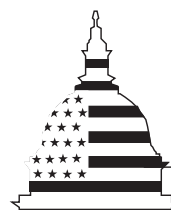


November 1999

# DEFENSE HEALTH CARE

## Tri-Service Strategy Needed to Justify Medical Resources for Readiness and Peacetime Care



G A O

Accountability \* Integrity \* Reliability

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**Health, Education, and  
Human Services Division**

B-282939

November 3, 1999

The Honorable Stephen E. Buyer  
Chairman  
The Honorable Neil Abercrombie  
Ranking Minority Member  
Subcommittee on Military Personnel  
Committee on Armed Services  
House of Representatives

The Honorable Wayne Allard  
Chairman  
The Honorable Max Cleland  
Ranking Minority Member  
Subcommittee on Personnel  
Committee on Armed Services  
United States Senate

The Department of Defense's (DOD) military health system (MHS), costing about \$16 billion annually, offers care to 8.2 million military and civilian beneficiaries. The system has a dual role of medically supporting wartime deployments—its readiness mission<sup>1</sup>—while caring for active duty members, retirees, and their families in peacetime. The Army, Navy, and Air Force provide most of the system's care through their own medical centers, hospitals, and clinics, totaling about 580 treatment facilities worldwide. Regional networks of civilian providers supply the remaining care. MHS has undergone major demographic changes and, today, serves more retirees than active duty beneficiaries and their respective families. Also, mirroring overall military end-strength decreases during this decade, military treatment facilities (MTF) have been closed or downsized, their budgets constrained, and medical practices shifted toward an emphasis on managed care. Such conditions have focused attention on the prospective need for MTFs, the coordination of peacetime care among them, and alternative care delivery approaches.

Among the areas affected by the changes is the national capital area (NCA), in and around Washington, D.C. There, the three services offer care to about 400,000 beneficiaries in 26 MTFs, including 3 medical centers. Concerned about potential service overlaps and whether increased efficiencies are possible, the Congress, in the 1998 Defense Authorization

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<sup>1</sup>MHS readiness needs are generally derived by projecting the active duty medical personnel and equipment required to support major wartime conflicts.

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Act mandated that we review the need for and coordination of care among NCA MTFs. This review is the second of two GAO reviews mandated by the act. In the first review, we examined the Navy's and Army's attempts in 1997 to downsize and close certain graduate medical education programs—the primary source of military physicians. In the resulting April 1998 report, we found that DOD and the two services lacked mutually acceptable criteria and methods for targeting the graduate medical education programs. DOD agreed with our recommendation to develop the needed guidance and is now doing so.<sup>2</sup>

As agreed with your offices, this review's objectives are to (1) evaluate the need for NCA MTFs and DOD's strategy for assessing such needs, (2) identify any obstacles hindering DOD's ability to make coherent needs assessments, and (3) determine whether current care coordination among NCA MTFs could be improved. We also agreed that, because NCA MTFs are integral parts of the overall MHS, we would assess recent DOD initiatives to make MHS management improvements. We conducted our work between March 1998 and September 1999 in accordance with generally accepted government auditing standards. For details on our methodology, see appendix I.

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## Results in Brief

Despite successful DOD and service efforts to improve MHS management, DOD still lacks a comprehensive tri-service strategy for determining and allocating medical resources among MTFs. Consequently, neither we nor DOD can fully address the need for, or appropriate size of, NCA MTFs or MTFs elsewhere in MHS. In the current health care environment, each service has its own needs determination and resource allocation approach. Generally, each allocates resources based on prior year budgets, facility size, location, historical workload, and readiness and political considerations. A tri-service strategy applied systemwide would enable DOD to assess the need for each MTF by taking into account the resources needed for both readiness and peacetime care available at all NCA MTFs. Also, resources available in the local civilian community need to be considered. Such a strategy would also provide a systematic basis for justifying budget requests. DOD has recently begun to address this fundamental deficiency.

A key obstacle to developing a tri-service strategy is the military services' long-standing independence. Historically, the services have had enough resources to maintain separate health care systems, with capabilities

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<sup>2</sup>Collaboration and Criteria Needed for Sizing Graduate Medical Education (GAO/HEHS-98-121, Apr. 29, 1998).

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overlapping during peacetime. As a result, over the years, formal interservice management efforts have been limited and, today, remain difficult to achieve. A second obstacle is that DOD and the services have not determined the cost of MHS' evolving readiness mission or the cost of its peacetime care. Without knowing such costs, DOD is hampered in justifying MHS' size and defending the need for individual MTFs. Exacerbating this has been the emerging peacetime care emphasis during this decade—projected to continue in the next—which competes for resources with MHS' basic readiness mission. Today, for example, retirees outnumber active duty beneficiaries and their respective families. Studies during the period have identified deficiencies in medical personnel readiness. As a result, questions recur about whether MHS is too large; what the potential extent of service overlap and inefficiencies are among MTFs and if all are needed; whether more attractive alternatives to MTF care are available; and whether military providers are being placed and trained properly to manage readiness effectively.

Regarding current service coordination within NCA, we found that MTFs have entered into numerous, varying agreements to share resources, such as one MTF sending specialty providers to other MTFs on a monthly basis. While the agreements appear beneficial, they are mostly ad hoc and results are not well documented. Such agreements are vulnerable to changes in MTF budgeting approaches and other factors that can affect the MTFs' willingness to coordinate their efforts. A recent DOD effort to further consolidate NCA MTF services by merging NCA medical centers met with major disagreements about what care should be provided and where. As a result, the effort was put on hold and the centers continue to operate independently.

During this decade, DOD and the services' Surgeons General have undertaken improvement initiatives, including implementing DOD's managed care program, TRICARE; reducing the number of medical personnel; consolidating graduate medical education programs; establishing partnerships with the Department of Veterans Affairs; reducing hospital stays; restructuring hospitals into more efficient clinics; and revising budget processes to more closely link funding to cost-effective health care. Recently, DOD began new initiatives. Among these, the most critical in our and DOD's view is to develop a tri-service strategy that takes into account current and projected beneficiary populations, focuses on MHS' basic wartime and peacetime care missions, and optimally seeks to realign MTF staffing and resource allocations. This action is needed to justify MHS' basic resource needs in a continually

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changing health care environment. Also, the realignment should help to maximize enrollment and provide more effective care to enrolled beneficiaries as a result of savings and the avoidance of unnecessary costs. Progress on this initiative must be made before most of the others can proceed.

The tri-service team assembled to develop the new MHS strategy faces a daunting challenge, given the task's complexity and the services' history of independence. For this reason, we believe DOD and the services need to continue dedicating high-level management attention to ensure the project succeeds. To enhance congressional oversight of this critical endeavor, we also believe DOD needs to periodically report to the cognizant congressional committees as the project progresses.

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## Background

MHS costs about \$16 billion annually and offers care to a beneficiary population of about 8.2 million active duty personnel<sup>3</sup> and their dependents, and military retirees and their dependents and survivors. By law, MHS has a dual role of supporting wartime and other deployments and providing peacetime care. For peacetime care, the services provide similar medical services worldwide to both military and civilian beneficiaries. However, the services differ in their medical support requirements for deployments. For example, the Army medically supports ground combat, the Navy supports the Naval Fleet and the Marine Corps on shipboard and land, and the Air Force is the primary means for air evacuation of wartime casualties.

MHS' readiness mission determines the minimum numbers of active duty medical personnel required by each service. Each service's readiness mission has two key components. The first component is the personnel<sup>4</sup> and equipment needed to support two major regional conflicts. If, for example, major conflicts developed in two parts of the world and the United States entered the conflicts, sufficient medical resources would be needed to care for an estimated number of U.S. casualties. Such resources would be needed where the conflict was occurring and where casualties were evacuated to, such as remote bases or stateside. Today's readiness mission, which continues to evolve, calls for a smaller, more mobile medical force than during the Cold War. The second component is the

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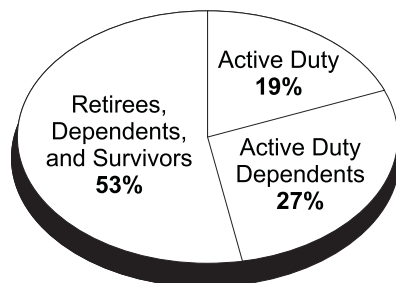
<sup>3</sup>Includes members of the Coast Guard and the Commissioned Corps of the National Oceanic and Atmospheric Administration and of the Public Health Service, who are eligible for care in the military health system.

<sup>4</sup>This includes reliance on medical forces activated from the reserves.

routine daily support for active duty personnel not in combat and their dependents assigned outside the United States and to certain remote U.S. locations. Both readiness mission components rely on a U.S. rotational base that allows medical personnel to rotate to and from assignments. Because assignments abroad are commonly only for 12 to 24 months, a continuous replacement flow is needed. Also, added medical personnel in training are needed to provide for attrition. Medical personnel are also available to help provide peacetime care. And, while MTFs are not required to provide peacetime care for non-active-duty beneficiaries, such care can provide readiness training for military providers.

As shown in figure 1, active duty personnel comprise a small percentage—19 percent—of the 8.2 million beneficiaries, and they have first priority for MTF care. Active duty dependents represent almost 30 percent of the eligible population. Retirees and their dependents and survivors are just over 50 percent of the beneficiary population.

Figure 1: Eligible Beneficiaries



Note: Due to rounding, pie slices do not add to 100.

Source: Defense Health Program, Fiscal Year 2000/2001 Biennial Budget Estimates (Feb. 1999).

About three-fourths or \$12 billion of MHS' costs are incurred by about 580 MTFs—15 medical centers, 76 hospitals, 374 medical clinics, and about 115 dental clinics. Medical centers are large critical care facilities that provide a broad range of inpatient and outpatient health care, serve as referral centers with specialized and consultative support, and provide graduate medical education. Hospitals provide inpatient and outpatient treatment with diagnostic and therapeutic services, such as preventive medicine. Clinics are smaller medical facilities offering primary care, mostly on an

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outpatient basis. Most MTFs are on military installations—in or near urban areas or remotely located—to support active duty personnel.<sup>5</sup> Some MTFs, mostly clinics, are located off installations in urban areas to more conveniently serve local retiree and other beneficiaries. And medical centers may be located off installations, where beneficiary populations can provide sufficient patient workload volume and mix. MTFs are similar to civilian medical centers, hospitals, and clinics, although military providers receive special training for readiness.

The remaining one-fourth, or about \$3.5 billion, of the system's cost is for care delivered through civilian support contracts under DOD's TRICARE program. TRICARE, introduced in 1994, is DOD's managed care approach to controlling costs and improving access and quality of care. Since March 1995, the civilian contracts have been implemented on a sequential regional basis across the nation. The contract that included NCA was implemented last—in June 1998.

TRICARE encompasses MTF care as well as civilian contracted care. TRICARE offers beneficiaries three health care options: Prime, Standard, and Extra. TRICARE Prime is the managed care approach that requires beneficiaries to enroll, does not require copayments for care, and offers them top priority for MTF care. Active duty personnel are automatically enrolled in Prime. DOD and the services consider Prime their best option for controlling costs and improving care access and quality. Beneficiaries may also elect the Standard and Extra care options, which are fee-for-service approaches not requiring beneficiary enrollment.

The Assistant Secretary of Defense for Health Affairs establishes MHS policy and coordinates TRICARE, including administering the support contracts. Further, Health Affairs plans and budgets for health care operations and maintenance.<sup>6</sup> Each service has its own medical department, headed by a Surgeon General, which operates its MTFs and recruits and funds its military medical personnel. Table 1 shows the number of MTFs by service and facility type, excluding clinics that provide

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<sup>5</sup>For example, many of the medical personnel needed to support the 82nd Airborne Division at Fort Bragg, North Carolina, provide services at Womack Army Medical Center, also located at Fort Bragg.

