forwarded an interim response to these questions. Enclosed is the final set of answers.

I trust this information will be helpful, please let me know if there is anything else we can provide.

Sincerely,

Robert L. Meyer
 Director
 Base Closure

Enclosure

cc: Senate and House Reading Rooms

Q'S FROM 17th
 * Dave/FXC See Depots (separate)
 * Mark/Morrell See UPT (separate)
 * CRAIG See Medical (separate)
 * STEVE, CRAIG, MARK See T&E/LAB



MED

MEDICAL JOINT CROSS-SERVICE GROUP

PROCESS

Questions submitted to Dr. Edward Martin

1. All but one of the 16 Joint Cross Service Group alternatives describe realignment of an acute care hospital to an outpatient clinic.

Why were so many of the Joint Cross Service Group's alternatives realignments rather than closures?

ANSWER: The Joint Cross Service Group (JCSG) did not attempt to eliminate a medical presence unless the medical facility was the host unit or the installation closed and there was not a significant active duty population projected to remain in the area. If a significant active duty population does remain, then a minimum of an ambulatory clinic will be required. This was the reason most of the proposed alternatives that the JCSG developed called for realignment to clinic status.

Is realignment to a clinic a cost effective way to eliminate excess capacity?

ANSWER: Yes, if it is clear that the hospital capability is not required. We parallel the civilian health care industry's move toward increased use of ambulatory service clinics instead of inpatient hospitals. The most significant difference in a super clinic and a small hospital is the requirement NOT to maintain a 24 hour blood bank, 24 hour nursing care and 24 hour ancillary services, such as pharmacy, laboratory and radiology. This is especially cost effective at locations with small inpatient services, and adequate civilian facilities in the immediate communities.

Would it be more cost effective to close rather than realign hospitals, especially in areas that have additional military hospitals or substantial civilian capacity?

ANSWER: The "733 Study" states that "on average, MTFs appear to provide a given amount of care at significantly less cost than is the case in the private sector." Aside from this, however, there are many other issues which mandate a medical presence on an installation other than the cost effectiveness of the medical care. Our rightsizing initiatives take into account factors such as readiness, operational medicine in support of a flying or other mission, lost time from training, TRICARE, etc.

2. What exactly did the Joint Cross Service Group have in mind when it used the word "clinic?"

ANSWER: The simplest definition of a "clinic" is a military treatment facility without inpatient services. In its April 15, 1995 Report to the BRAC 95 Review Group, the BRAC 95 Joint Cross-Service Group for MTFs and GME defined a clinic as "An outpatient treatment facility that has a

commanding officer, receives funds directly from the Service headquarters, and provides care to active duty and other beneficiaries.”

It is expected that the medical service plans developed for each realignment location will specify the services and personnel required to best support the remaining beneficiary population. In some cases that may be a “super clinic” in which there is significant capability to provide comprehensive ambulatory services to include same day surgery, laboratory, pharmacy and radiology services. A super clinic might also often include the capability for overnight care for active duty personnel who cannot return to the billets.

3. Who has the final say as to what is included in a clinic, and who decides how many people it takes to operate one?

ANSWER: The Military Departments have responsibility for providing medical and dental care for their personnel and allocation of staffing to provide those services. This is done by the medical command or line authority responsible for the military treatment facility. The responsible command takes many factors, including operational medicine, special base concerns, and local circumstances into consideration as they make these determinations.

TRICARE, the Department’s regionalized managed care plan brings together the health care delivery system of each of the military services, as well as the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), in a cooperative and supportive manner to better serve military patients and to better use the resources available to military medicine. The organization of TRICARE includes twelve regions, each administered by a lead agent, who is a commander of one of the military medical centers located within the region. These lead agents have developed, and are in the process of implementing, in collaboration with all the military treatment facility commanders in the region, integrated plans for the delivery of health care to beneficiaries residing in the region. This will shape the level of service and staffing found in each facility.

4. Given that direct care services in military hospitals are essentially free to beneficiaries, while services received under CHAMPUS involve co-payments and deductibles, do you believe it is reasonable to conclude that demand for services may diminish when direct care services are reduced?

ANSWER: It is possible that the number of visits may decrease slightly, but there probably would not be a corresponding decrease in the intensity of services. Various DoD studies, including the “733 study”, found an “induced-demand” effect given free MTF care in lieu of CHAMPUS; however, this applied mostly to routine outpatient care and not specialty care.

PRIOR ROUND AND NON-BRAC ACTIONS

5. Please describe how reductions in the medical area fit into the larger, DOD-wide drawdown context?

ANSWER: The Department of Defense is changing and so is its medical support. Assuming all BRAC and other DHP programming actions are implemented, the Department will have reduced our infrastructure by 59 hospitals and 12,000 beds worldwide since 1988.. This is a 35% reduction in hospitals and a 42% reduction in bed capacity. 17 facilities overseas were closed and 42 inpatient facilities within CONUS have been closed or realigned. 25 of those inpatient facilities have occurred due to BRAC 88, 91, and 93.

6. Do past BRAC actions and the current set of recommendations keep pace with changes in the rest of the military or are medical assets drawing down at a faster or slower pace?

ANSWER: Medical infrastructure reductions parallel similar changes occurring elsewhere in the Department. Overall active duty strength has decreased approximately 30% with a corresponding 35% reduction in hospitals and a 42% reduction in bed capacity.

7. In meetings with Commission staff, you described a number of hospital realignment actions taking place outside of the BRAC process.

Please specify what the Department is doing to eliminate excess inpatient capacity beyond the recommendations sent to this Commission. Please include name of hospital, details of the action, and the time frame during which the action is to occur.

ANSWER: Since the end of the Cold War, the Department has aggressively sought to reduce excess infrastructure. Over 58 hospitals will have closed or realigned. The Defense Health Program has also experienced approximately 12,000 normal bed reduction during this period. These reductions account for a 43% decrease in beds and a 35% decrease in number of inpatient facilities since 1988.

Within the continental United States, 42 hospitals will have closed by the end of BRAC 95, assuming the current recommendations are accepted. These actions were accomplished by the cumulative base realignment and closure rounds and the Defense Health Program initiatives. These initiatives include, but are not limited to the following type actions:

- Small Hospital Study
- Realignment of hospitals to ambulatory care centers
- Modification of emergency room services
- Evaluation of alternative staffing options and delivery models
- Reshaping the medical force to focus toward managed care and shift to ambulatory surgery
- Joint staffing

- Sharing agreements with the Department of Veterans Affairs

Discontinuation of inpatient services:

- Naval Station, Adak, Alaska
- Naval Home, Gulfport, Mississippi
- McConnell Air Force Base, Kansas
- Kirtland Air Force Base, New Mexico (resource sharing with DVA)
- Malstrom AFB, Montana
- Naval Hospital, Newport, Rhode Island
- Grissom Air Force Base, Indiana
- Reese Air Force Base, Texas
- McGuire Air Force Base, New Jersey

Defense Programming Action is slated to terminate inpatient services in the following Navy hospitals:

- Naval Hospital Charleston, South Carolina
- Naval Hospital Patuxent River, Maryland
- Naval Hospital Millington, Tennessee
- Naval Hospital Corpus Christi, Texas
- Naval Hospital Groton Connecticut

Discontinuation of emergency room services:

Emergency room services have been modified at 18 Air Force bases (level III to level IV emergency services)

- Seymour Johnson Air Force Base, North Carolina
- Griffiss Air Force Base, Indiana
- Sawyer Air Force Base, Michigan
- Moody Air Force Base, Georgia
- Cannon Air Force Base, New Mexico
- Holloman Air Force Base, New Mexico
- Castle Air Force Base, California
- Beale Air Force Base, California
- Little Rock Air Force Base, Arkansas
- Whiteman Air Force Base, Missouri
- Plattsburgh Air Force Base, New York
- Columbus Air Force Base, Ohio
- Laughlin Air Force Base, Texas
- Tyndall Air Force Base, Florida
- Reese Air Force Base, Texas
- McGuire Air Force Base, New Jersey
- Grand Forks Air Force Base, North Dakota
- Maxwell Air Force Base, Alabama

The Air Force is evaluating two other facilities.

Termination of Obstetric and nursery Services:

- March Air Force Base, California
- McClellan Air Force Base, California
- Beale Air Force Base, California
- Fairchild Air Force Base, Washington
- The Air Force is evaluating an additional eight facilities.

In particular, please describe current or planned actions for realignment, consolidation, or other "right-sizing" at the following facilities:

ANSWER:

- **Blanchfield Army Community Hospital, Fort Campbell, Kentucky**
- **Ireland Army Community Hospital, Fort Knox, Kentucky**

Ireland Army Community Hospital is consolidating small outlying clinics and realigning internally to focus on product line management.

- **Madigan Army Medical Center, Fort Lewis, Washington**
- **Naval Hospital Bremerton, Washington**
- **Naval Hospital Oak Harbor, Washington**

These three facilities are all in DoD Health Service Region 11 which recently began implementation of TRICARE, our regionalized managed care program for the Department of Defense. Madigan Army Medical Center (MAMC) is the lead agent for this area and has developed, and is in the process of implementing, in collaboration with all the military treatment facility commanders in this region, integrated plans for the delivery of health care to beneficiaries residing within the region. TRICARE brings together the health care delivery systems of each of the military services, as well as the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), in a cooperative and supportive effort to better serve military patients and to better use the resources available to military medicine.

The Puget Sound Federal Health Council was established three years ago. It includes representatives from the Military Departments, Veterans Administration, Coast Guard and University of Washington. The council fosters resource sharing initiatives, such as:

- consolidation of laboratory functions so as to obtain bulk rates on supplies and the designation of MAMC as the sole site for certain tests
- regionalization of the pharmacy to maximize prime vendor efforts
- transportation sharing to enhance medical evacuation between the facilities.

While Madigan Army Medical Center (MAMC) has no current plans to reduce beds or service from their present levels, these issues are, and have been, under constant review. As a result of utilization reviews and implementation of improved pre-admission process for surgical candidates, MAMC has reduced bed capacity to better match care requirements. Changes in services are also anticipated at a number of outlying clinics in response to BRAC initiatives now under study.

The Navy is realigning nine officer and seven enlisted billets to Naval Hospital, Bremerton, Washington to meet anticipated increase of over 9,100 active duty and their family members. There is a BRAC military construction project scheduled for FY 98 for ambulatory care additions.

- **Walter Reed Army Medical Center, DC**
- **Dewitt Army Community Hospital, Fort Belvoir, Virginia**
- **National Navy Medical Center, Maryland**
- **Malcolm Grow USAF Medical Center, Andrews AFB, Maryland**

ASD(Health Affairs) Medical Program Guidance, FY 1997 - 2001, requires the Services "to integrate, right size and eliminate unnecessary duplication in the National Capital Region." The medical treatment facilities in this area are aggressively working to pursue graduate medical education consolidation as well as clinical services realignment/integration. This is a maturing initiative with the two most mature actions being the OB/GYN/NICU realignment between Walter Reed Army Medical Center (WRAMC) and the National Navy Medical Center (NNMC) and mental health initiatives that involve all three medical centers in the national capital area. The OB/GYN/NICU initiative will permit concentration of resources for accommodation of larger beneficiary workloads (WRAMC will provide specialty gynecological services; NNMC will be responsible for neonatal ICU and problem obstetric cases). A similar initiative to consolidate and eliminate redundant mental health services within the region is expected to result in a 30% - 40% reduction in inpatient beds in the national capital area with significantly reduced outpatient CHAMPUS costs as well.

By October 1, 1995 WRAMC will have integrated all the Army medical assets within this area to provide command and control of a cost effective, multidisciplinary, customer focused health care network. This will allow appropriate shifting, consolidation, and efficiencies. DeWitt Army Community Hospital is in the middle of a major primary care initiative aimed at recapture of the primary care base in Northern Virginia and involves major realignments within the hospital and between outlying clinics to include PRIMUS clinics.

Malcolm Grow USAF Medical Center has decreased inpatient operating beds by 31% in the last two years.

- **McDonald Army Community Hospital, Fort Eustis, Virginia**
- **Naval Hospital Portsmouth, Virginia**
- **1st Medical Group, Langley AFB, Virginia**

The military services have a long tradition of cooperation and collaboration in the Tidewater area as evidenced by the many tri-service health care initiatives in this area in recent years. The Navy Medical Center, Portsmouth, Virginia is the Lead Agent for DoD Health Service Region II which includes all three facilities. Recent initiatives in this area include:

- the establishment of voice and data communication networks to allow joint utilization of medical resources
- integration of major information management systems to create enrollment, health care finder and provider networks
- establishment of a patient service center
- increased use of inpatient military resources and better, smarter, utilization of assets in the civilian community is resulting in a decline in both outpatient visits and hospital admissions.

The Navy is evaluating current staffing in this area and may realign some manpower resources into their Branch Clinic at Oceana. The 1st Medical Group at Langley AFB has decreased inpatient operating beds by 20% in the last two years and has developed resource sharing agreements in ENT and neonatology. In addition they have developed an oxygen contract buy-in with the Hampton VA Medical Center. McDonald Army Community Hospital will have a "TriPrime Clinic" open in January 1996 in a continuing effort to develop their primary care network.

- **Munson Army Community Hospital, Fort Leavenworth, Kansas**
- **Irwin Army Community Hospital, Fort Riley, Kansas**
- **351st Medical Group, Whiteman AFB, Missouri**

The distance between these facilities, and their relative size and mission, diminish many of the opportunities for effective resource sharing between them. Individually however they have all incorporated managed care principles into their operations which contribute to efficiency and right-sizing at their own facilities. For example, Irwin ACH at Fort Riley, Kansas has combined its pediatric and medical/surgical wards into one in an effort to better utilize available health care resources for the community they serve.

- **Womack Army Community Hospital, Fort Bragg, North Carolina**
- **Naval Hospital Cherry Point, North Carolina**
- **Naval Hospital Camp Lejeune, North Carolina**
- **4th Medical Group, Seymour Johnson AFB, NC**

These facilities are part of DoD Health Services Region Two; the Lead Agent being the Navy Medical Center, Portsmouth, Virginia. A managed care organization, Eastern Carolina Coordinated Care, has been established to maximize referrals to the MTFs through the TRICARE Service Center that assists in locating appointments for beneficiaries with preferred and participating providers.

