Prepared Statement

Of

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on Military Personnel

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Chairman Wilson, Ranking Member Davis, Members of the Committee, it is a privilege to appear before you today to provide you with an update on our efforts to implement important structural and governance reforms for the Military Health System (MHS). These reforms will make the MHS stronger, better, more relevant for the future and support our collective efforts to continuously improve our ability to deliver quality healthcare wherever and whenever called upon to do so.

The MHS of care has performed superbly in the life-saving treatment and rehabilitation of our service members during more than 12 years of war. We have achieved historic outcomes in lives saved and injury and illness prevented. Yet, the MHS faces quality, cost and access challenges similar to those of the US Health Care System.

In the coming years, the overall size of our military forces will be smaller, and that includes the medical forces that comprise the MHS. At the same time as our forces are drawing down, we are also cognizant of the fact that the practice of medicine in this country is changing. This new environment, and the welcome respite from war, will require new approaches to delivering health care, maintaining a medically ready force and ready medical force, while becoming a smaller and more agile force.

Secretary Hagel outlined his six strategic priorities for reshaping our forces and institutions for a different future. In his speech to the Center for Strategic and International Studies outlining these priorities, he stated "We are only beginning to see the dramatic shifts underway that will define our future and shape our interactions in the world … and require our national security institutions to adapt and to adjust…We will need to more efficiently match our resources to our most important national security requirements. We can do things better. We

must do things better – and we will.”

A similar adjustment in our medical strategy is also necessary, and it is underway.

We are fully aligned with the Secretary’s priorities. We have identified six strategic lines of effort for the coming year that will provide focus to our efforts:

1. Modernize MHS management with an enterprise focus;
2. Define and deliver the medical capabilities and manpower needed in the 21st century;
3. Invest in and expand strategic partnerships;
4. Balance our force structure;
5. Transform the TRICARE health program and
6. Expand our global health engagement strategy

These strategic lines of effort support our overall vision of an “Integrated Military Health System that delivers a coordinated continuum of preventive and curative services to eligible beneficiaries and is accountable for health outcomes and cost while supporting the Services’ warfighter requirements.”

Our remarks today will focus on the first priority I have identified here – modernizing our management structure. The establishment of the Defense Health Agency (DHA), on October 1, 2013, represented a major milestone for the Department, and is a leading example for how we will modernize and integrate our system of care. Since October 1, we have begun integrating several of the common tasks handled by the Army, Navy, and Air Force medical departments into ten “shared services” that now work as one under the DHA .

Although much attention has been focused on the stand-up of the DHA, its establishment serves as a starting point for a comprehensive, multi-year effort of enterprise-wide reform. Our focus remains fixed on our readiness mission and creating a stronger, better and more relevant military health system for the future -- a mission that ensures we maintain medically ready forces and a ready medical force to support them.

We have taken a number of steps to improve our agility in decision-making and program implementation, clinical and business process standardization, and a more integrated system of care at the market level – particularly in large military communities served by more than one military Service.

Our testimony is intended to provide Congress with the state of this implementation effort. We will provide you with background on decisions made, progress on our path to a more modern management structure, and future milestones established. We have made significant progress in the first 150 days of this reform effort, and are on track with most major milestones. We are committed to ensuring our reforms work as planned and are confident in our approach; we remain appreciative of the support the Congress has provided over the last year.

Background

The MHS is dedicated to improving the health of the population it serves, along with the quality and outcomes of the health care it provides. The MHS has adopted overall system performance aims of force readiness, population health, quality health care, and cost management. Known as the Quadruple Aim, this serves as our strategic framework to measure and improve the value that the MHS creates for its customers and various stakeholders.

We know that there are opportunities within the MHS to improve both efficiency and

effectiveness. Over almost 12 years of war, our ability to deliver highly integrated combat casualty care has demonstrated a clear benefit to wounded, ill, or injured Service members and timely support for Combatant Commanders. The result of this enhanced integration saved lives and created an interdependence of Service capability on the battlefield. By reorganizing peacetime healthcare operations using the principles that worked so well in combat, the MHS can achieve higher levels of quality improvement, improve consumer responsiveness, and deliver greater value for the military community. The Department had conducted 18 studies over the past 50 years on the optimal organization for managing and overseeing military medical activities. Each study indicated that a more joint, collaborative approach was required, but only incremental changes were introduced.