<sup>6</sup>DOD medical program funds are provided through a single Defense Health Program (DHP) appropriations account. This account provides funds for operations and maintenance, procurement, research, and development, but it excludes funds for active and reserve personnel (funded through the services) or for military construction (funded through a separate account). The Assistant Secretary of Defense for Health Affairs directs the distribution of the funds to the services, which allocate the funds to their facilities.



only dental care. MTF physicians and medical support<sup>7</sup> include active duty personnel (about 75 percent of all provider and support personnel) and civilians. Appendix II provides a profile of the NCA MTFs.

**Table 1: Worldwide MTFs by Service and Facility Type, as of May 1999**

	Medical centers	Hospitals	Clinics	Total
Army	7	21	178	206
Navy	3	22	148	173
Air Force	5	33	48	86
<b>Total</b>	<b>15</b>	<b>76</b>	<b>374</b>	<b>465</b>

Note: Facilities that provide only dental care are not included.

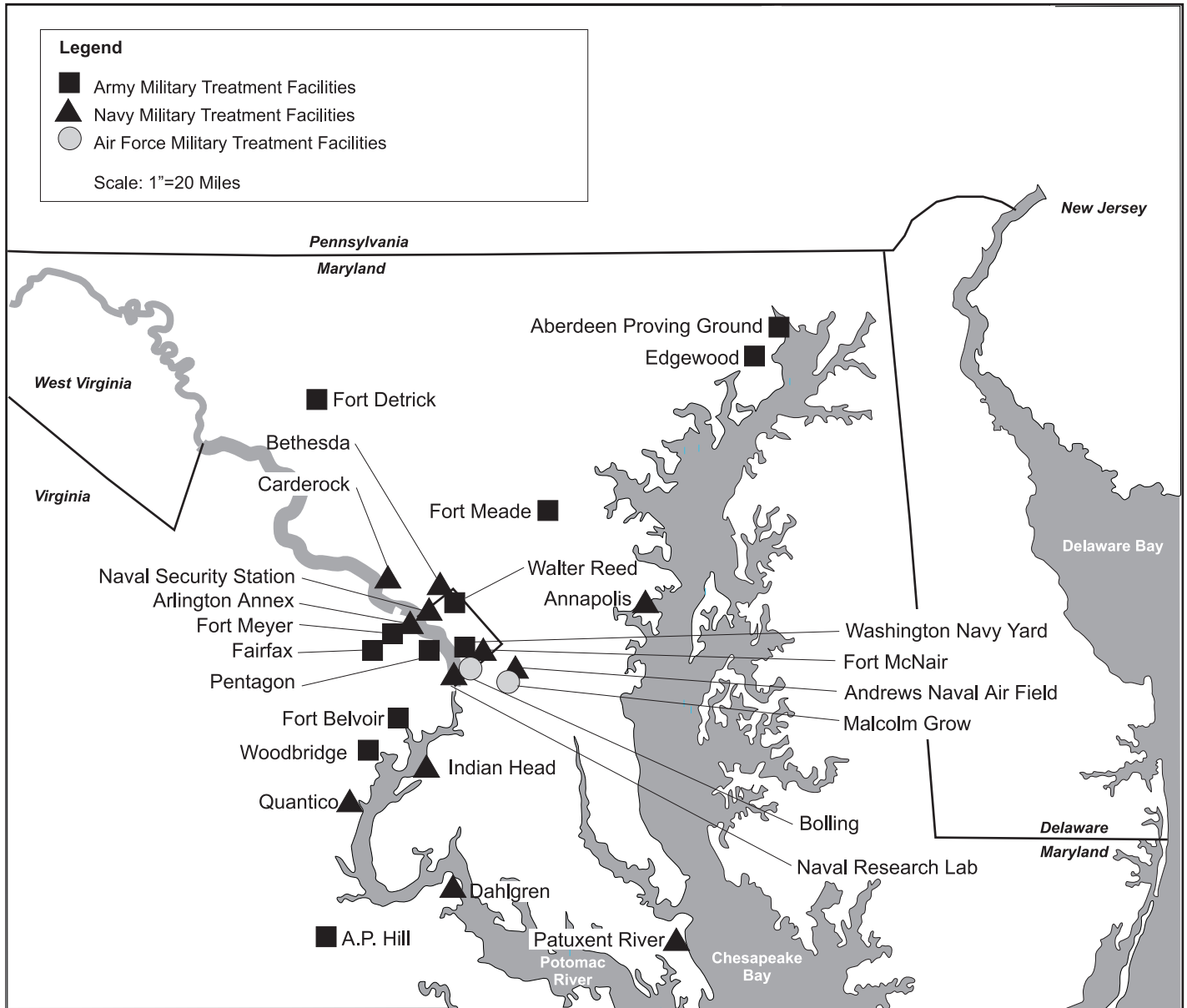
Source: DOD and each service's Office of the Surgeon General.

Reflecting the one-third decrease in active duty forces during the past 10 years, MHS has steadily declined, with military medical personnel declining 15 percent and one-third of the MTFs closing. These conditions, along with constrained MTF budgets, have raised concerns about the continued need for all medical facilities and assets and how peacetime care can best be optimized.

As an integral part of MHS, NCA has 26 MTFs in a radius of about 60 miles around Washington, D.C. (See fig. 2.) Three of these MTFs are medical centers—Walter Reed Army Medical Center in Washington, D.C.; National Naval Medical Center in Bethesda, Maryland; and the Air Force's Malcolm Grow Medical Center at Andrews Air Force Base in Maryland. The Army and Navy each have 12 MTFs, while the Air Force has only its medical center and 1 clinic.

<sup>7</sup>DOD medical personnel include physicians, dentists, nurses, administrators, medical technicians, veterinarians, and corpsmen.

Figure 2: MTFs in the National Capital Area



Source: Health Affairs, TRICARE Region 1 Lead Agent, and various MTF officials.

NCA includes about 5 percent of MHS' beneficiaries and, in fiscal year 1998, incurred about 5 percent or \$778 million of MHS' total costs. In 1998, the three medical centers accounted for 75 percent of the NCA MTFs' costs—including 95 percent of inpatient and 65 percent of outpatient costs. From 1995 to 1998, NCA inpatient admissions declined 44 percent and related costs declined 23 percent. Outpatient visits have also declined by 14 percent, but related costs have risen 22 percent, reflecting nationwide trends toward providing more costly care, including surgery, on an outpatient basis.

Walter Reed, located in Washington, D.C., near the Maryland border, began operating in 1909. It has branch clinics at the Pentagon and in the District at Fort McNair. The Army also has a community hospital at Fort Belvoir, Virginia, with four branch clinics in Virginia and a clinic at Fort Meade, Maryland, which also has three branch clinics in Maryland. The Naval Medical Center in Bethesda opened in 1942 about 5 miles north of Walter Reed. Bethesda has eight branch clinics in Washington, D.C.; Maryland; and Virginia. Separately, the Navy has two clinics in Maryland—at Annapolis and at Patuxent River—and one clinic in Quantico, Virginia. Malcolm Grow Medical Center opened in 1958 at Andrews Air Force Base in Maryland. The Air Force also has a clinic at Bolling Air Force Base in Washington, D.C. (See app. II for more details on NCA MTFs.)

## The Need for and Appropriate Size of NCA and Other MTFs Are Not Now Determinable

It is not possible to fully address the need for or appropriate size of NCA MTFs or MTFs elsewhere in MHS because DOD and the services lack an overall strategy for determining and allocating medical resources among MTFs. While efforts to coordinate care among services have occurred, DOD and the services have not systematically collaborated in seeking the most cost-effective placement and use of all medical resources. This is so even though MTFs in close proximity, such as the NCA MTFs, have overlapping care capabilities and treat any beneficiary regardless of service affiliation. The need for an overall strategy was reaffirmed recently when DOD suspended an effort to merge NCA medical centers and medical centers in San Antonio, Texas, for lack of clarity of the medical centers' missions.

Service officials told us that each service has its own distinct approach for determining and allocating MTF resources and generally does not take into account the other services' resources when making such decisions. Moreover, the services use different organizational structures to plan for and manage their NCA MTFs. While NCA MTFs are integral parts of the larger

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MHS, they are primarily concerned with the day-to-day delivery of peacetime care. NCA MTF officials told us, for example, that they focus their attention on such matters as budgets, rising pharmacy costs, beneficiary satisfaction, facility maintenance, medical and support personnel staffing levels, and the day-to-day running of a hospital or outpatient clinic. In addressing the need for their facilities, they largely refer to present and historical patient care workloads and the various care specialties their facilities provide. And, while officials generally cite readiness as their primary mission, beyond the numbers of military providers, none readily identified which health care activities and costs were needed to support readiness requirements. In this regard, the most recent major study of NCA MTF needs and operations and others like it prepared during the early 1990s have largely focused on peacetime care.<sup>8</sup>

In delivering services, we found that the NCA MTFs are interdependent. MTF service areas overlap, so the hospitals and clinics can serve the same patients. Thus, patients in an Army MTF may be Air Force or Navy active duty members, dependents, or retirees. Likewise, some MTF providers and support staff may come from another service through a cooperative agreement between the facilities. For example, providers from DeWitt Army Community Hospital at Fort Belvoir provide outpatient prenatal care at a Navy clinic at nearby Quantico and deliver babies at the Army hospital.

Further, many of the smaller NCA MTFs, which are branch clinics of the larger MTFs, also serve as referral sources for specialty care provided in any of the area's medical centers, which also serve populations outside the area. For example, both Bethesda and Walter Reed treat patients from around the world in specialty care such as open heart surgery and neurosurgery. Thus, NCA MTFs influence each others' workloads, and individual MTF need is not necessarily determined only by NCA care requirements.

Recently, the TRICARE managed care support contract that covers 13 northeastern states—including Maryland, Virginia, and Washington, D.C.—was implemented, introducing added care options for NCA beneficiaries. Many will be able to access both the MTF and the contractor's civilian care network. The TRICARE contractor becomes a fifth major player—along with the Army, Navy, Air Force, and DOD's Office of the Assistant Secretary for Health Affairs—in the management and

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<sup>8</sup>TRICARE Region 1 Integration of Specialty Services Study Final Report (Healthcare Studies, Vector Research, Inc., Oct. 10, 1995).

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delivery of NCA military health care. Thus, the contractor plays a supportive role with MTFs in helping to maintain military readiness and providing peacetime care. But this further complicates the process of determining the need for individual NCA MTFs and MTFs elsewhere and further underscores the need for DOD and the services to collaboratively determine each MTF's role in and share of the area's health care delivery.

During our review, DOD sought to merge NCA medical centers and medical centers in San Antonio. The attempts were suspended, however, when DOD concluded the medical centers' missions needed to be clarified before their peacetime care workloads could be analyzed for possible consolidation. To illustrate, the Air Force objected to the proposed elimination of certain services at Malcolm Grow that had limited patient workloads. Officials at Malcolm Grow argued that personnel providing the services were essential to its wartime tasks. Such arguments were coupled with the services' traditional objections to substantially altering their medical centers' structures and operations. As a result, the efforts were put on hold and the centers continue to operate as before. Until DOD and the services develop a comprehensive overall approach for justifying each MTF's size and resources, neither we nor DOD can assess NCA MTFs' needs.

