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THE MILITARY HEALTH SYSTEM: HEALTH AFFAIRS/TRICARE MANAGEMENT ACTIVITY ORGANIZATION

HEARING

BEFORE THE

MILITARY PERSONNEL SUBCOMMITTEE

OF THE

COMMITTEE ON ARMED SERVICES
HOUSE OF REPRESENTATIVES

ONE HUNDRED ELEVENTH CONGRESS

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THE MILITARY HEALTH SYSTEM: HEALTH AFFAIRS/ TRICARE MANAGEMENT ACTIVITY ORGANIZATION

HOUSE OF REPRESENTATIVES,
COMMITTEE ON ARMED SERVICES,
MILITARY PERSONNEL SUBCOMMITTEE,
Washington, DC, Wednesday, April 29, 2009.

The subcommittee met, pursuant to call, at 10:00 a.m., in room 2118, Rayburn House Office Building, Hon. Susan A. Davis (chairwoman of the subcommittee) presiding.

OPENING STATEMENT OF HON. SUSAN A. DAVIS, A REPRESENTATIVE FROM CALIFORNIA, CHAIRWOMAN, MILITARY PERSONNEL SUBCOMMITTEE

Mrs. DAVIS. Good morning. It is good to have you all here. The meeting will come to order.

Today, the Military Personnel Subcommittee will hold a hearing on the organization of the Office of the Assistant Secretary of Defense for Health Affairs. It is important to note that the Office of the Assistant Secretary of Defense for Health Affairs has a unique organization within the Department of Defense. It is the only merger of an Assistant Secretary's Office and the defense activity or agency, in this case the TRICARE Management Activity. In every other instance we can find, a defense agency or activity is a standalone entity, usually with a three-star or Senior Executive Service (SES) director and a two-star SES deputy or vice director.

The agency or activity falls under the Office of Secretary of Defense Office and the director reports to the OSD official such as an under secretary, an assistant secretary or deputy under secretary. But the two staffs in all those instances are separate and distinct. In Health Affairs (HA), however, the assistant secretary is also the director of the TRICARE Management Activity. Each of the Health Affairs deputy assistant secretaries are also dual-hatted as the TRICARE Management Activity division chiefs.

And, finally, if we have confused everybody by now, finally, last year, the Principal Deputy Assistant Secretary of Defense for Health Affairs was also designated as the Principal Deputy Director of the TRICARE Management Activity.

This new position actually has no corollary in other defense agencies or activities; and, frankly, its role has not yet been fully explained. So, as a result, the role of the two-star deputy director of the TRICARE Management Activity to many people is not exactly clear, and we are here to have you explain that to us.

In all of the other Office of the Secretary of Defense (OSD) offices that have a defense agency or activity underneath them, the under or assistant secretary staff develops policy and provides oversight,

while the agency or activity staff is responsible for executing that policy. This structure is the result of hard lessons learned with built-in checks and balances.

In Health Affairs, one set of people is responsible for both sets of functions; and, in fact, few refer colloquially to either Health Affairs or the TRICARE Management Activity (TMA), separately. They are simply known as the Health Affairs slash TRICARE Management Activity, or HA/TMA. So, with HA/TMA, we are clearly dealing with a different model from the rest of the Department; and we do not know if that is a good different, if it is a bad different or just different. It is therefore important for us to examine exactly how the HA/TMA is organized and operates today and then, most significantly, how that impacts the care we provide to our men and women in uniform. And isn't that really the bottom line here that we are seeking?

Our hearing will seek to answer the following questions:

What is the current organizational structure of Health Affairs/TRICARE Management Activity? What are the current roles and responsibilities of Health Affairs/TRICARE Management Activity? And is this unique structure that we have referred to appropriate to the roles and responsibilities of the office? What is the organizational relationship between HA/TMA and the services? Does that current organizational structure support the requirements of the services, most significantly? And are there any plans to reorganize HA/TMA; and, if so, what would that new organization look like? How does the Department plan to deal with the joint medical command headquarters Base Realignment and Closure (BRAC) recommendation?

For our witness panel today, we have all the key players from the Military Health System (MHS).

First is the individual to whom Health Affairs reports, the Acting Under Secretary of Defense for Personnel and Readiness, Ms. Gail McGinn. Ms. McGinn has been the Acting Under Secretary for just a few weeks now, so we understand the difficulty of being here today. But we appreciate it very much, and we look forward to the discussion with you.

Next is the Acting Assistant Secretary of Defense for Health Affairs, Ms. Ellen Embrey; and this is actually Ms. Embrey's first day as the Acting Assistant Secretary. So congratulations to you. You may not be feeling that way afterwards. But we are very happy to have you with us as well. I understand that you will be testifying also this afternoon before our counterpart subcommittee in the Senate.

We also have all of the service Surgeons General here today. And we certainly welcome you again, and we know that we have had an opportunity to meet with you in the past: Lieutenant General James Roudebush from the Air Force, Vice Admiral Adam Robinson from the Navy, Lieutenant General Eric Schoomaker from the Army, to get the service perspectives on the current HA/TMA organizational structure. And, finally, we are very delighted and fortunate to have the Deputy Director of the TRICARE Management Activity, Major General Granger here today as well.

General, I understand that this is your last week—we have a few milestones here today—your last week as the Deputy Director and

that you will be returning shortly, after several decades in uniform, to the private sector. And we certainly wish you well in your service moving forward; and we thank you very, very much for your contribution to our country.

So that is my introduction and, I want to turn to my colleague, Mr. Wilson who wants to welcome you as well.

[The prepared statement of Mrs. Davis can be found in the Appendix on page 35.]

Mrs. DAVIS. Mr. Wilson.

STATEMENT OF HON. JOE WILSON, A REPRESENTATIVE FROM SOUTH CAROLINA, RANKING MEMBER, MILITARY PERSONNEL SUBCOMMITTEE

Mr. WILSON. Thank you, Madam Chairman.

Today, the subcommittee meets to hear testimony from the Department of Defense and the service medical leadership regarding the current organizational structure of the Military Health System, MHS. I want to welcome our witnesses, and I look forward to their testimony.

A robust military medical system is essential to the health and well-being of our Armed Forces. General George Washington and the Continental Congress understood the necessity of good medical care during the fight for our independence. After suffering a sizeable number of casualties from disease, the Continental Congress established the Medical Department of the Army in July 1775. Washington then appointed the first director general and chief physician of the hospital of the Army. Since that time, our military medical system has provided care for the sick and injured during times of war and maintained the medical readiness of service members in peacetime. America expects nothing less.

With that being said, I want to make sure that the Military Health System is structured and organized to continue to provide world-class health care today and in the future. I am interested in hearing from our witnesses today on how the Military Health System is organized to carry out its multiple health care missions of maintaining medical readiness capabilities, providing peacetime health care to eligible beneficiaries, providing battlefield medicine to our brave men and women in Iraq and Afghanistan in the Global War on Terrorism, and caring for those brave men and women through the long recovery process when they become injured or wounded.

I am personally interested as the grateful father of four sons currently serving in the military today, including one of my sons, who is a Navy doctor, Admiral, so I am particularly proud of what you all are doing and what you are achieving for the young people who have the opportunity to serve in the military.

Is there a better way to structure the system as we look to the future? Are there opportunities to build on initiatives such as the joint task force capital medicine that was established to implement the base realignment and closure requirements in the National Capital Region?

I look forward to hearing from the uniformed leadership with us today, how they view the organization and structure of the MHS

and if it helps or hinders their ability to carry out their responsibility to provide medical care to all of our beneficiaries.

Before I close, I would like to recognize and congratulate Major General Elder Granger on his upcoming retirement from the Army. General Granger has served this Nation and our service members with distinction for over 32 years, and I was happy to point out to him he topped me by a year. I was in 31. So I am very, very grateful for your service.

Also, I want to alert you that we do have a condominium at Hilton Head. There is one left, and so you would be welcome to come to South Carolina.

I sincerely thank you for your service and wish you the best in your future endeavors. God bless you.

Thank you, Madam Chairwoman.

[The prepared statement of Mr. Wilson can be found in the Appendix on page 37.]

Mrs. DAVIS. Thank you, Mr. Wilson.

And now, Ms. McGinn, would you please begin. And then we will go right down the line.

And we are—I think we have told you that you have five minutes. We hope you can stick to that, since we have a large panel, and we certainly have a number of questions. Thank you very much.

STATEMENT OF GAIL H. MCGINN, ACTING UNDER SECRETARY OF DEFENSE, PERSONNEL AND READINESS

Ms. MCGINN. Thank you, Madam Chairman, members of the committee and thank you for the opportunity to be with you today to discuss the Military Health System organization. I have submitted a written statement for the record.

Health care, of course, plays a pivotal role in sustaining the All-Volunteer Force and its readiness. As we continue to respond to the realities of the post 9/11 world, the Department remains firmly focused on the health and well-being of our forces and their families, particularly the wounded, ill and injured, and to ensuring that all Department of Defense (DOD) beneficiaries receive the highest quality, most accessible and cost-effective health services available.

As you noticed, I am here performing the duties of the Under Secretary of Defense for Personnel and Readiness. But the Under Secretary of Defense for Personnel and Readiness exercises authority, direction and control over the Assistant Secretary of Defense for Health Affairs. He or she develops policies, plans and programs for health and medical affairs to provide health services and support to members of the Armed Forces, their families and others entitled to or determined eligible for Department of Defense care. The under secretary also ensures that policies and programs are designed and managed to improve standards of performance, economy and efficiency and that service providers are responsive to the requirements of their organizational customers.

Among other things, in exercising these responsibilities, the under secretary reviews the overall status of the Military Health System, chairs the Military Health System Executive Review, which is the Department's senior health care advisory body which

represents the stakeholder perspective; and he or she also chairs the congressionally mandated Joint Medical Readiness Council.

Over the last five years, Congress has enacted many new programs, has directed BRAC implementation and expanded our requirements to care for wounded warriors. At the same time, the Department has been asked to reduce health care costs, while increasing efficiencies.

In response, the Department has taken significant steps to improve unity of effort. For example, the Deputy Secretary of Defense established a joint command for the national capital area. Joint Task Force Capital Medical, JTF CapMed, achieved full operating capability on 30 September, 2008, and is meeting BRAC milestones for the creation of the Walter Reed National Military Medical Center at Bethesda.

For health care delivery in the San Antonio multi-service market, all governance decisions are accomplished in a joint collaborative manner to further enhance a culture of increased jointness and interoperability. Brooke Army Medical Center and the Air Force's Wilford Hall Medical Center have already completed an in-patient business plan for the new San Antonio Military Medical Center and are currently reviewing their integrated manpower needs and synchronizing construction with their transition schedule.

The Department is also standing up the joint medical education and training campus in San Antonio, Texas, to improve the quality and consistency of training of all enlisted personnel.

Under the Base Realignment and Closure Act, the Department is proceeding with plans to collocate the medical headquarters activities of Health Affairs, TRICARE Management Activity, the Army Medical Command, the Navy Bureau of Medicine and Air Force Medical Service. This collocation will increase unity of effort in policy, strategy and financial programming and yield greater consistency across the services in program execution, we believe.

Madam Chairwoman, the ultimate goal for the Under Secretary of Personnel and Readiness is to ensure a predictable, reliable, robust, effective, superior quality and readily accessible health care benefit for the DOD population. The testimony you will hear from my colleagues, Ms. Ellen Embrey and the Deputy Director of TRICARE Management Activity, will provide greater detail about their roles and responsibilities in these areas. Together, we continue to do all we can to improve the lives and health of those in our care.

We thank you for your generous support of military men and women and their families, and we look forward to your questions.

Mrs. DAVIS. Thank you.

[The prepared statement of Ms. McGinn can be found in the Appendix on page 38.]

Mrs. DAVIS. Please, Ms. Embrey.

STATEMENT OF ELLEN P. EMBREY, ACTING ASSISTANT SECRETARY OF DEFENSE, HEALTH AFFAIRS

Ms. EMBREY. Madam Chairwoman, members of the committee, thank you for the opportunity to respond to your request for information and to present the current Military Health System's organizational and governance structure.

Title 10 of the U.S. Code defines the key leadership roles and responsibilities of the organizations that comprise the Military Health System. Most of the organizations are represented here today. Ms. McGinn, Major General Granger and I represent the organizations from within the Office of the Secretary of Defense.

When I arrived in Health Affairs in January of 2002 at a lower level, I was one of the four deputy assistant secretaries in Health Affairs. At that time, there was a clear division of role and responsibility between the Office of Health Affairs and the supporting activity, TRICARE Management Activity.

Those structures were established in the late 1990s as an outcome of defense reform initiatives to control the rising cost of health care services, to improve access to care for the beneficiary population and to increase the consistency and quality of health care across the Department. The initiatives capped the Office of the Secretary of Defense and service headquarters staffs and realigned the majority of the former Health Affairs staff into the newly formed TRICARE Management Activity.

Today, Health Affairs staff remains capped at 42 military and civilian personnel. Its primary responsibility is to advise the Secretary of Defense on all health matters and to develop Department-wide policies and programs consistent with the Department's health care and medical readiness needs.

TRICARE's primary responsibility is to execute defense-wide programs, services and contracts that improve access, quality and consistency of health care services and to enable the Services to perform. Today's TRICARE workforce numbers more than 1,350 personnel worldwide.

The military Surgeons General lead and manage organizations and facilities that develop, enhance and execute the services' medical programs; and they guide joint operating programs in a lead or executive agent role.

The Joint Staff and the geographic and functional combatant commanders also have Surgeons General who advise them on contingency operations health planning, patient movement and tracking and theater health delivery services in commands around the globe.

Since September 11, 2001, the Department has had to adapt to several new environmental drivers and very much expanded requirements, including increased national security threats and force health protection needs and six years of continuous concurrent military operations in Iraq and Afghanistan with all of the medical force protection and other services that those operations entail.

Some 95,000 military medical personnel have deployed to support U.S. warfighters, in addition to providing mandatory health deployment assessments and reassessments, increased psychological health programs and services, expanded research and treatment protocols to address traumatic injuries, as well as wounded warrior rehabilitation and recovery programs, a new theater trauma registry and management program, and expanding and improving the electronic health systems.

Further, we have also engaged in the development, testing and implementation of common cognitive assessment tools for field and baseline assessments.

We also established a new defense center of excellence for psychological health and traumatic brain injury, to address that and other areas of urgent concern. We have conducted multiple global stabilization and reconstruction operations in response to catastrophic natural disasters at home and abroad. We have plans to address a strategically imminent threat of a global pandemic. We have promulgated and participated in international health regulations to address the threats of bioterrorism. We have implemented new BRAC and Quadrennial Defense Review (QDR) recommendations during that time frame to consolidate and align common functions. And we help support the medical aspects and development of the new Africa Command with a global health mission.

We have taken on other new and expanded areas of responsibility which are detailed in my testimony that has been submitted for the record.

So we have had a lot of stuff we have been managing in chaos for many years now. In order to address that, an updated charter for the Assistant Secretary of Defense for Health Affairs was published in June of 2008. It recognized the need to organize to help manage an MHS which grew from $20 billion in 2002 to a $45 billion program in 2009.

Madam Chairwoman, the world has changed dramatically since September 11th; and the MHS has had to evolve to meet its changing requirements. We do take a collaborative leadership approach in making those governance decisions. We work hard to develop win-win positions with our colleagues here at the table, and we engage on an ongoing basis on how to improve our focus for patient-centered care.

We believe we have improved the efficiency and effectiveness of the Military Health System as an enterprise; and with your help and continuing support, we hope we will continue to do the same. Thank you very much.

Mrs. DAVIS. Thank you.

[The prepared statement of Ms. Embrey can be found in the Appendix on page 44.]

Mrs. DAVIS. General Schoomaker.

STATEMENT OF LT. GEN. ERIC SCHOOMAKER, USA, COMMANDING GENERAL, U.S. ARMY MEDICAL COMMAND, THE SURGEON GENERAL, U.S. ARMY

General SCHOOMAKER. Madam Chairwoman, Representative Wilson, distinguished members of the Military Personnel Subcommittee, thank you for the opportunity to discuss the organization of the Military Health System.

First, I would like to take this opportunity to publicly thank the Honorable Dr. S. Ward Casscells for his years of principled, passionate service as the Assistant Secretary of Defense for Health Affairs. We bid farewell to Dr. Casscells last night. He is a friend; he is a mentor whom I greatly respect. His compassion and commitment to our service members and our families has been unparalleled. He is really one of my—one of our heroes at this table, and I don't say that lightly. His team in Health Affairs and the TRICARE Management Agency are hard-working and dedicated individuals, and I salute their service to the Nation.

Although the title of this hearing addresses the organization of Health Affairs and TMA, HA/TMA, I am not really so interested in organizational structure. I am—as you cited, Madam Chairwoman, in your opening comments and addressed in one of your questions, I am far more concerned about the nature of the functional relationships between and among the stakeholders in the Military Health System, the MHS.

To be more effective, form should always follow function. The function of the Military Health System must be first and foremost to support the warfighter on the battlefield. We must have trained and competent health care professionals delivering timely, effective and not just acceptable but truly world-class, cutting-edge care on the battlefield.

In order to recruit and retain these professionals, to acculturate them in the service of the Army, the Navy, the Air Force, the Marines and the Joint Medical Force and maintain their skills in peacetime and wartime, we maintain what we call a direct care system of military hospitals, health centers and clinics. The direct care system delivers a robust health care benefit to active duty soldiers, family members and retirees who live within a reasonable commuting distance to our military treatment facilities.

For an Army at war, care of our families is critical. The warrior must know that his or her family is safe and is being cared for, and the warrior and their families must be confident that if that warrior is injured or ill in the course of their duties that they are going to survive, they are going to return home, and they will have the best chance at full recovery and an active or productive life, either in uniform or out.

Each service maintains responsibility for operating and managing our portion of the direct care system. Our military clinics and hospitals, our graduate medical education programs and graduate programs in general, our medic training platforms are all the cornerstone of Army medicine's three-pronged mission to, first, promote, sustain and enhance soldier health; train, develop and equip a medical force that supports full spectrum operations; deliver leading-edge health services to our warriors and military family to optimize the clinical outcomes for those events.

For those health care services not available in a military treatment facility and for those beneficiaries who don't live near a military treatment facility (MTF), we have established contractual relationships with civilian health care providers to fill those gaps. This part of the benefit is what we call the private sector care, or PSC; and it is managed by the TRICARE Management Agency, or TMA.

The Office of the Assistant Secretary of Defense for Health Affairs, as you pointed out, sits above the direct care system and the private sector care, providing oversight and policy development.

In a nutshell, the MHS exists to support warfighters on the battlefield. The direct care system exists to deliver medical readiness. Private sector care supports and fills the gaps in the direct care system. If form is to follow function, then the MHS should be optimally organized to support the direct care system.

I don't believe this is always the case. For example, in the budgeting process, private sector care forecasts are considered "must pay", while direct care system estimates are considered "unfunded"

requirements. The Department's priority has been to fund the private sector care at 100 percent of projected requirements, while many of our direct care system needs are not addressed until year end when overforecasted PSC funding becomes available for distribution to the direct care system.

Since private sector care is often overprogrammed, they return money to the MHS, and they are seen as cost containing. Our direct care system health care bills are always after the fact and are seen as cost overruns. This resourcing construct appears to prioritize private sector care over the direct care system.

I believe that Health Affairs, TMA and the service Surgeons General need to take a holistic look at the MHS to ensure that our functional relationships such as those for resourcing, adoption of shared, evidence-based practices between the direct care system and the purchased care system, optimal documentation in exchange of clinical and other information are all oriented toward support of the direct care system and that the organizational structure of the MHS follows accordingly.

In closing, I would like to take this last opportunity to possibly publicly recognize my friend and colleague, Major General Elder Granger. He is a respected, gifted leader and clinician. He is a soldier/medic par excellence. It has truly been a privilege to serve with Elder, to be mentored by him. The Nation is truly richer for his service.

Thank you for holding this hearing, ma'am. I look forward to your questions.

Mrs. DAVIS. Thank you.

[The prepared statement of General Schoomaker can be found in the Appendix on page 56.]

Mrs. DAVIS. Admiral Robinson.

STATEMENT OF VICE ADM. ADAM ROBINSON, USN, SURGEON GENERAL, U.S. NAVY

Admiral ROBINSON. Good morning.

Chairwoman Davis, Ranking Member Wilson, distinguished members of the committee, I am grateful to have the opportunity to share Navy medicine's opinion about the current organization of the Office of the Secretary of Defense for Health Affairs and the TRICARE Management Activity organization.

Navy medicine is focused on meeting current operational and humanitarian mission requirements while proactively planning to meet the future health care needs of the Navy and the Marine Corps. These two distinct services have different needs, missions and operational requirements which require us to develop unique enhancements to our strategic ability, operational reach and tactical flexibility.

Much has been accomplished between Navy medicine and the MHS, yet exigencies within the current environment require us to reexamine these organizations and the working relationships responsible for providing health care for wounded service members and their families.

The experiences throughout my entire Navy career over 30 years, including a tour at Health Affairs, have shaped my position on our relationship with OSD(HA) and TMA. Given that background, I am

increasingly concerned that the lines between policy and execution have become blurred and may be compromising the effectiveness of this combined health care organization.

As Ms. Embrey mentions in her testimony, the deputy assistant secretaries are dual-hatted in developing policy at HA and in executing that policy at TMA. Having one controlling activity and authority over MHS policy and execution means that checks and balances can be compromised. These conflicting roles create challenges for the services since they blur execution decisions that then become policy decisions that may compromise care to our operational forces and our beneficiaries.

This structure also further divides the delivery of the benefit into two parts, in-house and network care, as General Schoomaker has outlined. What should be a collaborative process oftentimes becomes a competitive process.

HA/TMA's oversight of the network assets available through the TRICARE managed care support contracts limits Navy medicine from leveraging those network providers at their disposal. Navy medicine supports a regionalized government governance plan with a flag officer or a general officer providing oversight for direct and purchased care services that is controlling the network assets. Each of the services would lead one region, a model similar to what is currently in place with the leadership of the TRICARE regional offices. This model provides the tools at the regional level to integrate direct and private sector care with the goal of optimizing care within the medical treatment facilities.

Also, the ability to use network providers within the medical treatment facility may decrease the reliance of MTFs on contract support brought in to fill vacancies created by operational requirements.

I have also grown increasingly concerned about the way ahead in relationship to the JTF CapMed organization and the San Antonio regional military medical center. It is unclear to me why these two organizations are being organized differently if the intent, as stated in Dr. Chu's memo from June of 2007, suggests that in both organizations the services would retain operational control of individual MTFs and all deployable personnel.

The advisory role the services currently play in the policymaking process limits their ability to effectively impact the process. This limited role results in concerns and/or challenges not always being addressed when the final policy is disseminated.