In 2011, the Department established an internal task force to conduct a review of the governance of the MHS. The task force identified cost containment, greater integration, and increased unity of effort as priority objectives for the MHS. The Task Force was asked to identify the best governance model for the MHS as a whole, and in multi-service markets.

The Task Force performed analyses of all potential MHS governance organizational models to include an agency model, a single Service lead, a unified medical command and the status quo. Following extensive consultations among the Deputy Secretary of Defense, Chairman of the Joint Chiefs of Staff, Military Department Secretaries and Service Chiefs, and other officials of the Department, this19th study of MHS Governance led a number of sweeping reforms to military medicine that are now being implemented. The Deputy Secretary of Defense directed the Department to establish a DHA better integrate health services in multi-Service markets, and provide a long-term, joint solution to the provision of care in the National Capital Region.

Among the other options reviewed, a unified medical command was subject to detailed review and analysis by the Task Force, the Deputy Secretary, and the senior civilian and uniformed leadership of the Department. This option was rejected for multiple reasons. It was deemed certain to increase overall medical headquarters manpower needs while sustaining the size of the Service components. Additionally, a unified medical command would create a wholesale change in organizational philosophy and command structures within one Military Department, and significantly affect command structures in another. In sum, it was determined that a unified command was an overly disruptive solution that would add cost, complexity and not add value. A DHA was viewed as an alternative structure that could yield similar improvements in efficiency and effectiveness with significantly less organizational disruption.

On October 1, 2013, the Department formally established the DHA. The DHA includes management responsibilities over common activities and functions of the MHS, starting with an initial ten shared services, as outlined in the Deputy's memorandum: the TRICARE Health Plan, pharmacy programs, medical education and training, medical research and development, health information technology, facility planning, public health, medical logistics, acquisition, and budget and resource management. The DHA is also designated as a Combat Support Agency – an important designation that carries with it a process by which the agency is accountable to the Chairman, Joint Chiefs of Staff and the combatant commanders regarding the performance of the agency in meeting their needs.

As part of the governance reforms, the Department identified 6 multi-Service medical markets to be designated for enhanced authorities. We are now developing the 5-year business performance plans for FY15 that will govern the implementation and monitor the performance of these markets. On October 1, 2013, the Department stood down the Joint Task Force National

Capital Region – Medical (JTF CAPMED), and placed the inpatient medical facilities previously assigned to JTF CAPMED – Walter Reed National Military Medical Center and Fort Belvoir Community Hospital -- within the DHA. Furthermore, the National Capital Region Medical Directorate was also designated as the lead official /market manager for the National Capital Area multi-service market, encompassing all military medical facilities in the area.

DoD Implementation of MHS Governance Reforms

The Department recognized that in order to create a more integrated health system and achieve the potential benefit of a DHA we needed to reform our governance or decision-making process to drive performance and system improvement. We have engaged the Services more directly and explicitly into the governance process – both for policy-making and enterprise-wide operational decision-making. In addition to managing common functions and activities of the MHS, The DHA stands as a *supporting* organization, ensuring that the combatant commanders and the Service medical departments have the resource support they require to meet their mission. We have established, by charter, a number of integrated governing bodies to accomplish this.

The Military Health System Executive Review (MHSER) serves as a senior-level forum for DoD leadership input into the strategic, transitional, and emerging issues facing the MHS and the DoD. The MHSER informs the Secretary of Defense (SECDEF) and the Deputy Secretary of Defense (DEPSECDEF) on performance, challenges, and direction of the MHS. The MHSER is chaired by the Under Secretary of Defense (Personnel and Readiness)[USD(P&R)], and includes the Assistant Secretary of Defense (Health Affairs) [ASD(HA)], Service Vice Chiefs, Military Department Assistant Secretaries for Manpower and Reserve Affairs, the Assistant Commandant

of the Marine Corps, Director of Program Analysis and Evaluation, Principal Deputy Under Secretary of Defense (Comptroller), Director of the Joint Staff, and the DHA Director and Surgeons General as ex officio members.

The Senior Military Medical Action Council (SMMAC) is the highest governing body in the MHS. The SMMAC is chaired by the ASD(HA), and includes the Principal Deputy Assistant Secretary of Defense (Health Affairs) [PDASD(HA)], Military Department Surgeons General, DHA Director, Joint Staff Surgeon, and other attendees as required. The SMMAC presents enterprise-level guidance and operational issues for decision-making by the ASD(HA).

