



JUNE 11, 2015

DEPARTMENT OF DEFENSE VIEWS ON THE MILITARY COMPENSATION AND RETIREMENT MODERNIZATION COMMISSION'S RECOMMENDATIONS FOR MILITARY HEALTH CARE REFORM

U.S. SENATE, COMMITTEE ON ARMED SERVICES, SUBCOMMITTEE ON MILITARY PERSONNEL

ONE HUNDRED FOURTEENTH CONGRESS, FIRST SESSION

HEARING CONTENTS:

WITNESS TESTIMONY

MARK EDIGER [[pdf unavailable](#)]

Surgeon General, United States Air Force

C.FORREST FAISON III [[pdf unavailable](#)]

Deputy Surgeon General, United States Navy

PATRICIA D. HOROHO [[pdf unavailable](#)]

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JONATHAN WOODSON [[View pdf](#)]

Assistant Secretary of Defense for Health Affairs, Department of Defense

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PREPARED STATEMENT

OF

THE HONORABLE JONATHAN WOODSON, M.D.,

ASSISTANT SECRETARY OF DEFENSE

(HEALTH AFFAIRS)

AND

SURGEONS GENERAL OF THE MILITARY DEPARTMENTS

BEFORE THE

HOUSE ARMED SERVICES COMMITTEE

SUBCOMMITTEE ON MILITARY PERSONNEL

JUNE 11, 2015

Chairman Heck, Ranking Member Davis, Members of the Committee. Thank you for the opportunity to come before you today to specifically remark on the recent recommendations from the Military Compensation and Retirement Modernization Commission (MCRMC), as well as to discuss the state of the Military Health System (MHS), and our plans for the future. Our testimony reflects the shared perspective and vision of the entire MHS leadership team that is testifying before you today.

The Commission has performed a valuable service to the Department and the nation. The Commission's 18-month independent review reaffirmed many positive changes we are making to help enhance the Services' capability to recruit, train and retain America's All-Volunteer Force in the present and future, while supporting those who have served our Nation. In addition, it pointed out areas where we can do better. In many cases, we have come to similar conclusions about the challenges facing military medicine with the end of kinetic combat operations.

There were many important recommendations with which we concur, and have already moved into implementation. There were other recommendations that contained suggestions that matched actions that were already well under way. The Commission's endorsement of these approaches is both welcome and helpful.

The DoD Review Process of Commission Recommendations

After receiving the MCRMC's Final Report on January 29, 2015, the Department conducted rapid, comprehensive and concurrent reviews of each recommendation. In total, this review spanned more than six weeks, was conducted by more than 150 subject matter experts, and supported by three Federally Funded Research and Development Centers (FFRDCs) -- RAND, IDA and CNA. In addition, the Department collaborated with experts from the

Departments of Labor, Commerce, Education, and Veterans Affairs, as well as Offices of Management and Budget and Personnel Management, to ensure a holistic review. Senior leaders at every level of DoD reviewed and provided critical input.

As the Department's official response has made clear, the MCRMC's objectives are largely consistent with the Department's objectives in this complex but essential aspect of national defense, our military force. Where the Department differs, however, is how to best to achieve these objectives in some cases. Although the Commission's work covered a broad array of compensation and benefit issues, we will confine our remarks to those recommendations that focused on health matters.

Medical Readiness

Regarding the state of medical readiness, the Commission provided noteworthy assessments about the challenges we face in providing our military medical forces the appropriate opportunities to sustain the clinical skills required for wartime.

A major pillar of our military health system is maintaining the readiness of our military medical providers to support combatant commanders anytime and anywhere. This requirement is partially satisfied through the care provided to those who seek care within our military medical treatment facilities (MTFs). Other aspects of military medical readiness are supported through strategic partnerships with civilian and VA health systems through which many of our military medical providers supplement their readiness skills.

The Commission is correct in asserting that a number of military medical facilities do not have sufficient internal clinical volume or case mix to sustain these skills. The Commission is

also correct in concluding that the Department does not apply the same rigor to managing clinical aspects of joint medical capabilities as it does with other aspects of military capability.

We agree that combat trauma is an important capability that deserves special attention. Combat trauma readiness increases during conflict as medical personnel provide more casualty care than they generally do in garrison. Therefore, we are working on an enterprise-focused joint medical readiness management effort to guide resource allocation and tactics, techniques, and procedures in a way that promotes the continued sustainment of key medical capabilities during peacetime. Mitigation levers like strategic partnerships with civilian institutions and the VA, targeted patient throughput at MTFs that includes a planned marketing campaign to attract beneficiaries to use military hospitals for specific, complex surgical procedures, and investments in joint training are all part of our existing portfolio designed to address these challenges.