The services must be afforded a more active and influential role in the process. It is difficult for the services to have the responsibility to execute a policy and to be held accountable for said execution without the ability to affect and/or influence the policy.

Chairwoman Davis, I am proud to say that Navy medicine is built on a solid foundation of traditions and a remarkable legacy of force health protection. We are committed to preparing healthy and fit sailors and marines to protect our Nation and to be ready to deploy at any time. We could not accomplish our diverse mission on our own, so our relationship with Health Affairs and with the TRICARE Management Activity is critical to our success.

I hope my testimony provides you with the examples of how strengthening the relationship between HA/TMA and Navy medi-

cine and, for that matter, the service medical departments through increased cooperation directly benefits our sailors, airmen, soldiers, marines and their families.

Thank you very much.

Mrs. DAVIS. Thank you.

[The prepared statement of Admiral Robinson can be found in the Appendix on page 65.]

Mrs. DAVIS. General Roudebush.

STATEMENT OF LT. GEN. JAMES G. ROUDEBUSH, USAF, SURGEON GENERAL, U.S. AIR FORCE

General ROUDEBUSH. Good morning, Madam Chairwoman Davis, Ranking Member Wilson, distinguished members. Thank you very much for this opportunity to share our thoughts with you this morning regarding this very important subject.

Before I begin, I would like to join my colleagues in recognizing the extraordinary service of Dr. Ward Casscells, who has been a key member of this organization, a key member of our team for the last two years. I think his contributions are certainly something that I have appreciated. I have learned, we have worked together, and I think we have all profited from his presence.

Likewise, General Granger has been an extraordinary ally and partner in meeting some very demanding circumstances; and I could not be more pleased to have the chance to simply say thank you for the record for General Granger and his service.

As we meet this morning, Madam Chairwoman, I think it is important to understand that we operate as a team. Each one of us has a role. But in order to execute effectively, we have to execute as a team. And in order to meet the critically important and very demanding military health care mission, we must, we must operate as that team.

And on the team we each have roles. For Health Affairs, the role is policy, oversight, guidance, coordination, setting that strategic vector, and as we always work for our civilian leadership to give us the lead in terms of many of our activities.

TMA has their role, to manage and execute the defense health program which is a challenging construct, somewhat different than you will find in other departments and agencies but an activity that very much drives a good bit of our energy and focus in making sure that we get that particular aspect of resourcing correct.

And, of course, TMA is our executive agency that oversees the managed care support contract, our private sector care allies and partners in delivering the full and comprehensive benefit to our active duty men and women and their family members, our retirees, those who have fought the fight and their family members as well.

For the services, we have, as our role, a multifaceted responsibility.

First, we support our Chief and our Secretary in providing them a healthy, fit force and supporting their title 10 mission in executing our national military strategy.

Secondly, we support our separate service missions. For us in the Air Force, we support the Air Force mission here in the United States and globally, again, serving our Nation.

Thirdly, we support our combatant commanders' requirements, meeting their mission around the world in a variety of very challenging contingencies.

And lastly, of course, each medical service has organizational, training and equipping responsibility to be sure that the medics of today are able to meet that mission as well as the medics of tomorrow.

So the services have a role, TMA has a role, HA has a role, and if we each execute those roles properly, the end result will be effective health care to the men and women so richly deserving that.

I came into my position as the Deputy Surgeon one month before 9/11. I served as Deputy Surgeon until I assumed the role of Surgeon General in 2006. So I have some experience as a member of this team.

Over that time, I have seen good men and women working hard to meet a very challenging mission. And we must never forget that. As I watched this team execute, I observed over that time, as we all are aware today and has been pointed out, that Health Affairs began to take on more execution responsibilities by merging with the TRICARE Management Activity and with an increasing focus on the execution within the direct care system.

Now, we all work hard to execute our responsibilities, but we each have our lane, our roles responsibilities, and we need to be able to move within that lane to effectively accomplish those responsibilities. As we fast forward to this point in time, our direct care system, the service military medical system, Army, Navy and Air Force, is heavily tasked in meeting our critically important mission of providing that healthy, fit force, caring for our families and meeting the needs of our combatant commanders and our warfighters. We are doing it well, but it is a heavily tasked construct, and there is stress within the system.

Adding to that stress are challenges in recruiting and retention as well as recapitalizing aging infrastructure that was designed to meet the mission of the past and not necessarily designed to meet the mission of today. And, at the same time, we are working hard to be cost effective, because we understand that military health care is becoming an ever-increasing large part of the Department of Defense budget, and we each have the responsibility to be great stewards of that health care and providing the best return on every dollar. So I believe now is the right time to ensure that we are properly aligned as a team to meet this function.

HA focused on policy oversight and guidance; the services focused on those title 10 requirements, meeting our service missions, meeting the combatant commanders' mission; and I would suggest TMA focus on managing the defense health program, as they have in the past, but really honing in on the managed care support contract to leverage the direct care system, as very strongly recommended by the Task Force on the Future of Military Health Care, to be sure that the direct care system is the focus of our system, that its capacity is fully utilized, that its capabilities are fully leveraged and that it is, in fact, fully maintained and optimized to meet the very challenging mission.

So, in short, I believe the time is right. We owe this to every man and woman who raises their right hand and swears to support and

defend. We owe them the very best health care today, tomorrow, 10 years from now, 30 years from now; and we owe them that health care in these demanding places where they go in harm's way such that we will, in fact, save their life, bring them home safely to their family member, if that is at all possible, and ensure them that their health care needs will be met and will be our priority. We will earn that trust today, tomorrow and every day coming with your support.

I thank you for this opportunity to testify, and I look forward to your questions.

Mrs. DAVIS. Thank you.

[The prepared statement of General Roudebush can be found in the Appendix on page 70.]

Mrs. DAVIS. Major General Granger; and, once again, thank you very much for your service.

STATEMENT OF MAJ. GEN. ELDER GRANGER, USA, DEPUTY DIRECTOR, TRICARE MANAGEMENT ACTIVITY (TMA)

General GRANGER. Thank you.

Good morning, Madam Chairwoman Davis, Ranking Member Wilson, other members of the committee and to my distinguished colleagues to my right here. I want to thank you for your kind compliments.

I have really enjoyed my 32 years of active service and total of 36 years, including my time where I started off in Arkansas National Guard. I have had the awesome responsibility of serving as the Deputy Director of TRICARE Management Activity, and in this role my responsibility has been working with my colleagues to integrate the program for 9.4 million men and women around the world.

We have done a number of things through your help and support. We have been able to put in a very aggressive, robust disease management program that has reached over 150,000 and netted a cost avoidance of about $30 million. In addition to that, we have had a heavy focus on meeting the needs of men and women in our Guard and Reserve in remote areas by working with our colleagues to my right as well as reaching out to those family members in terms of mental health support, having a toll-free number where they can get help anytime, 7 days a week, 365 a year.

In addition to that, thanks to you all, we have been able to focus on prevention. Through your help, we will be able to put in place a very robust prevention program with no co-pays or deductibles designed to eliminate some of those barriers that we need to get good health care in this Nation.

Last but not least, we have been ranked for six years in a row the number one health plan in the Nation. That in itself is due to the complement of all of us working together, focusing totally on the mission of taking care of the men and women in our uniform services.

Last but not least, as I take off the uniform, it has truly been my honor to serve my colleagues for many, many years.

I look forward to your questions, Madam Chairman and Ranking Member Wilson. Those conclude my brief statement. Thank you very much, and God bless you all.

[The prepared statement of General Granger can be found in the Appendix on page 79.]

Mrs. DAVIS. Thank you very much. We appreciate all of your testimony here today.

I think there are a number of things that you have really identified, and one is the proper relationship between Health Affairs and TMA. I want to zero in for a second, General Schoomaker, on one of your statements; and I know that others will want to weigh in as well.

You described private sector care as a gap filler. But since the purchased care budget is roughly double that of the direct care budget, hasn't private sector care then really become the main effort or at least in terms of the budget? How has that impacted care and does there need to be a shift back towards the direct care system?

General SCHOOMAKER. Well, ma'am, there is no question as we have continued in this war, as we have continued to mobilize National Guard and Reserves, as we have continued to employ the private sector care to close the gaps in the so-called white space of America where care needs to be delivered and we don't have facilities, we see more private sector dollars being spent out there.

And I don't dispute the fact—I mean, the figures speak for themselves—that more and more money is going in that direction. But I started off my comments and I was gratified to hear that my colleagues are all in agreement with this, that at the end of this, we have to always remember that the centerpiece for the Military Health System is the direct care system and our ability to fully employ each one of our military treatment facilities in whatever form that exists to the fullest extent possible——

Mrs. DAVIS. Could you and others paint a picture of how you think that relationship might be better developed?

General SCHOOMAKER. Well, ma'am, I think in those catchment areas—and the Army experimented with this very early in the course of the transitioning to a comprehensive managed care, the primary care based managed care system, placing military commanders in those communities, in catchment areas, in the control of and responsible for both the direct care and the purchased care system; and then on a regional basis, like my colleague, Admiral Robinson, has pointed out, having a military commander responsible for both execution of the direct care dollar and care as well as the purchased care dollar and building seamlessness not only in terms of where money is spent but also in terms of practices and exchange of clinical information. I am firmly one who believes that our future in cost containment is going to reside around our ability to embrace outcomes-focused, evidence-based practices; and I think that is done best in concert and through the military commander.

Mrs. DAVIS. Do others want to comment? Do you think that the fact that that relationship perhaps doesn't exist today, that that is not where the balance is, that that gets in the way of doing what do you think is best?

Admiral ROBINSON. I think that the relationship does exist today. But I think the emphasis is not on the relationship of trying to bring the direct care system and the managed care system, the network, together. There is a system that keeps us in parallel, but we

are like two parallel railroad tracks. What we need to do—and this is the task force of the future of military health care—the number one recommendation was to bring together the direct care system, that is the uniform side, and the managed care side into the same system.

Instead of taking our patients and sending them to the network, the network is our network. We need to bring our networks to our MTFs. We need to bring—we need to merge a lot of the activities that are occurring in parallel in our system. But, in fact, very often the direct care side, that is the MTF commanders, really don't have visibility on what is occurring on the network side. I am not suggesting that they don't understand what the policies for accessing the network are or how to do that. I am suggesting that we don't really have a system that leverages our networks so that it can help us on the direct care side.

Mrs. DAVIS. Before we go on to the next member, I just wanted—Ms. Embrey, could you weigh in on this question a little bit? Because you have said that, basically, under title 10 that the Secretary defines roles and responsibilities. And I think there is some question whether or not that is actually really not quite as you characterized it. Could you please weigh in on that issue?

Ms. EMBREY. I think that the segregation has to do a little bit with how money is segregated. We have to budget, and there is a firewall between what we can—we have to budget for, what our beneficiary population seeks in the way of care in our network, and we also have to budget for what we believe the performance and productivity and demand signals in our military treatment facilities. And there is a firewall. We can't move money back and forth easily without a reprogramming request.

So I think part of it is artificial, institutional, and part of it is we attempted, I believe, to establish TRICARE regional offices, and when we originally established them from 11 regional areas to three, we asked each of the service Surgeons General to identify uniformed flag officers to manage that so that we could get to that uniformed integration of and support in a regional area, that kind of integration that was testified to. To date, the Navy has been the only one consistently providing that uniformed officer.

Mrs. DAVIS. Thank you. I know that we are going to come back to that issue.

Mr. Wilson.

Mr. WILSON. Thank you, Madam Chairwoman.

Again, thank you all for being here; and I want to congratulate you. I believe that military medicine is leading the world in technology, research.

It is so inspiring to me to know what you are doing in advancing—and I have visited the medical facilities with prosthetics, with head injury, trauma injury. What helps the military will also be so helpful to the civilian population, and I want to thank you for what you have done.

Specifically, as a veteran and a parent, I this month visited the Air Force Hospital there at Balad; and it was really encouraging to me to know that there is a 98 percent survival rate of our troops who are medivac'd to that hospital. I just think that is so reas-

suring. And the American people need to know the quality of care that is provided.

Specifically, prior to establishing the defense health program, funding—and this is for our service Surgeons General—funding for health care provided by the military services was included in the overall military service budget managed by the service secretary. Consequently, the Surgeons General had to compete with other programs within their service for resources.

Now that you have had several years of experience with the defense health program (DHP), what method do you prefer? In light of the current health care demands within DOD, what is the most appropriate mechanism for allocating resources between the direct care and purchased care system?

General ROUDEBUSH. Sir, as we have had experience with the DHP, we have two streams of resources. We have the dollars coming through the DHP, and we have the manpower which comes through our service secretaries. We have, I believe, established a system which in the main serves our purposes but does create some tension in terms of allocating resources.

I will tell you that my view is I think there is some rationale with the DHP in terms of looking at health care resources writ large, with across three services and a very large Military Health System. I will tell you that the countervailing pressure on that, though, is my Chief and my Secretary, who view the health of their men and women, our airmen and their families as very much their responsibility within their title 10 responsibilities. So I feel very well supported by my line in terms of competing for resources and properly allocating those very scarce resources across my activities.

The DHP is a balancing construct to a certain extent, and it does allow us to get the larger costs potentially of the private sector care which goes across services. That is not necessarily a simply service-specific issue, although with encatchment areas it can get very local. But, in the main, in being able to manage very large contracts, we do need to do that strategically from a corporate standpoint; and I think the DHP gives us the opportunity to do that.

I agree with my colleagues, however, that balancing between the direct care system and private sector care is very challenging.

The direct care system, to your point, Madam Chairwoman, is in fact the centerpiece and does actually three things: It helps us provide that healthy, fit force, it allows us to provide the benefit to all our beneficiaries to the full extent that we can, but it is also our training platform for our military medical personnel.

So the direct care system needs to be robust and the centerpiece.

Now, the private sector care wraparound to that needs to be in balance. And I agree with my colleagues that the direct care system needs to be trumped with private sector care being used to leverage the direct care system and also to leverage the capacity. Because the direct care system in many regards has sunk costs. So the greater capacity we have within the direct care system, the more cost effective our system is overall. So I think the DHP in the main allows us to get at that.

There is some tension with that. However, my chief, my secretary paid very close attention to that balance and that tension

which I think helps us keep some rationality and balance within it. But it does create tension.

Mr. WILSON. Thank you very much.

And General Schoomaker may want to comment, too.

General SCHOOMAKER. I will just say very quickly, sir, unequivocally, from my perspective, the creation of the DHP by the Atwood memorandum was a good thing. And to go back through the door of breaking health care costs among the services I think would be a backward step to take. It has allowed us to see, to develop a level playing field to the best of our ability across services. It has allowed us to raise to a much higher level of visibility the needs of our beneficiaries for care and for all of the even deployment-related issues that we have.

I think what you are hearing, and I can completely agree with General Roudebush, is you are hearing a series of tensions. One, the tension between the direct care system and the purchased care system and where that should be balanced, and the other is the balance between oversight and policy development by Health Affairs and execution by the services. Increasingly, we are seeing Health Affairs take on the role of execution; and doing that I think it erodes some of the goodness of the DHP.

Admiral ROBINSON. I, too, agree with my colleagues on the DHP. It would be wrong. I think it would be a major mistake to go back to any other system other than the DHP. Service input into how the DHP, how that DOD program is, in fact, executed is the tension that I think I would like to just comment on.

The services need to have some direct input into the processes of how the DHP is executed. In recent years that hasn't always been as clearly demonstrated to me. I am not suggesting it hasn't occurred. I just haven't been able to clearly see the occurrence of it.

So I think that is where we should look at it. But I would not change the system that we have developed. No.

Mr. WILSON. Thank you. Very encouraging. Thank you.

Mrs. DAVIS. Thank you.

Dr. Snyder.

Dr. SNYDER. Thank you, Madam Chair. Thank you all for being here.

I want to direct my questions to the three of you that hold the title of Surgeon General (SG). I am phrasing it that way because I don't think if the plural is Surgeons General or Surgeon Generals.

General SCHOOMAKER. Surgeons General.

Dr. SNYDER. This is one of those discussions this morning that is probably a very, very important one to a lot of our men and women in uniform and their families. It is just—it is one of these discussions which, while important, can give government a bad name. Because it comes across as a bunch of gobbledygook that most of us don't understand.

I appreciate you for being as forthcoming as you are in trying to sort it out and make recommendations, but I want to try to give you a couple of theoreticals and little anecdotal things.

Have you, the three of you, if you would walk me through how you—this tension that you all are describing, how it may impact on patient care. I will throw out a couple of examples, and you can

tell me if it doesn't have anything to do with it or examples of what you are talking about.

The first example is the special needs kids I think some of us have talked about before. General Schoomaker, you talked about supporting our warfighters overseas; and I think nothing creates more heartache for our folks overseas than if they have a special needs child and the child is not getting the kind of care that they think they need while at a military facility someplace. So let's take a child with insulin dependent diabetes or autism or something that requires a fairly intensive amount of help.

And the second example might be I think a lot of us have run into over the last several years, would be somebody in the Reserve Component who is mobilized for active duty for a period of 18 months or so. Their family then goes into the military health care system but may geographically be living in a place not near a base, not near providers who are used to dealing with TRICARE.

So what I would like each of you to do—and just tell me if I am off base and maybe the tensions we are talking about or you all are discussing have nothing to do with these examples—but how does what you are talking about relate specifically to our men and women and the care that they give? And if these are a couple of examples where it may give you an opportunity to describe how the tension may relate to the actual care that men and women and their families get.

General SCHOOMAKER. Well, candidly, sir, from my perspective, both of the cases—I will be interested in hearing what my colleagues have to say—both of those cases I think are not necessarily confounded by the tensions that we are creating here. I think both of them, in many cases, are attributed to the farsightedness and the vision of setting up a TRICARE system as we did 15 years ago or so.

In the case of special needs kids, we have an extraordinarily generous benefit which is fairly uniformly applied; and, in fact, I think it has resulted in the military health care system being one of the elements of families' decision with a special needs child to stay in uniform.

So I would have to say that that doesn't necessarily—I don't see my role in executing these programs as being interfered with in any way, shape or form in taking care of special needs kids.

I would have to say the same about the mobilized Reserve Component, the National Guard and Reserves, many of whom come from places in this country where we don't have a robust direct care system. In central Idaho, parts of Montana, Wyoming, we don't have large, robust medical centers and health service systems.

And so, having an effective purchase care system and a managed care support contractor that is reaching out and providing care to those families I think, again, reflects the farsightedness of a well-executed TRICARE program. I am not taking away from any of that part of it.

Admiral ROBINSON. I would connect this a little differently. I don't completely disagree with General Schoomaker, but I think that the autism and the insulin-dependent diabetic do come into

play in this regard. First of all, the private-sector care, the network care, and the direct care can both play here.

Let's take Twentynine Palms; I will just take a Marine Corps base in southern California. Very remote location, I am not going to be able to get network care there. It is going to have to be direct care. It is going to have to be uniform care.

Now, when I say I can't get it, there are people that will go there, but that is very difficult. So I have places in this country that are very difficult to, in fact, get network care. That means I need it in uniform.

However, very often there has also been—and I don't want to get caught in the mire of the gobbledygook, but there are also thoughts that very often we on the direct care side in uniform should be there for very specialized war-fighting activities that make us incredibly essential for the battle and for the things that the military system in fact was built to do. But, in fact, in 2009, we have taken on added responsibilities, which include garrison and family care.

So my question then is, I need pediatric endocrinologists as much as I need trauma surgeons, but it may be difficult sometimes to, in fact, get there because of how we have, in fact, looked at what we think we should get from the war-fighting versus the non-war-fighting situation.

Now, I am not suggesting to you that anyone is denying the Navy or the other services pediatric endocrinologists. I am just simply saying that there is a tension that does exist because of some thoughts and some assumptions made as to how we really should, in fact, divvy up our uniformed versus our network.

I would like to add just one other thing. I am not going to comment on the Reserve Component. I think that General Schoomaker's answer would be mine also. I would only like to say, overseas, with our EDIS, Educational and Developmental Intervention Services programs, and also our Exceptional Family Member programs, this is also the case. Because overseas we are not able to, in fact, engage network care. So if I don't have it, if I can't either contract it to bring it or if I don't have it in uniform, it is much more difficult to get.

And those are just challenges that I must look at. I am not suggesting that anyone is keeping me from getting there, but these are the challenges from an SG's perspective that I must look at.

General ROUDEBUSH. Congressman, I think you raise a point that really brings out the essence of what we are talking about this morning. There is a role and relationship, and it is not "either/or," it is "and."

For us in uniform, there are, in fact, places where we are going to need to have in uniform specialty capabilities for family members, because family care is mission impact. When our men and women are in harm's way, if they are not confident their families are fully cared for, they will not be focused on what is in front of them. And that has mission impact. So family care plays directly into the mission.

For us, TRICARE gives us that wraparound in those circumstances where we may not have the capability readily available for our Reserves in areas where we don't have a facility available, for example. Or for special needs youngsters, we may not have that

readily available within the uniformed service. TRICARE gives us that wraparound capability.

And, quite frankly, when you get to specialty care for our youngsters, that is rather expensive to make and sustain in uniform. And the more cost-effective solution and clinically effective solution, in many circumstances, is, in fact, to contract for that capability and that care through the private-sector TRICARE.

So it is not "either/or," it is "and," and finding the right balance, each of us within our roles, to get that mission accomplished. So I think you do raise an intersection that is critically important for us to get right.

Mrs. DAVIS. Thank you.

I am going to move on to Ms. Tsongas.

Ms. TSONGAS. Thank you.

I am enjoying this testimony. And I have to say, much of this is, as a new Member, relatively new Member, much of it is very new to me.

I have to say, many years ago, as a child of the Air Force, I needed very delicate eye surgery. And I was in an Air Force hospital at Langley Air Base and then subsequently at Tachikawa Air Base, and I received remarkable care. And, again, I was with Congressman Wilson in Balad, where we did see the remarkable work that you are doing.

But, obviously, we are in a time and an era when health care is far more complicated and far more expensive. And it is clear that you are wrestling with both on multiple layers.

My question, slightly different, though, is we have representatives of the different services, and you obviously have different cultures, sometimes very different needs, as a result of the roles you play. And I am just curious how this plays itself out, given the different tensions that you all have described. Is it another layer to it, or is it really not particularly significant?

General SCHOOMAKER. Well, I will speak for the Army. I think, ma'am, it is very significant. And I think it is why we, not for parochialism or not because we are looking to build duplication or triplication within the defense health system, why we insist on executing our programs within each one of our services.

Each one of the services, for very, very good reasons, has important differences in how it fights war and how its military health care uniformed members support the deployed force. And that is not to say that there aren't commonalities and, in some large metropolitan areas like in the national capital region or San Antonio, we can't find shared platforms where we can retain common skills, where we can share the opportunities in the greater Washington area where we have 36 or 37 different health care facilities across the three services, from Pennsylvania down to Quantico and as far west as Fort Belvoir. We have plenty of opportunities to share those platforms for caring for about a half-million beneficiaries.

