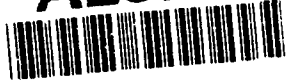


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**STUDY OF MANAGED CARE ACTIVITIES IN
USAF AND OTHER DOD MEDICAL TREATMENT FACILITIES**

A Graduate Management Project

Submitted to the Faculty of

Baylor University

In Partial Fulfillment of the

Requirements for the Degree

of

Master of Health Administration

by

Major Archie J. Summerlin, USAF, MSC

27 July 1990

"REPRODUCED AT GOVERNMENT EXPENSE"

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27 Jul 90

SUBJECT Graduate Management Project (GMP)

TO SGM/Col Charles R. Hardy

The attached copies of my GMP are forwarded for your review and approval.

Archie J. Summerlin
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27 JUL 1990

TO: HSHA-IHC (Program Director)
 Academy of Health Sciences, US Army
 Fort Sam Houston, TX 78234-6100

I have reviewed and approved Maj Summerlin's GMP. I am forwarding his GMP for your appropriate action.

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 Associate Administrator
 Medical Resource Management

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ABSTRACT

**Study of Managed Care Activities in
USAF and Other DoD Medical Treatment Facilities**

Managed care activities in the Uniformed Health Services of the United States are becoming the primary strategy for controlling the rising costs of delivering quality healthcare services to its beneficiaries. A few USAF Medical Treatment Facilities (MTFs) have centralized their managed care activities in anticipation of balancing their limited budgets with the growing demand for quality healthcare services. The WHMC Administrator understands that the need of the catchment area beneficiaries will have to be balanced and controlled if quality care is to be kept accessible to these patients. He feels a managed care activity at WHMC is the best way to ensure appropriate accessibility to care is provided at the most efficient costs. Therefore, this study was initiated to identify and examine the existing scope and structures of USAF and other DoD MTFs centralized managed care activities. Study information will be used to recommend actions for facilitating a Managed Care Activity at WHMC.

The study includes a review of current civilian and military literature delving into the aspects of managed care in today's healthcare arena to gain an understanding of the nature of managed care. The information on managed care activities at selected USAF and other DoD MTFs was collected through telephone interviews. All of the MTFs interviewed were actively involved with managed care operations through participation in a national managed care demonstration like the CHAMPUS Reform Initiative (CRI), the Catchment Area Management Project (CAM), or the Southeast Preferred Provider Project; or these facilities were conducting a managed care activity through their own planning and resources.

The conclusion is that the hospitals actively involved in managed care activities are able to document healthcare delivery cost control efficiencies. The scope of managed care activities, and size and structure of the interviewed MTFs managed care operations varied. The size of the managed care operations appeared to depend less on the size of the facility than on the commitment of the Chief Executive Officer and internal or external focus of managed care activities. The WHMC Administrator should start his centralized managed care activity with the appointment of an officer responsible for directing the activities of a WHMC Managed Care Implementation Group. This group, consisting of experts in marketing, special studies analysis, information systems, and medical resources utilization management, should provide the WHMC with a functional Managed Care Office within one year.

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I wish to thank the many individuals who assisted me in accomplishing this Graduate Management Project and my year long medical administrative residency at Wilford Hall USAF Medical Center (WHMC). First, thanks to Col Harold W. Grinstaff, the WHMC Administrator, for opening doors and providing support for a fruitful residency year. I also owe a great deal of gratitude to my preceptor, Col Charles R. Hardy who encouraged me to undertake this study and assisted with direction and patient consultation throughout my residency. To the Points of Contact at the various MTFs I telephonically interviewed, I feel indebted to their willingness to share insights into their managed care programs. I would also like to thank my Faculty Advisor, Maj Jack Neptune for his assistance and support.

ABSTRACT

**Study of Managed Care Activities in
USAF and Other DoD Medical Treatment Facilities**

Managed care activities in the Uniformed Health Services of the United States are becoming the primary strategy for controlling the rising costs of delivering quality healthcare services to its beneficiaries. A few USAF Medical Treatment Facilities (MTFs) have centralized their managed care activities in anticipation of balancing their limited budgets with the growing demand for quality healthcare services. The WHMC Administrator understands that the need of the catchment area beneficiaries will have to be balanced and controlled if quality care is to be kept accessible to these patients. He feels a managed care activity at WHMC is the best way to ensure appropriate accessibility to care is provided at the most efficient costs. Therefore, this study was initiated to identify and examine the existing scope and structures of USAF and other DoD MTFs centralized managed care activities. Study information will be used to recommend actions for facilitating a Managed Care Activity at WHMC.

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TABLE OF CONTENTS

PAGES

ACKNOWLEDGMENTS..... i

ABSTRACT..... ii

CHAPTER

I. INTRODUCTION..... 1

 Conditions Which Prompted the Study..... 3

 WHMC Background Information..... 3

 Wilford Hall USAF Medical Center (WHMC)..... 3

 WHMC Beneficiary Demographic Information..... 4

 WHMC Financial and Workload Data..... 4

 CHAMPUS Costs within the WHMC Area..... 5

 Current Managed Care Activities at WHMC..... 6

 Administrator's Interest in M/C Concept..... 10

 Management Problem/Question..... 11

 Literature Review..... 12

 Managed Care in the Civilian Sector..... 12

 Managed Care in the Military..... 16

 CHAMPUS Reform Initiative (CRI)..... 18

 Catchment Area Management (CAM) Project..... 18

 DoD Preferred Provider Organization Project..... 19

 Other Military Managed Care Initiatives..... 20

 Purpose..... 22

II. METHODOLOGY..... 23

 Selection of MTFs to be Included in Managed
 Care Analysis..... 24

 Beneficiary Demographic and CHAMPUS Expenditure Data.... 27

 Telephone Survey of Selected MTFs..... 29

 Expected Findings and Utility..... 35

III. RESULTS..... 36

"REPRODUCED AT GOVERNMENT EXPENSE"

IV. DISCUSSION.....40

 Description of Facilities Interviewed.....41

 MTF Managed Care Activities.....49

V. CONCLUSIONS AND RECOMMENDATIONS.....62

 Conclusions.....62

 Recommendations.....66

VI. REFERENCES.....68

LIST OF TABLES AND CHARTS

Chart - MTF Managed Care Activities Chart.....38

Table 1. Selected data on interviewed MTFs.....42

Table 2. Beneficiary Demographics for Catchment Areas.....45

Table 3. CHAMPUS Area Expenditures.....46

Table 4. Facilities as compared to WHMC.....48

Table 5. MTF Defined Managed Care.....49

Table 6. MTF Managed Care Activities.....51

Table 7. MTFs Office Size and Structure.....55

Table 8. Offices supporting M/C Activities with staff.....56

Table 9. Managed Care Reporting at MTFs.....58

Table 10. Expected Benefits from M/C Activities.....60

APPENDIX.....74

 A. Sample Telephone Interview Survey Form.....74

 B. Complete Telephone Interview Forms.....75

 C. Narrative Description of MTF M/C Activities.....91

**STUDY OF MANAGED CARE ACTIVITIES IN
USAF AND OTHER DOD MEDICAL TREATMENT FACILITIES**

INTRODUCTION

Managed care is one of the fastest growing cost and provider accessibility control systems in the U.S. healthcare delivery industry (Engoron & Stone, 1988). The rocketing growth of managed care, identified most often as Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), or any of a number of hybrids among these products, is in response to the soaring cost increases for healthcare (Lightfoot, 1988). National healthcare expenditures have risen from 9.1% of the gross national product (GNP) in 1985, to over 11% in 1988, and accounts for over \$600 billion of expenditures (Valliere, 1989). The future outlook for controlling healthcare expenditures in the U.S. is not bright as they are expected to continue rising to 15% of the GNP by the mid-1990s (Castro, 1988).

The massive Department of Defense (DoD) medical system is adversely affected by the rising costs in healthcare delivery. Military medical budgets are threatened continually with reductions or being held constant to control the costs of healthcare delivery. However, the number of beneficiaries to the DoD healthcare services appears to grow. It is becoming more difficult for these medical facility managers to balance static healthcare delivery budgets against a growing demand for services. Healthcare services to the beneficiaries of the U.S. military are provided by two distinctive

methods. One is the direct medical care system known as the Military Health Services System, consisting of approximately 168 hospitals and over 580 medical clinics (Gapen, 1990). The second DoD method of providing medical benefits is through the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). CHAMPUS was designed to supplement the direct care system and provide an entitlement to other than active duty beneficiaries located in areas not in proximity to a military health care facility (Torrens, 1978).

The costs for CHAMPUS have grown at an annual rate of 18% over the last 5 years and there is great concern over its continued rise and the subsequent negative impact upon the Uniformed Services Medical Systems Budget (C. J. Pool, personal communication, 8 February 1990). During fiscal year 1988, the CHAMPUS portion of this medical benefits system experienced a \$645 million budget funding shortfall to cover civilian healthcare expenses ('DoD health budget,' 1988). Because of the shortfall, the individual services of the DoD were forced to find a means of reprogramming funds from other military service programs to cover this budget deficit. The reprogramming action may have jeopardized the willingness of the military medical service's line counterparts to support future growth in medical activities.

The military medical service leadership is also becoming anxious over mission financing with the advent of changing political structures and the lessening of perceived threats in today's world. There is little optimism that the Military Health Services System

budget will be sufficiently funded to accomplish its total healthcare mission in the upcoming years. This forces the military medical services to search for opportunities to manage its costs and health care expenditures. Local MTF administrative and medical staffs must become proactive in developing activities directed at the effective management of deflating medical budgets. These activities should be based on managed care concepts which are designed to ensure that healthcare is made readily available to the patient, that the care provided is appropriate and necessary when delivered, and that it is delivered in the most cost efficient means. The Wilford Hall USAF Medical Center (WHMC) Administrator is acutely aware of the pressures to control health care costs and the need to explore innovative management technologies that ensure efficient and effective management of funds for its future healthcare services. To accomplish this at WHMC, the Administrator is actively investigating the merits and potential for a centralized managed care office.

Conditions Which Prompted the Study

Wilford Hall USAF Medical Center Background Information.

Wilford Hall USAF Medical Center (WHMC).

Wilford Hall USAF Medical Center (WHMC) is the Air Force's largest medical treatment facility with a building configuration for 1009 beds. The facility currently has an operating bed capacity of 818. It is one of the Air Force's only tertiary care medical centers, and has over 4,000 civilian and military personnel supporting its four-fold mission of medical treatment, readiness,

medical/dental post graduate education, and clinical investigations. The beneficiaries of WHMC are provided with access to more than 135 clinical specialties and subspecialties (WHMC/SGPA, 1989).

WHMC Beneficiary Demographic Information.

WHMC serves a beneficiary population of approximately 86,180 of which 22,881 are active duty, 15,378 are retired military, and 47,921 are dependents (DMIS, 1989). This number is not entirely accurate as a major portion of the WHMC assigned patient catchment area overlaps the patient catchment area of Brooke Army Medical Center (BAMC), a U.S. Army Medical Center also located in San Antonio. The BAMC beneficiaries include another 92,609 within the San Antonio area (DMIS, 1989), which brings the total beneficiary population within this area to greater than 178,000. This number of potential beneficiaries grows even greater considering WHMC serves as a specialty referral center for Air Force Facilities throughout the world and annually receives an additional 13,000 patients through the Aeromedical Evacuation System (WHMC/SGM, 1989a).

WHMC Financial and Workload Data.

WHMC's Operating and Maintenance Budget for Fiscal Year 1989 was \$35.5 million and its current FY 90 budget is set at \$80.9 million with a projected budget shortfall of \$18 million (WHMC/SGM, 1989a). This shortfall will have a definite negative impact on the facility and its ability to effectively carry out its mission.

Each month, there are approximately 2,050 patients admitted to the facility, over 76,000 outpatient visits, 602,000 laboratory

tests, 165,000 prescriptions filled, 46,000 X-Rays taken, and almost 1300 surgeries performed (WHMC/SGM, 1989a). These workload figures are indicative of a facility trying to manage an extremely heavy healthcare responsibility for the beneficiaries in the San Antonio area and throughout the world . However, this workload cannot continue without either funding the current budget shortfall or developing new cost effective and cost efficient methods of delivering healthcare.

CHAMPUS Costs within the WHMC Area.

Within the WHMC catchment area CHAMPUS expenditures are almost \$40 million per year (CHAMPUS, 1990a & b). WHMC's share of this expense is approximately \$14 million, and over the last three years the average increase in CHAMPUS expenditures for both inpatient and outpatient care has been over 25% (WHMC/SGARH, 1990a). This is a larger increase than the CHAMPUS national growth figure of 18% mentioned in the Introduction of this paper. The higher than national percentage increase may be due to the number and age distribution of the beneficiaries in the WHMC catchment area. However, these CHAMPUS expenditures, make CHAMPUS covered patients in the San Antonio area major consumers of civilian healthcare services. That status should provide market clout for military medical managers to successfully implement managed care initiatives designed to control utilization and produce healthcare delivery cost efficiencies.

Current Managed Care Activities at WHMC.

WHMC is currently conducting a number of military managed care activities through the Health Benefits Advice Office (HBA) and the Resource Management Office. These activities are not indigenous to Wilford Hall but were directed by the DoD or Air Force for implementation at local MTFs. These managed care programs include the Health Care Finder Program (HCF), Partnership Program, and the Veterans Administration/DoD Sharing Agreement Program (VA/DoD Sharing).

Health Care Finder (HCF) Program.

The HCF Program is designed to grant military medical treatment facilities permission to negotiate with local civilian practitioners for a discounted charge for services to CHAMPUS eligible patients. In return, patients requesting assistance in locating a civilian healthcare provider are given a list of the participating practitioners who agree to discount charges and/or to waive the beneficiary's deductible payments for care received (Headquarters AFOMS, 1990).

WHMC has an industrious HCF Program with almost 110 active agreements, and another 100 agreements pending processing of final documentation. A review of WHMC's HCF agreements showed the average fee to be charged by a WHMC HCF provider is 86% of the CHAMPUS allowable charges (WHMC/SGARH, 1990b). However, the WHMC HBA Office does not have sufficient personnel to audit charges for care sought to ensure the government is getting the agreed upon discount; nor has

the facility evaluated particular specialty needs to target their HCF efforts (Bunker, 1990). Therefore, WHMC has no meaningful HCF management measures to evaluate the effectiveness of their HCF Program (Bunker, 1990).

Partnership Program.

The Partnership Programs were established to provide DoD healthcare beneficiaries with more access to providers of care. It accomplishes this through agreements with civilian practitioners who come into the MTF to treat non-active duty beneficiaries (Internal Partnership), or who treat these patients outside the MTF (External Partnership). In the Internal Partnership, the civilian provider is given office space and resources to see patients, thus expanding accessibility to care for the eligible beneficiary population (WHMC/SGARH, 1989a). In return, the practitioner bills a discounted charge for his/her services to the CHAMPUS Program (K. M. Lofgren, personal communication, 15 Feb 1990).

WHMC has been very active in the Internal Partnership Program but not the External Partnership Program. Discounts from WHMC partners have averaged approximately 70% of the CHAMPUS allowable charges for care received within this catchment area (WHMC/SGARH, 1989b). The HBA personnel have done an excellent job of recruiting civilian provider participants, and the facility attempts to contract professional services which are identified as needed by the Ambulatory Care Service Department (TSgt Lofgren, personal communication, 15 Feb 90).

