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**DEFENSE HEALTH AGENCY**

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HEARING

BEFORE THE

SUBCOMMITTEE ON MILITARY PERSONNEL

OF THE

COMMITTEE ON ARMED SERVICES  
HOUSE OF REPRESENTATIVES

ONE HUNDRED THIRTEENTH CONGRESS

SECOND SESSION

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#### DEFENSE HEALTH AGENCY

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## DEFENSE HEALTH AGENCY

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HOUSE OF REPRESENTATIVES,  
COMMITTEE ON ARMED SERVICES,  
SUBCOMMITTEE ON MILITARY PERSONNEL,  
*Washington, DC, Wednesday, February 26, 2014.*

The subcommittee met, pursuant to call, at 2:00 p.m., in room 2212, Rayburn House Office Building, Hon. Joe Wilson (chairman of the subcommittee) presiding.

### **OPENING STATEMENT OF HON. JOE WILSON, A REPRESENTATIVE FROM SOUTH CAROLINA, CHAIRMAN, SUBCOMMITTEE ON MILITARY PERSONNEL**

Mr. WILSON. Ladies and gentlemen, welcome to a meeting of the House Armed Services Committee, Military Personnel Subcommittee. Today the subcommittee meets to hear testimony on the Defense Health Agency [DHA]. I would like to begin by acknowledging the remarkable military and civilian medical professionals who provide extraordinary care to our service members and their families here at home and around the world, often in some of the toughest and most austere environments.

I have firsthand knowledge of their dedication and sacrifice from my son, Lieutenant Commander Addison Wilson, Jr., who is a Navy orthopedic surgeon stationed in Naples, Italy.

In June 2011, the House passed legislation establishing a joint unified medical command as a method of making a streamlined and efficient Military Health System [MHS], which has been shown by multiple studies to be a potential source of great cost savings. Ultimately, the Department of Defense [DOD] rejected the option of a joint command, deciding instead to establish the Defense Health Agency as part of an overall restructure of governance of the Military Health System to drive efficiencies and cost savings. This was done, despite concerns raised by the Government Accountability Office [GAO] about the Department's analyses of options for restructuring the Military Health System.

I am anxious to hear from our witnesses how the Defense Health Agency is progressing, including your forecast for accomplishing the goals of increased efficiency and cost reduction. To that end, I would like the witnesses to address the following: First, the Government Accountability Office offered several recommendations regarding implementation of the Defense Health Agency. How has the Department addressed these recommendations? Was a comprehensive cost analysis of the Defense Health Agency conducted? And what were the results?

Second, in June of 2013, the Department estimated that the Defense Health Agency staffing requirement would be 1,081. By Octo-

ber 2013, that estimate nearly doubled to 1,941. What is the current DHA staffing level? If it has been deviated from the estimate, please explain why. Are further increases in staffing required?

Pardon me. The phone has come to life.

Third, given that 7 of the 10 shared services were implemented at the beginning of this fiscal year, are current savings and spending levels on par with projections, especially the pharmacy program, which was projected to attain early savings?

Finally, I would like to hear how the military surgeons general were involved in the implementation process.

I hope that our witnesses will address these important issues as directly as possible in their oral statements and in response to Member questions.

Before I introduce our panel, let me offer Ranking Member Susan Davis from California an opportunity to make opening remarks.

[The prepared statement of Mr. Wilson can be found in the Appendix on page 23.]

**STATEMENT OF HON. SUSAN A. DAVIS, A REPRESENTATIVE FROM CALIFORNIA, RANKING MEMBER, SUBCOMMITTEE ON MILITARY PERSONNEL**

Mrs. DAVIS. Thank you, Mr. Chairman. I also want to welcome Assistant Secretary Woodson, General Robb, and Ms. Farrell.

Given the recent budget released by the Secretary of Defense on Monday, I am certainly looking forward to and I am sure many people here are, to hearing from our DOD witnesses on the state of the Defense Health Agency and its efforts to consolidate functions, to better coordinate care, and reduce resources.

As we all know, military healthcare budget is nearly \$50 billion a year. And while we have a budget agreement for 2014, sequestration still remains in effect for 2015 and future years.

So difficult decisions will need to be made on how reductions are going to be implemented and how the impact of these reductions will be minimized as to not adversely impact beneficiaries or their quality of care provided to them. However, such achievements can only occur if there is transparency and accountability of how the Department makes and implements their decisions. The establishment and the implementation of the Defense Health Agency is a case study before us on where the Department can achieve transparency and accountability within the Military Health System.

Ms. Farrell, thank you for coming. I look forward to hearing GAO's assessment on the establishment of the DHA and whether there are further areas of concern that the subcommittee should continue to conduct oversight activities.

And I also look forward to hearing from Secretary Woodson, of course, good to see you again, and General Robb on how the DHA is moving forward, what efficiencies and savings have been achieved to date, what is expected over the long term, and where the DHA is in implementing all of the GAO's recommendations.

So we thank you very much. Mr. Chairman, and look forward to the discussion today.

Mr. WILSON. Thank you, Mrs. Davis.

We have three witnesses today. We would like each witness the opportunity to present his or her testimony and each Member an opportunity to question the witnesses. I would respectfully remind the witnesses that we desire you to summarize to the greatest extent possible the high points of your written testimony in 3 minutes. I assure you that your written comments and statements will be made part of the hearing record.

I also want to announce that to ensure all Members have an opportunity to question our witnesses we will use the 5-minute rule when recognizing Members for questioning.

At this time, without objection, I ask unanimous consent that an additional statement from the American Clinical Laboratory Association be included in the record of this hearing.

Without objection, so ordered.

[The information referred to can be found in the Appendix on page 69.]

Mr. WILSON. Let me welcome the panel. Returning, the Honorable Dr. Jonathan Woodson, M.D., Assistant Secretary of Defense, Health Affairs, Department of Defense.

Thank you for being here.

Lieutenant General Doctor Douglas J. Robb, Director, Defense Health Agency, U.S. Air Force, and Ms. Brenda S. Farrell, Director Defense Capabilities and Management, U.S. Government Accountability Office.

And before we begin, I would like to extend a special welcome to General Robb, as this is his first appearance before this subcommittee, and we appreciate your service to our country.

As we begin, Dr. Woodson, and then we will shift over, and then we will begin our questions. Thank you.

**STATEMENT OF HON. JONATHAN WOODSON, M.D., ASSISTANT SECRETARY OF DEFENSE FOR HEALTH AFFAIRS, DEPARTMENT OF DEFENSE**

Dr. WOODSON. Well, thank you very much, Chairman Wilson, Ranking Member Davis, members of the committee. It is indeed a privilege to be here today and update you on the Department's implementation of an important reform in the Military Health System, a needed reform in this era of significant challenges for the Department and American health care at large.

Our national security and defense strategies must be supported by a strong, relevant, agile, and forward-leaning Military Health System. Our service members deserve and the American people expect excellent care delivered reliably, effectively, efficiently, and compassionately anywhere our service members are stationed or deployed. We have good evidence that joint integrated care improves results in combat.

Today, if a Marine unfortunately is wounded in combat, he or she will be treated by a Navy corpsman immediately; transported by an Army medevac unit to a level 2 or 3 facility, staffed by Air Force, Army or Navy personnel working together; further strategically evacuated, receiving critical care en route by Air Force assets, to a level 4 or 5 facility where again definitive advanced care will be given by a multiservice healthcare team. This integrated, synchronized, coordinated combat casualty care system transcends

service and command distinction and has resulted in the highest survival rates and the lowest case fatality rates in recorded warfare.

This has come about not by chance but by designing a data-driven integrated system focused on wounded warrior care and improving outcomes. The system reduces variability and provides for evidence-based common clinical and business processes reform. Together with the surgeon generals, we have moved forward to bring this design to all of our healthcare operations.

Secretary Hagel has outlined his priorities for managing the significant change needed in the coming years. These include introducing institutional reforms, reevaluating our military force planning construct, preparing for prolonged readiness challenges, protecting investments in emerging military capabilities, balancing forces between Active and Reserves, and reforming personnel and compensation policies.

In order to meet our mission in these changing times, I have outlined six lines of effort for the Military Health System in support of the Secretary's priorities. These include modernize the Military Health System's management with an enterprise focus, define and deliver the medical capabilities and manpower needed in the 21st century, invest in and expand strategic partnerships, assess the balance of our medical force structure, modernize the TRICARE health program, and define the Military Health System's global health engagement requirements.

These strategic lines of effort will help us deliver on our overwhelming—or our overarching quadruple aims of readiness, improving the health of the populations we serve, improving the experience of care in our system, and responsibly managing the costs.

Today we will focus on the first priority, modernizing our management structure. The establishment of the Defense Health Agency represented a major milestone in the Department, and it serves as a starting point for comprehensive enterprise-wide reform.

In a few moments, General Robb will be sharing with you steps we have taken and some early successes. But I also want to provide additional context to our current situation. In addition to the significant changes underway in our national security posture, there is also dramatic change occurring in American health care that will affect how we do business and require us to refresh our thinking of health, health care, and healthcare delivery systems. In addition to rising costs, technology, subspecialization, information management, access, and workforce issues are challenging the American healthcare system. Health systems across the country, including ours, are focused on ways to reduce variation in care, improve patient safety, and more effectively use health information technology to improve clinical decisionmaking and outcomes.

Within the military, there are additional imperatives for designing an integrated health system, which includes more joint basing, joint operations, and maintaining readiness. My office, the service medical departments, and the Defense Health Agency are partners in this process. We have created an agile governance for policy and enterprise-wide operational decisionmaking. We are holding ourselves accountable, using a disciplined process for identifying opportunities and using common enterprise-wide performance meas-

ures to see and check what we are doing. We use the Government Accountability Office's approach to conducting our business case analyses and business process reengineering efforts. The GAO's reports to Congress have been helpful, and we have taken continuous corrective action to improve our analytic work and our project management.

The Department is proud of its progress and the progress it has made, but we need to be persistent in these efforts. I thank you for the opportunity to speak today, and I look forward to your questions.

[The joint prepared statement of Dr. Woodson and General Robb can be found in the Appendix on page 25.]

Mr. WILSON. Thank you, Secretary Woodson.

And again, welcome, General Robb.

**STATEMENT OF LT GEN DOUGLAS J. ROBB, USAF, DIRECTOR,  
DEFENSE HEALTH AGENCY**

General ROBB. Chairman Wilson, Ranking Member Davis, members of the committee. It is indeed an honor to be here for the first time and to join Dr. Woodson in updating you on the Defense Health Agency and our way forward over the coming months and years. Dr. Woodson has already provided the overarching strategy to make the MHS stronger, better, and more relevant for our future. I am pleased to share with you how the Defense Health Agency is going to contribute to that effort.

This agency came about after 18 studies over 50 years. The vast majority of the 17 previous studies had recommended greater integration of the Army, the Navy, and the Air Force assets. However, little or no change occurred from those earlier reports. However, we are proud that this, in the 18th study, conducted in the summer of 2011, that I served as the co-chair, the senior civilian military leaders in our Department did indeed come together. And we analyzed almost every possible organizational structure for the Department of Defense. The Department then took action and selected the Defense Health Agency as the best possible option to improve the effectiveness and the efficiency without the cost and disruption that would have accompanied other options.

In addition to providing the structure to create a more integrated system of care, the Department also designated the Defense Health Agency as a combat support agency. This is important. It makes me accountable to the Chairman of the Joint Chiefs of Staff, as well as Dr. Woodson, for ensuring that the medical readiness needs of our combatant commanders are met. And every 2 years, I will be graded by the chairman on how well we are meeting that mission.

This is the central principle that I have conveyed to the chairman, to the services, and to my own staff. 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. Consistent with the joint governance processes that Dr. Woodson outlined a few minutes ago, the DHA's role as an integrator is to enhance the ability of the services to accomplish their mission.

We have made significant progress in the first 150 days of this reform effort. And we are on track with most of our major milestones. Dr. Woodson mentioned the discipline and the rigor of our approach in improving how we do business. This approach has also provided all of us with insight into our most challenging issues. In some instances, this process has allowed us to rapidly introduce new processes, and we have accelerated timelines for implementation and achieved savings, reduced variation, and streamlined processes earlier than initially projected. Our written testimony provided examples of the status of all 10 of our shared services that comprise the Defense Health Agency. I will not repeat that summary here, but, rather, I want to highlight a few examples that illustrate the value of the path that we are on and the reason for optimism regarding the future.

In medical logistics, for example, we initially believed fiscal year 2014 would require nominal investments or additional costs to achieve the downstream savings in the fiscal year 2015 through fiscal year 2019 period. However, the DHA medical logistics community shared service implementation effort identified opportunities to change the buying behaviors even as we launched the agency in October. As a result, we are on a path to cover our investment costs and save over \$10 million when we previously projected no savings for this year.

Similarly, in the health information and technology shared service, there are a number of initiatives to reduce redundancy and consolidate IT contracts. The consolidation of the service medical chief information officers into the DHA has allowed us to move more quickly than we had anticipated, and we have identified savings of almost \$25 million in this fiscal year.

Of course, the most significant cost savings potential for the Department still remains in the purchase healthcare sector. Our efforts to improve the execution of the TRICARE health plan are focused on long-term systemic challenges and how we better integrate our direct care and private care health services delivery and contracts for healthcare support. As this generation of TRICARE contracts nears the end of its current term, the Department is looking to reshape contracts in ways that take advantage of strategic sourcing, improving integration with military medical facilities, reduce unnecessary overhead, and achieve greater simplicity and flexibility for the beneficiary and for the government.

A final personal observation, after 5 months in this position, as I work with my colleagues in the Army, the Navy, and the Air Force, and with my own team in the Defense Health Agency, we spend many hours studying how we can develop even more common clinical and business efforts in support of our warfighters. And at the end of each review, we can see progress that we are making, the differences that we are making. And more times than not and to a person, I hear the same thing: this is the right way to go. In my personal experience interacting with our partners, such as the Director of the Defense Logistics Agency, is that they clearly see the benefit of us operating as a single enterprise, and they are pleased that we can present a single point of contact for Military Health System issues. And the refrain from our internal team and

external partners is the same: we should have been doing this sooner.

But we are not looking backwards, we are looking to the future. Proud of the work we have accomplished, but even more eager to identify ways that we can integrate our system on behalf of the incredible people that we are privileged to serve. Again, I appreciate the opportunity to be with you today, and I look forward to your questions.

[The joint prepared statement of General Robb and Dr. Woodson can be found in the Appendix on page 25.]

Mr. WILSON. Thank you, General.  
Director Farrell.

**STATEMENT OF BRENDA S. FARRELL, DIRECTOR, DEFENSE CAPABILITIES AND MANAGEMENT, U.S. GOVERNMENT ACCOUNTABILITY OFFICE**

Ms. FARRELL. Thank you, Mr. Chairman.

Chairman Wilson, Ranking Member Davis, and members of the subcommittee, thank you for the opportunity to be here today to discuss whether the Defense Health Agency is positioned to achieve the goals of DOD's effort to reform its Military Health System. Let me briefly summarize my written statement.

DOD's Military Health System costs almost \$50 billion annually. The system's governance structure has been the subject of many studies since 1949, some recommending major changes to improve the cost efficiency of the system. GAO has conducted a body of work reviewing efforts to reform the system since 2006. In 2012, DOD announced the creation of the Defense Health Agency by October 1, 2013. Congress required DOD to provide its reform plans before the agency began initial operations. Further, GAO was mandated to review DOD's reform plans. My testimony today is based primarily on our report issued in November 2013 that assessed DOD's plans. My main message today is that DOD's senior leadership needs to take additional actions to increase transparency and enhance accountability of DOD's reform plans. These actions address staffing, cost, and performance measures.