But when it comes down to ships at sea and brigades in battle, some of the remote sites that General Roudebush and I in the Army have to service, the service cultures are very, very much a part of this. And it is why we, as service surgeons general and commanders of our medical forces, want to have a very firm grasp on the execution of these programs.

Admiral ROBINSON. Each service has a concept of care. I think that, as the long war has continued in both Iraq and Afghanistan, our concepts of care have actually become much closer together; they have merged.

From the Navy's perspective—I am not speaking now for the Army or the Air Force, but I don't think they are much different—patient- and family-centered care is our concept. It is what we think is important in order to make sure that we can meet the mission, both the operational—that is, the war mission—as well as the family and the garrison care mission, because we can't separate them out any longer.

Since people on the battlefield, men and women, can now e-mail and text message family members during an intense encounter, it is no longer the case that I can, in fact, not take care of families as I am also taking care of men and women on the battlefield. We have moved into another era of communication, of technology, and of the insistence by the people that are our beneficiaries that we, in fact, care for them in a very organized and meaningful way.

And that is what I think all three services do, but we all do it differently, leveraging those things that our service chiefs and the equities of Army, Navy, Air Force, and Marine Corps must have in order to meet their missions and, at the same time, making sure that we leave no patient, no family, and no member behind.

Ms. TSONGAS. And do the Health Affairs and TRICARE management acknowledge this, in your relationships? Or is it yet one more of those things that, again, is a source of tension?

Admiral ROBINSON. I think that Health Affairs does acknowledge that. I think that they do, in fact, understand the differences in the services and how to meet them.

I also think that, very often, the concept of what is important from a patient perspective can sometimes get clouded or get shaded in relationship to the business perspective of efficiencies and effectiveness. Now, that is the world that we live in, so I am not complaining to you about that, because everyone has to look at costs and has to look at the bottom line that we are trying to get done.

The key here in medicine is that patients usually, when they are coming to you and they need something to save their lives, they need something that they think is going to be absolutely essential to their wellbeing, are not interested in hearing the business rules involved in doing that. My job is to, in fact, take that into account and to balance that out with the needs of the patient.

Mrs. DAVIS. General, do you want to comment?

General ROUDEBUSH. Just very quickly.

At times, folks will talk about culture and say, well, culture is interesting. I would suggest to you that culture is a significant part of what we do.

We have an All-Volunteer Force. Every soldier joins the Army because he or she is attracted to the mission and the culture. Likewise, every sailor, Marine, and airman joins that service because they are attracted to the culture and the mission. Their families are wrapped in that culture. We care for our servicemen and their families within that culture and within that mission ethos.

So culture is a big part. And, particularly when these men and women are injured or ill, that culture wraps around them and sup-

ports them, helps them through that recovery, rehabilitation. So it does play a role.

And while many of the clinical activities are certainly the same in the Army, Navy, and the Air Force, that wraparound, that family, that team that is caring for them is an important part of the construct. And I think that can't be lost in the discussion.

Mrs. DAVIS. Thank you.

Mr. Jones.

Mr. JONES. Madam Chairman, thank you very much.

And I regret that I was not here for your opening statements, but I do appreciate what you are doing. This is a very difficult time for our men and women in uniform, certainly a very difficult time for our Nation. And, certainly, health care for the private sector, as well as the military sector, is at the forefront of many discussions here in Washington, as well as debates.

Admiral Robinson, I want to thank you. You and your staff did a very excellent job of responding to a question I had about autism and autism programs down at Camp Lejeune. And I was very much appreciative of the information and the work that you all are doing, quite frankly.

And, as I have heard many from each services talking about the fact that the world is becoming more complicated, looks like we are going to be in Afghanistan for a long period of time—I hope not, but it looks that way—and, therefore, there is going to be more stress and pressure on the military families. And, in a response—and this is not a criticism, but you realize that, as a Member of Congress, we have our districts, we have people in our districts, both military and nonmilitary, that have questions about services and programs for families. And I, again, was very pleased and satisfied with the response that you gave me to the questions that we asked on behalf of parents down at Camp Lejeune.

But the only point I want to make and ask you this question—and I know you don't have this before you, but we asked the question, "How many of the above dependents are enrolled in the TRICARE Extended Care Health Option (ECHO) program as of 12/31/08? Please break down your response by location, Camp Lejeune and San Diego." I won't go through your response; I want to get to the question.

Then you gave me that answer with the numbers, which was helpful, because obviously there are more children in that San Diego area, with the Navy base and Camp Pendleton, than there would be at Camp Lejeune. But still we have children with autism at Camp Lejeune.

So the next question was, "How many of the above dependents are receiving applied behavior analysis (ABA) services under the TRICARE Enhanced Autism Service Demonstration as of 12/31/08? Please break down your response by location." The response was, "There are 118 dependents receiving applied behavior analysis services, 68 Navy families and 50 Marine families, for the San Diego and Camp Pendleton catchment area. There are no dependents receiving ABA services under the TRICARE Enhancement Autism Service Demonstration in Naval Hospital Camp Lejeune, Naval Health Clinic Cherry Point, and Marine Corps Air Station New River."

So then the next question—now I am going to get to the final—"How many ABA therapist providers are serving military families in Camp Lejeune catchment area under the Autism Service Demonstration Project? How many providers have signed on in the San Diego area?" This is the question I was trying to get to. "There are no ABA network providers in the Naval Hospital Camp Lejeune area. There are 10 ABA supervisors and 82 ABA tutors serving military families in the San Diego area."

I am not being critical, because, again, we all know what the numbers game is. I mean, we are all under stress here in Congress, as well as you in the military. But my point would be, though, realizing there are more children in that San Diego area, the fact that we have none at Camp Lejeune, can that be re-evaluated?

And, I mean, not saying that we need to have the equal numbers of the professionals at Camp Lejeune that we have at San Diego or Camp Pendleton, but to say that we have none is somewhat of concern, not only to the parents down there, but to myself.

Is that something that can be reviewed to see if the justification, realizing the restraints that you are under—but is there any way we could see if we could get some of those professionals at the Navy Hospital at Camp Lejeune?

Admiral ROBINSON. Well, Mr. Jones, thank you very much for your compliments and also the fact that we have been working with your staff on some of these issues for a while, and I appreciate that.

The answer is, yes, it can be reviewed.

The second answer is that the fact that there are none may not tell the complete story, because there may be other sources of that type——

Mr. JONES. Right, that is true.

Admiral ROBINSON [continuing]. Of therapy that the children can receive.

Thirdly, the amount of contractors and people who will go and who will actually stop in Jacksonville, North Carolina, vice San Diego, California. So the geographic area does make a difference.

Bottom line, though, sir, to you is that we in Navy Medicine and, actually, we in the Military Health System are absolutely committed to children wherever they may be, no matter what their location. So we will revisit that and look at that.

I happen to know that the system that we have in Camp Lejeune is more complicated than the numbers you suggest because of differences in the network emphasis on certain of the behavioral health assets; how we are, in fact, deciding who can deliver that ABA care; who is involved. There are a number of facets to that particular question. But, yes, sir, we can look at that again, and we will, in fact.

Mr. JONES. Thank you, Admiral.

Thank you, Chairman.

Mrs. DAVIS. Thank you.

Ms. Fallin.

Ms. FALLIN. Thank you, Madam Chairman.

Appreciate all that you do for our Nation in delivery of medical care to our service men and women. I know it is tough under lim-

ited financial constraints that you have and so many different regions of the world that you have to deliver care.

I was just curious about—because we have had so many men and women serving, probably more than ever, in deployments across the world, and with the events after 9/11 and the fight on terrorism and the large numbers of men and women who have been called up, when they start to come back home to the United States, you are going to have a lot of veterans and a lot of soldiers who will be going into the health care system for many different reasons, whether it is just regular care from injuries or regular medical care or post-traumatic stress syndrome, whatever it might be.

What type of plans have we made? And do you have the resources you need to meet all the large numbers of people that will be coming home over the next many years?

General SCHOOMAKER. Well, ma'am, I mean, therein lies probably the biggest question we are all facing.

And, first of all, starting with what the estimates are of the kinds and types of illnesses and injuries that we are going to be seeing, I mean, the vast majority of wounds of war, quite frankly, are not visible wounds. And one of the major efforts that is undergoing right now within the Department of Defense is to get a grasp on what the state of current science and understanding of all of the neuropsychiatric injuries, whether they are physical injuries to the brain from concussion or whether they are psychological consequences of deployment and the exposure to war and the like.

We have conducted in the Military Health System, through epidemiologists out of the Walter Reed Institute of Research, over the last six years a recurring, fairly tight scientific study called, for the Army and Marine Corps, a Mental Health Advisory Team, which has done estimates of what the volume of problems is and what the nature of those problems are and when they emerge. And that has helped us.

We worked very closely with the Department of Veterans Affairs (VA) and our TRICARE managed care support contractors to ensure that we have the network of care available, both within the Federal system and within the private care system. But I think this is something that keeps all of us up at night.

Ms. FALLIN. Do you feel like your proposal on your system, the changes that you are talking about in your hearing today will move you closer to that goal?

General SCHOOMAKER. Well, ma'am, this kind of overlaps with the question that Congresswoman Tsongas had about the acknowledgment of the cultural differences and the challenges to each of the services.

Frankly, at my level of command, acknowledgment is represented in dollars. And, as I said in my opening statement earlier, when I find my budget not programmable in a predictable way but private-sector care programmable, then I have a very difficult time developing a stable business platform for my medical treatment facilities, which I am compelled to give a lot of my family and soldier care around. And that is a great deal of the tension that we have talked about here this morning.

Ms. FALLIN. One of the concerns I hear in my community and in the State of Oklahoma is how we don't have enough people to han-

dle post-traumatic stress syndrome, as far as counseling and diagnosis and psychiatry, whatever level of care it might be, that we don't have those people on board yet, and there is a shortage, and it is hard to get that care in the local states.

And what are we going to do to address those things? Is it a matter of funding?

Ms. EMBREY. The Department has recognized that there is a national shortage to the citizens of America and not just the military, although the military certainly has a high demand for those services. And we have been given a fair amount of resources from Congress to assist us in expanding that capability.

And we are leveraging many different approaches, to include bringing in social workers and other folks and tiering the capabilities so that we assure that the assets that have the certifications and capabilities are dealing with those that need those services and that we distribute the other services to sometimes nonclinical but certainly qualified individuals to aid in early intervention and then referral to appropriate higher-level care.

Ms. FALLIN. Ms. Chairman, if I can just finish one last question, someone had mentioned to me yesterday about some new research being done with—and I hope I am saying this right; you are the physicians—hyperbaric chambers, when it comes to the treatment of post-traumatic stress syndrome. Have you seen any type of research that might indicate it would be helpful?

General ROUDEBUSH. Ma'am, I believe what you are referring to is focused, at least for the moment, on traumatic brain injury and hyperbaric oxygen. And that, in fact, is being very aggressively pursued with the Defense Centers of Excellence on Psychological Health and Traumatic Brain Injury to really be sure that science is applied to that, to assure that we have the best therapeutic modalities positioned for the men and women, and that we are able to apply those therapies to the best outcome.

So, yes, ma'am, that is in the center of the scope and is being very aggressively pursued for all three services, as we have all individuals in harm's way with that particular outcome as a risk for these men and women.

Ms. FALLIN. Okay.

Thank you, Ms. Chairman.

General GRANGER. Madam Chairman, can I comment on that statement for a second?

In reference to the families, we have stood up with our managed care support contractor partners toll-free numbers they could call. And based upon data in the last three years, the number of family members using our mental health capability in our network has increased significantly. We would be glad to share that data with you for the record.

Thank you.

[The information referred to can be found in the Appendix on page 103.]

Mrs. DAVIS. Thank you. I appreciate that. I appreciate the question, because I think that we could certainly have a hearing focused solely on mental health care and what is happening to support the services that are out there, the kind of research and development that is being done, to be certain that we don't have

wholespread duplication, and, at the same time, what we are doing to really help the families be able to move through this problem that they are all having. And very, very important, so I appreciate some focus on that.

I wanted to—now, see, we have a vote coming up, and I don't know whether folks can come back. We can try and have two more questions, and then we will make a decision about whether to ask you to wait here. That may be it.

I just wanted to get back a second to the oversight question, because I understand the tension and the balance that we are talking about. I think, General Roudebush, you mentioned in your statement that, in many ways, TMA's current level of—the current level that you mentioned of the oversight over the military treatment facility is fairly extensive and somewhat excessive, as well.

And I just wonder if you could talk to us more about what you think the right structure then for Health Affairs for TMA would be to better provide oversight to the services?

General ROUDEBUSH. Yes, ma'am. It is a collaborative relationship. It really is an "and."

Health Affairs, my view, my experience, is most effective and, in fact, has and continues to be very effective at providing that strategic policy guidance, the coordinating oversight to assure that we are leveraging capabilities across all three services, taking efficiencies where those are certainly available to make the best return on every taxpayer's dollar.

But in terms of how that translates into the facilities, if you look at how we have operated in the past, responsibilities have been given to the service, in executive agencies, for example, to perform particular functions. Some of those executive agencies have been migrated into the TRICARE Management Activity. Now, I won't say that is uniformly good or uniformly bad. However, those kinds of responsibilities have been migrated away from the services. And I think we need to examine very closely the activities that are resident within TMA and resident within the services.

My strategic construct is that TMA is absolutely essential in managing the DHP to make sure that we have the right tension and balance across competing resources; and in managing the managed care support contracts, to be sure that the direct care system is the centerpiece and that our private-sector care is leveraged toward that.

Mrs. DAVIS. Where do you see that discussion taking place? Are you saying that you don't think that you are able to have a strong enough voice, that all of you are able to have a strong enough voice in that discussion, and that decisions are made perhaps irregardless of some of those wishes?

General ROUDEBUSH. I think perhaps the latter. There are times that decisions are made that we don't have full visibility and/or perhaps the coordination or input that we might prefer in some of those discussions.

And I would certainly welcome comments from my colleagues relative to that particular aspect.

General SCHOOMAKER. I would have to agree. I mean, candidly, I think all too often a lack of complete unanimity opinion among the three services when it comes to allocation of resources or pro-

gramming resources translates into Health Affairs making a decision on their own. And that is an area where I don't think it is a function of structure per se; it is a function of allocating to us a certain authority to be complete partners in this process.

And it keeps coming back, for me, to this struggle that I have and my service has in developing a stable business platform for all of my hospitals, when many of our needs are relegated to unfunded requirements until the very late part of the fiscal year in the budget year. It is a tough way to run a business.

Admiral ROBINSON. I would have to agree with that. I think that I can give you—I can go down into the interstices of this, which I am not going to do because it would not be helpful, but I agree with both colleagues. I think that the Surgeons General need to have a say that is meaningful, and the services need to have a say that is meaningful.

The services do not run nor is the DHP their account. They are all three responsible for that DHP account. And, therefore, they need to have some visibility of how it is executed. And that is absolutely important. Often, that has not occurred, in my tenure as Surgeon General.

Mrs. DAVIS. Major General, could you comment? Is that by design? Or what gets in the way of that?

General GRANGER. Let me tell you what gets in the way, ma'am. I would concur with my colleagues. What we are dealing with is policy at the Health Affairs level. We are talking about execution at their level, oversight, Health Affairs, and then having a feedback loop on how we work in a very collaborative way. The lines are blurred in terms of what is policy, what is execution, and what is feedback. And we don't——

Mrs. DAVIS. Is it because of the reporting process? Is that part of it?

General GRANGER. In my opinion, it is because of the reporting process. It is not exactly what is what, because when you say HAVMA, that could be all of us or none of us. That is my understanding.

So you need to separate what is policy oversight, execution by the services, what is the oversight of how they execute that, and what is the feedback loop we all get to make sure we are fulfilling the needs of our men and women in our uniformed services.

Mrs. DAVIS. Ms. Embrey or Ms. McGinn, would you like to comment?

Ms. EMBREY. I would like to comment, yes. I think——

Mrs. DAVIS. And quickly. I am sorry, we just have a few minutes. You can write us more about that, too. Go ahead.

Ms. EMBREY. Okay. I will tell you more in writing.

[The information referred to can be found in the Appendix on page 103.]

Mrs. DAVIS. If you would rather do that.

Mr. Wilson, did you——

Ms. EMBREY. I thought you wanted me to stop.

Mrs. DAVIS. Mr. Wilson, did you have a question, briefly?

Mr. WILSON. One brief question, to conclude.

The Office of the Assistant—this is for our DOD officials here—the Office of the Assistant Secretary for Defense for Health Affairs

sets the policy for the MHS. The TRICARE Management Activity implements the policies of the MHS. However, the leadership of the two organizations are the same.

What would be the checks and balances in such an organization?

Ms. EMBREY. The checks and balances are a series of governing councils where we engage all of the principal leaders of the Department at various levels. Each person who is double-hatted has an integrating council, which involves representation from the service surgeons generals as well as the joint staff and the combatant commands when appropriate.

We engage with them on the issues and discuss how the current policies aren't working and how to implement new policies or programs, whether they are directed by Congress in law, whether report guidance, or whether or not it is the Administration itself who says we need do something differently.

When we have a change in direction, as many as we have had over the last six years, we have had to leverage those integrating councils to understand what the problem is, get a common vision on the way forward, and to get consensus on the way to approach solving the problem in near term. And that is the way we have approached that over time.

We did not have available resources to be able to hire new SESs in the TMA structure as well as the HA structure. And so we double-hatted many individuals to ensure that the form followed the function, that the policy understood what the problems were, set up the programs to do it, and then set up the program evaluation and quality assurance programs necessary to make sure that, when they were implemented and executed in the services, that they were accomplished in a way that they were intended.

So I believe it has been a collaborative process all along. And that is my personal opinion.

Ms. MCGINN. And if I could add a 10-second check and balance to that, you do have an Under Secretary of Defense for Personnel and Readiness who has responsibility to oversee the Assistant Secretary for Health Affairs and, I think, also to look at the issues brought forward by the stakeholders.

As I said, he or she chairs the Military Health System Executive Review. Issues can be brought to that review from the stakeholders and discussed in that forum.

So there is an oversight responsibility there, as well.

Mr. WILSON. Fine. Thank you.

Mrs. DAVIS. Thank you very much.

I think there is obviously some difference of opinion, and I think part of what we are interested in is trying to make certain that everybody does have an opportunity to express that. And we would certainly look forward to working with all of you as we try to, you know, sort all this out.

The bottom line, as we said, is the care of the men and women who serve our country and their families. And we want to be certain that we are doing this in the most efficient way, that looks at costs, looks at access and care, care in a larger fashion of how people feel valued within the system.

And so we appreciate all of your remarks today. This is the beginning of this conversation, in many ways. We intend to look further at it. And we certainly appreciate your concern.

Members have an opportunity to submit their questions for the record.

And we wish you the best today. Thank you.

[Whereupon, at 11:33 a.m., the subcommittee was adjourned.]

A P P E N D I X

April 29, 2009

PREPARED STATEMENTS SUBMITTED FOR THE RECORD

April 29, 2009

Opening Statement of Chairwoman Susan Davis
Hearing on the Military Health System: Health Affairs/TRICARE Management Activity Organization
April 29, 2009

"Today, the Military Personnel Subcommittee will hold a hearing on the organization of the office of the Assistant Secretary of Defense for Health Affairs.

"It is important to note that the office of the Assistant Secretary of Defense for Health Affairs has a unique organization within the Department of Defense. It is the only merger of an assistant secretary's office and a Defense Activity or Agency, in this case the TRICARE Management Activity.

"In every other instance we can find, a Defense Agency or Activity is a stand-alone entity, usually with a three-star or Senior Executive Service director, and a two-star/SES deputy or vice director. The agency or activity falls under an office within the Office of the Secretary of Defense and the director reports to an Office of the Secretary of Defense official, such as an Under Secretary, Assistant Secretary, or Deputy Under Secretary, but the two staffs are separate and distinct.

"In Health Affairs, however, the Assistant Secretary is also the Director of the TRICARE Management Activity. Each of the Health Affairs' Deputy Assistant Secretaries are also dual-hatted as the TRICARE Management Activity division chiefs. Finally, last year the Principal Deputy Assistant Secretary of Defense for Health Affairs was also designated as the Principal Deputy Director of the TRICARE Management Activity. This new position has no corollary in other Defense agencies or activities, and frankly its role has not yet been explained. As a result, the role of the two-star Deputy Director of the TRICARE Management Activity is no longer clear.

"In all of the other OSD offices that have a Defense Agency or Activity underneath them, the Under or Assistant Secretary's staff develops policy and provides oversight, while the agency or activity staff is responsible for executing that policy. This structure is the result of hard lessons-learned, with built-in checks and balances. In Health Affairs, one set of people is responsible for both sets of functions. In fact, few refer colloquially to either Health Affairs or the TRICARE Management Activity separately: they are simply known as 'Health Affairs/TRICARE Management Activity' or HA-TMA.

"So with HA-TMA, we are clearly dealing with a different model than the rest of the Department. We do not know if that is good-different, bad-different, or just different. It is therefore important for us to examine this structure so that we may understand exactly how the organization operates and how that impacts care for our men and women in uniform, their families, and our retirees.

"Our hearing will seek to answer the following questions:

• What is the current organizational structure of Health Affairs/TRICARE Management Activity?
• What are the current roles and responsibilities of HA-TMA?
• Is the current unique structure of HA-TMA appropriate to the roles and responsibilities of the office?
• What is the organizational relationship between HA-TMA and the services?
• Does the current HA-TMA organizational structure support the requirements of the services?
• Are there any plans to reorganize HA-TMA? If so, what would the new organization look like?
• How does the Department plan to deal with the Joint Medical Command Headquarters BRAC recommendation?

"For our witness panel, we have all of the key players from the Military Health System. First is the individual to whom Health Affairs reports, the Acting Under Secretary of Defense for Personnel and Readiness, Ms. Gail McGinn. Ms. McGinn has been the Acting Under Secretary for just a few weeks now. Next is the Acting Assistant Secretary of Defense for Health Affairs, Ms. Ellen Embry. This is actually Ms. Embry's first day as the Acting Assistant Secretary, so congratulations. I understand that you will be testifying this afternoon before our counterpart subcommittee in the Senate.

"We also have all of the service surgeons-general, Lieutenant General James Roudebush from the Air Force, Vice Admiral Adam Robinson from the Navy, and Lieutenant General Eric Schoomaker from the Army, to get the service perspective on the current HA/TMA organizational structure. Finally, we are fortunate to have the Deputy Director of the TRICARE Management Activity, Major General Granger. General, I understand that this is your last week as the Deputy Director, and that you will be retiring shortly after several decades in uniform. I would like to thank you for your service, and wish you well in your future endeavors."