The Commission's recommendations relative to enterprise measuring and management of essential medical capabilities (EMC) are worth pursuing. We believe that the range of capabilities required to support the warfighter are broader than the Commission's emphasis on combat support and trauma care. We plan to define EMCs to include more than the specific trauma-related capabilities advocated by the Commission, and align those with operational readiness requirements. Consider the very different demand signal coming from our recent support to fight Ebola in western Africa and the demand signal coming from the counterinsurgency operations in Afghanistan. Furthermore, even in Operation Enduring Freedom (OEF)/Operation Iraqi Freedom (OIF) /Operation New Dawn (OND), 61% of those evacuated from theater were for disease related issues; of all medical encounters recorded in theater, 77% were for disease and non-injury concerns. These statistics are consistent with the history of medical needs in wartime.

Together with the Joint Staff Surgeon and Service Surgeons General, and assisted by Military-Department-led and Joint-Staff-facilitated working groups, the ASD(HA) will determine EMCs for reporting and will identify how to measure the EMCs. These EMCs will be validated through the Military Health System Executive Review (MHSER) to the Deputy Secretary of Defense for approval, after which they will be added to the standard Defense Readiness Reporting System. Thus, in much the same way that Services report unit readiness now, they will use existing reporting systems to report metrics depicting the inventory of ready EMCs as well as the health of the underlying pipelines that produce those capabilities.

The Commission also recommended the establishment of a Joint Readiness Command. The Department does not support the creation of an additional four-star combatant command, the Joint Medical Readiness oversight council (JMROC), and the J10.

In 2011, the Secretary of Defense established a Task Force on MHS Governance to assess the optimal organizational structure for military medicine. A Unified Medical Command was one of the options considered by the DoD Task Force. The Task Force determined that a new unified medical command would add to, rather than reduce, headquarters overhead. Existing Service medical headquarters would continue to be required and home station medical command and control would continue to be managed according to Service-specific governance models. Consequently, the Department believes that it currently has sufficient processes and governance structures to identify, track, and measure the readiness status of enterprise-wide and Service specific EMCs and therefore does not support creation of an additional new four-start combatant command.

The establishment of the Defense Health Agency and a comprehensive joint governance process has provided a viable and affordable way for the Department to leverage economies of

scale for those functions that are common among the Service Medical Departments. The Department of Defense has an effective means of jointly measuring, monitoring, and managing the readiness of the joint force. The MHS Executive Review (MHSER) council has been revitalized in the last two years – providing a team of senior military and civilian leaders from the Services, Joint Staff and major OSD staff agencies to oversee major policy decisions and operational performance of the MHS. In addition, the department will include the status of joint medical capabilities in the existing Deputy’s Management Action Group (DMAG) on readiness that are co-chaired by the Deputy Secretary and Vice Chairman of the Joints Chiefs, as well as the quarterly readiness review to Congress starting in FY 2016.

DoD and VA Collaboration

The Department supports the goals of the Commission and is committed to working even more closely with the VA to achieve greater data interoperability, improve the transition of our Service members back to civilian life, increase the number of DoD/VA sharing agreements for health care delivery, and coordinate with VA to determine the subset of medications important to transitioning Service members. The opportunities for sharing are vast and should be implemented where they align with both Departments strategic plans, make good business sense and serve the needs of our beneficiaries.

The standardization of common medical services and reimbursement methodology between the two Departments positively expands on the current work of the DoD/VA Joint Executive Council (JEC). Likewise, ensuring that Service members who leave the DoD are able to continue on all DoD prescribed medications builds on the President’s Executive Actions of August 2014.

The Departments have determined that interoperability of health information is a high priority. Both Departments exchange significant amount of health and personnel information with each other. In addition, both DoD and VA are increasingly purchasing more health services from the private sector. Thus, interoperability with a broader set of health system is an overarching objective and high priority for both Departments. The DoD is interacting with the Office of the National Coordinator for Health IT (ONC) at all levels and has participated fully in developing the new ONC Interoperability Roadmap. This work is foundational to the roll-out of the new DoD Electronic Health Record. The Department expects to announce our selection of an EHR vendor this year.

The DoD also supports continued efforts to solve the problem of access to needed pharmaceuticals for transitioning Service members created by different formularies in the two Departments. There has been substantial progress: the VA has a waiver process to immediately achieve the Commission's recommendation, and the President's August executive actions to address service member and veteran mental health and suicide prevention address the specific case of psychiatric drugs by providing a default assumption that VA will continue mental health prescriptions for transitioning service members.