Partnerships at WHMC fall into 10 specialty areas and currently involve 26 local practitioners (WHMC/SGARH, 1989a). These partnerships are producing approximately 4,100 additional outpatient visits per month in the Primary Care Clinic alone at WHMC. This is a positive trend in access for our patient population, but the overall costs to the CHAMPUS continues to show increases. Even though the Internal Partnership Program produces a cost avoidance of 30% of normal charges for healthcare services rendered through the partners, the increase in volume of patients being treated at WHMC raises the gross expenditures for the CHAMPUS Program. Ancillary service areas were not bolstered with expanded budgets for supplies, nor were extra personnel planned to support the additional workload to be produced by the Partnerships. Therefore, in addition to the overall CHAMPUS Program cost increase, WHMC experienced difficulties with supply budgets and personnel morale because of the additional work burden without additional support. In an interview with Chief Master Sergeant W. H. Fugate, Superintendent of Department of Pathology, the Chief expressed his concern that because of the increase in workload and the pressure upon his technician staff to perform additional lab tests without a matching manpower supplement, the Clinical Lab is experiencing a much higher turnover (voluntary separation) of experienced enlisted staff.

VA/DoD Sharing Agreements.

WHMC has also been active in developing and implementing sharing agreements with the Audie L. Murphy Veteran's Administration Memorial

Hospital in San Antonio, Texas. There are currently five major sharing agreements covering blood donor activities, lithotripsy treatment, OB-Gyn surgical services, research protocol support, and a vital agreement to provide services in the event of a disaster or loss of service at one or the other facility. The VA/DoD Sharing Agreements are managed by the Resource Management Directorate (SGM) at WHMC. SGM negotiates the needed services and their reimbursement rates, and maintains records on the cost avoidance from receiving the services through the VA Healthcare System rather than purchasing the services in the private healthcare sector. During the fiscal year 1989, Wilford Hall was able to offset over \$1.3 million of healthcare costs through VA/DoD Sharing Agreements (WHMC/SGM, 1989b).

The VA/DoD Sharing Program is a very active and beneficial program, however, there are a few negative aspects to it. One negative aspect is that the Resource Management Office (SGM) does not proactively investigate new resource sharing strategies. The VA/DoD Sharing Agreement Program was mandated by a DoD and Headquarters USAF/SG but is not supported with any additional manpower to operate the program. Therefore, the sharing agreement opportunities are often stumbled upon or action is requested by a functional area that identifies potential benefits from a VA/DoD sharing agreement. Also SGM negotiates the sharing agreements as an additional duty, not a primary function. It is generally accepted that the negotiations could prove more beneficial to the facility with a professional staff dedicated and trained for this area.

Administrator's Interest in Managed Care Concept.

The administrator of WHMC has closely followed the DoD initiatives and concepts of managed care and how the different functions of this healthcare management technology are being utilized to control healthcare expenditures. He is very interested in designing a centralized and integrated system to monitor and manage the delivery of healthcare services in the WHMC area that will maximize the value of the DoD healthcare dollars and minimize any burdens on beneficiaries (H. W. Grinstaff, personal communication, 7 January 1990). His interest in the development of a managed care function within the Medical Center has been stymied by the lack of funds needed to establish a centralized managed care operation. However, opportunities for new local healthcare cost control initiatives are growing and the Administrator feels the time is right for studying and initiating a central managed care function at WHMC.

Before centralizing the managed care activities at WHMC, the Administrator has requested a comprehensive survey to examine the various structures (reporting chain alignments) and sizes (staff size and scope of responsibilities) of differing USAF Medical Treatment Facility's managed care activities. The completed survey is expected to indicate what MTFs with centralized managed care offices are doing to control healthcare spending, the extent of managed care functions that are beneficial and effectively operating at the MTFs, and the most suitable reporting alignment that allows appropriate facility responsiveness to the needs of patients. In a personal interview

with Col Grinstaff, WHMC Administrator, it was learned that his vision for a future managed care function at WHMC calls for a centralized office function that can monitor the local healthcare market, assess the healthcare needs of the catchment area, and serve as a central referral appointment center for all beneficiaries in the San Antonio Area. The ultimate mission of managed care at WHMC would be to insure appropriate levels of quality care is made accessible to WHMC beneficiaries, that the care rendered is necessary for the patients health status, and the care is provided through the most cost efficient means whether within the direct military healthcare system or from a civilian source.

Management Problem/Question

What are the characteristics of successful managed care activities in the USAF and other DoD MTFs? Exploration of these characteristics will be beneficial to the Administrator of WHMC who would like to plan and organize a centralized managed care activity for his facility.

Characteristics of successful managed care activities in the question refer to the scope (range and/or number) of managed care functions being operated successfully in DoD MTFs. Successfully managed care activities in this study will be considered to be a subjective determination by the individual unit conducting the activity, or a higher echelon of the corporate management, that the studied activities are accomplishing the objectives they were designed to meet. These objectives are generalized as being

increased access to healthcare by beneficiaries, control of government spending for the delivery of healthcare through the MTF, or a combination of these two perceived or documented benefits.

The information gathered from exploring managed care activities in the MTFs will be used to profile successful managed care activities. Various aspects of the managed care activities profile can then be examined for applicability to WHMC and its healthcare operations. Managed care functions or activities deemed most applicable to WHMC by the researcher will be included in a recommendation for a possible managed care office at WHMC. The Administrator can use this recommendation to start planning a centralized managed care operation that will insure WHMC beneficiaries receive appropriate and high quality healthcare, at the most cost efficient means using an optimal combination of services through the direct care system, CHAMPUS, and the DoD/VA Sharing.

Literature Review

Managed Care in the Civilian Sector.

Managed care is loosely defined as an arrangement in which a third party directs patient access and utilization of health care (Flores, 1987). The purpose of managed care systems or programs is to make the costs of health care both reasonable and predictable. These programs strive to insure patient access to qualified physicians and other healthcare professionals when needed by their enrollees. The managed care organizations attempt to control the costs of healthcare by keeping its members healthy through early

detection and prompt treatment of illnesses and provide needed care through participating healthcare providers (Gumbiner, 1975).

The current trend of growth in managed care organizations began in the 1970's when industry took notice that the increase in healthcare costs started cutting deeply into their profits (Engoron & Stone, 1988). Then in the 1980's voluntary hospitals and privately practicing physicians in the U.S. were literally forcing a seemingly inexhaustible funding from employers, employees and government. This skyrocketing rise in the cost of healthcare, having become too burdensome, led businesses and industry to support and develop the health agencies called HMOs (Anderson, Herold, Butler, Kohrman, & Morrison, 1985).

Managed care in the United States had its beginnings in the 1920s when two doctors contracted with the city of Los Angeles, California, to provide healthcare to certain city employees for a predetermined fee (Jonas, 1986). Soon afterward major employers were paying to have healthcare plans organized for their workers. In 1973 the United States Government introduced a policy for Health Maintenance Organizations (HMO) and Pre-paid Health Plans by enacting the first HMO Act (P.L. 93-222), which authorized \$325 million over 5 years for grants and loans to help managed care organizations get under way (Jonas, 1986).

A Health Maintenance Organization is a formally organized system of health care delivery that combines delivery and financing functions and provides comprehensive services to an enrolled

membership, for a fixed, prepaid fee (Zelten, 1979). The methods employed by HMOs and other managed care operations are utilization management, membership enrollment, pre-negotiated provider charges, and referral networking. HMOs are generally classified into one of four different types (Fox & Heinen, 1987): Staff HMOs are organizations in which the providers are employees of the HMO. Group HMOs are those in which physicians are contracted to be participating providers at a negotiated capitation, or fixed sum per enrollee per month. Independent Practice Associations (IPAs) are those where the HMO contracts solo physicians and small specialty groups. The final type of HMO is a Network HMO which resembles Group Model HMOs, except the Network HMO contracts with more than one independent group practice.

Managed care in the form of HMOs began its most active period of growth after the 1973 HMO Act. Prior to 1973 there were only 30 HMOs serving about 3,000,000 enrollees throughout the U.S. (Ireland, 1988). By 1988, the number of HMOs climbed to 650 serving over 30,000,000 members, which equates to approximately 12% of the population in the United States (Ireland, 1988). The phenomenal increase of this type of managed care activity is expected to continue throughout the 1990s. Whereas the fee-for-service healthcare delivery system constituted about 95% of health care delivery during the 1980s, the pattern is expected to flipflop by the end of the 1990s, to 95% managed care (Lightfoot, 1988).

HMOs have moved from passive indemnity insurance plans to active

participation in the structuring and delivery of healthcare. The common characteristic of today's managed care programs is control: control of utilization, provider participation, and the price of care (McDermott, 1988). These control activities have become necessary in all sectors of the healthcare market in order to curb the rapid rise in national spending for healthcare services. In this regard, the U.S. Government, through the Health Care Financing Administration (HCFA), has taken steps to cap the spending in Medicare Part B expenditures (Robinson, 1989). The HCFA selected five Preferred Provider Organizations to participate in a national demonstration project to use utilization review tools to control healthcare expenditures (Robinson, 1989).

Relevant studies on the features of successful HMOs are not in abundant supply. However, a study commissioned by the Office of Health Maintenance Organizations in the U.S. Department of Health and Human Services to examine the essential qualities commonly shared by successful HMOs. This study found that the most important factors common to successful HMOs was their ability to determine what the customer's preferences were and adapting the corporation's services to meet these preferences, utilization management activities (prior hospitalization authorization, case management, etc.), and varying payment systems (Fox & Heinen, 1987). Therefore, success of managed care activities in the private sector should be measured through evaluation of the scope of healthcare coverage to beneficiaries, the number of enrollees in the HMO plan, enrollee (customer)

satisfaction, quality assurance, information systems, disease detection, financial assurance, and the organization's commitment to education (Sorrenti, 1988). Not all of these measuring methods are conducive to an examination of the military managed care activities; however, it is felt, by this novice researcher that an interview survey instrument can be developed to ascertain the important aspects of size (beneficiary demographics), scope of military managed care activities (number of MTF managed care functions), and the organization's financial assurance as it relates to the cost efficiencies manifested from these activities (savings generated by these activities).

Managed Care in the Military.

There is a proliferation of information on managed care technologies, operations and activities conducted in the civilian healthcare delivery systems that can be found in professional journals. However, literature on military managed care technologies in these same journals is sparse. This is unfortunate since it is obvious that the DoD Military Medical System is currently testing many managed care technologies and practices. The massive size of the DoD Medical System and its level of spending on healthcare delivery seemingly mandate the pursuit of managed care activities.

The DoD Medical Services System makes up about 4% of the healthcare delivered in the US (Jonas, 1986), and is funded through Congress from taxes supported by the American citizenry. This funding process places pressure on the massive DoD healthcare systems

to control the costs of its various medical programs.

As mentioned previously, healthcare in the military is usually provided by one of two methods, the direct care military medical treatment facility and the CHAMPUS program. The second system, the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) was originally designed as a supplement to the direct care system, increasing the entitlement for healthcare to other than active duty beneficiaries, but costs in this program have grown apace in recent years (Headquarters TAC, 1989). Between fiscal years 1985 and 1987, CHAMPUS costs rose from \$1.4 billion to \$2.1 billion or a 50% increase in federal spending for this intended supplemental coverage (United States General Accounting Office Report, 1989). In fact, CHAMPUS expenditures are nosing up to one-half the total cost of medical care provided in military direct care system: \$7.4 billion in military facilities in 1989 versus almost \$3 billion in CHAMPUS expenditures for the same period (Pool, 1990). Because of the considerable increases in CHAMPUS expenditures, the Office of the Assistant Secretary of Defense for Health Affairs commissioned the DoD to develop innovative programs and get the rising costs of providing healthcare in the military system under control. This action resulted in three major managed care initiatives: the CHAMPUS Reform Initiative, the Catchment Area Management Project, and the Southeast Fiscal Intermediary Preferred Provider Program.

Champus Reform Initiative (CRI).

The CHAMPUS Reform Initiative provides for a contracted civilian agency to manage and control the rising cost of delivering healthcare to CHAMPUS beneficiaries (Tomich, 1988). This initiative incorporates many managed care features, including a fixed price contract with risk sharing provisions, preferred provider network service (CHAMPUS Extra) and a HMO (CHAMPUS Prime). It also provides for resource sharing between the contractor and the local MTFs. This resource sharing is intended to bolster support staffs in the MTFs, when such action reduces CHAMPUS cost, or expands utilization management and quality assurance (OASD/HA, 1988). The Rand Corporation evaluated the CRI project after one year of operation. This preliminary evaluation found that, although the CRI experienced a rocky beginning, healthcare costs are running substantially below costs in other areas (Hosek, et.al., 1990).

Catchment Area Management (CAM) Project.

The second major health care cost control initiative for the Department of Defense is called the Catchment Area Management (CAM) Project. CAM is designed to contain the rapidly rising CHAMPUS expenditures within local MTF catchment areas while maintaining or improving accessibility, patient/staff satisfaction, and health care quality. To accomplish this, the MTF Commander is entrusted with the necessary resources and authority to manage both the delivery of health care services in the MTF, as well as control over the delivery of civilian healthcare services through CHAMPUS (Miller, 1989). The

CAM Project features networks of both direct care providers and ancillary services, an enrollment function, utilization management mechanisms to pre-authorize care, case management, retrospective review of individual cases and utilization patterns, a claims management function, and an information systems component (Headquarters TAC, 1989). The CAM programs are so newly operationalized that no formal evaluation has been accomplished on their success or failure.

DoD Preferred Provider Organization (PPO) Project.

The last major program being tested by DoD is the CHAMPUS Fiscal Intermediary-Preferred Provider Organization Demonstration (FI-PPO). The test site for the FI-PPO is the Southeast section of the United States, primarily Florida and Georgia. The National Defense Authorization Act for fiscal years 1988 and 1989 directed the modification of contracts with existing CHAMPUS Fiscal Intermediaries (FIs) to test the cost containment and cost reduction effects of delivering quality healthcare to CHAMPUS beneficiaries through managed care networks (OASD/HA, 1989). This program incorporates cost-containment features such as utilization review, preadmission screening, and contracting for care on a discounted basis, while supporting the military MTF commander's desire to maintain workload. The PPO Project is designed primarily to direct participating patients to a provider network and utilization review to avoid unnecessary inpatient care ('CHAMPUS PPO,' 1988).

Other Military Managed Care Initiatives.

The major DoD managed care initiatives have directed the course of future Uniformed Services healthcare management toward innovative programs to control the costs of delivering healthcare services. Each of the three services have developed central offices for implementing and monitoring the effects of these managed care initiatives. The Army established the Military-Civilian Health Services System at Headquarters Health Services Command, the Navy created the Alternative Healthcare Branch in Washington DC, and the Air Force has assigned this responsibility to the Deputy Chief of Patient Administration Division, Air Force Office of the Medical Services (AFOMS).

The DoD has also designed a means to grant project monies for smaller scale cost control projects to MTFs that develop innovative management initiatives aimed at the recapturing of CHAMPUS workload or reducing the overall government cost in healthcare. The Alternative Use of CHAMPUS Funds Program, as it is called, provides CHAMPUS money to facilities that plan new or expanded services to be offered to CHAMPUS eligible beneficiaries at the local MTF. The USAF has expanded this program and will provide seed money for local managed care projects with potential to allow more effective and efficient use of Air Force healthcare funds. This Air Force Program is called the Management Efficiencies Add Program. Wright-Patterson USAF Medical Center (WPMC) has already taken advantage of this program, and will receive over \$700,000 of funding for a 3-year

managed care project (Headquarters USAF/SGH, 1989). The Wright-Patterson project expects to set up a psuedo-CAM Office Infrastructure to control local healthcare costs. WPMC is also creating a data processing system designed to provide vital cost and healthcare delivery service management information. The type of information processing being designed is intended to support management decisions for the managed care programs already operational at most MTF's in the U.S. today (HCF, Partnership Program, VA-Dod Sharing). The WPMC project is barely one year into its operation, but the Wright-Patterson executive staff is optimistic about the success of their venture (Wright-Patterson Managed Care Project Proposal, 1988).