Reporting to the SMMAC is the Medical Deputies Action Group (MDAG), which ensures that actions are coordinated across the MHS and are in alignment with strategy, policies, directives, and initiatives of the MHS. The MDAG is chaired by the PDASD(HA), and includes the Deputy Surgeons General, DHA Deputy Director, and a Joint Staff Surgeon Representative. Reporting to the MDAG are four supporting governing bodies:

The Medical Operations Group (MOG) consists of the senior healthcare operations directors of the Service Medical Departments, the DHA Director of Healthcare Operations, and a Joint Staff Surgeon representative, with the chairmanship rotating among these members. The MOG carries out MDAG assigned tasks and provides a collaborative and transparent forum supporting enterprise-wide oversight of direct and purchased care systems focused on sustaining and improving the MHS integrated delivery system.

The Medical Business Operations Group (MBOG) consists of the senior resource managers of the Service Medical Departments and the DHA Director of Business Operations, with the chairmanship rotating among these members. The MBOG provides a collaborative and transparent forum for providing resource management input to the MDAG on direct and

purchased care issues and initiatives focused on sustaining and improving the MHS integrated delivery system.

The Human Resources and Manpower Workgroup (HR&MANPOWER WG) consists of the senior human resources and manpower representatives from the Service Medical Departments and the DHA, with the chairmanship rotating among these members. The HR&MANPOWER WG supports centralized, coordinated policy execution, and guidance for development of coordinated HR and manpower policies and procedures for the MHS.

The Enhanced Multi-Service Markets (eMSM) Leadership Group consists of the six eMSM Market Managers, with the chairmanship rotating among these members. The eMSM Leadership Group provides a collaborative and transparent forum for eMSM Managers to discuss clinical and business issues, policies, performance standards, and opportunities that relate to the strategic imperatives and operational performance of the eMSMs.

Finally, the ASD(HA) is supported and advised by the Policy Advisory Council (PAC), comprised of the Deputy Assistant Secretaries of Defense (Health Affairs), the DHA Deputy Director, the Deputy Surgeons General, and a representative of the Joint Staff. The PAC provides a forum for supporting MHS-wide policy development and oversight in a unified manner.

Enhanced Multi-Service Markets

A key feature of a better integrated health care delivery system is the coordination of care and resources across a variety of service delivery sites and activities within a geographical region – particularly in areas served by more than one military medical department.

In the reforms announced by the Deputy Secretary of Defense in March 2013, he identified six markets as eMSMs: the National Capital Area; Tidewater, VA; Colorado Springs, CO; San Antonio, TX; Puget Sound, WA; and Honolulu, HI. Together they account for 53 percent of the direct care inpatient volume and 39 percent of the eligible population within catchment areas. Market managers for each location have been specified and their future roles and responsibilities have been codified and approved. Since the eMSM managers will be accountable for performance of military treatment facilities operated by more than one military Service, a new governance structure with representation from the three Services and the DHA has been implemented to provide oversight for the planning, implementation, and execution of 5-year business performance plans. The internal functional structure of the eMSM offices has also been finalized. MHS leaders have agreed on standard performance measures for all eMSMs and the new governance structure will monitor these measures.

Measuring, Monitoring and Improving MHS Performance

In addition to a new governance structure for shared decision making, and the implementation of enhanced Multi-Service Market authorities, we have established a structured process for monitoring and improving performance. We are establishing core measures of performance for the enterprise along with supporting measures linked to each of our objectives. The performance of each shared service is reviewed monthly by the DHA Director. Similarly market performance is reviewed monthly by market managers using standard measures. Each quarter the Medical Deputies Action Group reviews both multi-Service market business plan performance and shared service performance. Any significant challenges will be addressed by

the Senior Military Medical Action Committee chaired by the ASD(HA).

We have also instituted a yearly MHS strategic planning session during which the previous year's performance is reviewed and new targets set, where appropriate, for each of our eight strategic objectives. The first of these strategic planning sessions was held in early September 2013.

Our strategic management approach links performance monitoring to improvement through focused reengineering of core processes. In the case of shared services, from the inception of our work, we assessed our re-engineering of the delivery of services from the perspective of the customer -- how it added value, and how this work aligned with our overarching strategy. We adopted the Government Accountability Office (GAO) approach for conducting our business case analyses (BCA) and business process reengineering (BPR). We have benefited from the GAO's review and constructive remarks regarding our processes for both BCA and BPR. Each of their analyses of our progress reports have been helpful, and we have taken corrective action to improve our own analytical work and project management.

