CERTIFIED

PUBLIC HEARING

PRESENTATION OF RECOMMENDATIONS AND METHODOLOGY

DEFENSE BASE REALIGNMENT AND CLOSURE COMMISSION (BRAC)

Thursday, May 19, 2005

Hart Senate Office Building, Room SH-216

Washington, D.C.

A T T E N D A N C E

COMMISSIONERS:

The Honorable James H. Bilbray

The Honorable Philip E. Coyle III

Admiral Harold W. Gehman, Jr., USN (Ret)

The Honorable James V. Hansen

General James T. Hill, USAF (Ret)

General Lloyd W. Newton, USAF (Ret)

The Honorable Samuel K. Skinner

Brigadier General Sue Ellen Turner, USAF (Ret)

WITNESSES:

The Honorable Dr. Ronald M. Sega, Director of Research and Engineering

Lieutenant General George P. Taylor, USAF Surgeon General

Mr. Donald C. Tison, Deputy G-8, US Army

CERTIFIED

ADMIRAL GEHMAN: Good morning, everybody. I am Commissioner Hal Gehman. I'm filling in for our chairman, Department of Veterans Affairs Secretary Tony Principi, who cannot be here this morning due to a long and previously held commitment.

That said, I'm pleased to welcome the Honorable Ron Sega, Director of Defense Research and Engineering, Lieutenant General George Peach Taylor, the Surgeon General of the Air Force, Mr. Donald C. Tison, Deputy G-8 of the US Army. These three officials are the lead DOD officials for the Technology, Medical, Headquarters and Support Activities of the Joint-Cross Service Groups.

Today's hearing is intended to shed more light on the work of the Joint-Cross Service Groups and their recommendations for restructuring our nation's defense installations and harnessing this process to advanced long-term transformation goals. Clearly the work of the Joint-Cross Service Groups was much different and much more extensive than any previous track analysis conducted by the Department of Defense.

As was noted at yesterday's hearing and Joint Cross Service issues, we are aware that you and your staffs have devoted an enormous amount of time, energy and brainpower into the final product that is the subject of our hearing. It is only logical and proper, therefore, that we afford you this opportunity to explain to the American public and to this

CERTIFIED

independent commission what you had proposed to do, how you proposed to implement these plans, and the underlying rationale for your recommendations.

This Commission takes its responsibilities very seriously to provide an objective and independent analysis of your recommendations. We will carefully study the recommendations in a transparent manner, steadily seek input from the affected communities to make sure they fully meet the congressionally mandated requirements.

I now request our witnesses to stand for the administration of the oath, which is required by the Base Closure and Realignment Statute. The oath will be administered by Mr. Dan Cowhig. Mr. Cowhig?

MR. COWHIG: Thank you, Mr. Chairman.

[Whereupon the witnesses were sworn.]

ADMIRAL GEHMAN: The Commission would be delighted to entertain any opening statements that you may have. Dr. Sega, would you care to go first?

DOCTOR SEGA: Good morning, Mr. Chairman, members of the Commission. Thank you for the opportunity to discuss the Base Realignment and Closure process and perspective of the Technical Joint-Cross Service Group. I request that our written statement be submitted for the record.

ADMIRAL GEHMAN: Without objection. We will do that.

[Written statements submitted as lay-ins for the record.]

DOCTOR SEGA: I'm Ron Sega, Director of Defense Research and Engineering. Today I address you as a different role, the

CERTIFIED

role of Chairman of the Technical Joint-Cross Service Group. The other TJCSG members were nominated by military services and appointed by the Infrastructure Steering Group, one from each service and one from the Joint Staff.

I would like to recognize a few members of the Technical Joint-Cross Service Group. Mr. Brian Simmons from the Army. Admiral J. Cohen from the Navy. Dr. Barry Dillon, Marine Corps. Mr. Al Shaffer, OSD. Mr. J. Erb, Joint Staff. These individuals and more, over 100 personnel have worked tirelessly for a two-year period to assure the recommendations set forth provide an infrastructure that is agile and adaptable to an ever-changing environment. I am proud and honored to be a member of this group.

The TJCSG recognized the challenge for developing an RDAT&E infrastructure that would address the Department of Defense needs for the next 20 years in a global environment, where knowledge and technology is changing rapidly. And I'd like to describe this by way of a chart.

The needs for the next 20 years will be different than today. Technology is developing rapidly. It's developing globally. Knowledge is being created at an ever-increasing rate. So our challenge was to look at today's infrastructure and assure ourselves that as we look at the various combinations of infrastructure in the Department of Defense, that we would be able to do the job today; and we would have an infrastructure that would help us move to the future.

CERTIFIED

We have new capabilities and activities, some of which we can anticipate, some of which we cannot. These factors suggest a need for an infrastructure with agility and surge capacity in cross-disciplines and functions; and it led us to an installation configuration that includes multidisciplinary and multifunctional centers of excellence.

The multidisciplinary centers should provide the environment for innovation; and the multifunctional centers should support, reducing cycle times from the generation of ideas to the fielding of enhanced operational capabilities.

As Secretary Rumsfeld stated in 2002, BRAC 2005 can make an even more profound contribution to transforming the department by rationalizing our infrastructure with defense strategy. BRAC 2005 should be the means by which we configure our current infrastructure into one which the operational capacity maximizes both war-fighting capability and efficiency.

The Technical Joint-Cross Service Group evaluated DOD technical facilities that perform any of three functions: Research, development and acquisition, and test and evaluation. To organize the group's reviewing deliberations, five subgroups were established as depicted in these charts; and they looked at the responsibility of evaluating sets of activities. The subgroups were Command, Control, Communications, Computers, Intelligence, Surveillance, C4ISR, headed by Matt Mleziva. He is here today as well. Air, Land, Sea, and Space Systems, Tom Mathes from the Army. Weapons and

CERTIFIED

Armaments, Dr. Karen Higgins from the Navy. Innovative Systems, Dr. Larry Schuette, Navy. Enabling Technologies, Dr. Bill Barry from OSD.

We selected this structure to help force our perspective on jointness, and it was through that construct that we had a view from many different perspectives in terms of the infrastructure on the technical side.

The subgroups conducted detailed analysis for capacity, military values, scenario development and analysis; and ultimately developed and evaluated candidate recommendations for submission to the ISG. Though the subgroup has a domain emphasis, the goal was an integrated approach to research, development and acquisition, and test and evaluation across the department for a 21st Century infrastructure.

At each stage of the analysis, the TJCSG reviewed the subgroup findings and provided oversight and direction that shaped subsequent analysis. In addition, we had a Capacity Integration Team, led by Mr. Al Shaffer, and an Analytic Team that also supported the efforts of the subgroups.

So to cross-cutting areas, the Integration Team and the Analytic Team also supported this organizational structure. We also coordinated with other Joint-Cross Service Groups. Some are depicted in this chart.

The most frequent coordinations were with the Education and Training JCSG. The headquarters and support activity, which we will hear from today, as well as the Medical JCSG and the Intelligence JCSG.

CERTIFIED

The DOD organizations that currently perform RDAT&E work cover a domain of approximately 650 technical facilities located at 282 installations. These technical facilities employ approximately 159,000 full-time equivalent government and onsite contractor personnel. DOD technical facilities executed approximately $130 billion in funding for fiscal year 2003; and by their efforts, produced a number of new and enhanced technical capabilities and systems.

The TJCSG established two overarching principles and overarching strategic framework. The two principles were:

One, provide efficiency of operations by consolidating technical facilities to enhance synergy and reduce excess capacity.

Second, maintain competition of ideas by retaining at least two geographically separated sites, each of which would have a similar combination of technologies and functions. This will also provide continuity of operations in the event of unexpected disruptions.

Now, consistent with these two principles, the TJCSG also developed a strategic framework centered around establishing multifunctional and multidisciplinary centers of excellence. This strategy emphasized developing synergies, either multifunctional; for example, combining research with development and acquisition or test and evaluation; and multidisciplinary, for example, coupling materials and electronics platforms.

CERTIFIED

These centers of excellence are designed to maximize the efficiencies and synergies of other work these facilities produce.

By using the concepts and strategic framework, our group provided recommendations to result in the following constructs:

The defense research laboratories, and that's the lower block on the chart, principally conducting basic and applied research in multidisciplinary technology areas. It's the foundation, the underpinning of the rest of the work that we do in RDAT&E.

The second area is integrated RDAT&E centers. Across the DOD technology areas, they're involved with maturing platforms and capabilities. It's also an alignment with some of our subgroups in this area.

The third, and in the purple color, is the integrated C4ISR centers, which are intended to enable and advance joint battle space awareness capability while initially emphasizing RDAT&E domain centers for ground, maritime, air and space. So this recommended infrastructure should also enable a joint management structure for the future.

Many cases you will see a co-locating or consolidation of activities that have a service emphasis to them, but the intent in the Technical Joint-Cross Service Group that the layout of infrastructure has recommended will enable more joint work in the future.

CERTIFIED

As the analytic process involved, TJCSG, frames analysis, consistent with the strategic framework, into the three constructs I just described. Our group examined the infrastructure in two critical divisions. First being the RDAT&E functions required for specific capability. For example, employing air platforms, weapons, and information systems. The second being the disciplines and functions required to support multiple capability areas. For example, human systems research for air, land, sea, and space platforms.

Throughout the process, the TJCSG interacted with the services for single service recommendations plus the JCSGs. For example, intelligence with the integrated C4ISR centers, headquarters and support agencies for specific movement of headquarters elements, medical or chem/bio defense and defense research laboratories and education and training for test evaluation capability, particularly for the open ranges.

Finally, the Technical Joint-Cross Service Group conducted a fair and comprehensive process, consistent with the Base Closure and Realignment Act of 1990 as amended and in accordance with the guidance from the Secretary of Defense. The TJCSG developed recommendations for an Infrastructure Steering Group, endorsed strategy-driven approach and the approved criteria and methodology described in TJCSG Analysis and Recommendations Volume XII, which you should be receiving later today.

CERTIFIED

These decisions were made carefully through a rigorous process with full agreement from the TJCSG. We believe the implementation of these RDAT&E recommendations will enable the department to provide advanced, agile and adaptable technical capabilities for our war-fighters.

Mr. Chairman, members of the committee, thank you for allowing me to represent the work of the Technical Joint-Cross Service Group.

ADMIRAL GEHMAN: Thank you, Secretary Sega. General Taylor, would you like to kick it off?

GENERAL TAYLOR: Mr. Chairman, distinguished members of the Commission, good morning. I'm very, very pleased to be here today on behalf of the Medical Joint-Cross Service Group, to present the results of a two-year comprehensive review of the Department of Defense's healthcare functions for Base Realignment and Closure 2005.

I forwarded to the Commission a written report that summarizes my comments. The goal of the BRAC is to reduce military infrastructure, saving taxpayer dollars. At the same time we apply the medical lessons learned from supporting a 21st Century military, carrying out a global war on terrorism.