Finally, reforms to the governance of the DoD/VA Health Executive Committee (HEC), aligned to five major business lines, provide clarity and focus to our sharing objectives. These changes will improve our integration efforts and better allow us to follow progress toward mutually established milestones.

TRICARE Extended Health Care Option (ECHO)

The Department supports the objective of expanding services available to family members with special needs. The stresses of frequent moves and repeated deployments make it hard for military families to care for family members with special medical or educational needs. While many state Medicaid programs provide highly valued support services, the level of support varies widely among the states and even within counties. More importantly, the waiting list for these services often approaches or even exceeds the average deployment length keeping these services out of the reach of many active duty families.

The Exceptional Family Member Program (EFMP) was created to alleviate some of these challenges. Specifically, active duty families enrolled in EFMP are eligible, based on qualifying conditions, for the TRICARE Extended Care Health Option (ECHO). ECHO, provides eligible active duty families with an integrated set of support services and supplies designed to reduce the disabling effects of the beneficiary's qualifying condition.

The Commission recommended improving support for dependents with special needs by expanding ECHO services to better align with those provided under state Medicaid waiver programs. Expanded services would be subject to the ECHO benefit cap of \$36,000 per fiscal year, per dependent.

The Department supports expanded services for family members with special needs. We plan to implement two services recommended by the Commission this year (for respite care and incontinence supplies). However, we believe that the full package of proposed changes requires additional time to evaluate, including any associated costs. By December 2015, we will have a more comprehensive assessment of the viability of the other recommendations put forward.

TRICARE Program

Only one proposal from the Commission requires even further study – and that is the recommendation to significantly alter the military health benefit provided to all 9.2 million DoD beneficiaries. We agree with the Commission that we need to continue to improve the military health system. This remains a critical issue, and the Department will work with the Commission and Congress to develop additional reform proposals for consideration as part of the Fiscal Year 2017 Budget.

TRICARE is an exceptional health benefit, tailored to meet the unique needs of military families. We believe its customized approach accommodates the unique mission of the Military Health System, best supports our overall readiness objectives, offers comprehensive choice to military beneficiaries, and provides the same global, highly affordable benefit to everyone – whether an 18 year old newly enlisted Service member or the Chairman of the Joint Chiefs of Staff.

We acknowledge that elements of TRICARE can be improved. We are specifically working to improve access to care, and TRICARE’s authorization and referral processes. We have recently released requests for proposal for the next generation of TRICARE contracts that will further streamline administration, and we have internal teams focused on near-term process improvements to access and referrals.

The health care reforms proposed in the Fiscal Year 2016 President’s Budget are a good first step and offer service members, retirees, and their families more control and choice over their health care decisions. They keep the overall, and highly successful, TRICARE program intact. The Department is looking forward to working with the Commission and Congress on drafting additional legislative proposals for the 2017 budget that would enhance the FY 2016

TRICARE proposals to further achieve the goals of the Department and those of the Commission.

Our Joint Future

The Military Health System is a unique and indispensable instrument of national security. Its value has been proven time and again in deployed environments, in responding to infectious disease outbreaks around the world (most recently with Ebola in West Africa), in disaster response and in humanitarian assistance missions, and above all in the routine delivery of care every day to the special population of Americans who we are privileged to serve. This mission attracts to the military some of the most respected medical professionals in the world.

The MHS is a complex organization with readiness at the center of the MHS mission. It draws strength from that complexity. Our health care delivery system, our health benefit, our education and training system, our medical research and development programs, and our public health capabilities complement each other in supporting this mission.

Components of the MHS – our Army, Navy, and Air Force medical services – each have unique missions, tied to the roles and responsibilities of their parent Service. Their affiliations with their line units strengthen the system, rather than diminish it, and enable us to meet our requirements to both our combatant commanders in theater and our commanders in garrison.

There are also similarities in how the Services operate, and the new Defense Health Agency is working as designed – to bring common solutions to shared challenges. Over the last 18 months, the Military Health System has introduced a modernized, enterprise-wide approach to managing its vast responsibilities. Our decision-making model is highly collaborative and effective. In pharmacy, health IT, medical logistics, health facilities, medical research, public

health, and more – our system is bringing a joint approach to clinical and business operations where it makes sense.

We have undertaken a comprehensive assessment of our military medical infrastructure. In order to optimize our military medical team, our future capital requirements must reflect changes that have affected all of American medicine, and we must match personnel resources with where our beneficiary populations reside, or where local community capability is absent. Where necessary, we will expand strategic partnerships with both interagency and civilian institutions in support of our mission.