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## Obstacles Impede Developing a Tri-Service Medical Resource Strategy

Currently, the Army, Navy, and Air Force have separate methods, rather than an overall tri-service strategy, for determining needs and allocating resources to MTFs. And the services define workload, such as patient visits, differently, which limits DOD's ability to measure performance across the services. Several obstacles have allowed such conditions and deterred development of a tri-service approach, including the services' long-standing independence and DOD and the services' not yet having identified readiness costs so that their systems' peacetime components can be cost-effectively managed. Exacerbating these obstacles is the emerging emphasis during this decade on peacetime care, which competes with MHS' evolving readiness mission. As a result, concerns continue about the system's size and potential MTF care overlaps and inefficiencies. Also at issue are whether potentially more attractive MTF care alternatives are available and whether military providers are being effectively placed and trained so that readiness is managed effectively.

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## Each Service Has Its Own Approach to Determining Needs and Allocating Resources

Currently, each service uses its own model for estimating the number of medical personnel needed to support its wartime missions, and each resisted DOD's efforts to apply a common model for determining minimum medical readiness requirement numbers. The services have agreed, however, to use a common approach when DOD's reengineering initiative, discussed in detail later, is implemented. The common model is referred to as the DOD sizing model. (See app. III for descriptions of the services' models.)

Each service also has its own method for allocating resources to its MTFs—that is, deciding where, how many, and what type of military providers, support staff, and related funds should be distributed to each MTF. To make such decisions, each service generally relies on historical staffing and workload levels, facility size, and readiness and political considerations. Also, each uses different models to support its decisions. At the same time, the services' separate methods for projecting and validating MTF resource needs are and have been in a continual state of change, and their reliability remains at issue. The Army, for example, in its latest MTF needs modeling effort,<sup>9</sup> reported that a year of mostly on-site MTF work is required to validate performance data from at least eight or nine sources, including MHS-wide cost and workload data systems. The Army also reported that its other ongoing resource allocation modeling exercises, while generally useful, were inadequate for specifically addressing facility and staffing needs. The Air Force's latest allocation model version similarly raised reliability issues. At Malcolm Grow, for example, officials argued that the model severely understated pediatric workload and, if followed, would have resulted in fewer personnel than needed to provide care.

Accurate, comparable MTF workload data are needed for performance measurement, cost-effectiveness assessments, and alternative care delivery evaluations. Such data include numbers and cost of outpatient clinical visits, inpatient admissions, and average length of stay. But each service defines workload differently, and as basic an element as a clinic visit is not counted the same. Also, the cost and workload data captured in DOD's information systems is neither accurately reported nor recorded.<sup>10</sup> Thus, cost and performance comparisons across MTFs are generally unreliable. For example, we reported this year that the results of the Medicare subvention demonstration—which is to demonstrate in six

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<sup>9</sup>Regional Uniform Benefit model (see app. III for a description of the model).

<sup>10</sup>Medicare Subvention Demonstration: DOD Data Limitations May Require Adjustments and Raise Broader Concerns (GAO/HEHS-99-39, May 28, 1999).

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selected locations the cost and other effects of serving Medicare-eligible military retirees as MTF enrollees—would be affected by cost data inaccuracies in DOD’s systems.

While differing in their modeling and resource allocation efforts, the services also respond differently to reductions in active duty MTF medical staffing and disagree on readiness needs. The Army, for example, apportions reductions among MTFs based on related reductions in the active duty forces each MTF supports. The Air Force generally shares the losses among MTFs but favors facilities that appear most productive. In the same vein, in 1993, a tri-service attempt to develop MTF provider workload standards was abandoned for lack of support and agreement among the services’ participants. And such service differences in MTF needs assessment have also been apparent in DOD-wide attempts to agree on medical readiness needs. DOD and service officials told us that the minimum numbers of active duty MTF physicians needed to treat active duty forces has been a major disagreement area.

Moreover, because of their independent approaches, DOD and the services have not collaborated in seeking the most overall cost-effective arrangement of medical resources. For example, the three large NCA medical centers—Walter Reed, Bethesda, and Malcolm Grow—are in close proximity and have overlapping service areas. But the centers are assigned their resources by the Army, Navy, and Air Force, respectively, independent of the other hospitals. As a result, these facilities provide duplicative services and, in some cases, lack sufficient workload.

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**Long-Standing Service Independence Makes Coordinated Strategy Development Difficult**

We and many others have reported that DOD has had difficulty modernizing its health system because of traditional rivalries among the services and their diverse organizational structures and duties. The lines of authority and accountability among hospital commanders, the service Surgeons General, and the Assistant Secretary of Defense for Health Affairs are complicated and sometimes at odds. MHS funding, for example, is controlled by different entities: The Assistant Secretary controls funding for operations, and each service controls funding for its military personnel who operate the system. The services generally have had, until recent years, enough resources to maintain independent health care systems with overlapping peacetime care capabilities. Thus, over the years, while some collaborative efforts were made, the services generally have not found it necessary to engage in formal interservice management efforts, even in today’s tight budget times.

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Past studies have suggested changes to the organization of military medicine, including merging the services' medical departments into a single health agency,<sup>11</sup> but the services have resisted such efforts. Each service believed it had unique medical needs and activities<sup>12</sup> and thus fought to maintain its own health system. Yet, some analysts have argued that, in wartime, the U.S. military fights and provides medical care under the authority of unified commands, not as individual services. The Navy, for example, handles sea, land, and air functions so that one system could perform all functions. These debates continue, while the services' NCA MTFs have sought to make informal care arrangements with one another for increased efficiencies, care access, and care quality. These activities are a sign that peacetime care delivery, for the most part, takes the same form regardless of service. However, a strategy for formally coordinating resource planning and distribution among the services while recognizing the uniqueness of their wartime missions has yet to be achieved.

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### Changing Readiness Needs and Costs Impair Justifying the Number and Size of MTFs

During the 1990s, following the end of the Cold War, the level of medical resources—and their costs—needed to ensure readiness has been widely debated. With the Soviet Union's dissolution and the emergence of regional threats, DOD's wartime medical needs changed markedly. In 1994, a DOD study, known as the "733 study," estimated that DOD had twice the military physicians it needed for wartime. The services disagreed with the 733 study and individually estimated that higher numbers of physicians were needed to meet their readiness missions. More recently, efforts begun in 1995 to update the 733 study have also met with resistance and disagreements, and the study's long overdue final report was not signed until May 1999—3 years after it was due. DOD pointed out, however, that rather than its numerical results, the study's analytical approach to determining medical requirements is to be considered its most important outcome.

In 1995, the Congressional Budget Office reported that MHS could decrease its physical capacity by 50 percent.<sup>13</sup> While medical resource reductions ensued, DOD and the services have yet to agree on what resources are needed for readiness versus peacetime care. In fact, a base closure and

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<sup>11</sup>The Feasibility of Uniting the Medical Services of the Various Branches of the Armed Forces Into a Single Corps, Congressional Research Service (Washington, D.C., Aug. 1993).

<sup>12</sup>Defense Health Care: Implementing Coordinated Care—A Status Report (GAO/HRD-92-10, Oct. 3, 1992).

<sup>13</sup>Restructuring Military Medical Care (Congressional Budget Office, July 1995).



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realignment study<sup>14</sup> concluded that no military medical downsizing effort, no matter how well designed, would accomplish meaningful, appropriate reductions until DOD and the services agreed on MHS' readiness needs and how best to meet them.

Without clear distinctions between medical readiness and peacetime care needs and costs, DOD and the Surgeons General are hampered in trying to justify the number and size of their MTFs. For example, MHS budget requests over the last 3 years have been insufficient to cover their costs, requiring DOD to request supplemental appropriations to the cognizant congressional subcommittee's dissatisfaction. To develop the basis they need, DOD and the services together have to define, assign cost to, and agree on what specific elements comprise medical readiness—namely, deployments; what activities, including training, prepare military providers for deployment; and what activities enable the rotation and sustainment of deployed active duty medical personnel. Not having done this, DOD and the services continue operating their health systems not knowing what percentage of their total costs are for readiness needs and what percentage are for nonreadiness, peacetime care. Another consequence is that DOD has little basis for deciding whether or not to make or buy its peacetime care services or otherwise to make informed management decisions about such care.

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## MHS' Emerging Peacetime Care Emphasis Competes With Readiness Mission

MHS' primary mission—and the justification for having active duty medical providers—is wartime medical readiness. But in the past 20 years, driven by budget pressures and a growing retiree population's demands, DOD has increasingly focused on providing peacetime care. Throughout the 1980s, MHS costs significantly escalated, fueled by large cost overruns in the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS).<sup>15</sup> Between 1980 and 1990, DOD's health care budget grew by almost 225 percent, and the largest single program growth—about 350 percent—occurred in CHAMPUS. Meanwhile, DOD's non-active-duty population continued to increase. During the 1990s, MHS budgets generally leveled off, while the numbers of retirees and their dependents grew to

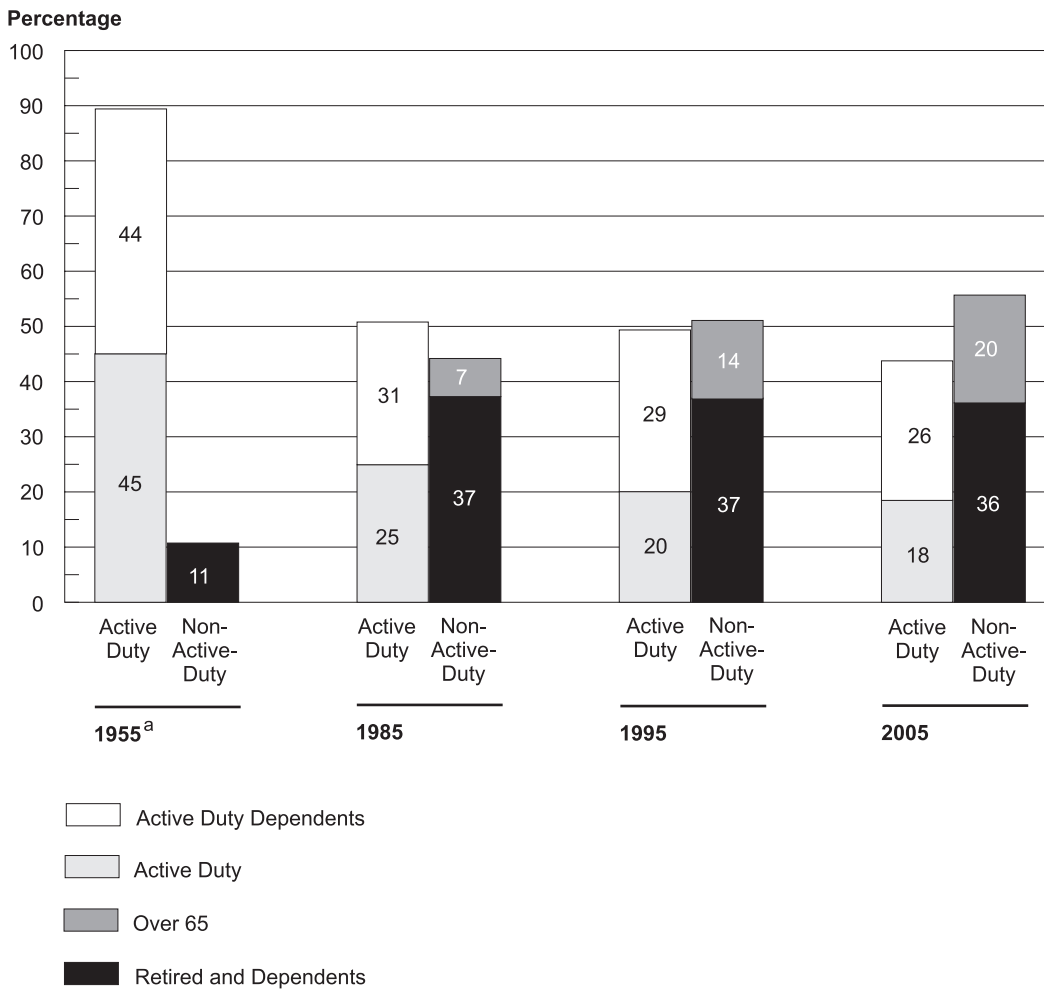
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<sup>14</sup>In July 1995, the Defense Base Closure and Realignment Commission submitted a report to the president recommending certain military bases for closure or realignment. The report also recommended that DOD pursue MTF consolidation and restructuring, including the use of civilian sector resources where it was cost-effective and maximizing the remaining military resources across service lines.