The MJCSG recommendations which you have are large and far-reaching actions that cut across the entire department's healthcare system, resulting in what we believe to be a premiere modernized 21st Century military medicine platform for a 21st Century military.

CERTIFIED

As the Air Force Surgeon General, I had the privilege to chair the Medical Joint-Cross Service Group. We cast our net proudly within the department. Other principle members of my group were the Navy Surgeon General, Deputy Surgeon General of the Army, the Joint Staff Surgeon, the Medical Officer for the Marine Corps, and the Chief Financial Officer for the Assistant Secretary of Defense for Health Affairs.

We have spent our professional lives ensuring our beneficiaries receive the best possible healthcare. Our group was charged with identifying, analyzing and quantifying all functions within the DOD healthcare system. These assigned functions included healthcare education and training, healthcare services, and medical and dental research development and acquisition.

The breadth and scope of these activities is quite large; and as you will see, our entire report spans some 400 pages of text, graphs and data.

We took our task quite seriously, as the impact of any recommendations we made would have pronounced effects, effects we were determined to ensure were to be clearing the way forward as we adopt and adapt to the advancing art and science of medicine and the needs of our armed forces.

Today injured marines can be moved from the streets of Fallujah through the hands of Navy, Army, and Air Force medical personnel in Bethesda all in less than 48 hours. The global war on terrorism has emphasized the value of joint interoperable and highly trained medical capabilities.

CERTIFIED

In fact, jointly staffed medical treatment facilities exist today in Balad Air Base, Iraq and have been in place for over ten years at Landstuhl Regional Medical Center in Germany. We know how to run jointly in combat and peace.

We also know we must have the best trained; and we have the best trained; and we have today the most combat-hardened medical force this nation has seen since the 1970s, something that remains an invaluable asset to this nation.

We are also very mindful of our great commitment to over nine million beneficiaries who depend on the Military Healthcare System for their care. Augmenting our military treatment facilities with our TRICARE partners, we deliver high-quality healthcare across globe.

Overseen by the General Accounting Office and the DOD Inspector General and Audit Agency, we gathered certified data from the field to assess capacity and to create a quantitatively derived measure to inform our assessment of military value of the entire military medical and dental infrastructure of the United States.

Based on an analysis of this data, we looked for opportunities to eliminate unnecessary infrastructure while creating a better, more effective and more efficient military health system for our nation. With the installations' responses in hand, each of the Medical Joint-Cross Service Group's subgroups identified realignment or closure scenarios that corroborated their strategies, were supported by data, and are matched to the published BRAC criteria.

CERTIFIED

We believe these scenarios would advance jointness, achieve synergy, capitalize on technology, exploit best practices, minimize redundancy, and are wise investments to create substantial savings to the department while maintaining the fundamental healthcare missions of the DOD.

Let me review briefly the work we accomplished. First I'd like to describe what we found from our look at the system as reflected in the data we received. We looked across the United States. We see many areas where world-class healthcare services are carried out. This is being accomplished on legacy platforms built in a different time, both medically and from a force production paradigm.

In many locations we had overlapping healthcare delivery capabilities and a fair amount of aging infrastructure. We also noted that large parts of our capacity and educational training as well as research development and acquisition is highly distributed and stovepiped.

The Medical Joint-Cross Service Group addressed this through the work of the three subgroups. The health services subgroup utilized three strategies to evaluate the medical and dental delivery functions. These functions include all primary care and specialty care required by a defined population surrounding a military treatment facility. Our review of overall medical capacity revealed little excess in dental, primary care or subspecialty outpatient care.

However, we found substantial inpatient capacity well in excess of current use even with the casualty streams we've

CERTIFIED

seen over the past three years. As a result, a three-fold approach was developed. First, our group analyzed the data, using the DOD-approved optimization process to identify an optimum level of reduced excess capacity and average military value in the DOD healthcare system as a whole while maintaining sufficient workloads to ensure provider currency and service capability.

This analysis identified 52 medical facilities with inpatient activities for further analysis. This analysis included a close review of the mission of the base, the capability and access to the local Veterans Administration facilities and civilian healthcare market and the ability of the Military Healthcare System to absorb any mission, such as medical education, that could not be carried out at that location. As a result, we recommend the closure of inpatient activities at nine locations. It is important to understand that we do not recommend any change in outpatient activities to include same-day surgery capabilities.

Second, we evaluated hospitals' efficiency at providing inpatient care in an effort to reduce excess capacity by reviewing inpatient services at those facilities with very small inpatient activities. This approach identified six additional facilities. Again, as with the optimization model, we looked hard at access and capabilities of the local Veterans Administration and civilian healthcare. As a result, we recommended an additional one facility closes inpatient activities.

CERTIFIED

Thirdly, our group assessed the multiservice market areas to determine if excess capacity should be reduced in these MSMs. These markets have multiple medical military treatment facilities in a single metropolitan location. Recommendations on two of these MSMs, the National Capital Region and San Antonio, resulted from looking at the healthcare delivered, the locations of delivery and the capacity of military value of the activities there.

For both the second and third approaches I've discussed, our group's goal was to ensure services could be located where they could best meet benefit demand.

The second subgroup addresses healthcare education and training. They evaluated all aspects of medical and dental education and training, both officer and enlisted, to identify potential opportunities to realign and consolidate programs within and between the medical departments.

The major result of this work was the recommendation to concentrate medical training jointly at Fort Sam, Houston, Texas. Additionally, the subgroup also monitored the effect of all the scenarios flowing from other subgroups on the ability of the department to execute its graduate medical and dental education programs.

Let me give you some insight into how we address residency and fellowship training. We assess the total training delivered by our medical military facilities around the country as well as their capacity to expand training. We looked at the -- we currently train -- we also looked at the

CERTIFIED

residency and fellowship training for military officers carried out in civilian institutions across the country today.

We currently train approximately three-quarters of our residents and fellows every year in military facilities. The rest receive their educational training in civilian and Veterans Administration institutions. We also asked the military's Surgeon General to give us their assessment of the minimum training that they thought should be accomplished within the military system.

This information was key as we addressed the median impacts to assure we would not take actions to seriously compromise the capability.

In the end, the impacts of our recommendation on these programs were relatively small. We are confident that we will be able to maintain over 95% of the current military training for medical core officers, assuming that the size of the medical core of the three services remains the same into the next decade.

As senior DOD medical professionals, we recognize that many of the recommendations will require hard work from our education staffs to maintain civilian certifications; but we believe this is eminently doable and that the impact of the recommendations we provide is of minimum risk.

The third subgroup addressed medical and dental research, development and acquisition. This subgroup evaluated all aspects of DOD's ability to sustain those capabilities

CERTIFIED

required to effectively discover, develop, acquire and field medical solutions to address evolving war-fighter needs.

This evaluation includes all aspects of medical and dental research and development from basic research to advanced demonstration and encompass both the initial procurement of developmental items and acquisition of nondevelopmental items required to sustain and optimize the health and performance of war-fighters in the operational theaters.

As graduate medical education, we were quite mindful of the human capital issues here. If we were to move programs to different locations, the movement of the existing civilian workforce cannot be ensured.

In the end, we believe strongly we are making the correct recommendations in our report, that we are taking a major step forward in creating joint centers of excellence and biomedical science at places near major metropolitan, educational and military locations where these joint centers can leverage the very best our nation has to offer.

The Infrastructure Executive Committee approved 21 of our candidate recommendations. The approved recommendations were consolidated, resulting in the six final recommendations we forwarded to you. Using the DOD's cost of Base Realignment and Closure Analysis, or COBRA tool, we recommend these recommendations call for an investment of $2.4 billion. We'll garner more than $5 billion in gross savings over 20 years and over $400 million in annual recurring savings forever.

CERTIFIED

Let me summarize the major changes we recommend. Not to say many of the other recommendations are not integrally woven into the web of our recommendations set. You will find they are innovative data-driven and mindful of the vital mission we have as a military healthcare system.

One, transform the National Capital Region by creating a jointly staffed 300-bed Walter Reed National Military Medical Center in Bethesda and build a 165-bed state-of-the-art community hospital at Fort Belvoir. This will allow the closure of the main post at today's Walter Reed Medical Center.

Transform San Antonio military healthcare delivery by expanding Brooke Medical Center to 425 beds, staffed from the existing Brooke and Wilford Hall Medical Center at Laughlin. This will allow the closure of the existing Wilford Hall main building and its replacement with a large state-of-the-art ambulatory medical center. In addition we recommend the enlisted medical training along with some Air Force medical officer training be located at Fort Sam, Houston, creating a joint center for medical training.

Three, realign the aerospace medicine clinical, training, research, development and acquisition activities from Brook City-Base, Texas, to Wright-Patterson Air Force Base, Ohio, to align them with the aerospace research, development and acquisition activities. This will enable the military to completely leave the city base.

CERTIFIED

Four, close inpatient activities at nine hospitals, converting them to large ambulatory surgery facilities, leveraging the local VA and civilian network for inpatient care.

Finally, five, create six new centers for medical excellence and biomedical research.

Again, the implementation of our recommendations will call for an investment of $2.4 billion but again, will result in a more leveraged infrastructure, better for our staff, better for our patients, better for our nation; and we believe we can save over $400 million annually for the taxpayer.

With the implementation of these recommendations, we will, indeed, be better able to leverage the immense talent in our workforce by placing them in locations with first-class resources.

There's no better example of our vision of the future than our recommendations for the National Capital Region and San Antonio. The new Walter Reed National Military Medical Center will be the centerpiece of military healthcare, clinical practice, education and research.

With its staff and location on the same campus, with the uniformed services University of Health Sciences, our military medical school as well as being across the street from the National Institutes of Health, the new Walter Reed National Military Medical Center will rival Mayo Clinic, Johns Hopkins and the other great medical institutions of the world. And it will be jointly staffed.

CERTIFIED

Just as today we have jointly staffed hospitals in Iraq and in Germany, we foresee the new Walter Reed National Military Medical Center staffed by the finest medical personnel in the Army, Navy and Air Force, working together just as we do in combat.

Similarly, in San Antonio we can build on the excellent expansion capabilities built into the Brooke Army Medical Center. As with the new Walter Reed National Military Medical Center, the San Antonio Medical Complex will feature a 425-bed medical center, including an expansion of emergency services to maintain our commitment to the San Antonio community.

There will be a 450,000-square foot ambulatory care facility and center of excellence in battlefield medicine and trauma as well as featuring a joint center for medical training. This will be another world-class operation, furthering clinical training, education and research.

In creating the Joint Biomedical Centers of Excellence, we were able to co-locate much of the activities carried out by the Army, Navy and Air Force, allowing them to share intellectual and material capital by placing them near their military operational counterparts of Wright-Patterson, Fort Detrick and Aberdeen. We believe we will be able to best leverage this investment in the future of our combat and combat support systems, tightly linking the medical operational and investments capabilities of the department.