Womack Army Medical Center continues to develop its primary care initiative, started in January 1992, with the objective of developing a primary care network that would be capable of offering managed care enrollment to 80% of the eligible population in preparation for the transition to TRICARE. The 4th Medical Group at Seymour Johnson AFB modified emergency medicine services from level III to level IV in 1993.

- **Naval Hospital Camp Pendleton, California**
- **Naval Hospital San Diego, California**

These facilities are part of DoD Health Services Region Nine; the Lead Agent being the Navy Medical Center, San Diego, California. San Diego is just entering its implementation of region-wide resource sharing. They have a long standing association with the Naval Hospital Camp Pendleton to assist in graduate medical training. Some general surgical residents from the Naval Medical Center, San Diego obtain their obstetrics training at Pendleton and transitional inters perform their family practice rotation there. In addition family practice residents from Camp Pendleton rotate through the medical center for specialty training not available at their facility. In addition, NMC San Diego routinely provides specialty physicians to NH Camp Pendleton, in particular pediatric support and orthopedic support assist in reducing CHAMPUS and supplemental care expenditures.

- **Evans Army Community Hospital, Fort Carson, Colorado**
- **USAF Academy Hospital, Colorado**

ASD(Health Affairs) Medical Program Guidance, FY 1997 - 2001, requires the Services "to integrate, right size and eliminate unnecessary duplication at... Ft. Carson Army Community Hospital/Air Force Academy Hospital." The two facilities have formed the Pikes Peak Area Initiative in a proactive effort to improve cooperation and collaboration between their facilities. Resource sharing in urology and ENT is underway. Evans ACH has reduced inpatient beds from 110 to 85 and combined medical and surgical wards.

- **Bliss Army Community Hospital, Fort Huachuca, Arizona**
- **355th Medical Group, Davis-Monthan AFB, Arizona**

These facilities are part of DoD Health Services Region Seven; the Lead Agent being William Beaumont Army Medical Center (WBAMC), Texas. There is a joint Davis-Monthan/WBAMC preferred provider network that covers all specialties. Referral workload is sent to William Beaumont and Wilford Hall Medical Center. The Air Force also used the Navy Clinic, Yuma, AZ for orthopedic cases. The Air Force hospital has decreased inpatient operating beds by 14% in the last two years.

- **Naval Hospital Pensacola, Florida**
- **646th Medical Group, Eglin AFB, Florida**
- **325th Medical Group, Tyndall AFB, Florida**
- **Keesler USAF Medical Center, Keesler AFB, Mississippi**

These facilities are all part of DoD Health Services Region Four; the Lead Agent being Keesler USAF Medical Center. The lead agent is exploring the idea of locating a tri-service alcohol rehabilitation program at Pensacola Naval Hospital for all the southeast. A region-wide reference laboratory service, for all beneficiaries in this area is also being pursued.

Pensacola NH and Keesler USAF Medical Center have agreements regarding several training programs and reciprocal medical board processing. Pensacola NH and the 646th Medical Group at Eglin AFB have combined efforts in procuring some highly specialized diagnostic equipment for their facilities. In addition Eglin cares for Pensacola's inpatient psychiatric patients in exchange for Pensacola taking Eglin's outpatient alcohol rehabilitation patients. Tyndall AFB refers all specialty required work to Keesler.

Other right-sizing initiatives have resulted in the 646th Medical Group decreasing inpatient operating beds by 19% in the last two years while Keesler has decreased beds by 8% in this same period.

- **Martin Army Community Hospital, Fort Benning, Georgia**
- **Lyster Army Community Hospital, Fort Rucker, Alabama**
- **502nd Medical Group, Maxwell AFB, Alabama**
- **653rd Medical Group, Robins AFB, Georgia**

The relative distance between these facilities limits many types of right-sizing opportunities although they do share assets. Robbins AFB is exploring possible sharing agreements with the Veterans Administration medical center in the area and with a local civilian medical facility. There has been a 50% decrease in operating beds at Maxwell AFB in the last two years.

- **Reynolds Army Community Hospital, Fort Sill, Oklahoma**
- **97th Medical group, Altus AFB, Oklahoma**
- **654th Medical Group, Tinker AFB, Oklahoma**
- **396th Medical Group, Sheppard AFB, Texas**

Reynolds Army Community Hospital has several initiatives to maximize assets. Resource sharing agreement with the adjacent VA outpatient clinic has been completed. Reynolds anticipates completion later this year of resource sharing agreements with two nearby Air Force facilities through their "Friends and Neighbors" program that promotes cost avoidance in such areas as orthopedics, general surgery, neurology, and dermatology. Their outlying family practice facilities have been consolidated in the main hospital facility thereby allowing turn in of excess buildings. Other consolidations of wards, clinics and staff have also occurred.

Tinker AFB, OK provides orthopedic surgeons to assist McDonnell AFB, KS. A proposal to convert the emergency room at Tinker AFB into a 24 hour acute care clinic is currently being developed. Sheppard AFB provides monthly manning assistance to Altus, Tinker, and Reese AFBs in such areas as ENT, audiology, orthopedics and podiatry. Other such cross-

sharing of assets in frequent between these facilities. Inpatient beds at Altus AFB have declined by 53% in the last two years and 29% at Tinker AFB.

- **Moncrief Army Community Hospital, Fort Stewart, Georgia**
- **363rd Medical Group, Shaw AFB, South Carolina**

Inpatient operating beds have decreased 17% in the last two years at Shaw AFB and the Special Care Inpatient Nursing Unit is being evaluated for closure. Air Force ophthalmologists care for Army beneficiaries at Moncrief Army Community Hospital. Army radiologists read mammography films for Shaw AFB and the Air Force provides gynecological care to Army beneficiaries at SHAW AFB.

- **Winn Army Community Hospital, Fort Stewart, Georgia**
- **Naval Hospital Beaufort, South Carolina**

No formal agreements or programs are in place though they share assets on a frequent basis. 66 miles separate the facilities making routine sharing difficult.

In regards to planned actions, please be specific about the status of those plans in Defense Health Program budgeting.

ANSWER: ASD(Health Affairs) Medical Program Guidance, FY 1997 - 2001, requires the Services "to integrate, right size and eliminate unnecessary duplication at Ft. Carson Army Community Hospital/Air Force Academy, at Brooke Army Medical Center/Wilford Hall USAF Medical Center, and in the National Capital Region."

In addition the programming guidance addresses graduate medical education: "The components shall integrate remaining duplicate training GME programs in the National Capital Region and San Antonio, Texas not later than FY 1998."

Also, please describe in detail the status of current plans to convert Naval Hospital Charleston, SC; Naval Hospital Patuxent River, MD; 9th Medical Group, Beale AFB, CA; 323rd FTW Hospital, Mather AFB, CA; and 438th Medical Group, Fort Dix, NJ into outpatient clinics.

ANSWER:
Navy hospitals

A "quick analysis" of these five facilities was performed in April 1994 and it was determined that ambulatory health care centers were viable alternatives at these sites. As a result of this "rightsizing," Navy could optimize manpower and fiscal resources by transferring end strength from these facilities to OCONUS and Fleet units, and by off-setting very expensive contracts in Navy MTFs. The contractual and MILCON savings realized by this action equate to over \$270 million dollars across the FYDP.

A complete analysis of each facility is currently in progress by BUMED. It is anticipated that this detailed analysis will be completed later this summer. If the analysis supports the earlier review, then the projected transition date should coincide with the implementation plan for realignment.

Change in service dates, now projected, are as follows:

Naval Hospital, Millington	Nov 96
Naval Hospital, Groton	Nov 97
Naval Hospital, Patuxent River	Nov 97
Naval Hospital, Corpus Christi	Nov 96
Naval Hospital, Charleston	Nov 97

Naval Hospital, Charleston

As a result of BRAC actions closing Naval Base Charleston and the decommissioning of many associated fleet units and the migration of many others, it became necessary to right-size the Naval Hospital, Charleston to support remaining active duty members and their families.

Naval Hospital, Charleston reduced operating beds from 130 to 90 in December 1992. As of October 1995, it is projected that approximately 29,000 active duty and family members will remain in the Charleston catchment area. Historic utilization rates project an average daily inpatient census of between 35 and 37 for that remaining population and the decision was made to further reduce operating beds to 40 effective 1 October 1995. As a result, external partnerships for routine inpatient obstetric service and inpatient psychiatric services were initiated and are in place.

The result of BRAC 95 and other fleet and operational movements is being carefully monitored to determine if it will be necessary to increase operating beds or, with the arrival of TRICARE in May 1997, to further decrease or eliminate inpatient beds. The plan would use contracts and partnerships for the limited number of active duty inpatient beds required and rightsize the Naval Hospital to an ambulatory care center later in 1997.

Air Force Hospitals

9th Medical Group, Beale AFB -- A change from hospital to clinic status is currently being evaluated. Obstetrical services closed in 1994 and inpatient operating beds have decreased 17% in the last two years.

323rd FTW Hospital, McClellan AFB -- Obstetrical services closed in 1994. Inpatient operating beds have declined 17% in the last two years.

438th Medical Group, Ft Dix -- This facility was reduced to clinic status from an inpatient facility on 1 January 1995.

Why isn't the Department doing these actions through the BRAC process?

ANSWER: Our purpose during BRAC 95 was to evaluate cross Service opportunities for Single Service asset sharing, decrease excess capacity, and reduce duplication within the Military Health Service System (MHSS). The alternatives submitted by the Joint Cross-Service Group on Military Treatment Facilities have been largely accomplished through the BRAC process and other ongoing management initiatives. I understand and support the rationale the Services have provided for maintaining most of the remaining facilities that were provided for their consideration.

The MHSS is sensitive to structuring itself to the needs of the world-wide community it serves, and has been aggressively addressing this issue outside the BRAC process. Additional rightsizing initiatives, such as the planned integration of Wilford Hall USAF Medical Center and Brooke Army Medical Center and the integration of Evans Army Community Hospital and the USAF Academy Hospital, will be addressed through future Defense program and budget review processes.

Our goal is to reduce unneeded infrastructure thus allowing us to use our resources for more critical requirements. The Services have taken different approaches to how to accomplish this. We are concerned with the results, not the process the Military Departments have taken to achieve them. Our cumulative record of infrastructure reductions since the end of the Cold War demonstrate the success of our efforts.

Given the frequency with which budgets can and do change, what assurances do you and the Commission have that these actions are really going to take place?

ANSWER: The ASD(Health Affairs) has been the program manager for the Department's health resources since 1991. As a consequence, we have worked on a joint basis for several years and will continue to develop and implement programs and systems that facilitate effective and efficient use of resources.

Do you believe it would be beneficial for the Commission to add any or all of the actions you describe to its list of actions to consider?

ANSWER: I don't think this is necessary. We are confident that the rightsizing initiatives now underway and planned can achieve the management goals we have established.

8. San Antonio, Texas is home to two large military medical centers and a large number of civilian hospitals. This appears to be an example of an opportunity to eliminate a substantial portion of excess capacity, and, indeed, the Air Force facility, Wilford Hall, was on the Joint Cross Service Group list of realignment alternatives. Yet neither facility is on the DOD list.

Why?

Why did the Air Force choose not to realign Wilford Hall to either a clinic, as the Joint Cross Service Group alternative suggests, or a community hospital?

Is there a plan to realign and consolidate services at Wilford Hall and Brooke Army Medical Center? If so, what is its status?

Are you comfortable with the Army and Air Force plans to enact such an alternative through the budget process? If not, do you feel that Commission action could better ensure that the necessary realignment takes place?

Given the unique aspects within both the Brooke Army Medical Center and Wilford Hall, would you envision any actual infrastructure operating efficiencies by a consolidation? Would you actually be able to close a facility by consolidation?

ANSWER: The Joint-Cross Service Group for Medical Treatment Facilities analysis did provide an alternative for consideration by the Air Force that realigned Willford Hall Medical Center (WHMC) to a clinic. This option was based on computer modeling that consolidated the acute and medical center inpatient care requirements in San Antonio at Brooke Army Medical Center and converted Willford Hall to an ambulatory care facility. The alternative was based on quantitative modeling results that suggest the reduced beds are not needed for wartime demand nor to meet the projected peacetime direct care inpatient requirements.

The Air Force evaluated, and strongly rejected, this alternative based on consideration of several additional factors that were not included in the model. Wilford Hall Medical Center is the premier Air Force medical facility and is known internationally for its specialty medical services and graduate medical education teaching program. It is the largest, single contributor to their readiness capability, houses 34% of their GME training programs of which 27 are unique to WHMC, and accounts for 41% of the total physician training man-years, is the only designated Specialty Treatment Center in the Air Force, as well as its only operating Level 1 Trauma Center. The Air Force believed that any decrease in capability along the lines of the two options indicated will impact negatively on both their wartime readiness mission and operational healthcare costs.

The Department fully agreed with the Air Force's assessment. We are currently developing a plan for consolidating health services throughout DoD Health Service Region VI that includes most of Texas, Oklahoma, Louisiana and Arkansas. One aspect of this is the integration Wilford Hall USAF Medical Center and Brooke Army Medical Center so as to eliminate any nonessential duplication of services in the San Antonio area. Integration of graduate medical education programs between these two facilities is already underway.

I believe this can, and will, be achieved by the management initiatives now planned and underway. It is expected there will be considerable operating efficiencies gained through these actions. I don't think action by the Defense Base Closure and Realignment Commission is necessary. We are confident that the rightsizing initiatives now underway and planned can achieve the management goals we have established.

REQUIREMENTS

9. The Commission staff understands that there is some disagreement within the Department in the area of wartime readiness requirements for hospital beds.

However, do even the highest estimates of required wartime beds exceed the current inventory of over 20,000 mobilization beds?

ANSWER: The General Accounting Office's report on DoD's 1995 process and recommendations for closure and realignment states, "several key variables that greatly affect the wartime demand for medical care are still in debate. And, while the cross-service group's analysis and other studies indicate some excess capacity in medical facilities will remain after BRAC 1995, it is unclear that there is consensus on wartime requirements and therefore on how much excess capacity exists DoD-wide."

