Prepared Statement

of

Lieutenant General Douglas Robb

Director, Defense Health Agency

REGARDING

THE MILITARY HEALTH SYSTEM

BEFORE THE

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Chairman Frelinghuysen, Ranking Member Visclosky and members of the Subcommittee, I am pleased to represent the Defense Health Agency (DHA) and present its request for funding of medical programs for fiscal year 2016. I am honored to represent the dedicated military and civilian medical professionals in the DHA whose work directly supports our combatant commanders, the Military Services, and the many individuals who rely upon us for their care. And I am also representing the Assistant Secretary of Defense (Health Affairs) (ASD(HA)) who is responsible for the overall Defense Health Program (DHP) appropriation.

The military health system (MHS) remains a vital component of our national security strategy. Our primary mission is to ensure a medically ready force, and a ready medical force. We ensure a ready medical force by sustaining the clinical skills of our medical forces, and delivering quality health services for 9.2 million eligible beneficiaries worldwide. The budget we have presented is fully aligned with our enduring commitments around the globe and with the strategic objectives of the Department.

In October 1, 2013, the Department established the Defense Health Agency, also designated as a Combat Support Agency, for the specific purpose of supporting the effective execution of the MHS mission. I am proud to be the first Director of the DHA. My responsibilities include managing and executing the DHP appropriation as directed by the ASD(HA); managing shared services to include the TRICARE health plan; supporting coordinated management of enhanced multi-service markets; and exercising authority, direction and control over two military hospitals in the National Capital Region (Walter Reed National Military Medical Center and Fort Belvoir Community Hospital).

Events of the past year reinforce the fundamental need to maintain a high state of readiness for all types of threats. The growth of ISIS, the outbreak of Ebola in western Africa, our continuing obligations in Afghanistan, and other notable events serve as visible reminders of the depth and breadth of the MHS's responsibilities and capabilities in providing medical support to military commanders for a wide range of threats. Ensuring this ready medical force is not a "pick-up game" – our capabilities and capacity must be equal to the threats we face. And we expect that demand for our military medical capabilities will remain high for the foreseeable future.

For Fiscal Year 2016, DoD is requesting approximately $32.2 billion for the Defense Health Program. Of this request, nearly $24 billion will support direct patient care activities in our military hospitals and clinics, as well as care purchased from our civilian sector partners. The DHA has responsibilities for distributing the financial resources that are under the authority, direction, and control of the Assistant Secretary of Defense (Health Affairs). This budget request will adequately fund daily operations plus our research programs; and it provides sufficient resources to procure needed medical equipment. Compared to last year's budget, this request represents an increase of less than 1 percent.

Congress has been extremely generous in granting the Department carryover authority each year. This has been an invaluable tool that provides needed flexibility to manage issues that emerge during the year of budget execution. Given the size of our program and the inherent uncertainty in medical usage and costs, and especially medical claims costs related to our TRICARE program, carryover authority allows DoD to better manage the financial volatility within our program. That authority has been helpful to the Department, and we request that it be continued in FY 2016.

This budget supports the core values of the MHS strategic plan, and our strategic framework – the Quadruple Aim: improved readiness, better health, better care, and lower cost. We are committed to sustaining the superb battlefield medical care we have provided to our warriors and the world-class treatment and rehabilitation for those who bear the wounds of past military conflicts. This budget also sustains the long-term medical research and development portfolio allowing us to continually improve our capability to reduce mortality from wounds, injuries and illness sustained on the battlefield.

While the MHS is highly valued as a system of care, we also recognize that it remains a microcosm of American medicine. We are buffeted by some of the same challenges as our civilian peers. We must migrate from a system of healthcare to a system of health. We must hold ourselves accountable for high quality and patient safety. We must serve as wise stewards of the taxpayer's dollars and balance resources and investments in ways that support recruitment, retention and meet the long-term obligations of those who have served us in the past. And, as a public institution, the MHS must develop and execute its strategy with full transparency both internal to the Department and with our external stakeholders.