First, DOD has not determined its staffing requirements, military, civilians, and contractors, for the new Defense Health Agency. DOD did not have the data to determine how the creation of the Defense Health Agency will affect the total number of the system's headquarters staff because it does not have a baseline assessment for current staff.

Notwithstanding, in 2011, using data that DOD later noted was inaccurate, DOD identified estimated personnel savings as part of the rationale for creating the new agency and identified a resulting savings of almost \$46 million. Our previous work highlighted the need for Federal agencies to have valid, reliable data, and to be aware of the size of their workforce, its deployment across the organization, and the knowledge, skills, and abilities needed for the agency to accomplish its mission. A baseline assessment of a number of current headquarters personnel is a crucial first step for developing an estimate of the number of personnel that will be required once the DHA is fully operational.

Second, DOD's cost savings estimates are unclear, as they were missing key details, such as the sources for savings for the various functions of its 10 shared services it is planning as part of the reform effort. DOD aggregated the separate business lines of its shared services, which obscures the size and the cost of planned efficiencies for each business line. A business case analysis requires detailed information to convince customers and stakeholders that the selected business process is the appropriate means for achieving performance.

In addition, DOD has not clarified its plans to monitor implementation costs. In major reengineering efforts, implementation costs can be the dominant cost element and the area of greatest uncertainty. DOD's past experience with large-scale projects, such as its initiative to acquire an electronic health records system, demonstrates the difficulties in controlling rising implementation costs. Greater clarity with regard to the sources of cost savings is also needed to allow senior leaders to monitor progress in achieving estimated savings.

Third, DOD did not include critical details in performance measures it developed to assess progress in achieving the seven goals of the reform effort. Specifically, DOD did not develop explanations for how each measure relates to the goals of the reform effort, did not define the specific measure to be developed, did not provide a baseline assessment of the current performance that is to be measured and, most importantly, did not identify quantifiable targets for assessing progress. Fully developed performance measures are key to senior leaders' ability to assess if DOD's reform effort is achieving the goals or if corrective action is needed.

Let me conclude by noting that our November 2013 report included recommendations in each of these areas to DOD, and DOD concurred with our recommendations. DOD has taken action to address these recommendations, but it has not completed them. We continue to believe that it is imperative for DOD to complete these actions so that decisionmakers will have accurate and complete information to gauge reform progress toward controlling costs versus adding to them.

Thank you, Mr. Chairman. I will be pleased to take questions when you are ready.

[The prepared statement of Ms. Farrell can be found in the Appendix on page 47.]

Mr. WILSON. Thank you very much, Ms. Farrell.

And we will begin now with each member of the subcommittee asking questions for 5 minutes.

And a person above reproach, Jeanette James, is going to keep the time.

And so this will be right on schedule. And we have votes within the next possible 45 minutes. So that is why the time is so important.

For each one of you, beginning with Secretary Woodson, when the Department announced its decision to stand up the Defense Health Agency as a more efficient governance structure, the Government Accountability Office offered several recommendations on improving the Department's decision process. In response, the Department agreed to develop a comprehensive cost analysis of the

Defense Health Agency structure. What were the results of the cost analysis?

Dr. WOODSON. Thank you very much for that question.

And I want to reiterate that we have appreciated the GAO review of our work. Some of the reports are a little out of sequence in terms of the work that was actually done. And we have clearly done a lot more work in terms of the analysis relative to the questions that have been asked.

The issue about the cost investment is a significant one. And one of the issues relative to that is that we are dealing with a lot of shifting sets of program. We know what the base cost and the base issues were relative to, let's say, TRICARE Management Activity [TMA]. But, in fact, what we are doing is we are layering on the shared services and bringing folks over from the service headquarters.

I think the issue really is that, as we look at all of the work that is done and we look at just fiscal year 2014, we projected about \$148 million in savings this year. And through the first quarter, we have already achieved \$80 million dollars of that savings.

And so the issue is that we are ahead of schedule in terms of the savings. And then, as we look at all of the areas, particularly related to the shared services, again, we are outpacing our projections. So, in the pharmacy area, of course, we are projecting about \$437 million in savings in fiscal year 2014. And we can submit for the record our estimation of these savings.

So the bottom-line message that I am saying is that—giving is that this is really, was complicated stuff in trying to identify what was being done and what was the cost in each of the headquarters, what was the baseline cost within the Defense Health Agency. But the performance to date has been better than projected.

And we can provide for you, again, a detailed assessment for every shared service, what the estimate was and where we are performing at this time. And, of course, to date, we have incorporated a total for OIC [officer in charge] of six of the shared services with four more to come on board.

[The information referred to can be found in the Appendix on page 75.]

Mr. WILSON. Thank you, Dr. Woodson. Actually, complicated but very impressive numbers.

General Robb.

General ROBB. In regards to—I will cover specific recommendations from the GAO report. And again, as Dr. Woodson had mentioned, it only covered the first two reports to Congress. In many of the issues that were raised by the GAO, and appropriately so, were addressed in the third MHS report to Congress. And what was good about their recommendations is it allowed us to focus on what we needed to concentrate on.

So, in the first GAO recommendation, we have established analytics function in the DHA. And that is key. We have never done that in MHS. And that is key because that is going to drive the standardization of the metrics across the enterprise. So we are well down the, again, the road to standardizing, again, an analytic function for our defense agency, which then will drive, like you said, the measures, quantifiable, objectable in a baseline assessment.

And then, just for some specific accomplishments, as far the execution, our MHS enterprise core dashboard has been developed. And, again, we are working its way through our new governance structure to get buy-in from the services. And then our multiservice market dashboard, where the rubber meets the road, where those, again, the joint execution of health care is going to occur, has also been approved and is currently being used. And, again, we are using that to help drive and to support our 5-year business plans.

On our second recommendation, we have—one of the objectives is that, you know, our 10 shared services are well on their way. Five of them stood up at IOC [initial operating capability] when four were actually scheduled, and one of them said, Hey, we are ready. And then, recently, we had budget and accounting just came on board ahead of time, and we have three more to go. So we have got that timeline, and we are staying on track. And again, for the record, we would be glad to give that to you.

And then more potential sources of cost savings. We had projected the cost savings for the 10 shared services. Again, 2014, we are—again, we weren't—you know, we are 2015 to 2019, we have predictions. We are looking at 2014. In fact, I review that monthly, and so does our new governance system. Again, as we are tracking the savings that are actually going to cover many of our initial investments. Been a long time since I have been in the military when we have been able to cover our costs actually ahead of time. And so we are excited about that. Because the folks out there, again, are dedicated to make this happen. And then, again, we are going to—we can share again the timelines for all our five shared services, actually the four that remain and where we are going with that.

And then the—each of our shared services has—and we talked about the specifics of it. Each one of them has started out with a minimum of five business case analysis and five businesses plus engineering. And again, the four that are already on board, plus the fifth one—I gave logistics as an example. You know, this isn't the future, this is already executing and already getting a return on investment. So, again, we track those monthly.

Our new governance system. We roll that up quarterly. We just had the quarterly review. Again, we are 120 days, now 150 days into this. And again, they are very transparent on being on target and on time and on glide slope to make sure that we meet those recommended savings that we said that we were going to do.

And then, number four, monitor implementations. Like I talked about, these reviews, that the transparency is none like I have ever seen it in my tenure in the MHS. One inside the DHA, working its way up through the directors in the shared services, and then, two, the new governance system that Dr. Woodson had shared with you where our ones, you know, our threes and fives, you know, our eights get together, almost like a joint staff model, and again work out the issues. And again transparency across the services, again, unheard of in my tenure in the MHS.

And then, finally, develop and present to Congress baseline assessment. So we—the staffing model for the DHA, again, is a work in progress. But Dr. Woodson, and I will allow Dr. Woodson to actually probably elaborate more on this. But we—there will be no

growth. I mean, my folks look at me, and I go, if you say that you need something and where is it coming from. I mean, it is clear there is no growth going to occur, especially in both the military and civilian as we walk this through.

So our DHA, and all our folks understand this, is made up of formerly known as TMA. But the shared services are the men and women, again, who do the dedicated work inside each service.

Mr. WILSON. Thank you, General.

My time is up.

General ROBB. Yes.

Mr. WILSON. Ms. Farrell, if you could just provide for the record later.

[The information referred to was not available at the time of printing.]

Mr. WILSON. And we proceed to our ranking member, Susan Davis.

Mrs. DAVIS. Thank you very much, Mr. Chairman.

I must say, I know that for a lot of people that are just deep in the weeds of this in the audience, I think that they have a good level of understanding. But if anybody else is watching, they may be a little confused, because it is difficult to sort of get a handle on this.

And I think one of the things that jumps out at me, I have a sense, Ms. Farrell, that you are trying to get much more detailed information, particularly in the staffing area. And yet, you know, we are hearing that that is being provided. And I am not exactly clear about that. So I am wondering, are you satisfied with the sources of savings in that arena?

Ms. FARRELL. It is true that our November 2013 report was based on the first two submissions to Congress. But for this testimony today we did obtain and review the third submission.

DOD noted in the comments to our 2013 report that many of the—that they agreed with our findings, and many of the actions would be taken and included in the third submission. However, our review of that submission shows that it is still lacking.

I do not want to take away from the very complex work under the leadership of Dr. Woodson and Lieutenant General Robb. This is a movement that we have seen much further than any of the other reform efforts. But we still do not see a baseline assessment, for example, that we were told would be in the third submission. It is our understanding that that might be in the 2014 strategic plan. Perhaps they can elaborate on that. We do not believe that at this time DOD officials can determine whether or not there will be an increase or a decrease in staffing, since they do not have that baseline. And we emphasize that the baseline should include not only military and civilians, but the contractor workforce. We issued a report last year that noted that the contractor services for DOD was about 90 percent of the DOD Federal employees. The contractor workforce is a significant part of the total workforce. DOD's guidance even instructs them to consider all personnel resources when making the manpower mix decisions, including that of contractors. So we would encourage them to get that inventory down.

Mrs. DAVIS. To include that. Because I guess, going to Dr. Woodson and General Robb, if we are trying to get a 20 percent savings and you don't have the baseline, how do we get there?

Dr. WOODSON. So, you know, that is an excellent question. And let me just give you sort of the idea of the complexity of this. We have to map what is a new agency. Right. This has never been done before.

Mrs. DAVIS. I want to say as well, I am delighted to see the shift.

Dr. WOODSON. Yes. It has, you know, got a core of, let's say, TMA. And we can map those numbers, so we know we are on a glide path to reducing those numbers down by 20 percent. We—the reason being is that we were under a previous mandate to do that under some Track Four Efficiencies and the like that the Secretary had outlined some time ago.

But the issue really is, never before in the history of the Military Health System have we had to map it back to the headquarters of the individual service headquarters and some of their sub-headquarters because of where the functions were being performed.

And so that is a complicated process, and we do have better fidelity on that now. But this will continue to be a work in progress.

Anecdotally, though, what we are—

Mrs. DAVIS. Excuse me, Dr. Woodson.

Can I just interrupt for a second because we are almost out of time. Because some of the information I have would suggest that in the IT consolidated services alone that we have seen the numbers really increase significantly there.

Dr. WOODSON. Yes.

Mrs. DAVIS. So how is that?

Dr. WOODSON. That is a great example. That is a great example. Because one of the agreements between the services is that the services wanted to get out of the health IT issue. And so all of their folks transferred to DHA. So you are going to see that swell. But what we found in the process is that we immediately see duplications in positions. And so we are working through what should be the glide path for reducing those positions. So it is the first time really that we have great—or understanding of this duplication that was occurring within the service. So that is an absolute great example. So, on the surface, it looks like a large bolus, and the reason is that the service divested themselves of those people, but at the same time, we immediately see where the duplications are.

Mrs. DAVIS. Okay. We will stop it there for now.

Thank you, Mr. Chairman.

Mr. WILSON. Thank you, Ms. Davis.

We now proceed to Congressman Dr. Joe Heck of Nevada.

Dr. HECK. Thank you, Mr. Chairman.

Thank you all for being here. I can just—can't even begin to fathom the task. I mean, it is not like somebody handed you a TDA [Table of Distribution and Allowances] and said, go build Defense Health Agency. So I understand the numbers are going to swing wide, like you just said. As you consolidate and people come into your house, that is—the good side is now you have increased visibility of where all these positions are. Now you can start to right-size the force.

And I have no doubt, Dr. Woodson, that based on your distinguished civilian and military career, that you are the right guy to get this done.

And, General Robb, being a fellow D.O. [Doctor of Osteopathy], I am sure you will be up to the task as well.

One of the shared lines of effort listed was medical research and development. How will that, if it will at all, impact, or what is the plan as it pertains to the congressionally directed medical research program?

Dr. WOODSON. I don't think that will negatively impact that at all. But what it does do is it brings again great focus on the research enterprise and allows us to set priorities more effectively and achieve efficiencies in carrying it out. What we have done, of course, is that in the old scheme, MRMC [Medical Research and Materiel Command] was the basis on which the services actually relied for many of its infrastructure operations and carrying out research. Although, of course, Navy had its assets and Air Force had its assets.

What we have done is we have linked the Defense Health Agency to MRMC so the director of the Defense Health Agency is now the deputy commander of MRMC. And it brings great clarity and great unity in the issue of setting research priorities. It actually allows us to leverage our dollars more effectively in setting the priorities, get out the waste and the infrastructure. Everything from, like, assurances to multiple IRBs [independent review boards] will be dealt with and will produce an efficiency in the research program that I don't think has ever been seen before.

Dr. HECK. Great. That is very encouraging and I think long overdue.

Now, I just want to ask, before I ask the question, were you all aware of the statement from the Clinical Laboratory Association that was going to be put into the record or what the issue is that is contained herein?

Dr. WOODSON. No.

Dr. HECK. Okay. So, evidently—there have been a lot of questions, and this is probably going to be something that is more at the tactical level than the strategic level, so if you need to take it for the record, please do. Questions about the TRICARE reimbursement on the laboratory-developed tests and the lack of reimbursement for some of the molecular genetic tests. And the question of why those tests were no longer being covered if they were performed by an outside provider vice if they were performed at an MTF [military treatment facility] and whether or not they were or are not FDA-approved, how that all came in. Some of the questions were, why was that decision made? How was that decision made? And what are we going to do to make sure that our beneficiaries have access to those tests when needed?

Dr. WOODSON. Thank you very much. I wasn't aware about the submission for the record, but I do know about the subject. I will take it and respond back to you fully. But let me give you the bottom line up front. We have recognized sort of a discrepancy. We have a program in place actually to fix it. And none of the beneficiaries will be denied the tests that they need to get great care.

[The information referred to can be found in the Appendix on page 75.]

Dr. HECK. Regardless of whether it is done at an MTF or a civilian location?

Dr. WOODSON. Exactly. We are going to harmonize that whole issue. It has to do with an issue of what we can pay for under TRICARE care versus what can be done within the direct-care system. It is a technical question that should never have come into play with actually administration. It should be an evidence-based decision about the test, not—

Dr. HECK. Great. I appreciate the quick response; look forward to the full response for the record. Thanks.

Yield back, Mr. Chair.

Mr. WILSON. Thank you very much, Dr. Heck.