Overall active duty strength has decreased approximately 30% with a corresponding 35% reduction in hospitals and a 42% reduction in bed capacity. For BRAC 95, our wartime requirements were based on the most current Defense Planning Guidance, which was approximately 10,000 beds. Our modeling of the MHSS required that any alternative solution retain the aggregate number of wartime beds to meet the MHSS system wide and Service specific bed requirements. We also defined requirements based on FY 94 direct care inpatient rates for active duty members, retired personnel, and their family members. The rates were applied to the projected 2001 populations associated with each catchment area and resulted in a bed requirement for each MTF. This requirement could be met by either the direct care system or civilian sector resources. Our model ensured enough beds were retained in the aggregate MHSS to meet the non-wartime requirement.

Tertiary care demand was also based on FY 94 direct care rates for our GME facilities. Demand was generated based on populations east and west of the Mississippi. Our model then found the "best fit" of our MHSS resources to meet the requirements.

SERVICES' RESPONSES TO JOINT CROSS SERVICE GROUP ALTERNATIVES

10. Eleven of the sixteen alternatives provided to the Services by the Joint Cross Service Group were not accepted.

Are you satisfied that the DOD list goes as far as it should in reducing medical infrastructure?

Do the eleven rejected alternatives represent missed opportunities?

ANSWER: There is probably some excess capacity still in our system. I don't at all consider these "missed opportunities." The alternatives submitted by the Joint Cross-Service Group on Military Treatment Facilities have been largely accomplished through the BRAC process and

other ongoing management initiatives. I understand and support the rationale the Services have provided for maintaining most of the remaining facilities that were provided for their consideration. Additional rightsizing initiatives will be addressed through future Defense program and budget review processes.

TESTIMONY BEFORE THE COMMISSION

11. In testimony before the Commission on April 17, 1995, you stated that there is a significant change in how DoD delivers care to eligible beneficiaries within its facilities. Specifically, you stated that the Air Force has stopped doing emergency services in 11 hospitals and closed 17 others. In addition, you testified that the Navy is in the final process of making judgment about downsizing five hospitals to clinics.

Please provide for the record the details upon which your statements were based. At a minimum, please include the locations of affected hospitals, the date the change became or will become effective, and what other plans your office may have to continue the significant changes in how DoD delivers care.

ANSWER: See question 7 above for the response.

Questions Submitted for General Shane

1. How did the Army define "clinic" for the Fort Lee and Fort Meade realignments and what was the basis for the size of the staff reductions in the recommendations for these two hospitals?

ANSWER: Both Kenner and Kimbrough General Community Hospitals perform same day surgery and would therefore normally generate a one day admission even without "inpatient services." Kenner and Kimbrough Army Community Hospitals did not receive a listing of what services to provide to qualify as a clinic. US Army Medical Command expectation is that the Medical Service Action Plan developed by Kenner and Kimbrough staffs will describe the services they think best for the community and the amount support staff. The staff reductions were developed using a manpower staffing assessment model (Benchmark). This methodology determined manpower requirements at 25 Army medical treatment facilities (MTF). By the end of CY 95, 100 percent of the Army MTFs will have been assessed using the Benchmark Requirements Determination Process. The Army Personnel Proponency Directorate (APPD) uses the model to determine AMEDD Program Objective Memorandum manpower requirements.

2. In developing the cost savings estimates for the two Army hospital realignment actions, what assumptions did the Army make about both inpatient and outpatient CHAMPUS cost increases?

ANSWER: Trade-off factors developed and validated by DoD project the civilian sector utilization when a MTF is realigned. Active duty family members' care would shift to outside sources at a ratio of 1:1. Beneficiaries other than active duty family members would seek care

from outside sources at a rate of 1:2.8 MTF dispositions and outpatient visits. All scenarios depicting the elimination of inpatient services at any MTF assume that sufficient personnel and funding resources remain to provide outpatient, diagnostic, ancillary, and referral services commensurate with the remaining mission.

The elimination of inpatient services would result in a 100 percent reduction in personnel supporting the inpatient services. A portion of these personnel would transfer with associated funding to other MTFs to provide the inpatient care formerly performed or subsequently referred by the realigning MTFs.

For Fort Lee, the costing assumes that the fiscal year 1994 dispositions would transfer to outside sources at the tradeoff factor rates shown above.

For Fort Meade, the costing assumes 85 percent of the fiscal year 1994 dispositions would transfer to Walter Reed Army Medical Center (WRAMC); the remaining 15 percent would live a significant distance outside the WRAMC catchment area to warrant their seeking care through CHAMPUS; i.e., the CHAMPUS deductible/copay would be less the cost/inconvenience of traveling to WRAMC.

3. Please explain why the Army accepted some of the Joint Cross Service Group alternatives but not others?

ANSWER: The Army accepted some JCSG alternatives and not others for operational and financial reasons. DeWitt Army Community Hospital (DACH), Fort Belvoir, VA, is a keystone to the Northern Virginia Primary Care Initiative that provides the area beneficiaries with scarce primary care services so vital to a successful managed care program. The closure or downsizing of DACH to a clinic would not have only jeopardized the primary care initiative (for which DACH received the Vice President's Reinventing Government Award), but might have caused ASD (HA) to lose valuable Congressional support for DoD's TRICARE program. The DACH averages about 42,000 outpatient visits per month, which is greater than the outpatient contribution of Malcom Grow Medical Center (39,000 monthly). Additionally, the realignment of DACH never had a return on investment which was primarily caused by the high increase to the recurring CHAMPUS cost of \$23.6 M/year.

Downsizing or closure of Lyster Army Community Hospital (LACH), Fort Rucker, AL, would impact readiness by reducing specialized medical support for the Army Aviation School. The closure or downsizing of LACH to a clinic would force active duty patients (flight students and cadre) to on-post care in Dothan, AL about 45 minutes away. The lack of on-post care would result in high levels of pilot "downtime." Additionally, the realignment scenario never had a return on investment.

Questions Submitted for Major General Blume

1. Based on documents provided to the Commission and discussions between the Commission staff and DoD representatives, it is understood that both the Army and the Navy performed

COBRA analyses for all of the Joint Cross Service Group alternatives, but that the Air Force did not perform any.

Is this correct? If so, why didn't the Air Force do the analyses needed to determine such an important aspect of the feasibility of the alternatives?

ANSWER: Yes, this is correct. The Air Force performed no COBRA analyses on the JCSG alternatives because any list provided by the model at that time was premature. The initial results provided by the model in December did not incorporate (remove) the Services' proposed bases for closure and realignment before it was run. Medical facilities at installations which should have been removed from the model included those at Reese and Kirtland AFBs; Army facilities at Fort McClellan, Fort Ritchie, and Fitzsimmons AMC; and Navy installations at Long Beach, and centers in Kentucky, Indiana, Maryland, New Jersey, and Pennsylvania.

Also, and just as important, the model used by the JCSG needed improvements and enhancements in order to provide an accurate list of alternatives for further discussion. Some of these included correcting the excessive flow of GME beds to OCONUS, disallowing binary constraints to keep a facility open at medical center level, and verifying that MTF data accurately reflected reality.

Did the Air Force actively participate in the Joint Cross Service Group effort?

ANSWER: Yes, officers from the Air Force Surgeon General's office participated in the Joint Cross Service Group effort; however, this involvement should not be interpreted as Air Force endorsement of the final results. The alternatives produced by the Joint Cross-Service Group would require review against the total Air Force installation BRAC evaluation and recommendations.

If the Air Force wasn't going to consider the Joint Cross Service Group alternatives, why did the Joint Cross Service Group bother to consider Air Force Hospitals at all?

ANSWER: The Air Force would have considered the Group's alternatives if the model had incorporated each of the Services' proposed bases for closure and realignment made in this round. But, since these alternatives were based on the current base structure and did not factor in the Services' BRAC 95 recommended closures and realignments, it was considered premature to pursue any action on this list of alternatives. Improving and enhancing the model, then returning it with the '95 BRAC basis included, would have certainly provided a worthwhile bases from which to discuss potential rightsizing actions and how best to meet the needs of our beneficiary population.

Additionally, and for your consideration, the Air Force prefers to facilitate medical mission changes programmatically rather than through the BRAC process in order to maintain a degree of flexibility in sculpting its future medical force. Flexibility is important in implementing TRICARE initiatives and delivery of health care to all beneficiaries. The Air Force advocates aggressive efforts in rightsizing its medical facilities based on its readiness

mission, along with TRICARE, through a strategic resourcing methodology. This methodology forges the results of a population-based, demand projection, business-case analysis with capitated-based resource allocation and incorporates best business practices to culminate in the most effective and efficient use of health care resources. Using these tools will methodically and purposely eliminate duplication of services and provide for an optimum product-line and personnel mix.

Question Submitted for Mr. Nemfakos

1. Please explain why the Navy did not accept either of the two Naval Hospital realignment alternatives on the Joint Cross Service Group list?

ANSWER: The alternative to realign Naval Hospital Beaufort to a clinic is not a feasible alternative. Navy Medicine has an obligation to support the operational requirements of the Fleet and Fleet Marine Force. Analysis showed the local civilian health care infrastructure has insufficient accredited inpatient and critical care capability to support the Marine Corps training operations at Parris Island and the Marine Corps Air Station at Beaufort. Naval Hospital Beaufort is the only hospital in the area with adequate inpatient and critical care capability to support any significant operational mishap. Therefore, realigning Naval Hospital Beaufort to an outpatient clinic would require the transfer of military medical personnel to a nearby Military Treatment Facility to meet inpatient care needs of the active duty population in the Beaufort area. Since there will be no savings associated with the elimination of military end strength and there will be increased CHAMPUS costs in the Beaufort area with the loss of military inpatient care capability, this alternative produces no savings for the Department of the Navy.

Although the alternative to realign Naval Hospital Corpus Christi to a clinic was cost effective, it is not feasible due to the personnel demographics of the area. The Naval Hospital Corpus Christi will provide care for the mine warfare helicopter assets relocating to Naval Air Facility Corpus Christi in support of the Mine Warfare Center of Excellence and for the strike training units being consolidated at Kingsville-Corpus Christi. Consequently, while the 1995 actions eliminate from Naval Air Station Corpus Christi the students who traditionally do not have their dependents with them during flight training, they bring in active duty members with their dependents who will all require medical care.



DEFENSE BASE CLOSURE AND REALIGNMENT COMMISSION
1700 NORTH MOORE STREET SUITE 1425
ARLINGTON, VA 22209
703-696-0504

Copy to Genig
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Memorandum

DATE: February 27, 1995
TO: Dave Lyles
FROM: Dave Lewis *D. Lewis*
THRU: Ed Brown, Ben Borden (in turn)
RE: Proposal For Medical Issues Hearing
CC: Frank Cirillo, Bob Cook, Jim Owsley, Alex Yellin

Though medical spending accounts for more than \$15 billion of the defense budget, hospitals and medical considerations in general are necessarily subsidiary to larger base closure and realignment decision making. However, access to military hospitals is still an important issue to many military health services system beneficiaries. Retirees who have chosen to make their home in an area near to a military hospital can be particularly vocal when the closure of that hospital is contemplated. Many retirees view continued access to their local military hospital as an obligation on the part of the government, and they consider CHAMPUS to be a poor substitute. Many retirees age 65 and over see their alternative in Medicare as even poorer than CHAMPUS.

On the other hand, closing military hospitals may have important positive effects on health care cost, quality, and access in the local community as a whole. Closure of a military hospital will likely increase demand for health care services in the civilian community -- both from residual active duty forces in the area and from retirees. As long as sufficient capacity exists, increased demand may lead to more efficient use of hospitals and other health resources in the area, lowering costs. As capacity adjusts to the new demand, more specialized services may become available, improving access to a broader range of services for everybody. And as providers gain experience in a wider variety of cases, overall quality may also improve.

These opposite effects are likely to create a confused, contradictory message for the Commissioners when they consider community inputs on hospital closure and realignment issues. For this reason I believe it would be useful to the Commissioners to hold a hearing

to specifically address medical issues. If the Commissioners could hear from and question DOD medical leadership -- the Assistant Secretary of Defense (Health Affairs) and the three Surgeons General -- about the process, impacts, and rationale behind hospital closures and realignments, it may help them to better understand the competing, often emotional arguments they are likely to hear later.

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Medical Treatment Facilities

The 1993 Commission's Report recommended the Department of Defense improve health care operations and cost effectiveness, ensure that accessible health care is available to remaining beneficiaries at closure and realignment sites, take an active role in identifying medical facility consolidations or closures, and continue pursuing formalized sharing agreements with the Veterans Administration (VA) and private sector hospitals. The Commission made five specific recommendations: (1) consolidate resources across Military Departments and specified geographic areas; (2) close military treatment facilities that are not cost-effective; (3) move assets across Military Departments and into other Service facilities to increase capabilities; (4) create health care programs that operate on a competitive basis, and (5) upgrade substandard facilities that are still required.

In response to dynamic changes in health care delivery, DoD developed a comprehensive managed care program called TRICARE. TRICARE is a regional managed care program that brings together the health care delivery systems of the military services, as well as the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). The program is designed to improve beneficiary access, assure affordable and high quality care, provide choice and contain overall DoD costs.

Twelve TRICARE regions are identified across the United States. Each is administered by a Lead Agent responsible for planning and coordinating the regional delivery of health care in that area. Individual medical commanders retain complete command and control of their health care programs, and with assistance from the Lead Agent, can refer patients to other DoD and designated specialty referral centers. Lead Agents also oversee regional contracts with civilian managed care companies.

The Department's actions to lessen any adverse medical impact at base realignment and closure sites include transition health care programs, managed care initiatives, retail pharmacy networks and meetings with beneficiaries. A retail pharmacy benefit is also included at each location where a provider network is developed. This program for CHAMPUS-eligible personnel will also be available to military Medicare-eligible beneficiaries residing within former BRAC catchment areas, when no other military medical pharmacy is present.

In addition, the Department has begun to test a mail-order pharmacy service in several states. As with the retail pharmacy benefit program, the mail-order pharmacy demonstration is also available to Medicare-eligible beneficiaries residing within former BRAC catchment areas, when no other military medical pharmacy is present.