The USAF Surgeon's Office is still soliciting managed care project proposals to assist in curbing the costs of delivering healthcare to its beneficiary population, especially those designed to control the rapid rise of CHAMPUS costs (Headquarters USAF/SG Ltr, 1989). With the existence and availability of these funding programs, the WHMC/Administrator has challenged his staff to discover new and innovative ways to develop managed care concepts. The WHMC Administrator's desire to centralize managed care efforts and to provide the most cost efficient healthcare to the WHMC beneficiaries now has a potential avenue available to drive a managed care plan to reality. Therefore, a study to help identify the size and structure of such a managed care function is thought to be both timely and necessary.

Purpose

The purpose of this study is to explore (through a telephone interview) and describe the characteristics of successful managed care activities in USAF and other DoD MTFs. This study is based on the presumption that a comprehensive analysis of managed care activities in military MTFs will provide beneficial direction to Wilford Hall USAF Medical Center in establishing a centralized managed care activities office.

Mr. Jeffrey Bauer, a senior research associate at University of Colorado's Graduate School of Business in Denver, was interviewed by the Healthcare Forum Journal on the future of healthcare services. In the interview he indicated that the most successful people in future healthcare will be those who are creative and open to different ways of doing things (Goman, 1988). Mr. Bauer also talked about managed care and he believes that there are so many alternative ways of setting up a managed care function that 'the one right way' just doesn't exist (Goman, 1988).

There is truly 'no one right way to set up a managed care function' in the DoD. The Uniformed Services are currently testing several different approaches to managed care in various military treatment facilities. The intent of this paper is to identify and examine the various Air Force and other military MTF approaches to centralized managed care operations. The findings of this study will be compiled into a MTF Managed Care Operations Chart. Then, with the observations from this chart, recommendations for implementation of

managed care activities at WHMC will be presented to assist the WHMC Administrator in meeting the needs of WHMC and its beneficiary population.

METHODOLOGY

Certain USAF MTFs are to be selected and surveyed to examine their managed care activities. Information on each of the MTF's managed care activities will be obtained through a telephonic interview with the selected MTF's Administrator or an individual the Administrator appoints as a point of contact for the survey. However, the Administrator of each facility will be contacted to advise him/her of the project and its purpose, and to solicit support in obtaining accurate information. Each interview will be conducted to assess the facility size and the scope of managed care activities the MTF is conducting in addition to the size of each facility's managed care office staff and the reporting alignment of this office. The facility's definition of managed care, and the benefits the organization expects to derive from its managed care activities will also be ascertained. The surveying researcher will also assess the opportunities for managed care programs at each of the surveyed facilities according to the beneficiary demographics and CHAMPUS expenditures in their catchment areas. The beneficiary demographic information and CHAMPUS expenditures will be obtained from appropriate DoD or USAF agencies. This information will be used to profile the USAF facilities operating managed care offices. The profile will then be prepared, examined and recommendations made to

the Administrator. With the managed care profile the WHMC Administrator will gain an understanding of what managed care activities in the USAF are successful and the recommendations for a managed care activity will assist him in initiating action for a centralized managed care office.

WHMC is much different from any other USAF MTF due to its size and range of healthcare services available to its beneficiary population. Because of this, the researcher will also attempt to locate other DoD MTFs, outside the USAF, comparable to WHMC in size for interviewing. A MTF from each service, the Army and Navy, will be sought for interview and the same comparisons as the USAF MTFs with WHMC will be attempted with these other DoD facilities. The search for an Army and Navy MTF will commence by calling the largest facilities (Walter Reed Army Medical Center and Bethesda Naval Medical Center) to determine if they have centralized managed care activities. According to the DMIS Medical Information Summary of 1988, these are the facilities most like WHMC in size and mission. If these facilities do not have a centralized managed care activity, then the researcher will seek the advice of the point of contact to determine a suitable facility to be interviewed.

Selection of MTFs to be Included in Managed Care Analysis

The selection process will commence with consultation of Major Bill Fredericks, AFOMS/SGAR, the officer in charge of managed care innovations in the USAF. With his help, a list of five or six USAF MTFs that are reporting successful managed care operations will be

established. The facilities list will be presented to Col Hardy, WHMC Director of Resource Management, the researcher's preceptor, for his concurrence of the facility selected and approval to interview. Successful managed care operations were previously defined in the Management Question section. These programs usually have documented their success in expanding healthcare access to beneficiaries or reducing the local healthcare delivery cost through the efforts of a centralized managed care function. Major Fredericks, as the Air Force focal point for managed care programs, will have the information available to identify those MTFs that best meet this definition.

The five or six USAF MTFs chosen to be examined and surveyed will represent approximately 10% of the USAF MTFs in the U.S. operating at least 20 beds. The facilities will be selected according to their size, the scope of managed care functions the facility is currently conducting, and/or the facility's participation in one of the major managed care initiatives being tested by the DoD.

Facility Size: Consideration for likeness in size to WHMC will be one criteria for selection of an MTF to be surveyed. Although selection of comparable size facilities to WHMC are seemingly impossible, since WHMC is by far the largest USAF MTF, the selection will be based on the facility's number of Full Time Equivalent (FTE) employees. A useful classification for size of organizations has been established by the Office of Management and Budget (OMB). The OMB classifies small organizations as having 20-99 FTEs, a medium

organization as having 100-499 FTEs, and large organizations as have 500 or more FTEs (OMB, 1982, as cited in Anselman, 1990). According to this classification, WHMC is a large organization; therefore, strong consideration for selecting at least one large MTF for surveying will be given in the selection process. However, MTFs from the Army and Navy will sought for interview to ensure a comparable size of MTF is examined.

Scope of Managed Care Functions: Facilities demonstrating a greater willingness to devote resources to managed care activities will be sought. Those facilities with the greatest number of managed care functions (utilization management, VA/DoD Sharing agreements, HCF Program, etc.) under a centralized office will be useful candidates for this survey. Major Fredericks' professional opinion will be sought in determining which of the Air Force facilities are the most active in the various managed care functions. Assistance in identifying MTFs outside the USAF are most active in managed care activities will be sought from the Medical Administrative Residents located at Walter Reed Army Medical Center and the Naval Hospital San Diego.

Participation in DoD sponsored Managed Care Initiatives:

One of the aims of the selection process will be to survey USAF MTFs participating in any one of the 3 major DoD managed care tests (CRI, CAM, FY PPO). Therefore, any MTF on the initial list which is participating in one of these three programs, even if it does not meet the other two criteria, may be selected. This will provide the

opportunity to observe what managed care office operations the DoD is supporting through its managed care initiatives.

The objective of the MTF selection process is to choose a combination of USAF and other DoD MTFs that will present an overview of how the various Air Force MTFs are organizing and operating their managed care functions. Differing size facilities will be included in the analysis to ensure that the innovative approaches to managed care activities being operated throughout the Air Force are studied. The examination of all levels of military managed care activities will be analyzed for and comments made about the various activity's applicability in a WHMC managed care environment.

MTF data to be analyzed on the selected facilities will be gathered in two ways. The researcher will request beneficiary demographics and CHAMPUS catchment area expenditure data from the appropriate governmental agencies. Other specific MTF managed care data will be obtained through a telephonic interview (survey) between the researcher and the Administrator of that facility or a point of contact selected by the Administrator. An example of the telephone interview format has already been determined and is contained in Appendix A. Each question on the survey format identifies a managed care data aspect to be used in the DoD Managed Care Activities analysis.

Beneficiary Demographic and CHAMPUS Expenditure Data

These two areas of data will be obtained to determine the potential opportunity for managed care within the catchment areas.

First, beneficiary demographic data will be requested from the Defense Medical Systems Support Center's Defense Medical Information System. The demographic data requested will be listed by category of beneficiaries (active duty, retired, dependent, etc.) within the different catchment areas. From this data, the number of beneficiaries within the catchment area and eligible to utilize the CHAMPUS program will be identified. The size of the CHAMPUS eligible beneficiary population will be compared between facilities to determine whether the MTFs have similar size beneficiary populations or if these populations vary.

CHAMPUS expenditures for the catchment area of each MTF to be surveyed will be obtained from the CHAMPUS Workload Summary Reports for the 1989 Fiscal Year. These reports are available through the OCHAMPUS Office, Denver, Colorado (CHAMPUS, 1989). CHAMPUS expenditures will be examined to determine which areas are experiencing the greatest spending in this supplemental program which has become such a financial concern. Again, the figures will be measured to determine if these successfully operated managed care offices have similar CHAMPUS expenditures.

The demographic and expenditure data will be identified in the USAF Managed Care Operations Chart to indicate the opportunity for managed care activities. An assumption made at this time is that the higher the number of CHAMPUS beneficiaries and the greater the CHAMPUS expenditures in a MTF's catchment area, then the more active the MTF should be in managed care operations. The activity of MTFs in

managed care operations refers to the number of managed care functions the facility is controlling under a central managed care office.

Telephone Survey of Selected MTFs

A telephone survey has been developed to identify the size of each surveyed facility, its mission statement, the MTF's definition of managed care, its managed care office size (number of FTEs and grade span of the positions), the reporting alignment of the managed care office, the number and extent of managed care activities being conducted, and the expected benefits the facility hopes to gain from these cost and utilization controls. This data will identify the range of military managed care activities in the selected military MTFs and will be analyzed to assess the applicability of the various MTF managed care operations for implementation at WHMC.

The survey will be conducted by the researcher with the point of contact at each facility. The information obtained on each facility surveyed, will be placed on a MTF Managed Care Operations Chart to help with the researcher's analysis and discussion. As a product of the analysis findings, the researcher will provide recommendations for the WHMC Administrator on implementing a possible managed care operations design and structure. The researcher's analysis and discussion of the USAF Managed Care Operations Chart will be reviewed by Col Hardy, as the researcher's preceptor, to validate the findings and approve the recommendation to be forwarded to the WHMC Administrator.

Description of Facilities.

Both the size and mission of the facilities being surveyed are important factors to be identified in this analysis of managed care. The facility's size will be based upon the number of active beds the facility is currently operating, the number of its Full Time Equivalents (military and civilian), number of patient bed days the facility has provided during the fiscal year 1989, and the number of outpatient visits conducted by the facility during the same year. This information will indicate the capabilities and productivity of the facilities being surveyed. It will identify the similarities and differences between the facilities according to their resources' availability and utilization. In discussing the differences between the facilities, this information may be used to suggest what type/size facilities are best suited for managed care activities when reviewing with the remainder of the information to be displayed on the chart.

The mission of the MTF will also be considered in order to ascertain what the unit's duty to the community and its beneficiaries is. The mission of an MTF is normally assigned to the facility by the Air Force at the time of opening; however, adjustments for the benefit of the local community's healthcare or for any special needs to support the base mission can be made by the MTF Commander. The MTFs' missions will be discussed in order to identify the uniformity of each MTF in its daily responsibility to conduct healthcare services for the overall USAF medical service mission. It will also

be evaluated to determine how similar it is to WHMC's mission. The WHMC mission, as stated earlier, is a four-fold mission of medical treatment, readiness, professional training, and clinical investigation. It is anticipated that most of the facilities interviewed will have at least 3 of these 4 missions.

Facility's Definition of Managed Care.

The surveyed MTF's definition of managed care will be requested to compare how each MTF views its managed care mission. Each facility may have a particular definition of managed care as it relates to its own activities. Some facilities may not yet have identified its objectives concerning its managed care endeavors. It will be interesting to see how closely these definitions match the DoD definition of managed care, which is, 'an integrated system of incentives, checks and balances on a healthcare system to maximize the value of health care dollars and minimize the burden on its beneficiaries' (Fant, 1990).

Once the definitions are obtained, some insight may be gained into various approaches to control the local delivery and costs of USAF healthcare. A subjective analysis by the researcher pertaining to each MTF's definition will be made to determine if the facility's managed care office is adequate to meet the requirements of its managed care definition. Information for this survey area of the USAF Managed Care Operations Chart will merely signify whether the facility has a definition for its managed care activities or not.

Size and Structure of Managed Care Office.

The size and structure of the managed care functions will be assessed to determine the degree of support the MTF's executive staffs are providing their managed care mission. The size will be a reflection of the resources the facility has dedicated to conduct the managed care functions. It will be measured specifically through the number of FTEs (civilian and military) or personnel assigned full time and part time by the facility to its managed care work station and the grade span of these managed care positions.

The structure in this analysis is defined as the reporting alignment of the managed care office. What level the managed care office reports to in the hierarchy of the facility's executive management is important when considering the type of recommendations for change to the facility's services that may be suggested by this office. The closer to the commander of the facility the Managed Care Office reports, will be considered the higher degree of importance placed on this function.

MTF Managed Care Activities.

The number and extent of managed care activities that the interviewed MTFs are conducting will be one of the most important comparisons performed. This comparison will identify what managed care functions are being conducted by the selected MTFs and how committed they are to each of these activities. These activities will be measured first according to the number of different managed care programs/activities utilized to expand healthcare services to

its beneficiaries, or providing that healthcare at the most cost efficient means to the government. The types of managed care activities each selected facility is involved with are:

-Health Care Finders/Preferred Provider Networks - any referral networking to civilian providers who have agreed to a prenegotiated discount for healthcare services they deliver.

-VA/DoD Sharing - the facility's participation in sharing services or resources with the Veterans Administration Hospitals for more efficient management of healthcare costs to the government.

-Utilization Management - utilization management will be any of the types of activities designed to control costs or services such as case management, discharge planning, concurrent review, and preadmission approval process.

-Partnerships - the delivery of care by civilian providers in the MTF (Internal Partnerships) for favorable discounts to the CHAMPUS program, or care provided to DoD healthcare beneficiaries by a uniformed service provider in a civilian facility (External Partnerships).

-Any Other Managed Care Activities - any innovative healthcare management policy/procedure being conducted by the MTF and designed to provide quality service to the beneficiaries at the most cost effective means to the government.

The next measurement of MTF managed care operations will be the extent to which these facilities are involved with these activities. The extent of involvement will be identified in two ways: mere

participation in managed care activities or active management of these functions. Participation, the first classification, is defined as the involvement of the facility with managed care functions primarily because a higher echelon of management has dictated that the facility will have that managed care function. For instance, an MTF may be participating in the Internal Partnership Program to the extent that it has negotiated with civilian providers, and these civilian provider partners are seeing patients in the MTF. However, the MTF may not be measuring the impact of the partnership on costs and access nor is it utilizing this type of information to determine which partners should continue participating and which partnerships should be ended. There is no active management of the managed care activity.

In the second classification of extent of MTF managed care involvement, active management of the managed care programs/activities is pursued. Active management will be defined as participation in the particular managed care activities along with periodic internal reports and reviews that have been established to monitor the functions and alter their directions, if needed. This information will be obtained by the researcher during the facility survey.

Expected Benefits from Managed Care Activities.

