Transcript

Department Of Defense Health Affairs Media Roundtable
Announcement of NDAA 2017, Section 703(d) Report to Congress

February 19, 2020

Presenters: Thomas McCaffery, Assistant Secretary Of Defense For Health Affairs; Dr. David Smith, Reform Leader For Health Care Management; Lieutenant General Ronald Place, Director, Defense Health Agency

ASSISTANT SECRETARY OF DEFENSE THOMAS MCCAFFREY OPENING STATEMENT:

Thanks for all of you joining us this morning. I think as many or all of you know, the Military Health System is in the midst of implementing several significant reforms aimed to building a more integrated and effective system of readiness and health. The National Defense Authorization Act of FY 2017, directed the Department to assess our hospitals and clinics, and to make recommendations for restructuring those facilities to ensure they are focused on military and force readiness. We reviewed all facilities through the lens of their contributions to military readiness. That includes making sure MTFs are operated to ensure service members are medically ready to train and deploy. It also means MTFs are effectively utilized as platforms that enable our military medical personnel to acquire and maintain the clinical skills and experience that prepares them for deployment and support of combat operations around the world.

Today, we submitted the required report to Congress that outlines the results of our analysis, including plans for changes in a scope of operations at 50 facilities across the U.S. This report details the department's readiness focus for medical facilities, while maintaining our commitment to provide all beneficiaries with access to quality health care. I will describe some of the changes in a moment, but first I'd like to reaffirm that the Military Health System remains committed to ensuring access to quality health care for every beneficiary we serve. Additionally, nothing is changing immediately, and we intend to mobilize every resource available to help our

beneficiaries and our staff navigate these changes. Our analysis demonstrates we need to adjust operations at 50 hospitals and clinics. The majority of the changes will be to outpatient clinics that currently are open to all beneficiaries, that we will modify to clinics for active duty service members only. These are the most significant changes for facilities and affect the largest number of our beneficiaries. Roughly 200,000 beneficiaries, currently empaneled for primary care at these MTFs will move over time into our TRICARE civilian provider networks.

Many are asking when these changes will be implemented. And, the short answer is, not right away. And that's because of how we intend to implement the changes. Before we transition any beneficiary from one of our hospitals or clinics, we will connect them with health care providers in our TRICARE network. And as you might expect, that process will take time. In fact, in several locations, with several MTFs, it could take several years for implementation.

The bottom line for our beneficiaries is that we will help guide them through every step of the enrollment change process when the time for action arrives. We will implement changes in a deliberate fashion at a pace local healthcare markets can handle.

Where are we making the changes? Later this morning, health.mil will publish a copy of the report that will include lists naming the changing facilities. I want to note a couple of important points about the report in this list. Our initial analysis indicated that of the 200 hundred-plus U.S.-based MTFs, 77 warranted a detailed assessment. That detailed assessment concluded that for 21 of these MTFs, their current scope of services should remain unchanged. That is for a variety of reasons, but most commonly, it is because our review indicated that the local civilian health care market did not, and likely could not, offer our beneficiaries appropriate access to health care. Thus, we are leaving these facilities open to all beneficiaries because of our commitment to military and veteran family access to quality health care. Second, you will notice several facilities listed as already in the process of changes. In some cases, locations have already completed a restructuring, not as a result of NDAA 2017 requirements, but because of

previous decisions by the military departments. The Department's analysis of these MTF's readiness needs support those decisions.

Let me close by saying that the idea of the Military Health System needing to focus our MTFs on their core mission of military readiness is not a new one. It has been the subject of outside analysis, internal health system reviews, examination by senior civilian and uniformed leaders, and very importantly, by the Congress. But simply much of our daily work at many facilities, while vitally important to our beneficiaries, is less relevant to supporting readiness. We are fortunate to have robust civilian provider networks in many locations that offer timely access to quality health care. And so we have an obligation to deliver access to care for our patients, but also to focus precious military resources on activities with the highest readiness value.

We are aware that seeing new care providers may be a big change for families. The doctor-patient relationship is an important one. And we recognize the shift from MTF-based care to civilian care may involve new out-of-pocket costs for some retirees.

I want to make clear that we are taking a careful, deliberate approach as we assess the market capacity of each location to accept new patients. If we determine market capacity in a particular location is more constrained than we estimated, we will reassess our plans and adjust as necessary. The bottom line is we are committed to refocusing our hospitals and clinics on readiness, and we are committed to providing access to health care to our beneficiaries. I am confident that the Military Health System can accomplish both of those goals.

With me this morning is Dr. Dave Smith, who led the team comprised of individuals from Health Affairs, as well as the military departments and the Defense Health Agency. This team is the team that compiled information and conducted the analysis for plans, and he will be available to answer the questions about the process that we used, and the conclusions that we drew from that process and analysis.

I also want to acknowledge that General Place, the director of the Defense Health Agency, is here as well. General Place, at the DHA, oversees our US-based MTFs, as well as the TRICARE

Health Plan. The DHA will be taking the lead role working with the military departments, the MTF leaders, installation commanders, and our network providers, on implementing the MTF-specific changes.

I also want to confirm that the change decisions that are reflected in the Report to Congress are made at a Department level, not at the Defense Health Agency. The changes in the report are not a result of DHA's new responsibility for managing the MTFs which was another directive coming from Congress as part of NDAA 2017. That said, it is going to be DHA's responsibility to, again, work with the military departments, our providers in the local communities, to plan and execute the detailed implementation plans at the MTF and market level. As the DHA collaborates on these plans, they will work with our managed care support contractors to help communicate details for each effective person when a time for action arrives. Until then, normal operations at these facilities will continue.