The development of each shared service concept of operations (CONOPS) has featured close collaboration and consensus building throughout the process. At the conclusion of this process, the DHA Director and Surgeons General jointly sign the CONOPS – communicating to both internal and external stakeholders the shared vision, expectations and responsibilities.

The discipline and rigor of our analytic approach has allowed us to establish, explicitly, how the DHA creates value for the military health system. This approach has also provided MHS leaders with insight into our most challenging issues. In some instances, this process has allowed us to rapidly introduce new processes and accelerate our cost savings potential. In other instances, we have extended some of our milestones in order to address the root causes of

problematic processes – and fix them.

We would like to review the progress we have made in the initial shared services that were implemented on October 1st – Medical Logistics, Health Information Technology, Pharmacy, TRICARE Health Plan, and Health Facilities.

For medical logistics, it was evident early in the process that the MHS needed to increase the proportion of purchasing from government-negotiated contract schedules, and reduce the amount of purchasing through government purchase cards. The value stream analysis quickly highlighted this opportunity; the Services' medical logistics leaders communicated this opportunity to the field and established draft measures to monitor performance. Although the formal performance measure targets have not been announced, DoD has already witnessed a significant decrease in the use of government purchase cards and has increased the anticipated cost savings. In our business process reengineering analysis, we did not project any savings in FY2014. As a result of this change in buying behavior, however, we are on a path toward saving over $10 million in this FY, and will also accelerating our savings in the out years.

Our Health Information Technology shared service represents an "all in" approach – in which virtually all health IT staff in the MHS will work for the agency. There are multiple value streams that have been developed and refined, to include the rationalization and consolidation of contracts to support our Health IT portfolio. Our original projections for Health IT, captured in our reports to Congress, anticipated additional costs in FY14 that would set the stage for savings in FY15 and beyond. Aggressive consolidation of IT management, progress toward establishing a single medical network infrastructure, and efforts to rationalize Service-specific systems that interface with centrally managed IT systems, however, have cumulatively allowed us to introduce savings of $24.7 million in the first year of this shared service. We believe this

approach will be particularly advantageous to DoD as we implement the new electronic health record (EHR). The DoD's EHR modernization project can be viewed as three separate, but related events: 1) procurement of an EHR; installation of the software across all venues of healthcare in the DoD; and 3) retirement of legacy systems. By consolidating all health IT functions within a single shared service, and aligning efforts with AT&L (responsible for the procurement), we can more closely coordinate all activities for full implementation.

In the Pharmacy shared service, the first major initiative for the DHA was to implement the NDAA-mandated TRICARE For Life (TFL) Home Delivery pilot. The agency has undertaken a comprehensive outreach and communication plan to reach beneficiaries and military pharmacies to advise them of the health, personal convenience and cost-saving benefits achieved by electing home delivery of prescription drugs. Although the formal announcement of the pilot project in the Federal Register was delayed by several months, the outreach effort has had a positive effect on beneficiary conversion to home delivery, and the Department anticipates that we will remain on target to achieve our projected cost savings in this area as well.

The TRICARE Health Plan shared service identified two initiatives for FY15. One of the most significant in our entire portfolio is the decision to move customer service inquiries and resolution to either telephone or online support. This initiative recognized that walk-in customer service was often inconvenient to many beneficiaries, greatly underutilized (accounting for less than 10% of all customer service inquires) and becoming increasingly cost prohibitive. Our business case analyses revealed that the Department was paying $30 on average for each walk-in visit, as opposed to $6 per call and much less for online inquiries. On April 1, 2014, we will migrate all contract customer service inquiries to these latter two venues.

Of course, the most significant cost savings potential for the Department remains in the

purchased health care sector. Over the last four years, the Department has identified a number of initiatives focused on the provider community – to include the implementation of outpatient prospective payment, reimbursement changes for Sole Community Hospitals, and changes in how we reimburse our Uniformed Services Family Health Plan providers for our dual-eligible Medicare/TRICARE beneficiaries. Cumulatively, these changes have led to impressive cost savings in our purchased care accounts, but now we must take a more comprehensive perspective in managing military health care costs

Efforts to improve the execution of the TRICARE Health Plan are focused on long-term systemic changes in how we better integrate our direct care and private sector health services delivery contracts for health services support. As this generation of TRICARE contracts nears the end of its contract term, the Department is looking to reshape our contracts in ways that can improve integration with military medical facilities, reduce unnecessary overhead and achieve greater simplicity for the beneficiary and the government. We have begun this work under the DHA, and will be communicating with industry later in 2014 about our plans.

