Prepared Statement

Of

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REGARDING

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BEFORE THE

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DEFENSE SUBCOMMITTEE

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Chairman Shelby, Ranking Member Durbin and members of the Subcommittee, we are pleased to represent the Office of the Secretary of Defense and the Defense Health Agency (DHA) to present our medical program funding request for fiscal year (FY) 2020. We are honored to represent the dedicated military and civilian medical professionals in the Military Health System (MHS) providing direct support to our combatant commanders and delivering or arranging health care for our 9.6 million beneficiaries.

The Defense Health Program (DHP) request in the FY20 President's Budget is fully aligned with our enduring commitments around the globe and with National Security and National Defense Strategies – along with the Department's 3 lines of effort: to increase the lethality of our fighting force; expand strategic partnerships; and bring business reforms to DoD.

Consistent with the National Defense Authorization Acts (NDAA) for FY 2017 and 2019, this budget reflects and supports a number of reforms to the Military Health System (MHS), including the multi-year transition of the management of military medical treatment facilities to the DHA to better integrate our system of readiness and health.

For FY 2020, DoD is requesting approximately $33 billion for the DHP representing a 4% decrease from last year's enacted base budget. Almost $25 billion, or 77%, of our request directly supports patient care – delivered either in our military hospitals and clinics ($9.6 billion) or in the private sector ($15 billion).

Over the last eight years, the total Unified Medical Budget (UMB) has grown at a slower rate than overall medical inflation in the country. This successful management of cost growth can be attributed to a number of factors to include reforms to TRICARE reimbursement, the management of TRICARE contracts, health care delivery operations, pharmaceutical pricing, the

migration to mandatory home delivery for many prescription drug refills, and the implementation of standardized business processes across the enterprise.

Even with these successes, the Department remains vigilant about variation in year-to-year expenditures, and we are appreciative that Congress continues to grant the Department carryover authority each year. Carryover authority allows DoD to maintain better funding flows to minimize disruption of health care services to our beneficiaries. We are committed to making our health care cost projections even more transparent in the year of execution, providing regular updates to the committee, and providing full visibility to Congress on potential plans for reprogramming funds within the fiscal year should that possibility unfold. Furthermore, we will ensure that available funding is directed toward unfunded medical readiness and health care delivery requirements. Carryover authority is an invaluable tool that provides the Department with needed flexibility to manage issues that emerge during the year of budget execution. We request that it be continued in FY 2020.

There are several significant programmatic issues detailed in the proposed FY 2020 budget that we wish to highlight today, following analyses and reforms, that Congress directed the Department to undertake. Taken together, these reforms represent the most significant change to the MHS in decades. They include: the realignment of our management structure for overseeing military medical treatment facilities (MTFs); the continued implementation and standardization of enterprise-wide activities in support of global medical support activities; and the restructuring of the Department's medical personnel end strength.

The FY 2017 National Defense Authorization Act (NDAA) enacted sweeping reforms to the organization and management of military medicine. The over-arching direction from

Congress was to consolidate and standardize many military health care functions in a way that better integrates readiness and health delivery throughout the Department. Included among these reforms: the expanded authority and responsibility of the DHA to manage MTFs worldwide; the authority to convert military medical positions to civilian; and the authority to adjust medical end-strengths and infrastructure in the MHS to maintain core competencies of health care providers.

The DHA is a strategic enabler to the Department in supporting the readiness needs of our Combatant Commands and the Military Departments. By building a management structure with an enterprise focus, we are ensuring a medically ready force and ready medical force for any contingency for which our forces are called to serve.

The DHA will enter FY 2020 prepared to manage these expanded responsibilities for the delivery of care across the MHS. On October 1, 2019, our current plan is to have all MTFs in the eastern region of the United States transition to DHA administration and management – placing over 50% of facilities, admissions, and enrollees under the DHA. Enterprise activities for medical logistics, health facilities, and acquisition will be fully managed by the DHA. We will also be preparing for the transition of the remaining facilities in the continental United States and Alaska, targeting an effective date of October 1, 2020. The transition of overseas MTFs is planned for October 1, 2021.