In combination, our Medical Joint-Cross Service Group recommendations are our assessment of what is best for the

CERTIFIED

department as it moves forward, building on the successes and the fine tradition of today's and yesterday's military medicine. We believe these recommendations provide a foundation for building a 21st Century medical system for our 21st Century military.

I am pleased and gratified with the Medical Joint-Cross Service Group's efforts. We look forward to the commission's review of these, keeping, we hope, in their focus, in your focus the principles that guided our deliberations to provide access to high-quality healthcare to the war-fighters and our beneficiaries.

Mr. Chairman and members of the Commission, I thank you for the opportunity to address you. I'd be pleased to respond to any questions you may have and to an ongoing dialogue we open today. Through this, we trust we will move together, closer to our jointly held goal to better serve those who have today and are serving our country in the past. Thank you very much.

ADMIRAL GEHMAN: Thank you, General Taylor. Mr. Tison?

MR. TISON: Morning, Mr. Chairman and distinguished committee members. Thank you for the opportunity to appear before you today in my role as Chairman of the Headquarters and Support Activities Joint-Cross Service Group. I assumed the chair from the Deputy Under Secretary of the Army, John McDonald, prior to his departure in May of 2003.

In addition to the written statement that was provided earlier, I would like to offer the Commission a few brief

CERTIFIED

comments that summarizes the Joint-Cross Service Group's efforts over the past two years.

The Office of the Secretary of Defense established headquarters in Support Activities Cross Service Group to address Base Realignment and Closure complications for common business-related functions and processes across the Department of Defense, military departments and defense agencies.

We had no counterpart previous BRAC rounds and therefore were charged with the fine appropriate function and subfunction areas for analysis. Our Joint-Cross Service Group has six members and about 35 full-time military duty, civilian and contractor personnel representing the four services, OSD and the Joint Staff.

The analysis was performed by three subgroups: The Geographic Clusters and Functional Subgroup, led by Mr. Bill Davidson, the Administrative Assistant to the Secretary of the Air Force; the Mobilization Subgroup, led by Mr. Mike Rhodes, the Assistant Deputy Commandant for Manpower and Reserve Affairs, United States Marine Corps; and the Major Administration and Headquarters Subgroup, led by Rear Admiral Jan Gaudio in the Commandant of Naval District Washington.

Our OSD member is Mr. Howard Becker, Deputy Director of Administration and Management OSD and Director of Washington Headquarters Services, who's with me today. Our Joint Staff member is Brigadier Select Dan Woodward, U.S. Air Force, who serves as Director of Force Structure Resources and Structure. Bill Davis's Geographic Subgroup analyzed common functions of

CERTIFIED

financial management, personnel management, corrections, installation management and selected in defense agencies. Mike Rhodes's Mobilization Subgroup analyzed function of joint mobilization. Rear Admiral Gaudio's Major Administrative and Headquarters Subgroup analyzed headquarters located within the DC area, select headquarters outside of the DC area to include combatant commands, service component commands, reserve component and recruiting headquarters and common support functions.

Since spring of 2003 the Joint-Cross Service Group has conducted 104 deliberative sessions. Most sessions lasted several hours, many consumed the better part of the day. This has resulted in 21 Base Closure and Realignment recommendations. Our Joint-Cross Service Group was guided by the overarching strategy to improve jointness; eliminate redundancy; eliminate implication and excess capacity; enhance force protection; exploit best business practices; increase effectiveness, efficiency and interoperability; and to reduce costs. Subgroups further interpreted this broad strategy to their functional assignments. I would like to quickly review with you the resulting strategies, providing samples of the recommendations that resulted.

The Joint-Cross Service Group attempted to rationalize the need for single-function administrative installations. For example, close coordination with the Army, the Joint-Cross Service Group recommended relocation of two large Army headquarters, enabling the closure of Fort McPherson, Georgia.

CERTIFIED

You do not see these in our section of the report as they were integrated into the installation closure relation.

The second strategy pursued by the Joint-Cross Service Group was rationalization of presence within the DC area. The department's concern with the heavy concentration of defense activities in the DC area led to recommendations to relocate major headquarters and field operating agencies elsewhere when it made sense to do so.

In close coordination with Dr. Sega and the Technical Joint-Cross Service Group recommended relocation of the consolidated Missile Development Agency to Redstone, a location where proponents for the Missile Defense Agency currently exist.

Pursuant to the strategy to reduce the department's dependency on lease space resulted in several recommendations to move organizations currently in leased space to DOD-owned space. These moves will save the DOD hundreds of millions of dollars over the next 20 years.

We recommend consolidation of components of major headquarters. For example, the Defense Information Systems Agency from eight locations to one. They recommend consolidation of common support functions of major headquarters. An example is the consolidation of components of Transcom. And fulfillment of remaining strategies recommendation of 12 joint bases, consolidation of the Defense Finance and Accounting Service from 26 locations to three, consolidation of Civilian Personnel Offices, establishment of

CERTIFIED

three Service Human Resources Centers of Excellence, creation of a joint corrections enterprise, and establishment of four joint mobilization sites.

We believe these recommendations will ultimately enable the Defense Department to achieve substantial savings while improving the common business-related functions and processes. The paybacks are immediate and have the potential to save the department over $900 million annually and over $9.5 billion over the following 20 years.

During the past 24 months, our Joint-Cross Service Group worked with the Department of Defense, Office of the Inspector General and Government Accountability Office to ensure deliberations and deliberate process and knowledge that was consistent with DOD policies, programs and procedures. We will continue to work closely with these three organizations during this next phase of the process to make certain our compliance with the BRAC statutes in the Department of Defense policy.

In conclusion, I look forward to the commission's comments on strategy of principles that have guided our deliberations. I trust that you will find our recommendations sounds and concur with them as presented by the Secretary of Defense. We will continue to work with you over this next phase of the process.

Mr. Chairman, this concludes my opening remarks. I am happy to answer any questions that you or your distinguished Commission members may have at this time.

CERTIFIED

ADMIRAL GEHMAN: Thank you very much, Mr. Tison. All three panel members, I would like to express my personal thanks for your appearance here today. Even though the detailed data sheets are just now arriving at our staff, we haven't had an opportunity to work through them.

The opportunity to hear from the Cross Service Function Groups' chiefs personally will add a lot to our deliberations, and we appreciate very much you being here. I'll ask one or two questions, and I'll turn it over to my colleagues here.

Secretary Sega, without mentioning any specific realignments or closures, going through the list very briefly, there are a number in there in which the economic payback is spread over many many, many years. Some ten years, some seven years, some more than that. And they involve a lot of people, a thousand or more, usually very, very skilled, highly educated kinds of people.

Without mentioning anyone in particular, because I don't have the details, would you tell me the depth that your group went into analyzing the pain versus the gain here, knowing full well that it looks good to consolidate like-kinds of activities; but when you look at the paybacks, they look pretty thin; and the personal turmoil involved looks pretty high.

Could you -- and there's no way to quantify that. So could you tell me about how you consider it?

MR. SEGA: Mr. Chairman, we do have a range in our -- in the recommendations that went forward through the Secretary to

CERTIFIED

the Commission that have paybacks from a very short period of time, from one year to the numbers that you mentioned. These are difficult decisions to make when people are being transferred from one location to another; but our overarching view was: What would provide the technical infrastructure to produce the capability for the future? And we looked at the nature of the activity that will go forward.

Some of that is multidisciplinary in nature; and so we looked at establishing centers that had disciplines that cross-fertilize, if you will, the issue of, for example, sensors and materials and people. And so as we go forward, we're looking at an infrastructure and a network-centric environment that includes sensors with people, sensors on equipment, and all being networked in a coherent way. So the issue of bringing efficiency and effectiveness to the facilities, especially in the research area, said that a few centers of excellence in the multidiscipline area should provide the benefit and allow us to accomplish the mission.

The other construct was in the multifunctional area. Now there, the issue of bringing an idea from the research phase through development and acquisition onto a field system was a driving factor. We believe that testing evaluation, for example, is viewed a bit differently as we go forward. That one should be looking at designing for testability at the very, very beginning of the research phase, including from the development and acquisition phase.

CERTIFIED

So the integration with people that are going to be involved in testing evaluation along with those that are doing the research, development and acquisition should reduce the cycle time and bring things from ideas to fill the systems more rapidly. So it was recognition of where we need to position ourselves for the 21st Century. So some of these alignments are very, very important.

Now, with those being set as a general principles, the data analysis was rigorous and significant; and when we have an opportunity to go through the data steps, that was very important as well. We looked at it from several perspectives. We organized for air, land, sea, space systems as well as weapons and armaments, C4ISR; but we looked at the cross-cutting threads. So it was different viewpoints to look at what would make the greatest impact.

Now, in terms of movement of people, very cognizant of the importance of the human capital piece here. In fact, this year we initiated a national defense education in our proposal to Congress to look at developing talent, particularly in critical skills for the Department of Defense that we'll need in the future.

So that was an important factor that we enfolded into the overall strategic framework and made sure it was consistent with the principles that we established.

ADMIRAL GEHMAN: Thank you. A large -- some portion of the RDAT&E budget might be called -- and these are my own terms. They might not be technically correct but essentially

CERTIFIED

pass-through money, where you take money and give it to universities or give it to contractors or something like that. A lot of it's done in-house at these 650 facilities you talked about.

Do you have any -- could you give me a ballpark figure for what percentage of your budget is essentially supervised and managed by the Department of Defense but the work is actually passed through to universities or to contractors? And how much of it is done in-house? Is it 50/50 or is it 90/10 or --

>> MR. SEGA: It varies by way of research, development and test acquisition. When we looked at the full RDAT&E; and we will go back and get the specifics; but it's probably in the range of the 70%, 80% area of moneys that are extramarital, in a sense there are contracts that are let outside of the government facility.

ADMIRAL GEHMAN: 30% to 20% are essentially done in-house by government employees? I understand you can't answer that for the record, but ballpark it's --

MR. SEGA: Somewhere in that range.

ADMIRAL GEHMAN: Thank you very much. I'll confirm my four questions later. General Taylor -- Turner. I'm sorry. I apologize.

GENERAL TURNER: Good morning. Are we on?

ADMIRAL GEHMAN: Just talk. It's voice activated.

GENERAL TURNER: It's a conspiracy here.

ADMIRAL GEHMAN: It's on. It's on. Good.

CERTIFIED

GENERAL TURNER: Good morning, everyone. As you might expect, I have a lot of medical kinds of questions for you Medical JCSG. I've asked a lot of them already, General Taylor.

I'm going to try not to repeat myself; but I'm also going to try to limit myself to just a few questions; but there's really a couple of things that need some clarification for the commissioner so that we're all on the same page when we go out and start our site visits and conduct the regional meetings.