The FY15 National Defense Authorization Act required the Government Accountability Office (GAO) to review the methodology used by the Department in the Modernization Study. Following GAO Review, we would like the ability to move forward with implementing reasonable steps to improve efficiency without further delay.

Our system is implementing recommendations that emerged from the Secretary's Review of the MHS that occurred in summer 2014 and culminated in the Secretary's Action Plan of October 1, 2014. Quality, accountable health care is the most consequential benefit a grateful nation owes its Service members and their families. We are committed to improve and deliver on that commitment.

We have strengthened policy and oversight of our patient safety and quality programs. We have implemented, or are implementing, a number of other system-wide initiatives to provide quality of care to all MHS patients. These initiatives include adoption of the Global Trigger Tool to establish more than one mechanism for capturing harm events; the expansion of surgical quality data collection and analysis to all Direct Care surgical facilities through our participation in the American College of Surgeons' National Surgical Quality Improvement

Program; and standardized MHS training to reduce variability in coding and documenting of care for mothers and newborns.

We have established 30 enterprise-wide measures of readiness, access, safety, quality, satisfaction, and cost. These include measures such as individual medical readiness, the average number of days to next available appointment (access), hospital acquired infection rates (safety), post-partum hemorrhage rates (quality), and satisfaction with getting care when needed. The ASD(HA), the Surgeons General and the Director, Defense Health Agency review these measures on a quarterly basis and share findings with the entire MHS community. We “drill-down” on essential core measures to drive improvement. I am encouraged by the direction in which we are moving along a number of measures, but there is much more to do.

We recognize that the patient is a partner in their health, not simply a customer. We have undertaken a long-term effort to increase transparency of health information. We have made it easier to find our existing, public information by consolidating quality, safety, access, and satisfaction measures in one location on our military health websites. In addition, we are in the midst of engaging with our beneficiaries to improve the usability of the information we place in the public domain. We are working with our partners at the Center for Medicare and Medicaid Services to participate in Hospital Compare. When unexpected events occur, we have a global Health Care Resolutions process in place to serve patients, patients’ families, and our medical staff in understanding what happened through an open, ongoing dialogue.

The Department has proposed a number of other actions that help accelerate our reform efforts and allow us to serve as responsible stewards of government resources. Fiscal pressures both within the Department and with health care in general require continued close attention to how our financial resources are used. Several Department proposals are under consideration by

Congress at this time.

We have proposed updates to prescription drug co-payments that further incentivize use of MTF and mail order pharmacies, and are closer to civilian sector copayments. We will continue to provide prescriptions in MTFs with no out-of-pocket cost to beneficiaries. Current fiscal realities compel us to consider the TRICARE benefit, along with a full range of management improvements, to achieve the efficiency objectives of both the Commission and the President's Budget request. Failing to do this would compel DoD to take additional reductions in the areas of readiness, modernization, and force structure. In addition, as the military services are making force structure changes, we would benefit from the ability to convert some military medical authorizations to civilian authorizations when it supports our readiness needs and management efficiency.

The Military Health System does not exist for its own sake. As our military forces continue to operate in Afghanistan, confront the threats posed by ISIS, stand fast with our allies and partners in maintaining peace and stability in other parts of the world, and remain ready to respond to any contingency at any time, they know they are supported by a health system that will do everything in its power to ensure their health and sustain their lives, as well as that of their families.

We are fortunate to be entrusted with serving as stewards of this system of care. This system has enjoyed many successes and medical breakthroughs over the last 13 years of war – including advancements in sophisticated blood clotting agents or aeromedical evacuation capabilities for critically injured patients, providing “care in the air” that was previously beyond our capabilities. Where there are areas that require further improvement, we have identified them, and begun a sustained effort to get better.

We are grateful for this opportunity to present our findings, and our way forward, and we look forward to your questions.

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We recognize that the patient is a partner in their health, not simply a customer. We have undertaken a long-term effort to increase transparency of health information. We have made it easier to find our existing, public information by consolidating quality, safety, access, and satisfaction measures in one location on our military health websites. In addition, we are in the midst of engaging with our beneficiaries to improve the usability of the information we place in the public domain. We are working with our partners at the Center for Medicare and Medicaid Services to participate in Hospital Compare. When unexpected events occur, we have a global Health Care Resolutions process in place to serve patients, patients’ families, and our medical staff in understanding what happened through an open, ongoing dialogue.