Each MTF interviewed will be asked to briefly comment on the benefits projected from their managed care activities. These expected benefits can be stated in terms of increased accessibility

to patients, cost savings/cost avoidance to the US Government financing of healthcare, or in terms of satisfaction to either healthcare providers or the facility's healthcare consumers. A portion of the projected benefits may have already partially been achieved, however, it is anticipated that most MTF centralized managed care programs have been in operation for less than a one year period, making measurement of these benefits difficult. Therefore, their subjective comments will be discussed and evaluated to determine if WHMC could expect similar benefits from such activities.

Expected Findings and Utility

This study is expected to help identify an appropriate size, structure, and scope of operations for a centralized managed care office at WHMC. The chart of managed care activities currently being conducted by USAF Medical Treatment Facilities operating in the United States will expose how these successful Managed Care Offices are organized and what services they are providing to manage healthcare delivery costs. The information review and analysis will culminate with a recommended managed care activity for WHMC, consistent with its mission and the current managed care structures in the field.

Other USAF MTFs may wish to review these findings to help centralize their managed care activities. There are definite similarities between all USAF MTFs concerning the obligation to provide accessibility to the highest quality of healthcare for its beneficiaries, at the most efficient use of government resources.

This report will hopefully serve as a guide for USAF healthcare organizations in their attempts to comply with these responsibilities.

RESULTS

The purpose of this study has been to explore the scope and structures of managed care activities currently operational in the USAF as well as other DoD medical treatment facilities. The information could then be used to recommend guidance to the WHMC Administrator in establishing a centralized managed care operation for WHMC. The results of the study indicate several interesting and encouraging aspects about the extent of managed care activities in the USAF DoD health care system today.

- DoD medical treatment facilities throughout the United States are planning and implementing centralized managed care activities. The executive staffs understand that the rising costs of healthcare delivery necessitate the consolidation of management activities to provide appropriate care at the most cost efficient means to the government and the patient.

- USAF medical treatment facilities of all sizes and range of services have consolidated managed care activities and appear confident that they are attaining goals beneficial to the US Government and their eligible patient population.

- The reason the participating facilities are involved with managed care activities appears to be twofold: 1) the vision of the administrator and his staff in realizing the benefits of a

managed care system, and 2) the Air Force or DoD selection of that facility to participate in a managed care demonstration program.

These findings were derived from the results of the telephonic survey conducted by the researcher between 4 June 1990 and 12 July 1990. The results of each interview have been documented in Appendix B and in the short narrative descriptions of each MTF contained in Appendix C. This information has been compiled into an MTF Managed Care Activities Chart which is listed on the next few pages. The Chart identifies four primary areas for the reader. It presents descriptive data on the individual MTFs (Box 1) and their catchment area beneficiary demographic information and CHAMPUS expenditures (Box 7). It also points out the scope and structure of managed care activities within the facilities (Boxes 3, 4, & 5), and identifies the MTF staff expectations of those managed care activities (Box 6). The MTF Managed Care Activities Chart also presents a description of the scope of each facility's mission (Box 2) for comparison purposes.

The MTF Managed Care Activities Chart is printed on the following two pages for quick review of the information collected from each MTF before the discussion of the findings.

MTF MANAGED CARE ACTIVITIES CHART

	BERH	DGMC	EGRH	KIRH	MGMC	MPMC	MAH	HRSD
1. Facility Size								
* operating beds	20	250	125	40	275	300	150	504
* monthly occupied bed days	360	6000	2641	653	5490	4673	5000	12645
* outpatient visits	10959	33000	33517	15601	38387	39020	9500	98427
* MTF FTEs	297	1548	1045	387	1305	1757	1500	2942
Facility managed care definition		X			X	X	X	

2. MTF Health Care Missions

Direct Patient Care	X	X	X	X	X	X	X	X
Medical/Dental Training		X			X	X	X	X
Readiness	X	X	X	X	X	X	X	X
Clinical Investigations		X						X

3. Managed Care Office

Size & Structure	# FTEs	SGA	SGA	SGA	SGM	SGAA	SGR	SG
Reporting Alignment	13	2	9	14	11	18	11	9
	SGA	SGA	SGA	SGA	SGM	SGAA	SGR	SG
	SGH	SGH	SGR					
	SGR							

4. Managed Care

Activities	X	X	X	X	X	X	X	X
Partnerships		X	X	X	X	X		
Health Care Finders	X	X	X	X	X	X		
Preferred Provider Network								
VA/DoD Sharing			X			X	X	X
Utilization Management	X					X	X	X
Other	X	X	X	X	X	X	X	X

Reporting Office Symbols:

- SG = MTF Commander
- SGA = Administrator/Director for Administration/
- SGH = Department of Clinical/Professional Services
- SGR = Patient Affairs/Patient Administration Office
- SGM = Medical Resource Management

MTF MANAGED CARE ACTIVITIES CHART (con't)

BERH DGMC EGRH XIRH MGMC WPMC MAH MHSB

5. Periodic M/C Reports

Monthly M/C Activity Reports X X X X X X X
 Dedicated Information System X X X X X

6. Expected Benefits

Cost Savings/Avoidance X X X X X X X
 Increase Patient Accessibility X X X X X X X
 Increase Provider Satisfaction X X X X X X X
 Increase Patient Satisfaction X X X X X X X
 Other X X X X X X X

7. M/C Opportunity Indicators

Beneficiary Demographics
 AD 5764 8943 14503 5923 15084 10026 24307 100199
 AD Dependents 8986 12808 23567 10570 29405 17867 27734 101470
 Retirees 10222 10390 9903 8606 11723 9455 9599 41024
 Dependents of Retirees 13956 14256 13775 11246 15270 13439 13361 53579
 Other 1707 2116 1794 1737 1913 1737 2953 9342
 Total 40635 48513 63542 38802 73395 52524 77954 305614
 CHAMPUS Eligible 30406 34192 45126 27348 52975 39240 48948 181385

Champus Area Expenditures (in 000's)

Hospital Services \$8,071 \$3,707 \$7,539 \$5,839 \$4,877 \$3,416 \$5,746 \$47,498
 Inpatient Prof. Svcs. \$1,924 \$686 \$2,469 \$1,251 \$763 \$642 \$1,729 \$14,917
 Outpatient Prof. Svcs. \$3,637 \$1,939 \$4,986 \$3,496 \$2,641 \$1,946 \$2,326 \$33,264
 Total \$13,633 \$6,331 \$14,813 \$10,586 \$8,281 \$6,003 \$9,807 \$95,678

Facilities:

BERH = Bergstrom AFB Hospital MGMC = Malcolm Grow USAF Medical Center
 DGMC = David Grant USAF Medical Center WPMC = Wright Patterson USAF Medical Center
 EGRH = Eglin USAF Regional Hospital MAH = Martin Army Hospital
 XIRH = Kirtland AFB Hospital MHSB = Naval Hospital San Diego

DISCUSSION

In his Medical Forces Review presentation to the U.S. Senate, Lt Gen Monte Miller, the Air Force Surgeon General, noted that the USAF Medical Services' most difficult challenge in the future will be to meet the healthcare needs of active duty members, their families and our retired military community with quality, affordable care (Department of the Air Force, 1990). Gen Miller was referring to the balancing act that military medical service managers must perform between their fiduciary responsibility to the American taxpayer and the obligation to provide quality healthcare to all eligible beneficiaries. If this balancing act is to be achieved, USAF MTFs will need to employ managed care activities to ensure that the full value of all medical services - either purchased or provided - is received (Department of the Air Force, 1990).

Several DoD and Air Force MTFs are currently operating Managed Care or Coordinated Care activities. These facilities are aggressively seeking to utilize managed care functions to their optimum benefit. This goal is accomplished by centralizing managed care functions to ensure quality, accessible healthcare is delivered at the most advantageous cost to the facility. USAF MTFs most active in managed care activities were identified and their senior administrative officers or an assigned POC interviewed to gain an understanding of the current managed care infrastructures in the field. The discussion of the results of these interviews will focus primarily on two areas. First, a description of the facilities

interviewed will be presented to identify the types of MTFs most active in managed care activities. Then a description of the managed care activities and organizational structures will be presented, followed by comments on the operational characteristics of these offices.

Description of Facilities Interviewed

Eight DoD Medical Treatment Facilities were interviewed for this study. Six of the MTFs were USAF facilities, one was a Navy facility, and the last one was an Army facility. The Air Force MTFs were the 67th Medical Group (Bergstrom), Bergstrom AFB, TX; David Grant USAF Medical Center (DGMC), Travis AFB, CA; USAF Regional Hospital Eglin (Eglin), Eglin AFB, FL; the USAF Hospital Kirtland (Kirtland), Kirtland AFB, NM; Malcolm Grow USAF Medical Center (MGMC), Andrews AFB, MD; and Wright Patterson USAF Medical Center (WPMC), Wright Patterson AFB, OH. The Army facility interviewed and studied was Martin Army Hospital (Martin AH), Fort Benning, GA; and the Naval MTF was the Naval Hospital San Diego (NHSD), San Diego, CA. These facilities are identified by unit abbreviation and state in the tables that follow.

MTF	Operating Beds	Monthly OBDs	Monthly OPVs	MTF Assg Personnel
Bergstrom, TX	20	360	10,959	297
DGMC, CA	250	6,000	33,000	1,548
Eglin, FL	125	2,641	33,517	1,045
Kirtland, NM	40	653	15,601	387
MGMC, MD	275	5,490	38,387	1,305
WPMC, OH	300	4,673	39,020	1,757
Martin AH, GA	150	5,000	9,500	1,500
WHSB, CA	504	12,645	98,427	2,942
WEMC	1,000	18,437	84,383	4,000

Table 1. Selected data on interviewed MTFs.

Table 1 describes the chosen MTFs in relation to their size (number of assigned personnel), number of operating beds, and their healthcare delivery productivity (occupied bed days (OBDs) and outpatient visits (OPVs)). The MTFs interviewed varied a great deal in bed size and personnel assigned. They ranged from a 20 operating bed facility to a facility with 504 beds (one of the largest Naval Hospitals in the U.S.).

Each of the USAF MTFs was recommended by an Air Force expert on managed care as a medical unit moving ahead of the other Air Force medical facilities to centralize managed care operations, or because the unit was selected to participate in a managed care project

demonstration. Table 1 shows that, regardless of size, Air Force MTFs are conducting centralized managed care functions to assist in the efficient utilization of their healthcare resources.

The other DoD facilities were identified through telephone conversations with Medical Administrative Residents at the major U.S. Army and Navy MTFs. Army and Navy MTFs were included in the study in order to obtain information from facilities closer to the size and mission of Wilford Hall USAF Medical Center. Calls were made to the Walter Reed, Fitzsimons, and Eisenhower Army Medical Centers to identify an Army MTF with an active centralized managed care office. All of these facilities were currently studying and planning for such an activity but none were operating one at the time. The Martin Army Hospital at Fort Benning, Georgia was referred to the researcher as an Army facility with one of the most active centralized managed care operations. A call to the Martin Army Hospital was conducted and a Point of Contact established. Although Martin Army Hospital is not an MTF comparable in size to WHMC, its scope of managed care activities does compare favorably with the AF MTFs interviewed. There was much less difficulty in locating a centralized managed care activity in the Navy. The Naval Hospital San Diego was contacted and turned out to be one of the most active of all DoD facilities in managed care operations.

Wilford Hall Medical Center is double the size of the largest MTF interviewed. This may seem to make study of these facilities invalid because of the differences in size and productivity, but

homogeneity of the facilities is not altogether necessary. This study is an attempt to explore and describe what centralized managed care activities currently exist in the DoD and, especially, the USAF. Therefore, small and large facilities are equally relevant to the study.

Greater similarity between the smaller interviewed MTFs and WHMC will appear as other aspects of the facilities healthcare responsibilities are described. For instance, one of the items addressed in the interviews was the mission of each facility. WHMC has a fourfold mission of patient care, readiness, professional training, and clinical research. Although the smaller facilities have only two (patient care and readiness) of these four missions, the three larger medical centers (DGMC, MGMC, and WPMC) all have at least three of the stated missions (patient care, readiness and training). Two of the MTFs (DGMC and NHSD) report having all four of the mission responsibilities assigned to WHMC.

Tables 2 and 3 describe the beneficiary population and the CHAMPUS expenditures for each of the MTFs catchment areas. These tables indicate more similarities between the interviewed MTFs and WHMC than the previous table. The number of eligible beneficiaries to healthcare services within these particular facilities and the expenditures within their CHAMPUS catchment area are two indicators of the potential need for cost efficiency efforts of managed care activities. Military managed care functions available to help reduce or control these costs are Partnership, HCFs, and the VA-DoD Sharing

Programs. All are aimed at providing appropriate healthcare services to the beneficiary populations with an emphasis on cost control. The cost control emphasis comes in the negotiating of favorable discounts for the medical service rendered in the private sector or through recapturing healthcare delivery from the more costly private systems back into the military direct care system.

MTF	Total Benef.*	CHAMPUS Eligible
Bergstrom, TX	40,635	30,406
DGMC, CA	48,513	34,192
Eglin, FL	63,542	45,126
Kirtland, NM	38,802	27,348
MGMC, MD	73,395	52,975
WPMC, OH	52,524	39,240
Martin AH, GA	77,954	48,948
WESD, CA	305,614	181,385
WHMC	86,180	55,640

Table 2. Beneficiary Demographics for Catchment Areas. (*Total Beneficiaries include all Active Duty, Retiree, Dependents and other DoD healthcare beneficiaries)

MTF	Hospital Services	Inpatient Prof Svcs	Outpatient Prof Svcs	Total
Bergstrom, TX	\$8,071	\$1,924	\$3,637	\$13,633
DGMC, CA	3,707	686	1,939	6,331
Eglin, FL	7,539	2,469	4,986	14,813
Kirtland, NM	5,839	1,251	3,496	10,586
MGMC, MD	4,877	763	2,641	8,281
WPMC, OH	3,416	642	1,946	6,003
Martin AH, GA	5,746	1,729	2,326	9,801
WESD, CA	47,498	14,917	33,264	95,678
WHMC	6,678	1,025	2,479	10,182

Table 3. CHAMPUS Area Expenditures. (Expenditures in 000's)

Table 2 presents the number of beneficiaries each MTF is responsible for providing care to. It is interesting to note that each facility has about the same percentage of CHAMPUS eligible beneficiaries to total beneficiaries (between 65% and 75%). That percentage of CHAMPUS eligible beneficiaries in each of the interviewed facilities is eligible to seek care outside the direct care system. Therefore, a strong marketing and advertising of services available and offered within the direct care system may be appropriate. The difference in numbers of beneficiaries between the facilities appears to be sizeable (27,348 for Kirtland, 52,975 for Malcolm Grow Medical Center and 181,385 for Naval Hospital San

Diego); however, the variances in the number of beneficiaries is attributable to the regional location within the U.S. and not primarily to the size of the base or MTF. MTFs in the South and Southeast tend to have a greater beneficiary population because these areas are preferred by retired military personnel. NHSD, which is in the San Diego area, is also a very favorable location for retired personnel and is a major location for the assignment of active duty navy personnel. However, among the facilities which were interviewed for their managed care activities, the smaller facilities did generally tend to have smaller beneficiary populations. Although WHMC is in the South, and in an area where there is a heavy concentration of military bases and units, it still has a CHAMPUS eligible population similar to Eglin, MGMC, and the NHSD.