And looking -- I just got your testimony today; but as I'm looking at it, a number of things, you know, really jumped right out at us; and that is, it was a big task. Bringing military medicine into the 21st Century in a reasonable and thoughtful way is tough; but I'm glad to see that we're moving in that direction.

One of the things that surprised me a lot about this whole entire process was the tremendous degree of secrecy that was able to be maintained throughout the entire process; and I guess on one hand, that was really good. On the other hand, when the list was released with very little detail attached to it -- and as you've already heard today, we're still awaiting more detail. The general public, the beneficiaries of the military healthcare system's services were, in large part, taken aback, particularly in those communities that I'll address in a moment where there are recommended big changes. So that was the good and the bad of that.

CERTIFIED

People want to know more detail about their particular circumstance, whether they're active duty, retired, dependents, widows, whatever. If they've been relying on the local MTF for inpatient, outpatient, support, specialty care, whatever, they want to know more information; and I hope that there's something underway in the Department of Defense to get that kind of information out to the local level to help reduce the shock. You know, knowledge is power no matter what; and so a little bit more would be really helpful.

But let me get to your testimony today; and I'll start with that which is closest to our location here in the capital area.

We're going to have a new military medical center over in the Bethesda campus. We're going to have a new one down in the San Antonio area kind of, sort of. We're going to have the remains at any rate. In San Antonio we're going to have -- the proposal is for the San Antonio Regional Medical Center, which basically closes Wilford Hall, moves the people, the inpatient capability over to combine with Brooke Army Medical Center.

That's been a joint very productive relationship for a long time, so that piece of it seems like it would work really well. And there will be an ambulatory care facility built at Wilford Hall. One question there is, and I'll come back to it. It's not clear to me if, in fact, the physical plant that we know as Wilford Hall Medical Center will, in fact, close

CERTIFIED

its doors and become something else. The -- I don't even want to use the words, but you know.

So how long would that kind of unfold? But then going back to the National Capital Region, we're going to have the new facility over in the Bethesda campus; but it's not going to be the National Capital Region Medical Center. It's going to be the Walter Reed Medical Center.

So initially, that raised the question to us -- well, does that mean that the existing Walter Reed campus really isn't closing? But in your testimony you, in fact, said that it was.

So I guess we would like -- I would like a little clarification. I think it would be helpful for the other commissioners, should anyone ask, to clarify for us exactly why the name was retained even though it's going to a new campus.

GENERAL TAYLOR: A couple points from -- Let's talk about San Antonio first. We looked at -- as you polled the people out and look at the work that's done, I think we both recognize that medicine has changed in the last ten or fifteen years. And you're able to run highly efficient smaller platforms for healthcare.

So by expanding Brooke Army -- the existing Brooke Army Medical Center out to 425 beds, we believe we can actually deliver more inpatient care than exists in the city today from a military standpoint. We looked at whether as part of that we need to continue ambulatory and outpatient services to

CERTIFIED

augment this new medical center. The best place to do that was at Wilford Hall.

When we did the analysis of rehabilitating Wilford Hall to create an ambulatory surgery center or building a new one, the analysis revealed that it's almost as efficient to build a brand-new one. So our recommendation is to build a brand-new facility on the medical campus and shut the windows at the existing main building at Wilford Hall.

For the National Capital Region, the election to use the term Walter Reed National Military Medical Center in Bethesda rather than just the National Military Medical Center I think is to provide continuity to the name we all associate with Walter Reed. Whether you're an Air Force officer, a Navy officer or an Army officer, there's great history, weight and tradition to the name Walter Reed.

So all of us felt, as a group, that the best thing would be to call this new national healthcare medical center the National Military Medical Center. The existing Walter Reed Army Medical Center has several campuses; so the intention behind this is to close the main post where Building One is and expand the capability of Bethesda but move the name over so the other campuses that are associated with Walter Reed would remain in tact, primarily the Forest Glen Research Annex.

As you know, just to talk a little about the transition, the intent of both of these locations is to not deliver one

CERTIFIED

less outpatient or inpatient visit than exists today. Simply a different location.

You and I understand that as we do this construction project, we're going to have to phase it carefully and float the patients across the system. As you expand the capability in Bethesda, you'll probably have to swing patients to the existing Walter Reed campus. Once the capacity's built there under Fort Belvoir, then you can begin closing down the main post.

Same way in San Antonio. As you expand out Brooke Army, you're going to have to flex patients into the Walter Reed National Military -- into Wilford Hall.

Once the Brooke Army Medical Center complex is rebuilt, then you can move the patients back in there. We like not to put a specific name on the San Antonio one. We figured the services would work that out.

GENERAL TURNER: Maintaining that same high level of services here in the Walter Reed is of particular importance, I would say, from -- in terms of the prosthetic and rehabilitative services that are --

GENERAL TAYLOR: Yes, ma'am. The intent is the prosthetics and the new amputee center that's open would move to the Bethesda campus.

GENERAL TURNER: Okay. Moving to the -- looking at your testimony, the recommendation of closed inpatient activities at nine hospitals, converting them to large ambulatory care facilities, leveraging the local civilian network for

CERTIFIED

inpatient care. You use that phrase a number of times in your testimony. Leveraging, as it relates to the VA hospital system, as well as TRICARE providers.

Could you speak a bit more to that in terms of how you determined that these nine localities would -- I'm assuming. Maybe I shouldn't -- that they all have a VA presence.

So could you speak to that a little bit in terms of assuring beneficiaries that what you believe is there for leveraging really is.

GENERAL TAYLOR: Two parts to that. First, when our modeling revealed facilities for us to take a strong look at either the optimization model or the efficiency model raised facilities that we should look to, one of the very first things we did was establish the depth and breadth of the local civilian healthcare system to include the VA, any VAs that were present.

So we looked at the location of hospitals. We looked at their current bed occupancy. We looked at their range of services. We looked at the travel distances. We looked at the qualifications of those neighboring facilities.

As I mentioned in my report, there were many locations where we felt this was inadequate; and therefore, we maintain even though we believe these to be inefficient operations, it was worth the investment in order to continue the inpatient healthcare at those locations.

So in all of our processes, that was a major part of our assessment is the ability to absorb. The other part that you

CERTIFIED

need to understand is that there was -- there is a congressionally mandated benefits work group that works for Dr. Winkenwerder, the Assistant Secretary for Health Affairs. We asked this work group to survey local healthcare markets and give us an assessment independent of our work of those markets where, in their opinion, beneficiary care would be difficult to obtain downtown locally.

They provided us with that overview assessment. In addition, the work group secretary for us, for every single one of our recommendations asked this work group, which is independent of us, to look at the adequacy of local healthcare for each of those recommendations; and their feedback was part of our deliberations. And as I mentioned earlier, we used most of this information on local healthcare was obtained from other source information, hospital reporting, that sort of thing, to see what the capacity is.

Finally, I think it's important to note that we in no way make any recommendation about who the professional staff is going to be inside these civilian institutions. As you know, the Air Force has been closing small hospitals over the last ten years. We've moved from a primarily hospital-based infrastructure to a clinic-based infrastructure.

In many locations we maintain surgeons and orthopedists and other specialists. We see patients in our military treatment facility and then take their patients to the civilian network and operate on them as the primary provider.

CERTIFIED

So this is not unusual for us to do, and it's done in a number of locations. So I think we are very comfortable that the civilian network at these locations can absorb the very small number of inpatients that we would be moving into the network.

GENERAL TURNER: Thank you very much.

ADMIRAL GEHMAN: Commissioner Skinner.

MR. SKINNER: I just have one question. There's been a lot of conversation over the last several months about the care that the families of reservists and National Guard, our war-fighters, to quote your word, General Taylor, are receiving and some delays and concerns they have.

I know there's some efforts underway to deal with that problem. I wonder if you could -- and maybe it goes to one of your associates, but maybe you can handle this as well.

I wonder if you could give us your impressions as to how this program and this realignment will assist to solve what is at least a perception, if not a reality, is the availability, the timely availability of care, especially as it relates to reservists and guard members, especially them and their families of those that are coming back, who are on active duty posts remote to their homes.

GENERAL TAYLOR: Yes, sir. None of our proposals did I tell you that we downsized any outpatient or subspecialty capability. The only places that that would occur would be at the locations where there's an actual base closure and the military medics move. Overall in the system, the total

CERTIFIED

inpatient capacity by these recommendations would drop slightly; but the surge capability is much larger, as I told you, in inpatient capacity.

A large amount of work is being done in terms of how we mobilize people and how we clear them medically and how we make capacity for them when they return. Remember, active duty are our prime responsibility; and therefore, if you look at the system, they're going to get first priority in all of our facilities no matter where they are. The majority of the work we do in our military treatment facilities are retirees, not necessarily on active duty. So we have a fair amount of volume to swing as reservists or active duty come back and we are able to take care of them in the system.

MR. SKINNER: Well, as you move to these super medical centers, and you basically move more towards outpatient surgery centers and the centers of excellence will have more care that is consistent with what you can do today with today's technology, what kind of capacity -- you talked about capacity. You'll obviously have probably fewer tertiary care long-term beds. When I say long-term beds, multiday bed stays and more surgery centers and outpatient centers and what kind of capacity do you anticipate as a result of this realignment on the upside rather than on the downside?

GENERAL TAYLOR: Let me get a measure that's used in Medicare and other open sources in terms of the amount of inpatient work is a thing called relative weighted product or RWP. When we look at the capacity of the system today, we have

CERTIFIED

the capacity to deliver over 400,000 of these RWPs a year. We're producing in the neighborhood of 230,000. So there's a huge capacity in the system. Most of that is born from having a lot of these small hospitals. So our system -- we redesign it as described in the recommendations -- we'll be able to deliver well over 210,000 RWPs. We still have the platforms for nearly 400,000 RWPs. So there would still be an 80% inpatient surge capacity if we were to go back and staff and open up those portions of the hospitals that were closed.

So we have substantial inpatient surge capacity; and again, except for locations where we're actually closing bases and forts, there's no change in outpatient and subspecialty care, which is where the majority of our returning guardsmen and reservists go for their medical evaluation boards and other things.

MR. SKINNER: If we had this additional -- and just educate me, if you would, one more second here. This is question 1c. Still same question.

Could you tell me, if we have this same capacity, why do we have all these concerns expressed by reservists and guardsmen and their families about their inability to get timely medical care? Is it just a matter of location and deployment and availability? Or is it something more?

GENERAL TAYLOR: A combination of location, how far you are from the military facility, priority in the system, gaining priority in the system. And I think the Army has done a marvelous job of setting up their community-based healthcare

system so we can move the Army, guard and reserves that are on medical hold near their home, near a military medical treatment facility or near a major facility to process them as quickly through the system as makes medical sense.