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We have proposed updates to prescription drug co-payments that further incentivize use of MTF and mail order pharmacies, and are closer to civilian sector copayments. We will continue to provide prescriptions in MTFs with no out-of-pocket cost to beneficiaries. Current fiscal realities compel us to consider the TRICARE benefit, along with a full range of management improvements, to achieve the efficiency objectives of both the Commission and the President's Budget request. Failing to do this would compel DoD to take additional reductions in the areas of readiness, modernization, and force structure. In addition, as the military services are making force structure changes, we would benefit from the ability to convert some military medical authorizations to civilian authorizations when it supports our readiness needs and management efficiency.

The Military Health System does not exist for its own sake. As our military forces continue to operate in Afghanistan, confront the threats posed by ISIS, stand fast with our allies and partners in maintaining peace and stability in other parts of the world, and remain ready to respond to any contingency at any time, they know they are supported by a health system that will do everything in its power to ensure their health and sustain their lives, as well as that of their families.

We are fortunate to be entrusted with serving as stewards of this system of care. This system has enjoyed many successes and medical breakthroughs over the last 13 years of war – including advancements in sophisticated blood clotting agents or aeromedical evacuation capabilities for critically injured patients, providing “care in the air” that was previously beyond our capabilities. Where there are areas that require further improvement, we have identified them, and begun a sustained effort to get better.

We are grateful for this opportunity to present our findings, and our way forward, and we look forward to your questions.

PREPARED STATEMENT

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SUBCOMMITTEE ON MILITARY PERSONNEL

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The Commission has performed a valuable service to the Department and the nation. The Commission's 18-month independent review reaffirmed many positive changes we are making to help enhance the Services' capability to recruit, train and retain America's All-Volunteer Force in the present and future, while supporting those who have served our Nation. In addition, it pointed out areas where we can do better. In many cases, we have come to similar conclusions about the challenges facing military medicine with the end of kinetic combat operations.

There were many important recommendations with which we concur, and have already moved into implementation. There were other recommendations that contained suggestions that matched actions that were already well under way. The Commission's endorsement of these approaches is both welcome and helpful.

The DoD Review Process of Commission Recommendations

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Departments of Labor, Commerce, Education, and Veterans Affairs, as well as Offices of Management and Budget and Personnel Management, to ensure a holistic review. Senior leaders at every level of DoD reviewed and provided critical input.

As the Department's official response has made clear, the MCRMC's objectives are largely consistent with the Department's objectives in this complex but essential aspect of national defense, our military force. Where the Department differs, however, is how to best to achieve these objectives in some cases. Although the Commission's work covered a broad array of compensation and benefit issues, we will confine our remarks to those recommendations that focused on health matters.

Medical Readiness

Regarding the state of medical readiness, the Commission provided noteworthy assessments about the challenges we face in providing our military medical forces the appropriate opportunities to sustain the clinical skills required for wartime.

A major pillar of our military health system is maintaining the readiness of our military medical providers to support combatant commanders anytime and anywhere. This requirement is partially satisfied through the care provided to those who seek care within our military medical treatment facilities (MTFs). Other aspects of military medical readiness are supported through strategic partnerships with civilian and VA health systems through which many of our military medical providers supplement their readiness skills.

The Commission is correct in asserting that a number of military medical facilities do not have sufficient internal clinical volume or case mix to sustain these skills. The Commission is

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We agree that combat trauma is an important capability that deserves special attention. Combat trauma readiness increases during conflict as medical personnel provide more casualty care than they generally do in garrison. Therefore, we are working on an enterprise-focused joint medical readiness management effort to guide resource allocation and tactics, techniques, and procedures in a way that promotes the continued sustainment of key medical capabilities during peacetime. Mitigation levers like strategic partnerships with civilian institutions and the VA, targeted patient throughput at MTFs that includes a planned marketing campaign to attract beneficiaries to use military hospitals for specific, complex surgical procedures, and investments in joint training are all part of our existing portfolio designed to address these challenges.

The Commission's recommendations relative to enterprise measuring and management of essential medical capabilities (EMC) are worth pursuing. We believe that the range of capabilities required to support the warfighter are broader than the Commission's emphasis on combat support and trauma care. We plan to define EMCs to include more than the specific trauma-related capabilities advocated by the Commission, and align those with operational readiness requirements. Consider the very different demand signal coming from our recent support to fight Ebola in western Africa and the demand signal coming from the counterinsurgency operations in Afghanistan. Furthermore, even in Operation Enduring Freedom (OEF)/Operation Iraqi Freedom (OIF) /Operation New Dawn (OND), 61% of those evacuated from theater were for disease related issues; of all medical encounters recorded in theater, 77% were for disease and non-injury concerns. These statistics are consistent with the history of medical needs in wartime.