By consolidating management of MTFs under the DHA, the MHS is positioned to reduce unwarranted variation in both clinical and administrative functions. By standardizing approaches to quality management, the MHS seeks to improve health outcomes, reduce errors and allow service members and other patients to recover more quickly by reducing the incidence of

hospital-based infections and other patient safety priorities. DHA's pharmacy operations established a standardized formulary, an enterprise-approach to managing the transition to mandatory refills of prescription drugs through its home delivery program, and movement to standardized pharmacy automation support in MTFs. Standardization in areas such as medical logistics and contracting help ensure the military medical work force functions with common equipment and supplies both in garrison and in the deployed environment.

With the expansion of DHA responsibilities directed both by the Secretary and by Congress, the Department is also streamlining military medical headquarters and reducing personnel overhead across the Military Departments. A ten percent (10%) reduction in headquarters medical personnel was applied across the Department in conjunction with the implementation of Section 702 of the NDAA for FY 2017, which consolidated responsibilities for management of military hospitals and clinics under the DHA.

The Department continues to manage other initiatives that reduce the growth in health care costs while ensuring our health benefit remains an exceptional tool for recruitment and retention of military personnel and their families. These DHA cost-saving initiatives strengthen the Department's financial posture without affecting access to care. We will continue to produce significant savings from the TRICARE contracts by restructuring terms and cost control initiatives for TRICARE contractors, and will continue to restructure contracts that incentivize greater risk-sharing. Payments to long-term care hospitals and inpatient rehabilitation facilities are being adjusted in a phased process to align with Medicare rates. We have increased IT savings through consolidation and rationalization of IT services and products. And, we have consolidated acquisition for education and training technologies and developed a DoD-wide common course catalog in our education and training programs.

The modest increase in retiree copayments beginning in 2018 also continues to produce cost savings to the Department. The Department is not proposing any further changes to patient cost-sharing in FY 2020.

The Department's budget proposes to increase investments in medical programs and services that directly support our medical readiness obligations. Notable areas include: increases for Air Force patient movement equipment, combat casualty care training, medical material and increased support for operations in the European Command, Central Command, and Africa Command areas of operations; and expansion of physical therapists in Marine Center Medical homes.

Another critical support component of our readiness mission is the fielding of a modernized Electronic Health Record (EHR) – MHS GENESIS. In August 2015, the Department awarded a multi-billion dollar contract for its new EHR system. In 2017, we began the initial deployment of MHS GENESIS in the Pacific Northwest. The purpose of the initial operational capability (IOC) deployment to four medical facilities in Washington State was to evaluate the system for full-scale deployment, identify additional change management issues, and resolve infrastructure and security concerns.

We are encouraged with the initial success of this deployment. Ms. Cummings' testimony provides specific examples of how MHS GENESIS has improved patient care and patient safety – to include the reduction of thousands of duplicative lab tests, and improvements in medication reconciliation at the time of patient discharge. We are proceeding with full deployment of MHS GENESIS world-wide over the coming five years. Later in FY 2019 we will begin deployment to additional sites in Northern California and Idaho. Together with the

Department of Veterans Affairs' decision to deploy the same commercial product in their system.

The DHA has also established an MHS Prescription Drug Monitoring Program (PDMP), similar to programs established by individual States and territories to help combat the national opioid crisis. Through this initiative, DHA will share prescription information with other State entities to ensure patients do not receive overlapping opioid prescriptions that can worsen an opioid use disorder or cause an overdose.

We remain committed to sustaining the superb battlefield medical care we have provided to our Warfighters and the world-class treatment and rehabilitation for those who bear the wounds of past military conflicts. Our proposed FY 2020 budget sustains the medical research and development portfolio, allowing us to continually improve our capability to reduce mortality from wounds, injuries, and illness sustained on the battlefield, and in the execution of our readiness responsibilities.