Certainly you don't want to put somebody on medical hold and return them home without adequately assisting their medical needs. There's a great deal of work that the Army's done; and I admire them for it; but it remains a huge issue when you're mobilizing as many people as you are in the Army.

MR. SKINNER: And many guardsmen and Army reservists feel that they're basically -- the cost's made up. They are putting in as much time as the active duty people. So thank you very much.

GENERAL TAYLOR: Of course.

ADMIRAL GEHMAN: General Newton.

GENERAL NEWTON: Thank you, Mr. Chairman.

Dr. Sega. If you can please give me some of your thoughts with reference to the considerations given when we try -- when you tried and your team tried to work the joint part of this infrastructure that you're deliberating on. I'm particularly interested in the consideration that's given to labs, for instance. I personally was expecting to see more jointness.

Can you share with me some of your thoughts that went into that process?

MR. SEGA: Mr. Commissioner, I would be glad to. We had for our look at the Joint-Cross Service Group in the technical

CERTIFIED

area was that the tech base, in particular, basic and applied research is moving more joint in nature. The question we had is what can we do efficiently in this process to bring forward multidisciplinary centers of excellence and provide the infrastructural lay-down that would enable a joint management structure and a greater flow of people and activity to be more joint in nature.

So what we have at the end, in terms of the large centers of excellence in the research area, there would be three that are the largest. One is the Naval Research Lab. We thought they were doing excellent work, and we didn't recommend actions there.

Wright-Patterson Air Force Base, we looked at a variety of realignments, of people that would increase the synergistic ability of folks there at that site to do research. For example, some of the medical-related work in human systems-related areas is now combined with some of the sensor's work that we also brought forward at Wright-Patterson to combine with their materials, expertise and other activities at Wright-Patterson. At Aberdeen, we brought -- they had a portion of the Army Research Lab there; and they had some testing evaluation facilities; and we were bringing in expertise in the area of sensors as well as those in terms of communications-related work to combine into another center that's multidisciplinary in nature.

Now, to be consistent with our principle of competition ideas, even at these three large centers that have intended

replication of work, for example, in materials and sensors, we thought that was a good thing. In the competition of ideas and that they were multidisciplinary in nature so there would be a cross-flow of people, ideas and work among these centers. Now there were others that provided an expertise that we thought was valuable as well.

For example, Adelphi in their work in centers was nearby; and we did the analysis of how the interaction would take place. The work we will also improve the multifunctional aspects of Hanscom Air Force Base with research with the development, acquisition and joining together there.

And so we lay down an infrastructural footprint that we think will encourage joint activity; and after Base Realignment and Closure, if these recommendations are accepted, that some movements and terms of management structure in more joint construct would be enabled by the infrastructure that we recommended. When we looked at the program managers that are funding -- and this is primarily the external work of the services and agencies -- we thought that there was value of bringing those organizations and people into a single site. And so the co-location of external program managers from the Office of Naval research, the Air Force Office of Scientific Research, the Army Research Office, the Defense Threat Reduction Agency, with the exception of two areas where they have very tight collaboration at -- in conventional weapons is an example, and DARPA, the Defense Advanced Research Projects Agency, the recommendation is to

CERTIFIED

bring that group together on the Bethesda campus. There would be some synergy with the people at National Institute of Health, which are right nearby.

Increasingly we are going to be looking at biology as an important discipline, whether it be for medical purposes or bio-inspired solutions for systems of the future. So that there's an advantage there as well as being with some of the expertise in the systems area. But on that campus, then, would reside not only the Army, Navy, Air Force, Marine Corps as well as agency people that are doing external management and funding at the universities. So that the ability to interact would be stronger.

DARPA brings things from new and clever ideas that are generated out of our defense laboratories, national laboratories, universities and other places and tries to accelerate them forward. So the -- being located, we thought, at a single location, this co-location would move us toward that joint goal.

GENERAL NEWTON: Thank you. Reference military value is certainly a key term that is a part of all of this. For us to see that in other more operational settings, it's pretty straightforward for us to understand it.

How does military value really play in its consideration in your area of specialty?

MR. SEGA: And this is a good point. I've asked for a chart that lays out these technical capability areas to be put

CERTIFIED

up here. As you go through the details of the report, ours is very complex.

We not only have our functions that we're responsible for; the research, development and acquisition thesis, you consider those the horizontal cuts here; but the Defense Technology Area Plan designates 12, and we split up the air and space pieces so that we have technical capability areas also across the top. Air platforms, ground vehicles, sea vehicles, space platforms, weapons, nuclear technology, materials and processes, biomedical, human systems, battle space environment, chemical and biological defense sensors and electronics, and systems.

And so each of those areas, these technical capabilities areas has a portion of the work that's in the research, access and development and research. So there are 39 bins.

And so as we went out for capacity and looked at military value, the four main criteria in the military value area are applied to every bin. There are attributes that are applied to every criteria, and one could continue this and add another part of this cue. May I just ask to add those as well.

So when we got a score that you will see in the report, it is specific to the bin. So if it's looking at human systems research, then we will analyze the technical facilities that are doing human systems research; and there will be a scoring. That score cannot be applied to even the next bin over of battle space environment. So it's specific for a technical capability and a function.

CERTIFIED

Now, some of the areas -- the laboratories in particular -- have, and I believe Aberdeen has all -- every one of these technical capabilities in some fashion, done; but as you look at the military value, it was done in our group bin by bin.

So that's the quantitative aspect of military value. The numbers of experts that we had on the subgroups and then the analysis provide expert military judgment in addition to the quantitative aspects of the analysis. The attributes of people, physical environment, physical structures and equipment, operational impact and synergy would be attributes associated with each criteria in each bin.

In addition to that, we had metrics associated with the attributes; and so it was done carefully; but it took an enormous amount of work; but we thought that was the way of giving the best view of what is taking place in our RDAT&E activities in the Department of Defense.

GENERAL NEWTON: Thank you. I'm glad I asked that question. I wanted you to use those last two charts. Thank you very much.

Dr. Taylor, clearly when we look at the medical arena, one could probably say that there was certainly a lot of work that took place here and a lot of changes of plans were taking place as well. Now, the beneficiaries out there, though, have certainly seen a number of changes over the years come before; and many of them have some horror stories about what has happened in the medical arena. If I was to ask you how would

CERTIFIED

you describe to them in your best words or your best judgment, what makes you think you have to right this time?

GENERAL TAYLOR: The major difference between today and ten years ago is the nature of the TRICARE benefit. Today we have TRICARE For Life, which is a medical for all those folks that are over 65. Before that time the people who were over age 65 would be dependent on the military treatment facilities; and when the military treatment facilities went away, the only access was through Medicare, and that included pharmacy.

The other great piece that we've created during the TRICARE benefit is retail and mail-order pharmacy open to all beneficiaries, over 65 dependents. So you're not completely dependent on military pharmacies.

The other part is we've been operating this new partnership with contractors. It's called TRICARE. We've been operating it for many years now. We built a strong relationship. We've built the networks. We understand what strengths each other brings to the system, the civilian strength to the system and what the military strength brings to the system.

With that said, over the last ten years, all of us have changed our footprints as we advance this medicine. For the Air Force, this was meant going through the painful decisions to close small hospitals and turn them into outpatient, some with same-day surgeries and some without. Through all of this, we've worked very closely with the local communities.

CERTIFIED

The local healthcare community, they now provide the care because they are now providing the care that was provided by the military facilities nearby. We understand at those locations where there are actual closures of military treatment facilities, for those retirees that remain behind, they will have to work very hard to transition them into a wholly run civilian system. And that will be difficult, and we know we will have to pay attention to that, as we have in the past.

I think the great issues of BRAC in the past: the loss of the formulary, the pharmacy, and the loss of access to the hospital for those over 65 who didn't have a wraparound program as TRICARE For Life is going to make a huge difference in this.

We understand that the larger locations, as in San Antonio and the National Capital Region, is going to be one of location. You'll go to a different place for your healthcare than the location that you normally went to. But again, the amount and level of care we're convinced, at least in these two major market areas, will remain the same. New platforms, new locations, better healthcare, better access.

GENERAL NEWTON: Okay. Thank you very much. Brooks City Base. There are some that would say -- well, it seems like the ideal model where we get other sources to help support the infrastructure of a base complex; and in this situation, it's now recommended for closure.

CERTIFIED

Can you share with us what considerations were given in your area that you have studied that would have had an impact on this particular facility? Any or none? Or --

GENERAL TAYLOR: Sir, I'm an aerospace medicine physician. I was trained at Brooks Air Force Base. That's where I did my residency training. That's where I got my basic wings as a flight surgeon. So there's no person that's closer to Brooks Air Force Base, which became Brooks City Base, than I am.

So a great deal of thought and study went into whether or not we should maintain the aerospace medicine activities at Brooks City Base or we should look at a different location. The options included leaving those activities at Brooks City Base, leveraging the Naval activities, air space activities at Pensacola or look at the existing aerospace activities, aerospace medicine and human systems activities that would be moved into Walter Reed.

GENERAL NEWTON: Wright-Patterson.

GENERAL TAYLOR: Wright-Patterson. I'm sorry. So in the end, we felt the best decision was to co-locate at Wright-Patterson, looking forward to the next 50 years. By doing that, and by moving other operations off of Brooks City Base, there's a surprising amount of military infrastructure that maintains even though we talked about leased and shared facilities and those sort of things.

In fact, the total investment in making this move's going to be about a little over $300 million in new facilities up at

CERTIFIED

Wright-Patterson and personnel moves and some facilities in Laughlin to move other associated assets there. In the end, we are going to save over $100 million per year. When you work out the 20-year net present value, it approaches a billion dollars.

So there's huge savings. There's huge collaboration. We're going to do it by placing aerospace medicine assets in the home of where aerospace research will be. And in the end, we believe that that was the best path forward for the DOD.

GENERAL NEWTON: Thank you very much. And thank you, gentlemen, very much for your testimony. Mr. Chairman?

ADMIRAL GEHMAN: General Hill.

GENERAL HILL: I have a couple questions; and I'll try to get off the medical thing; but I'm going to go back to Walter Reed because I'm still confused. I'm a slow learner.

The Georgia Avenue complex -- that part of the three or four Walter Reed campuses -- because you guys are semantics with me on this. The Georgia Avenue complex with the fence around it, when it closes, what, nothing remains there?

GENERAL TAYLOR: No military activities remain there. No, sir. That will enter the normal property the way the department takes care of it.

GENERAL HILL: Nothing remains there. Not the houses, not the museum, not the church?

GENERAL TAYLOR: No. No, sir, nothing. The garrison's gone. The main post closes. The difficulty we had in saying it closes because we didn't close the --

CERTIFIED

GENERAL HILL: You didn't close the housing area down the street and the other piece?

GENERAL TAYLOR: Yes, sir.

GENERAL HILL: Okay. I've got it. In the BRAC report -- one more medical question.

GENERAL TAYLOR: Yes, sir.