Improved Readiness

One of our most immediate and strategic challenges is to maintain a ready medical force. In the absence of war – and the welcome reduction in military casualties – we need to continue to ensure our clinical teams are challenged while serving here at home.

Unlike civilian health care institutions, our medical infrastructure – facilities, people, equipment – is not built based on local population projections. It is built upon our wartime requirements to be ready for the full range of military operations – combat, humanitarian, or

disaster response. This wartime requirement includes the provision of primary care services and the prevention of disease.

Once we determine what the Department needs to respond to multiple threats and contingencies, the next imperative is to keep our military medical professionals prepared for combat. Today, DoD is at 55 hospitals in our system of care – a number that has been shrinking even during the wartime years, largely due to the evolution in American health care delivery, the continued migration of care from inpatient to outpatient settings, and the increased sub-specialization of care. It is essential for the Department to adapt to these changing circumstances, and we are.

Over the last several years, the Department has undertaken a comprehensive analysis of our direct care system, known as the MHS Modernization Study, which is aimed at better matching our requirements and our infrastructure. Our overarching purpose is to ensure our medical teams are able to maintain their wartime skills. In the FY 2015 National Defense Authorization Act (NDAA), Congress asked the Department to provide our study along with answers to several other questions to the U.S. Government Accountability Office (GAO) so that they may assess our analytical approach. We plan to deliver the study and the answer to these questions in the coming month.

In addition to the ensuring our military forces and military medical forces are ready, our proposed budget reflects the life-long obligations we have to those who have been wounded or fallen ill in service to our nation. Specific research programs support efforts in combat casualty care, traumatic brain injury, psychological health, extremity injuries, burns, vision, hearing and other medical challenges that are of particular concern and interest to the military community. In

addition to our research programs, many seriously wounded service members are medically retired – and eligible for TRICARE benefits in addition to their VA care. Thus, our budget also reflects those long-term clinical and financial requirements to ensure these service members have access to the most current, evidence-based medicine.

The Department has made exceptional progress in implementing the President's Executive Order to improve mental health care for service members, veterans and their families: we have improved services for service members as they transition to the Department of Veterans Affairs (VA) after separation: we have launched comprehensive communications campaigns to raise awareness of how to best treat mental health issues and reduce the stigma associated with that treatment; we have introduced suicide prevention strategies; we have expanded the number of providers in our network; we have introduced tele-mental health capabilities to allow beneficiaries in remote locations to reach mental health specialists; we have embedded behavioral health specialists in our primary care medical homes; and we continue to invest – along with the VA – in cutting edge research to advance our understanding of how to prevent, diagnose and treat mental health conditions, to include post traumatic stress disorder. We are seeing signs of progress, to include success in reducing the stigma associated with mental health care, seeing more patients while simultaneously increasing access to care.

Another critical support component of our readiness mission is the fielding of a modernized Electronic Health Record. This major acquisition program has understandably generated great interest from Congress and from the private sector. In the FY2016 budget, DoD has requested $634.9M in support of its electronic health record modernization and interoperability efforts. Upon acquisition award, the DHA will continue to work closely with the Office of the Under Secretary of Defense for Acquisition, Technology and Logistics to

successfully implement the EHR. We will ensure the infrastructure is in place to support our technology, and we will ensure our people are trained and clinical and business processes are reengineered to best integrate the new technology into the military health care delivery system.

DoD and the VA continue to share more information than any two other large-scale health systems in the country. Providers in both agencies, through the Joint Legacy Viewer, have the ability to view the individual medical records in the counterpart system – whether that is DoD's AHLTA record or the VA's VIStA record. We know that our work is far from finished. DoD continues to improve data sharing efforts in partnership with the VA and the private sector to create an environment in which clinicians and patients from both Departments are able to share current and future healthcare information for continuity of care and improved treatment. By April 2015, we will have met all interoperability and data sharing requirements included in the FY2014 NDAA.

The demand for interoperability extends beyond just DoD-VA information sharing. Integration of our health information with the private sector is essential – more than half of the care provided to the DoD population is delivered through our TRICARE network partners.