Opening Statement of Ranking Member Joe Wilson
Hearing on the Military Health System: Health Affairs/TRICARE Management Activity Organization
April 29, 2009

"A robust military medical system is essential to the health and wellbeing of the armed forces. General George Washington and the Continental Congress understood the necessity of good medical care during the fight for our independence. After suffering a sizable number of casualties from disease, the Continental Congress established the Medical Department of the Army in July 1775. Washington then appointed the first Director General and Chief Physician of the Hospital of the Army.

"Since that time our military medical system has provided care for the sick and injured during times of war and maintained the medical readiness of service members in peacetime. America expects nothing less. With that being said, I want to make sure that the military health system is structured and organized to provide world class health care today and in the future.

"I am interested in hearing from our witnesses today how the military health system is organized to carry out its multiple health care missions of maintaining medical readiness capabilities, providing peacetime healthcare to eligible beneficiaries, providing battlefield medicine to our brave men and women in Iraq and Afghanistan in the Global War on Terrorism and caring for those brave men and women through the long recovery process when they become injured and wounded.

"Is there a better way to structure the system as we look to the future? Are there opportunities to build on initiatives such as the Joint Task Force-Capital Medicine that was established to implement the Base Realignment and Closure requirements in the National Capital Region?

"I look forward to hearing from the uniformed leadership with us today; how they view the organization and structure of the MHS and if it helps or hinders their ability to carry out their responsibility to provide medical care to all of our beneficiaries.

"Before I close I would like to recognize and congratulate Major General Elder Granger on his upcoming retirement from the Army. General Granger has served this nation and our service members with distinction for over 32 years. I sincerely thank you for your service and wish you the best in your future endeavors."

STATEMENT OF

MRS. GAIL MCGINN

PERFORMING THE DUTIES OF UNDER SECRETARY OF DEFENSE

FOR PERSONNEL AND READINESS

BEFORE THE

HOUSE ARMED SERVICES COMMITTEE

MILITARY PERSONNEL SUBCOMMITTEE

"THE MILITARY HEALTH SYSTEM: HEALTH AFFAIRS/TRICARE

MANAGEMENT ACTIVITY ORGANIZATION"

APRIL 29, 2009

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SUBCOMMITTEE ON MILITARY PERSONNEL

Madame Chairwoman, Members of the Subcommittee, thank you for the opportunity to be with you today to discuss the Military Health System organization. As you know, on September 11th, 2001 our world changed, driving changes to our requirements. As we work diligently to respond to new realities, the Department remains determinedly focused on the care, support and transition of wounded, ill and injured Service members. At the same time, we are also ever mindful of our obligations to provide the highest quality, most accessible, and cost effective health care services for all 9.4 million beneficiaries – those who serve today, and those who have served before. We have taken several steps in the last several years to regain the confidence of the American public and remain committed to earning that trust every day. In fulfilling its mission requirements, the Military Health System and its globally-engaged components are shaped by many internal and external factors, some of which I will touch upon in this testimony.

The Under Secretary of Defense (Personnel and Readiness) is a Principal Staff Assistant and advisor to the Secretary of Defense, to promulgate Department of Defense policies and assign responsibilities, functions, and authorities to execute those policies. The Under Secretary of Defense (Personnel and Readiness) reports directly to the Secretary of Defense, and is chartered with the following portfolio of responsibilities: Total Force management; National Guard and Reserve Component affairs; health affairs; readiness and training; military and civilian personnel requirements; language; dependents' education; equal opportunity; morale, welfare, recreation; and quality-of-life matters.

In carrying out responsibilities to develop policies, plans, and programs for Health Affairs, the Under Secretary of Defense (Personnel and Readiness) is charged to: provide and maintain readiness; provide health services and support to members of the Armed Forces during military operations; and provide health services and support to members of the Armed Forces, their dependents, and others entitled to or determined eligible for Department of Defense medical care.

The Under Secretary of Defense (Personnel and Readiness) also participates in planning, programming, and budgeting activities that relate to assigned areas of responsibility, serves on boards, committees, and other groups pertaining to assigned functional areas, and represents the Secretary of Defense on Personnel and Readiness. Two examples illustrate these responsibilities: (1) the Under Secretary of Defense (Personnel and Readiness) chairs the Military Health System Executive Review, the Department's senior healthcare advisory body comprised of the Service Assistant Secretaries (Manpower and Reserve Affairs), Service Vice Chiefs, Office of the Department of Defense Comptroller, Joint Staff Director, and Services Surgeons General; and (2) the Under Secretary of Defense (Personnel and Readiness) chairs the Congressionally-mandated Joint Medical Readiness Council.

In exercising authority, direction, and control over Health Affairs, the Under Secretary of Defense (Personnel and Readiness) ensures that policies and programs are designed and managed to improve standards of performance, economy, and efficiency, and these organizations are attentive and responsive to the requirements of their organizational customers, both internal and external to the Department of Defense.

Healthcare plays a key role in sustaining the all volunteer force. The Department must ensure consistent delivery of a quality healthcare benefit that is responsive to the needs of our population. The Department places great value on efforts to ensure an integrated framework for healthcare delivery within the Department – a framework that takes advantage of economies of scale in integrating the direct and purchased care components of the TRICARE program; ensures effective delivery of high quality clinical programs; and provides effective oversight of the Defense Health Program appropriation through a corporate process that engages senior Military Health System leadership under the direction of the Assistant Secretary of Defense (Health Affairs). In sum, our goal is to guarantee a predictable, reliable, robust, effective, superior quality, and readily accessible healthcare system for our beneficiary population. Our Military Health System is presently providing and must continue to provide benefits to remain in the future a vital recruitment, retention, and readiness tool. The issues identified in the testimonies for this hearing are not new and DoD leadership is aware of them. DoD is committed to constantly improving the organizational structure of the Military Health System and is aware

of various recommendations to improve internal communications, planning and coordination efforts. The input from all stakeholders is valued and is currently being reviewed.

The Assistant Secretary of Defense (Health Affairs) today also serves as the Director, TRICARE Management Activity. This structure enables the Assistant Secretary of Defense (Health Affairs) to effectively direct and manage the policy and program responsibilities for the Military Health System, to include enterprise support functions and corporate activities of the TRICARE Management Activity.

Within the Department, we continue to seek ways to organize most effectively, consistent with Congressional intent and law. In the last five years, Congress has enacted many new programs, directed BRAC implementation, and expanded our requirements to care for Wounded Warriors. At the same time, we have been asked to reduce healthcare costs while concurrently increasing our effectiveness in delivering these programs. We have undertaken administrative adaptations to improve unity of effort to address these emerging needs of the Department, and are devoted to responding to these requirements in a manner consistent with the intent of Congress.

To achieve more Jointness in the Department's medical activities, the Deputy Secretary of Defense issued a Program Decision Memorandum to develop plans to implement a Joint Medical Command by the 2008 Program Review. A task force was formed to frame options, but no consensus was achieved. In the alternative, during Fall 2006, the Under Secretary of Defense (Personnel and Readiness) and the Assistant Secretary of Defense (Health Affairs) developed a framework for achieving more Jointness and unity of effort, and after due consideration the Deputy Secretary of Defense approved this framework on November 27, 2006 ("Joint/Unified Medical Command Way Ahead" memorandum). The "Way Ahead" memorandum describes an incremental approach and achievable steps designed to yield efficiencies and economies of scale throughout the Military Health System, and some progress has been made.

In February 2009, the Assistant Secretary of Defense (Health Affairs) provided a second interim update in response to House Report 109-464, to accompany H.R. 5385. This update

described progress in implementing the tenets approved by the Deputy Secretary of Defense in this November 27, 2006 memorandum. Key points that were highlighted in this interim update included steps to streamlining governance processes; leverage efficiencies; standardize policy, training and doctrine for all our forces; rationalize span of control at both the tactical and strategic levels; and improve resource management, transparency and accountability. As noted in this interim response to Congress, some specific areas where the Department has made progress are:

- Joint Command for the National Capital Area: The Deputy Secretary of Defense established the Joint Task Force Capital Medical (JTF CapMed), which achieved full operating capability on September 30, 2008. The JTF CapMed is meeting BRAC milestones for the creation of the Walter Reed National Military Medical Center at Bethesda.

- Joint Approach for the Medical Education and Training Campus in San Antonio: Military Health System leadership has established the Flag Officer Steering Committee to provide oversight in planning. The goal in standing up the Joint Medical Education and Training Campus is to share among the Military Departments 90 percent of the enlisted curriculum in order to improve quality and consistency of training for all enlisted personnel, contributing to a culture of increased Jointness and interoperability.

- Joint Approach to Governance in San Antonio: In San Antonio, all governance decisions that affect the market are accomplished in a joint, collaborative manner. Brooke Army Medical Center and Wilford Hall Medical Center (Air Force) already have completed an inpatient business plan for the new San Antonio Military Medical Center and are currently reviewing their integrated manpower needs and synchronizing construction with their transition schedule.

- Co-location of medical headquarters with consolidation of common functions, operations, practices and cultures: At Congress' direction through the Base Realignment and Closure Act, the Department is proceeding with plans to collocate its medical headquarters activities. The collocation of the headquarters activities of Health Affairs, TRICARE Management

Activity, the Army Medical Command, Navy Bureau of Medicine and Air Force Medical Service will increase unity of effort in building Military Health System policy, strategy, and financial programming to yield greater consistency across the Services in program execution. We believe that collocation provides an opportunity to achieve consolidation of common headquarters functions and operations. Much work remains to be done in this regard.

Conclusion

Chairwoman Davis, the testimony you will receive from Health Affairs and the TRICARE Management Activity go into further detail on their roles and responsibilities. We will continue to improve to better serve the needs of America's military men and women and their families. In response to these events and the overall transformation of health care in the United States, the Military Health System leadership – both in the Office of the Secretary of Defense, the Military Departments, and the Joint Staff – is posturing itself for unity of effort. Thank you for your generous support of our wounded, ill and injured service members, veterans, and their families…the men and women served by our Military Health System. We look forward to your questions.

- END -

STATEMENT OF

MRS. ELLEN P. EMBREY

ACTING ASSISTANT SECRETARY OF DEFENSE

FOR HEALTH AFFAIRS

BEFORE THE

HOUSE ARMED SERVICES COMMITTEE

MILITARY PERSONNEL SUBCOMMITTEE

"THE MILITARY HEALTH SYSTEM: HEALTH AFFAIRS/TRICARE

MANAGEMENT ACTIVITY ORGANIZATION"

APRIL 29, 2009

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SUBCOMMITTEE ON MILITARY PERSONNEL

Madam Chairwoman, Members of the Committee, thank you for the opportunity to be here today to respond to your request for information and views about the Military Health System's organizational and governance structure.

Title 10, United States Code, defines the key leadership roles and responsibilities of the organizations that comprise the Military Health System. Most of those organizations and their leaders are present today. Ms. McGinn, Major General Granger and I represent the organizations within the Office of the Secretary of Defense.

When I arrived in the Office of the Assistant Secretary of Defense (Health Affairs) in January 2002, I was one of four Deputy Assistant Secretaries supporting the Assistant Secretary of Defense (Health Affairs), who in turn advised the Secretary of Defense and the Under Secretary of Defense for Personnel & Readiness. At that time, there was a clear division of roles and responsibilities between the Office of the Assistant Secretary of Defense (Health Affairs) and its supporting field activity, the TRICARE Management Activity. These structures were established in the late 1990s as an outcome of Defense Reform Initiatives, to control the rising cost of heath care services, improve access to care for the beneficiary population, and increase consistency and quality of care available across the Department—whether in military treatment facilities or through managed care contract providers. The initiative accommodated the Office of the Secretary of Defense personnel ceilings and realigned the majority of the former Health Affairs staff to a newly formed TRICARE Management Activity, which was also the successor to the series of field activities, including the Office of CHAMPUS.

The Office of the Assistant Secretary of Defense (Health Affairs) staff remains capped at a total of 42 military and civilian personnel, and its primary role and responsibility is to advise the Secretary of Defense on all health matters, and develop Department-wide policies and programs consistent with the Department's health care and medical readiness needs, including responsibility for central development, control and oversight of Defense Health Program resource planning, budgeting, and execution, and resource management of the $44 billion Military Health System.

The TRICARE Management Activity's primary role and responsibility is to execute defense-wide programs, services, and contracts to improve access, quality and consistency in Military Departments' execution of health care services to eligible service-members, their families, and retirees. Now a workforce of over 1,367 personnel that are assigned worldwide, TRICARE Management Activity provides services, support and assistance to the military treatment facilities to improve access and deliver the benefit.

The military departments' Surgeons General lead and manage organizations and facilities that develop, enhance and execute their military department's medical readiness, health care delivery, professional development, and research & development programs. This includes responsibility for taking on joint operating programs in a lead or executive agent role, such as the Armed Forces Blood Program Office, the Veterinary Corps, Military Vaccine Activity, and Vaccine Healthcare Centers Network. Within each military department, the Surgeon General has responsibility to manage medical treatment facilities consistent with national quality and accreditation standards and to ensure timely access to care for their beneficiary population.

Additionally, the Joint Staff and the geographic and functional Combatant Commanders have Command Surgeons that advise them on contingency operations health planning, patient movement and tracking, and theater health delivery services in geographic and functional commands around the globe.

Since the events of September 11, 2001, the Department has had to adapt to a series of new environmental drivers and expanded requirements:

- Increased national security threats around the globe and associated force health protection requirements, including reintroduction of the anthrax and smallpox vaccination programs
- Six years of continuous concurrent overseas contingency military operations in Iraq and Afghanistan;

- Ongoing mobilization of National Guard and Reserve component members
- Expanded health & dental care benefit programs for mobilized Reservists
- 95,000 military medical personnel deployed to support war-fighters
- New requirements to assess and track individual medical readiness
- Significant increases in support for deploying forces, e.g.:
  - Mandatory health assessments before, during, and twice after deployment
  - Substantial increases in demand for psychological health programs and services; requirements to establish the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury
  - Requirements to establish several other Centers of Excellence, such as the Vision, Hearing and Amputee Centers of Excellence
  - Research and treatments to address traumatic injuries associated with blasts, particularly brain injury
  - New requirements for wounded warrior rehabilitation and recovery care, including case management and care coordination services.
  - Requirements to establish a new theater trauma registry and electronic health system to collect and track theater health encounters; and
  - Development, testing, and implementation of common cognitive assessment tools for field and baseline assessments.

- Global stabilization and reconstruction operations in response to catastrophic natural disasters in Indonesia, Pakistan, Philippines, Mississippi, Louisiana and Texas
- Imminent threat of global pandemic (SARS and H5N1 influenza)
- Necessity for much greater coordination and collaboration with the Department of Veterans Affairs, Health & Human Services, and Homeland Security
- Promulgation of new international health regulations to address threats of bioterrorism

- Establishment of the Uniformed Services University of the Health Sciences Center for Humanitarian Assistance Medicine
- Implementation of new Base Realignment and Closure and Quadrennial Defense Review recommendations that called for consolidation, alignment of common functions, unity of effort
- Mandate for new Joint Capabilities Integrated Development System methodology to identify and prioritize joint war-fighting capabilities, which assigned Office of the Secretary of Defense Principal Staff Advisors as portfolio managers to accelerate development of joint capabilities
- Significant growth in biomedical research & development program to address gaps in science and technologies to support maximum restoration of function for wounded warriors
- Establishment of the new Africa Combatant Command, with global health mission to provide humanitarian assistance, establish public health infrastructure, assist allied countries in management of disease to win hearts and minds
- Growth of MHS costs from $20B in 2002 to $44B in 2009
- New strategic priorities established to optimize human performance, particularly physical and mental resilience
- Awarding and managing the second generation of multi-billion dollar TRICARE contracts which are key components for integrating the delivery of health care for our beneficiaries by the Military Health System.
- Initiating acquisition of the third generation of multi-billion TRICARE contracts which will be brought on-line in the near future.

An updated Charter for the Assistant Secretary of Defense (Health Affairs) was published in June 2008 to include many of the new responsibilities derived from the aforementioned environment factors and new or expanded mission requirements.

Roles and Responsibilities of Health Affairs and TRICARE Management Activity

Madam Chairwoman, indeed our world has changed dramatically in the last decade, as has the Department of Defense and its components. It is no surprise that Health Affairs and the TRICARE Management Activity have also evolved during this time period to meet the emerging requirements for leading the Military Health System. We take a collaborative leadership approach in developing, to the maximum extent possible, win-win solutions with Department and Line Senior Leaders, the Services' Surgeons General, the Joint Staff Surgeon, and Combatant Commanders and their Surgeons. The issues identified in the testimonies for this hearing are not new and DoD leadership is aware of them. DoD is committed to constantly improving the organizational structure of the Military Health System and is aware of various recommendations to improve internal communications, planning and coordination efforts. The input from all stakeholders is valued and is currently being reviewed. " I would like to briefly describe the roles and responsibilities of Health Affairs and the TRICARE Management Activity. The following summarizes key roles and responsibilities from Department of Defense Directive 5136.01, "Assistant Secretary of Defense (Health Affairs) – ASD(HA)," dated June 4, 2008:

The Assistant Secretary of Defense (Health Affairs) is the principal advisor to the Secretary of Defense and the Under Secretary of Defense (Personnel & Readiness) for all DoD health policies, programs, and force health protection activities. This includes:

- Ensuring the effective execution of the Department's medical mission,
- Providing and maintaining readiness for medical services and support to:
    - members of the Armed Forces including during military operations;
    - their dependents;
    - those held in the control of the Armed Forces; and
    - others entitled to or eligible for DoD medical care and benefits, including under the TRICARE Program.

In carrying out these responsibilities, the Assistant Secretary of Defense (Health Affairs) exercises authority, direction, and control over the DoD medical and dental personnel authorizations and policy, facilities, programs, funding, and other resources in the Department of Defense.

The Assistant Secretary of Defense (Health Affairs) is further charged to:

- Develop policies, conduct analyses, provide advice, and make recommendations to the Under Secretary of Defense (Personnel & Readiness) and the Secretary of Defense, and
- Issue guidance to the Department's components on matters pertaining to the Military Health System.

Such policies, procedures, and standards shall govern management of all Defense health and medical programs – clinical; research; medical materiel and logistics; medical infrastructure; human capital, to include medical special pays; medical education and training; patient rights, responsibilities, and privacy; quality assurance; health records; organ and tissue donation; veterinary services; health promotion; medical materiel; and the Armed Services Blood Program.

The Assistant Secretary also serves as the program manager for all Defense health and medical resources, and steers the Unified Medical Program through the planning, programming, budgeting, and execution process, to include representations before Congress. Other responsibilities include:

- Serving as principal advisor within the Department on Chemical, Biological, Radiological, and Nuclear (CBRN) medical defense programs;
- Serving as principal advisor within the Department on force health, including policy, readiness, and medical research.

The Assistant Secretary also establishes standards and procedures for mental health evaluations, combat stress control, and comprehensive health surveillance; and develops policies and standards to ensure effective and efficient results through the

approved joint process for joint medical capabilities integration, clinical standardization, and operational validation of all medical materiel.

In sum, the Assistant Secretary of Defense (Health Affairs) must ensure that they are attentive and responsive to the requirements of a wide variety of internal and external stakeholders. It is also important to note that the Assistant Secretary of Defense (Health Affairs) may not direct a change in the structure of the chain of command within a Military Department or with respect to medical personnel assigned to that command.

Department of Defense Directive 5136.12, establishes the roles and responsibilities of the TRICARE Management Activity.

Three mission requirements of the TRICARE Management Activity are: (1) manage TRICARE; (2) manage and execute the Defense Health Program (DHP) Appropriation and the DoD Unified Medical Program; and (3) support the Uniformed Services in implementation of the TRICARE Program and the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS).

The Deputy Director, TRICARE Management Activity (TMA) leads the accomplishment of these mission requirements in partnership with the Director, TMA and his key leadership staff.

Organization of Health Affairs and TRICARE Management Activity

In 2002, a weekly Senior Military Medical Advisory Council was established to consult with the Military Department's Surgeons General on a routine basis in governing change within the Military Health System. In addition, weekly Deputy Assistant Secretary of Defense-led integrating councils were established to ensure that policy changes necessary to adapt to new and expanded missions were accomplished with the fullest participation of the Surgeons General, their Deputies, and other Office of Secretary of Defense staff elements. Chartered workgroups appropriate to each of the

integrating councils were established to bring policy revisions, program changes, and new requirements to the councils to enable accelerated policy decisions.

In 2002, then Assistant Secretary of Defense (Health Affairs) Winkenwerder determined that he needed to leverage the Assistant Secretary's authority to ensure effective execution of the Department's medical mission...including the TRICARE program. Thus, Dr. Winkenwerder reorganized to ensure unambiguous alignment of policy and program execution strategies and stronger support to the Military Departments to accelerate required change. Specifically, he designated: 1) his position as both the Assistant Secretary of Defense (Health Affairs) and the Director, TRICARE Management Activity; 2) the Principal Deputy Assistant Secretary of Defense (Health Affairs) also as the Principal Deputy Director of TRICARE Management Activity; and 3) each Deputy Assistant Secretary of Defense as both policy and program developer in Health Affairs as well as a TRICARE Management Activity Functional Chief to manage execution of related support programs and services to the Military Departments. The dual-hatted Health Affairs/TRICARE Management Activity key senior leaders also reduced the requirement to recruit and appoint additional Senior Executive Service personnel to perform execution responsibilities in TRICARE Management Activity. These positions continue to perform in a dual-hatted status and, in my opinion, are the most efficient way to ensure that new policy and programs are supported and executed by the Military Departments in a timely manner. This execution role complements the Military Departments execution responsibilities as outlined in Title 10, US Code.

Today, Military Health System enterprise-wide deliberations follow the tenets of a March 2006 Assistant Secretary of Defense (Health Affairs) memorandum, "Policy on Military Health System Decision Making Process." The Military Departments' Surgeons General play a critical role in this oversight process. Health Affairs, TRICARE Management Activity, and the Services' Surgeons General and their staffs engage from the action officer level to the level of the principals.

The Military Health System is governed through ongoing collaboration, consensus, and compromise. We achieve this through a governance structure which engages key stakeholders on a weekly basis, including determining outcome performance measures for which we will be held accountable. This process provides a framework to achieve agreement and approval on what is in the best interest of the Military Health System. The process also provides a weekly venue in which all voices are heard.

A critical part of this framework is the use of integrating councils. Each Deputy Assistant Secretary of Defense (DASD) for Health Affairs chairs an integrating council to ensure functional integration of complex issues. Each week, at the action officer level (typically O6-Colonel-Captain level), functional steering groups work through key decision issues in areas such as clinical policy, force health protection and readiness, health plan operations, and financial management. Decision recommendations roll-up to the two-star Deputy Surgeon General level in integrating councils. Finally, each week the Senior Military Medical Advisory Council – chaired by the Assistant Secretary of Defense (Health Affairs) and including the Services' Surgeons General and the DASDs – meet to review informational and decision briefings. Four-star level Senior Military Department officials and line leaders are also formally engaged in the decision-making process through the Military Health System Executive Review.