<sup>15</sup>Before TRICARE was fully implemented, DOD operated CHAMPUS, an insurance-like program that paid for a portion of the care military families and retirees under age 65 received from private sector health care providers.

more than half of the total beneficiary population. This trend, developing over the past 40 years, is projected to continue. (See fig. 3.)

**Figure 3: Actual and Projected Active and Non-Active-Duty Beneficiaries and Their Respective Dependents for Selected Years**



<sup>a</sup>Available data do not categorize retirees and their dependents as under or over age 65.

Source: Office of the Assistant Secretary for Health Affairs.

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In 1994, the Congressional Research Service reported that the growing portion of DOD's budget for civilian medical care had become a concern. Also, we and others reported that, while DOD was aggressively pursuing its peacetime care duties, training for medical readiness received less attention.

Also at issue is whether military care providers have the training and skills needed for war. After the Gulf War, we<sup>16</sup> and DOD's Inspector General<sup>17</sup> questioned DOD's ability to meet wartime medical needs. Among other things, we found large numbers of medical personnel were not deployable due to their unacceptable physical conditions, lack of required skills, mismatched medical specialties, and a pervasive lack of wartime readiness training. Since then, the services have worked to correct these problems, but concerns persist. For example, the Air Force and Navy are now shifting requirements and providers needed for wartime deployments from their smaller MTFs to larger facilities to help ensure adequate training. But each service generally makes these decisions independent of the others, so that the physicians may be placed in the same proximities where patient workloads may be insufficient to train all the physicians.

Recent legislation continues the peacetime care emphasis. For example, the Balanced Budget Act of 1997 authorized a Medicare subvention demonstration, which extends TRICARE benefits to those aged 65 and over. Also, the fiscal year 1999 Defense Authorization Act mandated a pharmacy demonstration that gives those 65 and over increased access to the pharmacy benefit through mail order and retail pharmacies. The Federal Employees Health Benefits Program (FEHBP) demonstration, which was also authorized by the 1999 act, provides another MTF care alternative for those 65 and over by offering health care coverage that federal civilian employees have. Finally, the 1999 act also called for a demonstration of the effects of providing another TRICARE benefit supplement for senior retirees. Managing such alternative care demonstrations while seeking to eliminate MTF service overlaps and

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<sup>16</sup>Medical Readiness: Efforts Are Under Way for DOD Training in Civilian Trauma Centers (GAO/NSIAD-98-75, Apr. 1, 1998), Chemical and Biological Defense: Emphasis Remains Insufficient to Resolve Continuing Problems (GAO/NSIAD-96-103, Mar. 29, 1996), Operation Desert Storm: Problems With Air Force Medical Readiness (GAO/NSIAD-94-58, Dec. 30, 1993), Operation Desert Storm: Improvements Required in the Navy's Wartime Medical Program (GAO/NSIAD-93-189, July 28, 1993), Medical Readiness Training: Limited Participation by Army Medical Personnel (GAO/NSIAD-93-205, June 30, 1993), and Operation Desert Storm: Full Army Medical Capability Not Achieved (GAO/NSIAD-92-175, Aug. 18, 1992).

<sup>17</sup>Medical Mobilization Planning and Execution (Inspector General, DOD, Report No. 93-INS-13, Sept. 30, 1993).

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inefficiencies make DOD's need for a comprehensive tri-service resource management strategy all the more urgent.

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## Numerous NCA Coordination Agreements Seem Beneficial, but an Overall Strategy Is Needed

Driven by tight budgets and rising costs, NCA MTFs have entered into numerous agreements to share resources since 1995.<sup>18</sup> These agreements cover a wide range of services, both within and across military departments, and illustrate the need for and potential benefits of MTF resource sharing in areas such as NCA. However, the agreements focus on improving the MTFs' everyday peacetime care delivery rather than being built into an overall strategic plan founded on MHS' readiness needs and optimal use of each MTF's resources.

Thus, while NCA MTFs have many coordination agreements, it is unclear how well each facility's agreements support its particular health system role. Also, the agreements' largely informal nature make them vulnerable to proposed MTF budgeting changes and to MTF commanders' rotation, both of which can affect MTFs' willingness to share resources. Such conditions for NCA care coordination provide little assurance that optimal results are being achieved and argue, in our view, for an overall resource planning and allocation strategy. Such a strategy would provide for the major coordination activities needed to support each MTF's dual mission.

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## NCA MTFs Have Entered Into Numerous Agreements Aimed at Enhancing Peacetime Care

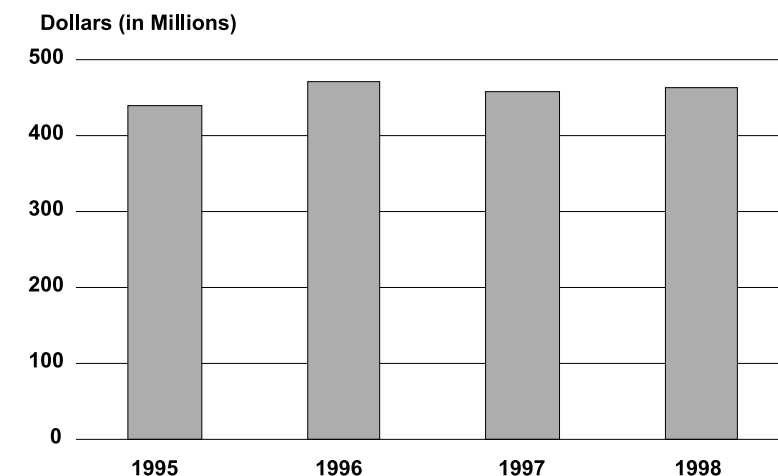
Since 1995, NCA MTFs have entered into numerous agreements to share personnel, facility space, and equipment to enhance care delivery. Such agreements demonstrate that MTF commanders recognize the need and have taken the initiative to look beyond their own facilities to best provide medical care. Most agreements are handled directly by and among the NCA MTF commanders.<sup>19</sup> MTF commanders told us that the service agreements have largely been driven by rising care costs and recent level budgets. (See fig. 4.)

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<sup>18</sup>About 150 agreements were in effect among NCA MTFs at the time of our review. Almost all involved one or more of the three medical centers. Agreements ranged in scope and duration from continuing divisions of specialty care among the medical centers to small exchanges of personnel to cover short-term MTF shortages.

<sup>19</sup>An NCA Federal Health Council informally oversees coordination among NCA MTFs. The Council consists of the three medical center commanders and the Uniform Services University of the Health Sciences and, recently, the Department of Veterans Affairs Medical Center in Washington, D.C. The council, through its work groups, continues to identify and assess opportunities to coordinate military medical care delivery.

**Figure 4: National Capital Area MTF Budgets**



Source: Operations and maintenance budget data from NCA MTFs.

The NCA MTF budget total increased only 5 percent between 1995 and 1998 (in dollars not adjusted for inflation). Conversely, the cost of providing care has risen significantly. The NCA cost per inpatient admission has increased from \$6,224 in 1995 to \$8,648 in 1998—a 39-percent increase. The NCA cost per outpatient visit has increased from \$126 in 1995 to \$177 in 1998—a 41-percent increase.

The following illustrate the variety of current NCA coordination agreements with respect to genesis, purpose, size, and complexity. Due to the varying availability of information about them, the examples are not presented for comparative purposes nor did we attempt to judge their individual or collective costs and benefits.

- Exemplifying care coordination within the same service, in 1998, Walter Reed and Kimbrough Army Ambulatory Care Clinic at Fort Meade arranged to have Walter Reed provide surgeons to Fort Meade for outpatient surgeries in areas such as orthopedics and ear, nose, and throat. Fort Meade provides the surgical space, support staff, and supplies. During fiscal year 1998, Walter Reed's surgeons performed over 1,000 outpatient surgeries at Fort Meade, with patients coming from Walter Reed, each service, and across the area. Benefits cited included reducing Walter Reed's surgical backlogs and improving training for surgeons, anesthesia nurses, and support staffs.

- Illustrating care coordination between two different service MTFs, in 1995, Fort Belvoir's DeWitt Army hospital agreed to provide obstetric services at Quantico, a Navy clinic about 23 miles away, and deliver the babies at Fort Belvoir. The Army hospital sends an obstetrician or nurse practitioner to Quantico about twice a week for routine outpatient obstetrical visits. Officials told us that, so far, about 120 deliveries have been done at Fort Belvoir. They estimated savings of \$128,000, comparing the MTF costs with alternative civilian care the services would have otherwise had to reimburse. Also, Fort Belvoir officials cited the added convenience for beneficiaries of receiving routine obstetrical care at their local MTF.
- Illustrating an agreement that crosses the three services, in 1998, the NCA MTFs leased a common type of communication pager from a single vendor for their medical staffs. MTF officials estimated savings at over \$66,000 a year. Other benefits cited were equipment uniformity and reliability, a consolidated directory of pager users, and ease of contact among physicians, particularly those serving patients in more than one MTF.
- Representing an extensive tri-service care arrangement, in 1995, the three NCA military medical centers agreed to divide the provision of inpatient mental health care. Walter Reed now provides all the adult psychiatric care, Bethesda provides all the adolescent psychiatric care, and Malcolm Grow provides all the substance abuse services in the area. An exception to normal coordination agreements, this arrangement was supported by a cost analysis because of the considerable MTF costs associated with mental health care. The arrangement involves no exchange of funds but does include exchange of personnel, with doctors and nurses of one service working in the other services' hospitals. The major benefits expected are better cost control and mental health care quality.
- One set of interservice agreements was not locally initiated. In response to DOD directives since 1994 that unnecessary, duplicative graduate medical education programs in the same area should be consolidated, Walter Reed and Bethesda agreed to integrate nearly a dozen such programs. And the centers continue reviewing the feasibility of combining more of their programs. One integrated program, inpatient neurology, for example, is now administered by Walter Reed, is jointly staffed, and has nine Army and six Navy trainees. The Army and Navy have made other attempts to significantly downsize their programs, including 1997 Navy efforts to eliminate some of its NCA graduate medical education programs and the Army's attempt to do so at William Beaumont Army Medical Center in El Paso, Texas. But, the efforts were thwarted by lack of DOD and service agreement on criteria for deciding which programs to target.

## MTF Coordination Could Be Improved by Being Built Into Systemwide Planning

The current NCA service coordination agreements have certain general characteristics. While appearing to improve care access and quality at particular facilities, the agreements are not part of any overall plan for military care delivery in NCA. And, with few exceptions, they were entered into without formal cost analyses and generally are voluntary and nonbinding. Also, the agreements commonly do not entail fund transfers among the services or MTFs, although MTF officials told us that their goal was that no MTF would be financially disadvantaged by the agreements. Another characteristic is that readiness requirements were not driving forces in entering into the agreements. Rather, MTF officials told us that, while they informally considered the agreements' effects on readiness, perceived dollar savings and improving peacetime care delivery were the main reasons for sharing their resources. Officials told us that achieving the agreements depended heavily on the initiative of senior NCA medical officers. And, except for the merger of NCA graduate medical education programs, DOD and the services' surgeons general have not had substantial influence on the NCA coordination agreements.