Together with the Joint Staff Surgeon and Service Surgeons General, and assisted by Military-Department-led and Joint-Staff-facilitated working groups, the ASD(HA) will determine EMCs for reporting and will identify how to measure the EMCs. These EMCs will be validated through the Military Health System Executive Review (MHSER) to the Deputy Secretary of Defense for approval, after which they will be added to the standard Defense Readiness Reporting System. Thus, in much the same way that Services report unit readiness now, they will use existing reporting systems to report metrics depicting the inventory of ready EMCs as well as the health of the underlying pipelines that produce those capabilities.

The Commission also recommended the establishment of a Joint Readiness Command. The Department does not support the creation of an additional four-star combatant command, the Joint Medical Readiness oversight council (JMROC), and the J10.

In 2011, the Secretary of Defense established a Task Force on MHS Governance to assess the optimal organizational structure for military medicine. A Unified Medical Command was one of the options considered by the DoD Task Force. The Task Force determined that a new unified medical command would add to, rather than reduce, headquarters overhead. Existing Service medical headquarters would continue to be required and home station medical command and control would continue to be managed according to Service-specific governance models. Consequently, the Department believes that it currently has sufficient processes and governance structures to identify, track, and measure the readiness status of enterprise-wide and Service specific EMCs and therefore does not support creation of an additional new four-start combatant command.

The establishment of the Defense Health Agency and a comprehensive joint governance process has provided a viable and affordable way for the Department to leverage economies of

scale for those functions that are common among the Service Medical Departments. The Department of Defense has an effective means of jointly measuring, monitoring, and managing the readiness of the joint force. The MHS Executive Review (MHSER) council has been revitalized in the last two years – providing a team of senior military and civilian leaders from the Services, Joint Staff and major OSD staff agencies to oversee major policy decisions and operational performance of the MHS. In addition, the department will include the status of joint medical capabilities in the existing Deputy’s Management Action Group (DMAG) on readiness that are co-chaired by the Deputy Secretary and Vice Chairman of the Joints Chiefs, as well as the quarterly readiness review to Congress starting in FY 2016.

DoD and VA Collaboration

The Department supports the goals of the Commission and is committed to working even more closely with the VA to achieve greater data interoperability, improve the transition of our Service members back to civilian life, increase the number of DoD/VA sharing agreements for health care delivery, and coordinate with VA to determine the subset of medications important to transitioning Service members. The opportunities for sharing are vast and should be implemented where they align with both Departments strategic plans, make good business sense and serve the needs of our beneficiaries.

The standardization of common medical services and reimbursement methodology between the two Departments positively expands on the current work of the DoD/VA Joint Executive Council (JEC). Likewise, ensuring that Service members who leave the DoD are able to continue on all DoD prescribed medications builds on the President’s Executive Actions of August 2014.

The Departments have determined that interoperability of health information is a high priority. Both Departments exchange significant amount of health and personnel information with each other. In addition, both DoD and VA are increasingly purchasing more health services from the private sector. Thus, interoperability with a broader set of health system is an overarching objective and high priority for both Departments. The DoD is interacting with the Office of the National Coordinator for Health IT (ONC) at all levels and has participated fully in developing the new ONC Interoperability Roadmap. This work is foundational to the roll-out of the new DoD Electronic Health Record. The Department expects to announce our selection of an EHR vendor this year.

The DoD also supports continued efforts to solve the problem of access to needed pharmaceuticals for transitioning Service members created by different formularies in the two Departments. There has been substantial progress: the VA has a waiver process to immediately achieve the Commission's recommendation, and the President's August executive actions to address service member and veteran mental health and suicide prevention address the specific case of psychiatric drugs by providing a default assumption that VA will continue mental health prescriptions for transitioning service members.

Finally, reforms to the governance of the DoD/VA Health Executive Committee (HEC), aligned to five major business lines, provide clarity and focus to our sharing objectives. These changes will improve our integration efforts and better allow us to follow progress toward mutually established milestones.

TRICARE Extended Health Care Option (ECHO)

The Department supports the objective of expanding services available to family members with special needs. The stresses of frequent moves and repeated deployments make it hard for military families to care for family members with special medical or educational needs. While many state Medicaid programs provide highly valued support services, the level of support varies widely among the states and even within counties. More importantly, the waiting list for these services often approaches or even exceeds the average deployment length keeping these services out of the reach of many active duty families.

The Exceptional Family Member Program (EFMP) was created to alleviate some of these challenges. Specifically, active duty families enrolled in EFMP are eligible, based on qualifying conditions, for the TRICARE Extended Care Health Option (ECHO). ECHO, provides eligible active duty families with an integrated set of support services and supplies designed to reduce the disabling effects of the beneficiary's qualifying condition.