The formal Request for Proposal to acquire an off-the-shelf product was released in 2014, and proposals are in the process of review. The Department anticipates that this approach will save between $2 and $5 billion over the previous strategy.

Our readiness mission extends to the long-term investments we make in the area of global health. The Ebola crisis and response is only the most current example of our global health capabilities and obligations. While our nation's role in confronting the national security threat

from infectious disease in west Africa has been truly a game-changing military engagement, it still only represents one element of our global health strategy.

Our military-to-military medical global health engagements are helping to build host-nation public health capacity, reduce the spread of HIV, and foster greater interagency cooperation in support of our national objectives. Our response to disasters in Haiti, the Philippines, Japan, and other incidents have been important in ways that go beyond the core mission of saving lives and restoring infrastructure. We have helped create the capacity of host-nations to better prepare for and manage crises locally. We have strengthened relationships with international and non-governmental organizations, and our military medical infectious disease research has been instrumental in charting paths forward in understanding how to diagnose, treat and prevent diseases before they become epidemics.

Better Health

We are continuing our internal efforts to "move from healthcare to health." Operation Live Well remains the overarching framework for a set of programs and services we are offering to our military community. We have made important strides to address the high utilization of tobacco products among our service members.

Additionally, we are assessing the successes from the Healthy Base Initiative in which fourteen military installations and defense agency offices around the world participated in customized local efforts to improve health, and well-being. Although there are many actions we can take to improve readiness, health and cost control, no single item can have as broad an effect across all of our strategic aims as a measurable change in individual and community health

behaviors. This work is important not merely for the health of the existing force, but also to ensure the health of the future force and their families. An important recruiting pool for our military forces includes the sons and daughters of those serving on active duty today. Health behaviors are established early in life – and we are committed to ensuring the entire beneficiary population has the resources and education to live well.

Better Care

The DHA is deeply involved in the conduct and follow-on actions from the Secretary of Defense's Review of the Military Health System. The overall findings from that review found that the quality of care delivered in military hospitals and clinics is comparable to that found in civilian medicine. But "good" isn't good enough. Our vision is to serve as national leaders in healthcare quality, access and patient safety. We are now moving forward with an implementation plan for that vision.

A major outcome from the MHS Review was to better implement principles of a high-reliability organization (HRO), those areas "where harm prevention and quality improvement are second nature to all in the organization." For the MHS, this does not represent a fundamental change, but an evolution in culture and practice that permeates every level of the organization. Over the last thirteen years, this relentless search for how we can improve – whether it was survival from battlefield trauma or reduction in diseases – showed that, as an organization we were able to be self-critical in search of week over week, month over month improvement.

Since October, the High Reliability Organization Task Force – comprised of clinical leaders from the Army, Navy, Air Force, DHA and Office of the Secretary – has been setting the

Department's high level principles, while allowing flexibility in execution that respects the unique missions and needs of the individual Services. This is a long-term strategy for the DoD and for the MHS. We have experience in setting standards for safety, quality and superior outcomes in some of the harshest environments around the globe. We have the people with the skills and experience to light the way.

One of the key findings from the MHS Review was that no single set of metrics was used across the enterprise to monitor performance in access, quality and safety. On January 1, 2015, the Defense Health Agency, to better support the enterprise and the Services' paths toward greater excellence as an HRO, established the MHS Partnership for Improvement (P4I) system in collaboration with the Military Services, providing a set of common measures across both direct care and purchased care settings that included clear performance goals with standardized metrics.

We also continue to invest in one of the cornerstones of our efforts to improve access, quality, safety and health care outcomes. One hundred percent of our Patient-Centered Medical Home (PCMH) is now fully accredited by the National Committee on Quality Assurance. We have introduced a 24/7 nurse advice line that is integrated with the PCMH, and provides an additional, round-the-clock, resource for beneficiaries to connect with medical professionals or receive medical appointments when needed.

Responsible Stewards of Taxpayer Resources

Underpinning our overarching strategy are our efforts to modernize MHS management with an enterprise focus. The establishment of the DHA is central to this effort. Within twelve months of standing up, we had successfully established ten shared services within the agency: 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.