The current NCA agreements may be made financially unattractive by pending MTF budgeting changes and may or may not withstand a requirement that they be more consistently and formally justified. NCA MTF officials told us that under a proposed budgeting approach—enrollment-based capitation<sup>20</sup>—MTFs would be funded based largely on their enrolled populations. The officials told us that if the approach was adopted without allowing for the current no-cost service exchanges among facilities, MTFs would be deterred from entering care coordination agreements unless they are reimbursed. For example, the Naval Medical Center at Bethesda routinely sends physicians to other Naval clinics at no cost to treat beneficiaries not enrolled at Bethesda. Bethesda officials told us that, under enrollment-based capitation, they would be hesitant to continue such agreements unless reimbursed for the physicians' costs. Also, officials told us that the administrative burden of pricing and recording medical care given and received under the agreements could seriously affect any agreement's viability. As a result, agreements would be abandoned or never started, and individual MTFs would have the care gaps and overlaps that the current agreements attempt to address. Thus, to facilitate voluntary MTF participation, most agreements have been kept informal and nonbinding. But such conditions

<sup>20</sup>Under enrollment-based capitation, an MTF's per enrollee funding rates would be based on the MTF's estimated care costs. And, if an MTF's enrollee is referred to and receives care at another MTF, the home MTF would reimburse the provider MTF at the provider's service rates. This may create disincentives for commanders of smaller NCA clinics, such as Annapolis and Quantico, to refer their enrollees for needed care at the larger, more costly NCA MTFs, like Bethesda.

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do not ensure that optimal results are being achieved, may not be supportive of the system's basic mission, and argue for an overall tri-service strategy for determining needs and allocating resources.

Therefore, while the NCA MTF coordination agreements are numerous and appear beneficial, we believe the key strategic question is, how well do they individually and collectively support each MTF's health system role? And, further, which of the current and what additional MTF coordination is needed to support MHS' readiness and peacetime mission? But DOD and the services do not have a systemwide strategic plan that positions them to identify such NCA MTF coordination needs and provide for the most effective arrangements. Such a strategy, for example, might specifically recognize the need to coordinate costly mental health services, while providing parameters within which MTF commanders could exercise discretion in arranging smaller, more temporary resource exchanges.

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## **DOD and the Services Have Begun Addressing Problems, but Success Requires Their Total Commitment**

During the past decade, DOD experienced many of the same challenges that confronted U.S. health care generally—increasing costs, uneven care access, and disparate benefit and cost-sharing packages for similar categories of beneficiaries. In response, DOD and the services' Surgeons General initiated, with congressional authority, a series of demonstration programs across the country to explore ways to more cost-effectively manage and deliver care to military beneficiaries. These demonstration programs provided many valuable lessons, which DOD has applied to its health care system.

In 1994, such experiences led DOD to introduce a nationwide managed care program called TRICARE to improve beneficiary access to high-quality care while controlling MHS' costs. Also, DOD and the Surgeons General improved military care management by consolidating graduate medical education programs; establishing partnerships with the Department of Veterans Affairs; reducing hospital stays; restructuring hospitals into smaller, more efficient clinics; revising MTF budget processes to more closely link funding to cost-effective health care; and a host of other improvements.

DOD and the Surgeons General recognize that their medical system continues to evolve and its appropriate size and relative costs and effectiveness will continue to undergo intense scrutiny. As a result, in 1998, DOD began 29 separate initiatives to modernize MHS management. (See app. IV.) The initiatives were prompted by increasing concerns about



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whether DOD and the services had the right medical resources in the right places to meet readiness needs and to optimize peacetime health care. Other concerns included rising system costs, recent tight MTF budgets, and growing competition from such potential care alternatives as FEHBP. DOD's initiatives range from improving medical technician training to resizing and consolidating medical centers. As DOD pursued these efforts, one initiative emerged as the central focus for the others. This initiative is DOD's and the services' development of an overall medical resource strategy to provide for readiness needs and optimize care delivery.

DOD officials told us they view the initiative as critical to MHS' future. They also told us the effort has so far received DOD and service collaboration and commitment. But the officials told us that many obstacles exist, including maintaining tri-service—both medical and line—support, and getting buy-in from key external stakeholders such as cognizant congressional committees.

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### System Improvement Initiatives Address Tri-Service Issues

The 29 initiatives begun in 1998 address tri-service issues, such as centralized purchasing, pharmacy management, outsourcing functions, improved information systems, and graduate medical education development. Regarding centralized purchasing, for example, DOD is seeking to standardize medical and surgical supplies, while achieving economies of scale through joint purchasing. DOD's initiatives to address pharmacy management problems—which we reported on in 1998<sup>21</sup>—include linking existing pharmacy databases to facilitate reviews of drug use, cost, and safety and to standardize drug formularies across the various military pharmacies.

Another initiative looks at the advantages and feasibility of buying medical training services, such as for pharmacy and radiology technicians, from the private sector. Such training is now provided within MHS. The initiative to improve information systems seeks to enhance and integrate military health data systems and to consolidate their administration. The graduate medical education initiative is attempting to develop a departmentwide policy for targeting such programs for consolidation, downsizing, and closure, which responds to recommendations we made in a 1998 report.

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<sup>21</sup>Defense Health Care: A Fully Integrated Pharmacy System Would Improve Beneficiary Services and Cost-Effectiveness (GAO/HEHS-98-176, June 12, 1998).

## Focus on Tri-Service Strategy Is Emerging

Soon after DOD and the services began these efforts, they found that a more fundamental strategy was needed to more completely address basic system problems and decide how large the military medical system should be, including where resources should be placed and used to best support readiness and provide peacetime care. Thus, in November 1998, DOD established a tri-service team of senior officers<sup>22</sup> to develop such a strategy. Among the team's goals are to devise an approach to determine each MTF's correct size, identify excesses and shortages of medical personnel by specialty, and determine the right MTF provider mixes. DOD officials agree with us that, until this is done, it is not possible to judge the need for nor relative efficiency of MTFs in their health system. Because the analytical tools needed to make these key decisions were not available, the team identified the following eight areas as crucial to the strategy's development.

- Develop a tri-service approach for determining medical personnel readiness requirements and for distributing them among MTFs. Determining medical readiness requirements has been the subject of heated controversy and study since the end of the Cold War. This year, however, the three services agreed to tie their baseline staffing to an existing DOD sizing model. When fully implemented, the model is expected to determine minimum wartime service staffing levels. Based on such staffing levels, and using common tri-service guidelines, each service will design its own staffing distribution model to fit its mission, facility capabilities, and the needs of beneficiaries served by those facilities.
- Cost out MTF-readiness-related services so that both readiness and nonreadiness costs can be defined and defended. Never done before, this essential step would enable DOD and the services to identify which of their care system costs can be subjected to "make versus buy" decisions. This task is complicated by the services' differing definitions of readiness and how indirect MTF costs, such as facility maintenance, should be apportioned between the dual missions. Of course, the resultant cost of DOD medical readiness is highly sensitive to how expansive or narrow a definition of readiness activities is finally used. That is, if the readiness definition is broader, more MTF costs can be justified and fewer peacetime costs would be subject to make versus buy decisions.
- Use civilian best practices to develop provider (primary and specialty care) to beneficiary workload ratios. This task's purpose is to standardize resource distribution among MTFs and to help ensure that sufficient population and workload exist at each MTF to use and properly train military providers for readiness and cost-effective care. A private care

<sup>22</sup>The team also includes Health Affairs and TRICARE Management Activity representatives.

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ratio, for example, is about 2,000 beneficiaries per primary care provider. According to DOD officials, adjusting for readiness training, a military provider would serve from 1,300 to 1,900 beneficiaries. Another goal for this exercise is to minimize MTF underuse. DOD officials told us that such workload standards will help identify unused MTF capacity and enable MTFs to recapture beneficiaries now using civilian support contractors and less expensively care for them.

- Establish uniform workload reporting. Decisions on where providers should be placed and what MTF care alternatives should be considered require accurate, consistent, comparable data on MTF and the support contractors' workload, costs, and performance. But MTF cost and workload data problems have been pervasive, and DOD continues to struggle with its data system inaccuracies. As we and others have reported, the root cause has been DOD's and the services' lack of oversight and incentives to ensure the data's accuracy, timeliness, and completeness. In response to our recent report on its Medicare subvention demonstration, however, DOD has acted to improve its data and otherwise committed itself to overhauling its data systems.<sup>23</sup>
- Implement an enrollment-based capitation budget approach for MTFs. This proposed approach represents a significant change from the MTFs' historical budget approaches, which largely based each year's budget on the prior year's budget and workload. Capitated budgeting for MTFs would pay them a fixed amount for enrolled beneficiaries, with certain other allowances. The aim is to focus MTFs on providing care primarily to its enrolled population and to urge MTF commanders to manage within these budgets.
- After identifying an MTF's readiness-based resource needs, determine what added resources would make it as efficient and cost-effective as possible. This task recognizes that an MTF's readiness-based medical needs normally have to be supplemented with other care capabilities to enable the facility to optimally function as a full care facility. The question is whether such added care should be provided in the MTF by a military or civilian provider, or bought from the private sector.
- Use utilization management and clinical practice guidelines to optimize health outcomes across the health system. A major shift in military care philosophy, this approach would change the system's current emphasis on intervention following disease or injury to preventive services aimed at improving and maintaining the beneficiary population's health. Another goal is to maximize clinical productivity, treatment consistency, and care quality. DOD officials told us that the critical step in making the philosophical shift is to maximize MTF beneficiary enrollment so the

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<sup>23</sup>GAO/HEHS-99-39, May 28, 1999.

services can truly manage their health care. Currently, MTFs also provide space-available care, which tends to be episodic and leaves beneficiaries with alternatives to enrolling in managed care. Recently, we reported that the lack of a universal enrollment requirement had other adverse effects significantly limiting DOD's ability to predict MHS costs and effectively plan and manage its health care system.<sup>24</sup> Also, in 1998, we testified that maximum enrollment was needed to take full advantage of cost-effective managed care principles and practices.<sup>25</sup>

- Identify measures needed to assess progress toward system health goals. Currently, numerous performance indicators are in use for gauging MTFs' and contractors' performance, such as hospital stay lengths, appointment delays, and number of outpatient visits. The goal is to identify measures that will enable the services to comparatively assess progress toward system goals. Also, a key outcome is to identify and use measures that mirror civilian performance and quality indicators to facilitate cross-sector comparisons of quality of care.

The completion of these tasks should help the services properly size each of their MTFs. The idea is that the process would begin with the determination of each service's readiness requirements. Next, decisions would be made about how to distribute providers among the MTFs. Such decisions would consider each MTF's readiness role, the beneficiary population to be served, and the availability of other MTF and civilian services. With this information in hand, each MTF's readiness-based resources would be projected using adjusted civilian best practice norms. Because such resources alone are usually too limited in numbers, mix, and support to amount to an effective peacetime care system, other staff—both active duty and civilians—would be added. Once the best MTF profile has been developed, its empirical care levels would be assessed to identify whether unused capacity may exist. An overall goal is to fill this unused capacity by recapturing beneficiaries currently served by TRICARE contractors.