The Commission recommended improving support for dependents with special needs by expanding ECHO services to better align with those provided under state Medicaid waiver programs. Expanded services would be subject to the ECHO benefit cap of \$36,000 per fiscal year, per dependent.

The Department supports expanded services for family members with special needs. We plan to implement two services recommended by the Commission this year (for respite care and incontinence supplies). However, we believe that the full package of proposed changes requires additional time to evaluate, including any associated costs. By December 2015, we will have a more comprehensive assessment of the viability of the other recommendations put forward.

TRICARE Program

Only one proposal from the Commission requires even further study – and that is the recommendation to significantly alter the military health benefit provided to all 9.2 million DoD beneficiaries. We agree with the Commission that we need to continue to improve the military health system. This remains a critical issue, and the Department will work with the Commission and Congress to develop additional reform proposals for consideration as part of the Fiscal Year 2017 Budget.

TRICARE is an exceptional health benefit, tailored to meet the unique needs of military families. We believe its customized approach accommodates the unique mission of the Military Health System, best supports our overall readiness objectives, offers comprehensive choice to military beneficiaries, and provides the same global, highly affordable benefit to everyone – whether an 18 year old newly enlisted Service member or the Chairman of the Joint Chiefs of Staff.

We acknowledge that elements of TRICARE can be improved. We are specifically working to improve access to care, and TRICARE’s authorization and referral processes. We have recently released requests for proposal for the next generation of TRICARE contracts that will further streamline administration, and we have internal teams focused on near-term process improvements to access and referrals.

The health care reforms proposed in the Fiscal Year 2016 President’s Budget are a good first step and offer service members, retirees, and their families more control and choice over their health care decisions. They keep the overall, and highly successful, TRICARE program intact. The Department is looking forward to working with the Commission and Congress on drafting additional legislative proposals for the 2017 budget that would enhance the FY 2016

TRICARE proposals to further achieve the goals of the Department and those of the Commission.

Our Joint Future

The Military Health System is a unique and indispensable instrument of national security. Its value has been proven time and again in deployed environments, in responding to infectious disease outbreaks around the world (most recently with Ebola in West Africa), in disaster response and in humanitarian assistance missions, and above all in the routine delivery of care every day to the special population of Americans who we are privileged to serve. This mission attracts to the military some of the most respected medical professionals in the world.

The MHS is a complex organization with readiness at the center of the MHS mission. It draws strength from that complexity. Our health care delivery system, our health benefit, our education and training system, our medical research and development programs, and our public health capabilities complement each other in supporting this mission.

Components of the MHS – our Army, Navy, and Air Force medical services – each have unique missions, tied to the roles and responsibilities of their parent Service. Their affiliations with their line units strengthen the system, rather than diminish it, and enable us to meet our requirements to both our combatant commanders in theater and our commanders in garrison.

There are also similarities in how the Services operate, and the new Defense Health Agency is working as designed – to bring common solutions to shared challenges. Over the last 18 months, the Military Health System has introduced a modernized, enterprise-wide approach to managing its vast responsibilities. Our decision-making model is highly collaborative and effective. In pharmacy, health IT, medical logistics, health facilities, medical research, public

health, and more – our system is bringing a joint approach to clinical and business operations where it makes sense.

We have undertaken a comprehensive assessment of our military medical infrastructure. In order to optimize our military medical team, our future capital requirements must reflect changes that have affected all of American medicine, and we must match personnel resources with where our beneficiary populations reside, or where local community capability is absent. Where necessary, we will expand strategic partnerships with both interagency and civilian institutions in support of our mission.

The FY15 National Defense Authorization Act required the Government Accountability Office (GAO) to review the methodology used by the Department in the Modernization Study. Following GAO Review, we would like the ability to move forward with implementing reasonable steps to improve efficiency without further delay.

Our system is implementing recommendations that emerged from the Secretary's Review of the MHS that occurred in summer 2014 and culminated in the Secretary's Action Plan of October 1, 2014. Quality, accountable health care is the most consequential benefit a grateful nation owes its Service members and their families. We are committed to improve and deliver on that commitment.

We have strengthened policy and oversight of our patient safety and quality programs. We have implemented, or are implementing, a number of other system-wide initiatives to provide quality of care to all MHS patients. These initiatives include adoption of the Global Trigger Tool to establish more than one mechanism for capturing harm events; the expansion of surgical quality data collection and analysis to all Direct Care surgical facilities through our participation in the American College of Surgeons' National Surgical Quality Improvement

Program; and standardized MHS training to reduce variability in coding and documenting of care for mothers and newborns.