We really appreciate you being here today. And so we will—I was conferring with the ranking member, Susan Davis. We will continue for another round, and then we will recess and run across the street.

For Dr. Woodson and General Robb, in June of 2013, the Department estimated the Defense Health Agency staffing requirement would be 1,081. By October 2013, that estimate nearly doubled to 1,941. What is the current Defense Health Agency staffing level? Please explain any deviation from the estimate. Are further increases in staffing requirements expected?

Secretary Woodson.

Dr. WOODSON. Thank you, Chairman, for that question.

Again, this gets back to the issue of mapping individuals, where they are coming from and what category they fall in. So let me try and walk you through this. First of all, we need to understand that the Defense Health Agency again is—was much more than TMA. We are laying on shared service and bringing in people from the services to do this work.

The baseline staffing for TMA had been estimated in previous reports at over 2,800, basically. And this admittedly took civilians and uniformed people and contractors.

Again, as it looks now, right with the six shared services that are in, we are at 1,900. It looks like the core staffing, though, is, again, at a glide slope of about 900, with a look to reduce them to about 754. And what we are going to have to do is map out all of these various categories and again matrix it back to the headquarters to make sure that the headquarters are not growing when they shift—even when they shift people over. So it is a complicated process.

The data we have thus far suggests that we are on a glide slope to reduce. We do understand, as mentioned before, that we have gotten in duplications, if you will. So health IT is again that issue where we are going to have to sort these individuals out. But never before has anyone attempted to look at the grand scheme of the MHS and map the FTEs [full-time equivalents] and the duplication. And we are in that process. But I really feel very sure that we are going to produce the efficiencies just simply because they are showing up almost every day in terms of the duplications.

Mr. WILSON. That is encouraging.

General Robb.

General ROBB. Again, I will support Dr. Woodson in the sense of we are building this. And as you see, an agency isn't headquarters. An agency is an institution that provides a service that we are supporting our organization. So when you look at it from that perspective, for example, HIT [healthcare information technology] was a prime example. And it depends on the shared service. Some of it would be just executive oversight and management. But the rest, like HIT, they are the ones doing the work. They are the ones that are the CIO [chief information officer] shops for the services. So, before, they used to be in the service; now they are in our agency. And so—and there has been no—there is no growth in the sense that the numbers.

Now, Dr. Woodson talks about once we bring all those CIOs together, they have already identified redundancies, and they have already—again, as they do the business case analysis and the business process reengineering, this is realtime; in other words, this wasn't all done last summer, much less at IOC. And again, there is work to be done in R&D [research and development] and education training. But HIT is a great example. So we have identified civilians for reduction. We have identified military members for a reduction because of the duplication. And again, as you can imagine—and, ma'am, to your point, contracts. And so there is—that area there is ripe for, one, inventory, and, two, reset.

Dr. WOODSON. If I might add just one other example to give sort of clarity on these numbers and how we have moved in a positive direction. If you were to take, let's say, just the movement of the NCR [National Capital Region] Directorate into the DHA, JTF CAPMED [Joint Task Force National Capital Region Medical] had probably about 130, 140-plus individuals with a manning document that was probably about 176 or so. We have reduced that to 42.

Mr. WILSON. My goodness.

Dr. WOODSON. Forty-two. And this is the power of the construct and the shared entity.

Mr. WILSON. We appreciate your oversight.

And we now proceed to Ranking Member Susan Davis.

Mrs. DAVIS. Thank you. I know we have talked about those shared services. Could you share a little bit more about the consolidation of education and training services as well, and how is that figuring in with these cost savings? Where can we go with that?

Dr. WOODSON. So, thank you, again, for that question.

So one of the I think enabling factors in standing up the DHA was the fact that we had begun in certain isolated pockets to go to joint entities. The Medical Education and Training Center in San Antonio is one of those issues. In my opening statement, where I talked about that medic who first attended to the wounded Marine, although he was a Navy corpsman, he probably was trained at the Medical Education Training Center next to the Air Force buddy and an Army buddy, basically. So it was an easy move for that entity to come into education and training.

But beyond that, we educate all the time medical personnel. And so the money we spend on continuing medical education and e-learning, graduate medical education, and the like, are all opportunities to harmonize, synergize, and produce efficiencies in that area.

Mrs. DAVIS. And you feel that—where—because—in some ways, we want to be sure that we are—we are really allowing the kinds of, I guess, creativity to come forward. And do you think that is going to be better served?

Dr. WOODSON. That is an excellent question. And I think that is probably the most pertinent question we can ask.

We have been talking about standardization, efficiencies, reducing variability. And sometimes that is considered counter to innovation and, you know, really moving, advancing ahead.

The truth of the matter is that if you manage the processes correctly, one helps the other. So reducing variability is about identifying the best standard and then making sure we create wisdom without—in the system so everybody operates at that best standard.

But at the same time, I have stood up an innovation cell to ensure that we are linking the appropriate communities of interest so that we can find new ideas, whether it is advances in strategies for education or strategies for care, we can feed it and resource those appropriately, see if they are validated by measuring, putting metrics against them, and then, at the earliest opportunity, spreading it across the enterprise. So we have not neglected the issue of innovation.

Mrs. DAVIS. Can you overlay employee satisfaction on that? Because it is my understanding, again, that as we look at that right now that the Defense Health Agency is kind of ranked fairly low. And I don't know whether that is just because we are in a transition. I mean, this is a difficult time for everybody. But how are you evaluating morale? And where you see that it is low, to what do you attribute that?

Dr. WOODSON. So another great question.

I think, you know, our experience is that when you talk to folks in the field, they are excited about the change. They recognize that they have been working with their brothers and sisters in the other services for some time. And they recognize the opportunities of working in fellow service institutions.

I think the issues—we have to be careful at this time in our history. We have been at war for 13-plus years. We have got all of these budget issues in the news. Everybody is talking about downsizing and the like. And it gets to be a very confusing picture about what is driving morale.

I think in the medical community, what we are hearing when you talk to the individual, everybody is nervous about change. We are human beings; we get nervous about change. But the issue is they are excited about the possibilities I think that this new endeavor creates. So I have a different take on it. I think there is some general anxiety out there about all that is going on. I don't see the morale within the medical community as having suffered.

Mrs. DAVIS. Director Farrell, do you pick up that also when you are doing your gathering information? Is that something you could weigh in on?

Ms. FARRELL. We have ongoing work that is driven by this committee specifically looking at the integration of medical education in San Antonio. I would note that that is an effort that actually started with BRAC in 2005, for consolidation of facilities, not nec-

essarily the education itself, that being the courses. So we are currently looking at what integration has actually taken place. What is the morale of the students? What are the strengths? Are there any issues that are developing? And we will be reporting that back to this committee next month.

Mrs. DAVIS. All right. Thank you very much.

Thank you, Mr. Chairman.

Mr. WILSON. Thank you, Ms. Davis.

Now Congressman Dr. Joe Heck.

Dr. HECK. Thanks, Mr. Chair, for the second round of questioning. Actually, my questions are in response to some of the other answers to the other questions.

On medical education, is USUHS [Uniformed Services University of Health Science] going to be within your wiring diagram now?

Dr. WOODSON. So USUHS is—yes, it is a report to me.

Dr. HECK. And as you move these other entities now, like using IT from the services into DHA, who is the bill payer? Do they stay on the services' books or are you picking up the tab?

Dr. WOODSON. So a lot of that we have been picking up the tab for, anyway. That is DHP [Defense Health Program] money. And so it is very interesting. This project is just fascinating in some sense.

So one of the things we had to figure out is, you know, where the money goes. And so one of the initiatives, of course, is we have developed a common cost accounting system. Never been done before. So that we can track.

The bottom-line answer to your question, though, is that it is DHP money, so we have been the bill payer. It is just that we are now being able to centralize the portfolios, clean up the portfolios so that we don't have duplicate IT programs and the like. And it is just much more efficient. But we are the bill payer.

Dr. HECK. And then, lastly, the whole concept for this was put into place or developed prior to sequestration passing. With the advent of sequestration, how do you see that, or does it impact your ability to move forward on what you need to do with DHA?

Dr. WOODSON. Thank you, again, for another good question.

I hope everyone realizes that last year was a very challenging year for us, right? We had the program cuts for the Budget Control Act. We had sequestration. We had furloughs. We had—this agency stood up in the middle of a government shutdown. And yet it has delivered on the promise of the savings and is getting the job done.

In direct answer to your question, though, thank God we started down this path. Because if we had not and we had these budgetary concerns and all of the issues in forced management, forced reduction and the coming concerns, it would have spelled disaster, I think, for the Military Health System. So we started with vision in mind about what we need to do, because it was right. It turns out it serves a purpose of efficiency and meeting the budgetary issues as well.

Dr. HECK. Great. Again, thank you all for what you are doing. Yield back.

Mr. WILSON. Thank you very much, Dr. Heck.

And thank you all for being here today.

And indeed, we appreciate your promoting efficiencies, as you indicated, in an extraordinarily disruptive environment. That is very impressive.

If there is no further comment, we shall be adjourned.

[Whereupon, at 3:31 p.m., the subcommittee was adjourned.]

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**A P P E N D I X**

FEBRUARY 26, 2014

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**PREPARED STATEMENTS SUBMITTED FOR THE RECORD**

FEBRUARY 26, 2014

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**Opening Remarks – Chairman Wilson**  
**Military Personnel Subcommittee Hearing**  
**Defense Health Agency**  
**February 26, 2014**

Today the Subcommittee meets to hear testimony on the Defense Health Agency. I would like to begin by acknowledging the remarkable military and civilian medical professionals who provide extraordinary care to our service members and their families here at home and around the world, often in some of the toughest and most austere environments. I have firsthand knowledge of their dedication and sacrifice from my son, Addison, who is a Navy orthopedic surgeon stationed in Naples, Italy.

In 2011, the House passed legislation establishing a Joint/Unified Medical Command as a method of making a streamlined and efficient military health system, which has been shown by multiple studies to be a potential source of great cost savings. Ultimately, the Department of Defense rejected the option of a Joint Command deciding instead to establish the Defense Health Agency as part of an overall restructure of the governance of the Military Health System to drive efficiencies and cost savings. This was done despite concerns raised by the Government Accountability Office about the Department's analyses of options for restructuring the military health system.

I am anxious to hear from our witnesses how the Defense Health Agency is progressing, including your forecast for accomplishing the goals of increased efficiency and cost reduction. To that end, I would like the witnesses to address the following:

- The Government Accountability Office offered several recommendations regarding implementation of the Defense Health Agency. How has the Department addressed these recommendations? Was a comprehensive cost analysis of the Defense Health Agency conducted and what were the results?

- In June of 2013 the Department estimated that the Defense Health Agency staffing requirement would be 1,081. By October 2013 that estimate nearly doubled to 1,941. What is the current DHA staffing level? If it has deviated from the estimate, please explain why. Are further increases in staffing requirements expected?
- Given that seven of the ten shared services were implemented at the beginning of this fiscal year, are current spending and saving levels on par with the projections, especially the Pharmacy Program which was projected to attain early savings?

Finally, I would like to hear how the military Surgeons General were involved in the implementation process.

I hope that our witnesses will address these important issues as directly as possible in their oral statements and in response to Member questions.

Before I introduce our panel, let me offer Ranking Member Susan Davis, from California, an opportunity to make her opening remarks.

**Prepared Statement**

**Of**

**The Honorable Jonathan Woodson, M.D.,**

**Assistant Secretary of Defense (Health Affairs)**

**And**

**Lieutenant General (Dr) Douglas Robb**

**Director, Defense Health Agency**

**Before the House Armed Services Committee Subcommittee**

**on Military Personnel**

**February 26, 2014**

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 21<sup>st</sup> 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, this 19<sup>th</sup> 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 1<sup>st</sup> – 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 inquiries) 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.



**Jonathan Woodson**

**Assistant Secretary of Defense (Health Affairs)**



Dr. Jonathan Woodson is the Assistant Secretary of Defense for Health Affairs. In this role, he administers the more than \$50 billion Military Health System (MHS) budget and serves as principal advisor to the Secretary of Defense for health issues. The MHS comprises over 133,000 military and civilian doctors, nurses, medical educators, researchers, healthcare providers, allied health professionals, and health administration personnel worldwide, providing our nation with an unequalled integrated healthcare delivery, expeditionary medical, educational, and research capability.

Dr. Woodson ensures the effective execution of the Department of Defense (DoD) medical mission. He oversees the development of medical policies, analyses, and recommendations to the Secretary of Defense and the Undersecretary for Personnel and Readiness, and issues guidance to DoD components on medical matters. He also serves as the principal advisor to the Undersecretary for Personnel and Readiness on matters of chemical, biological, radiological, and nuclear (CBRN) medical defense programs and deployment matters pertaining to force health.

Dr. Woodson co-chairs the Armed Services Biomedical Research Evaluation and Management Committee, which facilitates oversight of DoD biomedical research. In addition, Dr. Woodson exercises authority, direction, and control over the Defense Health Agency (DHA); the Uniformed Services University of the Health Sciences (USUHS); the Armed Forces Radiobiology Research Institute (AFRRI); the Defense Center of Excellence for Psychological Health and Traumatic Brain Injury (DCoE); the Armed Forces Institute of Pathology; and the Armed Services Blood Program Office.

Prior to his appointment by President Obama, Dr. Woodson served as Associate Dean for Diversity and Multicultural Affairs and Professor of Surgery at the Boston University School of Medicine (BUSM), and senior attending vascular surgeon at Boston Medical Center (BMC). Dr. Woodson holds the rank of brigadier general in the U.S. Army Reserve, and served as Assistant Surgeon General for Reserve Affairs, Force Structure and Mobilization in the Office of the Surgeon General, and as Deputy Commander of the Army Reserve Medical Command.

Dr. Woodson is a graduate of the City College of New York and the New York University School of Medicine. He received his postgraduate medical education at the Massachusetts General Hospital, Harvard Medical School and completed residency training in internal medicine, and general and vascular surgery. He is board certified in internal medicine, general surgery, vascular surgery and critical care surgery. He also holds a Master's Degree in Strategic Studies (concentration in strategic leadership) from the U.S. Army War College.

In 1992, he was awarded a research fellowship at the Association of American Medical Colleges Health Services Research Institute. He has authored/coauthored a number of publications and book chapters on vascular trauma and outcomes in vascular limb salvage surgery.

His prior military assignments include deployments to Saudi Arabia (Operation Desert Storm), Kosovo, Operation Enduring Freedom and Operation Iraqi Freedom. He has also served as a Senior Medical Officer with the National Disaster Management System, where he responded to the September 11th attack in New York City. Dr. Woodson's military awards and decorations include the Legion of Merit, the Bronze Star Medal, and the Meritorious Service Medal (with oak leaf cluster).

In 2007, he was named one of the top Vascular Surgeons in Boston and in 2008 was listed as one of the Top Surgeons in the U.S. He is the recipient of the 2009 Gold Humanism in Medicine Award from the Association of American Medical Colleges.