DoD already shares thousands of services with the VA and has entered into numerous joint ventures. DoD is pursuing new opportunities with the VA while taking a sound management approach to furthering the VA/DoD Health Care Resources Sharing Program as the Military Health Services System (MHSS) moves into the TRICARE managed care arena. Individual sharing agreements are part of each of the comprehensive regional plans. Guidelines to military facility commanders will encourage the military services to evaluate the possibility and feasibility of using Federal capabilities, where and when it is mutually cost effective. Additionally, the Departments are in the process of signing a Memorandum of Understanding, implementing legislation that allows VA to establish a contractual health care provider relationship with DoD Managed Care contractors.

The Deputy Secretary's BRAC guidance memorandum of January 7, 1994, provided the authority for establishment of the Joint Cross-Service Group for Military Treatment Facilities (MTFs) and Graduate Medical Education (GME). The MTF and GME group developed criteria, data sources, and measurements consistent with the BRAC criteria. Through quantitative and qualitative analysis, DoD identified closure and consolidation alternatives for Service consideration. The alternatives would reduce excess capacity in the MHSS while ensuring required infrastructure for wartime missions. The Services evaluated the alternatives in consonance with their overall basing studies and analyses. The Assistant Secretary of Defense (Health Affairs) and the Services are also pursuing physical plant efficiencies through the DoD Planning, Programming, and Budgeting System process.

DoD has moved conscientiously toward bringing the Military Department's healthcare facilities into compliance with governing life and fire safety codes to ensure that appropriate, quality health care delivery is achieved in a safe and efficient setting. Revitalizing the physical plant resources supporting our health care delivery system is paramount in providing necessary, cost-effective, care to eligible beneficiaries while supporting the medical readiness mission.

Cumulative Economic Impact

The 1993 Commission made two key recommendations regarding cumulative economic impact. First, the Commission recommended that "the Secretary of Defense **make** clear that cumulative economic impact alone is an insufficient cause for removing a **base with** inadequate military value from consideration for closure or realignment. Economic **impact** should be given weight only when analyzing candidate bases with comparable, **sufficient** military value." Guidance issued by the Joint Cross-Service Group on Economic **Impact** specifically addressed this issue by directing DoD components to consider **cumulative** economic impact as part of the economic impact criterion and within the context of **all eight** final selection criteria. Second, the Commission recommended "clarifying and **standardizing**

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DEFENSE BASE CLOSURE AND REALIGNMENT COMMISSION

Military Health Care Orientation

Updated 21 March 1995

Overview of MHSS -- Missions

- **Readiness**
- **Peacetime**
 - » **Direct Care**
 - » **CHAMPUS (present and future)**

FY 95 Programmed MHSS Costs

- ***Personnel Costs ----- \$5 Billion***
- ***Other Direct Care Costs ----- \$6.4 Billion***
- ***Medical Construction ----- \$0.3 Billion***
- ***Total Direct Care Costs ----- \$11.7 Billion***
- ***CHAMPUS ----- \$3.6 Billion***
- ***Total MHSS ----- \$15.2 Billion***

Source: Office of the Assistant Secretary of Defense (Health Affairs)

Note: Totals Do Not Add Due To Rounding

FY 93-95 MHSS Staffing (in thousands)

	<u><i>FY 93</i></u>	<u><i>FY 94</i></u>	<u><i>FY 95</i></u>
<i>ARMY</i>	<i>90</i>	<i>90</i>	<i>86</i>
<i>NAVY</i>	<i>55</i>	<i>56</i>	<i>56</i>
<i>USAF</i>	<u><i>48</i></u>	<u><i>51</i></u>	<u><i>51</i></u>
<i>DOD Total</i>	<i>193</i>	<i>197</i>	<i>193</i>

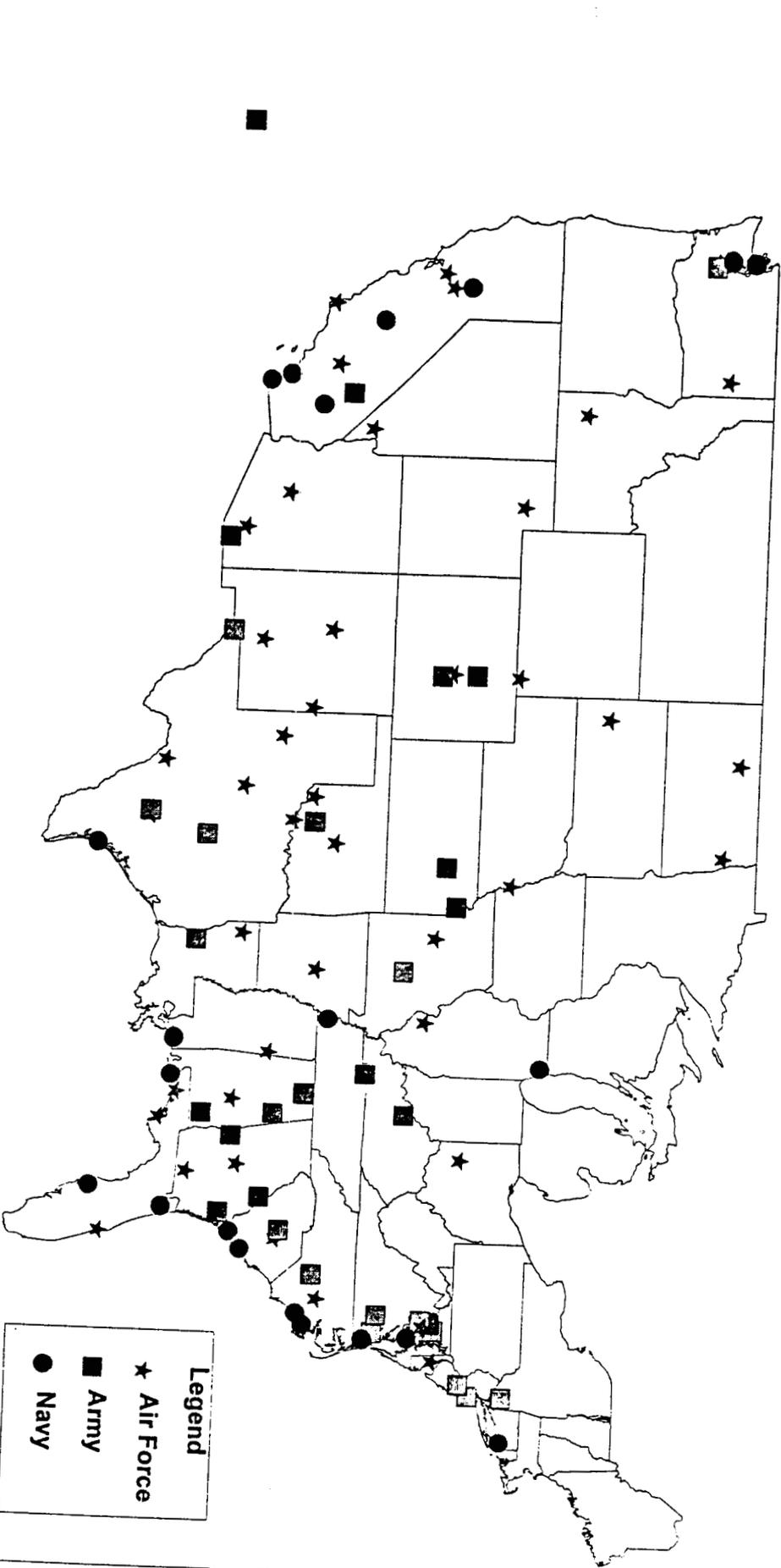
Source: Office of the Assistant Secretary of Defense (Health Affairs)

MHSS Overview -- Statistics (Hospitals)

	Large (>200)	Medium (50-200)	Small (<50)	Total
Army	8	12	12	32
Navy	3	8	8	19
USAF	2	10	36	48
Total	13	30	56	99

Note: 22 Small Hospitals With Less Than 20 Beds,
8 Small Hospitals With Less Than 10 Beds.

U.S. Military Hospitals



MHSS Overview -- Statistics (Beds)

	Operating Beds	Available Beds	Expanded Beds	Wartime Required (2 MRC)
Army	4,751	7,464	9,682	6,030
Navy	2,395	3,383	3,865	2,600
USAF	2,538	4,761	6,501	980
Total	9,684	15,608	20,048	9,610

Source: JCSG Linear Programming Model Dataset

MHSS Overview -- Populations Served (US)

- *Active Duty* 1.5 Million
- *Family Members of Active Duty* 2.3 Million
- *Retirees* -----
- *Family Members of Retirees* ----- 4 Million
- *Survivors* -----
- *Total Beneficiaries* ----- 7.9 Million

Source: Office of the Assistant Secretary of Defense (Health Affairs)

Note: Total Does Not Add Due To Rounding

MHSS Overview -- Organization

- **Assistant Secretary of Defense (Health Affairs)**
- **Services**
 - » **Medical Hierarchies**
 - » **Commands**

MHSS Overview -- Differences

- ***Budget Incentives***
- ***Multiple Eligibility***
 - » ***"Ghosts"***
- ***Benefit Inequalities***
- ***Cross Service Care***

Prior BRAC Actions

- ***1988-1993 Reductions***
 - » ***4 Army ----- 642 Operating Beds***
 - » ***4 Navy ----- 621 Operating Beds***
 - » ***17 Air Force ---- 560 Operating Beds***
 - » ***25 Facilities -- 1,823 Operating Beds***

BRAC 1995 Recommendations

- ***1995 Round***
 - » ***Roles***
 - ***JCSG***
 - ***Services***
 - » ***Recommendations***
 - ***JCSG***
 - ***6 Army (417 Beds)***
 - ***2 Navy (91 Beds)***
 - ***8 Air Force (1,044 Beds)***
 - ***DOD List***
 - ***4 Army (307Beds)***
 - ***0 Navy***
 - ***2 Air Force (29 Beds)***

Closure Issues

- ***Readiness***
 - » *Requirements vs. Capacity*
 - » *VA and NDMS Back-Up*
- ***Costs***
 - » *DOD Remains Responsible For Some Care*
 - » *CHAMPUS Costs vs. Direct Care*
- ***Access***
 - » *Active Duty & Family Members*
 - » *Retirees & Family Members*
 - » *65+ Beneficiaries*
- ***Civilian Community Impacts***
 - » *Cost*
 - » *Quality*
 - » *Access*
- ***Possible Mitigating Factors***
 - » *TRICARE*
 - » *Pharmacy Benefits*
 - » *Medicare Subvention*

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Hospital Issues

Page 10. Question 1: Secretary Widnall, during Mr. Boatright's testimony, he indicated that the Air Force does not agree with the hospital bed requirement figure used by the Hospital Joint Cross Service Group.

What is the correct figure for the Air Force's requirement for hospital beds in the United States?

Answer: The Air Force's operating bed requirement for peacetime support in the United States is 2255. This figure is based on workload demand and reflects a percentage of the average daily patient load at our medical facilities.

Page 10, Question 1a: Does this requirement figure take into consideration the capacities of the Army and Navy, as well as the contingency beds provided by the Department of Veterans Affairs and the National Disaster Medical System (NDMS).

Answer: No. Wartime, contingency operations and disaster casualty requirements include but exceed this baseline number. Expansion bed missions are in addition to this number. The number, therefore, is limited to Air Force, peacetime inpatient workload only and does not account for Army, Navy, Department of Veteran's Affairs or NDMS beds availability.

Page 10, Question 2: Secretary Widnall, Mr Boatright also stated that the Air Force believes that hospital closure and realignment decisions are premature at this point and that they should follow this round of base closures and realignments.

Why didn't the Air Force develop a list of hospital closures and realignments that is predicated on the acceptance of the rest of the Air Force BRAC list?

Answer: Recommendation on the closure of medical treatment facilities are integral to the Air Force recommendations. However, not only Air Force but all DoD closures and realignments must be considered in order to develop a list such as that proposed by the Medical Joint Group. Mission transfers, with the associated personnel moves, will impact the health care delivery systems in all regions where a realignment or mission change associated with BRAC occurs. The Air Force has aggressively been sizing the Medical Service separate from the BRAC actions. During the period FY 94-96, the following actions have been or are planned to occur: Three hospitals have been downsized to clinics, 4 more are being evaluated, and 18 emergency rooms are being modified. Three obstetrics services have been closed, 1 is awaiting approval to close and 6 are being evaluated for closure. Strategic Resourcing has reduced manpower requirements by 10 percent and 1,350 operating beds have been reduced. Joint staffing has been initiated at 6 MTFs and is being considered at 2 more. AFMS Medical Force Review has been initiated to identify the baseline medical readiness needs with an estimated completion date of May 95. Finally, the Strategic Resourcing process, initiated for the first time in Dec 94, is designed to size our medical facilities based on the most economical source of care for our total beneficiary population. This process will continue to drive proper sizing of the AFMS into the next century. The vast majority of proposed actions can be accomplished without resort to BRAC.

Page 10. Question 3: Secretary Widnall, Mr. Boatright testified that hospitals can be closed and realigned outside of the BRAC process.

While this is likely to be true for small and medium hospitals, is it true for large hospitals?

Answer: Closing or realigning even large hospitals would likely not break the BRAC thresholds. In addition, since only portions of those hospitals would be relocated, there is even less likelihood that a BRAC threshold would be broken.

Page 10, Question 3a: Does the Air Force intend to address the potential cost effectiveness of realigning large hospitals, such as the three medical centers identified by the joint cross service group?

Answer: Yes, but not through the BRAC process. Strategic Resourcing is being developed to address present and future resource requirements of the total AFMS. This process considers the total MILPERS and Direct Care dollars (O&M, CHAMPUS) required to operate a medical facility in each catchment area. The decision process will include a cost comparison of the sources of care, quality considerations, and access impacts. The goal of the entire process is to ensure that the most cost effective source of high quality, appropriate access to care is provided to our beneficiary population. Since medical facilities are being closed at bases being closed or realigned under BRAC, the Air Force is realizing a substantial reduction in medical facilities. Through Strategic Resourcing the remaining medical facilities will be rightsized based on cost effectiveness.

Page 10, Question 4: Secretary Widnall, how did the Air Force consider the medical needs of the active duty personnel, retirees, and their family members remaining in the area of hospitals to be closed?