Although the stand-up of the shared services were at differing levels of maturity at the one-year mark, we were able to exceed our own milestones for achieving efficiencies and realizing savings. In FY2014, we estimated that the organization was able to achieve $236 million in savings, implementing a number of actions identified through a rigorous and replicable business case analysis and business process reengineering. Each Shared Service is responsible for tracking and reporting on savings at a detailed level, with regular reviews of progress toward the identified goals. Some examples of initiatives that are driving savings include the legislatively-directed transition of prescription drugs from retail venues to either home delivery or MTF outlets; standardization of medical supplies and equipment; greater use of eCommerce for medical supply purchases; contract consolidation; and pharmaceutical purchasing consolidation and standardization.

But the DHA's establishment is not merely about savings and efficiency. 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. Within each of the Shared Services there is exciting, cutting-edge work underway to ensure and sustain the medical readiness of the total force and readiness of our medical force. I want to touch upon some noteworthy accomplishments made in FY 2014.

The Education and Training Directorate reached initial operating capability (IOC) on August 10, 2014 and has already implemented a one-stop learning management system, which will serve as a new home for online tools and a resource to acquire joint executive skills and

knowledge. The Education and Training Directorate has also built strategic partnerships with the Medical Evaluation and Treatment Clinic (METC) at Walter Reed National Military Medical Center. As it moves toward full operational capability (FOC), the Directorate is in the process of building a military medical education consortium to serve as a network of critical partnerships between civilian and military institutions in support of education and training. Furthermore, this Shared Service is working to advance cutting-edge modeling and simulation technology to replace live animals and support medical training requirements. We have consolidated 23 separate learning management systems into a single, consolidated learning management system in support of three Services.

The Healthcare Operations Directorate has continued to improve delivery models by launching such initiatives as ePrescribing with civilian providers and the Nurse Advice Line – a 24/7 call center that provides instant access to a team of registered nurses who can answer urgent healthcare questions from beneficiaries. Healthcare Operations has also enhanced support to warfighters by providing a central point for coordinating operations across the DHA for efforts such as the Ebola Task Force and supporting development of the Director's Mission Essential Tasks.

The Research, Development and Acquisition Directorate (RDA), in coordination with the Services, created an advanced development capability for Defense Health Program R&D, allowing the MHS to take groundbreaking science and technology achievements and translate them into clinical care and operational use. The execution of the Advanced Development Program will deliver over 20 new products/clinical practice guidelines in the next five years, which include devices to slow or stop non-compressible hemorrhage; eye-tracking systems that can measure cognitive issues related to TBI; and changes to clinical practice across the

continuum of care in the area of wound healing. With a core annual investment of over $600M, the RDA program is the largest medical research program in DoD and will allow the MHS to continue to develop innovative technologies in areas of trauma care and mental health that will allow wounded warriors to return to the battlefield and lead rich, fulfilling lives post-combat. We greatly appreciate Congress' strong advocacy and support for comprehensive military medical research – support that is particularly important to sustain during a period of time in which the value of research in the areas of infectious disease threats has been so prominent.

The Health Information Technology (HIT) Directorate manages IT shared services and is the oversight authority for IT-related expenditures, promoting greater accountability. We have integrated three parallel, Service-managed health information technology offices into a single, consolidated operation. In 18 months, HIT has helped the Defense Health Headquarters consolidate around a single email and calendar sharing system. Additionally, the Directorate has established a plan to develop and implement a standard infrastructure to support the Electronic Health Record (EHR) Modernization in support of the OUSD(AT&L) EHR acquisition. This infrastructure includes seamlessly integrated Wide, Local, and Wireless Networks; a secure access and authentication capability; a desktop design standardization service; a centrally managed and integrated computing infrastructure; and a consolidated MHS enterprise IT service desk. Furthermore, DHA HIT is actively engaged in collaborative pre-planning to fulfill MHS implementation, training and sustainment needs once a new DoD EHR solution has been acquired.