With the thousands of CHAMPUS eligible beneficiaries within each of the MTFs' catchment areas, it seems evident that there are opportunities for managed care activities. Table 3 identifies these opportunities more clearly by presenting the CHAMPUS expenditures for each MTF area. These costs surprisingly indicate an almost inverse finding from the CHAMPUS eligible population (Table 2). Although Table 2 portrayed the larger facilities as having the greater CHAMPUS eligible populations, Table 3 shows the smaller as facilities having the greater CHAMPUS expenditures. Logically, this can be attributed to the fact that the larger facilities have more healthcare resources in their direct care system that can be used by its beneficiaries. And again NHSD, having such a large beneficiary population, differs

from the norm and has much greater CHAMPUS expenditures. WHMC CHAMPUS expenditures seem to coincide with the larger USAF MTFs. This may also be an indication that strategies for managed care functions between larger and smaller facilities will differ. Smaller facilities should concentrate more on negotiating service discounts with external providers, and the larger USAF facilities may wish to concentrate more on internal efficiencies through utilization management strategies to control costs.

MTF	Size* Comparison	Facility Mission	Facility Assg Pers	Central. M/C Office
Bergstrom, TX	-	-	-	+
DGMC, CA	+	+	-	-
Eglin, FL	+	-	-	+
Kirtland, NM	-	-	-	+
MGMC, MD	+	+	-	+
WPAC, OH	+	+	-	+
Martin AH, GA	+	+	-	+
WHSB, CA	+	+	+	+

Table 4. Facilities as compared to WHMC.
 (*Size comparisons are IAW OMB classifications of small, medium, and large organizations)

Table 4 is a recap of similarities and differences between the interviewed facilities and WHMC. It should be noted that the size comparison when based on the OMB Classification of Organization Sizes makes most of the facilities comparable in size to one another.

This classification is based on the fact that organizations with greater than 500 employees are considered to be large facilities. Therefore, the majority of the interviewed facilities fit into this large organization category with WHMC. However, in the actual count of personnel working in the facility, only NHSD approximates the Wilford Hall Medical Center. Also, over half of the facilities interviewed have basically the same military healthcare mission as WHMC.

MTF Managed Care Activities

The remainder of the discussion centers on the interviewed MTFs' managed care activities. In exploring the centralized managed care activities, we hoped to gain insight for guidance into development of a central managed care office at WHMC.

MTF	Yes	No
Bergstrom, TX		X
DGMC, CA	X	
Eglin, FL		X
Kirtland, NM	X	
MGMC, MD	X	
WPMC, OH	X	
Martin AH, GA	X	
NHSD, CA		X

Table 5. MTF Defined Managed Care
 Table 5 indicates how many and which of the MTFs interviewed

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have their own definition of managed care. The majority of the facilities interviewed have a definition of managed care that is followed in their managed care operations, these definitions are stated in Appendix B, the documented telephonic interviews. Of course, some of the definitions of managed care are more refined than others. For instance, the definition of managed care for WPMC was found in their Managed Care Office Functional Description which asserted that "these efforts are conducted to arrange and/or provide quality healthcare for all active duty, and CHAMPUS eligible patients, maximizing savings to the U.S. Government, ensuring most appropriate source of care for the patient while maintaining quality healthcare and minimal cost to the patient and the government" (Wright Patterson USAF Medical Center, 1989). DGMC's definition was taken from the USAF Surgeon General letter calling for new ways of looking at managed care and appears to be a very brief and concise definition of managed care. Its definition states that managed care is "the application of appropriate healthcare resources to achieve an optimum clinical outcome and value" (USAF/SG Letter, 1989b). Two of the six facilities did not have a documented definition of managed care. However, one of those MTFs, the Bergstrom Hospital, had specific objectives of managed care activities to be performed as outlined in the USAF's MEDEXCEL Test Program. All of the MTFs' definitions were in line with the DoD definition of maximizing the value of healthcare dollars and working in the best interest of their beneficiaries.

MTF	Partner- ships	HCF	VA/DoD Sharing	UM	Other
Bergstrom, TX	X	X		X	X
DGMC, CA					X
Eglin, FL	X	X			
Kirtland, NM	X	X	X		X
MGMC, MD	X	X			X
WPMC, OH	X	X	X	X	X
Martin AH, GA				X	X
WHSD, CA	X			X	X

Table 6. MTF Managed Care Activities.

Table 6 presents the managed care activities being conducted by the MTFs interviewed within a centralized managed care activity. As can be deduced from the table, most of the facilities have the Partnership and Health Care Finder Programs under their centralized managed care activity. David Grant Medical Center appears to be an anomaly, but actually is not. David Grant Medical Center is exempted from operating these managed care functions since it is participating in the CHAMPUS Reform Initiative (CRI). At David Grant Medical Center, the Partnership and Health Care Finder Program functions are actually being conducted and controlled by the CRI contractor. For that reason the 'other' category has been indicated for David Grant Medical Center. This facility is actually benefiting more from managed care activities than most of the other facilities

interviewed. The Naval Hospital at San Diego is also participating in the CRI demonstration. However, they have elected to run many of these activities to supplement and support the CRI contractor.

The VA/DoD sharing activity was the least used managed care alternative function by the MTFs interviewed. Most of the facilities interviewed do not have VA Medical Services within their area, therefore there were no agreements. The Kirtland Hospital was the most active in this area and can be considered operationally linked to the VA Medical Center in Albuquerque, New Mexico. Most of its cost control methods involve sharing of inpatient and outpatient services with the VA Center.

Utilization management (UM) is actively being conducted by Bergstrom Hospital, while WPMC is just starting to develop its UM function under managed care. The Bergstrom Hospital's UM is directed by a clinical nurse, and it conducts case management, discharge planning, and utilization review for patients within the direct care system. For those persons receiving care in the civilian sector, the state Professional Review Organization performs concurrent audits and prior admission authorization activities. USAF Hospital Kirtland also has a full time nursing officer within its Strategic Planning Committee to perform some utilization management and quality of care review duties.

The Other category of activities identified in Table 6 includes the performance of auditing, to ensure the managed care activities are being measured for accomplishment of their objectives; and cost

analysis sections that have been set up by some MTFs to compare costs between the private and direct health care markets or to help justify investment of special project monies to expand services. Bergstrom and David Grant Medical Center have a membership enrollment process. Wright Patterson Medical Center is using their managed care office for centralized strategic planning. A few of the facilities are trying to aid the claims process by providing administrative assistance to file the claims in order to gain better response for the patients and providers. There are marketing analysis functions, and special studies function to help identify programs of assistance. Malcolm Grow Medical Center has added the Coordination of Benefits Program (COB) to its managed care activity. The COB is now called the third Party Collection Program and is responsible for collecting money through billing third party insurers for care rendered to CHAMPUS eligible beneficiaries in the direct care system.

Personnel resources dedicated to the managed care activities and their organizational alignment are described in Table 7. The methods by which the personnel resources are obtained and supported differ from facility to facility. For instance, at David Grant Medical Center, there are two officers performing the facility's managed care function as an additional duty and acting as liaison for managed care activities within the administrative directorate and the clinical services directorate. They coordinate managed care activities with the contractor and are kept abreast of the services the contractor (Foundation Health Corp) is rendering. Some MTFs (MGMC, Eglin and

WPMC) have taken authorizations from their existing manning and assigned these positions to their managed care activity. Bergstrom Hospital and Wright Patterson Medical Center have received funding support for all or a portion of their managed care positions from outside their Operations and Maintenance Budgets. Bergstrom's Managed Care Operation is fully funded through the Air Force MEDEXCEL Demonstration Program. Wright Patterson Medical Center obtained additional funding support for their managed care positions through the USAF Management Efficiencies Add Program; however, they also obtained needed managed care activity manpower from existing resources.

MTF	#FTEs	Reporting Alignment
Bergstrom, TX	13	SGA
DGMC, CA	2	SGA/SGH
Eglin, FL	9	SGA
Kirtland, NM	14	SGA
MGMC, MD	11	SGM
WPMC, OH	18	SGAA
Martin AH, GA	11	SGR ¹
NHSD, CA	9	SG ²

Table 7. MTFs Office Size and Structure.

The number of personnel assigned to the MTFs' managed care activities do not vary greatly. The one exception, of course, is David Grant Medical Center, but as previously mentioned, this organization only requires these individuals to act as liaison between the facility and the national CHAMPUS CRI contractor (Foundation Health Corp). Wright Patterson Medical Center has the largest staff with 18 personnel assigned to their managed care directorate. The managed care activities at WPMC report to a GS-11 employee who serves as the Director, and he reports to the Associate

¹ Managed Care Activities at Martin Army Hospital report to the Patient Administration Officer, which in the Air Force equates to the Patient Affairs Administrator.

² NHSD Director of Healthcare Planning and Development reports to the Facility Commander which equates to the SG in Air Force MTFs.

Administrator of the Medical Center. The next largest managed care staffs, of the those interviewed, are located at Kirtland and Bergstrom. Both of these hospitals are operating under specialized programs which are supported with additional funds outside their normal operations and maintenance budgets.

MTF	Direct M/C Office Staff	Departments that support Managed Care Activity			Total M/C Staff
		SGH	SGM	SGR	
Bergstrom, TX	2	3		9	14
DGMC, CA	1	1			2
Eglin, FL	2 ¹			7	9
Kirtland, NM	4		2	6	12
MGMC, MD	3 ²		5	3	11
WPMC, OH	18				18
Martin AH, GA	11				11
WBSD, CA	9				9

Table 8. Offices supporting M/C Activities with Staff.

In a close study of Table 8, it appears to the observer that the personnel performing managed care duties tend to be scattered among different sections. The one truly centralized managed care activity

¹ The Eglin Hospital Managed Care Officer also serves as the Patient Affairs Administrator.

² The MGMC Managed Care Officer also serves as the Medical Center's Assistant Resource Management Officer.

is at Wright Patterson, with 18 full time personnel assigned to the Department of Managed Healthcare. The Bergstrom Hospital has one officer and an NCO to oversee and coordinate the activities of the personnel performing its managed care activities. However, at Bergstrom the Clinical Services Directorate and the Patient Affairs Office also provide personnel to perform the managed care duties. The Kirtland Hospital is divided into two separate managed care departments, the first called a Strategic Planning Group, tasked to negotiate the sharing agreements and contracts with the VA Hospital only, and the Patient Administrative Staff who negotiate the Partnerships, Health Care Finder Programs and other managed care activities with the private healthcare sector. However, both of the managed care functions at Kirtland Hospital report to the Administrator for their reporting alignment. The remainder of the hospitals typically have an MSC Officer in charge of the activities progress reporting, with full time support coming from personnel in other functional areas. All personnel, except as noted in the chart, regardless of the section they work within, are full time employees of the unit's managed care activities.

The reporting alignment of the managed care activities within the facilities, as indicated in Table 6, vary little. Most of the reporting is done through the Administrator or an administrative area, even though several of the functions are supported by other sections like the Patient Administration Department (SGR), the Medical Resource Management Office (SGM), or personnel from the

Clinical Services Department (SGH). Malcolm Grow showed the greatest variance in its managed care reporting alignment. At Malcolm Grow the managed care activities were all being conducted through the Resource Management Office (SGM). Malcolm Grow has combined the Medical Services Account function with its Coordination of Benefits Program for third party collections, the Health Benefits Advisory function, and a new Alternative Care Referral Service (ACRO). The ACRO is used to help direct CHAMPUS Eligible Beneficiaries to private sector healthcare providers participating in the Healthcare Finder Program and controls the supplemental and cooperative care programs. All report to the Assistant Medical Resource Management Officer.

"REPRODUCED AT GOVERNMENT EXPENSE"

MTF	Monthly M/C Report	Dedicated Info Sys
Bergstrom, TX	X	X
DGMC, CA		
Eglin, FL	X	X
Kirtland, NM	X	
MGMC, MD	X	
WPMC, OH	X	
Martin AH, GA		
NHSD, CA	X	

Table 9. Managed Care Reporting at MTFs.

Table 9 indicates that all of the facilities with centralized managed care activities require some monthly type of reporting, but

only a few MTFs provide a dedicated information system to support their managed care operations. The reason, as ascertained in interviews with the POC's, seems to be that all of the facilities lack the systems hardware and computer programs required to generate pertinent information to support their programs. Wright Patterson is working on information programs that will consolidate data from the Medical Expense and Performance Reporting System, referral and appointment systems, and network with other DoD and civilian systems to organize necessary information for decisions concerning managed care efforts. They have the appropriate hardware on hand for the link-ups; however, they have not yet installed these systems. A common factor found among all of the interviewed facilities was the recognition by the various staffs of the need for a reporting/information system that would combine data sources to produce comprehensible products for their managed care operation. Currently these facilities are using existing systems such as AQCESS, MEPRS, and other military information systems to piece meal data for review.

MTF	Cost Savings	Increased Pt Access	Increased Prov Satis	Increased Pt Satis
Bergstrom, TX	X	X		X
DGMC, CA	X	X	X	X
Eglin, FL	X	X		X
Kirtland, NM	X	X		
MGMC, MD	X			
WPNC, OH	X	X		X
Martin AH, GA	X	X		
NHSD, CA		X	X	

Table 10. Expected Benefits from M/C Activities.

The final table, Table 10, indicates benefits the MTFs expect or have actually realized from their managed care activities. It is almost unanimous that cost savings or cost avoidance will be or has been a benefit from these services. Some units have documented as much as \$3 million of cost avoidance which the facility has attained through direct or indirect influence of their managed care activities in less than a full year. Provider satisfaction mentioned in this section refers to private practicing physicians who are pleased that the managed care function is helping to either file their claim for services rendered, or is assisting them in determining the status of previously filed claims.

The examination of the selected MTFs indicated one major point that can be stated. USAF and other DoD MTFs are conducting managed

care activities aimed at controlling the costs of delivering quality healthcare. One of the major indicators for the opportunity of managed care activities has been the cost of CHAMPUS in the various catchment areas. This is due to the CHAMPUS program's growth of costs which have become very noticeable to the Congressional Budgeters who debate considerably the causes and remedies for this growth (Tomich, 1990). Therefore, much of the managed care activity being conducted in DoD MTFs today is in response to Congress' call for more cost efficiency actions in healthcare purchased from the private healthcare market by DoD healthcare beneficiaries.

Although the size of the managed care operations and staffs varied, it is obvious that one of the deficiencies of the existing functions is information systems support. According to much of the literature in this area, the types of information needed to operate a managed care activity include patient demographics, market analysis to assist in determining healthcare services mix needed, communication with beneficiaries on the services available (advertising), strategic planning and performance monitoring (Boland, 1989; Linton & Peachey, 1989; Aronow, 1988). Although most of this information can be obtained through various DoD or specific service branch agencies the information lacks the necessity and sensitivity of time requirements and area peculiarities. Therefore, appropriately designed and programmed managed care information systems can help the MTFs respond to the needs of their catchment area beneficiaries.

CONCLUSION AND RECOMMENDATIONS**Conclusions**

Exploration of the characteristics of centralized managed care activities within the DoD has helped to describe the scope and structure of existing managed care activities for use by WHMC in organizing and establishing a managed care activity of its own. This research has shown that the interviewed military MTFs conducting managed care activities feel they are successfully realizing benefits from these functions. MTFs interviewed were varied in size and mission, in area of the country and demographic mix, and in their involvement with managed care functions. Therefore, the study was able to capture a glimpse of the wide range of managed care structures that, according to Air Force experts in managed care, are successfully operating in the field today.

The level of participation in the various managed care activities seemed to be linked to two factors. One of these factors was the MTFs involvement with a national demonstration or test for managed care. The second factor was primarily the insight and initiative of the Administrator, attempting to apply the necessary resources that would achieve savings and increase accessibility which in essence is activating managed care concepts.