GENERAL HILL: Where you make these joint bases and the medical thing, for example, I'm going to use the Maddigan Lewis -- Maddigan McCord because I'm familiar with it. Built a brand-new really magnificent structure at McCord for a clinic. Does that clinic stay open? That clinic closes?

GENERAL TAYLOR: Yes, sir.

GENERAL HILL: All of it then goes over to Maddigan?

GENERAL TAYLOR: Those parts of the clinic that are necessary for maintaining the primary care and those associated people that will come over to Maddigan will occur. Clearly we don't need a lot of the super structure that goes into running a separate building. It's just the pharmacy, laboratory, radiology are merged in; and you get efficiencies from doing that.

It's very clear from the data from Maddigan Army Medical Center that they have the capacity to absorb this, and this is what we did. It allowed us to take some head space off of the Air Force assets; and as you know, these are not very far apart.

Of course, as you understand, if you're an Air Force officer now operating inside a large hospital rather than a

CERTIFIED

stand-alone clinic, you have much more depth of assets, clinical expertise. It's exciting for us.

GENERAL HILL: Nothing gets done out of that clinic?

GENERAL TAYLOR: Yes, sir. That's our recommendation.

GENERAL HILL: Okay. In the BRAC report from the Technical Joint-Cross Service Group, you recommended nine closures and transferred those recommendations to respective military service or other Joint Service Group for inclusion in their recommendations.

What were those -- what was the outcome of those transferred recommendations?

MR. SEGA: I think the report said that our recommendations were toward closures or other related activities, related functions. The Technical Cross Service Groups, by and large, were to locate the functions and recommend the realignment of functions and then the services; and in our case with the exception of one site, which was the Mesa site in Arizona, where the Air Force asked us to use the data that we had, we had collected data that enabled the analysis to be done. With that exception, all closure activities from the TJCSG were done by the services. And so we would recommend functions to be aligned; and so they got included; and it was many cases just part of the work that was being done in that facility.

So I'd like to take the details for the record because it's not as simple as the facility doing only areas that were within our purview in many cases.

CERTIFIED

GENERAL HILL: Okay. That would be fine. I'd like to have a little -- some discussion now of what happens in the National Capital Region with all this movement around.

One is as we looked at the -- this is preliminary data. We've looked at all of this. The Air Force and the Army are very specific where they're move to. The Navy has got what appears to us to be a blank check. It just says, we're going to move to certain -- these might be the areas we're moving to. Where's the Navy moving?

MR. TISON: The Navy will principally move to Arlington Service Center, the Potomac Yards as well as to the Washington Naval Yard.

The challenge we had -- and we worked this closely with the Navy as well as with counsel. We closed and moved out of Eshelby to the Navy Annex. We needed to have some flexibility with the service staff, but those are the principle places they would go.

GENERAL HILL: And you know the costs involved in all that?

MR. TISON: Yes, sir. We worked the costs. We would be happy to share those with you.

GENERAL HILL: As I looked at all of these moves, and if you look at Belvoir, and anyone who has lived in this part of the world as I have in my 37 -- years of service, not age. I just look old.

I'm having a hard time understanding how 11,000 more people are absorbed into Belvoir and into the surrounding

CERTIFIED

community and into the traffic pattern out there. Did y'all look at that?

MR. TISON: That's a great question. As we went through our deliberations, I think Secretary Wynne talked with us a little bit yesterday.

One of the ways we ensured integration was to look at the services. As we looked either at all the Joint-Cross Service Groups, at moves, the process was suited by each of these services looking at what I would call hot spots, looking at the numbers of folks that are around, there are, indeed, a good number of folks going to Fort Belvoir.

Fort Belvoir is essentially three campuses, North Post, South Post and Proving Grounds. Doing the work with the Army and their engineers, they felt it quite feasible to take on that load, particularly looking at the Engineering Proving Grounds, which is largely underdeveloped; but I was looking for the question yesterday. The Army, with part of their cost structure, has put in about $125 million to handle infrastructure improvements for that.

GENERAL HILL: What I'm talking about is the community issue. How do you get to and into, given the force protection measures that are in place today, into Belvoir?

For example, we'll take the hospital issue. The current location where DeWitt Clinic is today is not, as I understand it, will be the hospital location for the new one; is that correct?

CERTIFIED

So then as you think your way through that, how do -- where do you build that to minimize the traffic flow? And thinking your way through that, when we have a regional hearing here, I can hear the Fairfax County people discussing this with us. We need some answers to all this.

MR. TISON: Yes, sir. I will refer that to someone in the Army who has worked that out more closely than I have. I know there has been discussion about Light Rail, about access to the Engineering Proving Grounds when that's developed. To access out of the 95/395 corridor or off the Springfield Parkway extension that's being planned. I think that's well under way in how they are going to do that. Extension from the Lorton VRE is another one that's being pursued.

I think there's a good many opportunities that can be pursued with that in working with the engineering community as well as with the base folks who thought that was clearly feasible once you use the Engineering Proving Ground.

GENERAL HILL: Okay. I have one final question. And that -- you co-located the defense investigative agencies in the one place. Why not just create a defense investigative agency?

MR. TISON: You ask great questions that challenged us in many of our deliberations. We looked at -- we used that as an example. We looked at opportunities for going full joint to go into single-service sites.

As we developed our scenarios, we looked outside an area or inside an area. What drove us with the -- with going to a

CERTIFIED

co-location first was, in our view, looking with the services and the distinctions and how they did their business of investigations, their co-locations was probably a good first step to get them together. Issues such as sharing in a crime lab. A lot of what's been described as backroom operations you get from a co-location, and that gets you there.

What also intrigued us typically with the Quantico location was the proximity to the FBI work, which we thought was a great asset. Ms. Hobb mentioned yesterday about the work occurring at DSS, which we thought built upon that as well. The challenge you have is perhaps how fast you could push the process in terms of jointness. By and large we took a pretty fair slice out of doing that. The investigative agencies just weren't there yet in terms of full joint perspective.

GENERAL HILL: Thank you very much.

ADMIRAL GEHMAN: Mr. Bilbray.

MR. BILBRAY: Thank you, Mr. Chairman. First of all, I think you're courageous to do this on the hospitals because as a former congressman, no one complains as much as dependents do about hospital care in the military or maybe the bed issue is even more.

You have nine hospital closings. I was going through the list trying to figure out who they were. I know Walter Reed's going over to Bethesda. Could you just mention the nine hospitals you're disposing the inpatient care?

GENERAL TAYLOR: Yes, sir. Hang on a sec.

CERTIFIED

The nine are: Marine Corps, Naval Air Station. Cherry Point Hospital, Great Lakes, those are the two naval facilities. For the Army it is Fort Knox, Fort Eustis. For the Air Force, it's Andrews Hospital, MacDill, Scott Air Force Academy and Keesler.

MR. BILBRAY: In the super centers, who's in command? Is it a rotation command in the services? Or does the Air Force run one of the super centers, the Navy the other? How do you determine who's in command of the centers?

GENERAL TAYLOR: Sir, that's work to be done. We elected within the Cross Service Group not to address cross-command and controls because of the difficulty opening up those different avenues.

Doing these major construction projects will take years, so I would foresee not seeing the new National Capital Region as we describe it until sometime in the 2010 timeframe. So we have some time to address any changes in the current existing command and control structure that we see in the locations where we already had joint staffing, Navy hospital in Okinawa, Landstuhl Medical Center how we do that today.

MR. BILBRAY: To be developed later, huh?

GENERAL TAYLOR: Yes, sir.

MR. BILBRAY: The other question I have -- and it's been a big concern to me and some of my colleagues that have more military experience than I certainly do. I mentioned the fact that guards reserve independence.

CERTIFIED

I heard when I was in Congress even the active military dependents, and TRICARE may be working fine. I left Congress in '95; so it's been ten years; but certainly the complaints coming from dependents that they really want to be treated in a military hospital by military personnel, did not want to get thrown out into the community to doctors they didn't know and didn't particularly have any relationship with.

In what you're talking about now, it seems like it's even going to be more and more they will be able to be treated. They'll be treated by civilian doctors except if they live in the super center or something like that; is that correct?

GENERAL TAYLOR: Sir, like I said, the amount of outpatient care we have will only change at those locations where we're closing bases like Ellsworth and others places.

MR. BILBRAY: May be closing.

GENERAL TAYLOR: Maybe we're closing. We recommend closing.

In the outpatient they will remain the same as they are today. Limited inpatient closings, remember many of these places we're talking about have an average inpatient census of four. So it's not a large volume at these locations.

So understanding your concerns about access to healthcare. There are nine million DOD beneficiaries. Among the three services we have -- we currently have a little over three million enrolled to military treatment facilities as their prime provider.

CERTIFIED

MR. BILBRAY: Any of these that are being closed -- I know that Dallas Air Force Base Hospital is not on the list, but it's a combined VA/military hospital. Are any of these combined with the Veterans Administration?

GENERAL TAYLOR: No, sir. Early in the process, we looked at whether we should bring Veterans Administration in on this works.

It's just completed their CARES project or Capital Asset Realignment process. In the end we felt it was complex enough work without trying to look at integrating VA activities at the same time.

We did send a request for the secretary to ask the VA whether they had any transformational ideas that we could take advantage of. Of course many people understand stronger joint DOD VA activities; and I think the results of this Commission's work and the decision of the President and Congress will allow us to open up even stronger opportunities with the VA than exists today.

MR. BILBRAY: What is the longest -- getting out of this super centers. How far is the longest trip anybody had to make to get to one? You don't have one in Alaska. Undoubtedly keeping a hospital open there, but in the continental United States, but in the old 48, what's the longest anybody would have to go for the inpatient center?

GENERAL TAYLOR: Well, I think if you lived in Iowa you'd have a long way to go. You'd have to go to Wright-

CERTIFIED

Patterson. This would be the closest large facility, but this is no different -- largely different from today.

Understand that under TRICARE rules, if you have to travel more than a couple hours for specialty care, you can use the local civilian healthcare system. So these large patient movements over long distances have really starkly dropped; and part of the attraction, which has resulted in a reduced workload at these large centers that exist today, so part of the idea of refreshing them, building a larger state-of-the-art platform -- people will travel long distances to goes to Mayo Clinic. I'm hoping people will travel long distances to go to the new Walter Reed or go to the new San Antonio complex or San Diego or Portsmouth or any of our other large hospitals.

MR. BILBRAY: Thank you. Mr. Chairman.

ADMIRAL GEHMAN: Thank you. Commissioner Coyle.

MR. COYLE: Thank you. Gentlemen, thank you for your testimony this morning. Dr. Sega, I didn't think you answered General Newton's question; so I want to follow up on that.

For all the good words about jointness that we've heard in our hearings so far from Secretary Rumsfeld, from the Chairman of the Joint Chiefs of Staff and others, the Technical Joint-Cross Service Group didn't recommend much that would improve jointness in technical arenas.