Beyond these formal and institutionalized informational and decision forums, informal communication, collaboration, and coordination occur at all levels nearly daily among Health Affairs, TRICARE Management Activity, and the Services – from action officers to the most senior officials. Our decisions impact the Department's Unified Medical Program, which represents nearly 8 percent…and growing…of the Department's topline budget, affecting:

- Full continuum of care services for every member of our Nation's military, their families, our wounded warriors, our retirees and their families
- Clinical and force health protection and readiness programs and policies
- Health benefit delivery programs, services and contracts
- Our infrastructure (physical facilities)

- Resource management across the enterprise– fiscal and human capital management
- Information technologies and related patient information

Although there are no current plans for any significant reorganization of Health Affairs and the TRICARE Management Activity, we are considering some minor adjustments of personnel reporting relationships – notably, to appropriately align personnel performing the functions of the Principal Deputy's portfolio under the Principal Deputy's supervisory chain within the TRICARE Management Activity.

Finally, BRAC has directed a co-located medical headquarters in the National Capital Area (affecting Health Affairs, TRICARE Management Activity, and Services' Surgeons General staffs). In Fall 2008, an "Implementation Team" was formed to bring this requirement from concept to fruition. The Deputy Director, TRICARE Management Activity currently chairs this team, and the Services' Deputy Surgeons General are members. The team will focus on issues such as space and force protection requirements, as well as explore alternative frameworks for sharing common services in the new headquarters location. I believe this co-location initiative offers significant opportunities to achieve unity of effort.

Conclusion

Madam Chairwoman, the Military Health System is the largest, most dynamically complex health care organization in the world. Each individual component – Health Affairs, TRICARE Management Activity, the Military Departments' Surgeons General and their respective medical departments and services, the Joint Staff Surgeon, and the Combatant Command Surgeons – deserves great credit for what we have accomplished collectively in this ever changing environment. Together we have significantly improved the efficiency and effectiveness of the Military Health System, under extraordinary circumstances, and with your help and support, we will remain committed to better serving the needs of America's military men and women and their families.

I look forward to answering your questions.

- END -

UNCLASSIFIED

FINAL VERSION

STATEMENT BY

LIEUTENANT GENERAL ERIC B. SCHOOMAKER, MD, PhD
THE SURGEON GENERAL OF THE UNITED STATES ARMY
AND COMMANDER, US ARMY MEDICAL COMMAND

COMMITTEE ON ARMED SERVICES

SUBCOMMITTEE ON MILITARY PERSONNEL

UNITED STATES HOUSE OF REPRESENTATIVES

FIRST SESSION, 111TH CONGRESS

THE MILITARY HEALTH SYSTEM: HEALTH AFFAIRS/TRICARE
MANAGEMENT ACTIVITY ORGANIZATION

29 APR 2009

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COMMITTEE ON ARMED SERVICES

Chairwoman Davis, Representative Wilson, and distinguished Members of the Military Personnel Subcommittee, thank you for the opportunity to discuss the organization of the Military Health System (MHS). First, I would like to publicly thank the Honorable S. Ward Casscells for his years of principled, passionate service as Assistant Secretary of Defense for Health Affairs. Dr. Casscells is a friend and mentor whom I greatly respect. His compassion and commitment to service members and families is unparalleled. He is one of my heroes, and I do not say that lightly. His team at Health Affairs (HA) and the TRICARE Management Activity (TMA) are hard-working, dedicated individuals. I salute their service to the Nation.

As the Army Surgeon General and Commander of the Army Medical Command (MEDCOM), I am very focused on my Title 10 responsibilities to support the Secretary of the Army and the Chief of Staff of the Army. The structure of the MHS is critical to the Army's ability to execute our mission effectively. The mission of Army Medicine is to:

- Promote, Sustain and Enhance Soldier Health
- Train, Develop and Equip a Medical Force that Supports Full Spectrum Operations
- Deliver Leading Edge Health Services to Our Warriors and Military Family to Optimize Outcomes

A structure that places execution within the Services and oversight within Health Affairs has served us well for many years. It is essential to the success of the Service Medical Departments and the MHS that HA work with the military Services to establish a strategic vision and direction for military medicine; ensure the viability of a robust direct care system; advocate for healthcare programs within the Department of Defense (DoD); serve as a policy developer and integrator across the Services; and operate in a transparent, open manner. In this structure, the Service Medical Departments must be given latitude to achieve their missions within the context of their Service identity and culture. It

is a delicate balance between Service autonomy and Departmental standardization and control. This balance is most easily achieved by ensuring that the Services remain the operational arm, while HA remains focused on policy and strategy.

Health Affairs currently operates a field activity—the TRICARE Management Activity (TMA)—and has other direct reporting organizations, such as the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury. Recently, HA and TMA have begun assuming more control of operational activities at some risk to their strategic role. The Army Medical Department, acting on behalf of the Secretary of the Army, once exercised DoD Executive Agent responsibilities, functions, and authorities for 33 organizations. While some of these organizations have been absorbed into the US Army Medical Command, a number of them have become part of the HA/TMA organizational structure. As HA becomes more involved in maintaining operational control over an increasing array of subordinate operating activities, it appears to have become an increasing challenge for them to maintain focus on their strategic development and broad policy responsibilities. HA leaders operating in the execution lane are sometimes forced to compete alongside the Services for resources and appropriate attention. Many senior leaders of HA are dual-hatted as TMA leaders. This leads to the perception that TMA is an unequal stakeholder in the MHS, outweighing the influence of the Services, who have only their own vote. I am concerned that the role of the Services is diminished in many MHS forums because TMA is perceived as "first among equals."

In short, the Services are executors of broad policy guidelines for Force Health Protection and the provision of healthcare services—we perform service-specific mission analysis of these broad guidelines; issue Army-, Navy-, and Air Force-specific orders; we execute these orders; we execute programs, and we execute the delivery of the health benefit. Health Affairs is best suited as a policy-making organization, providing oversight, leadership, and policy integration

to the Service Medical Departments and the TMA. Heath Affairs has been increasingly assuming roles and responsibilities that are more suited to the operational or execution level. I am concerned that this trend will obscure and minimize service-specific challenges in achieving desired clinical and programmatic outcomes and threaten the viability of the direct care system.

The Service Medical Departments interact daily with HA and our sister Services on committees and fora that allow us to discuss mutual areas of concern, share best practices, and move the MHS forward. One example is the Clinical Proponency Steering Committee, which provides a forum for best practices in the clinical arena. It is through this body that the Army presented findings and recommendations that led to the development of a comprehensive policy related to malaria prophylaxis.

In my opinion, HA is well-suited to its policy integrator role and should capitalize on this important role. Similarly, HA is well-suited to its strategic development role. Dr. Casscells and his leadership team recently reached out to the Services to request participation in the development of an MHS strategy, and I look forward to continuing our work with HA to build and communicate a clear, transparent, and understandable way ahead for the MHS.

In January of this year, Dr. Casscells solicited input from the Service Surgeons General regarding the year ahead for the MHS. I highlighted several areas where I felt that HA was best situated to assist the Services. Two of these topics have already been the subject of congressional hearings before this subcommittee.

1. Access to Care - As the individual accountable for the delivery of healthcare services for all components of the Army and DoD beneficiaries served by Army military treatment facilities (MTFs), access to care is my number one priority in the MEDCOM. Our patients are frustrated with not being able to see us in a timely and hassle-free manner. We must maximize the capacity of our installation MTFs and enroll beneficiaries to that capacity. Enrollment must be in balance with MTF capacity and is the foundation for meeting access to care standards. In addition to proper enrollment, I intend to improve access through

increased provider availability and beneficiary knowledge on how to obtain access. We will work to reduce friction at key access points, such as phone service, online appointments, and follow-up appointments. Additionally, we will relook clinic schedule management, improve accounting for all patients requiring access to primary care, and leverage the civilian network and technology. All of these efforts will be under command oversight, and will ultimately increase provider team continuity, decrease inappropriate utilization, simplify the appointment process, and improve communication through the use of the Electronic Health Record (EHR).

The Services control our part of the healthcare delivery system, but we do not control the TRICARE network. The TRICARE network exists to support and supplement the direct care system, not to compete against it. A robust and integrated TRICARE network is a requirement throughout the MHS; there is not a single Army MTF that provides all clinical services. This is so important that I have reorganized the MEDCOMs regional medical commands to be aligned with TRICARE Regional Offices and regions. This is intended to promote a more seamless delivery of care within these regions. TMA's oversight of the 3 regional contractors is crucial. The goal is for the care received, whether from the MTF or from the network, to be seamless. TMA and the TRICARE network must be responsive to the needs of the local MTF commander who is charged with overall responsibility for ensuring patients obtain the right care, at the right time, in the right venue. A collaborative approach led by HA in support of the direct care system can significantly improve access to care.

2. Leverage Information Technology (IT) - Crucial to the long-term sustainment of military medicine is the development and propagation of IT systems that support both clinical and business activities across the three services. For reasons of effectiveness and efficiency, HA needs to deliver IT systems to the Services so we can perform our mission. The creation of secure, integrated, dynamic IT systems will allow the MHS to operate in a more tri-service manner to leverage other federal agencies and tap into leading edge academic practices and research, which is necessary to improve overall MHS

performance, minimize IT costs, and reduce duplication of effort. This is the development of a "knowledge network"—the future of health improvement and healthcare delivery. HA's process for defining, funding, and altering IT system requirements should emphasize flexibility and responsiveness in responding to the Services' evolving needs. We must leverage technology to incorporate best practices from the public and private sectors with respect to health care purchasing, as well as managing the business of health care. We must provide timely, secure, standard, transparent, adaptable, affordable systems and processes that, in coordination with other elements, enable performance improvement, ensure healthy outcomes, and identify best practices across the MHS.

3. Electronic Health Record (EHR) - As discussed before this subcommittee last month, the MHS has been talking about creating a comprehensive EHR for a decade and poured a tremendous amount of money into it. We all recognize the vital and transformative role of an effective EHR in enabling our move into 21st Century military medicine. The MHS has made strategic progress toward this end, but our providers continue to be frustrated by the slow and cumbersome process of improving the system and making it easier to use at the provider-patient interface. HA's leadership and sustained effort is critical to turn our vision of an EHR into reality. But here again, HA's operational focus has self-admittedly distracted it from focusing on an overarching strategic plan. Our EHR should be compatible with the Department of Veterans Affairs and have an open-enough system architecture to be compatible with our network providers. The treatment received from the network needs to be incorporated into our EHR, and we need to improve our system for providing documentation to off-post providers when we see their patients in our MTFs. We need to establish firm goals, milestones, and penalties for the contractors we have hired to develop this system for us, and we need to hold them accountable. A comprehensive, globally available EHR will have a very strong impact on the practice of evidence-based medicine and assist tremendously with improving continuity of care by

improving the information flow between the various providers and facilities where our beneficiaries receive care.

4. Human Capital Management Strategy - We need to leverage Health Affairs to lead a dialogue with the Services and the Office of Personnel Management in order to assist us in developing a strategy that enables us to unify and streamline recruitment and retention across all specialties and skill sets. We must implement a "lifecycle management" approach to our human capital, to include all corps of each Service, all skill sets, and civilians. In order to compete with the civilian sector, each Service needs to be able to run our own bonus and compensation structure and tailor our own programs in order to compete for quality people in each of our unique environments and market places. Having a one-size-fits-each-Service policy is too constrictive and does not help.

5. Medical Military Construction (MILCON) - We are halfway through the greatest medical infrastructure reset in our lifetimes, and this is a great opportunity to set the medical infrastructure conditions for the next two generations of Soldiers. We must be successful and this must remain a key focus for us. HA has played a visionary and courageous role in this effort. We need a comprehensive and strongly supported approach from DoD to protect us from the danger of short-term thinking about the long-term medical MILCON needs. HA can help us garner and prioritize MILCON resources and/or funding to create a medical infrastructure that meets the demands of our beneficiary population. HA should facilitate an integrated MILCON infrastructure to support "centers of care" in geographical locations to meet increased health care demands and ensure the efficient use of resources.

6. Joint Governance - If we are to have integrated service medical platforms (like the San Antonio Military Medical Community, the Military Education and Training Center, Joint Task Force CAPMED, and the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury), we need to have a way to connect those platforms across the Services to policy and strategic leadership levels. We need to re-establish roles and clarify missions.

Draw the lines in bold colors among the Services, TMA, and HA. Currently, within the MHS, each of the three Services and HA/TMA engage tactical challenges parochially. Too often, we avoid true strategic engagement which compromises trust and has a suboptimal effect on ensuring the desired outcomes. There is no standardized approach or roadmap on how to establish joint governance, and each area is being handled differently. Nonetheless, the Services have come together as partners and we are making progress toward integrated operations while still maintaining Service identity.

Collaborating and sharing resources across the joint services makes absolute sense, but we must establish a methodology to ease the transition without sacrificing our Title 10 responsibilities. Command and Control, establishing an approved joint manning document to assign personnel to joint organizations, and ensuring the leadership of joint organizations represent the interests of all the Services are issues that we need to address at the HA level.

7. Standardized Approach to Preventive Medicine and Force Health Protection (FHP) - We must make the shift to a Preventive/Health Promotion Model, rather than continuing to provide reactive medical care with uncontrolled demand. This takes adequate resourcing, education of our staff and our beneficiaries, superb information systems, comprehensive population health surveillance, and well-documented care. While strategically engaged with prevention and FHP measures, we cannot lessen or dilute the attention given to evidence-based practices and science-driven improvements in interventional care directed at optimal clinical outcomes. Again, standardization of clinical practices, shared metrics for measuring success across the Services, and an optimal EHR system are needed to make this happen. Acknowledging the importance of this shift, the MEDCOM is reorganizing to establish a Public Health Command which attends to comprehensive force health protection.

8. MHS Strategic Objective - The MHS has dramatically improved the identification and dissemination of system-wide performance expectations. What is now needed is further refinement of these objectives by providing more specificity in terms of what constitutes overall MHS system success and how

each Service can contribute in the form of actionable, leading metrics. We must maintain the proper balance between measures of process as lead indicators and outcome measures as lag indicators. We must establish metrics that measure whether a management strategy produces the desired outcomes. These metrics should address both clinical and administrative performance.

Health Affairs and TMA can help us by embracing a strategic intent that reflects what the MHS wants to achieve in the long term, as well as providing a sense of direction, discovery, and opportunity that can be communicated across the MHS to all employees. There is no more fertile time for this to occur than at this point in the Nation's examination of its healthcare delivery. HA's strategic intent should focus less on today's problems and more on tomorrow's opportunities. HA must develop policies and enabling systems which permit the Services to translate the MHS strategy into action.

Unfortunately, none of these issues is easy—they are all complex, inter-related problems that require thoughtful, collaborative, and sustained effort from all stakeholders in the MHS. Despite the difficulty and complexity of the challenge, I firmly believe that the MHS has the talent, the capability, and the commitment to achieve this vision, set a high standard for healthcare in the United States, and serve to inform the broader healthcare reform dialogue.

I would like to thank the Military Personnel Subcommittee for valuing the role of military medicine and the vital importance of robust direct care systems and for supporting our continuing efforts to improve. Health Affairs plays a critical role in the success of the Service Medical Departments. By focusing on its roles of policy development and strategic leadership, and by operating in an open and transparent manner, Health Affairs can continue to add tremendous value to the MHS and, most importantly, meet the healthcare needs of the finest beneficiaries in the world—the men and women of the US military.

**Not for Publication until released by
the House Armed Services Committee**

Statement of

Vice Admiral Adam M. Robinson, USN, MC

Surgeon General of the Navy

Before the

Subcommittee on Military Personnel

of the

House Armed Services Committee

Subject:

**The Military Health System:
Health Affairs/TRICARE Management Activity Organization**

April 29, 2009

**Not for Publication until released by
the House Armed Services Committee**

Chairwoman Davis, Ranking Member Wilson, distinguished members of the committee; I am grateful to have the opportunity to share Navy Medicine's opinion about the current organization of the Office of the Secretary of Defense for Health Affairs (OSD (HA)) and the Tricare Management Activity (TMA) Organization, and suggest some changes that will serve to benefit the delivery of healthcare to all whom we are honored to serve.

Navy Medicine continues on course, because our focus has been, and will always be, providing the best healthcare for our Sailors, Marines, and their family members. We are focused on strengthening Navy Medicine today, and at the same time we are proactively planning to meet future healthcare requirements. We are enhancing our strategic ability, operational reach, and tactical flexibility. We are the only medical department who meets the needs of two distinct departments and operational missions – our sailors and Marines. As Marine Corps forces shift their efforts to Afghanistan, Navy Medicine will be there providing the highest quality combat medical support.

In recent weeks, the subcommittee heard from Health Affairs, TMA, the Department of Defense, and the Services. You have heard how medical military construction projects are being funded under a new model that prioritizes facilities across the Military Health System (MHS). You have also heard how health information technology enterprise-wide solutions across the MHS are having a positive impact on the quality of the care we provide. There is no question that centralized decision-making has benefits in certain areas. The discussion now is on which areas and how those decisions are made.

Much has been accomplished between Navy Medicine and the MHS, yet exigencies within the current environment require us to reexamine these organizations and the working relationships responsible for providing healthcare for wounded service members and their families. We must provide this health care to our beneficiaries and at the same time ensure American taxpayers we are responsible and accountable. It is a fact – growing resource constraints call us to operate more efficiently without compromising healthcare quality and workload goals.

Throughout my over 30-year career in Navy Medicine, I have served as the acting Deputy Assistant Secretary of Defense at Health Affairs for Clinical and Program Policy, the commanding officer of a Military Treatment Facility (MTF) overseas and as the commanding officer of National Naval Medical Center in Bethesda, as well as Surgeon General. These experiences have shaped my position on the Navy Medical Department's relationship with OSD (HA) and TMA. Given that background, I am increasingly concerned that the lines between policy and execution have become blurred and may be compromising the effectiveness of this combined healthcare organization. The issues identified in the testimonies for this hearing are not new, and DoD leadership is aware of them. DoD is committed to constantly improving the organizational structure of the Military Health System, and is aware of various recommendations to improve internal communications, planning, and coordination efforts. The input from all stakeholders is valued and is currently being reviewed.

The Assistant Secretary of Defense for Health Affairs (ASD (HA)) serves as the principal advisor to the Secretary of Defense for all Department of Defense (DoD) health policies programs, and activities. The TMA organization -- under the direction of that

same ASD (HA) -- is responsible for providing the Services and the Services' medical departments with program direction for the execution of policy within the MHS as it relates to delivery of the benefit.

The Deputy Assistant Secretaries serve a dual role – in developing policy at HA and in executing that policy at TMA. Having one controlling authority over MHS policy and execution means checks and balances can be compromised. These conflicting roles create challenges for the Services, since they blur execution decisions that then become policy decisions that may compromise care to our operational forces and beneficiaries. The need to balance delivery of the benefit with support of operational forces can be lost when the majority of the funding is controlled by HA/TMA. This structure also further divides the delivery of the benefit into two parts: in-house and network care. What should be a collaborative process often times becomes a competitive one. In addition, by overseeing policy and execution, long term planning and discussion designed to meet the specific needs of individual services may not properly occur.

HA/TMA's oversight of the network assets available through the Tricare Managed Care Support Contracts limits Navy Medicine from leveraging those network providers at their disposal. Navy Medicine supports a regionalized governance plan with a Flag Officer/General Officer providing oversight for direct and purchased care services, i.e., controlling the network assets. Each of the Services would lead one region, a model similar to what is currently in place with the leadership of the Tricare Regional Offices. This model provides the tools at the regional level to integrate direct and private sector care with the goal of optimizing care within the MTF. Also, the ability to use network

providers within MTFs may decrease the reliance of MTFs on contract support brought in to fill vacancies created by operational requirements.

The advisory role the Services currently play in the policy-making process limits their ability to effectively impact the process. This limited role results in concerns and/or challenges not always being addressed when the final policy is disseminated. The Services must play a more active and influential role in the process. It is difficult for the Services to have the responsibility to execute a policy, and to be held accountable for said execution, without the ability to affect and/or influence the process.

As the provider for two military services, I am acutely aware of what I need to do to address the differences in mission and culture. HA/TMA may not take those unique characteristics into consideration.

Chairwoman Davis, I am proud to say that Navy Medicine is built on a solid foundation of proud traditions and a remarkable legacy of Force Health Protection. We are committed to preparing healthy and fit Sailors and Marines to protect our nation and be ready to deploy. Our Navy Medicine teams are flexible enough to perform a Global War on Terror mission, a homeland security mission, a humanitarian assistance mission, and a disaster relief mission; while at the same time provide direct health care to our nation's heroes and their family members at home and overseas…as well as our cherished retirees. We could not accomplish our diverse missions on our own so our relationship with HA and TMA is critical to our success. I hope my testimony provides you with examples of how strengthening the relationship between HA, TMA and Navy Medicine through increased cooperation directly benefits our Sailors, Marines and their families.

DEPARTMENT OF THE AIR FORCE

PRESENTATION TO THE COMMITTEE ON ARMED SERVICES

SUBCOMMITTEE ON MILITARY PERSONNEL

UNITED STATES HOUSE OF REPRESENTATIVES

SUBJECT: The Military Health System: Health Affairs/TRICARE Management Activity Organization

STATEMENT OF: Lieutenant General (Dr.) James G. Roudebush
Air Force Surgeon General

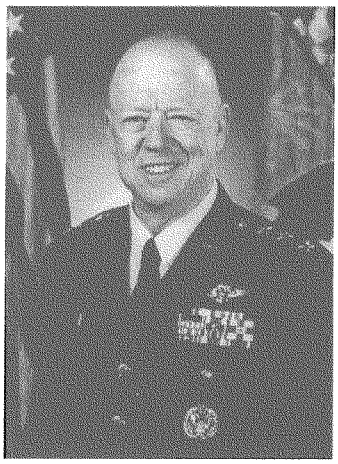
April 29, 2009

NOT FOR PUBLICATION UNTIL RELEASED
BY THE COMMITTEE ON ARMED SERVICES
UNITED STATES HOUSE OF REPRESENTATIVES

BIOGRAPHY

UNITED STATES AIR FORCE

LIEUTENANT GENERAL (DR.) JAMES G. ROUDEBUSH



Lt. Gen. (Dr.) James G. Roudebush is the Surgeon General of the Air Force, Headquarters U.S. Air Force, Washington, D.C. General Roudebush serves as functional manager of the U.S. Air Force Medical Service. In this capacity, he advises the Secretary of the Air Force and Air Force Chief of Staff, as well as the Assistant Secretary of Defense for Health Affairs on matters pertaining to the medical aspects of the air expeditionary force and the health of Air Force people. General Roudebush has authority to commit resources worldwide for the Air Force Medical Service, to make decisions affecting the delivery of medical services, and to develop plans, programs and procedures to support worldwide medical service missions. He exercises direction, guidance and technical management of more than 43,100 people assigned to 75 medical facilities worldwide.