Finally, the Health Facilities shared service – focused on our major capital infrastructure – has reached all major milestones and seamlessly integrated Service personnel into their agency division. Their long-term perspective is vital for our efforts to ensure we match our resources investments in new medical facilities with the needs and demands of our military beneficiary population.

A sixth shared service, Budget and Resource Management, reached Initial Operating Capability (IOC) on February 9, 2014. One more shared service, Procurement / Contracting, will achieve IOC in the coming weeks.

For every shared service, we remain committed to the process that we have undertaken.

With almost one year of experience in following this process, we are aware of the challenges inherent in changing how large systems operate and change. We are benefiting from the consistent, transparent manner in which we are conducting these analyses, and sustained by the support from subject matter experts in the field and in our headquarters who have validated our approach. We are confident that the work underway will produce the long-term value that our customers and our stakeholders expect.

At Attachment A, we provide an update on additional accomplishments that we have achieved to date; the current status of our performance measures and metrics, and the areas in which additional time is needed to develop a quality product that is aligned with our strategy.

Headquarters Staffing

In our Reports to Congress, we have provided baseline numbers of staff in the DHA at Initial Operating Capability (IOC). Our core principle remains sacrosanct: There will be no growth in overall military medical headquarters end strength. We have been consistent in our messages to both our own employees and external stakeholders: our primary means of cost savings will not occur from simplistic reductions in staffing but rather from improvements in processes that lead to overall reductions in healthcare costs.

The stand-down of the JTF CAPMED and the establishment of the NCR Directorate afforded us an opportunity to streamline business processes and reduce headquarters staffing from 152 to 42 FTEs. Further opportunities for reducing staffing within the DHA should come about as business process reengineering efforts mature and more efficient processes reduce the need for personnel.

Staff reductions have also been projected in the FY15-19 POM process. Additionally, Service-specific headquarters staffing levels, particularly as they relate to military staffing, are subject to a variety of variables that are independently managed by the Services. Nonetheless, the overall trajectory of headquarters staffing is likely to result in headquarters manpower levels that are lower than exist today.

The Department is proud of the progress it has made in the implementation of these reforms to the Military Health System. More agile, joint and transparent decision-making has been the hallmark of our effort. We recognize that significant challenges remain before us, and we are committed to addressing those challenges in a disciplined and rigorous manner. Thank you for the opportunity to share with you our continuing efforts to ensure the sustainment our core readiness mission and service on behalf of all military beneficiaries. We look forward to your questions.

Attachment A

MHS Governance Performance and Progress

☑ MHS Governance councils have been established and are operational.

☑ The DHA Director was selected by the DoD leadership, confirmed by the Senate, and assumed his new responsibilities on October 1, 2013. All subordinate directors, reporting to the DHA Director have been identified and are working within the DHA. This includes both flag officers and civilian SESs.

☑ The DHA Charter was approved by the Deputy Secretary of Defense and is now in force as DoD Directive 5136.13, and DoD Directive 5136.01, Assistant Secretary of Defense (Health Affairs) was updated to reflect changes to responsibilities, relationships and authorities that resulted from the Deputy Secretary's decision.

☑ The Department has completed Concepts of Operations for eight of the ten shared services. By April 1, 2014, three shared services will join the five shared services already operational within the DHA.

☑ An Analytics Cell has been established within the DHA to provide enterprise-wide support for measures and metrics.

☑ Our market plans for increasing enrollment and recapturing care have been developed and are awaiting governance approval.

☑ Core measures for eMSM performance to include measures of care coordination and integration have been established. All six eMSMs are developing their business plans that will improve performance in these areas. MHS leaders held their first eMSM quarterly review of performance.

☑ Measures and reimbursement rates for pay-for-value model have been developed, but not yet approved.

Work Underway

☐Strategic Plan. Originally projected for December 2013, the Department is finalizing the 2014 MHS Strategic Plan, We are conducting a strategic review in the context of the implementation of the DHA. We expect a final version of the plan in May 2014.

☐Performance Dashboards. eMSM and MHS enterprise dashboards are in development and pending deployment early in 2014.

☐Improved Care for Complex Patients. We have begun development of dashboards for the top five chronic illnesses based on high frequency and/or high cost and utilization and also plan to deploy by May 2014.