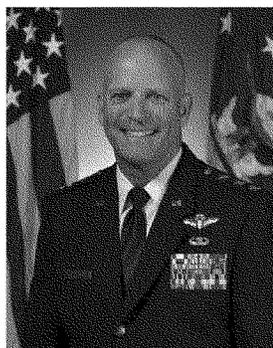
## BIOGRAPHY



UNITED STATES AIR FORCE

### LIEUTENANT GENERAL (DR.) DOUGLAS J. ROBB

Lt. Gen. (Dr.) Douglas J. Robb is the Director, Defense Health Agency (DHA), Defense Health Headquarters, Falls Church, Va. He leads a joint, integrated Combat Support Agency enabling the Army, Navy, Air Force, and Marine Corps medical services to provide a medically ready force and ready medical force to Combatant Commands in both peacetime and wartime. In support of an integrated, affordable, and high quality military health service, the DHA directs the execution of ten joint shared services to include the health plan (TRICARE), pharmacy, health information technology, research and acquisition, education and training, public health, medical logistics, facility management, budget resource management, and contracting. The DHA administers the TRICARE Health Plan providing worldwide medical, dental and pharmacy programs to more than 9.6 million uniformed service members, retirees and their families. The DHA exercises authority, direction, and control over the inpatient facilities and their subordinate clinics assigned to the DHA in the National Capital Region Directorate and also manages the execution of policy as issued by the Assistant Secretary of Defense for Health Affairs.



General Robb entered the Air Force in June 1979 as a graduate of the U.S. Air Force Academy. He is board certified in aerospace medicine. He has spent 20 years in the practice of aerospace medicine in support of Air Force, joint, and coalition aviation forces. Clinically, he has held the positions of chief of flight medicine; aerospace medicine squadron commander; and hospital and medical center commander. Additionally, he has held staff positions as the chief flight surgeon for U.S. Air Forces in Europe, Command Surgeon, U.S. Central Command, Command Surgeon, Air Mobility Command, and Joint Staff Surgeon, Office of the Chairman, Joint Chiefs of Staff. Prior to his current position, General Robb served as Deputy Director, TRICARE Management Activity. A chief flight surgeon with more than 1,500 flying hours, he has maintained additional crewmember status in the A-7, OV-10, F-16, C-9, C-130, and KC-135 aircraft.

#### EDUCATION

1979 Bachelor of Science degree in biological sciences, U.S. Air Force Academy, Colorado Springs, Colo.

1984 Medical degree, Chicago College of Osteopathic Medicine, Ill.

1992 Master's degree in public health in occupational medicine, Harvard School of Public Health, Cambridge, Mass.

1994 Residency training and board certification in aerospace medicine and occupational medicine, Brooks AFB, Texas  
 2000 National War College, Fort Lesley J. McNair, Washington, D.C.  
 2002 Medical Executive Skills Capstone, Washington, D.C.  
 2003 Interagency Institute for Federal Health Care Executives, George Washington University, Washington, D.C.

#### **ASSIGNMENTS**

1. June 1979 - August 1980, maintenance officer, 13th Tactical Fighter Squadron, MacDill AFB, Fla.
2. September 1980 - June 1984, student, Chicago College of Osteopathic Medicine, Ill.
3. July 1984 - June 1985, family practice resident, Carswell Regional Hospital, Carswell AFB, Texas.
4. July 1985 - July 1987, flight surgeon, 429th Tactical Fighter Squadron and 4450th Tactical Group, Nellis AFB, Nev.
5. August 1987 - August 1988, flight surgeon, 19th Tactical Air Squadron, Osan Air Base, South Korea.
6. September 1988 - August 1991, flight surgeon, 526th Fighter Squadron, Ramstein AB, Germany.
7. September 1991 - June 1992, student, Harvard School of Public Health, Cambridge, Mass.
8. July 1992 - July 1994, medical resident, Aerospace Medicine, Brooks AFB, Texas.
9. August 1994 - June 1997, Commander, 347th Aerospace Medicine Squadron, Moody AFB, Ga. (June 1996 - July 1996, Commander, 4404th Medical Group [provisional], Southwest Asia).
10. July 1997- July 1999, Chief, Aerospace Medicine, Office of the Surgeon General, Headquarters U.S. Air Forces in Europe, Ramstein AB, Germany.
11. August 1999 - July 2000, student, National War College, Fort Lesley J. McNair, Washington, D.C.
12. June 2000 - July 2002, Commander, 59th Aeromedical-Dental Group, Lackland AFB, Texas.
13. July 2002 - June 2004, Commander, 10th Medical Group, and Command Surgeon, U.S. Air Force Academy, Colorado Springs, Colo.
14. June 2004 - June 2007, Command Surgeon, U.S. Central Command, MacDill AFB, Fla.
15. July 2007 - July 2008, Commander, 81st Medical Group, Keesler AFB, Miss.
16. July 2008 - August 2010, Command Surgeon, Air Mobility Command, Scott AFB, Ill.
17. September 2010 - June 2013, Joint Staff Surgeon, Office of the Chairman, Joint Chiefs of Staff, the Pentagon, Washington, D.C.
18. July 2013- September 2013, Deputy Director, TRICARE Management Activity, Defense Health Headquarters, Falls Church, Va.
19. October 2013 - present, Director, Defense Health Agency, Defense Health Headquarters, Falls Church, Va.

#### **SUMMARY OF JOINT ASSIGNMENTS**

1. June 2004 - June 2007, Command Surgeon, U.S. Central Command, MacDill AFB, Fla., as a colonel
2. September 2010 - June 2013, Joint Staff Surgeon, Office of the Chairman, Joint Chiefs of Staff, the Pentagon, Washington, D.C., as a major general
3. July 2013 - September 2013, Deputy Director, TRICARE Management Activity, Defense Health Headquarters, Falls Church, Va., as a major general
4. October 2013 - present, Director, Defense Health Agency, Defense Health Headquarters, Falls Church, Va., as a lieutenant general

#### **FLIGHT INFORMATION**

Ratings: Chief flight surgeon, airborne and air assault  
 Flight hours: More than 1,500  
 Aircraft flown: A-7, OV-10, F-16, C-9, C-130, T-43, C-21 and KC-135

**MAJOR AWARDS AND DECORATIONS**

Defense Superior Service Medal with oak leaf cluster  
Legion of Merit  
Meritorious Service Medal with three oak leaf clusters  
Joint Service Commendation Medal  
Air Force Commendation Medal with "V" device two oak leaf clusters  
Air Force Achievement Medal

**EFFECTIVE DATES OF PROMOTION**

Second Lieutenant May 30, 1979  
Captain Nov. 30, 1983  
Major Nov. 30, 1989  
Lieutenant Colonel Nov. 30, 1995  
Colonel May 30, 2000  
Brigadier General June 1, 2007  
Major General Aug. 3, 2009  
Lieutenant General Oct. 1, 2013

(Current as of October 2013)

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United States Government Accountability Office



Testimony  
Before the Subcommittee on Military  
Personnel, Committee on Armed  
Services, House of Representatives

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For Release on Delivery  
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## MILITARY HEALTH SYSTEM

### Sustained Senior Leadership Needed to Fully Develop Plans for Achieving Cost Savings

Statement of Brenda S. Farrell, Director,  
Defense Capabilities and Management

# GAO Highlights

Highlights of GAO-14-396T, a testimony before the Subcommittee on Military Personnel, Committee on Armed Services, House of Representatives

## Why GAO Did This Study

DOD's MHS costs almost \$50 billion annually and is expected to grow to \$70 billion by 2028. The MHS governance structure has been the subject of many studies, some recommending major changes. In 2006, DOD considered potential governance structure changes but left its existing structure in place, approving instead a shared-services directorate to consolidate common MHS functions (e.g., shared information-technology services) that ultimately was never developed. In 2012, DOD announced the creation of the DHA by October 1, 2013, with seven main goals: (1) consolidate functions (shared services) common to DOD, (2) deliver more-integrated health care in areas with more than one military service, (3) establish more-standardized processes, (4) more-closely align financial incentives with health and readiness outcomes, (5) match other resources with missions, (6) deliver more primary care and other health services, and (7) better coordinate care over time and across treatment settings. Section 731 of the National Defense Authorization Act for Fiscal Year 2013 required DOD to provide three submissions in March, June, and September 2013, detailing its plan to reform the MHS.

This testimony addresses the additional actions that would increase transparency and enhance accountability of DOD's reform plans. It is based primarily on (1) GAO's November 2013 report which assessed DOD's first two submissions of its reform plans to Congress and (2) selected updates. For the updates, GAO analyzed DOD's third reform plan and interviewed a DOD representative.

View GAO-14-396T. For more information, contact Brenda S. Farrell at (202) 512-3604 or farrellb@gao.gov.

February 26, 2014

## MILITARY HEALTH SYSTEM

### Sustained Senior Leadership Needed to Fully Develop Plans for Achieving Cost Savings

#### What GAO Found

Department of Defense (DOD) senior leadership has demonstrated a commitment to oversee implementation of its military health system's (MHS) reform and has taken a number of actions to enhance the reform efforts. For example, in March 2013, DOD chartered the MHS Governance Transition Organization to provide oversight, management, and support for the implementation. This entity is chartered to exist until October 2015, when the Defense Health Agency (DHA) is expected to reach full operating capability. Formation of this entity addresses an issue GAO reported on in April 2012—that DOD did not form such a team to oversee its 2006 MHS reform effort.

GAO's November 2013 report identified several areas in DOD's implementation plan where sustained senior leadership attention is needed to help ensure the reform achieves its goals including:

- **Undetermined staffing requirements:** DOD did not have the data to determine how the creation of the DHA will affect the total number of MHS headquarters staff because it had not conducted an accurate baseline assessment of current staffing levels. Notwithstanding, using data that service officials later believed were inaccurate, in 2011, DOD identified anticipated annual personnel savings of \$46.5 million as part of the rationale for creating the DHA.
- **Unclear cost estimates:** DOD's cost savings estimates were missing key details such as the source of the savings. DOD aggregated the separate functions of its shared services, which obscures the size and cost of planned efficiencies for each function. A business case analysis requires detailed information to convince customers and stakeholders that the selected business process is the appropriate means for achieving performance. In addition, business-case analyses should demonstrate the sensitivity of the outcome to changes in assumptions. However, DOD did not assess the risk that implementation costs could increase.
- **Incomplete performance measures:** DOD did not develop explanations for how each measure relates to the goals of the reform effort, did not define the specific measure to be developed; did not provide a baseline assessment of the current performance that is to be measured; and, most importantly, did not identify quantifiable targets for assessing progress. In its third submission, DOD provided some additional information, but did not provide fully developed performance measures for any of its seven reform goals.

DOD concurred with all of GAO's recommendations, including: (1) develop a baseline assessment of the number of personnel currently working within the MHS headquarters and an estimate for the DHA at full operating capability; (2) develop a more thorough explanation of the potential sources of cost savings from DOD's implementation of shared services; and (3) develop performance measures that are clear, quantifiable, objective, and include a baseline assessment of current performance. In February 2014, a DOD representative said that DOD has taken action to address the recommendations, but it has not completed implementation. GAO continues to believe that it is imperative for DOD to complete these actions so decision makers will have complete information to gauge reform progress.

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Chairman Wilson, Ranking Member Davis, and Members of the Subcommittee:

Thank you for the opportunity to be here today to discuss whether the Defense Health Agency (DHA) is positioned to achieve the goals of the Department of Defense's (DOD) efforts to reform the military health system (MHS). DOD plans to spend almost \$50 billion on the MHS in fiscal year 2014. This number has grown from approximately \$20 billion in fiscal year 2000, and is projected by the Congressional Budget Office to continue to grow to \$70 billion in 2028. In an effort to create a more integrated and cost effective MHS, in March 2012, the Deputy Secretary of Defense directed the establishment of a Defense Health Agency, which officially began operations on October 1, 2013. Throughout the implementation of the DHA, senior DOD leadership, including the Deputy Secretary of Defense, the Assistant Secretary of Defense (Health Affairs), and the service Surgeons General have demonstrated a commitment to oversee implementation for reform of the MHS. However, we have identified several areas where sustained senior leadership, including additional information, is needed to help ensure the reform achieves its goals, including greater cost effectiveness.

My statement today summarizes key findings from our November 2013 report<sup>1</sup> which assessed DOD's implementation plans for reform of the MHS and includes selected updates. Specifically, it addresses: (1) the staffing requirements of the DHA; (2) the sources of the cost savings that DOD estimates will be realized from its shared-services goal, and the importance of monitoring and more fully developing the associated implementation costs; (3) milestones to assess progress in implementing all seven goals of the reform efforts; and (4) performance measures to evaluate achievement of the reform's goals.

The National Defense Authorization Act for Fiscal Year 2013 required DOD to submit its plans for implementing its reform effort in three submissions—the first in March 2013, the second in June 2013, and the third in September 2013—and mandated that we review DOD's first two submissions.<sup>2</sup> We examined the March and June 2013 submissions as

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<sup>1</sup>GAO, *Defense Health Care Reform: Additional Implementation Details Would Increase Transparency of DOD's Plans and Enhance Accountability* GAO-14-49 (Washington, D.C.: Nov. 6, 2013).

<sup>2</sup>National Defense Authorization Act for Fiscal Year 2013, Pub. L. No. 112-239, § 731 (2013).

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well as an August 2013 supplemental report to Congress of DOD's plan to implement the reform effort and reported the results in November 2013. For that report, we compared DOD's submissions for reforming the MHS governance structure with the statutory requirements and key management practices contained in GAO's Business Process Reengineering Assessment Guide and other relevant GAO work.<sup>3</sup> In the course of our work, we interviewed officials from the Office of the Assistant Secretary of Defense for Health Affairs, MHS Transition Office, and the military Surgeons General. For the purposes of this testimony, in February 2014, we subsequently examined DOD's third and final reform plan, which was submitted to Congress in November 2013, and discussed the status of our November 2013 report recommendations with an official within the Office of the Secretary of Defense (Health Affairs) who represented the department. The work upon which this statement is based was conducted in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives. Additional details about the scope and methodology can be found in our November 2013 report, and a list of related products appears at the end of my statement.

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## Background

Since 1949, the governance structure of the MHS has been the subject of numerous studies conducted by DOD internal and external boards, commissions, task forces, and GAO, and several of those studies have led to recommendations for a major organizational realignment. After studying several options for reorganizing the defense organizations that constitute the MHS, in 2006 the Deputy Secretary of Defense approved multiple initiatives including a shared services directorate to integrate the services these organizations provide, such as information technology, and make the MHS more cost-effective. DOD implemented those initiatives to varying extents; however, the directorate was never formed and the overarching governance structure of the MHS did not change. Further, Congress expressed concern that DOD had not yet developed a

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<sup>3</sup>GAO, *Business Process Reengineering Assessment Guide*, GAO/AIMD-10.1.15 (Washington, D.C.: May 1997); *Streamlining Government: Questions to Consider When Evaluating Proposals to Consolidate Physical Infrastructure and Management Functions*, GAO-12-542 (Washington, D.C.: May 23, 2012); GAO, *Defense Health Care: Applying Key Management Practices Should Help Achieve Efficiencies within the Military Health System* GAO-12-224 (Washington, D.C.: Apr. 12, 2012).

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comprehensive plan to enhance quality, efficiencies, and savings in the MHS. DOD's senior leadership established a task force in 2011 to review various options for changing the governance structure of the system. This task force reported the results of its review to the congressional defense committees in March 2012 and, in October 2013, implemented its recommended course of action by establishing the DHA. According to DOD, with the creation of the DHA, the military services' respective Surgeons General will continue to oversee medical forces and the operation of health care systems, including their military hospitals, and the DHA will support the services in executing their respective medical missions.

DOD created the DHA with the intent of creating a more cost-effective and integrated MHS. This reform effort comprises seven overarching goals:

- consolidate functions (shared services) common to DOD;
- deliver more-integrated health care in areas with more than one military service;
- establish more-standardized processes;
- more-closely align financial incentives with health and readiness outcomes;
- match other resources with missions;
- deliver more primary care and other health services; and
- better coordinate care over time and across treatment settings.