Answer: Statutory requirements dictate that a joint services working group shall solicit the views of persons adversely affected by installation closures and realignments on the issue of suitable substitutes for furnishing health care. In most cases, no hospital or clinic will remain after the closure or major realignment of an installation.

Alternatives Submitted to Services

<u>Facility Name</u>	<u>Location</u>
Noble Army Community Hospital	Fort McClellan, AL
Lyster Army Community Hospital	Fort Rucker, AL
Fitzsimons Army Medical Center	Aurora, CO
USAF Academy Hospital	Air Force Academy - <i>private</i>
USAF Medical Center Scott AFB	*Scott AFB, IL <i>transcribe to will do with</i>
Kimbrough Army Community Hospital	Fort Meade, MD
Wright Patterson USAF Medical Center	Wright Patterson AFB, OH <i>rec - med d to hosp BRAC</i>
Naval Hospital Beaufort	Beaufort, SC
363rd Medical Group	Shaw AFB, SC <i>will house 2 mil valve on key</i>
6th Medical Squadron	Reese AFB, TX <i>will close</i>
Naval Hospital, Corpus Christi	Corpus Christi, TX
Wilford Hall Medical Center	Lackland AFB, TX <i>San Antonio Brooks (Army) only med center</i>
396th Medical Group	Sheppard AFB, TX <i>under district local H/C</i>
1st Medical Group	Langley AFB, VA <i>will valve, can't quantify it prox. to Ft Sill</i>
Dewitt Army Community Hospital	Fort Belvoir, VA <i>water tower, AC</i>
Kenner Army Community Hospital	Fort Lee, VA <i>will valve</i>

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MHSS Infrastructure Reductions (FY 88 - FY 97)

- **Baseline - FY 88 Health Facility Planning Review**
- **Normal beds decreased by ~12,000, or 43%**
- **Expanded beds decreased by ~20,000, or 48%**
- **Number of hospitals decreased by 58 facilities, or 35%**

* Includes DHP Program Initiatives and BRAC 95

MHSS Infrastructure Reductions

1988 HEALTH FACILITY PLANNING REVIEW				
	# HOSP	OPER	NORMAL	EXPANDED
AIR FORCE	82	5,219	9,124	11,371
ARMY	50	7,781	11,647	19,231
NAVY	36	4,164	7,758	11,446
TOTALS	168	17,164	28,529	42,048

	# HOSP	OPER	NORMAL	EXPANDED
CURRENT INVENTORY	110	10,040	16,894	22,861
REDUCTIONS SINCE 1988	58	7,124	11,635	19,187
% DECREASE SINCE 1988	35 %	42 %	41 %	46 %

58 MTF REDUCTIONS - SINCE - 1988

CONUS (41)

BRAC-III (25)

Letterman AMC, CA
Ft. Ord, CA

NH Long Beach, CA
NH Orlando, FL

K.I. Sawyer AFB, MI
Pease AFB, NH
England AFB, LA
George AFB, CA
Williams AFB, AZ
Chanute AFB, IL
Carswell AFB, TX
Castle AFB, CA
March AFB, CA

OTHER Management Initiatives (6)

Naval Station, Adak, AK
Naval Home, Gulfport, MS
McConnell AFB, KS

Ft. Devens, Ma
Ft. B. Harrison, IN

NH Philadelphia, PA
NH Oakland, CA

Plattsburgh AFB, NY
Eaker AFB, AR
Myrtle Beach AFB, SC
Wurtsmith AFB, MI
Homestead AFB, FL
Bergstrom AFB, TX
Loring AFB, ME
Griffiss AFB, NY

BRAC 95 & DHP Program Reductions (10)

Fitzsimons AMC, CO
Ft. Lee, VA
NH Charleston, SC
NH Patuxent River, MD
NH Millington, TN

Ft. McClellan, AL
Ft. Meade, MD
NH Corpus Christi, TX
NH Groton, CT
Reese AFB, TX

OCONUS (17)

Hellenikon AB, GR
Augsburg, GE
Bad Cannstatt, GE
Bremerhaven, GE
Clark AB, PI
Hahn AB, GE
Torrejon AB, SP
NH Subic Bay, PI
SHAPE, BE
Weisbaden MC, GE
Frankfurt AMC, GE
Iraklion AS, GR
Nurnberg, GE
RAF Upper Heyford, UK
Vicenza, IT
Berlin, GE
Gorgus, PM

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CRS Issue Brief

Military Medical Care Services: Questions and Answers

Updated December 6, 1994

by
Richard A. Best, Jr.
Foreign Affairs and National Defense Division



Military Medical Care Services: Questions and Answers

SUMMARY

The primary mission of the Military Health Services System (MHSS) is to maintain the health of military personnel so they can carry out their military missions, and to be prepared to deliver health care during time of war. In support of those in uniform, the military medical system also provides, where space is available, health care services in Department of Defense (DOD) medical facilities to dependents of active duty servicemembers and to retirees and their dependents. The Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) is the military equivalent of a health insurance plan, run by DOD, for active duty dependents, military retirees, and the dependents of retirees, survivors of deceased members, and certain former spouses. CHAMPUS reimburses beneficiaries for portions of the costs of health care received from civilian providers.

The MHSS covers roughly 8.3 million people in FY1994 and includes some 135 hospitals, 500 medical clinics and 300 dental clinics operating worldwide and employs some 54,000 civilians and 107,000 active-duty military personnel. Some facilities, however, are scheduled for disestablishment under the Base Realignment and Closure (BRAC) process. For FY1995 DOD is authorized over \$15.3 billion for health care spending of which \$3.9 billion is for CHAMPUS.

The MHSS is headed by the Assistant Secretary of Defense for Health Affairs (ASD/HA), Dr. Stephen C. Joseph. The Army, Navy, and Air Force have extensive medical establishments. The possibility of further centralization to reduce further the role of the three military departments remains under consideration.

Concern over the increasing share of the Defense budget allocated to health care has led to a number of reforms. DOD has, for some years, been moving in the direction of managed care with a number of experimental programs. Although often well received, they have not invariably led to cost savings. Reductions in direct care for dependents and retirees in military facilities can actually lead to growth in overall DOD health spending, since beneficiaries whose access to military medical facilities is limited may turn to more costly private care with reimbursement under CHAMPUS. Improving the system may also attract new users, and thus higher costs to DOD, since many eligible dependents currently do not use it. Recently, the DOD has initiated a management initiative, TRICARE, to coordinate the efforts of the services' medical facilities. The Administration called for the closure of DOD's Uniformed Services University of the Health Sciences (USUHS), but Congress has kept the school in operation.

National health care reform proposals under consideration in the 103rd Congress would not have significantly altered health care for active duty personnel, but would have affected dependents and retirees using military health care. Some plans envisioned premiums being paid by employers of non-active duty beneficiaries for guaranteed coverage in DOD medical facilities.

MOST RECENT DEVELOPMENTS

The unwillingness of the 103rd Congress to enact major health care reform legislation will not affect ongoing Defense Department efforts to realign military health care and move increasingly towards managed care. Important budgetary questions remain, given the growing costs of military health care within a declining overall Defense budget.

BACKGROUND AND ANALYSIS

Questions and Answers

1. What Is the Structure and Purpose of the Military Health Services System?

The Military Health Services System (MHSS) provides medical care to active duty military personnel, eligible military retirees, and eligible dependents of both groups. The primary mission of the medical services system is to maintain the health of military personnel, so they can carry out their military missions, and to be prepared to deliver health care during time of war. This mission involves medical testing and screening of recruits, emergency medical treatment of those involved in hostilities, and the maintenance of physical standards of those serving in the armed services. In support of those in uniform, the military medical system also provides, where space is available, health care services to dependents of active duty servicemembers and to retirees and their dependents. Some former spouses are also included. According to an estimate developed by the Congressional Budget Office (CBO), the MHSS covered roughly 8.5 million eligible people in FY1994. However, as many as two million eligible dependents and retirees do not make use of the system. Some have private insurance through civilian employment, others use Medicare or Veterans Administration facilities. At some point, however, a substantial number could seek care in military hospitals or through the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). The Defense Enrollment Eligibility Reporting System (DEERS) is a computerized data bank listing persons eligible for some type of military medical care.

Under the Secretary of Defense, the MHSS is headed by the Assistant Secretary of Defense for Health Affairs (ASD/HA), Dr. Stephen C. Joseph. An October 1991 reorganization strengthened the role of the ASD/HA by giving the incumbent planning, programming, and budgeting responsibilities for the MHSS, including facilities operated by the Army, Navy (which also provides health care services to the Marine Corps), and Air Force. Subsequently, the Office of the Secretary of Defense (OSD) forwards a budget request to Congress for the Defense Health Program (DHP) which includes monies needed for procuring equipment for the MHSS, operation and maintenance, and care for civilian beneficiaries. Funding for the compensation of military personnel assigned to the MHSS is contained in the Military Personnel appropriation accounts of the individual military departments. The Surgeons General of the military departments retain considerable responsibility for managing military medical facilities. The possibility of further centralization to reduce further the role of the three military departments (including perhaps a move towards a more unitary "purple-suited" system) remains under consideration. (See David F. Burrelli, *The Feasibility of Uniting the*

care or certain types of outpatient care and live within a catchment area, *i.e.*, a geographical area surrounding a military hospital, they must seek care first at that military medical facility and must have a document (a non-availability statement (NAS)) stating that the needed care was not available at that military facility, before CHAMPUS will pay a share of their care at a non-military facility. CHAMPUS excludes certain types of care, such as most dentistry and chiropractic services.

The share of the costs that CHAMPUS beneficiaries are required to pay depends on a number of factors including the beneficiary's status (*i.e.*, retiree, dependent of active duty member, or dependent of a retiree), the type of care received (*e.g.*, inpatient or outpatient), and whether or not the physician or hospital accepts CHAMPUS assignments (if not, the payer for care is reimbursed by CHAMPUS only for CHAMPUS-allowable charges and services, which may vary from those actually billed). In accordance with the Defense Appropriation Act of FY1993 (P.L. 102-396), providers are limited to charging 115% of the amount CHAMPUS authorizes for a given procedure. Some observers have expressed concern that this move will limit the number and quality of providers who are willing to accept patients eligible for CHAMPUS. For more information on CHAMPUS payments and deductibles, see *CHAMPUS Handbook*, October 1994, pp. 62-77.

CHAMPUS costs have grown dramatically since the program's inception, almost tripling from \$1.2 billion in FY1984 to an estimated \$3.9 billion in FY1994, with the percentage of DOD health care costs allocated to CHAMPUS also increasing.

Medicare. Active duty military personnel have been fully covered by Social Security and have paid Social Security taxes since Jan. 1, 1957. Social Security coverage includes eligibility for health care coverage under Medicare at age 65. It was the legislative intent of the Congress that retired members of the uniformed services and their eligible dependents be provided with medical care after they retire from the military, usually between their late-30s and mid-40s. CHAMPUS was intended to supplement -- not to replace -- military health care. Likewise, Congress did not intend that CHAMPUS should replace Medicare as a supplemental benefit to military health care. For this reason, retirees become ineligible to receive CHAMPUS benefits when at age 65 they become eligible for Medicare. However, military retirees continue to be eligible for health care in military medical care facilities irrespective of age. Disabled persons under 65 who are entitled to Medicare may continue to receive CHAMPUS benefits as a second payer to Medicare (with some restrictions).

3. Have Military Personnel been Promised Free Medical Care for Life?

Some military personnel and former military personnel maintain that they and their dependents were promised "free medical care for life" at the time of their enlistment. Such promises have in fact been made by military recruiters and in recruiting brochures, but they were not based upon laws or official regulations which provide only for *access* to military medical facilities for non-active duty personnel *if space is available* as described above. Space may not be available and CHAMPUS care can involve significant costs to beneficiaries. RADM Harold M. Koenig, the Deputy Assistant Secretary of Defense for Health Affairs, testified in May 1993: "We have a medical care program for life for our beneficiaries, and it is pretty well defined in the law. That easily gets interpreted to, or reinterpreted into, free medical care for the rest of your life. That is a pretty easy transition for people to make in their thinking, and

5. How Much Does Military Medicine Cost Beneficiaries and How Much Does It Cost the Government?

Costs to Beneficiaries. Active duty servicemembers receive covered medical care in military facilities without additional costs other than small *per diem* charges. CHAMPUS beneficiaries pay differing amounts depending on their status and where they receive care. If care can be obtained at military facilities, there is no charge for medical services and only small daily charges for hospital stays. At present, for outpatient care in civilian hospitals and clinics, there is a yearly deductible of \$150.00 for one person and \$300.00 for a family. After the yearly deductible is met, dependents of active duty personnel pay 20% of CHAMPUS-approved care; all others pay 25%. For inpatient care, there is no deductible for CHAMPUS-approved care, but families of active duty service members pay \$25.00 per stay (or a smaller *per diem*). Other CHAMPUS beneficiaries will pay the lesser of 25% of the billed charges or a fixed daily amount (\$323. in FY1995) of care covered by CHAMPUS. In addition, there is a "cap" on annual care; active duty families are reimbursed for allowable expenses over \$1000 and other CHAMPUS families are reimbursed for allowable expenses over \$7,500. These figures are generalized; there are a number of important exceptions that are explained in the *CHAMPUS Handbook* and in the underlying Federal Regulations (32 CFR 199). Beneficiaries are urged to check with their CHAMPUS Health Benefits Advisor before seeking care.

Cost to the Government. Prior to FY1992, funding for health care in DOD was appropriated to each of the three military departments, but subsequently a DOD-wide Defense Health Plan (DHP) appropriation was established which included accounts for Operation and Maintenance (O&M); Research, Development, Training and Evaluation (RDT&E); and Procurement. The DHP includes hospitals, clinics, the Uniformed Services University of the Health Sciences (USUHS), and other training facilities along with CHAMPUS expenses. Salaries of military personnel continue to be appropriated to the military departments in Military Personnel accounts.

Appropriations bills for the Department of Defense include funds for the Defense Health Program (in the Defense Agencies, Operation and Maintenance account) and funds for military personnel who staff the Defense Health Program (in the Military Personnel accounts of the three military departments). Congress has authorized and appropriated over \$9.9 billion for the Defense Health Program in FY1995. The salaries of military personnel, however, are paid from the Military Personnel accounts of the three military departments (in FY1995 they are projected to be \$5.1 billion.) The Administration's total health care request for FY1995 approximated \$15.3 billion (5.9% of the DOD budget); in real terms, one-third greater than spent on military medicine a decade ago.