The best managed care structure for WHMC cannot be identified nor recommended with any strict statistical confidence and/or reliability through this exploration of the current managed care activities. Further studies to measure the success of DoD Managed

Care Activities, relating their healthcare delivery cost savings or increases to patient access to the various segments of managed care programs should be conducted to determine the most beneficial managed care programs. However, it is presumed that the leadership for most types of managed care activities in USAF MTFs will come from the individual MTF's Chief Executive Officer (Administrator). This is consistent with practically all facilities interviewed. Therefore, the reporting alignment of a centralized managed care activity should be through the WHMC Administrator. When the Administrator initiates the development of WHMC's managed care activity, he should include at least these four different functions: an analysis and studies branch, a marketing branch, an auditing and information systems branch, and a utilization management branch.

The Analysis and Studies Branch should be designed to perform an initial and periodic market analysis comparing the needs of the beneficiary population to the internal and external healthcare services available (Aronow, 1988). The personnel assigned to this function should be proficient in strategic planning and skilled at analyzing needs assessment. This function would also be the central point of action for studies to determine cost efficiencies of planned services. The efficiency studies can be used to identify the beneficiary population's need for certain healthcare services and the most cost effective means of satisfying that healthcare need. The completed studies will help justify resources support requested through various resources funding programs such as the USAF

Management Efficiencies Add Program and the CHAMPUS Alternative Use of Funds Program.

The second function of the centralized managed care activity should be a Marketing Branch to include responsibilities for carefully developing needed healthcare delivery programs, and appropriately advertising these services to the beneficiary population (Aronow, 1988). Patient education and health promotions campaigns could be coordinated through this office. It would also be the office responsible for negotiating various contracts with the Partnerships, Health Care Finders, and VA/DoD Sharing Agreements to ensure the greatest possible patient access to quality healthcare services.

An Auditing and Information Systems Branch should also be organized to ensure standards of measurement for each managed care program and function are performed and checked for accomplishments consistent with the program design (Boland, 1988). This branch should also insure the quality and appropriateness of the healthcare being rendered to all categories of patients is conducted in compliance with CHAMPUS and other requirements. This functional area would also identify the information needs to measure its accomplishments of and to track any trends for development of future managed care activities at WHMC.

The last section/branch recommended for inclusion is a Utilization Management Branch. This section would include reporting on such activities as case management, discharge planning, and

reviews of care being provided by HCF Partners and the direct care system clinicians. UM Functions are best accomplished and understood by the clinician staff, therefore, it would be appropriate for the managed care officer to try and co-opt the support of the clinical services (such as SGH) for assistance in accomplishing these duties (Linton & Peachy, 1989).

A centralized managed care activity can become a reality at WHMC. The time has come when such activities are necessary to take advantage of the vast potential to apply cost efficiencies to the services available to such a large beneficiary population as the WHMC serves. Investment in a staff or line function for a managed care activity will provide enormous benefits that can be measured and improved upon. This service should not be limited to only external negotiations, but should emphasize administrative and provider participation for the maximum benefit to the MTF, the patients, providers, and the U.S. taxpayer.

The size of staff required to effectively operate a managed care activity will not necessarily depend upon the number of beneficiaries or the CHAMPUS costs in the WHMC catchment area. There has been no formula identifying the number of managed care positions needed per bed, outpatient visit number, or size of facility requirements. But it should be evident that the number of personnel needed to conduct a centralized managed care activity will depend upon the number of functions the managed care activity centralizes and operates under its responsibilities. Also, smaller facilities appear to need more

personnel to negotiate with the external market/private healthcare sector for discounts on services to be provided to CHAMPUS beneficiaries seeking care outside the direct care system. These smaller facilities would need less internal shifting of services, since their medical capabilities to increase radiation therapy or psychiatric patient beds may not exist. However, larger facilities, such as WHMC, Naval Hospital San Diego, Wright Patterson, etc., having such large facilities and wide range of services are more able to recapture high cost care regimens into their facilities. Therefore, more studies and recommendations for internal shifting of services is warranted and more personnel needed to assist in studying these options.

If WHMC initiates a managed care function, it will be a pioneer undertaking whose time has come to be tested in the San Antonio Texas military medical community. One can expect the scope of managed care activities to take years to develop into its final structure and mission. But the process should begin under the control of the Administrator for investigation, planning, and implementation. In time, managed care activities will become the administrative tool able to strike a balance between providing accessibility to quality care and making sure the care provided is necessary and delivered in the most cost efficient manner.

Recommendations

The following recommendations are made for the WHMC Administrator in regard to a centralized managed care activity:

1. The administrator should identify a managed care director to initiate an implementation study for a centralized managed care activity at WHMC.

2. The new director should perform a market analysis for the San Antonio catchment area to identify the potential WHMC market population, their medical needs, and the external and internal healthcare delivery resources needed to support this needs assessment.

3. The administrator should also provide the managed care director with sufficient support staff to conduct an analysis and studies function, to identify information systems requirements, to assist with strategic planning and marketing functions, and to outline possible utilization management strategies. These four functions will be instrumental in assisting the development of a centralized managed care activity. Each of these positions should be filled by an individual that has a keen interest and expertise in the applicable area. This new staff could be designated as the WHMC Managed Care Implementation Group.

4. Utilize the market study/analysis to justify a request to the USAF Management Efficiencies Add Program for additional monetary support to implement a Centralized Managed Care Activity at WHMC. The scope of managed care activities, size of managed care personnel staff, and reporting structure should be determined by the WHMC Managed Care Implementation Group.

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MANAGED CARE
MTF INTERVIEW FORM

Facility Name: _____
Survey Point of Contact: _____

1. Size and Mission of MTF:
 - A. Number of operating beds at MTF: _____
 - B. Number of monthly Bed Days: _____
 - C. Number of monthly Outpatient Visits (OPVs): _____
 - D. Number FTEs: Military _____ + Civilian _____
 - D. Mission of MTF: _____

2. Does your MTF have a definition of managed care? _____ If yes, please give your MTF's definition: _____

3. Size and Alignment of MTF's Managed Care Office:
 - A. Number of FTEs in Managed Care Office:
 - (1). Number of Military FTEs: _____
 - (2). Number of civilian FTEs: _____
 - B. Managed Care Office reports to:
 - (1) Hospital Commander _____
 - (2) Administrator _____
 - (3) Chief, Clinical Services _____
 - (4) Director, Patient Administration Division _____
 - (5) Other: _____

4. Managed Care Activities operating at MTF:
 - A. Partnership Program (No. of Agreements _____).
 - B. Health Care Finder Program (No. of Agreements _____).
 - C. Managed Care Network (No. of Agreements _____).
 - D. VA/DoD Sharing (No. of Agreements _____).
 - E. Utilization Management.
 - F. Case Management.
 - G. Other: _____
 - H. Does your facility utilize periodic management reports of managed care activities? If yes, describe reports.
 - I. Does your facility have an Information System to support your managed care activities? If yes, describe system.

5. Expected Benefits from Managed Care Activities.
 - A. Cost Savings/Cost Avoidance: _____
 - B. Increase Patient Accessibility: _____
 - C. Increase Provider Satisfaction: _____
 - D. Increase Patient Satisfaction: _____
 - E. Other: _____

6. Comments on Managed Care Program: _____

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**Managed Care
MTF INTERVIEW FORM**

Facility Name: USAF Hospital Kirtland, Kirtland AFB, NM

Survey Point of Contact: Lt Col David Camacho, Administrator;
Maj Tony Woodson, POC, AV-245-3576

1. Size and Mission of MTF:

- A. Number of operating beds at MTF: 40
- B. Number of monthly Bed Days: 653
- C. Number of monthly Outpatient Visits (OPVs): 15,601
- D. Number FTEs: Military 317 + Civilian 70

E. Mission of MTF: Kirtland Hospital provides medical care to beneficiaries of DoD and is part of the Air Force/Veterans Administration Project for sharing federal healthcare services. Together USAF Hospital Kirtland and the VA Medical Center make up the complex referred to as the New Mexico Regional Federal Medical Center. The Kirtland Hospital has general medical and surgical capability, as well as outpatient surgery; physical therapy; neurology; pediatrics; ENT; primary care; OB-GYN; mental health; flight medicine; occupational health; oral surgery; dental; allergy/immunology; and orthopedic capabilities. A staff of 92 officers, 205 enlisted personnel, 70 civilians, and 14 fulltime assistants provide healthcare services to a population of approximately 4566 AF AD, 91 Army AD, 157 Navy/Marine AD, 11987 AD family members, and in excess of 25,000 retired personnel and their dependents.

2. Does your MTF have a definition of managed care: No
If yes please give your MTF's definition of managed care:

3. Size and Alignment of MTF's Managed Care Office:

- A. Number of FTEs in Managed Care Office:
 - (1) Number of Military FTEs: 4
 - (2) Number of civilian FTEs: 8

- B. Managed Care Office reports to:
 - (1) Hospital Commander
 - (2) Administrator X
 - (3) Chief, Clinical Services
 - (4) Director, Patient Administration Division
 - (5) Other: Joint Planning Committee reports to

Administrator. There are also two claims adjusters who report through Patient Affairs (SGR) and two Resource Managed personnel/clerks performing audits of records. So the reporting for managed care is done through SGA/R/M.

4. Managed Care Activities operating at MTF:

- X A. Partnership Program (# of Agreements 13)
- X B. Health Care Finder Program (# of Agreements 35)
- C. Managed Care Network (# of Agreements)
- X D. VA/DoD Sharing (# of Agreements 25).
- E. Utilization Management.
- F. Case Management.
- G. Other:

- Mega Partner -Univ NM School of Medicine
- CHAMPUS Restore- no cost sharing to patient.

H. Does your facility utilize periodic management reports of managed care activities? If yes, describe reports. Only current requirement is weekly consultations with VA.

I. Does your facility have an Information System to support your managed care activities? If yes, describe system. Staff is reviewing the medical services reporting system without too much success.

5. Expected Benefits from Managed Care Activities:

- A. Cost Savings/Cost Avoidance: X
- B. Increase Patient Accessibility: X
- C. Increase Provider Satisfaction:
- D. Increase Patient Satisfaction:
- E. Other:

6. Comments on Managed Care Program:

Kirtland has a great deal of resource sharing with the VA facility with whom they occupy their physical plant. This AF Hospital has hired civilian physicians through what they term the VA pass-through method. Kirtland is operating two types of internal partnership program. One is called the Mega Partners and the other the CHAMPUS Restore Program. The goal of the two programs is to create access to medical care at reasonable costs to the government and the patients.

**Managed Care
MTF INTERVIEW FORM**

Facility Name: USAF Medical Center Wright Patterson
Wright Patterson AFB, OH

Survey Point of Contact: Col T. Cunningham, Administrator;
Mr. O. B. Murray, Director, Managed Care Office, AV 787-0684

1. Size and Mission of MTF:

- A. Number of operating beds at MTF: 301
- B. Number of monthly Bed Days: 4674
- C. Number of monthly Outpatient Visits (OPVs): 40,520
- D. Number FTEs: Military 1285 + Civilian 369

E. Mission of MTF: The vision of the USAF Medical Center, Wright Patterson is to become the center of excellence for health care delivery in DoD Region Six, the Air Force, and the Department of Defense. The medical center will be prepared to deal with a rapidly changing external environment through implementation of the Total Quality Management process. That process must position the medical center to deliver reasonably priced, state-of-the-art medicine and service to meet the needs of the patient population. Our actions must reflect the organization motto 'dedicated to mission, committed to excellence', by an unyielding cultural imperative for continuous improvement.

2. Does your MTF have a definition of managed care: Yes If yes please give your MTF's definition of managed care: Same as the mission stated above.

3. Size and Alignment of MTF's Managed Care Office:

- A. Number of FTEs in Managed Care Office:
 - (1) Number of Military FTEs: 4
 - (2) Number of civilian FTEs: 14
- B. Managed Care Office reports to:
 - (1) Hospital Commander _____
 - (2) Administrator _____
 - (3) Chief, Clinical Services _____
 - (4) Director, Patient Administration Division _____
 - (5) Other: Associate Administrator (SGAA).

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- 4. Managed Care Activities operating at MTF:
 - A. Partnership Program (# of Agreements 11)
 - B. Health Care Finder Program (# of Agreements 100)
 - C. Managed Care Network (# of Agreements)
 - D. VA/DoD Sharing (# of Agreements 3).
 - E. Utilization Management. (To start reviewing referrals soon)
 - F. Case Management.
 - G. Other:
 - Audit Function for measuring program compliance
 - Computer Link with Fiscal Intermediary
 - Alternative Use Programs (Mgt Efficiencies Studies).
 - H. Does your facility utilize periodic management reports of managed care activities? If yes, describe reports. The audit position produces monthly reports to brief the MTF Executive Staff Committee.
 - I. Does your facility have an Information System to support your managed care activities? If yes, describe system. The Alternative Use Program has its own Wang system plus a laboratory system and the AQCESS system which they use to produce reports. They also have an AT&T System to network all of these different data systems together. They will also try to hook up to the local VA hospital.

- 5. Expected Benefits from Managed Care Activities:
 - A. Cost Savings/Cost Avoidance: X
 - B. Increase Patient Accessibility: X
 - C. Increase Provider Satisfaction:
 - D. Increase Patient Satisfaction: X
 - E. Other:

6. Comments on Managed Care Program:
There have been difficulties in obtaining money to conduct this large of a centralized program of Managed Care Activities. Base functions which must hire personnel and account for them do not fully understand the purpose and intent of the project.

**Managed Care
MTF INTERVIEW FORM**

Facility Name: Malcolm Grow USAF Medical Center
Andrews AFB, DC

Survey Point of Contact: Col P. Bellisario, Administrator;
Lt Jim Baron, Resource Management Officer/Managed Care Officer, POC,
AV 858-2475

1. Size and Mission of MTF:

- A. Number of operating beds at MTF: 275
- B. Number of monthly Bed Days: 5490
- C. Number of monthly Outpatient Visits (OPVs): 33,323
- D. Number FTEs: Military 1029 + Civilian 270
- E. Mission of MTF: Enhance Medical Readiness posture to

support the wartime mission; support the operational mission of the
Air Force; firm commitment of excellence in the delivery of
healthcare; provide education and training to assigned and affiliated
personnel; foster, provide, and sustain a premier military
healthcare environment.

2. Does your MTF have a definition of managed care: Yes If yes
please give your MTF's definition of managed care: It is the
Alternative Care Referral Offices endeavor to ensure that the most
appropriate source of care for the patient be used, while
maintaining quality healthcare at minimal cost to both the patient
and the government.

3. Size and Alignment of MTF's Managed Care Office:

- A. Number of FTEs in Managed Care Office:
 - (1) Number of Military FTEs: 2
 - (2) Number of civilian FTEs: 9
- B. Managed Care Office reports to:
 - (1) Hospital Commander _____
 - (2) Administrator _____
 - (3) Chief, Clinical Services _____
 - (4) Director, Patient Administration Division _____
 - (5) Other: Director, Resource Management

4. Managed Care Activities operating at MTF:

- A. Partnership Program (# of Agreements 7)
- B. Health Care Finder Program (# of Agree. 15)
- C. Managed Care Network (# of Agreements)
- D. VA/DoD Sharing (# of Agreements).
- E. Utilization Management.
- F. Case Management.
- G. Other:

Cost Analysis
Auditor/Analyzer
Central Referral Agency (ACRO)
Coordination of Benefits activities

H. Does your facility utilize periodic management reports of managed care activities? If yes, describe reports.
Report to Executive Committee and Professional Staff

I. Does your facility have an Information System to support your managed care activities? If yes, describe system.
There are some Z-248 machines. But no specially designed data bases.