The Deputy Secretary of Defense directed the formation of a team to develop an implementation plan for the governance changes. As a result, in March 2013, the Assistant Secretary of Defense for Health Affairs chartered the MHS Governance Transition Organization to provide oversight, management, and support for the implementation of MHS governance reforms. The formation of this MHS Governance Transition Organization addresses an issue we previously reported on—that DOD

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had not formed an overarching team to manage the implementation of the 2006 attempt to improve the department's medical governance structure.<sup>4</sup>

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### **DOD Does Not Have an Accurate Baseline Assessment of Current Staffing to Determine Potential Savings and Future Staffing Needs of the DHA**

As we reported in November 2013, DOD has not conducted an accurate baseline assessment of the headquarters personnel currently working in the MHS—that is, personnel working at each military service's headquarters and at the Office of the Secretary of Defense. In addition, DOD has not determined the number of personnel required for the DHA when it is fully operational in 2015, as currently planned. Our previous work<sup>5</sup> highlighted the need for federal agencies to have valid, reliable data and to be aware of the size of their workforce, its deployment across the organization, and the knowledge, skills, and abilities needed for the agency to accomplish its mission.<sup>6</sup> A baseline assessment of the number of current headquarters personnel is a crucial first step for developing an estimate of the number of personnel that will be required once DHA is fully operational.

In its September 2011 analysis of options to reform the MHS, DOD identified anticipated personnel savings as part of the rationale for the reform effort and estimated a resulting estimated annual personnel cost savings of \$46.5 million. The Deputy Secretary of Defense based the decision to establish the DHA, in part, on this estimate of personnel savings. In contrast, we reported in November 2013 that DOD officials told us that there would be no net increase in personnel numbers across the MHS headquarters as a result of the creation of the DHA. Further, we reported that, according to DOD officials, military service officials believed that DOD's previous baseline assessment that was reflected in the \$46.5 million cost savings estimate did not accurately reflect the current number of headquarters personnel working in the MHS.<sup>7</sup>

We also reported in November 2013 that, according to DOD officials, the number of military, civilian, and contractor positions required when the

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<sup>4</sup> GAO-12-224.

<sup>5</sup> GAO/AIMD-10.1.15.

<sup>6</sup> GAO, *A Model of Strategic Human Capital Management*, GAO-02-373SP (Washington, D.C.: March 2002).

<sup>7</sup> GAO-14-49.

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DHA is fully operational in 2015 could be significantly higher for certain headquarters functions than the estimates for the number of positions required at the time of the DHA's establishment in October 2013. For example, we reported that according to a senior official responsible for information technology in the MHS, the number of staff required to provide information-technology services when DHA began initial operations in October 2013 was estimated at about 400 military and civilian positions; however, that estimate could increase to about 3,500 military and civilian positions and about 5,000 contractor equivalent positions once the DHA becomes fully operational in 2015. We concluded that DOD was unable to determine whether the establishment of the DHA would result in an increase or decrease in the number of headquarters personnel because the department had not completed an accurate baseline assessment of the number of headquarters personnel working in the MHS across the services and the Office of the Secretary of Defense.

In our November 2013 report, we recommended that DOD develop a baseline assessment of the current number of military, civilian, and contractor personnel currently working within the MHS headquarters and an estimate for the DHA at full operating capability, including estimates of changes in contractor full-time equivalents.<sup>8</sup> DOD concurred with our recommendation. In our November 2013 report, we noted that DOD officials told us that they planned to conduct a baseline assessment of headquarters staffing levels and submit a revised estimate of its staffing needs in the department's third and final implementation plan submission. In the final submission which we reviewed for this statement, DOD did not include a baseline assessment of the number of personnel currently working in the MHS headquarters across the services and the Office of the Secretary of Defense, nor did it include an estimate of the staffing needs once the DHA is fully operational in 2015. Instead, DOD reported that the DHA would include 1,941 military and civilian personnel as of its initial operating capability on October 1, 2013. Additionally, the plan's estimate of staffing in October 2013 does not account for any contractor positions currently associated with the MHS's headquarters functions. As the DHA moves toward full operating capability, accurate baseline staffing data is critical for senior leadership to make informed decisions about the resources required to manage the MHS. Such data have become even more critical since the Deputy Secretary of Defense announced a

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<sup>8</sup>GAO-14-49.

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20 percent reduction in DOD management headquarters spending over 5 fiscal years beginning in fiscal year 2014.

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### DOD Has Not Clarified the Sources of Cost Savings and Its Plan to Monitor Implementation Costs

DOD has not provided discrete cost savings estimates for the various functions it has identified as part of its 10 shared service projects it is planning as part of the MHS reform. In addition, DOD has not clarified its plan to monitor implementation costs. According to GAO's *Business Process Reengineering Assessment Guide*, an initial business case is a high-level document aimed at convincing customers and stakeholders that reengineering the selected business process is the appropriate means for achieving performance and cost-savings goals.<sup>9</sup> The Guide identifies that as the reengineering process matures, the business case should include detailed qualitative and quantitative analysis in support of selecting and implementing the new process that includes a statement regarding benefits, costs, and risks. In addition, business-case analyses should demonstrate the sensitivity of the outcome to changes in assumptions, with a focus on the dominant benefit and cost elements and the areas of greatest uncertainty. In the context of major business-process reengineering efforts, such as DOD's shared services, implementation costs can be the dominant cost element and the area of greatest uncertainty.

In November 2013, we reported<sup>10</sup> that DOD officials stated that while some efficiencies in the reform effort might be achieved by reducing headquarters staffing levels, DOD expected that the greatest cost savings would be realized through a more integrated approach to the MHS, standardization, and the implementation of shared services, such as such as information technology, medical logistics, and contracting. In our September 2012 report<sup>11</sup> on DOD's analysis of options for governance of the MHS, we recommended that DOD perform a business-case analysis to demonstrate the extent to which sharing services would result in cost savings. In its second and third implementation plan submissions for the DHA, DOD identified the functions it would consolidate and the anticipated aggregate savings and implementation costs. However,

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<sup>9</sup>GAO/AIMD-10.1.15.

<sup>10</sup>GAO-14-49.

<sup>11</sup>GAO, *Defense Health Care: Additional Analysis of Costs and Benefits of Potential Governance Structures Is Needed*, GAO-12-911 (Washington, D.C.: Sept. 26, 2012).

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DOD's submissions did not include detailed quantitative analysis regarding the sources of its cost-savings estimates or provide a basis for or an explanation of key assumptions and rationales used in estimating such savings. For example, DOD identified the consolidation of medical logistics functions and a resulting aggregated cost-savings range of between \$132 million and \$353 million from fiscal years 2014 through 2019. However, the plan did not explain which function within this area (e.g., equipment or housekeeping) would be the larger source of those savings. Similarly, DOD's second implementation plan submission identified that DOD plans to achieve savings in administration of its health care plan for servicemembers, TRICARE, by closing walk-in help centers and transitioning to a phone-based system. Further, it plans to achieve savings through better coordination of TRICARE benefit payments with other health insurers. However, as in the case of the consolidation of medical logistics functions, DOD did not identify separate cost-savings estimates for each planned effort (e.g., transitioning to a phone-based system) and instead presented the estimated cost savings as an aggregated amount of between \$503 million and \$787 million.

DOD's second implementation plan submission included risk-adjusted estimates of net cost savings for shared services based on uncertainty regarding these projects' effectiveness and that are presented as a range, with a 10 percent to 100 percent chance of achieving the maximum estimated savings for each shared service. However, while DOD assessed the risk of its reforms failing to achieve their maximum potential cost savings, it did not similarly assess the risk that estimated implementation costs may increase and affect net savings. As noted above, our prior work emphasizes that business-case analyses should demonstrate the sensitivity of the outcome to changes in assumptions, with a focus on the dominant benefit and cost elements and the areas of greatest uncertainty. DOD's analysis did not assess the risk that estimated implementation costs may increase. In instances where estimated implementation costs increase, overall savings may be negatively affected.

DOD's past experience with large-scale projects demonstrates its difficulties in controlling rising implementation costs. For example, in October 2010, we previously found that after obligating approximately \$2 billion over the 13-year life of its initiative to acquire an electronic health record system, as of September 2010 DOD had delivered various capabilities for outpatient care and dental care documentation, but scaled back other capabilities it had originally planned to deliver, such as replacement of legacy systems and inpatient-care management. In

addition, users continued to experience significant problems with the performance (speed, usability, and availability) of the portions of the system that have been deployed.<sup>12</sup> According to DOD's estimates, collectively, the 10 shared services to be implemented as part of the MHS reform effort require an investment in information-technology capabilities of about \$273 million between fiscal years 2014 and 2019. Given DOD's past experience in this area, rising implementation costs are an area of specific concern.

In our November 2013 report, we recommended that DOD develop a more thorough explanation of the potential sources of cost savings from the implementation of its shared-services projects and monitor the cost of the implementation process, and DOD concurred with our recommendations.<sup>13</sup> However, DOD's third implementation plan submission did not provide additional information concerning the potential sources of cost savings, nor did it clarify its plan to monitor implementation costs. In February 2014, a DOD representative told us that DOD has developed a process for leadership to monitor implementation costs, and we plan to review DOD's process to determine if it addresses our recommendation. As DOD implements its shared services, greater clarity with regard to the sources of cost savings is also needed to allow senior leaders to monitor progress in achieving cost savings.

### DOD Does Not Have Interim Milestones For All Reform Goals

DOD has developed some milestones and activities associated with each of its reform goals, including identifying steps to reach each reform goal's initial operating capability. However, DOD did not consistently identify milestones between initial operating capability and final operating capability, nor did it include steps to achieve all seven reform goals. Practices of successful performance management show that interim milestones can be used to show progress towards implementing efforts or to make adjustments when necessary.<sup>14</sup> Specifically, we found that

<sup>12</sup> GAO, *Information Technology: Opportunities Exist to Improve Management of DOD's Electronic Health Record Initiative*, GAO-11-50, (Washington, D.C.: Oct. 6, 2010).

<sup>13</sup> GAO-14-49.

<sup>14</sup> GAO, *Agency Performance Plans: Examples of Practices That Can Improve Usefulness to Decisionmakers*, GAO/GGD/AIMD-99-69 (Washington, D.C.: Feb. 26, 1999) and *Executive Guide: Effectively Implementing the Government Performance and Results Act*, GAO/GGD-96-118 (Washington, D.C.: June 1996).

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developing and using specific milestones and timelines to guide and gauge progress toward achieving an agency's desired results informs management of the rate of progress toward achieving goals and whether adjustments need to be made in order to maintain progress within given time frames.

DOD's March 2013 submission was required to include a detailed schedule for carrying out the reform of the governance of the MHS, including a schedule for meeting the goals of the reform. However, in that submission, DOD provided a schedule of activities leading up to its first major milestone—initial operating capability of October 1, 2013. This schedule of activities did not provide information related to activities beyond this first major milestone, and it did not present milestones for achieving each of the supporting seven goals of the reform. In that March 2013 submission, DOD also did not include some key features of effective schedules identified in our prior work, such as interim milestones or related timelines for all of the activities supporting the reform. Specifically, the submission did not contain any interim actions or milestones between October 1, 2013 and October 1, 2015—the planned final operating capability date. Furthermore, the schedule provided in the submission does not clearly establish how each of the supporting seven goals of the reform will be met.

Subsequent to DOD's March 2013 submission, the House Report accompanying a bill for the National Defense Authorization Act for Fiscal Year 2014 directed the Secretary of Defense to provide the House Armed Services Committee with, among other things, a detailed schedule for managing the reform effort. In response, DOD submitted a supplemental report on August 16, 2013, that included estimated interim milestones for the achievement of three of the reform goals that it had not initially provided in either of its earlier submissions.

In our November 2013 report, we recommended that DOD develop a comprehensive timeline that includes interim milestones for all reform goals that could be used to show implementation progress, and DOD concurred with our recommendation.<sup>15</sup> DOD's third implementation plan submission contained additional timeline activities for its reform goal concerning the implementation of shared services, with milestones

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<sup>15</sup>GAO-14-49.

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leading up to each shared services' initial operating capability. However, DOD has not consistently identified milestones for all activities between initial operating capability and final operating capability for each of the goals of its reform. While senior leaders now have more interim milestones by which to track the implementation of the DHA, they continue to lack milestones subsequent to initial operating capability in a number of areas. Unless DOD develops interim milestones for its reform timelines, it may not be able to adequately monitor its progress toward achieving its goals by October 2015.

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**DOD Does Not Have Fully Developed Performance Measures That Could Be Used to Assess Progress in Establishing the DHA**

DOD did not include critical details in the performance measures it developed to assess progress in achieving the seven goals of the reform effort. Specifically, DOD did not develop explanations for how each measure relates to the goals of the reform effort; did not define the specific measure to be developed; did not provide a baseline assessment of the current performance that is to be measured; and, most importantly, did not identify quantifiable targets for assessing the progress of each reform goal.

We have previously concluded that federal agencies engaging in large projects, including the consolidation of management functions, can use performance measures to determine how well they are achieving their goals and identify areas for improvement, if needed.<sup>16</sup> Additionally, we have found that by tracking and developing a performance baseline for all measures, agencies can better evaluate progress made and determine whether goals are being achieved. Identifying and reporting deviations from the baseline as a program proceeds provides valuable information for these decision makers as they identify areas of risk and diagnose their causes.

In November 2013, we reported that in its June submission of its implementation plan, DOD had listed 87 performance measures to assess progress in achieving the seven objectives of the reform effort,<sup>17</sup> but that those measures did not exhibit important attributes of successful

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<sup>16</sup>GAO-12-542.

<sup>17</sup>GAO-14-49. As noted in our report, some performance measures were used to assess multiple objectives.

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performance measures that we had established in our prior work.<sup>18</sup> Specifically, we found that DOD provided only the measures' names, with no accompanying explanation for how each measure relates to the goals of the reform effort, definition of the specific measure to be developed, or quantifiable, numerical target for performance, nor had DOD provided a baseline assessment of the current performance to be measured. For example, DOD listed "Emergency Room Utilization Rate" as a performance measure, but did not explain how that measure relates to the objective of consolidating delivery of health care in areas with more than one military service. Further, we found that DOD did not provide an explanation of what each measure will evaluate, which could be used to determine the extent to which each measure provides new information beyond that provided by other measures. For example, two of the measures listed under the objective to deliver more-comprehensive primary care and integrated health services using advanced patient-centered medical homes are "satisfaction with provider communications" and "satisfaction with health care." As presented in DOD's June submission of its implementation plan, it is unclear whether there is any overlap between these measures, because the aspects of satisfaction are not clarified by any accompanying explanation or definition.

We also reported that decision makers would not be able to determine the objectivity of DOD's measures because there is no information accompanying the measures that indicates specifically what is to be observed, in which population or conditions, and in what time frame. For example, one of the measures is "savings achieved versus savings projected." This measure does not indicate specifically how savings will be measured, and does not indicate what time frame will be used to compare what savings were projected versus what were actually achieved.