The CHAMPUS portion of the FY1995 budget submission comes to \$3.9 billion, approximately the same as FY1994 appropriations. Earlier difficulties with significant cost-overruns in CHAMPUS expenditures have been largely overcome; in recent years costs have remained close to appropriated levels. Although designated beneficiaries are "entitled" to CHAMPUS (or access to DOD facilities), the Defense Health Program is not treated as an "entitlement" for budgetary purposes; unlike "pure" entitlements, it is subject to the annual authorization and appropriations process. Any budgetary shortfall must be made up from elsewhere in the Defense budget or a supplementary appropriation must be sought.

visit), no claims forms, and no deductibles. CHAMPUS Prime also includes certain preventive health care, including routine physicals, that may not be part of regular CHAMPUS coverage. The third option under the CRI is CHAMPUS Extra, a preferred provider organization, in which beneficiaries have a somewhat greater choice of doctors, but must accept higher charges. A program similar to those in California and Hawaii has been underway in New Orleans although there is no military hospital in the area.

According to user surveys, there is considerable satisfaction with CRI. Especially popular is the elimination of deductibles, co-payments, and complicated claims forms. A \$3.5 billion, 5-year contract for continued CRI services in California and Hawaii was awarded in July 1993 to the Aetna Life and Casualty Co., but is being re-competed at the recommendation of the General Accounting Office, based on vendor protests. On the other hand, DOD has found that the greater utilization encouraged by CRI inevitably generates greater costs that offset administrative economies.

Another effort is Catchment Area Management (CAM), in which commanders of five military hospitals have been given responsibility for managing health care services for beneficiaries within a 40-mile radius of their facility (known as the catchment area). In the CAMs, hospital commanders negotiate with networks of health care providers and civilians have been hired at military facilities to provide additional services. The goal has been to improve efficiency and reduce costs.

Other programs, including a tri-service effort in Tidewater Virginia have been developed to coordinate DOD health care. Special attention has been given to problems relating to mental health care, the costs of which expanded greatly in the 1980s.

It is widely considered that a key element of effective cost controls is making a more accurate determination of the number of potential beneficiaries and designing an appropriate mix of military and civilian care for this population. This approach is known as "capitated budgeting." Costs can be based on realistic estimates of the beneficiary population, rather than on open-ended payments that fluctuate and have no built-in inducements for cost containment. Since care in the MHSS is an entitlement for all persons within certain categories, estimating the number of persons who will use the system at a given location in a given year is inherently difficult. Despite the fact that the number of persons eligible for CHAMPUS care is accurately known, predicting actual CHAMPUS utilization is difficult for DOD planners. Usage is dependent upon the availability of DOD facilities and whether beneficiaries have alternate health care coverage through their own or a family member's civilian employment.

In July 1993, the House Armed Services Committee suggested in its report on the FY1994 Defense Authorization Act (H. Rept. 103-200) that, given experience with diverse experimental programs such as CRI and CAM, "it is time for the Department of Defense to move toward a more uniform benefit structure with similar cost-sharing requirements within each category of beneficiary and maximum choice among beneficiary enrollment options" (Pp. 302-303). In September 1993, the House Appropriations Committee indicated its belief that "adjustments necessary as a result of national health care reform are likely to be minimal on the [Defense] Department, and therefore the Department's successes achieved thus far should be implemented immediately." (House Report No. 103-254, p. 282.) As required by Section 733, P.L. 102-190 of Dec. 5, 1991, the National Defense Authorization Act for FY1992 and

premiums required for joining a uniformed services plan and some cost-sharing, but the Administration's plan would have eliminated deductibles. Estimates suggested that premiums for individuals would range from \$35-\$50 and \$75-\$100 per year for families, with no fees for families of junior enlisted personnel. Cost-sharing would range from \$5-\$15 per doctor's visit. Under the Administration's proposals, costs of premiums for non-active duty beneficiaries who are employed would be recouped from employers or, in the case of Medicare-eligible beneficiaries, from Medicare. DOD would pay 80% of the premiums for unemployed beneficiaries. No changes were contemplated for active duty personnel or for beneficiaries living overseas.

In marking up H.R. 3600 on July 28, 1994, the House Armed Services Committee did not address the employer mandate issue, but did support a requirement that Medicare reimburse DOD for care it provides to Medicare-eligible beneficiaries. It was estimated that DOD would receive \$1 billion annually. S. 2343, introduced on Aug. 1, 1994 by Senator Nunn, Chairman of the Senate Armed Services Committee, stated the sense of the Senate that Medicare reimbursement for care delivered to Medicare-eligible beneficiaries at DOD facilities is essential if the TRICARE program is to compete effectively with other health care delivery systems. The legislation did not, however, reach the Senate floor.

Some observers noted that the Administration original proposal would have offered several advantages over the current situation: first, beneficiaries would have certainty of access; second, the burden of paperwork would be much reduced; third, costs to beneficiaries would be reduced. Perhaps most importantly, the new structure would require uniformed services health plans to compete on the basis of consumer satisfaction with other plans that could enroll beneficiaries at DOD expense. On the other hand, observers question whether financing arrangements contemplated would be adequate for the viability of the program without major additional allocations of DOD funds. Some Members have expressed opposition to any requirement that employers of non-active duty beneficiaries contribute to health care expenses that have heretofore be considered DOD's responsibility. There were also concerns that self-employed beneficiaries of DOD medical care would be responsible for considerably greater costs than at present.

Except for the single-payer ("Canadian-style") health care proposal (H.R. 1200), which would simply abolish CHAMPUS, other health care reform proposals in the 103rd Congress did not directly address military medicine.

Despite the failure of the 103rd Congress to enact national health care legislation, it is likely that current reforms of DOD health care, especially moves towards managed care, will continue as reflected in the effort to implement TRICARE.

9. Should Medicare Reimburse DOD for Care Provided to Medicare-eligible Beneficiaries?

Even in the absence of comprehensive national health care reform legislation, there is support for Medicare reimbursement of DOD health care provided to beneficiaries eligible for Medicare. It is estimated that currently some \$1.2 billion annually is spent by DOD to provide care for Medicare eligible beneficiaries. As Tricare is implemented pursuant to Congressional direction, DOD argues that access by retirees over 65 will be extremely limited unless Medicare reimbursement provides additional

There are also social/psychological considerations involving career retention. Some military personnel claim that they have been told from the day they met with a recruiter that military medical care would be free. To "change the rules" for a person in mid-career or for a person who has honorably and loyally served and is now retired, it is argued, constitutes an erosion of benefits and the betrayal of a trust. This is especially a concern for individuals who have become dependent upon such care. Although grandfathering the benefits for those currently in the service and applying user's fees to future recruits is a possibility, it has not received notable consideration in the debate on this issue.

12. What Will be the Impact of Base Relocations and Closures on Military Medical Care?

Base relocations and closures undertaken as part of the restructuring of the Defense Department in the post-Cold War period have included changes in the military health services system. Criteria for realignments and closures, established by DOD with congressional consent, include the need to deploy a force structure capable of protecting the national security, anticipated funding levels, and a number of military, fiscal, and environmental considerations that encompass community economic impact and community infrastructure. Three Base Realignment and Closure Commissions have specifically considered the effect of closing DOD hospitals and clinics on active duty military personnel as well as on other beneficiaries and potential beneficiaries of the MHSS. The first two BRAC Commissions recommended 18 military hospital closures; the third BRAC Commission recommended an additional 10. Facilities scheduled for closure include hospitals in Philadelphia, PA; Oakland, CA; Orlando, FL; San Francisco, CA; Ft. Devens, MA; Ft. Ord, CA; and Long Beach, CA. In one case, the commission overruled a DOD proposal to close the Naval Hospital in Charleston, SC. (See Andrew C. Mayer and David E. Lockwood, *Military Base Closures: Issues for the 103rd Congress*, CRS Issue Brief IB92113; also, David F. Burrelli, *Military Retiree Health Care: Base Closures and Realignments*, CRS Report 92-730 F, Sept. 21, 1992.)

At congressional encouragement, DOD has developed transition medical plans for each closure site. In some locations, CHAMPUS beneficiaries can use managed care plans created as part of the CHAMPUS Reform Initiative or other programs. Medicare-eligible users of closed military hospitals will be encouraged to avail themselves of HMO and pharmacy programs established by the Department of Health and Human Services. Nonetheless, the closure of military hospitals and clinics can be a source of anxiety, especially in communities that have attracted large numbers of new residents seeking access to the MHSS.

13. What is the Future of the Uniformed Services University of the Health Sciences?

The National Performance Review, chaired by Vice President Gore, recommended the closure of the Uniformed Services University of the Health Sciences (USUHS), located in Bethesda, MD. Proponents of closure argue that the University is not cost-effective and that adequate numbers of well-qualified medical personnel can be attracted to the uniformed services from civilian institutions by scholarships that are much less costly. They have estimated that closing the University would save some \$300 million over 5 years. Opponents countered that the training at the University is more directly

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WASHINGTON, DC

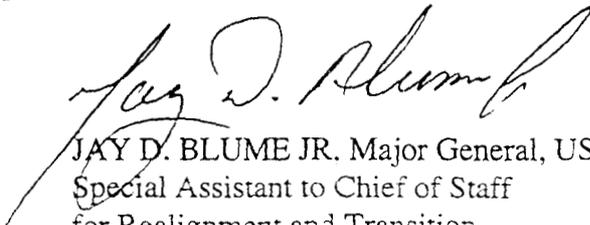
11 APR 1995

MEMORANDUM FOR BASE CLOSURE COMMISSION (Mr Frank Cirillo)

FROM: HQ USAF/RT
1670 Air Force Pentagon
Washington, DC 20330-1670

SUBJECT: Response to Request for Air Force Analyses of Medical Joint Cross-Service Group Alternatives

Attached is the Air Force response to your March 20, 1995 request for Air Force Analyses of Medical Joint Cross-Service Group Alternatives.


JAY D. BLUME JR. Major General, USAF
Special Assistant to Chief of Staff
for Realignment and Transition

3 Tabs

1. AF/SG Formal Response to Commission Request
2. Formal Response to MJCSG Alternatives
3. Point Paper and Slides

DEPARTMENT OF THE AIR FORCE
HEADQUARTERS UNITED STATES AIR FORCE

11.0 APR 1995

MEMORANDUM FOR AF/RT

FROM: HQ USAF/SG

SUBJECT: Air Force Medical Joint Cross-Service Group (JCSG) Analyses (AF/RT # 276)

The Defense Base Closure and Realignment Commission's Air Force Team Leader requested that the Air Force provide results of all analyses performed regarding the hospital realignment alternatives provided by the Medical Joint Cross Service Group. He also requested documentation of the overall feasibility, cost, quality, and access implications of the alternatives, and the specific reasons why the Air Force did not adopt the JCSG alternatives.

We performed no in-depth analyses (cost, quality, access, etc.) on the JCSG for MTF's alternatives. As indicated in SAF/MII's memo to the Chairman of the Medical JCSG (atch 1), the methodology appeared reasonable and consistent with our internal process; however, it was quite premature to pursue these downsizing alternatives. Alternatives were based on current base structure, not the proposed structure inclusive of the 1995 base realignment and closure (BRAC) recommendations. We recommended rerunning the model with improvements and incorporating the 1995 BRAC recommendations to determine candidates which would then generate dialogue between Services and DoD on how best to meet the needs of our beneficiaries.

In addition, we remain extremely concerned that MTF-specific inclusions as BRAC actions that downsize hospitals to clinics may unreasonably limit future flexibility. Flexibility is important if we are to implement our TRICARE initiatives and delivery of healthcare to all beneficiaries. Instead we strongly advocate our progressive efforts to rightsize and sculpt the future Air Force Medical Service based on our primary mission, readiness, TRICARE, strategic resourcing, and best business practices. The point paper and accompanying briefing slides at attachment 2 address these issues in greater detail.

If you have any questions or concerns, please don't hesitate to contact my point of contact for BRAC, Capt Davis, HQ USAF/SGMM, DSN 297-5550.


CHARLES H. ROADMAN II
Major General, USAF, MC
Deputy Surgeon General

2 Attachments

1. SAF/MII Memo, 29 Dec 94
2. Point Paper



DEPARTMENT OF THE AIR FORCE
WASHINGTON DC 20330-1000

DEC 29 1994

OFFICE OF THE ASSISTANT SECRETARY

MEMORANDUM FOR THE CHAIRMAN, MEDICAL JOINT CROSS-SERVICE
GROUP

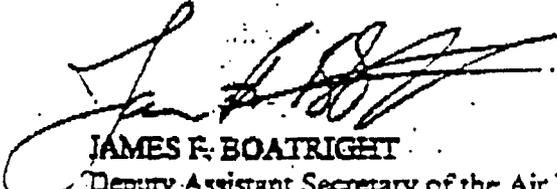
FROM: SAF/MI

SUBJECT: BRAC 95 Joint Cross Service Group for Military Treatment Facilities
(MTFs) and Graduate Medical Education (GME) Revised Alternative
(Your Memo, 5 Dec 94)

We have reviewed your closure and realignment alternatives for MTFs. The methodology appears reasonable and consistent with our internal process. However, your candidate list raises issues which bear considerable analysis regarding the impact on Air Force line operations. Since these alternatives are based on the current base structure, it would be premature to pursue these downsizing alternatives at this time. Instead, since medical treatment facilities will be closed generally at installations identified for closure by the Military Departments, we recommend that you return your model once this information is known. At that time we could consider any additional downsizing alternatives that may result.

Additionally, we are concerned that inclusion as BRAC actions of alternatives that merely downsize hospitals to clinics may unreasonably limit future flexibility. Unlike stand alone hospitals, such actions do not normally meet BRAC civilian personnel thresholds. As a result, implementation of these recommendations should remain outside the BRAC process, so that potential revisions of these actions may be taken without congressional actions to reverse a BRAC-directed downsizing.

Attached you will find a functional assessment of the methodology and the alternatives. We applaud your efforts and obvious interservice cooperation.