The tri-service team's goal is to complete its overall planning effort by April 2000 to be ready for resource planning and budgeting for the year 2002. However, the team faces daunting tasks, not the least of which are defining readiness and its costs; sustaining DOD and the services' commitment to the effort; obtaining buy-in from line command and other key stakeholders, including cognizant congressional committees and

<sup>24</sup>Defense Health Program: Reporting of Funding Adjustments Would Assist Congressional Oversight (GAO/HEHS-99-79, Apr. 29, 1999).

<sup>25</sup>Defense Health Care: Operational Difficulties and System Uncertainties Pose Continuing Challenges for TRICARE (GAO/T-HEHS-98-100, Feb. 26, 1998).

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members; obtaining accurate cost and workload data; and achieving the shift from medical intervention to preventive health care.

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## Conclusions

DOD is operating a \$16-billion-a-year health care system, the bulk of which is provided through MTFs. But DOD has not identified how much it spends for wartime medical readiness—its primary mission. Meanwhile, the beneficiary population has changed significantly, and retirees now outnumber active duty beneficiaries and their respective beneficiaries—and the trend is continuing. Moreover, MHS' growing day-to-day medical focus is on its other mission, peacetime care delivery. A pivotal system deficiency is that DOD and the services lack a comprehensive strategy for ensuring that the right resources are budgeted for and located in the right places to meet readiness needs and cost-effectively provide peacetime care. The problems have persisted due to service independence and mission differences and because, historically, the services have had enough resources to maintain separate overlapping systems.

Absent a comprehensive strategy for determining and allocating resources across the services' MTFs, neither we nor DOD can adequately judge the need for NCA MTFs or their appropriate size. Likewise, while NCA service coordination agreements among MTFs appear beneficial and show good faith efforts to improve care and reduce costs, the agreements are ad hoc and not governed by a systemwide strategy that would help guide such decisions and maximize outcomes. Meanwhile, MTFs are challenged to be cost-effective care providers by a growing peacetime workload coupled with rising costs, fewer military medical personnel, and competition from alternative care sources such as FEHBP.

DOD and the services have recently recognized that the time has come for such a strategy—one that clearly defines readiness costs and justifies peacetime care based on make versus buy analyses—and have taken actions aimed at developing it. Among a series of DOD system improvement initiatives begun this year is one now aimed at identifying medical resource needs and developing an approach for distributing resources among MTFs, identifying readiness costs, determining peacetime care needs that MTFs can most cost-effectively meet, and shifting care emphasis from medical intervention to prevention. As we have reported and testified in the past, DOD also needs to enroll as many beneficiaries as possible at MTFs to be better able to predict MHS costs and truly manage beneficiary

health care. In short, maximizing enrollment is critical to the tri-service strategy.

We support the thrust of DOD's initiative believing that such a resource strategy would position it and the services to make informed, prudent decisions about MTF resource needs. But major obstacles exist, such as the difficulty in defining and obtaining consensus on readiness needs and costs, and sustaining DOD and tri-service commitment over the long term. Thus, we believe DOD and the services need to dedicate top-level management attention to ensuring the project's successful completion. And, to enhance congressional oversight of this critical endeavor, DOD needs to periodically report on the project's progress.

## Recommendations

To ensure, among other matters, that the defense medical system is properly sized, that inefficiencies and overlaps among MTFs are eliminated, and that readiness is effectively managed, we recommend that the Secretary of Defense direct the Assistant Secretary of Defense for Health Affairs and the services' Surgeons General to

- complete the development and implementation of a comprehensive tri-service medical resource planning and allocation strategy that clearly defines the cost of readiness and justifies nonreadiness peacetime care based principally on cost-effectiveness analyses;
- emphasize MTF beneficiary enrollment as a key element of the tri-service strategy, and make every effort to enroll as many current MTF users as possible so that the services and MTFs can truly manage health care;
- ensure that the overall strategy identifies and provides for significant care coordination opportunities such as in the NCA;
- work with the line commanders and key stakeholders such as cognizant congressional committees and key members, advocacy groups, and others to obtain support for the implementation of the strategy; and
- periodically report progress toward developing and implementing the strategy to cognizant House and Senate committees.

Developing and implementing the tri-service medical resource strategy may require actions by and coordination with other DOD Assistant Secretaries; therefore, as appropriate, the Secretary should direct the affected Assistant Secretaries' support and participation.

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## Agency Comments and Our Evaluation

In its written comments on a draft of this report, DOD agreed with the report and each of our recommendations. It also agreed that the tri-service team assembled to develop and coordinate implementation of the resource planning and allocation strategy faces a formidable challenge. Hence, DOD stated that the Department's senior leadership is now and will continue providing oversight and support for the project and that the project plan was provided to the Senate and House Appropriations Committees on September 23, 1999—during this draft report's comment period. DOD plans to brief the cognizant congressional oversight committees, seek their buy-in and support, and keep them apprised of the project's progress. DOD's comments are reprinted as appendix V.

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We are sending copies of this report to the Honorable William S. Cohen, Secretary of Defense, and will make copies available to others upon request.

Please contact me at (202) 512-7101 or Dan Brier, Assistant Director, at (202) 512-6803 if you or your staff have any questions concerning this report. Other GAO staff who made contributions to this report are Elkins Cox, Allan Richardson, Cheryl Brand, and Cherie Starck.



Stephen P. Backhus  
Director, Veterans' Affairs and  
Military Health Care Issues

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**Abbreviations**

CHAMPUS	Civilian Health And Medical Program of the Uniformed Services
DHP	Defense Health Program
DOD	Department of Defense
FEHBP	Federal Employees Health Benefits Program
MHS	military health system
MTF	military treatment facility
NCA	national capital area

# Scope and Methodology

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To assess the need for NCA MTFs and the coordination of health care among MTFs, we examined the roles and activities of those MTFs and their related guidance and support from DOD and service command levels. We interviewed officials and analyzed records at each of those levels to assess the information and processes officials use for determining MTF resource needs and coordinating resource use. The scope of our work necessarily extended beyond the national capital area to include issues affecting MHS as a whole, with its dual mission of maintaining wartime readiness and providing peacetime care, because NCA MTFs are integral parts of that system and its dual mission. However, this review focuses on MHS within the United States and does not include those MTFs located overseas.

Beginning our work among the 26 NCA MTFs, we conducted interviews and analyses at the 3 military medical centers—representing 75 percent of NCA MTF costs—and at 8 other MTFs, including all of the larger ones and a selection of smaller branch clinics. There, we discussed and analyzed information on how and to what extent MTF resource requirements are defined, measured, and justified, taking into account the MTFs' dual missions. We also analyzed beneficiary population, workload, and cost data associated with NCA MTFs compared to national totals to generally assess the level of services provided to NCA beneficiaries. Through discussions with MTF officials, and focusing on a selection of NCA MTF coordination agreements, we examined the nature, purpose, achievements, and future expectations of care coordination activities among MTFs.

We did not attempt to verify or compare costs and benefits among the NCA MTF coordination agreements because of the limited and widely varying data on those agreements. We contacted civilian NCA health care provider organizations along with health care consultants to obtain comparable information on how civilian health care facilities coordinate local health care services.

Because each of the military services has its own methods for determining health care needs and allocating resources among its MTFs, we reviewed those processes at the services' regional and Surgeon General levels. There we discussed and obtained data on the services' modeling tools and other guidance and analytical processes affecting MTF resource allocation decisions and coordination of care among MTFs. That included considering how the services' independent approaches differed in design and effects on their MTFs. We then followed up on the application of such independent tools to find how they affect selected NCA MTFs in terms of supporting

readiness and providing peacetime care and to identify any problems in their applications.

We assessed the current and potential effects of TRICARE implementation on MTF needs and coordination in the national capital area and elsewhere, based on the experiences and expectations of the MTFs we visited, the expected role as viewed by the TRICARE lead agent and DOD, and our current and prior TRICARE work. We also relied on current and prior work and our reports and those by others in assessing the role, needs, and performance of MHS.

Finally, we considered the purposes and potential effects of a broad approach, begun by DOD and the services during our review, to improve MHS management. Of the approach's 29 initiatives, we focused on the one that appears to be key—the development of a tri-service medical resource planning and distribution plan intended to optimize use of MTF resources. Through a series of discussions and review of the plan with the team leading that effort and with others, we considered the initiative's potential to address the problems we found in the services' approaches to MTF needs assessment and care coordination in the national capital area and elsewhere.

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# Profile of MTFs in the National Capital Area

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## Organization of NCA MTFs

The services use separate structures to plan and manage their NCA MTFs. For example, the Army's 12 NCA MTFs are centrally managed as part of the Walter Reed Health Care System. This system is also part of a single regional command that covers 21 states and the District of Columbia. In contrast, only some of the Navy's 12 NCA MTFs are directed by the Naval Medical Center in Bethesda, Maryland; the other clinics report to a Navy Health Support Office in Norfolk, Virginia. The Air Force's one NCA medical center and its one NCA clinic separately report to different major commands. Along with operating independently, each service's complex command structure can limit the extent to which resource use is coordinated among the service's facilities. For example, the Air Force medical center has sought control of the clinic to reduce duplicative administrative costs and staffing. But the clinic reports to the Office of the Air Force Surgeon General, who has retained the current structure.

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## Army NCA MTFs

All Army NCA MTFs come under the Walter Reed Health Care System and consist of the medical center, a community hospital, a clinic with same-day surgery capability, and their respective clinics. Walter Reed Medical Center is a 350-bed tertiary care facility located in a residential area of the District of Columbia, near the Maryland border. The center, which began admitting patients in 1909, provides primary health care services and about 50 specialty and subspecialty services. Walter Reed is also a worldwide referral center and has research and medical training programs. Walter Reed's wartime mission is being a designated casualty receiving center for injured military personnel. Further, over one-third of its military personnel are designated to deploy during war. Walter Reed has branch clinics at the Pentagon in Virginia and Fort McNair in Washington, D.C. These outlying facilities offer the beneficiary convenient access to routine and urgent primary health care services with referral to Walter Reed for specialty care. These facilities treat beneficiaries in MHS who might otherwise seek care in the civilian sector.

DeWitt Army Community Hospital, located in Fort Belvoir, Virginia, is the only NCA inpatient military facility in northern Virginia. It is a 68-bed hospital with an intensive care unit, medical/surgical wards, labor and delivery and mother/baby wards, pharmacies, and a 24-hour emergency room. DeWitt provides a number of specialty services and has a family medicine residency training program. DeWitt hospital and its clinics provide the primary medical support for several major Army commands and crosses service lines by providing obstetric and orthopedic services to Marines and their family members at the Quantico, Virginia, naval clinic.

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DeWitt's clinics are at Fort Meyer and A.P. Hill, Virginia. A.P. Hill, the southernmost NCA MTF, provides care to reservists on active duty and the cadre of active duty running the reserve training facility there. DeWitt also has clinics in Fairfax and Woodbridge, Virginia, where there are concentrations of dependent and retiree beneficiary populations.

Kimbrough Ambulatory Care Center at Fort Meade, Maryland, provides primary care as well as a wide range of same-day surgery. Specialty services include general surgery; orthopedics; vascular surgery; urology; ophthalmology; gynecology; and ear, nose, and throat. The clinic performs approximately 2,000 ambulatory surgeries each year using assigned providers and staff from Walter Reed and the Naval Medical Center in Bethesda. Kimbrough's clinics at Aberdeen Proving Ground, Edgewood, and Fort Detrick, Maryland, offer primary care services. Kimbrough cares for personnel assigned to the National Security Agency and the Defense Information School. Fort Detrick supports the U.S. Army Medical Research and Development Command. Aberdeen and Edgewood support a variety of Advanced Individual Training programs conducted by the U.S. Army Ordnance Corps.