The general entered the Air Force in 1975 after receiving a Bachelor of Medicine degree from the University of Nebraska at Lincoln, and a Doctor of Medicine degree from the University of Nebraska College of Medicine. He completed residency training in family practice at the Wright-Patterson Air Force Medical Center, Ohio, in 1978, and aerospace medicine at Brooks Air Force Base, Texas, in 1984. The general commanded a wing clinic and wing hospital before becoming Deputy Commander of the Air Force Materiel Command Human Systems Center. He has served as Command Surgeon for U.S. Central Command, Pacific Air Forces, U.S. Transportation Command and Headquarters Air Mobility Command. Prior to his selection as the 19th Surgeon General, he served as the Deputy Surgeon General of the U.S. Air Force.

EDUCATION

1971 Bachelor of Medicine degree, University of Nebraska at Lincoln
1975 Doctor of Medicine degree, University of Nebraska College of Medicine
1978 Residency training in family practice, Wright-Patterson USAF Medical Center, Wright-Patterson AFB, Ohio
1980 Aerospace Medicine Primary Course, Brooks AFB, Texas
1981 Tri-Service Combat Casualty Care Course, Fort Sam Houston, Texas
1983 Master's degree in public health, University of Texas School of Public Health, San Antonio
1984 Residency in aerospace medicine, Brooks AFB, Texas
1988 Air War College, by seminar

1978 Residency training in family practice, Wright-Patterson USAF Medical Center, Wright-Patterson AFB, Ohio
1980 Aerospace Medicine Primary Course, Brooks AFB, Texas
1981 Tri-Service Combat Casualty Care Course, Fort Sam Houston, Texas
1983 Master's degree in public health, University of Texas School of Public Health, San Antonio
1984 Residency in aerospace medicine, Brooks AFB, Texas
1988 Air War College, by seminar
1989 Institute for Federal Health Care Executives, George Washington University, Washington, D.C.
1992 National War College, Fort Lesley J. McNair, Washington, D.C.
1993 Executive Management Course, Defense Systems Management College, Fort Belvoir, Va.

ASSIGNMENTS
1. July 1975 - July 1978, resident in family practice, Wright-Patterson USAF Medical Center, Wright-Patterson AFB, Ohio
2. July 1978 - September 1982, physician in family practice and flight surgeon, USAF Hospital, Francis E. Warren AFB, Wyo.
3. October 1982 - July 1984, resident in aerospace medicine, USAF School of Aerospace Medicine, Brooks AFB, Texas
4. August 1984 - September 1986, Chief of Aerospace Medicine, 81st Tactical Fighter Wing, Royal Air Force Bentwaters, England
5. September 1986 - July 1988, Commander, USAF Clinic, 81st Tactical Fighter Wing, Royal Air Force Bentwaters, England
6. August 1988 - June 1991, Commander, 36th Tactical Fighter Wing Hospital, Bitburg Air Base, Germany
7. August 1991 - July 1992, student, National War College, Fort Lesley J. McNair, Washington, D.C.
8. August 1992 - March 1994, Vice Commander, Human Systems Center, Brooks AFB, Texas
9. March 1994 - January 1997, Command Surgeon, U.S. Central Command, MacDill AFB, Fla.
10. February 1997 - June 1998, Command Surgeon, Pacific Air Forces, Hickam AFB, Hawaii
11. July 1998 - July 2000, Commander, 89th Medical Group, Andrews AFB, Md.
12. July 2000 - June 2001, Command Surgeon, U.S. Transportation Command and Headquarters Air Mobility Command, Scott AFB, Ill.
13. July 2001 - July 2006, Deputy Surgeon General, Headquarters U.S. Air Force, Bolling AFB, Washington, D.C.
14. August 2006 - present, Surgeon General, Headquarters U.S. Air Force, Washington, D.C.

FLIGHT INFORMATION
Rating: Chief flight surgeon
Flight hours: More than 1,100
Aircraft flown: C-5, C-9, C-21, C-130, EC-135, F-15, F-16, H-53, KC-135, KC-10, T-37, T-38, UH-1 and UH-60

BADGES
Chief Physician Badge
Chief Flight Surgeon Badge

MAJOR AWARDS AND DECORATIONS
Distinguished Service Medal
Defense Superior Service Medal with oak leaf cluster
Legion of Merit with oak leaf cluster
Meritorious Service Medal with two oak leaf clusters
Air Force Commendation Medal
Joint Meritorious Unit Award
Air Force Outstanding Unit Award with oak leaf cluster
National Defense Service Medal with bronze star
Southwest Asia Service Medal with bronze star
Air Force Overseas Long Tour Ribbon with oak leaf cluster

Air Force Longevity Service Award with silver oak leaf cluster
Small Arms Expert Marksmanship Ribbon
Air Force Training Ribbon

PROFESSIONAL MEMBERSHIPS AND ASSOCIATIONS
Society of USAF Flight Surgeons
Aerospace Medical Association
International Association of Military Flight Surgeon Pilots
Association of Military Surgeons of the United States
Air Force Association
American Medical Association

EFFECTIVE DATES OF PROMOTION
Second Lieutenant May 15, 1972
First Lieutenant May 15, 1974
Captain May 15, 1975
Major Dec. 8, 1979
Lieutenant Colonel Dec. 8, 1985
Colonel Jan. 31, 1991
Brigadier General July 1, 1998
Major General May 24, 2001
Lieutenant General Aug. 4, 2006

(Current as of May 2008)

Chairwoman Davis, Representative Wilson, and esteemed members of the Committee, thank you for inviting me here today to discuss the organizational structure of OSD Health Affairs (HA) and the TRICARE Management Activity (TMA). This is an important issue that should be jointly addressed by OSD and the Service Surgeons General, as the stakes for our beneficiaries are very high. I carefully considered the issues you identified and will seek to address them in my testimony.

In reviewing whether the HA/TMA structure is appropriate to the roles and responsibilities of the office, we identified what we view as strengths and weaknesses. The current structure of HA is generally conducive to its role in developing policies, crafting strategic plans, aligning financial plans, and integrating Military Health System (MHS) functions to create synergistic effects. Of concern is the growth in HA and DASD "dual hat" responsibilities to include oversight of selected execution activities within TMA. Also of concern, TMA has broadened beyond its traditional role of MCSC oversight and DHP budget execution to include oversight of MTF-level financial and business plan execution as well as aspects of readiness (Service Title X responsibilities). Within this broad portfolio, TMA has significant challenges in executing health plan management and managing growth in Private Sector Care (PSC) cost. Although TRICARE benefit expansion and Operations ENDURING FREEDOM and IRAQI FREEDOM can be cited as contributing to rising costs, private sector care costs have grown rapidly over the last 13 years. The amount of care delivered in the private sector, as highlighted in the Task Force on the Future of Military Health Care Final Report (December 2007), is substantial. "In 1996, the DoD obligation for medical service contracts was $1.6 billion, and by 2005 this obligation had increased to $8 billion—a 412 percent increase."

As of Fiscal Year (FY) 2007, total PSC costs were $11.4 billion. According to 2009 Defense Health Program Private Sector Care Trend data, actual costs for PSC in FY 2008 increased to $12.3 billion, and the projected requirement for FY 2009 is $14.2 billion. Despite significant PSC cost growth, TMA remained focused on Military Treatment Facility (MTF) oversight. As previously noted, TMA provided extensive oversight of MTF level performance by financial and business execution tracking to enhance efficiency, which duplicates Service Medical Department's Title 10 responsibility. We believe the MHS would be better served by TMA efforts focused on control of PSC costs and augmenting the direct care system where possible.

During the past few years, TMA's staff in the National Capitol Region grew from 360 (does not include contract staff—data unavailable per TMA) in 2000 to 1,430 in 2009 which includes 861 contractors. Beyond the 1,430 staff working in Washington, D.C., TMA also employs 206 staff (does not include contract staff—data unavailable per TMA) at four TRICARE Regional Offices (TRO). Although part of the TMA staff growth can be attributed to new program responsibilities (i.e. TROs, Joint Medical Information Systems Office, Military Medical Support Office), and a percentage of the PSC growth can be attributed to an expansion of legislated TRICARE benefits, the continued PSC cost escalation remains a significant concern.

Title X of the United States Code charges the military Services with the responsibility to organize, train, equip, and provide forces. The Service Medical Departments execute the medical component of this responsibility in support of line and combatant commanders. We view the role of HA, and, TMA, respectively, as defining and establishing policy for the MHS

and managing the TRICARE MCSC, both of which support the Services' ability to execute Title 10 responsibilities.

It is our position that HA and TMA organizational structures should be clarified to concentrate efforts on their specific roles. HA should be organized to focus on policy issues and the strategic direction of the MHS. TMA should be organized and staffed to control PSC cost growth, oversee TRICARE MCSC, and partner with the Services to take advantage of Direct Care System capabilities, as recommended by the Task Force on the Future of Military Healthcare.

The Service Medical Departments do play a role in HA/TMA. Along with HA, we serve as stakeholders in a board of directors-style management of the MHS and the Defense Health Program (DHP). With HA and TMA, the Service Medical Departments oversee funding strategies to support the provision of peacetime health care delivery. Each Service Medical Department advocates for their specific peacetime health care resourcing needs and manages the resources provided to meet mission requirements. We are each represented in various HA and TMA management divisions and on committees striving to improve MHS peacetime health care delivery effectiveness. Service SGs ensure Service-specific requirements and standards are met. Service Line leadership is directly engaged in reviewing MHS policy and metrics to ensure optimal health services anytime, anywhere for our warfighting forces and military families.

Health Affairs (HA) supports the requirements of the Services at the policy and strategic planning level. HA and TMA complement the Service Medical Departments in the delivery of peacetime health care around the globe for more than 9.2 million beneficiaries. They serve as advocates when defending, resourcing, and clarifying policy decisions (i.e., National Defense

Authorization Act, POM) with senior DoD and congressional officials (i.e., congressional oversight subcommittees, Office of Management and Budget). HA and TMA have also worked with Service Medical Departments to plan, program, budget, and execute their Defense Health Program portfolios in support of the military mission.

I defer to the Assistant Secretary of Defense for Health Affairs regarding any plans to reorganize Health Affairs or the TRICARE Management Activity. We recommend that any new HA organization continue to be structured and staffed much as it is today. TMA should reduce the breadth of their portfolio, reduce contract support to minimize costs and focus their efforts on controlling PSC cost. Moreover, as outlined in the Task Force on the Future of Military Health Care Final Report (December 2007), the MHS should develop an integrated strategy between the DCS and PSC which will "permit the maintenance and enhancement of the DCS's support of the military mission while allowing for the optimization of the delivery of health care to all DoD beneficiaries." Ultimately, savings generated by streamlining the size of TMA, reducing the PSC wedge, and implementing an integrated DCS/PSC strategy could be recapitalized into the DCS for the benefit of our beneficiaries and American taxpayers, or could be returned to the DoD for allocation to DoD priorities.

Finally, I will address plans for the "Joint Medical Command Headquarters." First, I would note the use of the term "Joint Medical Command Headquarters" can be misunderstood. The 2005 Base Realignment and Closure Law Recommendation 198 requires the "**collocation** of the Navy Bureau of Medicine, Office of the Surgeon General of the Air Force, the Air Force Medical Operating Activity, the Air Force Medical Support Activity, Office of the Secretary of Defense (Health Affairs), TRICARE Management Activity, Office of the Army Surgeon General and US Army Medical Command to a single, contiguous site that meets the current Department

of Defense Anti-Terrorism/Force Protection standards for new construction at either the National Naval Medical Center, Bethesda, Maryland, Bolling Air Force Base, D.C., or federally owned or leased space in the National Capital Region and consolidate common support activity."

In compliance with the 2005 Base Realignment and Closure law, the Air Force plans to relocate 541 personnel to the new co-located DoD medical headquarters. A two-star-level Implementation Team and an action officer-level Transition Team to develop collocation and shared services plans for the DoD medical headquarters functions should maximize operational effectiveness between the Service Medical Departments, HA, and TMA.. The Implementation Team initiated this effort by targeting several opportunities to create synergies and leverage economies of scale within the following functions: clinical operations, financial management, administrative support, maintenance, information technology, and consolidation of administrative support contracts where possible to harvest additional savings. We believe and are hopeful this collaborative partnership will create new synergies which will strengthen the MHS for the future.

In conclusion, there is clearly much work to be done as an enterprise on identifying the right organizational solution. The Air Force Medical Service remains committed to working with HA, TMA and our sister Services to ensure the MHS is organized in the most effective manner to provide quality health care to military families, while being good stewards of American taxpayer dollars. I thank you for your continued support.

THE MILITARY HEALTH SYSTEM: HEALTH AFFAIRS/TRICARE MANAGEMENT ACTIVITY

OVERVIEW STATEMENT

BY MAJOR GENERAL ELDER GRANGER, MD

DEPUTY DIRECTOR, TRICARE MANAGEMENT ACTIVITY

BEFORE THE

MILITARY PERSONNEL SUBCOMMITTEE

ARMED SERVICES COMMITTEE

UNITED STATES HOUSE OF REPRESENTATIVES

APRIL 29, 2009

NOT FOR PUBLIC RELEASE UNTIL

RELEASED BY COMMITTEE

Madam Chairwoman, Members of the Committee, I am pleased to talk to you today about TRICARE—a critical component of the Military Health System (MHS)—and the efficiencies we have implemented over the past several years to address the growing cost of health care in this nation. With the support of Congress, I believe we have been able to make TRICARE a model health care delivery system.

I have had the pleasure to serve as the Deputy Director for TRICARE Management Activity since December 2005, and these past three plus years have been both extremely busy and challenging. We have launched many new benefits and programs while identifying the most effective and efficient way to deliver health care for 9.4 million of our nation's heroes and their families. The issues identified in the testimonies for this hearing are not new and DoD leadership is aware of them. DoD is committed to constantly improving the organizational structure of the Military Health System and is aware of various recommendations to improve internal communications, planning and coordination efforts. The input from all stakeholders is valued and is currently being reviewed.

TRICARE is a worldwide healthcare program that supports soldiers, sailors, airmen, marines, coast guardsmen, active duty and family members, reservists, and retired members and their families – wherever they live. Around the globe, TRICARE is there – through the integrated healthcare delivery system of military medical facilities and civilian healthcare providers operating under national and international contractors. We ensure the care is delivered and paid for, that standards are uniformly met, and in accordance to access standards. We are also implementing the Department of Defense's strategic objectives for managing military health services. We are improving business operations, providing effective and efficient support to the

warfighters, and maintaining a high level of financial accountability. Some of the most significant accomplishments are the following:

- We reduced 12 lead agent offices to three regional offices and the number of regional contracts from six to three while improving access, beneficiary services, and program management. We carved pharmacy, marketing, and other programs out of the large contracts increasing cost savings and program effectiveness.
- We combined the TRICARE National mail order pharmacy with the National Retail pharmacy and incentivized the contractor to migrate prescriptions—including expensive specialty drugs--from retail to mail order, a significant cost savings.
- We are consolidating overseas support contracts to improve operational efficiencies and beneficiary satisfaction while reducing administrative costs.
- We increased patient satisfaction, receiving high marks on the 2007 American Customer Satisfaction Index (ACSI) of 89 for inpatient care and 84 for outpatient care.
- Now that TRICARE Reserve Select (TRS) has been in place since 2005, we were able to calculate premiums for 2009 based on actual cost data obtained from 2006 and 2007. Effective January 1, 2009, TRICARE reduced the rates for TRS significantly. Monthly premiums for TRS individual coverage were reduced 44 percent, from $81.00 to $47.51, and TRS family coverage plans were reduced 29 percent, from $253.00 to $180.17. It's an excellent health care option that we are proud to offer our Guard and Reserve force.
- Extensively worked with the managed care support contractors to implement standardized disease management programs for asthma, congestive heart failure, and diabetes that reached over 50,000 beneficiaries and netted TRICARE over $30 million in cost avoidance.

- In response to needs to expand capabilities for Wounded Warriors and their families, we responded with new and innovative programs, such as our Behavioral Health Care Provider Locator and Appointment Assistance Service to facilitate access and provide assistance for active duty and active duty family members in obtaining behavioral health care appointments.
- We have a robust studies, surveys and research program that assesses efficacy and identifies areas for improvement in both the direct care and purchased care systems.

The purchased care sector is now delivering between 60 and 70 percent of the health care in the MHS. Through focused management initiatives by the TRICARE Management Activity and our Managed Care Support Contractor partners we ensure this care is delivered efficiently and effectively. One example of our success in this regard is found in our claims processing performance. During fiscal year 2008 we achieved claims processing timeliness of 95 percent of claims completed within 30 days. Our contractors consistently exceed a claims payment accuracy rate of 99 percent. A second example is found in our customer service and issue response performance as measured against telephone response standards for timeliness, hold times, and call resolution. All have regularly exceeded the 95 percent contract requirement standard.

The MHS is a unique health care delivery system, and the military and civilian leaders who guide it never forget the debt we owe to the brave men and women – those who serve today and those who have gone before – who willingly put their lives on the line to defend the freedoms we enjoy every day, as well as their Great American families. We remain focused on satisfying the needs of these patriots by always providing them world-class health care of the right kind, delivered at the right time, in the right place.

Madam Chairwoman, thank you for the opportunity to be with you today. I look forward to your questions.

DOCUMENTS SUBMITTED FOR THE RECORD

April 29, 2009

TRICARE North Region Behavioral Health
Telephone Numbers and Web Sites

Description	Telephone Number/Web Site
Behavioral Health Care Provider Locator Line The Behavioral Health Care Provider Locator and Appointment Assistance Line assists active duty service members (ADSMs) and active duty family members (ADFMs) in locating civilian behavioral health care providers and schedule routine and urgent outpatient behavioral health appointments in the TRICARE network. – Available from 8 a.m. to 6 p.m. Eastern Time (7 a.m. to 5 p.m. Central Time), Monday through Friday, excluding holidays. – Non-enrolled ADFMs, retired service members, their families and others should call Health Net's 1-877-TRICARE (1-877-874-2273) general number for behavioral health care assistance. – Note: This appointment assistance line is not a crisis intervention line. If a beneficiary calls our Behavioral Health Provider Location and Appointment Assistance Line or our general customer service number and has a life threatening condition, we will immediately direct him or her to emergency services. However, if the beneficiary's situation is so critical that he or she is unable to hang up and call for emergency services, we will immediately connect him or her with a suicide prevention representative at the National Suicide Prevention Lifeline (1-800-273-TALK).	**1-877-747-9579**
TRICARE North Region Customer Service Line Health Net operates several call centers across the nation enabling continuity of operations for time zone coverage, regional natural occurrences and peak call times. – Available from 7:00am to 7:00pm Eastern time and 6:00am to 6:00pm Central time. Monday through Friday, excluding holidays. – Provider Locator Function 24 hours a day, 7 days a week, 365 days per year. This function, along with the Provider Directory on Health Net's Web site and assistance at the TRICARE Service Centers, helps beneficiaries locate a TRICARE provider. – A dedicated line for TRICARE Reserve Select beneficiaries at 1-800-555-2605 is also available.	**1-877-TRICARE (1-877-874-2273)**
Health Net Federal Services Web Site The Health Net Federal Services TRICARE North Region Web site offers a number of customer service and behavioral health educational information for beneficiaries and providers. – Benefits, exclusions and limitations; referral and prior authorization requirements and provider types; links to resources (e.g., Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (DCOE) Outreach Center); common behavioral health diagnosis; children and behavioral health care; Post-Traumatic Stress Disorder information	**www.healthnetfederalservices.com** **Beneficiary Portal: Authorizations Tab – Behavioral Health box** **Provider Portal: Authorizations Tab – Behavioral Health box**

Description	Telephone Number/Web Site
Online Behavioral Health Resource Center The Online Behavioral Health Resource Center is available to all TRICARE beneficiaries. This online center is designed to help beneficiaries balance work, family and other aspects of life. Available in both English and Spanish, offering comprehensive articles, information sheets, quick tips, calculators and more on topics such as emotional health; family and work; health and fitness and financial and legal.	**www.healthnetfederalservices.com** **- Beneficiary portal - Behavioral Health tab**
Military & Family Life Consultant Military & Family Life Consultants (MFLCs) support active duty, National Guard and Reserve members and their families stationed around the world by providing direct, face-to-face non-medical counseling and education regarding daily life stressors related to deployment and reintegration. The counselors address concerns of stress, relationships, family problems, financial issues, grief and loss, conflict resolution, and the emotional challenges of transitioning from combat back to civilian life and family.	**1-800-646-5613** **www.mhngs.com**

TRICARE South Region Behavioral Health Telephone Numbers and Web Sites

Description	Telephone Number/Web Site
Warrior Navigation & Assistance Program (WNAP) The Warrior Navigation & Assistance Program (WNAP), to support active duty, Guard and Reserve warriors in transition and their families with information and assistance about the TRICARE program and seamless transition through the military health system. The new program offers these warriors and their families person-to-person guidance and access to a new advocacy unit, specially trained around unique challenges that many warriors may face as it relates to access to care or the need for information on all available resources, whether it is the Military Health System, Veterans Affairs or community assets. It also offers a broad spectrum of clinical programs designed to meet the special needs of soldiers, sailors, airmen, marines, coast guard and their families. Additionally this new specialized unit will also oversee education and assistance initiatives for civilian providers caring for warriors and their families. In addition, the WNAP includes: -- Enhancements to HMHS website (www.humana-military.com), for example: -- Many brochures are available to help warrior and families understand their benefit, such as the "Information and Resources for Combat Veterans" brochure -- Addition of the AchieveSolutions website, featuring educational resources and tools: https://www.achievesolutions.net/tricaresouth -- Expanded outreach to Guard and Reserve, transition coordinators and other military officials to educate beneficiaries on all aspects of the TRICARE program -- Care Management initiatives, including: -- Behavioral health support -- Seamless transition for warriors and families ensuring that they are provided with the care they need, when they need it -- Provider education regarding the unique needs for warriors returning home and their families; including resources and tools for providers on our website --	**1-888-4GO-WNAP**
TRICARE Behavioral Health Information Humana Military HealthCare Services (HMHS) has partnered with ValueOptions to provide TRICARE behavioral health assistance and service to those eligible beneficiaries residing in the TRICARE South Region. The South Region includes Alabama, Arkansas, Florida, Georgia, Louisiana, Mississippi, Oklahoma, South Carolina, Tennessee (excluding the Ft Campbell area) and a major portion of Texas (excluding the El Paso area). Dedicated behavioral health agents are available Monday- Friday 8AM-7 PM ET, excluding federal holidays, to assist callers in accessing behavioral health services, providing information regarding the TRICARE behavioral health benefit and responding to all other general behavioral health inquiries.	**1-800-700-8646**