Specific research programs support efforts in combat casualty care, traumatic brain injury, psychological health, extremity injuries, burns, vision, hearing and other medical challenges that are militarily relevant and support the warfighter. This budget proposes increased funding for battlefield injury research and establishes a permanent baseline for mission-essential research. Additionally, we have sustained funding for technology and advanced concept development. The successful investment of research dollars has also allowed us to move proven advances in areas such as clinical enterprise intelligence and the Defense Occupational and Environmental Health Readiness System into Operations and Maintenance funding lines, and out of medical research.

The process established, through the Congressionally-Directed Medical Research Program (CDMRP), allows the Department to also ensure innovative, external research opportunities identified by Congress are well-managed. We intend to sustain our CDMRP management infrastructure into the future.

As part of the reforms directed by the FY 2017 and 2019 NDAAs, the Department has undertaken several initiatives regarding our military medical personnel. First, the Military Departments, the Joint Staff, and organizations within the Office of the Secretary of Defense conducted the required assessment of the operational medical requirements needed to support the National Defense Strategy. As a result of this assessment, the Military Departments plan to reduce overall uniformed medical positions. This proposed restructuring will permit the Military Departments to repurpose active duty medical end strength for other operational/modernization efforts needed to support the National Defense Strategy.

The Military Departments and DHA are working closely together on the process for implementing these reductions responsibly and carefully. We are now identifying the alternative models – civilian hires, contract staff, military-civilian partnerships, or use of existing TRICARE networks – that will best meet the needs of beneficiaries. We will continue to meet all standards for timely access for our beneficiaries, and while care delivery locations may change, our commitment to provide high quality healthcare will remain steadfast.

As part of the MHS's effort to optimize our operations, we continue to standardize and strengthen our financial management tools. We are proud that the DHA was certified as audit compliant, as part of the broader federal government and DoD goals to achieve full audit compliance. We are continuing our implementation of a common cost accounting methodology

within the MHS that will improve accountability and transparency to the Department, the Services, Congress, and the public with improved insight into how resources are allocated in support of our mission. The DHA has adopted the Army's General Fund Enterprise Business System (GFEBS) as its cost accounting system, and the Uniformed Services University of Health Sciences has also migrated to this system. Navy Medicine is in the process of migrating from the Standard Accounting and Reporting System – Field Level in the coming years and we intend to begin transitioning the Air Force shortly after the Navy is complete.

Similar to our cost accounting standardization, we are proud of our efforts to standardize and centralize our performance management systems. We have created standard MHS-wide performance dashboards that provide stakeholders – both medical and line leadership – at all levels of the military with visibility into how we are preforming on key metrics. These dashboards show longitudinal performance in measures of readiness, health, access, quality, safety and cost. For readiness, we monitor both the medical readiness of the force – particularly the number of individuals with deployment-limiting conditions, as well as the readiness of the medical forces. We are expanding our ability to assess the number of military providers who are meeting our established "Knowledge, Skills, and Abilities (KSAs)" clinical competency and proficiency levels. We monitor critical indicators of quality and safety – – that point us toward high reliability as a system of care. Access to primary care and specialty care are measured along with patient satisfaction to ensure we are meeting patient expectations. And "costs per member per month" provide us with a metric used throughout the health industry to measure the efficiency with which we deliver needed medical services.

Our dashboards can be viewed at an enterprise level, by Service, by market, and by individual hospital or clinic. We have adapted the dashboard to provide us with metrics on the 8

MTFs that now report directly to the DHA, and will continue to adapt this management system as the MTF transition progresses. Commanders can assess their performance against expected benchmarks, against peer institutions, and – where possible – against civilian sector performance as well. These dashboards help us to both assess how we are doing in these areas, and where we need to invest resources, training, or management attention in order to achieve further improvement.

The FY 2020 budget represents a balanced, comprehensive strategy that aligns with the Secretary's priorities and begins to fulfill our requirements associated with congressionally directed system reforms. We look forward to working with you over the coming months to further refine and articulate our objectives in a manner that improves value for everyone – our warfighters, our combatant commanders, our patients, our medical force, and the American taxpayer.

Thank you for inviting us here today to speak with you about the essential integration between readiness and health, and about our plans to further improve our health system in support of the National Defense Strategy and for our beneficiary population.