JAMES F. BOATRIGHT

Deputy Assistant Secretary of the Air Force
(Installations)

Attachment:
Functional Assessment



DEPARTMENT OF THE AIR FORCE
HEADQUARTERS UNITED STATES AIR FORCE



16 Dec 94

MEMORANDUM FOR THE CHAIRMAN, MEDICAL JOINT CROSS SERVICE GROUP

FROM: AF/SG

SUBJECT: Functional Assessment of Medical JCSG Alternatives (Your Memo, 5 Dec 94)

We have analyzed the closure and realignment alternatives for MTFs as recommended by the Medical JCSG. As an overview comment, we believe proceeding with analysis of this list is premature as we don't know the impact of the Service BRAC recommendations. However, for discussion purposes, we would offer the following comments.

a. Overall, we have concern with some aspects of the model, but believe with enhancements, it could be a useful screening tool for identifying opportunities for consolidation of medical resources. Enhancements include correcting the excessive flow of GME beds to OCONUS, disallowing binary constraints to keep a facility open at medical center level, and verifying that MTF data accurately reflect reality.

b. Another concern is the impact on our TRICARE initiatives and delivery of healthcare to all beneficiaries. We need to discuss among the Services' Surgeons General how we will ensure availability of resources—staffing and funding—to support TRICARE. Deleting medical centers and a number of community hospitals would appear to hamper our plans for ensuring quality, cost-effective care for our beneficiaries.

c. As to specific feedback on the alternatives included in this initial list, we have concerns about all of the candidates. With dialogue, some of these concerns could be resolved. Four of the alternatives (Shaw, Langley, Lackland, and USAF Academy) have readiness or other Service-specific mission implications. Three of the alternatives (Sheppard, Scott and Wright-Patterson) rely on use of civilian medical resources for inpatient care. As a concept, this has potential, but more extensive evaluation of availability by product-line is required. The last candidate, Reese, is a test location where we are evaluating closure of inpatient care, which has local base, community, and Congressional support. We want to preserve the ability to continue this test, keeping our options open to size the medical asset to best fit the mission requirement.

This first set of alternatives provides some insight into the usefulness of the model to identify opportunities for reducing medical infrastructure. However, the model output should be used as a candidate-generator, not a decision maker.

JAN-23-1995 09:59 FROM HQ USAF REALIGN AND TRANS TO

*78-52824847355 P.004/004

I recommend updating the inputs after the Service realignment and closure lists are available in Jan 95. Consider retaining the model with improvements and using the output to generate dialogue between the Services and DoD as to how best to meet the needs of our beneficiary population.

My POC is CMSgt DuMez, AF/SGMM, DSN 297-5550.



EDGAR R. ANDERSON, JR.
Lieutenant General, USAF, MC
Surgeon General

POINT PAPER

ON

JOINT CROSS SERVICE GROUP (JCSG) FOR MTF AND GME FOR BRAC 95

PURPOSE

- Provide information about basic operations and recommendations from Medical JCSG to prepare Air Force leadership for upcoming testimony with the BRAC commissioners

BACKGROUND

- DepSECDEF established JCSGs in five areas with medical as one (UPT, Labs, Depots, Economic Impact)
 - In response to '93 Commission's Report that DoD improve health care operations and cost effectiveness, ensure that accessible health care is available to remaining beneficiaries at closure and realignment sites, take an active role in identifying medical facility consolidations or closures, and continue pursuing formalized sharing agreements with VA and private sector hospitals
 - DoD developed comprehensive managed care program called TRICARE
 - Regional managed care program that brings together the health care delivery systems of the military services, as well as CHAMPUS
 - TRICARE designed to improve beneficiary access, assure affordable and high quality care
 - Develop guidance for DoD component conduct of cross-service analyses and recommend additional cross-service closure or realignment alternatives for consideration by Services
 - Enhance opportunities for consideration of cross-service tradeoffs and multi-Service use of remaining infrastructure
- Primary tool used in developing medical alternatives for consideration by Services was DoD approved Fixed Integer Linear Programming Model
 - Model incorporated characteristics based on charter to minimize excess capacity and maintain high quality facilities within the Military Health Services System
 - Ensured MTFs located at sites with significant active duty and family members remained open
 - Used operating beds as gross primary capacity measure and maintained minimum number of wartime beds based on most recent defense guidance
 - Bed demand generated on acute care and medical center requirements using beneficiary specific FY 94 direct care inpatient rates
 - Medical center beds allocated in CONUS to east and west of Mississippi River based on requirements generated within those areas
 - Binary constraints also built into model to keep open a medical facility
 - Underserved primary care areas

Capt Davis/AF/SGMM/(202)767-5550/6 Apr 95

- Insufficient acute care beds in the community
- Less than 2 accredited acute care medical facilities
- When supporting 25,000 active duty and family members
- In overlapping catchment areas, model flows patients to consolidate inpatient care
- JCSG for medical provided a list of realignment and closure alternatives to SAF/MII 5 Dec 94
 - 16 medical candidates for realignment and closure: 6 Army, 2 Navy, and 8 Air Force
 - One Army alternative was for complete closure (Fitzsimons Army Medical Center (AMC))
 - AF/SG's reservations about results (see AF/SG Memo, 16 Dec 94 and SAF/MII Memo, 29 Dec 94 attached)

- AF/SG's reservations about results (see AF/SG Memo, 16 Dec 94 and SAF/MII Memo, 29 Dec 94 attached)
- Premature - results were based on current force structure, no BRAC 95 Services' input
- Some inconsistencies/problems with the model
 - GME beds inappropriately flowed from CONUS to OCONUS; patient flow across Pacific to Tripler from the western US
 - Model constraints inappropriately applied to medical centers, did not recognize downsizing consideration to community hospital (bedded facility versus clinic)
 - Gross results based on gross measures; did not consider product-lines, cost effectiveness, and our number one mission - readiness, such as first deployer and air transportable hospital missions
 - Model ran before Service's base closure and realignment nominees could be incorporated or dropped
- Concern about writing medical realignment (downsizing) into BRAC law reduces our flexibility to rightsize
- Concern about negative impact to TRICARE initiatives
- Of all Air Force candidates, one appears viable, others have impact on readiness, wing mission, and costs
 - Reese MTF implemented two year test of ambulatory care center in 1994
 - Scott Medical Center downsized to community hospital although name did not change (political issue)
- AF/SG prefers flexible "rightsizing initiatives" to sculpt future Air Force medical force versus placing direction in BRAC law (see attached briefing slides and supporting justification)
 - Small hospital working groups
 - OB task force
 - Strategic resourcing
 - Ambulatory care shift, joint staffing arrangements, and AF/VA sharing
 - AF Medical Service rightsizing task force will quantify future size of service

RECOMMENDATION

- Information to be used by senior Air Force leadership's preparation for upcoming BRAC hearings
- 2 Attachments
 1. SAF/MII Memo, 29 Dec 94 with atch
 2. Briefing slides

JAN-23-1995 08:58 FROM HQ USAF REALIGN AND TRANS TO *78-52824847356 P.002/004



DEPARTMENT OF THE AIR FORCE
 WASHINGTON DC 20330-1000

DEC 29 1994

OFFICE OF THE ASSISTANT SECRETARY

MEMORANDUM FOR THE CHAIRMAN, MEDICAL JOINT CROSS-SERVICE GROUP

FROM: SAF/MII

SUBJECT: BRAC 95 Joint Cross Service Group for Military Treatment Facilities (MTFs) and Graduate Medical Education (GME) Revised Alternative (Your Memo, 5 Dec 94)

We have reviewed your closure and realignment alternatives for MTFs. The methodology appears reasonable and consistent with our internal process. However, your candidate list raises issues which bear considerable analysis regarding the impact on Air Force line operations. Since these alternatives are based on the current base structure, it would be premature to pursue these downsizing alternatives at this time. Instead, since medical treatment facilities will be closed generally at installations identified for closure by the Military Departments, we recommend that you rerun your model once this information is known. At that time we could consider any additional downsizing alternatives that may result.

Additionally, we are concerned that inclusion as BRAC actions of alternatives that merely downsize hospitals to clinics may unreasonably limit future flexibility. Unlike stand alone hospitals, such actions do not normally meet BRAC civilian personnel thresholds. As a result, implementation of these recommendations should remain contingent on BRAC

merely downsize hospitals to clinics may unreasonably limit future flexibility. Unlike stand alone hospitals, such actions do not normally meet BRAC civilian personnel thresholds. As a result, implementation of these recommendations should remain outside the BRAC process, so that potential revisions of these actions may be taken without congressional actions to reverse a BRAC-directed downsizing.

Attached you will find a functional assessment of the methodology and the alternatives. We applaud your efforts and obvious interservice cooperation.



JAMES F. BOATRIGHT
Deputy Assistant Secretary of the Air Force
(Installations)

Attachment:
Functional Assessment

atc h j



DEPARTMENT OF THE AIR FORCE
HEADQUARTERS UNITED STATES AIR FORCE



16 Dec 94

MEMORANDUM FOR THE CHAIRMAN, MEDICAL JOINT CROSS SERVICE GROUP

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b. Another concern is the impact on our TRICARE initiatives and delivery of healthcare to all beneficiaries. We need to discuss among the Services' Surgeons General how we will ensure availability of resources—staffing and funding—to support TRICARE. Deleting medical centers and a number of community hospitals would appear to hamper our plans for ensuring quality, cost-effective care for our beneficiaries.

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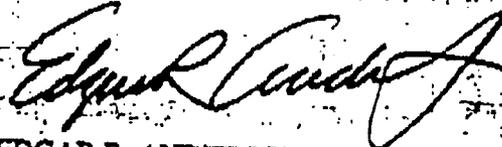
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JAN-83-1995 08:59 FROM HQ USAF REALIGN AND TRANS TO

*7#-92024047356 P.004/004

I recommend updating the inputs after the Service realignment and closure lists are available in Jan.95. Consider running the model with improvements and using the output to generate dialogue between the Services and DoD as to how best to meet the needs of our beneficiary population.

My POC is CMSgt DuMax, AF/SGMM, DSN 297-5550.



EDGAR R. ANDERSON, JR.
Lieutenant General, USAF, MC
Surgeon General

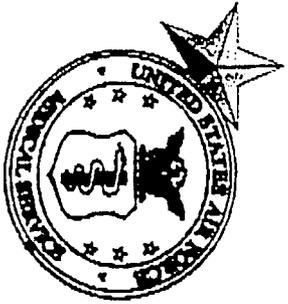


AIR FORCE MEDICAL SIZING

Brig Gen Michael K. Wyrick
Director, Medical Programs and Resources
Office of the Surgeon General

7 February 1995

1



- Introduction

- Reason: BRAC About To Be Signed Into Law. Options Could Impact Rightsizing Flexibility
- Purpose: To Identify Air Force Medical Rightsizing Initiatives
- Bottom Line: Not Necessary to Write Medical Facility Changes Into BRAC Law



- Overview
 - Environmental Assessment
 - Methods
 - Impacts
 - Conclusion



ENVIRONMENTAL ASSESSMENT

- ◆ Defense Guidance
- ◆ Federal Budget Reduction
- ◆ PBD Actions
- ◆ Sizing the AFMS
- ◆ Roles and Missions
- ◆ BRAC
- ◆ "733 Study"
- ◆ Health Care Reform
- ◆ Uniform Benefit
- ◆ OASD(HA) Letter to Senate (17 Aug 94)
- ◆ OMNIBUS Legislation
- ◆ Leadership, Strategic Management, Business Case Analysis
- ◆ Objective Medical Group



METHOD

- Small Hospital Working Groups
- OB Task Force
- Strategic Resourcing
- Rightsizing Initiatives
- BRAC 95/Medical Joint Cross Service Group
- AFMS Rightsizing Task Force



METHOD

- Small Hospital Working Groups
 - Air Force
 - Comprehensive Market Analysis by Base (CONUS)
 - Demand for Inpatient Services by Product Line
 - Cost, Quality, and Access of Community Resources
 - Impact on Readiness Mission
 - OASD(HA)
- Evaluated MTFs Under 50 Beds in CONUS/Alaska



IMPACT

- Small Hospital Working Groups

- Air Force: 33 of 54 CONUS MTFs Evaluated

- Realign Hospitals to Ambulatory Care Centers

- Done: McConnell (6), Reese (4), McGuire (20)

- Evaluating: Maxwell (30), Laughlin (5), Columbus (5), Patrick (15)

- Modifying Emergency Room Services

- Done: 18 Bases

- Evaluating: Hill, F.E. Warren

- OASD(HA): Evaluated 57 Small DOD Hospitals

- Recommended 15 Air Force MTFs for Further Study

- McGuire*, Reese*, Beale, Columbus, Davis-Monthan, Fairchild,

- Little Rock, McClellan, Moody, Patrick, Robins, Seymour-Johnson,

- Griffiss**, Plattsburgh**, Sawyer**

* Rightsized **BRAC III Sites



METHOD

- OB Task Force
 - Comprehensive Business Case Evaluation
 - Demand for Obstetric Services by Base
 - Availability and Quality of Community Resources
 - Costs and Access
 - Impact on Readiness
 - Evaluate Alternative Staffing Options
 - Evaluate Alternative Delivery Models



IMPACT

- OB Task Force
 - 40 OB Services Considered (CONUS/OS)
 - Obstetric and Nursery Service Closures
 - Done: March, McClellan, Beale
 - Waiting DoD Approval: Fairchild
 - Evaluating: Barksdale, Luke, Moody, Dyess, Sheppard, Lajes, Laughlin, Hill



METHOD

- Strategic Resourcing
 - Business Case Analysis
 - Population Based, Demand Projection
 - Make Vs Buy Decision by MTF by Product-Line
 - Reshaping Future Medical Force
 - Focus Toward Managed Care
 - Shift to Ambulatory Surgery



IMPACT

- Strategic Resourcing
 - FY 95: 7% Reduction in Manpower Requirements
 - FY 96: Two Major Commands Requirements Below FY 95 Funded Authorizations
- Overall 3% Reduction



METHOD

- Rightsizing Initiatives
 - Ambulatory Care
 - Joint Staffing
 - AF/VA Sharing



IMPACT

- Rightsizing Initiatives
 - Ambulatory Care Shift
 - Reduced Operating Beds
 - Dropped 700 Beds in 1994
 - 350 Bed Projected Decrease in 1995