In our November 2013 report, we recommended that DOD provide more detailed information on its performance measures—specifically, that DOD develop and present to Congress measures that are clear, quantifiable,

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<sup>18</sup>GAO, *Tax Administration: IRS Needs to Further Refine Its Tax Filing Season Performance Measures*, GAO-03-143 (Washington, D.C.: Nov. 22, 2002); *GPRA Performance Reports*, GAO/GGD-96-66R (Washington, D.C.: Feb. 14, 1996); *Missile Defense: Opportunity to Refocus on Strengthening Acquisition Management*, GAO-13-432 (Washington, D.C.: Apr. 26, 2013); *Performance Measurement and Evaluation: Definitions and Relationships*, GAO-11-646SP (Washington, D.C.: May 2011); and GAO/GGD/AIMD-99-69.

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objective, and include a baseline assessment of current performance.<sup>19</sup> In the third submission of its implementation plan, DOD provided some additional information, such as baselines and performance targets, for the performance measures under two of its seven reform goals. In this submission, DOD included tables with expanded information for the performance measures for its goals related to (1) delivering more-comprehensive primary care and integrated health services using advanced patient-centered medical homes, and (2) coordinating care over time and across treatment settings to improve outcomes in the management of chronic illness, particularly for patients with complex medical and social problems. For these objectives, DOD listed the measures' names, and, where available, estimates of current and target performance. For those measures without a definition or baseline, DOD provided a date by when the measures would be defined and when the baseline performance level would be established.

As of DOD's final submission, much of the information to be included in these two tables was still to be determined. As a result, many of the entries in the tables represented placeholders for information, rather than actual baselines or performance targets. Further, DOD did not include this additional information for any of the performance measures listed under its other five reform goals. In this third submission, DOD noted that it was in the process of developing measures and respective performance targets to be published in its 2014 strategic plan for the MHS, which it expected to issue in December 2013. In February 2014, a DOD representative told us that the strategic plan is now expected to be released in May 2014. Fully developed performance measures are key to senior leaders' ability to assess if DOD's reform effort is achieving its goals or if corrective action is required.

In summary, DOD's reform efforts represent positive steps to improve the efficiency of the governance of the MHS, and these reforms have progressed much further than previous attempts to improve the governance structure. As we noted in previous reports, the successful implementation of the DHA will require committed senior leadership to sustain the momentum created by the current reform effort. This leadership, in turn, will help to provide oversight and accountability for the improvement process. However, senior leaders need appropriate

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<sup>19</sup>GAO-14-49.

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information to make decisions and guide the reform. The first step to determine what is needed for the implementation of the DHA is a baseline assessment of current MHS staffing, followed by an estimate of DHA staffing at full operating capability. In addition, a detailed quantitative analysis regarding the sources of cost savings and a plan to monitor implementation costs would provide greater clarity to DOD's shared-service consolidation projects. Moreover, the development of comprehensive milestones for all of the reform goals would allow decision makers to track the progress of DOD's reform efforts toward achieving its goals. Finally, the completion of a set of fully developed performance measures across all seven of DOD's stated goals for the DHA would ensure that DOD's senior leaders and other decision makers have the necessary information to assess DOD's progress in creating a more cost-effective and integrated MHS.

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Chairman Wilson, Ranking Member Davis, and Members of the Subcommittee, this concludes my prepared statement. I would be pleased to respond to any questions that you may have at this time.

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### GAO Contact and Staff Acknowledgments

For further information about this statement, please contact Brenda S. Farrell at (202) 512-3604 or farrellb@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement. Individuals who made key contributions to this testimony are Lori Atkinson, Assistant Director; Beckie Beale; Jeff Heit; Mae Jones; and Adam Smith.

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## Related GAO Products

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*Defense Health Care Reform: Additional Implementation Details Would Increase Transparency of DOD's Plans and Enhance Accountability.* GAO-14-49. Washington, D.C.: November 6, 2013.

*Defense Health Care: Additional Analysis of Costs and Benefits of Potential Governance Structures Is Needed.* GAO-12-911. Washington, D.C.: September 26, 2012.

*Defense Health Care: Applying Key Management Practices Should Help Achieve Efficiencies within the Military Health System.* GAO-12-224. Washington, D.C.: April 12, 2012.

*Opportunities to Reduce Potential Duplication in Government Programs, Save Tax Dollars, and Enhance Revenue.* GAO-11-318SP. Washington, D.C.: March 1, 2011.

*Military Personnel: DOD Addressing Challenges in Iraq and Afghanistan but Opportunities Exist to Enhance the Planning Process for Army Medical Personnel Requirements.* GAO-11-163. Washington, D.C.: February 10, 2011.

*Military Personnel: Enhanced Collaboration and Process Improvements Needed for Determining Military Treatment Facility Medical Personnel Requirements.* GAO-10-696. Washington, D.C.: July 29, 2010.

*Defense Health Care: DOD Needs to Address the Expected Benefits, Costs, and Risks for Its Newly Approved Medical Command Structure.* GAO-08-122. Washington, D.C.: October 12, 2007.

*Defense Health Care: Tri-Service Strategy Needed to Justify Medical Resources for Readiness and Peacetime Care.* GAO/HEHS-00-10. Washington, D.C.: November 3, 1999.

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**Short Bio for Brenda S. Farrell**  
**Director, Defense Capabilities and Management**  
**U.S. Government Accountability Office**  
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In April 2007, Ms. Farrell was appointed to serve as a director in GAO's Defense Capabilities and Management Team where she is responsible for military and civilian personnel issues, including related medical readiness issues. Prior to her appointment with the Defense Capabilities and Management Team, Ms. Farrell served for 14 months as an Acting Director for GAO's Strategic Issues Team where she was responsible for overseeing three major bodies of work related to strategic human capital management, government regulation, and decennial census issues. Before joining the Strategic Issues Team, Ms. Farrell was an Assistant Director for Defense Capabilities and Management and led military personnel engagements encompassing military pay and benefits, Reserve and National Guard mobilization issues, and senior military officer requirements and career development. Ms. Farrell began her career at GAO in 1981, and has served in a number of issue areas associated with national security issues. She received her bachelor's degree in sociology from the University of Louisville. In 2000/2001, she attended the National Defense University, Industrial College of the Armed Forces and earned a master's degree in national resources strategy. Ms. Farrell completed the leadership development program at Eckerd College in 2004, and in 2005, she completed the Senior Executive Fellow Program at Harvard University. In March 2007, she graduated from the CAPSTONE program at the National Defense University for newly appointed general and flag officers being the first GAO SES to complete this program. Ms. Farrell was the project director for a seminar on organizational transformation, co-sponsored by GAO, the World Bank, and the INTOSAI Development Initiative, held in November 2007, for the heads of Supreme Audit Institutions. Most notable is Ms. Farrell's body of work on DOD's Personnel Security Clearance Program that helped lead to the removal of this program from GAO's High Risk List in 2011. To date, this program is the only DOD area to be removed the high risk list. Ms. Farrell was the recipient of a GAO meritorious award for sustained extraordinary performance leading multiple, highly complex, defense reviews, as well as numerous other awards including several Results through Teamwork awards, and awards for high quality products.



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**DOCUMENTS SUBMITTED FOR THE RECORD**

FEBRUARY 26, 2014

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**Statement of:**

**The American Clinical Laboratory Association**

**for:**

**United States House of Representatives  
Armed Services Committee  
Military Personnel Subcommittee**

**Hearing on:**

**Defense Health Agency**

**February 26, 2014  
2:00pm**

ACLA  
1100 New York Avenue, NW, Suite 725W  
Washington, DC 20005

Page 1 of 4

The American Clinical Laboratory Association (ACLA) thanks the Members of the House Military Personnel Subcommittee for consideration of our comments for the hearing, "Defense Health Agency." ACLA is a not-for-profit association representing the nation's leading national and regional clinical laboratories on key issues of common concern, including federal and state government reimbursement and regulatory policies.

Clinical laboratories provide critical testing services to TRICARE beneficiaries. Clinical laboratory tests guide more than 70% of medical decisions made by healthcare professionals. The information provided by clinical labs helps diagnose, treat and monitor patients as accurately and quickly as possible. Our member laboratories proudly provide clinical laboratory services to our men and women in the armed services and their families.

ACLA submits this statement for the record as to express its strong opposition to TRICARE's current policy of non-coverage for molecular diagnostic tests provided to TRICARE beneficiaries seeking care through the community provider network. There is no sound clinical or regulatory rationale for this decision. The decision should be reversed and coverage restored so that TRICARE beneficiaries and their families have access to the same standard of care available to TRICARE beneficiaries at Military Treatment Facilities and to patients covered by hundreds of public and private insurance plans.

The Defense Health Agency (DHA) ceased providing coverage for over 100 molecular diagnostic tests in January 2013. These tests were placed on the No Government Pay Procedure Code List (NGPPCL) without notice or explanation, and denied reimbursement. These tests include critical tests for Cystic Fibrosis, Fragile X syndrome, spinal muscular atrophy, and many common cancers.

It is important to note that these molecular diagnostic tests were not new tests in 2013; they were simply assigned new CPT codes (the procedure codes used to identify various medical procedures). Prior to 2013, laboratories billed for these services using a series of methodology and procedure codes representing the steps the laboratory performed to complete the test. Under the old coding, virtually all private and public payers, including TRICARE, reimbursed laboratories for these services.

In January 2013, all payers switched to new codes identifying the individual test. Most payers promptly covered the tests utilizing the new codes; however, TRICARE has become an outlier with its persistent policy of non-coverage. What is more perplexing, is that TRICARE's policy of non-coverage is inconsistent as these tests are covered if provided through a Military Treatment Facility, but not if provided through TRICARE's community provider network.

Molecular diagnostic tests represent the ever-advancing forefront of diagnostic medicine, and ensure that patients receive appropriate treatment. Without such testing, TRICARE beneficiaries will receive care that is inferior to that available to the general public. Molecular diagnostics ensure that disease is defined with enough precision that the right intervention can be available

from the start of treatment, not after trial and error with multiple drug regimens and not after the disease has gotten worse.

Many of the molecular tests currently being denied reimbursement represent the standard of care as expressed in professional guidelines. Cystic Fibrosis testing is the Standard of Care under the VA/DoD Clinical Practice Guideline for Management of Pregnancy and the American Congress of Obstetricians and Gynecologists' (ACOG) Guidelines. Furthermore, accurate EGFR mutation testing has been shown to both lower treatment costs and improve patient outcomes in non-small cell lung cancer (NSCLC), and is recommended for all NSCLC patients prior to initiating chemotherapy in the National Comprehensive Cancer Network (NCCN) guidelines. However, these tests, along with most other molecular diagnostic tests, are currently uncovered procedures, thereby depriving TRICARE beneficiaries of these valuable diagnostic tools.

TRICARE's rationale for failing to cover these tests is that they are Laboratory Developed Tests (LDTs); that is, they are tests that are created in-house by the laboratories furnishing them in accordance with the requirements of the federal Clinical Laboratory Improvement Amendments (CLIA). Laboratories do not sell the LDTs themselves, but use them to perform tests whose results are then furnished to physicians. Many, if not most, molecular diagnostics today are performed as LDTs. Despite TRICARE's history of covering these laboratory developed tests, and TRICARE's ongoing coverage of many other LDTs, the Defense Health Agency has stated that this subset of LDTs can no longer be covered because, it argues, the tests are medical devices and have not been approved by the Food & Drug Administration (FDA).

This position is a plain misinterpretation of TRICARE's own regulations. Those regulations look to whether or not a medical device can be lawfully marketed without approval or clearance from the FDA when determining TRICARE coverage. If it cannot, then TRICARE will not cover it. However, no such restriction applies to LDTs. LDTs can, and are, legally marketed without FDA approval; and therefore, TRICARE has no basis to exclude LDTs from coverage. In fact, FDA has repeatedly stated that it is exercising enforcement discretion and not requiring pre-market approval of LDTs.

TRICARE is also wrong in other key areas. ACLA disagrees with the determination that LDTs are medical devices; rather they are services performed and validated by certified medical physicians and professionals. Further, TRICARE's position is in conflict with the definition of "device" in the Food, Drug and Cosmetic Act as well as the definition of "taxable medical device" in the Internal Revenue Service final regulations implementing the medical device excise tax under the Affordable Care Act.

Finally, TRICARE continues to cover many LDTs not approved or cleared by the FDA outside of molecular diagnostic tests. Currently, all TRICARE beneficiaries have access to most laboratory developed tests. These tests include complete blood counts, pap tests, screening for cholesterol and diabetes, and many other LDTs. These tests continue to be covered by TRICARE, despite the fact that they are LDTs and they do not have FDA approval.

In the case of the molecular diagnostic tests, such as Cystic Fibrosis and EGFR testing, these tests are available for some – but not all – TRICARE beneficiaries. DHA has confirmed that these tests remain available to beneficiaries accessing services at a Military Treatment Facility (MTF), but they are not available for beneficiaries obtaining care from a civilian provider. DHA has also stated that Cystic Fibrosis screening, which is recommended by DoD/VA Clinical Guidelines for the Management of Pregnancy, is available for newborns, but not for pregnant women who do not receive services at an MTF.

Recognizing the vital role of these tests in health care delivery, many clinical laboratories continued to provide these services to TRICARE beneficiaries, despite the lack of reimbursement. This cannot continue, and TRICARE beneficiaries may have to pay the out-of-pocket costs of these tests, or may choose to forego care.

The decision by DHA to deny reimbursement for molecular diagnostic testing is not supported by regulations, or by best medical practices. We strongly believe TRICARE must resume paying for these tests immediately.

Thank you for the opportunity to share our views. We look forward to continuing to work with you and the Defense Health Agency on policies that maintain TRICARE beneficiary access to laboratory diagnostic testing and services.

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**WITNESS RESPONSES TO QUESTIONS ASKED DURING  
THE HEARING**

FEBRUARY 26, 2014

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## **RESPONSES TO QUESTIONS SUBMITTED BY MR. WILSON**

Dr. WOODSON and General ROBB. GAO recommended that DOD develop (1) a comprehensive cost analysis for its potential MHS governance options, (2) a business case analysis and strategy for implementing its shared services concept, and (3) more complete analyses of the options' strengths and weaknesses. DOD concurred with developing a business case analysis for its shared services concept. DOD did not concur with the other 2 recommendations, stating that further analysis would not alter its conclusions. Section 731 of the FY 2013 required that the Department report to Congress on the progress achieved in standing up the Defense Health Agency and Shared Services. In our first report to the congressional defense committees, dated March 15, 2013, we identified our reform efforts and provided detailed goals, milestones and schedules for implementing the Defense Health Agency (DHA), the enhanced multi-Service markets (eMSMs), and the National Capital Region (NCR) Directorate. In our second report, dated June 27, 2013, we provided our strategic objectives, success measures, and business case analyses for four of the initial ten identified shared services. In the third report, dated October 25, 2013, we provide specific information for each shared service, including our assessments for the remaining six shared services, to be implemented in FY 2014. [See page 9.]

## **RESPONSES TO QUESTIONS SUBMITTED BY DR. HECK**

Dr. WOODSON and General ROBB. Providing safe and effective care for our beneficiaries is our top priority. The DOD is committed to ensuring that our beneficiaries have access to the full array of proven health services, technologies, and products available in the United States. Title 32, Code of Federal Regulations (CFR), Section 199.4(g)(15)(i), provides that TRICARE cannot cost-share unproven drugs, devices, medical treatments, or procedures, and that a drug, device, or medical treatment or procedure is unproven if the drug or device cannot be lawfully marketed without the approval or clearance of the United States Food and Drug Administration (FDA). The Federal Food, Drug, and Cosmetic Act (FFDCA) provides for the regulation of medical devices. These medical devices are defined broadly in Title 21, United States Code, Section 321, to include: "an instrument, apparatus, implement, machine, contrivance, implant, in vitro reagent, or other similar or related articles, including any component, part or accessory which is . . . intended for use in the diagnosis of disease or other conditions, or in the cure, mitigation, treatment or prevention of disease." A laboratory developed test (LDT) is a test developed by a single clinical laboratory that provides testing to the public, but does not sell the lab kit or its technological processes to other labs. LDTs are considered to be medical devices by the FDA and the Defense Health Agency (DHA).