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There are also similarities in how the Services operate, and the new Defense Health Agency is working as designed – to bring common solutions to shared challenges. Over the last 18 months, the Military Health System has introduced a modernized, enterprise-wide approach to managing its vast responsibilities. Our decision-making model is highly collaborative and effective. In pharmacy, health IT, medical logistics, health facilities, medical research, public

health, and more – our system is bringing a joint approach to clinical and business operations where it makes sense.

We have undertaken a comprehensive assessment of our military medical infrastructure. In order to optimize our military medical team, our future capital requirements must reflect changes that have affected all of American medicine, and we must match personnel resources with where our beneficiary populations reside, or where local community capability is absent. Where necessary, we will expand strategic partnerships with both interagency and civilian institutions in support of our mission.

The FY15 National Defense Authorization Act required the Government Accountability Office (GAO) to review the methodology used by the Department in the Modernization Study. Following GAO Review, we would like the ability to move forward with implementing reasonable steps to improve efficiency without further delay.

Our system is implementing recommendations that emerged from the Secretary's Review of the MHS that occurred in summer 2014 and culminated in the Secretary's Action Plan of October 1, 2014. Quality, accountable health care is the most consequential benefit a grateful nation owes its Service members and their families. We are committed to improve and deliver on that commitment.

We have strengthened policy and oversight of our patient safety and quality programs. We have implemented, or are implementing, a number of other system-wide initiatives to provide quality of care to all MHS patients. These initiatives include adoption of the Global Trigger Tool to establish more than one mechanism for capturing harm events; the expansion of surgical quality data collection and analysis to all Direct Care surgical facilities through our participation in the American College of Surgeons' National Surgical Quality Improvement

Program; and standardized MHS training to reduce variability in coding and documenting of care for mothers and newborns.

We have established 30 enterprise-wide measures of readiness, access, safety, quality, satisfaction, and cost. These include measures such as individual medical readiness, the average number of days to next available appointment (access), hospital acquired infection rates (safety), post-partum hemorrhage rates (quality), and satisfaction with getting care when needed. The ASD(HA), the Surgeons General and the Director, Defense Health Agency review these measures on a quarterly basis and share findings with the entire MHS community. We “drill-down” on essential core measures to drive improvement. I am encouraged by the direction in which we are moving along a number of measures, but there is much more to do.

We recognize that the patient is a partner in their health, not simply a customer. We have undertaken a long-term effort to increase transparency of health information. We have made it easier to find our existing, public information by consolidating quality, safety, access, and satisfaction measures in one location on our military health websites. In addition, we are in the midst of engaging with our beneficiaries to improve the usability of the information we place in the public domain. We are working with our partners at the Center for Medicare and Medicaid Services to participate in Hospital Compare. When unexpected events occur, we have a global Health Care Resolutions process in place to serve patients, patients’ families, and our medical staff in understanding what happened through an open, ongoing dialogue.

The Department has proposed a number of other actions that help accelerate our reform efforts and allow us to serve as responsible stewards of government resources. Fiscal pressures both within the Department and with health care in general require continued close attention to how our financial resources are used. Several Department proposals are under consideration by

Congress at this time.

We have proposed updates to prescription drug co-payments that further incentivize use of MTF and mail order pharmacies, and are closer to civilian sector copayments. We will continue to provide prescriptions in MTFs with no out-of-pocket cost to beneficiaries. Current fiscal realities compel us to consider the TRICARE benefit, along with a full range of management improvements, to achieve the efficiency objectives of both the Commission and the President's Budget request. Failing to do this would compel DoD to take additional reductions in the areas of readiness, modernization, and force structure. In addition, as the military services are making force structure changes, we would benefit from the ability to convert some military medical authorizations to civilian authorizations when it supports our readiness needs and management efficiency.

The Military Health System does not exist for its own sake. As our military forces continue to operate in Afghanistan, confront the threats posed by ISIS, stand fast with our allies and partners in maintaining peace and stability in other parts of the world, and remain ready to respond to any contingency at any time, they know they are supported by a health system that will do everything in its power to ensure their health and sustain their lives, as well as that of their families.

We are fortunate to be entrusted with serving as stewards of this system of care. This system has enjoyed many successes and medical breakthroughs over the last 13 years of war – including advancements in sophisticated blood clotting agents or aeromedical evacuation capabilities for critically injured patients, providing “care in the air” that was previously beyond our capabilities. Where there are areas that require further improvement, we have identified them, and begun a sustained effort to get better.

We are grateful for this opportunity to present our findings, and our way forward, and we look forward to your questions.