TRICARE South Region Behavioral Health Telephone Numbers and Web Sites

Behavioral Health Provider Locator and Appointment Assistance Line The Behavioral Health Provider Locator and Appointment Assistance Line provides assistance to TRICARE South Region Active Duty Service Members and their enrolled Family Members in locating a behavioral health provider and scheduling urgent and routine outpatient behavioral health appointments with TRICARE providers in the community. Representatives are available Monday- Friday 8AM-7 PM ET, excluding federal holidays.	**1-877-298-3514**
Behavioral Health Resources Special behavioral health portal for beneficiaries and providers is located on the HMHS website. Users have access to a variety of behavioral health resources, tools, self-assessment quizzes and articles, such as: **http://www.humanamilitary.com/south/bene/healthwellness/BehavioralHealth/BehavioralHealth.asp** 1. **Achieve Solutions** **https://www.achievesolutions.net/achievesolutions/en/tricaresouth/Home.do** an online resource, available in both English and Spanish, filled with educational information and content regarding behavioral health, EAP and work/life issues. The site contains more than 6,000 articles covering 200 different topics, such as Anxiety, Health and Wellness, Relationships, Depression and more. To help ensure confidentiality, TRICARE beneficiaries are able to access this secure resource without requiring a password or user ID 2. **Suicide Awareness –** this center contains articles, tip sheets and web resources focused on Suicide Awareness and Prevention to include all military service branch programs, the National Guard Virtual Armory program and other national programs. In addition, two videos were developed to help bring awareness to members and their loved ones. One video is aimed at family members of military members whom they feel may be depressed and contemplating suicide. The video discusses warning signs and symptoms, resources, and help that is available to them. The other video is aimed at military members themselves who may be experiencing suicidal ideations. It encourages the member to take a brief self-assessment quiz, seek services, if necessary and provides them access to a TRICARE South behavioral health clinician 24 hours a day/7 days a week to assist them in obtaining any needed behavioral health services 3. **Life Manager -** a "one stop shop" instrument that brings together various resources and services to help military members and their families meet their unique needs. Life Manager can help individuals assess mood, focus on concerns and identify solutions to life's challenges, both large and small. The tool can be "entered"	**www.humana-military.com** **http://www.humanamilitary.com/south/bene/healthwellness/BehavioralHealth/BehavioralHealth.asp** **https://www.achievesolutions.net/achievesolutions/en/tricaresouth/Home.do**

through any one of three "doorways": Today I'm Feeling, My Self-Assessments or My Life. The "Feelings" section allows users to identify and then explore why they may be experiencing stress, grief, anger, etc., and then find ways to address these feelings. The "Self-Assessments" section enables users to increase self-knowledge and learn ways to increase their skills. The "My Life" section enables users to focus on the impact of specific events, such as having a baby or buying a home. 4. **Teen Corner** - a resource designed specifically to help teens and their parents tackle hard-to-cope with life issues. Being a teenager, or the parent of a teenager, is hard work. Teens are faced with challenges and decisions their parents never had to face and life just seems to move faster now. Add to that the stress of a parent deployed, injured or deceased and the emotional challenges teens struggle with can be overwhelming. From information on alcohol and drugs to managing emotions and how to choose a college and obtain financial aid, Teen Life is there.	
Additional Services Provided ✓ ***Achieve Solutions ® website:*** ***https://www.achievesolutions.net/achievesolutions/en/tricaresouth/Home.do*** • ***HMHS BH Website URL: http://www.humana-military.com/south/bene/health-wellness/BehavioralHealth/BehavioralHealth.asp*** • Behavioral health and work/life online educational resource • Available in both English and Spanish • Implemented August 2007 • Three new enhancements in 2008 o **Teen Life-** designed specifically to help teens and their parents tackle hard-to-cope with life issues o **Suicide Awareness-** portal containing web links to each military service branch Suicide Prevention programs, as well as, two videos aimed at the military population. Individuals are provided a contact number to a 24/7 on call TRICARE South Behavioral Health clinician who will assist them with obtaining appropriate behavioral health services o **Life Manager-** designed to help individuals assess mood, focus on concerns and identify solutions to life's challenges	***https://www.achievesolutions.net/achievesolutions/en/tricaresouth/Home.do*** ***http://www.humana-military.com/south/bene/health-wellness/BehavioralHealth/BehavioralHealth.asp*** www.humana-military.com

• From April 08- April 09, visitors viewed over 158,600 pages in 100,000 topic searches • Located at www.humana-military.com; Beneficiary Health and Wellness; Behavioral Health	

TRICARE West Region Behavioral Health Resources

RESOURCE/OUTREACH INITIATIVE	DESCRIPTION	Phone or URL
Provider Locator and Appointing Line	This service was created to assist ADSM and ADFM enrolled in any Prime program, to find local behavioral health care providers and set appointments. ADSM must have a referral from their PCM before calling.	Provider Locator and Appointing Line 1-866-651-4970
Continuing Education Seminars on Post-Deployment Behavioral Health Issues for West Region Providers	National Guard and Reserve members often return to their community providers following deployment in the Global War on Terror. These continuing education seminars are aimed at educating network primary care managers and behavioral health clinicians about deployment-related behavioral health issues. TriWest has successfully hosted these seminars for over 1200 providers across the West Region.	Continuing Education page http://www.triwest.com/provider/continuingEd.aspx
24/7 Behavioral Health Contact Center	The 24/7 Contact Center serves as a first line intervention in decreasing barriers to beneficiaries seeking behavioral health care. Representatives provide information regarding the behavioral health benefit, identify local providers, and assist with appropriate referrals, and triage calls that need transfer to the Crisis Line. In addition to the services related to behavioral health, the BH Contact Center assists with after-hours medical urgent care referrals and emergency transfers to appropriate facilities.	Contact Center 1-888-TRIWEST (1-888-874-9378)
24/7 Behavioral Health Crisis Line	The Crisis Line has been certified by the American Association of Suicidology and is staffed with behavioral health clinicians, 24/7, who provide crisis intervention and suicide prevention services.	Behavioral Health Crisis Line 1-866-284-3743
Behavioral Health Portal	The TriWest Behavioral Health Portal is an online resource organized for three audiences: beneficiaries, providers, and military leaders. Topics and resources focus on the psychosocial and clinical mental health needs of a military population. Evidence-based information is organized to provide brief topic overviews, and links to a variety of self-help resources, TRICARE behavioral health benefit details, more in-depth education, and links to professional help.	Behavioral Health Portal http://www.triwest.com/beneficiary/BehavioralHealth.aspx
Behavioral Health resource map	Life events such as military deployments can be highly stressful, but our beneficiaries don't have to go through them alone. TriWest established this resource map to provide another level of psychosocial support for beneficiaries living in the 21-state West Region. From state specific assistance, Red Cross military family Service resource listings are organized here. Beneficiaries can access this resource 24/7 at www.triwest.com	Behavioral Health Resource Map http://www.triwest.com/unauth/newContent/ newBehavioralHealth/wrMap/default.asp

TRICARE West Region Behavioral Health Resources

RESOURCE/OUTREACH INITIATIVE	DESCRIPTION	Phone or URL
Help From Home DVD Series	TriWest produced "Getting Home…All the Way Home" to assist Service members and their families with readjustment/reintegration following military deployment. That first DVD has been distributed to Reserve Component members during their demobilization. The user-friendly format is another communication vehicle to deliver accurate information about deployment-related behavioral health issues, resources and TRICARE benefits. TriWest's message of behavioral health support for families of deployed Service members is offered in the newest DVD, "On the Homefront" and includes West Region military families sharing their deployment and reunion experiences, with special focus on maintaining family life. Messages from children and teens about their deployment experiences are also featured. Both DVDs and/or streaming video for online viewing, are available free of charge to West Region beneficiaries, providers and military leaders through www.triwest.com.	Help From Home DVD Web site http://www.triwest.com/unauth/newContent/ newBehavioralHealth/DVD.asp
TRICARE 2 You eNewsletter	Monthly eNewsletter with information and links to behavioral health information.	TRICARE 2 You eNewsletter archive http://www.triwest.com/unauth/content/ member_services/health_matters/archives_t2u.asp
TRICARE 2 You Videos	Streaming videos on various topics including the following behavioral health topics: Behavioral Health for Active Duty Behavioral Health for Family Members Behavioral Health Resources Getting Home, All the Way Home	TRICARE 2 You Video Library http://www.triwest.com/corporate/mediacenter.aspx?lib=t2u
TRICARE 2 You Online Library	RSS feed and links to base articles and streaming videos on various topics including behavioral health.	TRICARE 2 You Online Library http://www.triwest.com/t2u

TRICARE West Region Behavioral Health Resources

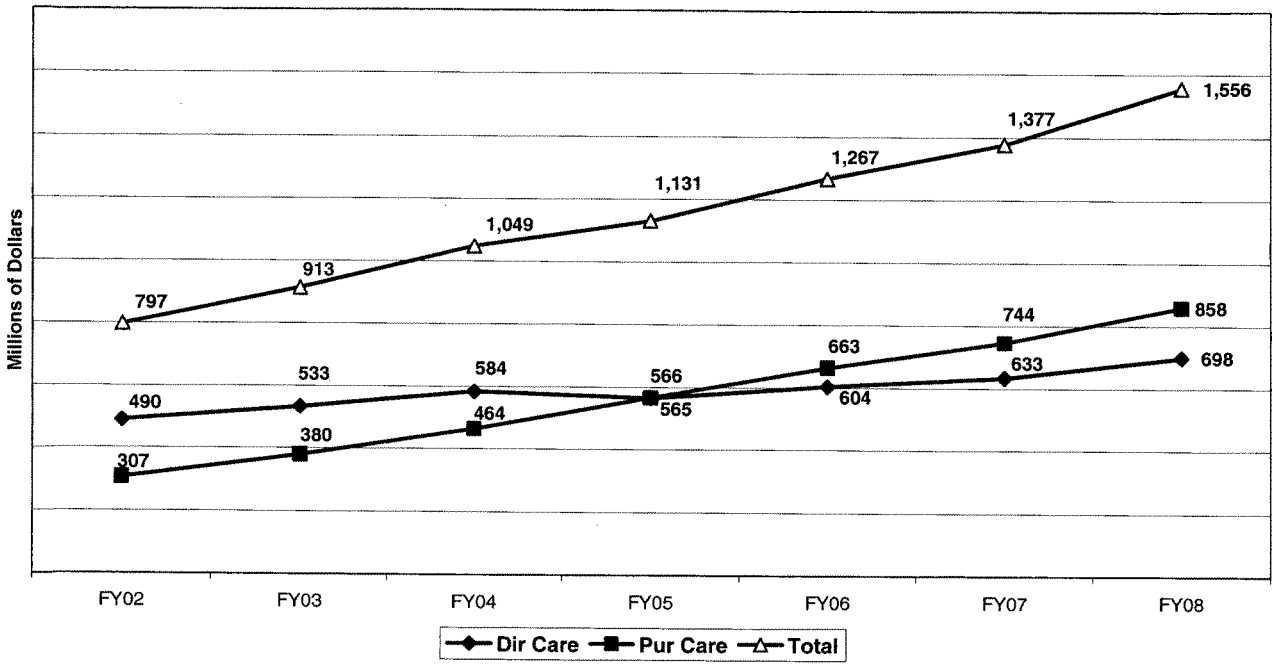
RESOURCE/OUTREACH INITIATIVE	DESCRIPTION	Phone or URL
Guard and Reserve Online Resource Center	TriWest created this page to house a collection of links to services available to reserve component members pre-, during- and post-deployment. These links provide convenient access to TriWest's behavioral health resources. It is hosted at www.triwest.com/ngr, TriWest's National Guard and Reserve portal, which has been broadly publicized throughout the military and civilian press and has received positive endorsement from Reserve Affairs.	Guard and Reserve Resource Center http://www.triwest.com/unauth/content/ngr/service.asp
National Guard and Reserve Briefing Video	TriWest's briefing videos help reserve component members understand their benefits and how those benefits are affected by their activation status. Behavioral health is just one of the many subjects covered. These briefings are also available at the National Guard and Reserve portal, www.triwest.com/ngr.	National Guard and Reserve Portal www.triwest.com/ngr Video links are in the lower right corner
Healing Heroes Portal	TriWest's Healing Heroes page offers wounded, ill or injured servicemembers, their families and their case managers access to the information and services they need in a single location--including a brief summary of all the benefits to which they may be entitled. Behavioral Health information, links to the Help From Home dvds and contact information for the Crisis Line are featured.	Healing Heroes Portal http://www.triwest.com/hh
Stop the Silence. Start Healing: Dr. John Fortunado	A short educational video featuring Dr. John Fortunado, Chief of Restoration & Resilience Center at William Beaumont Army Medical Center, explaining the importance of seeking timely behavioral health assistance.	Stop the Silence. Start Healing. http://www.triwest.com/corporate/ standalone.aspx?lib=BHSTIGMA/Fortunato
Stop the Silence. Start Healing: Dr. Heidi Kraft	An interview with Heidi Kraft PhD, former Navy psychologist, addressing how to support a service member in need and the importance of overcoming stigma in seeking behavioral health help.	Stop the Silence. Start Healing. http://media.triwest.com/video/ console.asp?video=BHSTIGMA/Dr_Kraft.flv&skin=TW
QuickAlert	The QuickAlert e-mail notification system provides West Region beneficiaries with instant updates of their authorization and referral status, greatly facilitating the behavioral health and specialty care appointing process and expediting treatment.	QuickAlert page http://www.triwest.com/register

TRICARE West Region Behavioral Health Resources

RESOURCE/OUTREACH INITIATIVE	DESCRIPTION	Phone or URL
National Resources	TriWest posts links to national-level external behavioral health resources and services throughout its Web site, raising awareness of new initiatives and providing TRICARE's West Region beneficiaries with easy access to valuable resources. This includes TRICARE's Mental Health Resource Center, DCoE's Real Warriors's Site and many others. TriWest also uses its online news center to share TMA and DoD behavioral health initiatives with its West Region audience.	http://www.triwest.com/beneficiary/frames.aspx?page=http://www.triwest.com/unauth/newContent/newBehavioralHealth/wrMap/default.asp
Handbooks and brochures	TriWest provides a comprehensive virtual library of handbooks and brochures explaining behavioral health TRICARE benefits and services available to TRICARE's West Region beneficiaries. This includes behavioral health resource guides, suicide prevention information and survior benefits.	http://www.triwest.com/beneficiary/beneficiarymaterials.aspx
Suicide Prevention & Awareness information	TriWest developed a brochure in partnership with the Suicide Prevention Action Network (SPAN) with information about behavioral health support and suicide prevention resources. The downloadable, printable brochure is posted to TriWest's Behavioral Health Portal.	http://www.triwest.com/document_library/pdf_docs/SPAN_Military_Brochure.pdf

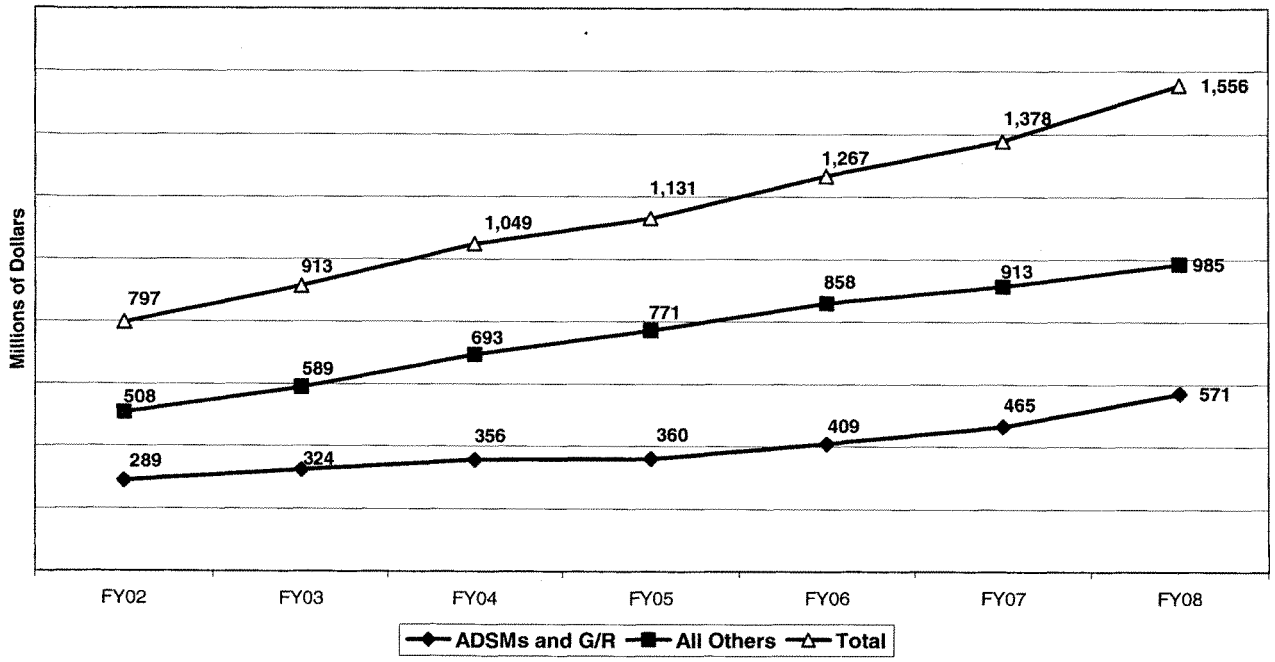
TRICARE Mental Health Expenditures and Utilization Trends, FY 02-08

Purchased Care, Direct Care, and Total MHS Mental Health Expenditures, FY 02-08



Excludes spending for Medicare-eligible beneficiaries.

Mental Health Expenditures for ADSMs and Guard/Reserve, FY 02-08



Excludes spending for Medicare-eligible beneficiaries.

Summary

- Since FY02, demand for mental health services has increased in the MHS
- Most of the increase has been met by purchased care, especially for dependents of ADSMs and for NADDs<65
  - (see Appendix tables)
- Use of MH services increased significantly from FY 07-08
  - spending for non-pharmacy mental health care increased by 18% and non-pharmacy mental health care spending for ADSMs and G/R increased by 25%

WITNESS RESPONSES TO QUESTIONS ASKED DURING THE HEARING

April 29, 2009

RESPONSE TO QUESTION SUBMITTED BY MRS. DAVIS

Ms. EMBREY. Health Affairs believes all leaders in the Military Health System are afforded numerous opportunities for their voices to be heard through our corporate governance structure. Today, Military Health System enterprise-wide deliberations follow the tenets of a March 2006 Assistant Secretary of Defense (Health Affairs) memorandum, "Policy on Military Health System Decision Making Process." The Services' Surgeons General play a critical role in this oversight process. Health Affairs, TRICARE Management Activity, the Services' Surgeons General and their staffs engage from the level of subject matter experts to the level of the senior principals.

The Military Health System is governed through ongoing collaboration, consensus, and compromise. We achieve this through a governance structure which engages key stakeholders on a weekly basis. We use the same structure and collaborative leadership process to determine outcome performance measures for which all Military Health System components are held accountable. This process provides a framework to achieve agreement and approval on what is in the best interest of the Military Health System. The process also provides a weekly venue in which all voices have an opportunity to be heard.

A critical part of this framework is the use of integrating councils. Each Deputy Assistant Secretary of Defense (DASD) for Health Affairs and the Deputy Director, TRICARE Management Activity chairs an integrating council to ensure functional integration of complex issues. Each week, at the subject matter expert level (typically O-6 level), functional steering groups work through key decision issues in areas such as clinical policy, force health protection and readiness, health plan operations, and financial management. Decision recommendations from these working groups roll-up to the two-star integrating councils, in which the Deputy Surgeons General participate. Finally, each week the Senior Military Medical Advisory Council—chaired by the Assistant Secretary of Defense (Health Affairs) and including the Services' Surgeons General—meets to review informational and decision briefings. Four-star level Military Department officials (i.e., senior civilian leadership) and Service line leaders are also formally engaged in the decision making process through the Military Health System Executive Review.

Beyond these formal and institutionalized informational and decision forums, informal communication, collaboration, and coordination occur at all levels nearly daily among Health Affairs, TRICARE Management Activity, and the Services—from action officers to the most senior officials. [See page 27.]

RESPONSE TO QUESTIONS SUBMITTED BY MS. FALLIN AND MRS. DAVIS

General GRANGER. We have stood up toll-free numbers that our beneficiaries can call. These resources are provided by TRICARE region in the attached documents.

Additionally, regarding the trend in family member utilization of network mental health capability, the TRICARE Management Activity recently completed its annual assessment of expenditure and utilization trends for mental health services in both direct care (military treatment facility) and purchased care venues. The update added data for Fiscal Year (FY) 2008 to those previously gathered for the FY 2002-2007. Substantial year-over-year percentage increases continue in mental health care expenditures and workload for TRICARE beneficiaries, with the bulk of the increase directed to care for our Active Duty and Reserve warriors, as well as for their families. From FY 2007-2008, expenditures increased by 15 percent. Inpatient days grew by 16 percent, and outpatient visits grew by 15 percent. The private sector has displayed an impressive capacity to accommodate increases in demand for mental health services for TRICARE beneficiaries. Over the period FY 2002-2008, purchased care inpatient days increased by 97 percent, and outpatient visits increased 133 percent. Corresponding changes in direct care workload were a decrease of 19 percent (inpatient days) and an increase of 25 percent (outpatient visits). Please refer to the attached slides for details. [See page 25.]

[The slides referred to can be found in the Appendix on page 87.]

QUESTIONS SUBMITTED BY MEMBERS POST HEARING

April 29, 2009

QUESTIONS SUBMITTED BY MRS. DAVIS

Mrs. DAVIS. Under what authority has the ASD(HA) dual-hatted himself (herself) as the Director of TMA?

Ms. EMBREY. The Under Secretary of Defense (Personnel & Readiness) (USD(P&R)) is chartered under Department of Defense Directive (DoDD) 5124.02, dated June 23, 2008, as the Principal Staff Advisor to the Secretary of Defense for, among other responsibilities, health affairs. In this capacity, the USD(P&R) exercises authority over the Assistant Secretary of Defense (Health Affairs) (ASD(HA)) and develops policies, plans, and programs for health and medical affairs. The USD(P&R) is charged to "ensure that P&R policies and programs are designed and managed to improve standards of performance, economy, and efficiency, and that all Defense Agencies and DoD Field Activities under the authority, direction, and control of the USD(P&R) are attentive and responsive to the requirements of their organizational customers, both internal and external to the Department of Defense (DoD)."