The FDA has stated that clinical laboratories developing LDTs are acting as manufacturers of medical devices and are subject to FDA jurisdiction under the FFDCA, thus requiring either a Premarket Notification 510(k) or Premarket Approval. However, the FDA has chosen to exercise "enforcement discretion" regarding regulatory oversight of LDTs, meaning the FDA has not required the removal of these tests from the market. As a result, LDTs are available in the market without FDA approval or clearance. However, when the FDA elects to exercise enforcement discretion, this choice does not change the fact that the law applies to those products. Consequently, and in accordance with the federal regulations governing the TRICARE program, medical devices, including LDTs, that require FDA approval or clearance for marketing when such approval or clearance has not been given may not be cost-shared by TRICARE.

As stated above, there has not been a change in TRICARE's underlying coverage policies regarding non-FDA approved LDTs. Our managed care support contractors (MCSCs) and beneficiaries are aware of TRICARE's existing coverage policies, including the exclusion for devices that are not FDA cleared/approved. The adoption of new Current Procedural Terminology (CPT) codes, effective January 1, 2013, provided payers, including the DOD, with greater transparency in billing for laboratory tests. These coding changes allowed the DHA to identify specific LDTs that: (1) have not been approved or cleared by the FDA, and/or (2) failed to meet TRICARE cri-

teria for coverage (e.g. demand genetic testing that is not medically necessary and does not assist in the medical management of the patient). While the revised codes allowed TRICARE to accurately determine TRICARE coverage for specific tests, there was no change in TRICARE's underlying coverage policies. Consistent with the change in CPT coding, the DHA moved LDTs that were not FDA approved or otherwise failed to meet TRICARE coverage criteria to the Government's No Pay Procedure Code List.

The DHA recognizes that some non-FDA approved LDTs may be useful to providers and patients with certain treatment decisions. This is due, in part, to the ongoing development of new medical tests and technologies. In the absence of FDA approval/clearance of LDTs, we need to establish an alternative process to ensure safety and efficacy. As a result of beneficiary and provider input, TRICARE has chosen to initiate a new demonstration project to review the safety and efficacy of a broad range of non-FDA approved LDTs with potential high utilization and potential high clinical impact for our beneficiaries. This demonstration project will collect data to support potential future regulatory revisions and enhance the flexibility of the MHS in responding to emerging technologies. This new effort will expand upon our existing demonstration project, which provides coverage for certain LDTs that inform clinical decision making in cancer diagnosis and treatment. Under the new demonstration project, we will assess the safety and efficacy of a broader range of LDTs with potential high utilization and potential high clinical impact on our TRICARE beneficiaries. This demonstration project will also collect the additional and necessary data to support future regulatory revisions. In keeping with other demonstration projects, LDTs approved under the new demonstration project will be covered by TRICARE during the demonstration period and will also be available in Military Treatment Facilities (MTFs). Once formalized, details of the demonstration project will be published in the Federal Register.

We recognize there are differences between the purchased care sectors and direct care sectors (MTFs) in the ability to obtain certain LDTs; however, this is due to differing functions and specific federal regulatory requirements for the purchased care sector. The new demonstration project is an important first step in ensuring patients seen in either the direct or purchased care sectors have the same access to non-FDA approved LDTs that are determined to be safe and effective. LDTs approved under the new demonstration for our purchased care sector will be integrated into the direct care sector providing more consistency between both systems. [See page 14.]

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**QUESTIONS SUBMITTED BY MEMBERS POST HEARING**

FEBRUARY 26, 2014

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## QUESTIONS SUBMITTED BY MR. WILSON

Mr. WILSON. Families report significant barriers and delays to enroll in the ABA Pilot and that care is often delayed by months. Can you please tell me how many beneficiaries are currently receiving services under the ABA Pilot? Please provide explanation for treatment delays.

Dr. WOODSON. Based on contractor feedback (TRICARE purchased-care claims can be submitted up to one year after the service is provided and, therefore, claims data incomplete and not a reliable indicator of current ABA Pilot participation), as of January 31, 2014 there were 94 beneficiaries approved to receive Applied Behavior Analysis (ABA) for treatment of Autism Spectrum Disorder (ASD) under the ABA Pilot and another 168 pending approval. Completion of psychometric testing and assessment is required for approval. Obtaining the required psychometric testing—Autism Diagnostic Observation Schedule, Second Edition (ADOS-2) and/or Vineland Adaptive Behavior Scale II (Vineland-II), is the primary reason for reported delays. There have been several meetings between the Managed Care Support Contractors and the Director, TRICARE Health Plan to address this issue. Also, individual outreach has been conducted to families in the approval process to assist them in completing any needed actions to include completion of psychometric testing.

Mr. WILSON. Why are the enrollment and authorization requirements for the ABA Pilot more burdensome than authorizations under the Autism Demonstration and the TRICARE Basic program?

Dr. WOODSON. In sum, the enrollment and authorization requirements for the Applied Behavior Analysis (ABA) Pilot are more burdensome than authorizations under the Autism Demonstration as the ABA Pilot will evaluate the feasibility of using standardized measures, not currently a requirement under the ECHO Autism Demonstration, to assess ABA treatment progress and report its findings to Congress concerning the ABA Pilot for Non-Active Duty family members (NADFMs).

One objective of the ABA Pilot is to evaluate the use of standardized measures to assess ABA treatment progress based on the Behavior Analyst Certification Board (BACB) Guidelines for Health Plan Coverage of Applied Behavior Analysis Treatment of Autism Spectrum Disorders (2012). The guidelines recommend that data from standardized tests are helpful to “inform issues related to selection and prioritization of treatment goals and determining a response to treatment.” This standardized psychological testing requirement applies only to beneficiaries who choose to participate in the ABA Pilot. There is no change for any other TRICARE beneficiaries—whether Active Duty family members (ADFMs) or NADFMs—receiving ABA under the TRICARE Basic Program, or for ADFMs receiving autism-related services under the Extended Care Health Option Autism Demonstration.

An on-going series of focus groups is being held to solicit feedback in hopes of using this information to optimally meet the needs of beneficiaries.

Mr. WILSON. Families report that dollar caps under the Autism Demonstration and the ABA Pilot prevent them from accessing recommended treatment services. Can you please explain why so many families cannot obtain coverage for treatment services that have been medically prescribed?

Dr. WOODSON. The National Defense Authorization Act for FY 2009 section 732, established the limit of Government liability for Extended Care Health Option (ECHO) benefits at \$36,000 per year. This change was implemented on April 1, 2009. In FY 2013, 4.2 percent of Active Duty Family Members using only ECHO program services (218 of 5,131 users) had annual expenditures at or near the \$36,000 annual cap (we define this as those with more than \$35,000 annually). The \$36,000 annual cap for ABA services under the ABA Pilot mirrors the Extended Care Health Option (ECHO) cap.

Under the TRICARE program, all necessary medical care is provided without a cap or dollar limit. This medical or behavioral health care is provided through the basic TRICARE program whether the beneficiary has chosen TRICARE Prime or TRICARE Standard. These medical and behavioral therapies include those which are provided for ABA services. The tutor services which are a part of some ABA approaches are provided through the ECHO.

Mr. WILSON. Based on the testimony of Dr. Woodson and General Robb savings from the consolidation of Medical Logistics is projected to be \$10 million. What is the amount of savings at this time?

Dr. WOODSON. Defense Health Agency Medical Logistics initiatives have resulted in \$8.2M in FY14 savings to date.

Mr. WILSON. Based on the testimony of Dr. Woodson and General Robb \$24.7 million is the projected savings from consolidation of Health Information Technology. In what fiscal year will this savings be attained? Please provide a detailed explanation of where these savings come from.

Dr. WOODSON. As of February 26, 2014, the Defense Health Agency has achieved \$24.7M in Health Information Technology (IT) savings for FY 2014.

These savings are attributable to efficiencies implemented in FY14 in the following areas:

Reengineering IT Management: \$3.8M is attributed to reductions in the operations and consultant contracts

Infrastructure Consolidation: \$12.2M is attributed to contract efficiencies in Service medical software licenses, help desk operations, and information assurance activities

Portfolio Rationalization: \$8.7M is attributed to contract efficiencies in Service medical systems trainers and systems support

Mr. WILSON. The Department has outlined how closing walk-in customer service centers in favor of call center based customer service will provide savings. How does the Department plan to gauge customer satisfaction with the new process? What method will the Department use to survey, including how the survey will be conducted and what population of customers will be queried.

Dr. WOODSON. The Department uses a survey to monitor how well our contractors' Customer Service Call Centers are performing. Monthly a random survey of recent TRICARE users (those with a claim within the past 30 days) is conducted. The beneficiaries selected are called and asked if they used the Call Center in the past month and, if so, to please rate the services provided on a scale of 1-6. Since December 2013, 86% to 98% of those surveyed each month rated services provided by the call centers as "completely satisfied, very satisfied or somewhat satisfied."

Additionally, the Department has made several changes to the [tricare.mil](http://tricare.mil) website and the online enrollment portal to ensure the other "self-service" options are user-friendly. The website usage has increased each month since December 2013 (27,000 daily users to 32,000 users) and the online enrollment and enrollment change application from 36,000 to 55,000 monthly users.

The survey results and feedback received from our military treatment facilities, military associations, and beneficiary inquiries are closely monitored by the Defense Health Agency leadership to ensure TRICARE beneficiaries continue to receive prompt, quality customer services.

Mr. WILSON. Please discuss, in detail, the cost savings to date from changes in purchased care accounts

Dr. WOODSON. **Prior Year Initiatives:** The following savings initiatives were implemented in previous years to slow the growth in DOD's health care costs.

- **Federal Ceiling Price:** Beginning in 2008, the Department implemented regulations and extensive administrative procedures to implement a change in law (*known as Federal Ceiling Price*) that required pharmaceutical manufacturers to provide discounts for drugs for TRICARE beneficiaries through retail network pharmacies.
  - Federal Ceiling Price discounts for drugs are at least 24% less than the average manufacturer's price for its non-Federal customers.
  - Discounts are achieved through quarterly collection of refunds from pharmaceutical manufacturers based on the quantity of their brand name drug utilized in the TRICARE retail network pharmacies.
- **TRICARE Home Delivery:** The Department implemented a comprehensive pharmaceutical Home Delivery (mail order) marketing program in 2010, which has contributed to an overall increase in Home Delivery of pharmaceuticals and a decline at retail locations. FY 2013 results continued to build on FY 2012 positive trends:
  - In FY 2013, mail order use increased by 15.6% compared to FY 2012. The monthly volume of over 1.5M prescriptions continued the upward trend from 2012 for TRICARE Home Delivery.
  - Retail prescription volume fell 6% in FY 2013 as compared to FY 2012.
- **TRICARE For Life Pilot:** A FY 2013 NDAA-directed TRICARE For Life Pharmacy Pilot will start mid-February 2014. This pilot will require TRICARE For Life beneficiaries who fill prescriptions for select maintenance medications at a

retail network pharmacy to switch to either home delivery or a military pharmacy.

- **Outpatient Prospective Payment System:** In 2009, by aligning its payments with Medicare rates (known as the Outpatient Prospective Payment System), the Department instituted changes in the way it reimburses private hospitals for outpatient services provided to TRICARE.
    - Over a four-year transition period that commenced in mid-2009, TRICARE pays hospitals on a prospective payment basis for hospital outpatient services, which allows for a reasonable profit and eliminates excessive facility charges.
  - **TRICARE Prime Enrollment Fees:** In FY 2012, the Department was allowed to implement a modest increase in Prime enrollment fee (\$30/\$60 per year increase for individual/family coverage), indexed to annual retiree COLA starting in FY 2013.
  - **Pharmacy co-pay adjustment:** The Department implemented pharmacy co-pay changes in FY 2012 and the FY 2013 National Defense Authorization Act included some additional adjustments to the TRICARE pharmacy co-pay structure.
  - **U.S. Family Health Plan (USFHP):** In FY 2013, we implemented a lower and more accurate capitation rate to reimburse USFHP plans for health care delivery. As part of the FY 2012 President's Budget Request, the Department submitted a legislative proposal requiring new USFHP enrollees to move to the TRICARE for Life (TFL) Program upon becoming eligible for Medicare like all other military retirees. This proposal was enacted as part of the FY 2012 National Defense Authorization Act. This change is reducing demand on the Medicare Eligible Retiree Health Care Fund (MERHCF) because, previously, TRICARE was the primary payer for TFL-eligible retirees enrolled in USFHP instead of the second payer to Medicare as is the case for all other TFL retirees not residing overseas.
  - **Managed Care Support Contract (MCSC) Specific Initiatives and Demos**
    - The third generation of TRICARE contracts (known as T3) requires network discount guarantees and other utilization management strategies which show significant positive results and are holding the rate of purchased sector health care cost growth below the national average.
    - Two demonstration projects (in the North Region and South Region) were initiated to enroll beneficiaries in network Primary Care Medical Homes to discover if this will increase quality and coordination of care and decrease costs as per the literature.
    - Managed Care Support Contractors each instituted care coordination systems/initiatives and utilization management initiatives as enhancements in the contracts that drive cost savings through better care coordination and management.
    - A demonstration project was initiated to reduce emergency room costs by allowing U.S. Coast Guard beneficiaries in the South region to access urgent care center visits without authorization where medically appropriate.
    - A comprehensive model to assist MTFs to identify healthcare recapture opportunities was developed. The model is now in use in all three regions.
    - An initiative that places reasonable limits on services, such as physical therapy, has resulted in significant savings without diminishing the outcome of the care provided.
    - The implementation of improved use of information, coupled with outreach to both patients and providers, has demonstrated initial results of a decrease of over ten percent in inpatient hospital care. Inpatient hospital care is the most expensive form of care provided.
- Current Year Initiatives:** The following savings initiatives have started or are planned to start in FY 2014 to slow the growth in DOD's health care costs.
- **Sole Community Hospital:** The Department has revised its payment rules to reimburse inpatient care claims at sole community hospitals by complying with federal law and aligning its reimbursement more closely with Medicare rates.
    - Previously, we reimbursed at rates that were, on average, 75–85% higher than rates used by Medicare.
    - New payment rules went into effect on January 1, 2014. Reimbursement changes will phase-in over multiple years that will help hospital's reduce potential impacts, reducing the Department's health care costs and leading to significant cost savings for the agency. There is also an adjustment available to qualifying network hospitals serving a disproportionate number of Active Duty Service members and Active Duty family members, and deemed essential for readiness.