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## Navy NCA MTFs

The National Naval Medical Center at Bethesda, Maryland; its branch clinics; and separate clinics at Annapolis and Patuxent River, Maryland, and Quantico, Virginia, comprise the Navy NCA MTFs. Bethesda has 239 beds and provides primary health care services but is known for its specialty and subspecialty services, such as mother and infant care and breast care. Bethesda is a worldwide referral center, providing services for 16 different specialties, as well as conducting medical training programs and research. Bethesda's readiness mission includes staffing the USN Comfort, a hospital ship, as well as contributing staff to Navy and Marine ships, bases, and hospitals in the United States and overseas.

Bethesda has eight branch clinics located throughout Washington, D.C.; Maryland; and Virginia that support Navy active duty commands. The outlying facilities offer beneficiaries convenient access to primary health care services with referral to Bethesda for specialty care. The clinics treat beneficiaries in MHS who might otherwise seek care from civilian providers.

The Indian Head, Maryland, and Arlington Annex and Dahlgren, Virginia, clinics provide outpatient primary care, occupational medicine, preventive medicine, and industrial hygiene services to all eligible DOD beneficiaries.

The Washington Navy Yard clinic and Naval Air Facility, Washington, clinic at Andrews Air Force Base provide outpatient primary care, occupational medicine, preventive medicine, and industrial hygiene services to active duty personnel along with occupational medicine services for civil service personnel. Naval Air Facility provides physical exams for most Navy and Marine Corps personnel in Washington, D.C., and medical support and training to reserve personnel. The Carderock, Virginia, clinic and the clinic at the Naval Research Laboratory in Washington, D.C., provide occupational medicine and industrial hygiene services to active duty and civil service personnel. The Naval Security Station, Maryland, clinic provides sick call services to active duty personnel located at the Naval Security Station.

The Naval Medical Clinic in Annapolis provides primary care for all beneficiaries but mostly focuses care on the 4,000 midshipmen at the Naval Academy. The Naval Medical Clinic in Quantico provides primary care for all beneficiaries and care for trainees at the Marine Officer School. The Naval Medical Clinic in Patuxent River provides primary care for a mix of active duty, dependent, and retiree beneficiaries.

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## **Air Force NCA MTFs**

There are only two Air Force NCA MTFs: Malcolm Grow Medical Center and Bolling clinic, each reporting to separate commands. Malcolm Grow, the 89th Medical Group, is a 70-bed tertiary center located at Andrews Air Force Base, Maryland. The center reports to the Air Mobility Command in Scott Air Force Base, Illinois, and provides primary health care services but is known for more than 30 specialty and subspecialty clinics. It is also has a family practice residency program. During wartime, Malcolm Grow is the entry port for all patients air evacuated from overseas locations in Europe. The 89th Medical Group also provides physiological training, which consists of intense altitude chamber training to familiarize personnel with the physiological effects of flying.

Bolling clinic, the 11th Medical Group, is located at Bolling Air Force Base in Washington, D.C., and provides primary medical and dental care to eligible DOD beneficiaries, which includes Defense Intelligence Agency, Naval Research Laboratory, and Bellevue Navy Housing staff. It reports to the Air Force Surgeon General's office. Flight surgeons also provide medical support to the offices of the Secretary of Defense and the Chairman of the Joint Chiefs of Staff.

**Appendix II  
Profile of MTFs in the National Capital Area**

**Selected NCA MTF  
Data**

Table II.1 lists the NCA MTFs, the number of hospital beds, their 1998 DHP operations and maintenance (O&M) budget, their 1998 personnel numbers, and workload data.

**Table II.1: NCA MTFs' Number of Beds, Budget, Personnel, and Outpatient Workload, 1998**

MTF	Number of beds	DHP O&M budget	Personnel			Total	Outpatient visits
			Military	Civilian	Contract		
<b>Army</b>							
Walter Reed	350	\$147,839,900	1,804	1,185	155	3,144	645,975
DeWitt	68	59,945,000	340	399	104	843	611,019
Kimbrough	Outpatient only	46,349,000	273	423	32	728	321,691
<b>Navy</b>							
Bethesda	239	146,847,000	2,599	926	215	3,740	555,059
Annapolis	Outpatient only	6,455,000	122	36	14	172	89,257
Patuxent River	Outpatient only	7,361,000	152	67	5	224	73,109
Quantico	Outpatient only	8,451,000	194	51	16	261	89,569
<b>Air Force</b>							
Malcolm Grow	70	33,213,000	1,314	264	•	1,578	394,477
Bolling	Outpatient only	5,390,000	189	28	1	218	52,644

Note: Walter Reed figures include Pentagon clinic and Fort McNair; DeWitt includes clinics at Fairfax, Fort Myer, A.P. Hill, and Woodbridge; Kimbrough includes clinics at Aberdeen, Edgewood, and Fort Detrick; Bethesda includes branch clinics at Dahlgren, Indian Head, Arlington Annex, Washington Navy Yard, Naval Air Facility, Carderock, Naval Research Lab, and Security Station.

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# Service Models

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Historically, the Army, Navy, and Air Force—because of their independence, diverse organizational structures, and general lack of coordination—have developed their own approaches for identifying, allocating, and validating MTF requirements. The approaches include an array of technical, mathematical-based models. The brief descriptions below indicate the variety and changing nature of models used; they are not comprehensive, comparative assessments.

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## Army Models

For wartime requirements, the Army, unlike the Navy and Air Force, begins with its Total Army Analysis model to determine the number and type of support units, including medical, needed to support the Army's combat forces in wartime and other contingencies. In addition to the two near-simultaneous major regional conflicts, the model also includes requirements for post-hostility requirements—such as treating civilians and refugees—operations other than war, homeland defense, and domestic disaster relief. Building on the baseline obtained from the model, the Army uses its Total Army Medical Department Personnel Structure model to determine additional military medical personnel needed for rotation and training.

Recently, the Army's North Atlantic Regional Medical Command began comparing medical personnel levels among MTFs within the command to correct imbalances caused by changes in the medical environment. Changes that affect the size of MTFs include TRICARE implementation, shift from inpatient to outpatient care, base closure and realignments, downsizing of the active duty force, increased deployments, decreased budgets, and increased costs of providing health care. Thus, the North Atlantic Regional Medical Command developed the Regional Uniform Benefit model, which compares and validates medical personnel allocation. The objectives of the model are to distribute resources to meet population needs, benchmark productivity and performance, optimize contract dollars, and develop "what if" analyses before implementing a change in services or a facility. For example, at an MTF outside the national capital area, the model identified excess resources, which resulted in a decrease of about 120 staff, a decrease in its budget by \$5.5 million, and the elimination of a plan to build a new surgical suite. The model has been completed at most NCA MTFs except at Walter Reed. The model has been briefed to other Army offices and may be expanded beyond the North Atlantic Regional Command. Army officials told us that the Automated Staffing Assessment model and other models, while useful, had been inadequate in addressing total facility and personnel needs.



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## Navy Models

The Navy uses its Total Health Care Support Readiness Requirements to project its active duty medical force readiness requirements. The Navy readiness mission is to support all Navy and Marine Corps operational missions, including wartime and day-to-day operations. This includes mobilizing hospital ships—USN Mercy on the West Coast and the USN Comfort on the East Coast—supporting Navy Fleet and Marine Corps operations ashore and afloat and numerous Fleet hospitals, as well as maintaining military treatment facilities outside the United States. Its day-to-day operational support mission allows Navy medical personnel to rotate between the United States, ships at sea, and overseas assignments. Also included is training of medical personnel.

The Navy uses a number of models to determine wartime requirements, allocate military medical personnel among MTFs, and validate MTF manpower requirements. The Total Health Care Support Readiness Requirements model defines readiness requirements as the minimum number of military medical personnel required to support and sustain its readiness mission. This model is the basis for DOD's overall sizing model. The Navy uses its allocation model called the CONUS Healthcare Readiness Infrastructure Sizing model to allocate military medical personnel among its MTFs in the United States. The model attempts to validate the number of military personnel needed by the MTF to staff its assigned wartime tasks. All military personnel in excess of wartime requirements assigned to the MTF are considered to be part of the Navy peacetime healthcare mission. Finally, the Navy uses its efficiency reviews to further validate the number and type of personnel needed at an MTF to provide the peacetime health care benefit using workload, number of personnel, and workload standards. An efficiency review determines how an MTF's military and civilian staffing compares with applicable standards.

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## Air Force Models

The Air Force projects its requirements for military medical personnel using DOD's overall sizing model. This model identifies the number of military medical personnel needed to support the Air Force's mission of supplying air-transportable hospitals, contingency hospitals, and critical care air transport teams. In addition, the Air Force has decided that military medical personnel should provide primary care services to active duty personnel and active duty family members at all bases. According to Air Force officials, this has resulted in an additional requirement of about 200 military medical personnel.

The Air Force Surgeon General and the major commands, such as the Air Mobility Command, that fund and control the various MTFs, distribute the wartime taskings and allocate associated military medical personnel needed among MTFs based on major command wartime requirements and on which MTFs can best support those requirements. The Air Force tries to concentrate many of the wartime taskings at large MTFs that have the beneficiary population—high volume of workload—to support military provider readiness training. The Air Force also uses its Strategic Resourcing Portfolio, an economic manpower sizing model, as a tool to help determine where it may be economical and feasible to allocate military medical personnel.

Currently, the Strategic Resourcing Portfolio projects the numbers and mix of personnel needed at an MTF based on the demographics of the beneficiary population, historical workload,<sup>26</sup> and the cost of providing health care services. The model also reflects the number of military medical personnel assigned to meet the MTF's wartime taskings. The health care services provided by the military personnel in excess of this number and by civilian personnel are part of the peacetime mission. However, the latest edition of this model raised reliability issues, as we reported.

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<sup>26</sup>In the future, when TRICARE is fully implemented, it will be based on the enrolled population.

# DOD's 29 Reengineering, Consolidation, and Optimization Initiatives

Prompted by concerns about whether it could meet readiness needs, as well as optimize peacetime health care, DOD began 29 separate initiatives to modernize MHS management in 1998. DOD's 29 reengineering, consolidation, and optimization initiatives and their objectives are listed below.

Pharmacy national mail order program: Redirect patients from using Standard CHAMPUS pharmacies to retail network pharmacies.

Pharmacy automation and formulary management.

Pharmacy distribution and pricing agreements.

System/facility optimization:

- Improve care management consistent with recognized science-based best clinical practice.
- Improve practice patterns.
- Implement evidence-based medicine and prevention.
- Reduce inappropriate variance from and speed adoption of clinical/administration best practice.
- Implement utilization management system for all of TRICARE.
- Recapture most local area care to MTFs where cost beneficial.
- Optimize enrollee-to-provider ratio (for example, 1,500 enrollees per physician).
- Right size hospitals and clinics.
- Right size each MTF's primary and specialty care providers.
- Improve care management of high-intensity illnesses.
- Increase number and speed adoption of clinical guidelines for high-intensity, high-cost illnesses.
- Develop patient safety initiative with the Department of Veterans Affairs and other agencies.
- Implement MHS quality initiatives, and develop quality initiatives with Department of Health and Human Services, Department of Veterans Affairs, and Office of Personnel Management.
- Reengineer clinic infrastructure to support modern ambulatory care.
- Reengineer clinical and administrative processes to meet access and satisfaction standards.
- Increase percentage of users who are enrolled.
- Increase nonphysician support in clinical settings.
- Shift nonemergent and nonurgent care in the emergency rooms to other ambulatory care settings.

- Retain flexibility in MHS to respond to future internal and external factors.
- Determine MHS readiness requirements for nonphysicians as well as for physicians and move to that number, unless a make versus buy analysis indicates additional in-house MTF staffing is advantageous.