The ASD(HA) is chartered under DoDD 5136.01, dated June 4, 2008, as the principal advisor to the Secretary of Defense and the USD(P&R) for all DoD health policies, programs, and force health protection activities. The ASD(HA) is charged to ensure the effective execution of the Department's medical mission, providing and maintaining readiness for medical services and support. The ASD(HA) exercises authority, direction, and control over the DoD medical and dental personnel authorizations and policy, facilities, programs, funding, and other resources in DoD. In this regard, the ASD(HA) serves as program manager for all DoD health and medical resources, and prepares and submits the DoD Unified Medical Program budget to provide resources for the Military Health System.

The TRICARE Management Activity (TMA) was established through Defense Reform Initiative Directive #14, signed on January 5, 1998 by then-Deputy Secretary of Defense Hamre. TMA is a field operating activity operating under the direction of the USD(P&R). Per DoDD 5136.12, the mission of TMA is to (1) manage TRICARE; (2) manage and execute the Defense Health Program (DHP) Appropriation and the DoD Unified Medical Program; and (3) support the Uniformed Services in implementation of the TRICARE Program.

The Unified Medical Program has grown at an increasing rate over the past decade due to a number of factors, to include medical inflation, increased number of users, enhanced benefits, and addition of benefits for the over-65 population. The Military Health System leadership has sought ways to ensure movement toward integrated health care delivery during this period of increasing system complexity (i.e., better integration among OSD policy, TRICARE health plan management and contract oversight, and the Services' health care delivery operations). In 2002, the USD(P&R) in concert with the ASD(HA) made a management decision to flatten the senior management layer of Health Affairs and the TRICARE Management Activity by designating the ASD(HA) with the additional responsibility of Director, TMA. This action is consistent with exercising the responsibilities outlined in DoDD 5124.02 and DoDD 5136.01, enabling singular leadership focus on ensuring health policy and health plan operations operate in a congruent manner.

Mrs. DAVIS. The jobs/functions of the Assistant Secretary of Defense for Health Affairs and Director of the TRICARE Management Activity (TMA) seem to be different. How are you able to maintain separate accounting of these distinct functions? When the TMA was created, wasn't there a separate Director? Did that not work?

Ms. EMBREY. TMA was formed under Defense Reform Initiative Directive #14, January 5, 1998, from the consolidation of the TRICARE Support Office, the Defense Medical Programs Activity, and the integration of the health management programs previously located in the Office of the Assistant Secretary of Defense (Health Affairs)—OASD(HA).

The ASD(HA) is charged to execute the longitudinal array of the Department's medical mission, which is to provide and maintain readiness, to provide medical services and support to members of the Armed Forces during military operations, and provide medical services and support to members of the Armed Forces, their

dependents, and others entitled to DoD medical care. These ASD(HA) duties range from policy formulation to serving as the program manager for TRICARE health and medical resources, supervising and administering TRICARE programs, funding, and other resources within the Department of Defense.

The Military Health System (MHS) leadership's goals include further integration between the direct care setting (predominantly Army, Navy, and Air Force military treatment facilities) and the purchased care component as the model for health care delivery in the Department of Defense. To effect this continued transition and better integrate MHS components, the ASD(HA), upon consultation with the USD(P&R), accepted the additional responsibility of Director, TMA in 2002, to exercise more direct control in addressing system-wide policy and operational issues inherent in managing a complex and expanding Unified Medical Program. Thus, the ASD(HA), who also serves as Director, TMA, brings together policy and operational issues in planning at the Department level. The Deputy Director, TMA oversees the day-to-day management activities of TMA (notably, guiding the health plan and purchased care component of the MHS). In doing so, the Director and the Deputy Director, TMA work in concert to administer DoD medical and dental programs authorized under Title 10, and oversee program direction for the execution of policy within the MHS.

Mrs. DAVIS. How many more SESs are needed in HA? Why are they needed? How many more are needed in TMA and why?

Ms. EMBREY. Senior Executive Service (SES) employees provide the top level executive leadership in the Department of Defense. This leadership is imperative within Personnel and Readiness, Health Affairs, and TRICARE Management Activity (TMA) to manage the Department's dynamic $47 billion Unified Medical Program and to effectively interface within the Office of the Secretary of Defense (OSD), and with the Joint Staff and Service senior officials (noncareer appointees, SESs, and General/Flag Officers). At the same time, we remain cognizant that SES requirements are greater than existing SES resources; thus, it is imperative that leadership within the Department continue their efforts to balance competing needs for these valuable resources.

Specifically related to HA and TMA requirements, Section 717 of the National Defense Authorization Act for Fiscal Year 2006 established the qualifications for the three CONUS TRICARE Regional Office Directors as Flag Officers or SESs; accordingly, we have recently added permanent SES leadership to two of the three TRICARE Regions (South and North, with a Flag Officer serving in the West). Additionally, to manage the complex MHS portfolio, we have identified a future requirement for four additional SES positions in Health Affairs and one additional SES position in the TMA.

Health Affairs:

1. Deputy Chief, Clinical and Program Policy Integration—this position would work for the noncareer Deputy Assistant Secretary for Clinical and Program Policy as a career Senior Medical Officer, providing policy and oversight for direct and purchased care systems and all other functions.
2. Deputy Director, Force Health Protection and Readiness—this position would work under the Deputy Assistant Secretary of Defense for Force Health Protection, providing policy and oversight for research, vaccine, surveillance, surveys, deployment assessments, and epidemiology
3. Deputy Director, Medical RDT&E—this position would work for the Deputy Assistant Secretary of Defense for Force Health Protection, providing policy and oversight to annual $3 billion medical research program.
4. Chief, Health Program Communication and External Affairs—this position would integrate the interagency and communications portfolio to ensure consistency of messaging and unified effort within the interagency efforts (e.g., VA/DoD Program Office), with Congress, and with other external audiences.

TRICARE Management Activity

1. Deputy CIO for Operations and Electronic Health Record (EHR)—this position would direct requirements for development and integration of programs for $1B annual medical EHR efforts across the MHS, supporting all Military Services and health care delivery to our 9.4 million beneficiaries.

Mrs. DAVIS. There is some perception of the fox watching the henhouse. Do you think this structure could lead to lack of strong oversight, when the policy making staff in turn executes the policies? How is this conflict prevented?

Ms. EMBREY. In 2002, the Under Secretary of Defense (Personnel & Readiness) and the Assistant Secretary of Defense (Health Affairs) leveraged the Assistant Sec-

retary's authority to ensure effective execution of the Department's medical mission, consistent with Department of Defense Directive 5136.01, through the management decision to provide additional responsibilities to key Health Affairs leaders. This action ensured alignment of policy and program execution strategies with a focus on enhanced support to the Military Departments. The "dual hatted" positions are: 1) the Assistant Secretary of Defense (Health Affairs) is also the Director, TRICARE Management Activity (TMA); 2) the Principal Deputy Assistant Secretary of Defense (Health Affairs) is also the Principal Deputy Director of TMA; and 3) each Deputy Assistant Secretary of Defense (DASD) is also a TMA Functional Chief to manage execution of related support programs and services to the Military Departments (Chief Medical Officer, Chief Financial Officer, and Chief of Force Health Protection and Readiness Programs).

This is not a case of the "fox watching the henhouse." In their Health Affairs roles, the DASDs are policy developers, whereas in their TMA roles, these same Functional Chiefs, who have separate staffs, serve the entire Military Health System as implementers. This is similar to the Service Surgeons General who have health care policy and execution roles (for example, the Army Surgeon General also serves as Commander, Army Medical Command).

The Health Affairs/TMA positions continue to perform in a dual DASD-Functional Chief status and are a very efficient way to ensure new policies and programs are supported and executed in a timely manner. This role complements the Military Departments execution responsibilities as outlined in Title 10, United States Code.

To prevent the "fox watching the henhouse," the Military Health System employs an inclusive oversight processes. This governance structure enables enterprise-wide deliberations of key issues. Governance follows the tenets of a March 2006 Assistant Secretary of Defense (Health Affairs) memorandum, "Policy on Military Health System Decision Making Process." The Services' Surgeons General were involved in the development of this oversight process. Health Affairs, TMA, and the Services' Surgeons General and their staffs engage from the subject matter expert level to the level of the senior principals through weekly Integrating Councils and the Senior Military Medical Advisory Council.

Mrs. DAVIS. Has the Department of Defense Inspector General looked into this organizational structure?

Ms. EMBREY. The Department of Defense Inspector General has not looked into this organizational structure.

Mrs. DAVIS. The OSD staff, of which the OASD(HA) is a part, is funded by a separate appropriation from TMA, which is funded by the Defense Health Program (DHP). It appears that this dual-hatting relationship could result in the augmentation of the OSD appropriations by the DHP. I understand TMA provides office space, contract support, people, video equipment, gym membership, Blackberries, conference support with meals, cell phones, etc. to HA. Is that true? What legal authorities have been consulted to allow this? I understand the ASD(HA) requested the appropriations committees expand the use of the DHP for purposes other than health care for uniform personnel and their families and retirees: An example cited last year was the need for the DHP to pay for HA administrative support items. This year it is for humanitarian and other reasons. Can you explain the rationale for this?

Ms. EMBREY. The Department remains vigilant about the issue you have raised regarding the dual-hatting relationship and the need to ensure that there is no augmentation of funds. The Department reviews all appropriations made which involve the dual-hatted function to ensure the funding supports the Chapter 55 of Title 10 (Defense Health Program—DHP) mission and is in accordance with appropriations law. When a question is identified, we consult with the TRICARE Management Activity and DoD Offices of General Counsel as appropriate.

Recently, we have been doing an in depth review of all activities involving dual-hatting to ensure that any existing errors are corrected and prevented from occurring in the future. For instance, we completed a review of all cell phones and Blackberries and any that were not clearly for dual-hatted personnel are now funded with OSD appropriations. Additionally, we have been carefully reviewing conferences (including meals) to ensure that the funds expended are consistent with the mission of the DHP. With regard to contract personnel support, only those that directly support the DHP mission are funded with DHP dollars. While some of these are housed in OSD funded space, the rationale is to co-locate these personnel with the dual-hatted individual whom they support. We also recently reviewed the contract for gym membership and determined that it would be more appropriate for HA staff (non dual-hatted) to be funded with OSD dollars.

With regard to the question about expanding the use of the DHP—we have attempted to identify programs that are consistent with, and supportive of, larger de-

partmental initiatives where we believe the DHP may have a role. However, we would only expend funds for these additional missions with Congressional approval.

The Department agrees that the dual-hatting does require extra vigilance to ensure that there is no augmentation of funds. However, the intent behind the dual-hatting is sound and has provided for a strong and consistent connection between policy and operations as intended.

Mrs. DAVIS. Please explain the differences between the Principal Deputy Director of TMA and the Deputy Director of TMA? These two positions seem redundant.

Ms. EMBREY. These two positions have distinct executive level roles and responsibilities. Consistent with the Assistant Secretary of Defense (Health Affairs)—ASD(HA)—who carries the additional responsibility of Director, TRICARE Management Activity (TMA), the Principal Deputy Assistant Secretary of Defense (HA)—PDASD(HA)—also carries the additional responsibility of Principal Deputy Director, TMA—PDD(TMA). In this capacity, the PDD(TMA) performs the role of Chief Operating Officer of the Military Health System Headquarters, assisting the ASD(HA)/Director, TMA in all matters. The PDD(TMA) assists the ASD(HA)/Director, TMA in fulfilling responsibilities for the effective execution of the Department's medical mission—to provide, and to maintain readiness to provide health services and support to members of the Armed Forces during military operations, and to provide health services and support to members of the Armed Forces, their family members, and others entitled to DoD health care. The PDD(TMA) may also discharge all duties in the absence of the ASD(HA), except those that qualify as "statutory." To carry out this portfolio of duties in support of the HA mission, the PDD(TMA) participates as a member of executive level Military Health System committees (e.g., Senior Military Medical Oversight Committee) to assist in formulation of OASD(HA) policies.

The PDD(TMA) has a specific portfolio of responsibilities related to interagency, planning, government relations, and communications activities. Specifically, the PDD(TMA) maintains the portfolio for external relationships with Congress, the Office of Management and Budget, Centers for Medicare and Medicaid Services, beneficiary organizations, and the media. All matters pertaining to the Department of Veterans Affairs are also coordinated through the PDD(TMA). The PDD(TMA) also has overall responsibility for strategic planning within the Office of the ASD(HA).

The Deputy Director, TMA, serving under the Director, TMA, is the program executive for TRICARE health and medical resources. The Deputy Director is the principal advisor to the ASD(HA) on health plan management and Defense health contracting matters. The Deputy Director supervises and administers the TRICARE program and manages and executes the purchased care portion of the Defense Health Program consistent with guidance from the ASD(HA). The Deputy Director directs and manages daily operations of the TMA, to include oversight of the functioning of TMA divisions (for example, pharmacy operations, health plan operations), the three TRICARE Regional Offices in the Continental United States, and TRICARE Area Offices outside the Continental United States.

QUESTIONS SUBMITTED BY MR. WILSON

Mr. WILSON. General Schoomaker, Admiral Robinson and General Roudebush: In each of your witness statements you express your concern regarding the blurring of the line between Health Affairs (HA) and the TRICARE Management Activity (TMA) or in other words policy and execution. What are some examples of how the current structure affects your ability to execute the responsibilities given to you by your service leadership and meet customer expectation?

General SCHOOMAKER. Health Affairs (HA) is best suited as a policy-making organization providing oversight, leadership, and policy integration to the Service Medical Departments and the TRICARE Management Activity (TMA). HA has been increasingly assuming roles and responsibilities that are more suited to the operational or execution level. I am concerned that this trend will diminish the roles of the Services and the viability of the direct care system. I offer the following examples:

EXAMPLE #1—The Defense Centers of Excellence for Psychological Health (PH) and Traumatic Brain Injury (TBI). Funds for TBI/PH programs were appropriated in 2007 at which time TMA established a "Red Cell" to establish a program and approve Service requests for funding. This limited the Services' flexibility to react to changing requirements and created extensive delays in our ability to execute. As a result, the majority of the funding was not executed until nearly 15 months after being appropriated. Congress has directed the establishment of other Centers of Excellence such as for Hearing and for Vision. Responsibility for executing these Cen-

ters of Excellence has thus far remained with HA, but I believe execution would be managed more appropriately by one of the Services.

EXAMPLE #2—Military Health System Support Initiatives (MHSSI) program. TMA established this program to enable Military Treatment Facilities (MTFs) to obtain private sector care funding to invest in direct care initiatives that generate savings in the private sector. The program requires MTFs to provide detailed business cases and extensive justification to TMA and the TRICARE Regional Offices for relatively small amounts of funding. MTF commanders do not have the authority to move funding between direct and private sector to meet the needs of their market.

EXAMPLE #3—American Recovery and Reinvestment Act (ARRA) Funding. The Army was to receive $220M from the ARRA for medical facility renovation and modernization. TMA assumed centralized management of these projects and funding rather than allowing the Services to use their established processes with the Corps of Engineers. This centralized management has caused delays—Army projects that were ready to be funded in April remain unfunded.

Admiral ROBINSON. The structure of the Military Health System, comprised of HA, TMA, and the Services, can be cumbersome. The structure generates tension as parties struggle to balance the support of the operational forces and the operation of an integrated health care system that provides patient and family-centered health care to beneficiaries both within Medical Treatment Facilities (MTFs) and the Managed Care Support Contractor (MCSC) network. The ability of the Services to influence this balancing act is somewhat limited since HA/TMA controls the majority of the funding and how it is allocated. While HA/TMA leads in policy development and execution, the Services are ultimately accountable to ensure the needs of their beneficiaries are met and that personnel are ready to deploy.

The challenges presented by the current structure are evident at the local and regional levels of health care delivery. While Navy Medicine is ultimately responsible to ensure that all our beneficiaries receive safe, effective and accessible care, our MTF Commanders/Commanding Officers have a specific responsibility for the beneficiaries enrolled to their MTFs and for ensuring the continuity of their care as they receive health care services both within the MTF and within the MCSC network. However, MTF Commanders/Commanding Officers have no direct command and control over the actions or performance of the MCSC at the local level that would enhance their ability to operate an integrated health care system. The MCSCs answer to TMA via its TRICARE Regional Offices. For example, the lack of a referral management process that includes the Services, for care provided by the MCSCs, shifts tremendous amounts of workload to MTFs as they attempt to obtain consult results generated by network providers.

These challenges are also manifest in the health information management systems that are funded, designed, developed, and maintained by HA/TMA. These systems have consistently been plagued by performance and technical shortcomings. Issues have not been resolved in a timely manner or on an agreed upon schedule. Products are either not delivered at all, delivered years late, delivered with multiple defects, or delivered incomplete. This often requires that Navy Medicine develop interim solutions by expending its own resources, both time and money, because many issues simply cannot wait for an adequate solution to be provided by HA/TMA. Additionally, HA/TMA has failed to recognize the need for decision support tools in areas such as patient and staff scheduling, discharge management, patient and room management, and the implementation of evidence-based practice. Future system development needs to more heavily engage the Services who will actually utilize these products in their MTFs and ensure that systems are developed and deployed with the needed expertise, an in modern, flexible electronic architecture.

Challenges also exist in the area of performance measurement, as HA/TMA metrics are insufficient to measure the cost, quality, and effectiveness of the care provided to our beneficiaries, whether in the private sector or the direct care system.

Current HA/TMA policy and management, as it relates to facility planning, does not result in facility projects that meet the future needs of our system. Current policy is based on historical workload and assumes that the care provided was appropriate, effective, and efficient.

HA/TMA has not met the health services research needs of Navy Medicine. While HA/TMA is well positioned to implement a health services research program that would improve the effectiveness of the care provided by Navy Medicine and the military health system as a whole, it has not done so.

Lastly, HA/TMA's current approach to financial management does not meet the needs of Navy Medicine. The current budget allocation process, the Prospective Payment System, misaligns financial resources and creates incentives for the over-utili-

zation of health services. The cost accounting system, Medical Expense & Performance Reporting System, fails to help managers understand whether health care resources are being appropriately utilized. The current budget process, based on annual appropriations, also creates a cumbersome, inefficient means for financing a health care entitlement program.

General ROUDEBUSH. As I stated in my recent testimony, the current structure of HA is generally conducive to its role in developing policies, crafting strategic plans, aligning financial plans, and integrating Military Health System (MHS) functions to create synergistic effects. Our concern continues to be with the growth in HA and Deputy Assistant Secretary of Defense (DASD-HA) "dual-hat" responsibilities to include oversight of selected execution activities within TMA and the broadened TMA role in budget execution oversight of Military Treatment Facility (MTF) Business Plans and Readiness. We believe this broadened role has distracted TMA from the mission of managing the cost growth in Private Sector Care (PSC). Some examples of how TMA's current organizational structure impact Service Title X responsibilities include:

EXAMPLE #1: Approximately 5 years ago, TMA implemented the Prospective Payment System (PPS) which directs a performance-based budgeting system to incentivize MTF efficiencies. PPS is intended to provide military treatment facilities budgets based on actual direct care workload produced such as hospital admissions, prescriptions filled, and clinic visits instead of historic resources levels. For each service to be successful in PPS, the military treatment facilities must adopt a workload based or "fee for service" approach to healthcare versus one that focuses on medical outcomes and improving patients' health. Also, PPS does not complement how resources are appropriated since "incentive" funds may be redistributed 8 months after the fact.

EXAMPLE #2: HA/TMA issuance of operational guidance to MTFs without complete coordination with the Services and other DoD agencies. An example is authorizing the use of Defense Health Program funds from PSC dollars for civilian care rendered to active duty members within a theater of operations rather than using GWOT/Overseas Contingency Operations funds. This involvement by HA/TMA and lack of complete coordination diminishes the role of the Services and the viability of the Direct Care System.

EXAMPLE #3: From a systems perspective, TMA's organizational construct has increased the potential for duplication of effort. Specifically, an example is TMA's decision to remove funding from AHLTA's (DoD's Electronic Health Record) inpatient functionality without an interim or long-term solution. As a result of these decisions, the Air Force Medical Service and other Services had to pull funds from existing priorities within the Direct Care System to pay for a solution.

In conclusion, we believe HA/TMA can be organized to effectively address MHS policy issues and strategic direction. Additionally, the focus of TMA should be on reducing PSC cost growth and managing the TRICARE Health Plan. Thank you for the opportunity to provide our Service perspective.

Mr. WILSON. In your discussion of a human capital management strategy your testimony states "Having a one-size-fits-each-service policy is too constrictive..." What do you mean by that statement? What are examples of the policy being too constrictive?

General SCHOOMAKER. The Assistant Secretary of Defense for Health Affairs (ASD-HA) controls all health professions special pays within the Department. Incentive and retention pay is established with "Service consent" by a majority vote. These pays are equivalent across Services with only a few variations. Each Service has the opportunity to implement or not implement a specific bonus package, but we do not have the ability to change it. As such, any time we identify a needed change, we must seek concurrence with all the Services.

For accession pay, ASD-HA allows the Services latitude by establishing a cap and giving the Services flexibility within that cap. Under the new consolidation of special pay authorized in the 2008 National Defense Authorization Act, Health Affairs still directs what will happen—the Services have no authority.

Ultimately, I would like the ability to customize bonus packages to meet the needs of the recipient. Our competitors in the civilian market can offer financial, education, reimbursements, and other forms of compensation to suit each need. The Department is currently limited to financial compensation only.

Mr. WILSON. In your written testimony you indicate that the Department is considering some minor adjustments of personnel reporting relationships within TMA. In November 2006, the then Deputy Secretary of Defense Gordon England directed the Military Health System to reorganize. In August 2008, Dr. Casscells directed

another reorganization effective October 1, 2008. What is the purpose of all of these reorganizations? Please describe the adjustments you plan to make in detail. Why is it necessary to make these adjustments now?

Ms. EMBREY. Prior to his departure, the former Assistant Secretary of Defense (Health Affairs)—ASD(HA)—signed but did not issue a memorandum, which when implemented, would have formally realigned certain functions into the portfolio of the Principal Deputy Assistant Secretary of Defense (Health Affairs)—PDASD(HA)—who also serves as the Principal Deputy Director, TRICARE Management Activity—PDD(TMA). These functions are: Program Integration, Office of Strategy Management, Military Health System (MHS) Strategic Communications, and DoD/VA Program Coordination Office. The realignment was intended to align functions and staff to achieve unity of effort and consistency of message.

Whereas these functions are within the manning structure of TMA, they perform the essential role enabling the ASD(HA) to set a strategic direction for the MHS, engage in the interagency arena and with Congress, and ensure consistent messaging internally and externally. Thus, aligning these functions into the portfolio of the PDASD(HA)/PDD(TMA) would have strengthened the ability of the ASD(HA)/Director, TMA to present a unified voice for the MHS and Unified Medical Program.

That notwithstanding, I reassessed the appropriateness of this action's timing and subsequently rescinded the memorandum signed by the former ASD(HA). Realignment decisions will be deferred until a new Under Secretary of Defense for Personnel & Readiness and a new ASD(HA) are confirmed, and have the opportunity to assess the issue and to consider alternative courses of action.

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