- **Electronic Prescribing:** TRICARE's focus is on implementing electronic prescribing from civilian providers to MTF pharmacies. Implementing e-prescribing at MTFs will result in an increase in MTF filled prescriptions, which is the least expensive point of service, and a decrease in retail pharmacy-filled prescriptions which is the most expensive point of service. A 1% shift in non-specialty maintenance medications (270,000 prescriptions) to MTFs from retail pharmacies has substantial cost-avoidance to the MHS. The electronic prescribing is currently in a test phase with a projected roll out date of mid-2014.
  - **Other Health Insurance:** Beneficiaries do not always provide their Other Health Insurance (OHI) information to ensure TRICARE pays second on any civilian claims or to allow MTFs to bill for care rendered. The Defense Health Agency (DHA) will contract with a commercial vendor to identify missing OHI policy information to decrease the cost of purchased care claims and increase the MTF's revenues.
  - **Prime Service Area Reduction:** On October 1, 2013, the Department reduced the number of TRICARE Prime Service Areas (PSAs) in the United States. PSAs are now being maintained only around MTFs and base realignment and closure (BRAC) sites. This initiative has been planned since 2007.
    - No beneficiary lost TRICARE health care benefits. The retirees and their family members living in an affected area could re-enroll to a more distant PSA, if one was available within 100 miles from their residence, or they had immediate access to TRICARE Standard. TRICARE Standard is the basic entitlement by law.
    - Fiscal Year 2014 NDAA also allows each affected eligible beneficiary who was enrolled in TRICARE Prime as of September 30, 2013, to may make a one-time election to continue such enrollment in TRICARE Prime contingent upon certain provisions.
  - **TRICARE Service Center (TSC) Initiative:** The TSCs will no longer provide walk-in customer service at the 189 TSCs in all 50 States, as of April 1, 2014.
    - TSCs were established 20 years ago to assist beneficiaries with questions concerning enrollment, billing benefits, etc., when TRICARE replaced CHAMPUS. They are regional contractor-operated offices, with a limited number of staff providing face-to-face customer services.
    - With more and more beneficiaries now using electronic communications for assistance (internet, mobile applications, telephone, etc.), walk-in customer service is no longer deemed necessary or cost effective. It is the most expensive customer service option available.
    - Few, if any, commercial health plans offer a similar walk-in customer service. Due to the unique nature of the overseas environment, all overseas TSCs will continue providing walk-in customer services.
    - All TSC walk-in services can be provided by long-standing and well tested toll-free call centers or multiple internet and mobile sites.
  - **Health Plan Headquarters Initiatives:**
    - Consolidation of the MCSC under a single TRICARE Regional Office Director has resulted in increased consistency in the award fee process and savings in awards.
    - Initiatives to decrease print materials and the move to increased electronic communications have resulted in substantial savings over previous years.
- Mr. WILSON. Based on the testimony of Dr. Woodson and General Robb savings from the consolidation of Medical Logistics is projected to be \$10 million. What is the amount of savings at this time?
- General ROBB. Defense Health Agency Medical Logistics initiatives have resulted in \$8.2M in FY14 savings to date.
- Mr. WILSON. Based on the testimony of Dr. Woodson and General Robb \$24.7 million is the projected savings from consolidation of Health Information Technology. In what fiscal year will this savings be attained? Please provide a detailed explanation of where these savings come from.
- General ROBB. These savings are attributable to efficiencies implemented in FY14 in the following areas:
- Reengineering IT Management: \$3.8M is attributed to reductions in the operations and consultant contracts
  - Infrastructure Consolidation: \$12.2M is attributed to contract efficiencies in Service medical software licenses, help desk operations, and information assurance activities
  - Portfolio Rationalization: \$8.7M is attributed to contract efficiencies in Service medical systems trainers and systems support

**QUESTIONS SUBMITTED BY MS. TSONGAS**

Ms. TSONGAS. What can TRICARE do to help address the issue of obese and overweight DOD dependents and obese or overweight Active Duty personnel?

Dr. WOODSON. The Department is addressing the issue of obese and overweight DOD dependents and obese or overweight Active Duty personnel by actively screening weight as part of the Military Health System (MHS) strategy to provide improved patient-centered delivery of healthcare services in place within our Patient Centered Medical Homes. Adults with a Body Mass Index (BMI) of 25 or adolescents and children with a BMI greater than the 85th percentile are typically encouraged to receive nutritional and physical activity counseling as part of the primary care visit. Additionally, as part of the National Prevention Strategy, we are working to shape the physical and nutritional environment on installations making the healthy choice the easy choice. Specifically, a demonstration project called The Healthy Base Initiative (HBI), is designed to test pilot initiatives to inform a strategic way ahead to improve the health of the community. For example, the Military Nutrition Environment Assessment Tool (m-NEAT) built in collaboration with the Services will assist individuals with evaluating the nutritional quality of foods provided at all military and commercial dining environments on installations. This approach will pay dividends in both readiness and in better health for our beneficiaries.

Ms. TSONGAS. What are TRICARE's processes and procedures for the review of new medical treatments including new categories of FDA-approved pharmaceutical products not currently covered by TRICARE?

Dr. WOODSON. TRICARE only covers medically necessary services and supplies for which the safety and efficacy have been proven. In order to ensure our beneficiaries are receiving safe and effective care, TRICARE uses a "hierarchy of reliable evidence" to determine when a drug, device, or medical procedure is safe and effective. This also prevents our beneficiaries from being exposed to less than fully developed and tested medical procedures and to avoid the associated risk of unnecessary or unproven treatment. The below list shows the documentation TRICARE utilizes during coverage reviews.

TRICARE uses the following hierarchy of reliable evidence:

1. Well controlled studies of clinically meaningful endpoints, published in refereed medical literature. 2. Published formal technology assessments. 3. Published reports of national professional medical associations. 4. Published national medical policy organization positions; and 5. Published reports of national expert opinion organizations.

Specifically not included in the meaning of reliable evidence are reports, articles or statements by providers or groups of providers containing only abstracts, anecdotal evidence or personal-professional opinions.

Ms. TSONGAS. What is the medical cost to TRICARE for conditions and diseases associated with obesity?

Dr. WOODSON. Regarding the medical cost to TRICARE, a cost of disease model published in 2010 of the cost of overweight and obesity for TRICARE estimated a charge to TRICARE of approximately \$1.1 billion annually. This analysis incorporated the role of excess weight in the development of a range of chronic medical conditions such as type 2 diabetes, cardiovascular disease, stroke and some types of cancers, all of which increase medical costs, impact quality of life, and contribute to premature mortality. This estimate, which focused on TRICARE prime beneficiaries, represents a significant proportion of cost but likely underestimates the total annual medical costs to the DOD.

**QUESTIONS SUBMITTED BY MR. SCOTT**

Mr. SCOTT. In response to a recent Congressional inquiry, the DOD stated they were only immunizing military personnel stationed in Asia against Japanese encephalitis (JE) "based on Service guidance, unit mission or other occupational requirements (for example those who operationally deploy to a high-risk field environment)", which is resulting in extremely low vaccine coverage rates except for the Marines and a few other special operations units. Why is the DOD Not following the recommendations issued by the CDC and Dr. Woodson to immunize all "Service members, Department of Defense civilians, and beneficiaries who are, or will be, stationed or visiting for more than 30 days in JE endemic areas"?

Dr. WOODSON. The Department of Defense follows the Centers for Disease Control and Prevention (CDC) recommendations and the Health Affairs guidance. The Health Affairs guidance mirrors the recommendations from the CDC. Individuals deploying to endemic or rural areas in the U.S. Pacific Command (PACOM) should be administered the JE vaccine in accordance with the latest PACOM Force Health

Protection guidance. The Services and PACOM may issue more specific requirements based on a medical threat within the area of operations and have done so for certain Marine and special operations units.

#### **QUESTIONS SUBMITTED BY MR. BARBER**

Mr. BARBER. Numerous newspaper articles indicate an adversarial relationship between the TRICARE contractor, beneficiaries and local providers in the Philippines. Constituents complain about a lack of reliable information on the benefit and a lack of responsiveness to customer support. Major national pharmacy firms and the Red Cross and all of its field offices have refused to work with the contractor denying beneficiary access to numerous pharmacies and a major source of blood. One of four internationally accredited hospitals and the only one in the southern Philippines cannot be used by beneficiaries for what appears to be nothing more than a paperwork exercise as it is obviously a licensed and legitimate hospital with better quality than many currently certified and hospitals.

In 2008 the beneficiaries were promised an onsite employee that would listen to their issues and learn the nuances of the local health care industry so access to care could be restored. In 2011 the DODIG, as the result of a multi-year investigation of the contractor, recommended to the TRICARE Management Activity, "Consider establishing a TRICARE presence in the Philippines to service military retirees and their dependents." Their response was "TMA is in the process of selecting a location for a TRICARE Satellite Office in Manila, Philippines to provide assistance to military retirees and their dependents residing there. The office will be staffed by a TMA Government employee, and TMA is currently in the process of advertising that position." Yet in 2014 there is no such position and my constituents indicate DHA is now silent when questioned about the promised position.

Given the adversarial relationship that has developed between the contractor, beneficiaries and the local health care industry and the current ongoing Demonstration, that also appears to be in trouble, wouldn't it be prudent to take immediate action to place the promised employee on the ground so they can work with beneficiaries and the local health care industry to finally insure good access to care to these beneficiaries?

General ROBB. All three of the major national pharmacy firms operating in the Republic of the Philippines are TRICARE certified. Mercury Drug was certified in September 2010; Rose Pharmacy in April 2012; and Watsons Pharmacy in July 2013. Certification of these pharmaceutical companies at the corporate level allow TRICARE beneficiaries to access any of these pharmacies' stores, regardless of where in the country they are located. The Philippine National Red Cross is TRICARE certified effective February 19, 2014. Similar to the certification of the pharmacy companies, certification of the Red Cross at the national level allows TRICARE beneficiaries to access any of the 80 Red Cross Chapters in the Philippines to obtain the necessary testing and blood supplies they may need. Due to the delay in certifying the Philippine National Red Cross, the Defense Health Agency has directed the TRICARE Overseas Program contractor to reprocess all previously submitted claims since September 2010 and provide the appropriate reimbursement to the beneficiaries for their out of pocket expenses for testing and blood supplies obtained from any Philippine Red Cross chapter.

In 2008, the Deputy Director, TRICARE Management Activity (TMA), visited the Republic of the Philippines. Based on what he saw and heard from the retired beneficiaries, as well as his awareness of significant fraud issues in the Philippines, the Deputy Director directed establishment of a satellite office in the Philippines to enable the TRICARE Area Office-Pacific to better support beneficiaries living there. At that time, office space was identified at the old Clark Air Force Base, and coordination was completed to have a U.S. citizen who would staff the office fall under the protection of the U.S. Embassy. Since that time, the space at the old Clark Air Force Base is no longer available.

In 2012, the Deputy Director, TMA reversed the previous decision to establish a satellite office in the Philippines in light of several factors. These factors included the award of the TRICARE Overseas Program (TOP) contract in 2009 to International SOS Assistance (International SOS). This contract requires the operation of a 24/7 Regional Call Center, staffed with customer service representatives trained to assist beneficiaries and host nation providers with questions about claims, locating a provider, benefit determinations, and authorizations for care. Additionally, the agency had decided to implement the Philippine Demonstration Project which is designed to increase access to quality health care, eliminate the need for beneficiaries to file their own claims, and control costs. The Demonstration Project began in Jan-

uary 2013. Nowhere else do we have a TRICARE office specifically to support the retiree population in any other overseas location and establishing one in the Philippines would be potentially precedent-setting, resulting in retirees living in other overseas locations expecting to have a satellite office established specifically to support them. And finally, in this resource constrained environment, establishing a satellite office in the Philippines was not a fiscally sound decision.

The purpose of the Philippine Demonstration is to test an alternative method for the delivery of health care in the Philippines to continue to control costs, reduce aberrant billing activity, and eliminate balance-billing issues while providing quality health care to TRICARE Standard beneficiaries residing in the Philippines and receiving care in designated demonstration area(s). This will be accomplished by using approved demonstration providers who have agreed to accept TRICARE reimbursement as payment in full, file the claim on behalf of the beneficiary, collect only the applicable cost-share and deductible, and agree to on-site verification and provider certification.

Selection of Approved Demonstration Providers was based on a thorough review of claims history over the past two years with the objective to recruit and retain a sufficient number and mix of Approved Providers in designated demonstration areas. Criteria for the selection of approved providers consisted (1) the number of claims submitted by the providers/facilities and (2) whether or not the providers/facilities were under any type of pre-payment review. As of March 2014, there are 11 approved institutional facilities that provide inpatient services and 323 approved individual providers in designated demonstration areas. Additionally, throughout the Philippines there are 301 certified institutional facilities that provide inpatient services and 4,335 individual certified providers.

#### QUESTIONS SUBMITTED BY MR. CASTRO

Mr. CASTRO. DOD has had great success with the creation of the Armed Forces Institute of Regenerative Medicine (AFIRM), a medical research consortium established to bring the best minds across military and civilian research communities to focus on a high priority area for the military. DOD has recently joined with the Department of Veteran's Affairs to create consortiums in Traumatic Brain Injury and Post Traumatic Stress which are also high priority areas for the military. What are the next priority areas of research where these civilian/military consortiums should take place, especially in looking to maintain advances in military medicine and translating the lessons learned from Iraq and Afghanistan into civilian medicine?

Dr. WOODSON and General ROBB. The DOD is exploring the feasibility of research collaborations or research consortia for a systems approach to all transport, equipment, and clinical aspects of en-route trauma care, hearing loss, prosthetics, and artificial vision.

Civilian-military consortia would focus on medical (e.g., medications, blood products, oxygen-carrying substitutes) and procedural (e.g., devices to control pain and hemorrhage and to promote perfusion to the brain and heart) strategies in the pre-hospital and en-route care setting. These consortia would synergize the development of new monitoring and triage devices (e.g., predicting those in the early stages of shock) as well as expand data gathering and telemedicine capabilities.

Mr. CASTRO. In this era of declining budgets what steps is the Defense Health Agency taking to assure that its medical research and development remains focused on the high priority gaps defined in the 2008 Guidance for the Development of the Force? Have these gaps been resolved and if not, how are we resolving them and are they properly resourced?

Dr. WOODSON. The Office of the Assistant Secretary of Defense for Health Affairs (OASD(HA)) conducts regular reviews and analyses of the medical research and development (R&D) portfolio to assure that investments are aligned to capability gaps, to assess the current state of science in a gap area, and to identify R&D gaps and needs that inform future resource strategies.

The Military Health System strategic priorities that drive R&D investments are based on the Joint Capabilities Integration and Development System (JCIDS) that informed the 2008 Guidance for the Development of the Force gaps. Using the JCIDS, the DOD re-validates and re-evaluates joint force health protection and readiness capabilities through the Capabilities Based Assessments (CBA) process. A CBA, sponsored by the OASD(HA), will re-validate, revise, or establish new capability requirements and associated capability gaps based upon operational lessons learned, changing needs, and gap assessment. Gap resolution is an on-going process. Over the last five years, considerable progress has been made in specific gap resolution for the 2008 guidance but the CBA will revise existing gaps or create new gaps.

Mr. CASTRO. In this era of declining budgets what steps is the Defense Health Agency taking to assure that its medical research and development remains focused on the high priority gaps defined in the 2008 Guidance for the Development of the Force? Have these gaps been resolved and if not, how are we resolving them and are they properly resourced?

General ROBB. The Office of the Assistant Secretary of Defense for Health Affairs (OASD(HA)) conducts regular reviews and analyses of the medical research and development (R&D) portfolio to assure that investments are aligned to capability gaps, to assess the current state of science in a gap area, and to identify R&D gaps and needs that inform future resource strategies. During this fiscal year, the Defense Health Agency will begin to assume management responsibility for medical R&D.

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