Consolidate medical information management/information technology activities within DHP:

- Consolidate administration into a single activity.
- Move to more “paperless” processing.
- Improve the integration and connectivity of multiple systems to support user needs.
- Improve information systems, such as Composite Health Care System II, Government-Computerized Patient Record, and pharmacy management.

Reduce/flatten/lean infrastructure: Eliminate duplicate management activities/functions at intermediate commands in the three military departments and TRICARE regional lead agents.

Reduce cross-service duplications:

- Consolidate preventive medicine.
- Consolidate environmental health.
- Consolidate blood donor labs.

Consolidate the number of medical centers.

Merge overlapping NCA medical centers and San Antonio medical centers.

Reengineer aeromedical evacuation (program analysis and evaluation).

Reengineer Air Force Institute of Pathology.

Managed care support contract:

- Reduce TRICARE managed care support contract administrative costs.
- Reduce/consolidate number of change orders for managed care support contracts.
- Extend contracts when advantageous to government and beneficiaries.

Managed Care Support 3.0 contract: Implement new managed care support contract structure/process.

Contract policy/payment change.

Military construction projects: Refer or reduce certain military construction projects (Air Force Institute of Pathology, classroom project at Army Medical Center and School, Center for Health Promotion and Preventative Medicine).

Accelerate military personnel reductions (Air Force).

Consolidate graduate medical education administration and development of Department graduate medical education policy.

Purchasing/acquisition activities for all medical supplies used in MTFs (excluding fielded medical units and deployable medical systems):

- Regionalize.
- Implement universal product numbers, joint purchasing, standardization for medical and surgical supplies.

Nationalize or regionalize maintenance and repair contracts for medical equipment used in medical and dental treatment facilities and in medical training activities.

Outsourcing of advanced medical technical training for areas such as laboratory, radiology, electrocardiograph, and pharmacy technologists, as well as all other outsourcing initiatives related to quadrennial Defense reviews.

Consolidate medical facility acquisition and life-cycle management activities into a single-facility life-cycle management organization.

Beneficiary support:

- Emphasize themes: "Taking care of our own," "Protecting our forces' health," "Customer first."
- Support and improve patient self-care and reduce overutilization of care.
- Improve communication through increased use of Internet and other information tools.
- Implement report cards and other performance assessment tools.
- Implement consumer councils in all MTFs.
- Strengthen grievance resolution procedures.
- Expand customer satisfaction assessment to all of TRICARE.

TRICARE benefit policy:

- Simplify, rationalize, and make more uniform the TRICARE benefit (include pharmacy).
- Carry out successful TRICARE Senior demonstration.
- Carry out successful DOD demonstration (MacDill).
- Obtain authorization for TRICARE Senior (Medicare reimbursement) nationwide.

TRICARE staff training and education:

- Increase training in “good” managed care for MTF staff.
- Move trauma training into the private sector wherever it makes economic or readiness sense.
- Use Internet and other advanced distributive learning tools.

Improve assessment, purchase, and use of medical technology.

Outsourcing quadrennial Defense reviews: Outsource functions better done by the private sector.

Reengineer, improve prevention:

- Focus on and shift resources to outcome-based, evidence-based prevention.
- Implement “putting prevention into practice.”
- Push reduction in high-priority areas—tobacco use, alcohol abuse, injuries.
- Increased immunization rates.
- Increase line support of troop fitness and wellness.
- Improve infectious disease prevention, surveillance, and response.

Improve resourcing:

- Adjust payments to Uniform Services Treatment Facilities.
- Move to capitation funding more quickly.
- Reduce double payments by Medicare and DOD.
- Increase third-party collection rates.

Improve MHS management:

- Manage MHS by performance at all levels.
- Design/refine/implement performance measures—outcomes, cost, access, quality.
- Further develop/reinforce partnership among Health Affairs and the services.
- Strengthen leadership at all levels of MHS.
- Make smart make versus buy decisions throughout MHS.
- Develop/implement strategic communications with customers, public, DOD, and the Congress.
- Develop stronger market analysis and marketing efforts.
- Refine budget preparation to improve collaboration and earlier determination of MHS priorities.
- Strengthen fraud and abuse reduction efforts with Inspector General.

# Comments From the Department of Defense



HEALTH AFFAIRS

THE ASSISTANT SECRETARY OF DEFENSE

WASHINGTON, D. C. 20301-1200

Mr. Stephen P. Backhus  
Director, Veterans' Affairs and Military Health Care Issues  
Health, Education, and Human Services Division  
U.S. General Accounting Office  
Washington, DC 20548

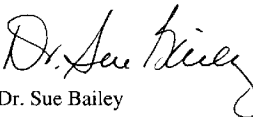
07 OCT 1999

Dear Mr. Backhus:

This is the Department of Defense (DoD) response to the GAO draft report "Defense Health Care: Tri-Service Strategy Needed to Justify Medical Resources for Readiness and Peacetime Care," dated 20 September 1999 (GAO Code 101615 /OSD Case 1899)." This draft report has been reviewed by my staff and coordinated with the three Surgeons General, and the TRICARE Management Activity. Specific responses to each recommendation are provided in the attached enclosure.

DoD concurs with the recommendations in the draft GAO report and is committed to achieving a Military Health System (MHS) that is a national benchmark for both quality and cost effectiveness while meeting its unique military readiness challenges of providing global health care. The Department has developed a comprehensive strategy, the High Performance MHS Optimization Plan, which your reviewers have noted with both enthusiasm and support. The Senior MHS leadership to include the ASD(HA) and the three Surgeons General continue to develop and pursue initiatives that provide for an integrated tri-service health system. As noted in your draft report, the tri-service Reengineering Coordination Team assembled to develop and coordinate implementation of the new MHS strategy faces a daunting challenge given the task's complexity. There have already been significant system-wide improvements, and we are committed to continuing these efforts until fully implemented over the next few years. We have engaged the Department's senior leadership to provide oversight and support with implementing the High Performance MHS Optimization Plan. In addition, the Department, provided both the Senate and House Appropriations Committees on 23 September 1999, our plan seeking their support and providing our assurance that we will keep them fully informed of our progress.

Please feel free to address any questions to my project officers on this matter, COL Daniel Blum, (functional) at (703) 681-1724 or Mr. Gunther J. Zimmerman (GAO/IG Liaison) at (703) 681-7889.

  
Dr. Sue Bailey

Enclosure:  
As stated



**GAO DRAFT REPORT – DATED SEPTEMBER 20, 1999**  
**GAO CODE 101615/OSD CASE 1899**

**“DEFENSE HEALTH CARE: TRI-SERVICE STRATEGY NEEDED TO JUSTIFY  
MEDICAL RESOURCES FOR READINESS AND PEACETIME CARE”**

**DEPARTMENT OF DEFENSE COMMENTS  
TO THE RECOMMENDATIONS**

To ensure, among other matters, that the defense medical system is properly sized, that inefficiencies and overlaps among military treatment facilities (MTFs) are eliminated, and that readiness is effectively managed, we recommend that the Secretary of Defense direct the Assistant Secretary of Defense for Health Affairs and the services' Surgeons General to:

**RECOMMENDATION 1:** Complete the development and implementation of a comprehensive tri-service medical resource planning and allocation strategy that clearly defines the cost of readiness and justifies non-readiness peacetime care principally on cost effectiveness analyses. (P.32/GAO Draft Report)

Now on p. 29.

**DOD RESPONSE:** Concur. The Military Health System (MHS) Optimization Plan and the Reengineering Coordination Team (RCT) have established aggressive milestones and timelines for developing a tri-service resourcing and a readiness-costing model. In FY 00 we will test an enrollment based resourcing model that also identifies unique MTF costs that are not related to funding an enrolled population.

**RECOMMENDATION 2:** Emphasize MTF beneficiary enrollment as a key element of the tri-service strategy, and make every effort to enroll as many current MTF users as possible so that services and MTFs can truly manage health care. (p. 32/GAO Draft Report)

Now on p. 29.

**DOD RESPONSE:** Concur. The Department is developing a tri-service enrollment model and policy to provide a consistent tool to develop enrollment targets and measure enrollment levels. MHS optimization focuses on providing preventive health services to a primarily enrolled population and implementing the tenets of population health improvement. Best utilization of existing military treatment facilities and recapturing of more expensive contractor network workload is also dependent on knowing the population to be provided health care through enrollment. The Enrollment Based Capitation (EBC) model and other tri-service resourcing models are being evaluated to identify the best approach to provide appropriate prospective incentives to MTFs for emphasizing Prime enrollment.

**RECOMMENDATION 3:** Ensure that the overall strategy identifies and provides for significant coordination opportunities such as in the National Capital Area (NCA). (p. 32/GAO Draft Report)

Now on p. 29.

**DOD RESPONSE:** Concur. The twenty-one existing agreements among the NCA medical treatment facilities are indicative of opportunities for sharing of resources in other locations with

overlapping catchment areas. The process by which those opportunities are identified and capitalized upon should be codified within regional health plans developed by local MTF commanders with support of the Lead Agent and Service Surgeons General. With emphasis on enrollment and full implementation of MHS optimization, both MTF functions and resources will be realigned to provide the best overarching health care delivery strategy and minimize costly and duplicative infrastructure.

**RECOMMENDATION 4:** Work with the line commands and such key stakeholders as cognizant congressional committees and key members, advocacy groups, and others to obtain support for the implementation of the strategy. (p.33/GAO Draft Report)

Now on p. 29.

**DOD RESPONSE:** Concur. The ASD(HA) established a senior, flag-level/civilian equivalent, MHS Reengineering and Optimization Oversight Steering Committee in August 1998, to provide guidance and oversight of MHS efforts that were initially directed in a Department Program Decision Memorandum. A Defense Medical Oversight Committee (DMOC) was established in late summer 1999 to make recommendation to the Defense Resource Board on health policy and resourcing issues. The DMOC is composed of Senior Department officials, including the Under Secretary of Defense (Personnel and Readiness), the Under Secretary of Defense (Comptroller), the Assistant Secretary of Defense (Health Affairs), the Service Under Secretaries, the Service Vice Chief of Staffs, Assistant Commandant of the Marine Corps, Director for Logistics of the Joint Chiefs of Staff, and the Service Surgeons General. The DMOC was presented with an initial briefing on the Strategy for Implementing the MHS Optimization Plan on 8 September 1999. Appropriate congressional oversight committees and key stakeholders will be briefed for the purpose of seeking their support.

**RECOMMENDATION 5:** Periodically report progress toward developing and implementing the strategy to cognizant House and Senate committees. (p. 33/GAO Draft Report)

Now on p. 29.

**DOD RESPONSE:** Concur. On 23 September 1999 the House and Senate Appropriation Committees were provided with a written report on the MHS Optimization Plan with assurance that we would keep them informed of our progress. We have begun to schedule briefings with committee members who have expressed interest in our plan.

**RECOMMENDATION 6:** Developing and implementing the tri-service medical resource strategy may require actions by and coordination with the other DoD Assistant Secretaries; therefore, as appropriate, the GAO recommended the Secretary should direct the affected Assistant Secretaries' support and participation. (p. 33/GAO Draft Report)

Now on p. 30.

**DOD RESPONSE:** Concur. The senior leadership within OSD and the Military Departments must be fully engaged in developing and supporting the overarching MHS strategy for health care delivery and meeting mission readiness requirements. The DEPSECDEF directed the initial review of MHS initiatives for reengineering opportunities and identification of system-wide savings for reinvestment within the MHS, which culminated in development of the MHS Optimization Plan. The Department's senior leadership has already become engaged, and is expected to continue their involvement with overseeing MHS optimization.

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