In FY2014, the Business Operations Directorate earned an unqualified audit opinion for the fifth straight year for purchased care. The DHA has begun the FY2015 DHP audit

examination of the entire program and will shift to full audit in FY2016. In the area of medical logistics, this Directorate partnered with DLA and MHS clinicians to further standardize medical supplies and equipment, and leveraged buying power to obtain lower product costs for more than 1,400 products. As we move towards FOC, this Directorate will also integrate business and financial planning to execute a more effective Program Objective Memorandum (POM) '17 and drive increased commonality across the Services in how they account for purchases. Additionally, the establishment of Health Facilities as a shared service has provided the Department with the ability to streamline our business process for assessing, resourcing, outfitting and maintaining our global medical infrastructure.

Over the past several years, the MHS has introduced a series of measures that have cumulatively reduced government expenditures by billions of dollars. Through these efforts, we have decreased administrative overhead at our headquarters (and will further streamline our headquarters operations in the coming years); we are increasing our joint purchasing of medical supplies and equipment; the establishment of federal ceiling prices for drugs has saved almost $800 million annually as well as encouraging the use of the less costly mail order pharmacy. We have aligned our payments to hospitals for outpatient services with Medicare, which were fully implemented in FY 2014. And, our ongoing efforts to combat fraud will continue to yield savings based on targeting improper billings by civilian providers.

An essential part of responsible financial stewardship is the management of TRICARE, our military health benefit. Medical cost growth has slowed relative to its meteoric rise in the past decade. Yet, costs continue to rise in ways that threaten other priorities. Within DoD, however, every dollar spent in healthcare is a dollar not spent on modernizing, training or equipping the force. To this end, we again proposed a series of modest efforts to re-balance the

health cost shares borne by the government and the beneficiaries we serve. These proposals are offered after we have instituted a number of internal reforms to improve our own efficiency. And, finally, these proposals still ensure the Department will continue to provide one of the most comprehensive health benefits offered by any employer in this country.

The Department's FY 2016 TRICARE proposal maintains the core objectives of the President's Budget FY 2015 Consolidated TRICARE plan: current active duty service members continue to receive health care free of charge; Active Duty Family Members (ADFMs) are given the option for free health care regardless of assignment location, but with financial incentives to obtain the most cost effective care; and retirees and their dependents will continue to share in their health care costs, with new incentives to obtain the most cost effective care.

We have made adjustments in our proposal from PB FY 2015 that address shortcomings noted by the beneficiary organizations both in their testimony and in their discussions with us. First, we ensured that Active Duty Family Members were held harmless from additional out-of-pocket costs based on their geographic assignment. Second, this proposal addresses the Emergency Department (ED) overutilization and proposes a copay for inappropriate ED use. This latter shortcoming is particularly important to correct as TRICARE beneficiaries use hospital EDs, the most costly method of delivering care, at twice the rate of their civilian counterparts.

The 2016 proposal introduces two care management alternatives within the consolidated TRICARE plan: Care managed by a Primary Care Manager (PCM) at the MTF (PCM Managed) or Self-Managed Care. ADFMs have the option to select between the two alternatives.

ADFMs who choose PCM Managed care will be enrolled in an MTF, and when they require care that the MTF cannot provide, the PCM will issue a referral for that care. This option results in no network copays for the ADFM.

ADFMs who choose Self-Managed care can choose, on a case-by-case basis, to receive free MTF care, pay modest copays for network care, or they can pay a percentage of the cost for out-of-network care after paying an annual deductible. ADFMs who live remotely from an MTF must Self-Manage their care, and they will be exempt from copays, cost shares and deductibles.

In order to address the second shortcoming from the PB FY 2015 plan – decrease misuse of ED care – new fees will apply for all ED care that does not constitute a real emergency.

At the same time as DoD TRICARE proposals are being put forward in this budget, the Department is also prepared to release updated TRICARE Requests for Proposal. The Department plans to reduce the number of contracts from three to two, and we have included other refinements that will help support our efforts to continuously improve quality, safety and contractor performance. A timely release of the RFP and competitive acquisition process will provide the Department with the opportunity to both improve service and reduce administrative costs as compared to the existing contract structure.