You did recommend combining Army activities with other Army activities, as you said in response to General Newton; and you did recommend combining Navy activities with other

CERTIFIED

Navy activities, and Air Force activities with other activities in the technical area.

But from what I can see, you recommended very little in the way of cross servicing or jointness that would bring services together in a technical way. And my question is: Why didn't you?

MR. SEGA: The plan going forward with the -- and our principles and our strategy going forward is consistent with, I think, the intent of your question, in terms of pushing toward a infrastructure and an activity in the Department of Defense that is more joint in nature in the technical areas. We concurred with that.

We had for -- before I got to the Department of Defense -- an ongoing process that we look at the work being done in research, basic research, applied research, advanced technology and development in a way that examines what we need to do as well as what the services and agency are doing; and that process is called reliance.

So from the reliance process, it is our hope that in these areas that are largely co-locating, consolidating at the service level will evolve to more of a joint character.

Now there are some areas that we had recommended rotorcraft, for example, we did move I think the B22 or work of the Air Force Wright-Patterson; and I think the additional inputs from Warner Robbins up to Redstone, for example, and the rotorcraft. So there's a couple of small examples. By and large, what you see as our infrastructure is consolidation

CERTIFIED

in service -- current service assets; but we could, and it is our hope that we would evolve through an extended reliance process, if you will, to take the infrastructural lay-down if it's approved and look at more joint activity in that infrastructure.

So we did consider that; and it was, in a sense, a step a bit too far to do -- to do the management structure at the same time of the infrastructure; but we looked at the infrastructure that would enable it and take advantages across this that we have currently and reliance and comprehensive reviews and things along those lines to move us a step toward I think what you're talking about.

MR. COYLE: And as part of your response to General Newton, you said, I believe, that after this BRAC round is complete, if the Commission supports the recommendations you've made that you then, after this BRAC round, that you saw opportunities for jointness that -- opportunities that could be implemented to approve jointness.

Could you provide for the record what those opportunities are?

MR. SEGA: We will do that; but I also want to clarify that since 2001 when I arrived, we haven't stopped the pursuit of more joint activity in the technical area; and we will pursue that forward. We believe that the BRAC recommendations want to do that faster, and we will provide the detail for the record.

CERTIFIED

MR. COYLE: Thank you. I also want to follow up on Admiral Gehman's question. As he noted, you've recommended a number of consolidations across the country that would challenge highly skilled technical specialists, scientists and engineers to move or change careers.

And my question is: What specific work did you do to determine that the receiving locations that are proposed would be the best places for consolidation? And how did you determine that critical technical expertise would not be lost in the process?

MR. SEGA: The answer to your question is one that involves not only a look at the data but also the judgment with the expertise that we had in our subcommittees.

But the future state that we're looking at is what was the principle that drove us to look at a variety of options. As you go into the detail of our analysis, you'll see that we looked at various options of sites; and we did them back and forth in terms of potential moves. It would be more beneficial to move in one direction than the other.

We did look at the people part as our number one attribute that follows every criteria when we did our assessment in this 39-bin construct; but the enabler for our future technical ability, in my view, is the human capital; and that is, the talent is incredibly important.

We believe that the end state -- and it's not an end state in terms of a stopping in time; and it's one of our challenges that there is going to be infrastructure required

CERTIFIED

that we have not anticipated. Technology will move forward; and it may be that none of the laboratories that we have suggested in this BRAC recommendation set will be adequate for that new technology that we didn't anticipate. So it's a dynamic process. But the multifunctional, multidisciplinary center should be world class.

We took into consideration the group that was being affected by the realignment. It was their input that, by and large, was the one that we took in terms of the infrastructure that we would have to build in a new location to accommodate what they are doing in the functions that they were performing.

So it was to the best of our ability to provide a world-class environment to attract world-class people into our laboratory structure, and that was our goal.

MR. COYLE: For example, there could be trade-offs between the cost to go to a particular location and the retention of scientific and technical skills. It might be that a proposed location could be a little bit more costly than some other location but much better from the point of view of retaining the people that we need.

Did you do those kinds of trade-offs? And can you provide them for the record?

MR. SEGA: We did locate trades, but we will provide them for the record. But in a sense, that goes to Admiral Gehman's initial comment in terms of to look at some of our paybacks, not all of them but a few of them are on the longer

CERTIFIED

side. So there are other factors that drove us to the value of that particular recommendation and the consolidation or the realignment that was underpinning to it. So cost was on the A factor in our consideration deliberations.

MR. COYLE: I understand. General Taylor, you're proposing to shut down the high onset gravitational centrifuge at home; and as I read, the word is disestablishment. I guess that means you won't have it anymore under your proposal and move the people at home and who do physiological work to Brooks. Do I have that right?

GENERAL TAYLOR: No, sir. The whole scenario is to take the current long arm centrifuge that is at Brooks City Base, to move that to Wright-Patterson so they will have two centrifuges, a long arm and short arm. Those training the fighter pilots today instead of being done at home will be done at Wright-Patterson.

MR. COYLE: Are you saying the high onset GE centrifuge would be moved to Wright-Patterson?

GENERAL TAYLOR: Yes, sir.

MR. COYLE: I ask because for a number of years there's been concern raised about the Air Force's willingness to support research related to G-lock for the best safety and health of our pilots. And I was wondering if the proposed change at home was a step in the wrong direction.

GENERAL TAYLOR: No, sir. We are hoping that this will actually re-energize in the place of aerospace research and

CERTIFIED

then make that a dual-use facility for both training and research.

MR. COYLE: Thank you. Mr. Tison, while we've noted significant changes in the medical service arena that have been proposed, you didn't make much in the way of headquarters changes in the capital, National Capital Region to improve jointness.

It's been said for years that if the Department of Defense leadership really wanted to convey to the military departments its commitment to jointness, that it would make changes in the military district of Washington by creating one or more joint commands here.

You didn't do that; and my question is, why not?

MR. TISON: Sir, we did work with the Joint Staff on that. Part of that process is ongoing, sir. As they work through Northcom and they would be looking at Belvista, Washington, Navy District, Washington, as well to see other different types of organizations. We were at a point the terms organization work the Joint Staff was doing to propose that at this time.

MR. COYLE: Thank you. I have no more questions.

MR. HANSEN: I have a few.

ADMIRAL GEHMAN: Mr. Hansen.

MR. HANSEN: Thank you, Mr. Chairman. We have a place out in the west called Dugway Proving Ground. Dugway Proving Ground is one of the largest bases the military has. Huge. Not too many people work there, but a lot of things go on in

CERTIFIED

technology. A lot of things go on with special access programs. Most people -- I mean, they don't want to know what's going on out there; but the kind of people that go there are PhDs, are scientists. They know a lot of very technical --

And the problem that area's got, and commanding officers always lament the fact you can never get anybody to go there. And you finally get somebody to go there, you almost have to build him a house and the whole thing.

I notice you guys are doing things with moving folks in the China Lake area. There's some requests for some very talented people to move.

How do you do it?

MR. SEGA: How do you --

MR. HANSEN: What's incentive to move? I mean, you can't order a lot of these civilians to move.

MR. SEGA: That's a great question. People are motivated by various things. In the technical community one strong motivation is challenging work and something that is meaningful and to accomplish that infrastructure is part of it.

Some resources to do your work is important. To work with highly talented colleagues on a team is a motivation.

MR. HANSEN: Excuse me, Mr. Secretary. Do you feel this is going to be a problem if this is implemented?

MR. SEGA: What I have -- this is my first BRAC; but the ones that are on the team, the Techno Joint-Cross Service

CERTIFIED

that's been through previous realignment closure activities have passed along various good news and some not so good news stories in terms of people that are moving. But there are lessons learned; and it is my hope when we do this, that we will take advantage of those lessons learned and be successful.

We appreciate the work and the talent that we have currently in our technical workforce.

MR. HANSEN: As I read your reports, it kind of seems to stick out that all of you are talking about substantial savings. I remember on BRAC '91, '93, '95, the committee setting them for 22 years. We tried to do a study. When do you get it? When's the point of returns? Have you extrapolated that out? When is the point we start seeing some savings? One of the big things with BRAC -- one of the big things, anyway, is to save money.

GENERAL TAYLOR: Sir, I'll just speak up. I think that's a question best addressed to Mr. Secretary Wynn, who oversaw the whole process; and I think the BRAC office has some sense of what the investment's going to cost and when the payoffs will occur.

For all of us, I think we have immediate actions that will result in immediate payoffs and others will take a great investment in time and effort before you begin paying off.

MR. HANSEN: You know the '88, '91, '93, I recall we were looking about eight years before we really started seeing it turn around a little bit and pay off.

CERTIFIED

Does that sound about right? I know that's a very difficult thing because each one wants to stand on two feet a little differently.

MR. TISON: That's a question probably Secretary Wynn will be better able to answer. Some of our returns are much more immediate. Some of our base scenarios where you can look at a lot of operation consolidating joint bases. We look at, first, savings really right away; and that would generate roughly -- the ones we looked at somewhere between $180 to $200 million that could be expanded.

You look at contract actions, fleet maintenance and so forth, but there are others that will have a significant investment either in military construction or moves that will have longer payback. It really is a portfolio. We'll have to share with you how that works.

MR. HANSEN: General Taylor, the medical closures realignment seem to depend to a certain measure on support by VA hospitals. The VA healthcare system is already a little stressed -- as I see it, horribly stressed and underfunded; and as a result, they seem to have cut back on two categories of services.

What extent is your closure realignment plan dependent on VA for inpatient service, outpatient service, specialized services, such as mental healthcare?

GENERAL TAYLOR: Sir, the Veterans Administration are part of our TRICARE partnership with civilians' installations across the US. They're very valuable partners in this

CERTIFIED

process, but they're one of the members of the entire US healthcare system. Very clearly because they're all part of the federal system, it makes sense for us to partner with them in logistics. And we had some areas of pharmacy sharing; we had some inpatient sharing; and I think it's really important. But by and large, the vast amount of our nonmilitary healthcare is delivered by the civilian US healthcare system.

MR. HANSEN: Has your plan been coordinated with VA?

GENERAL TAYLOR: No, sir. No, sir. We consider the VA closures as part of our process. Looking at the locations, we see what's happening to the VA in those locations.

MR. HANSEN: Let me thank you all for your great work and your team, how fantastic you are. We'll see how it all comes out. Commissioner?

ADMIRAL GEHMAN: Thank you. Gentlemen, I agree. As I said in my opening statement that previous BRACs have not attempted this cross-functional kind of thing before; and it is a very difficult interoperational thing.

I just have a couple of questions; and my questions, you may not be able to answer them; but I ask them for the record.

Secretary Sega, in your opening remarks you say the domain of the RDAT&E universe that you looked at included 650 technical facilities, located at 146 separate installations.