IMPACT

- Rightsizing Initiatives (Cont'd)
 - Joint Staffing
 - Currently - Landstuhl, Camp Lester
 - Considering - Charleston, Tripler
 - AF/VA Sharing
 - VA Host - Kirtland, Davis-Monthan (Temporary)
 - AF Host - Travis, Nellis, Minot, Elmendorf
 - Joint Construction - Elmendorf
 - Considering - Patrick



METHOD

- BRAC
 - Air Force
 - MTFs at Affected Bases Close
- Medical JCSSG
 - Linear Model Developed
 - Tri-Service Input



IMPACT

- BRAC
 - Air Force
 - 21 Air Force Bases Closed or Realigned
 - Previous BRAC Rounds Have Reduced Manpower By 9 Percent Since FY 93
 - Medical JCSG
 - Model
 - Provided a Force Evaluation Method
 - Produced Alternative Futures



METHOD

- AFMS Rightsizing Task Force
 - Purpose: To Quantify Future Size Of AFMS
 - Active Duty Medical Service
 - Role Of Aeromedical Evacuation
 - Role Of Air Reserve Components
 - Readiness Policies
 - Lead Agent Vs MAJCOMs



SUMMARY

MEDICAL FORCE SIZING IMPACT FY 94-96

Method

Small Hospital Working Group

OB Task Force

Strategic Resourcing/BCA

Rightsizing:

Ambulatory Care Shift

Joint Staffing

AF/V/A Sharing

BRAC I, II, III

AFMS Medical Force Review

Impact

3 Hospitals Downsized to Clinics; 4 More Being Evaluated; 18 ERs Modified

3 OB Services Closed; 1 Waiting Approval

8 Services Being Evaluated for Closure

10% Manpower Requirements Reduction in 2 FYs

1,050 Operating Beds Reduced in Past 2 Years

At 5 MTFs; 2 More MTFs Being Evaluated

6 Sharing Arrangements; Another Pending

21 Air Force Bases Closed/Realigned

In Progress; ECD: May 95



CONCLUSION

- AF Rightsizing Outside of BRAC Process
- If Installation Closes, MTF Will Close
- Not Necessary to Include Medical Rightsizing Initiatives In BRAC Law



- **Shaw Hospital**
 - Readiness Mission
 - First Deployer Role with ATTH Responsibility
 - Integral to 20th Fighter Wing
 - Rural Medicine
 - 10 Miles from Sumter, SC
 - At Least 30 Minute Drive to Moncrief Hospital, Fort Jackson
 - 30,000 Beneficiary Population
 - Strategic Resourcing/BCA will Rightsize MTF in Future
 - Political Impact (South Carolina)



• Sheppard Hospital

– Health Care Services

- Civilian Health Care Resources Limited

- Insufficient Beds to Shift Work From Sheppard to Community

- Binary in Model Should Have Triggered

- Cost of Civilian Care Could Be Significant, Negative Factor

- Large Mental Health Referral Center

- Inpatient Alcohol Rehab Center (ARC)

- Operating Beds Increased by 15 in Past Year

- Additional Growth Forecasted With More Missions (Schools) Moving Into Sheppard Due to Realignments and Closures

- Connection with School House (Enlisted Training) and MTF

- Readiness Mission Supports Large Contingency Hospital 2



• Wilford Hall Medical Center

- Bed Capacity of One Mainframe (BAMC) Inadequate to Serve Combined Patient Population
 - Total Combined Operating Beds Required - 897
 - WHMC - 530; BAMC - 367
 - BAMC Bed Capacity is 450
- Added Responsibilities of TRICARE/Lead Agent
- Single Air Force Point for Basic Military Training
 - Approximately 35,000 Inductees Trained Annually
- Flying Ambulance Surgical Teams (FAST)
- Mission Support to AFSOC
- DoD STS for Transplants



- Air Force Academy
 - Negative Impact on Cadet Mission
 - Cadet Lost Time Increased Due to Loss of Specialty Providers



- Other Candidates

- Scott
 - World-Wide Aeromedical Evacuation Role
- Wright-Patterson
 - TRICARE Lead Agent for DoD Region V
- Langley
 - Readiness Mission - First Deployer Role with ATH Responsibility and Integral to 1st Fighter Wing
- Reese
 - Ambulatory Surgery Center Demonstration Site

COMMISSION ITSILIN 6

SPECIAL ASST TO THE CHIEF OF STAFF FOR REALIGNMENT & TRANSITION AF/RT TASKER/ROUTING SHEET

=====

SUBJECT: AFMED JCSG ANALYSES SUSPENSE: 7 April

DATE: 27 MAR AF/RT CONTROL #: 276

=====

ROUTING

GENERAL BLUME X COORD AF/RTR X Rec'd 27/1015 MAR 95 by

LT COL TRIPP _____ - 297-6208 AF/RTT _____

ACTION OFFICER: FAK 202 767-6208
MAJ Jim Davis /SGHM

=====

ACTION REQUIRED

- RT INFORMATION AND/OR FILE
- _____ APPROPRIATE ACTION/COORD
- _____ PREPARE FOR AF/RT SIGNATURE/COORD
- _____ RESPOND DIRECT WITH COPY TO AF/RT
- _____ PREPARE COMMENTS AND RECOMMENDATIONS
- _____ PREPARE POINT PAPER
- _____ PROVIDE BRIEFING

FOR ALL CONGRESSIONALS, PLEASE PROVIDE COPIES TO
MAJ D'EUFEMIA FOR HER SCAN FILE
and MAJOR SHAPIRO

RETURN THIS SHEET TO LT COL TRIPP

REMARKS:

Reference Commission
letter 20 Mar Tasker 950 321-
in ^{RT} cover letter. attach
original tasking. comment on
whether this is certified data
or not. (For RT sig)

COORD WITH:

- COPIES TO: RT FILE ①
- u < Hill ① RT Library ①
- Senate ①
- OSD BRAC Office ①
- Commission ②

6-0504

REQUESTER: Cirillo DBCRC

BE SURE TO INCLUDE THIS FORM WITH YOUR RESPONSE. CLEAR THE
SUSPENSE WITH LT COL TRIPP, AF/RT, 38678, IF ANSWERED VERBALLY.
CONTACT THIS OFFICE IF CHANGES ARE REQUIRED.

7 COPIES



DEFENSE BASE CLOSURE AND REALIGNMENT COMMISSION
1700 NORTH MOORE STREET SUITE 1425
ARLINGTON, VA 22209
703-696-0504

March 20, 1995

*Rec in mail
27 Mar*

Major General Jay Blume
Special Assistant for Base Realignment and Transition
1670 Air Force Pentagon
Washington, D.C. 20330-1670

Please refer to this number
when responding 950.321-13

Dear General Blume:

I request that the Air Force provide the results of all analyses performed regarding the hospital realignment alternatives provided to the Air Force by the Medical Joint Cross Service Group, as well as any other analyses performed by the Air Force of potential hospital closures or realignments.

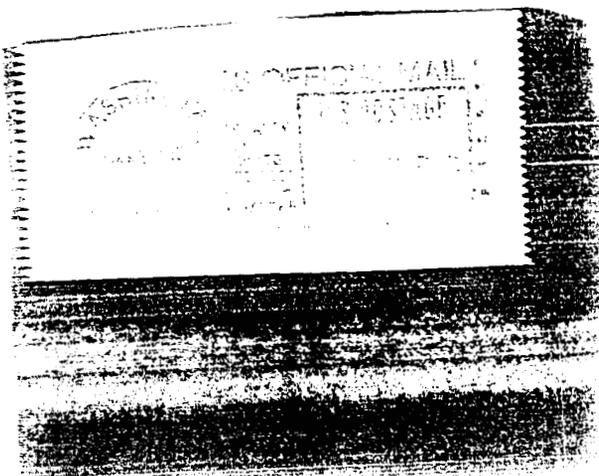
Included should be documentation of the overall feasibility, cost, quality, and access implications of the alternatives, and the specific reasons why the Air Force did not adopt the JCSG alternatives. This information should specifically address, though not be limited to, the analysis referred to on attachment 1, page 4 of the 13 December BCEG meeting minutes (copy enclosed). The Commission needs this information not later than April 7, 1995 in order to complete its analysis of the Joint Cross Service Group alternatives.

Thank you for your assistance and cooperation in this matter.

Sincerely,

Francis A. Cirillo Jr., PE
Air Force Team Leader

Enclosure





9 JAN 1995

OFFICE OF THE ASSISTANT SECRETARY

MEMORANDUM FOR RECORD

FROM: SAF/MII

SUBJECT: Minutes of Air Force Base Closure Executive Group (AF/BCEG) Meeting

The AF/BCEG meeting was convened by Mr Boatright, SAF/MII, at 1030 hours on 13 December 1994, in Room 5D1027, the Pentagon. The following personnel were in attendance:

a. AF/BCEG members:

Mr. Boatright, SAF/MII, Co-Chairman
 Maj Gen Blume, AF/RT, Co-Chairman
 Mr. Beach, SAF/FM
 Mr. McCall, SAF/MIQ
 Maj Gen McGinty, AF/DPP
 Mr. Orr, AF/LGM
 Mr. Durante, SAF/AQX
 Mr. Kuhn, SAF/GCN
 Brig Gen Weaver, NGB/CF
 Brig Gen Bradley, AF/RE

b. Other key attendees:

Col Mayfield, AF/RTR
 Col Walters, AF/PE
 Col Pease, AF/XOOA
 Col Renton, SAF/MII
 Lt Col Black, AF/RTR
 Lt Col Kring, NGB
 Mr. Reinertson, AF/CEP
 Maj Richardson, AF/RTR
 CMSgt Dumez, AF/SGM

The meeting was called to order by Mr. Boatright. He discussed the problems associated with meeting the January 3, 1995, deadline imposed by OSD for preliminary candidates for closure or realignment.

CMSgt Dumez, AF/SGM, presented the alternatives developed by the Medical JCSG, using the slides at Atch 1. There was great concern that the alternatives were developed prematurely, since any decisions should reflect the BRAC 95 basing changes. In addition, the



BCEG CLOSE HOLD

Base Closure Executive Group

JOINT CROSS-SERVICE GROUP FOR MTFs AND GME

MEDICAL JCSG

BCEG CLOSE HOLD

1 12/15/64



BCEG CLOSE HOLD

Base Closure Executive Group

MEDICAL JCSG

- GROUP MEMBERSHIP
- GOAL - REDUCE MEDICAL INFRASTRUCTURE
- METHODOLOGY
- RESULTS/RECOMMENDATIONS

BCEG CLOSE HOLD

2 12/15/64



BCEG CLOSE HOLD

Base Closure Executive Group

MEDICAL JCSG

- GROUP MEMBERSHIP
 - CHAIRMAN - Dr (Adm) Edward Martin, OASD(HA)
 - SERVICES REPRESENTATIVES
 - PA&E
 - JCS/J-4 (MEDICAL)
 - COMPTROLLER
 - DASD/ECONOMIC REINVEST & BRAC
 - DoD IG

BCEG CLOSE HOLD

3 12/15/94



BCEG CLOSE HOLD

Base Closure Executive Group

MEDICAL JCSG

- GOAL
 - Determine if DoD medical infrastructure for inpatient capacity exceeds requirement
 - Provide candidates for realignment or closure

BCEG CLOSE HOLD

4 12/15/94



BCEG CLOSE HOLD

Base Closure Executive Group

MEDICAL JCSG

- METHODOLOGY
 - Categorized MTFs
 - Medical Centers
 - Community Hospitals
 - Clinics
 - Functional Value
 - Patient Population
 - Civilian Medical Resources
 - MTF Physical Plant
 - Contingency Factors
 - Civilian Cost Comparison

BCEG CLOSE HOLD

5 12/15/94



BCEG CLOSE HOLD

Base Closure Executive Group

MEDICAL JCSG

- METHODOLOGY Continued
 - Data Collected, Validated by SG, and Checked by Service Audit Agencies and DoD IG
 - Linear Programming Model Used
 - Reduce excessive capacity
 - Maintain average functional value system-wide
 - Maintain expanded beds to meet Service wartime and DoD peacetime requirements

BCEG CLOSE HOLD

6 12/15/94



BCEG CLOSE HOLD

Base Closure Executive Group

MEDICAL JCSG

- RESULTS
- Based on Current Force Size
 - Excess capacity (operating beds) identified
 - 16 medical candidates for realignment or closure
 - 6 Army
 - 2 Navy
 - 8 AF
 - 2 Medical Centers
 - 6 Hospitals
 - No Complete Closures

BCEG CLOSE HOLD

7 12/15/64



BCEG CLOSE HOLD

Base Closure Executive Group

MEDICAL JCSG

- AF Candidates
 - Reese - Demonstration Test Now
 - Shaw - Readiness issue
 - Langley - Readiness issue
 - USAF Academy - Cadet Mission
 - Sheppard - Question Cost-Effectiveness
 - Scott - Question Cost-Effectiveness
 - Wright-Patterson - Question Cost-Effectiveness
 - Lackland - Significant issues

BCEG CLOSE HOLD

8 12/15/64



BCEG CLOSE HOLD

Base Closure Executive Group

MEDICAL JCSG

- Concerns
 - Write medical realignment into law?
 - Real savings under BRAC?
 - Impact to mission, morale?
 - Flaws in the model

BCEG CLOSE HOLD

9 12/15/04



BCEG CLOSE HOLD

Base Closure Executive Group

MEDICAL JCSG

- Recommendation
 - Support any site if AF closure candidate
 - Support Reese as a continued demonstration site
 - Defer all others until after Services closure inputs analyzed

BCEG CLOSE HOLD

10 12/15/04

Military Hospitals -- U.S.

	Hospitals	Operating Beds	Available Beds	Expanded Beds
Army	32	4,751	7,464	9,682
Navy	19	2,395	3,383	3,865
USAF	48	2,538	4,761	6,501
Total	99	9,684	15,608	20,048

Source: JCSG Linear Programming Model Dataset

Wartime Bed Requirements

ARMY	6030
NAVY	2600
AIR FORCE	980
TOTAL	9610