We consider the comprehensive benefits we offer supports our objectives of ensuring a medically ready force and ready medical force. It offers an important tool in the recruitment and retention of a skilled volunteer force. And this proposal upholds our commitment to all military beneficiaries, and to the readiness of our armed forces – a commitment to maintain one of the best health care benefits in the country, to protect the most vulnerable members of our population from cost increases, to invest in both health care and health, for the greatest military force in the world, both now and for generations to come.

In addition to presenting you with next year's budget and proposals, I want to address the threats faced by sequestration and I want to highlight what the Assistant Secretary of Defense has promised cannot and will not be compromised -- promises he has made in multiple settings and every year in which sequestration is a threat.

First, our commitment to quality of care is sacrosanct. We will not allow quality to suffer or place any patient at risk. Period.

The Department will also ensure that the care provided to our wounded warriors is maintained. Our focus on their medical treatment and rehabilitation will continue. It is our goal to make sure that from the wounded warrior's perspective, they should see no difference in the care they receive before, during or after sequestration. And we will sustain our close collaboration with other federal and private sector partners, including the VA.

Finally, to the greatest extent possible, we will work to sustain access to our military hospitals and clinics for our service members, their families, retirees and their families. In patient care areas, nearly 40% of our medical staff in military hospitals and clinics is civilian. Civilian hiring freezes can have immediate effects on both access to care and to staff morale. With some exceptions, civilians who remain in place face potential cost reduction measures – an impact most keenly felt by those valued members of our workforce with lower incomes. These measures could also impact access to care – perhaps causing inconvenience and dissatisfaction among those patients accustomed to getting their care in military treatment facilities. Furthermore, patients who formerly received care in a military treatment facility may need to obtain care in the private sector at an increased cost to the Department.

But there are other, significant, negative long-term effects on the overall Military Health System. By directing all resources to the provision of patient care under sequestration, we will have less funding to address medical facility maintenance and the needed restoration and modernization projects. This will negatively affect the healthcare environment and potentially drive substantial bills for facility maintenance in the future. While we will continue to fund projects that directly affect patient safety or that are emergent in nature, we will see a degradation in the aesthetic quality and functionality of our medical facilities. This can impact the morale of both the medical staff and the patients and can greatly degrade the patient's experience of healthcare within the military health system. Many of our facilities are older and require substantial upkeep. To delay these medical facility projects only exacerbates the problem and ultimately the medical staff – and more concerning, the patients – suffer the consequences. This is not a sustainable strategy.

In order to continue our health care operations, we will dramatically reduce our investment in equipment. This means equipment will be used longer and will require more maintenance – increasing the potential for equipment breakdowns and increasing maintenance costs. At some point, equipment becomes obsolete and cannot be repaired any longer.

Research and Development projects will also suffer. Congressionally directed research projects are not protected under sequestration. We will protect our core research projects that are directed towards wounded warrior issues. Other core research projects may need to be reduced so that we can "make ends meet" in the delivery of health care. This means that important, promising research projects could be slowed or stopped altogether.

The long-term effects on our ability to recruit and retain the best military and civilian medical experts this country can offer is also at risk. Sustaining a high quality military health system for all of our beneficiaries is our mission and a personal, moral obligation.

We understand DoD must do its part in addressing the nation's budget concerns; however, it must be done in a responsible and judicious manner. The path forced upon us through sequestration is neither. I remain hopeful that Congress can still reach an agreement that will allow us to shape our future in a more careful, deliberate and rationale manner.

The DHA is a strategic enabler to the Department in achieving savings and efficiencies in a responsible, business-focused manner. By building a management structure with an enterprise focus, we are ensuring a medically ready force and ready medical force are ready for any contingency for which they are called to serve. And we are seeing results. The DHA is already exceeding projected savings in just our first year of operations.

I am honored to represent, on behalf of the ASD(HA), the men and women of the Military Health System before you today, and I look forward to answering any questions you may have.