5. Expected Benefits from Managed Care Activities:

- A. Cost Savings/Cost Avoidance: X
- B. Increase Patient Accessibility:
- C. Increase Provider Satisfaction:
- D. Increase Patient Satisfaction:
- E. Other:

6. Comments on Managed Care Program:

The newly formed ACRO may also take in the clinical records functions for auditing and monitoring purposes.

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**Managed Care
MTF INTERVIEW FORM**

Facility Name: 67th Medical Group, Bergstrom AFB, TX

Survey Point of Contact: Col Larry Steiger, Administrator;
Assigned POC: Capt Sally Ryan, OIC, Managed Care, AV 685-4299

1. Size and Mission of MTF:

- A. Number of operating beds at MTF: 20
- B. Number of monthly Bed Days: 360
- C. Number of monthly Outpatient Visits (OPVs): 10,959
- D. Number FTEs: Military 261 + Civilian 36
- E. Mission of MTF: To provide medical and dental care;

flight medicine and environmental health services; and hospital support on an area basis for all satellite, tenant or assigned units and other authorized personnel. To support wartime and contingency operations by providing health care to residual forces, by coordinating local National Disaster Medical System (NDMS) activities and by deploying two Air Transportable Clinics (FFLGE); one Medical Support Element (FFDAD); one Mobile Second Echelon Medical Treatment Unit, Medium (FFGLD); one Mobile Second Echelon Decontamination Unit (FFGLB); one Second Echelon Patient Retrieval Unit (FFGLE); one Air Transportable Hospital First Augmentation Personnel Team (FFGK2); one Air Transportable Hospital Second Augmentation Personnel Team (FFGK4); and one Air Transportable Hospital Core Personnel Team (FFGK5).

2. Does your MTF have a definition of managed care: No
If yes please give your MTF's definition of managed care:

3. Size and Alignment of MTF's Managed Care Office:

- A. Number of FTEs in Managed Care Office:
 - (1) Number of Military FTEs: 4
 - (2) Number of civilian FTEs: 10
- B. Managed Care Office reports to:
 - (1) Hospital Commander
 - (2) Administrator X (member svcs)
 - (3) Chief, Clinical Services X (UM branch)
 - (4) Director, Patient Administration Division X (member svcs)
 - (5) Other:

4. Managed Care Activities operating at MTF:

- A. Partnership Program (# of Agreements 31)
- B. Health Care Finder Program (# of Agreements)
- C. Managed Care Network (# of Agreements)
- D. VA/DoD Sharing (# of Agreements).
- E. Utilization Management. (actions reported to SGH)
- F. Case Management.
- G. Other:

Enrollment
Daily managed care activity reports
Civilian admissions.

H. Does your facility utilize periodic management reports of managed care activities? If yes, describe reports. Daily Admission Reports from PRO, requested on line computer to the FI's, Enrollment statistics.

I. Does your facility have an Information System to support your managed care activities? If yes, describe system. Only have AQCESS.

5. Expected Benefits from Managed Care Activities:

- A. Cost Savings/Cost Avoidance: X
- B. Increase Patient Accessibility: X
- C. Increase Provider Satisfaction:
- D. Increase Patient Satisfaction: X

E. Other: Bergstrom has a managed care network, which is the HCF program, run by the managed care office. Patients have less hassle from the network providers.

6. Comments on Managed Care Program:

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**Managed Care
MTF INTERVIEW FORM**

Facility Name: David Grant USAF Medical Center (DGMC)
Travis AFB, CA 94535-5300

Survey Point of Contact: Col R. J. Chappelle, Administrator;
Assigned POC: LtCol Phil Marley, Associate Administrator, AV
799-7416.

1. Size and Mission of MTF:

- A. Number of operating beds at MTF: 250
- B. Number of monthly Bed Days: 6000
- C. Number of monthly Outpatient Visits (OPVs): 33000
- D. Number FTEs: Military 1301 + Civilian 247
- E. Mission of MTF: Fourfold mission of medical readiness,

deliver/arrange for medical care, medical education/training, and
clinical investigations.

2. Does your MTF have a definition of managed care: Yes If yes
please give your MTF's definition of managed care: DGMC has adopted
the latest definition of managed care from the USAF Surgeon General
which is 'the application of appropriate health care resources to
achieve an optimum clinical outcome and value.

3. Size and Alignment of MTF's Managed Care Office:

- A. Number of FTEs in Managed Care Office:
 - (1) Number of Military FTEs: 2 Part-time liaison
Officers.
 - (2) Number of civilian FTEs: _____
- B. Managed Care Office reports to:
 - (1) Hospital Commander _____
 - (2) Administrator X
 - (3) Chief, Clinical Services X
 - (4) Director, Patient Administration Division (5)
 - Other: liaison with Foundation Healthcare Plan.

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4. Managed Care Activities operating at MTF:

- A. Partnership Program (# of Agreements___)
- B. Health Care Finder Program (# of Agreements)
- C. Managed Care Network (# of Agreements___)
- D. VA/DoD Sharing (# of Agreements___).
- E. Utilization Management. (actions reported to SGH)
- F. Case Management.
- G. Other: All managed care activities are conducted by the Foundation Healthcare Plan personnel.

H. Does your facility utilize periodic management reports of managed care activities? If yes, describe reports. OASD/HA receives reports from the Foundation operation.

I. Does your facility have an Information System to support your managed care activities? If yes describe system. Facility has computer link with Foundation and utilizes this asset at times to assist participating private physicians to obtain information on claims.

5. Expected Benefits from Managed Care Activities:

- A. Cost Savings/Cost Avoidance: X
- B. Increase Patient Accessibility: X
- C. Increase Provider Satisfaction: X
- D. Increase Patient Satisfaction: X
- E. Other: _____

6. Comments on Managed Care Program:

CRI has had good results. LtCol Marley is a devout advocate of the CRI Plan and thinks this program will expand to other sectors of the country because of the enormous market clout of the Foundation to attain healthcare delivery cost efficiencies.

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**Managed Care
MTF INTERVIEW FORM**

Facility Name: Eglin USAF Regional Hospital
Eglin AFB, FL 32542-5300

Survey Point of Contact: Col Richard McGough, Administrator;
Assigned POC: Capt Dianne Keltz, Director, Managed Care/Patient
Affairs, AV 872-7396

1. Size and Mission of MTF:

- A. Number of operating beds at MTF: 125
- B. Number of monthly Bed Days: 2641
- C. Number of monthly Outpatient Visits (OPVs): 33,517
- D. Number FTEs: Military 800 + Civilian 245
- E. Mission of MTF: Provide healthcare for all

beneficiaries, perform as DoD Referral Center, readiness and mobility.

2. Does your MTF have a definition of managed care: No
If yes please give your MTF's definition of managed care:

3. Size and Alignment of MTF's Managed Care Office:

- A. Number of FTEs in Managed Care Office:
 - (1) Number of Military FTEs: 3
 - (2) Number of civilian FTEs: 6
- B. Managed Care Office reports to:
 - (1) Hospital Commander
 - (2) Administrator X
 - (3) Chief, Clinical Services
 - (4) Director, Patient Administration Division (5) Other:

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4. Managed Care Activities operating at MTF:

- A. Partnership Program (# of Agreements 36)
- B. Health Care Finder Program (# of Agreements 128)
- C. Managed Care Network (# of Agreements)
- D. VA/DoD Sharing (# of Agreements).
- E. Utilization Management. (actions reported to SGH)
- F. Case Management.
- G. Other:

H. Does your facility utilize periodic management reports of managed care activities? If yes, describe reports. Executive Committee is briefed every week on the status of partnerships. Admissions from Partners and costs of both CHAMPUS Claims and MEDICARE are reviewed.

I. Does your facility have an Information System to support your managed care activities? If yes describe system. Demonstration for AQCESS and CHCS Systems.

5. Expected Benefits from Managed Care Activities:

- A. Cost Savings/Cost Avoidance: X
- B. Increased Patient Accessibility: X
- C. Increase Provider Satisfaction:
- D. Increase Patient Satisfaction: X
- E. Other:

6. Comments on Managed Care Program: None

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**Managed Care
MTF INTERVIEW FORM**

Facility Name: Martin Army Hospital
Fort Benning, GA

Survey Point of Contact: Capt Michael Payton, Patient
Administration Officer, AV 784-1594.

1. Size and Mission of MTF:

- A. Number of operating beds at MTF: 150
- B. Number of monthly Bed Days: 5000
- C. Number of monthly Outpatient Visits (OPVs): 9500
- D. Number FTEs: Military 650 + Civilian 850
- E. Mission of MTF: Mission statement is a very long

statement, however, the Martin Army Hospital has a threefold mission which includes direct patient care, a lesser training mission for GME, and readiness.

2. Does your MTF have a definition of managed care: Yes

If yes please give your MTF's definition of managed care: Managed care is a system that organizes and connects various elements of the healthcare delivery system and manages the delivery of that system efficiently for the benefit of patients, providers, and bill payors.

3. Size and Alignment of MTF's Managed Care Office:

- A. Number of FTEs in Managed Care Office:
 - (1) Number of Military FTEs: 2 Officers
 - (2) Number of civilian FTEs: 6 (with 3 more authorizations waiting to be hired).

B. Managed Care Office reports to:

- (1) Hospital Commander _____
- (2) Administrator _____
- (3) Chief, Clinical Services _____
- (4) Director, Patient Administration Division X (PAD Officer serves part time as Managed Care Officer.)
- (5) Other: _____

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4. Managed Care Activities operating at MTF:
- A. Partnership Program (# of Agreements 8)
 - * B. Health Care Finder Program (# of Agreements)
 - C. Managed Care Network (# of Agreements)
 - D. VA/DoD Sharing (# of Agreements 1).
 - E. Utilization Management.
 - F. Case Management. (Nurse performs for Supplemental Care patients in civilian facilities.)
 - G. Other:
 - *Participates in the SE PPO Project for HCFs.
 - MTF has 5 major healthcare contracts with civilian providers.
 - H. Does your facility utilize periodic management reports of managed care activities? If yes, describe reports. Manually inputs all information into Z-248s.
 - I. Does your facility have an Information System to support your managed care activities? If yes, describe system. Z-248 stand-alone computers with own spreadsheets for information.

5. Expected Benefits from Managed Care Activities:
- A. Cost Savings/Cost Avoidance: \$65,000 from case mgt
 - B. Increase Patient Accessibility: 5000+ OPV increase
 - C. Increase Provider Satisfaction:
 - D. Increase Patient Satisfaction:
 - E. Other:

6. Comments on Managed Care Program: None

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**Managed Care
MTF INTERVIEW FORM**

Facility Name: Naval Hospital San Diego
San Diego, CA 92134-5000

Survey Point of Contact: Commander Dan Ford, Assistant Director,
Office of Healthcare Planning and Development. AV 522-7165.

1. Size and Mission of MTF:

- A. Number of operating beds at MTF: 504
- B. Number of monthly Bed Days: 12,645
- C. Number of monthly Outpatient Visits (OPVs): 98,427
- D. Number FTEs: Military 2542 + Civilian 400
- E. Mission of MTF: NHSD has several pages of mission statements, but it was established that it has basically the same fourfold mission as WHMC. The fourfold mission includes direct patient care, GME Training, readiness, and clinical research.

2. Does your MTF have a definition of managed care: NO
If yes please give your MTF's definition of managed care: The facility has no formal definition, but in talking with Commander Ford it was established that their goals/objectives for the Office of Healthcare Planning and Development are to optimize utilization of the MTF, improve access to care for all beneficiaries, and to control changes in cost.

3. Size and Alignment of MTF's Managed Care Office:

- A. Number of FTEs in Managed Care Office:
 - (1) Number of Military FTEs: 5 (0-6 to 0-1)
 - (2) Number of civilian FTEs: 4 (GS-5's to 12)
 - B. Managed Care Office reports to:
 - (1) Hospital Commander X
 - (2) Administrator _____
 - (3) Chief, Clinical Services _____
 - (4) Director, Patient Administration Division (5) _____
- Other: _____.

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- 4. Managed Care Activities operating at MTF:
 - X A. Partnership Program (* of Agreements___)
 - * B. HCF Program (* of Agreements_)
 - ___ C. Managed Care Network (* of Agreements___)
 - ___ D. VA/DoD Sharing (* of Agreements___).
 - ** E. Utilization Management. (actions reported to SGH)
 - ** F. Case Management.
 - ___ G. Other: * NHSD is participating in the CRI

Demonstration therefore has the HCF Activity conducted by the contractor.

** NHSD is searching for a person that they can hire as a GS-12, DRG Expert. This position will be involved with case management and utilization review.

- NHSD has an excellent analysis and studies function to accomplish efficiency reviews.

- One of the 02 Officers acts as a Resource Sharing Expert.

H. Does your facility utilize periodic management reports of managed care activities? If yes, describe reports. Monthly reports to the commander on resource sharing and other managed care activities.

I. Does your facility have an Information System to support your managed care activities? If yes describe system. No specifically dedicated systems for managed care operation.

5. Expected Benefits from Managed Care Activities.

A. Cost Savings/Cost Avoidance: _____

B. Increase Patient Accessibility: Added 20 beds to inpatient Psychiatry Ward, established a Pediatric Intensive Care Unit, doubled radiation therapy workload production.

C. Increase Provider Satisfaction: Efficiencies Review studies recommended and established the Satellite Chart Housing System for clinical records completion by providers. Placed the storage and records closer to the providers. Able to cut a delinquent records completion from 3000 to less than 300 per month, using one-half the personnel.

D. Increase Patient Satisfaction: _____

E. Other: _____

6. Comments on Managed Care Program: None

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NARRATIVE DESCRIPTION OF THE
67TH Medical Group, Bergstrom AFB, TX

The 67th Medical Group, Bergstrom AFB, Texas is a USAF Hospital authorized to operate 20 beds. The Hospital has a twofold mission of providing medical and dental care to its beneficiaries as well as preparing for wartime contingencies. Point of Contact for the telephone interview was Capt Sally Ryan. Capt Ryan is the Catchment Area Management (CAM) Project Officer for the Bergstrom area and as such serves as the Bergstrom Hospital's Chief, Managed Care Office.

Centralized Managed Care Activities at Bergstrom Hospital started in 1989 with the unit's selection to participate in the USAF's MEDEXCEL Program (CAM Project). Bergstrom Hospital currently has 14 fulltime personnel assigned to its managed care activities. These activities are broken into two separate functional areas, the Member Services Activities and a Utilization Management Activity. Capt Ryan is in charge of the centralized managed care activity. She along with one NCO run the managed care office that acts as a staff agency to the Administrator and coordinates and monitors the two functional managed care activities.

The Member Services Activity, which consists of four Patient Advisors, four personnel to make appointments and referrals, and a receptionist, all report to the Patient Administration Department (SGR). This office is responsible for implementing the CAM Project enrollment of beneficiaries, and providing beneficiaries with program information, and acts as a referral agency for patients seeking care outside the facility. The Utilization Management (UM) Services consists of three personnel: a nurse, a case management worker, and a secretary. The UM personnel report to the Chief, Clinical Services Department (SGH). This section is responsible for the implementation of case management, discharge planning, and utilization review for patients within the direct care system. This section has also arranged to coordinate with the local Professional Review Organization (Texas Medical Foundation) to provide prior authorizations, and concurrent reviews for CHAMPUS patients receiving care in the private healthcare market. The Managed Care Office monitors the managed care activities and expenses to advise the Hospital Administrator and Commander on the appropriateness of military medical spending within the catchment area.