Do you have any idea of what the result of all of this is? If approved, what those numbers would look like if we did all of this? In other words, that's the beginning number. What's the end look like, the end state look like?

CERTIFIED

MR. SEGA: I would like to take it on for the record to get the actual details, but there are an awful lot of technical facilities.

ADMIRAL GEHMAN: It would be useful at a medical level to know whether you made a big impact or little impact or what.

My second question is: Briefly going through the BRAC report, very briefly without the data very carefully here, I look at the section that says, consolidate air and space C4IS -- C4ISR, which is, to me, the nervous system that creates jointness.

That is, if the people can talk, and the systems are interoperable, and you can share data, and you are all looking at the same enemy, the lieutenant colonels will figure out what to do; and I see this consolidate session does not include any data facilities.

Did the Navy decline to play? Or these are all Air Force facilities being consolidated here. The Navy does air C4ISR. Can you make a comment on that?

MR. SEGA: I'd be glad to. The consolidations that we made, and we highlighted it, as you recall the purple block, was something that we thought was so important to the C4ISR that we gave it a special category; and we had a -- one of our subgroups address that directly.

We also understood that as we organized just for getting the work done, the integration was so key, we had to do C4ISR in nearly everything we did. We will be, as I hope with

CERTIFIED

Commissioner Coyle's comment -- would be participating in these that are in the air side as well; but the C4ISR places that we will eventually have and everything include an east and West Coast center; and that will not be exclusively focusing on the service of the Navy but also air and space.

The San Diego facility as well as Little Creek, Virginia, will be consolidated centers for the Navy in these areas of C4ISR. So that was an immediate piece of movement in that we had in realignments we had to establish those centers; but I can assure you it's critically important to the Department of Defense that Navy expertise is integrated with the rest of the services and agencies to move us forward in C4ISR.

ADMIRAL GEHMAN: I have a similar question under what I think we used to call energetics; that's guns and ammunition. Again, going by this report creating a site for guns and ammunition, I see all the sites here. It looks like the Navy and the Army are consolidating, but here it looks like the Air Force decided not to play. Am I misreading this?

MR. SEGA: I would like to get back to you on the details of where the Air Force is; but the Picatinny arsenal will be -- if the recommendations are approved would be a major center for small arms, in particular the working the large caliber; but we also have work in Crane and other places that will continue to work in the area of guns and ammunition.

However, we're also looking at, in a broader context, at the chemistry and the explosives that are potentially coming forward. Nanotechnology and other things to potentially help

CERTIFIED

drive that, but energetic material can be used as an explosive. Energetic material in another form potentially as a propellant and another form of potentially releasing energy for electrical power. And so we've also tried to concentrate activity to improve our output in the area of understanding end products in the area of energetics that would be across service and application.

ADMIRAL GEHMAN: Good. These are areas that we'll have to look at in some more detail. As you can tell from my question, I want both more and less.

GENERAL TAYLOR: Sure.

ADMIRAL GEHMAN: Mr. Tison, I just have one question for you. I do not know what happens at these sorts of offices called the Defense Office of Hearings and Appeals. They're located around the country and were all being rolled into Fort Meade.

My question, though, is: Are you disenfranchising people from coming to regional offices to work out whatever it is that they appeal there? In Phoenix and California and all that, in an effort to consolidate everything in one place?

MR. TISON: Sir, we don't believe we are. This is part of the adjudication process. Once you go through the security system, screening your process goes for adjudication agencies who decides that; and of course there's an appeals process. We'll continue to look at that, but our sense is that it is now extremely transactional. You don't need to have a --

ADMIRAL GEHMAN: These are not kind of walk-in places.

CERTIFIED

MR. TISON: No sir. These are very small organizations.

ADMIRAL GEHMAN: Very good. Commissioners, do you have any additional questions before we finish? Yes.

GENERAL TURNER: General Taylor, back to you. I was looking at your written testimony again; and I had one of those ah-hah moments. Back to Laughlin Air Force Base, which most people know as the basic training base in the Air Force. So there's lots of young folks. The proposal is for a large state-of-the-art ambulatory medicine center. That's not the way I read it the first time.

Is ambulatory medicine center the correct terminology?

GENERAL TAYLOR: The way we've been phrasing it is a large outpatient clinic with ambulatory surgery capability. The troop clinic will still be there. Big dental activity will still be there.

GENERAL TURNER: Okay. That clarifies that. And briefly, could you clarify for the commissioners what level of emergency services would be available for those basic trainees?

GENERAL TAYLOR: It would be up to the Laughlin folks to make the decision as to whether they run a 24-hour capability or not. If you don't know, we have independent duty medical technicians embedded into the troop activities today. So they have access to the IDMTs, and it would be up to the Laughlin community to decide if they want to run a 24-hour urgent care unit or not.

CERTIFIED

ADMIRAL GEHMAN: Any other commissioners I may recognize? If not, thank you very much. The witnesses are appreciated very much.

The Commission is still in session. We're not going to adjourn. We have other matters to attend to. It will take us about two minutes. So if you could just remain seated if you want and watch the entertainment.

Commissioners, we have two or three items that need to be taken care of. The first is the Commission has previously circulated to you a set of proposed rules for the commission's operations, and you've had an opportunity to look at them. Does any commissioner wish to speak or make any comments or questions.

MR. BILBRAY: Mr. Chairman, I'd like to move that we adopt the rules.

ADMIRAL GEHMAN: We have his motion. Do we have a second?

MR. COYLE: Second.

ADMIRAL GEHMAN: Thank you very much. Any discussion at all about the rules? All right. I would ask for a vote. All in favor, please say aye.

MR. BILBRAY: Aye.

MR. COYLE: Aye.

ADMIRAL GEHMAN: Opposed? None. The rules are adopted. Thank you very much.

CERTIFIED

The second administrative matter we want to talk about is travel. This concludes the series of public hearings for this Commission in the Washington, DC, area.

The Commission is now going to begin a rigorous program of travel to the sites to be closed. We have kind of arbitrarily cut off a level. We're going to visit something like 60 to 65 of the most impacted sites. There will be a travel schedule posted on our website probably by this weekend. Our travel begins as early as next Tuesday. Some sites will be visited by one commissioner. Some sites will be visited by more commissioners. The sites which fell just below the cutoff list will still be visited. They will be visited by a senior member of our staff. Once again, for that -- that schedule will be promulgated.

A second bit of travel that we're going to embark on now is the travel to attend regional hearings. We will hold as many regional hearings as we think is appropriate. The current number is something like 16. We're going to hold regional hearings all over the country, within driving distance of two or three of the most impacted major posts and facilities. The hearings will be conducted by three or four commissioners, usually a day long; and we will divide the day up among the various facilities which would like to make a presentation, local communities which would like to make presentations.

That schedule will also be developed very, very shortly. We have it almost ready to go. I think we just probably need

CERTIFIED

the rest of today to finish it off; and it will also be promulgated so the public will know where and when the regional hearings will occur.

And that's what the Commission is going to be doing for the next about 30 days. Yeah, more. Probably from now until the first of July at least or more. And the Commission will not sit as a total commission -- we currently are not scheduled to sit again in that -- during that period; but we might; but we currently have no more meetings on the Commission all together.

Next item, administrative item. I'm going to say a few things about my prior involvement in BRAC-related activities and how those activities will impact my work as a commissioner. It's a matter of public record that I served for a time in a non-paid advisory capacity to the Governor of the Commonwealth of Virginia, helping the governor develop and understanding the BRAC process and devise an appropriate game plan for providing an input to the BRAC process at the state and local level.

These activities, by the way, the activities of retired senior offense officials, working with local communities to assure the decisions of the Department of Defense and the BRAC Commission are informed by the best possible data are essential to the work of this Commission. This Commission would not be doing its job if we did not go out and get public input and listen very carefully to their insights, observations and criticisms.

CERTIFIED

Once I was nominated to this Commission, I immediately resigned from the Governor of Virginia's Advisory Commission; but because of my prior work for the Governor of Virginia regarding the BRAC process, I believe that it's in the best interest of the Commission for me to recuse myself from any substantial participation for any decisions involving Virginia military facilities and from any substantial participation in any decisions involving any facilities which are proposed to be realigned in favor of the Commonwealth of Virginia.

I understand that the law does not require me to take this step, but I believe that this recusal is necessary to ensure the public's confidence in the BRAC Commission's work. I don't want even the appearance of an impropriety to in any way affect the Commission's final recommendations. This process is far too important and involves far too many people.

MR. HANSEN: Thank you, Mr. Chairman. I too have a recusal. I've served the people of Utah for forty-two years; twelve years as a city councilman, eight years has a legislator, two years as speaker of the house, and my last twenty-two years as a member of Congress.

My role now as a member of the Base Closure and Realignment Commission requires that I set aside any special interest in my home state to represent the nation as a whole. I must be beyond challenge regarding my fairness and impartiality. Because of the importance of public confidence in our work and to avoid even the appearance of conflict of interest, I am recusing myself from substantial participation

CERTIFIED

in any part of the BRAC process that should affect any installation in the State of Utah. Thank you, Mr. Chairman.

ADMIRAL GEHMAN: Thank you, Mr. Hansen. Mr. Bilbray.

MR. BILBRAY: Yes. Mr. Chairman, I have some of the same problems Congressman Hansen has.

I advocated for the State of Nevada for many years as a member of the Nevada State Senate and in the United States Congress. Therefore, in advice of the Ethics Council to our Commission, I am recusing myself from any substantial work in regard to the State of Nevada in these particular deliberations.

ADMIRAL GEHMAN: Thank you very much. Anybody else? Mr. Coyle.

MR. COYLE: Thank you, Mr. Chairman. As you know, I served briefly on an advisory council formed by Governor Arnold Schwarzenegger, whose purpose was to help California communities understand and prepare for BRAC 2005.

I resigned from that council as soon as I knew that I would be nominated to this commission. During my brief service on the council, I took no position one way or the other on which military base would be affected. Further, I did not participate in deliberations or votes resulting in recommendations or findings regarding specific California bases. Also, from what I've understood since leaving the council, the council made no recommendations regarding the closure or realignment of specific California bases.

CERTIFIED

Nevertheless, I understand that my service on the council could be viewed as creating the appearance of a loss of impartiality regarding California.

I've been a resident of California for most of my adult life; and all of our children were born or raised there. Accordingly, I will recuse myself from substantial participation relative to military installations in California. Mr. Chairman, it is my intent and commitment to conduct myself with integrity on the 2005 Defense Base Realignment and Closure Commission and to act in an independent, open, fair and impartial manner. Thank you.

ADMIRAL GEHMAN: Thank you very much. There's no more business. After a short recess, several members of the Commission will be available to meet with the press. Thank you again, witnesses. Commission's adjourned.

[Whereupon, at 11:43 a.m., the hearing was adjourned]

CERTIFIED