Capt Ryan expects their Centralized Managed Care Activity to provide a measure of control in the growth of medical costs. This CAM demonstration gives the facility control of payments to participating physicians; therefore, they can place more demands on the participating civilian physicians for greater cost efficiencies. Bergstrom is also improving patient accessibility of healthcare to their beneficiaries through a formal network of providers.

NARRATIVE DESCRIPTION OF THE
USAF Hospital Kirtland, Kirtland AFB, New Mexico

USAF Hospital Kirtland, Kirtland AFB, NM is authorized to operate a forty bed hospital. The Kirtland Hospital is in a very unique situation, as it is co-located with the Albuquerque Veterans Administration Hospital in New Mexico. Kirtland Hospital is part of an Air Force/Veterans Administration Project for sharing federal healthcare services. USAF Hospital Kirtland and the VA Medical Center make up the complex referred to as the New Mexico Regional Federal Medical Center. Because of this special project, the USAF Hospital is presented with special opportunities of cost controlling activities through sharing of medical resources and services with the VA Hospital.

The Kirtland Managed Care Activities are divided between two offices. There is a Joint Planning Group composed of four personnel and they have the responsibility to plan and negotiate all sharing agreements between the VA and the Air Force. The second office is the Extended Civilian Healthcare Office (ECHO) which has eight fulltime personnel and carries out the Health Benefits Advisor function (2 personnel), the supplemental care and cooperative care program (2 personnel), assists in filing claims for certain healthcare provider partners (2 personnel), and audits partnership records of care (2 personnel). The ECHO activities are not totally centralized and personnel conducting the separate functions are located either in the Medical Resources Management Office (Audits and Paying of Supplemental Care) on the Patient Administration Department which controls the HBA's and personnel assisting the Mega Partners in filing claims.

The Joint Planning Group (JPG) consists of the Chief of the Group, an MSC Officer, a Nurse, an NCO, and a civilian secretary. The Joint Planning Committee reports directly to the Administrator of the Kirtland Hospital and is responsible for keeping the executive staff apprised of all managed care activities within the facility. The JPG also studies the possibilities of new managed care initiatives that can be financed by DoD or Air Force Programs such as the CHAMPUS Alternative Use of Funds Program. This planning group has already developed a medical cost savings initiative called CHAMPUS Restore, in which CHAMPUS eligibles that cannot be cared for in the direct care system are disengaged and referred to the VA Hospital where there is no deductible or cost sharing for the patient, and care is provided at lower costs to the government.

The ECHO Office has also initiated cost efficient methods of healthcare delivery. This staff developed a new type of Partnership, they call the Mega Partners. The Mega is located and contracted through the New Mexico Medical School and are providing needed care within the Kirtland Hospital. Part of the Mega

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Partnership agreement is that the ECHO Office assist the partner providers in filing their claims to CHAMPUS.

The Joint Planning Group and ECHO are serving the Kirtland Hospital well. The facility was able to save over \$1.5 million during fiscal year 1989 in the CHAMPUS Restore initiative, and are very positive about the ability of the Mega partners to provide expanded access to its beneficiaries at the most efficient costs to the government. Both of these offices have a reporting line to the Administrator of the Kirtland Hospital.

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NARRATIVE DESCRIPTION OF THE
Wright Patterson USAF Medical Center,
Wright Patterson AFB, OH

Wright Patterson USAF Medical Center (WPMC) is authorized 301 operational beds. WPMC has the largest centralized managed care operations among USAF MTFs and possibly in the DoD. The managed care operations are a result of the vision and initiative of the Administrator. Col Cunningham (WHMC Administrator) has forged ahead by having his personnel obtain funding through the Air Force Management Efficiencies Add Program to support testing a CAM Infrastructure to better manage the cost of healthcare.

The WPMC Managed Care Directorate consists of 18 full-time staff members who operate this service with total quality management emphasis (TQM). The Directorate is led by a GS-11 employee and a 1st Lieutenant Assistant Director. The Managed Care Directorate reports to the Associate Administrator (SGAA), but, has the constant informal attention and support of the Administrator and facility Commander. The goal of the managed care office is to assist WPMC in positioning the medical center to deliver reasonably priced, state-of-the-art medicine and service to meet the needs of the patient population.

The 16 remaining managed care positions are filled with full-time employees. These managed care employees work within two different sections in the Managed Care Directorate. The first section is called the Program Development section and provides strategic planning, marketing, auditing, and a special studies function. The special studies section is geared to taking advantage of special funding opportunities to increase access to care. The second section is a Beneficiary Services function with a referral scheduling activity that includes 1 Registered Nurse and 2 Licensed Practical Nurses. It advises patients where appropriate care can be obtained from participating Healthcare Finder Providers. This section also provides the Supplemental care functions and the normal Health Benefits Advice Office.

Since 1989 WPMC has been able to increase visits under its partnerships by 5000 between inpatient and outpatient clinic visits. They have also shown a \$16,000-20,000 per month savings through an Internal Partnership contract with a local Cardiovascular Service. WPMC has also been able to add 240 surgeries through the CHAMPUS Alternative Funds Use Program and are projecting many more areas of savings in the future. WPMC has been planning for an information system to support its managed care activity. It currently has a computer link to the Fiscal Intermediary to determine the status of certain partner provider claims and the prevailing rates for other activities. They are also in possession of a WANG system and AT&T computer hardware that will provide them with the needed information

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system to manage healthcare and its costs more efficiently. WPMC is not currently conducting Utilization Management functions within their centralized office but are planning to coordinate this function in the near future.

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NARRATIVE DESCRIPTION OF THE
David Grant USAF Medical Center
Travis AFB, CA

David Grant USAF Medical Center (DGMC) is authorized 250 operational beds. It has a fourfold mission of patient care, medical/dental graduate training, readiness, and clinical investigations. DGMC does not have a centralized managed care system within its facility; however, it is operating within the CHAMPUS Reform Initiative area, and therefore has the CRI contractor to perform many of the cost containment managed care activities. The Point of Contact at DGMC was Lt Col Phillip Marler, Associate Administrator (SGAA).

Although the CRI contractor handles many of the cost containment activities such as the partnership and Healthcare Finder activities, DGMC has designated two liaison officers to coordinate managed care activities with the CRI Contractor. The liaison officers are the Associate Administrator (SGAA) and the Assistant Administrator of Clinical Services (SGH). DGMC has maintained its Health Benefits Advisors, which are under the control of Patient Affairs (SGR). Also located at DGMC are 5 to 6 registered nurses provided by the CRI contractor. These nurses were placed there to control the flow of patients to the network of providers that they have negotiated or the direct care system. The liaison officers assist in the managed care activities by identifying and researching opportunities of Resource Sharing Contracts with the CRI contractor. The contractor will support the MTF with resources for adding services or expanding services aimed at recapturing CHAMPUS healthcare expenditures into the direct care system.

Lt Col Marler is convinced that this CRI contract will expand out of the test phase area of California and Hawaii and into other parts of the United States. The size of the Contractor and his financial clout to negotiate contracts is a definite advantage to controlling rising cost. Also, the opportunity for resource sharing with the MTFs will benefit cost efficiency initiatives and the access to healthcare services by the beneficiaries.

NARRATIVE DESCRIPTION OF THE
MANAGED CARE ACTIVITY AT
USAF Regional Hospital Eglin, Eglin AFB, FL

The USAF Regional Hospital Eglin is a 125 bed facility with a mission of patient care and readiness, and a minor medical training function. Eglin has established a centralized managed care office, taking positions from within its own existing resources to develop this function. The centralized managed care office currently falls under the Patient Affairs Directorate, reporting to the Facility Administrator. Capt Dianne Keltz was the interview point of contact, she is the current Patient Affairs Administrator. Capt Keltz stated that there are plans to change the name of her position to the Director of Managed Care.

The Managed Care Activities at the Eglin Regional Hospital currently consist of nine personnel, plus Capt Keltz who serves part-time as the Director of Managed Care, and part-time as the Associate Administrator, Patient Affairs. The other nine personnel are full-time managed care employees who work in the Health Benefits Advisors Office (7 personnel) and a managed care office (2 NCOs). The centralized managed care activities include the Partnership Program, the Health Care Finder Program, and a function to monitor the costs and availability of care to its beneficiaries. This office is responsible for performing studies to validate requests for support (Alternate Use of CHAMPUS Funds) to expand healthcare services or initiate new medical services. The centralization was implemented within the last year and the service is still evolving into a legitimate and beneficial service to the hospital and its beneficiaries.

Capt Keltz has indicated that the Managed Care Activity at Eglin has successfully identified and implemented Partnership and Healthcare Finder Program agreements that are providing needed services at the most cost efficient means to their beneficiaries and the government. Eglin's primary savings have come through the Partnership Program. They have documented \$3 million savings from internal partnerships and \$1.2 million through the surgical services that were expanded by the Management Efficiencies Add Program. The managed care system seems to be very beneficial to the Eglin Hospital mission and they hope to expand the program with additional personnel in the near future.

NARRATIVE DESCRIPTION OF THE
Managed Care Activity at
Malcolm Grow USAF Medical Center, Andrews AFB, DC

Malcolm Grow USAF Medical Center (MGMC) is one of the six USAF Medical Centers in the United States. It is authorized 275 beds and has a threefold mission of patient care, medical/dental training, and readiness. MGMC's centralized managed care office reports to the Associate Administrator, Medical Resource Management (SGM). The Point of Contact for the interview was 1st Lt Jim Baron, who served as the facilities Managed Care Officer. Lt Baron also works as the Assistant Resource Management Officer.

The Managed Care Activity at MGMC consists of eleven personnel working under the Medical Resource Management Department. The Officer in Charge, Lt Baron, serves as the Managed Care Director on a part-time basis. However, the remaining personnel are all working full-time in their managed care activities. Managed Care activities at MGMC are a little different from what has previously been observed. It includes five personnel working in the Medical Service Account (MSA), four personnel performing the Alternative Care Referral Office, and two personnel working the new third party collections program. MGMC is different because it includes the MSA and third party collections activities within the managed care office. The MSA office helps Managed Care perform cost analysis and audit functions for the various partnerships. The Coordination of Benefits service identifies patients with healthcare insurance and collects from the third party the charges for the care provided to the beneficiary. It is also different in that the managed care activities fall under the Medical Resource Management Office rather than the Patient Affairs Directorate (SGR) or directly under the Administrator (SGA). The four personnel working in the Alternative Care Referral Office include 2 Health Benefits Advisors and two personnel to work the supplemental and cooperative care programs. The last two personnel try to counsel every individual that must seek care outside the direct care system.

The MGMC Managed Care Activity has only been in existence for a few months. They are not fully operational as they are still identifying areas to include under their responsibility. Their plans are to have one central referral agency for all beneficiaries to call before seeking care in the private sector, and to negotiate all health care agreements (Partnerships and HCFs) to no higher than 70% of allowable charges. They are also investigating projects and potential resource support to expand their Alcohol Rehabilitation Center and Psychiatric Internship. These services are projected to recapture high expenditure CHAMPUS care.

NARRATIVE DESCRIPTION OF THE
Naval Hospital San Diego, Sandiego, CA

The Naval Hospital San Diego (NHSD) is one of the largest US Navy medical treatment facilities in the United States. It is authorized for 504 beds and has a fourfold mission of patient care, readiness, training, and clinical research just as WHMC has. The catchment area around NHSD has the largest number of DoD healthcare beneficiaries in all of the United States and is an excellent installation in which to conduct managed care activities. The interview Point of Contact at this facility was Commander Dan Ford, the facilities Assistant Director, Healthcare and Planning Directorate. The Healthcare and Planning Directorate is the MTF's centralized managed care activity and has been in operation for almost two years. NHSD, being in California, is participating in the CHAMPUS Reform Initiative (CRI) and has had the benefit of assistance from a contracted managed care agency.

The Healthcare Planning and Development Office acts as a staff agency to the Commanding Officer for managed care activities. Although NHSD is supported with the CRI Program, the facility administration has decided to operate a centralized managed care office. This office was established to take advantage of the opportunities presented from studying and aggressively pursue new healthcare accessibility and cost efficiency actions. The Healthcare Planning and Development Office consists of nine full-time employees including a physician (O-6 grade level) director, a Medical Service Corps assistant director (O-5 grade level), three junior company grade officers, two GS-12 civilian employees, and two GS-5 civilian employees.

The types of managed care functions that NHSD Hospital personnel perform are selected aspects of the Partnership Program; Resource Sharing with the CRI Contractor planning; internal and external marketing to override any negative press the facility may receive; health services contracting; Efficiency Review Studies Branch; and they are actively pursuing a DRG expert that can assist them in case management and discharge planning.

NHSD has established a strong internal managed care activity that is supported by the CRI Managed Care Contractor through resource sharing. To date, resource sharing with the CRI contractor has supported NHSD with an expansion of 20 beds to their inpatient psychiatry service and added a Pediatric Intensive Care Unit to the hospital. NHSD has also received financial support to obtain sufficient resources enabling them to double their workload in radiation technology areas.

The NHSD is committed to the principles of managed care and has the appropriate support from the medical staff and the Commanding Officer to make their managed care activities successful.

NARRATIVE DESCRIPTION OF THE
Managed Care Activity at
Martin Army Hospital

The Martin Army Hospital is a 150 facility operating in the Fort Benning, Georgia area. It has a centralized managed care function called the Coordinated Care Branch. This Coordinated Care Branch reports through the Patient Administration Officer. Capt Michael Payton, the Point of Contact for the telephone interview, serves as the Chief of the Coordinated Care Branch, and he also serves as the Patient Administration Officer. Although the facility has had this managed care operation for almost a year, it is still evolving as the organization identifies what is needed to conduct their managed care activities.

The Martin Army Hospital Coordinated Care Branch currently consist of eight personnel. The office staff include an MSC Officer and Nurse Officer, one civilian (GS-6) for contracts, one civilian (GS-11) for coordinating the PRIMUS Clinic, two civilian Health Benefits Advisors (GS-7/5), and two more civilians to work the Supplemental Care Program. These personnel will soon be joined by a civilian (GS-11) Health Services Manager, and two civilian personnel to coordinate and assist with managed care budgeting and planning decisions.

Martin Army Hospital's Coordinated Care Branch operates an active Partnership Program, and has a few VA/DoD Sharing Agreements with the Tuskegee VA Hospital. They are also participating in the Southeast Preferred Provider Organization Project which is an outside agency assisting in establishing a network of healthcare services for referral of CHAMPUS eligible beneficiaries who require care outside the direct care system. The Nurse on the staff is responsible for providing a dialogue between the civilian facility and the direct care system for supplemental and cooperative care patients. The Coordinated Care Branch is also working hard to identify and study areas that could be supported with CHAMPUS Alternative Use of Funds Projects. They are attempting to identify any procedures or services where access to care is needed by their beneficiaries or where cost efficiency actions could reduce the cost of delivering quality healthcare. Thus far (FY 1989-90) the Coordinated Care Branch has documented \$65,000 of cost avoidance from hiring additional nursing support for the Martin Hospital, and they have increased their outpatient visits by over 5000 during a period in FY 1989. Capt Payton is confident that the Coordinated Care Branch will produce even greater results in the future.