The health system is committed to maximum transparency at every step in this process. It's our priority to help approximately 200,000 out of the over 9 million beneficiaries who will be affected by these changes to retain uninterrupted access to health care as we help transition them to new providers. Again, I appreciate you carving out time this morning, and we are happy to answer any questions you may have.

**Question:** My question is really about oversight of this transition. I know you said DHA is going to be handling the transition and communication itself but, in terms of making sure that the provider network in the areas can, in fact, handle the influx of patients, and that network, should the contractor say it's ready, actually be ready once it starts. What is the oversight of that and what will the process be for making sure people are actually getting what they need?

**Hon. McCaffery:** Yes, that responsibility will be with the Defense Health Agency, as I indicated. We now have under that one roof, under DHA, both the responsibility to oversee and manage all of the MTFs, but they also are the entity that operates and oversees the TRICARE program. So, it will be the Defense Health Agency, working with the local MTF leader, the installation commander, and our TRICARE network partners in making those determinations in terms of assessing, indeed, the ability of that civilian healthcare market to take on additional patients. When you receive the report, you can dive into the

report. It makes very clear that we recognize this is a MTF-by-MTF, market-by-market implementation. We readily recognize that some of these changes may take two, three, four years to implement because it's going to be contingent upon that local health care market to be able to take on those additional patients. It will be the Defense Health Agency that will make that call and work with the local providers.

**Question:** Thanks for taking my question. Can you give us an idea of the breakdown of military active duty family members who are affected, retirees and family members, percentage wise?
**Hon. McCaffery:** Yes. So roughly, if you look at the approximately 200,000 beneficiaries we believe will be impacted by these changes over time, roughly 80,000 of those are active duty family members, and the remaining are retirees and their families.

**Question:** And then, as a follow up to that. What happens to the military positions that are like pediatricians and professional people that are not really geared towards warfighter treatments. Are they part of that 18,000 that we hear about, and when will we see the results of those studies.
**Hon. McCaffery:** That's a good question. Let me step back and underscore that this direction from Congress to right size or realign our hospitals and clinics to better meet readiness requirements is separate and distinct from what the Department proposed last year in terms of military manpower end-strength reductions. That said, one of the things that Congress, in the current NDAA ‘20 required the Department, before we can implement those manpower reductions, we have to do a number of analyses and reports that articulate to Congress how we came up with our proposed reductions, and how we will mitigate any impact on access to care. We owe that to Congress in June. And, part of that plan in analysis, we will be incorporating any impacts that this resizing or restructuring of hospitals and clinics will have with regard to manpower. So it will be integrated into that report in June.

**Question:** In the Defense Health program ‘21 budget, it looks like you guys were bucketing this downsizing as part of the Defense Wide Review and claiming something like $36 million in savings in ‘21. So I'm just wondering, to what extent is the nature and character of this list driven by the Defense Wide Review and/or budget concerns more generally. So, would we have

seen a similar list without the Defense Wide Review, I guess that's my question.

**Hon. McCaffery:** Oh, yes, most definitely. As I mentioned, actually the conclusions and findings from the review that are in the report were directed by Congress back in NDAA 2017. There were multiple phases to that effort. And, this is the final report identifying the results of the review and our proposals for restructuring. So, that was that was in the offing before the Defense Wide Review. And again, I want to reiterate that the focus of this effort is very consistent with some of the principles of the Defense Wide Review is ensuring that we are directing and investing our resources to things that tie directly back to support of the National Defense Strategy. That's what this review is about. It is recognizing, and Congress recognizes this as well, that our military hospitals and clinics are first and foremost, military facilities that exist with the primary focus on being the platforms by which we train our military providers to do their job, and also to ensure that our active duty get the care they need to make sure that they are medically ready to do their job. So, this is really about making sure we meet our readiness requirements, and we are investing resources accordingly.

**Question:** Just a quick follow…that $30 million figure I mentioned, should we read into that? If you guys think that this these populations are going to be cheaper to serve in the purchase care market.

**Hon. McCaffery:** I'm going to let Dr. Smith weigh in here in terms of our overall methodology and how we came up with these savings that we have booked for FY 21.

**Dr. Smith:** So, the thought is that we're going to be able to, from a readiness point of view, move military providers to locations where they will be able to get more reps and do that care. We have generally found that through our contracts that our care often is cheaper in the network. From a government purchase point of view, than the cost of actually doing it within our direct-care system in some locations. And clearly, as part of our methodology, that was one of the questions that we asked. But, the principal question was, are we getting readiness value out of this location that is worth the cost, if you will, compared to putting that somewhere else in the system. And so, I hope that answers your question, but that's the basis of where we were, we got this.

**Question:** I just wanted to clarify on the savings part of this. How much total are you anticipating these changes will save and over what number of fiscal years?
**Dr. Smith:** We are recognizing that, as Mr McCaffrey pointed out, that this will take anywhere from two to five years depending on the location. So we're anticipating that there will be savings that will gradually increase over the course of this period of time. And at this point, they're projections. We won't know the actual numbers until we're clearly into the process. So, for '21, the number that has been mentioned is what we have put into the budget, which is $36 million. But we fully anticipate that there will be more savings than that over the course of the implementation of this plan.

**Question:** Can you say what the projection is? The Total?
**Hon. McCaffery:** No. As Dr. Smith indicated, this is a challenge for us in that we are saying this is going to be MTF-by-MTF, over multiple years, and we haven't yet developed the detailed execution plans. That's the next step. That will be done again MTF-by-MTF, market-by-market. So, it's very hard for us to have a projection of what this is going to mean over, you know, three, four or five years.

**Question:** If I could just follow up. I just wanted to clarify the number of facilities. I think at the top, if I heard you correctly, you said that there was a total of 300 facilities in CONUS, but Congressional Research Service indicates there's like 600. Could you just clarify the total number of facilities that this 50 fits into?
**Hon. McCaffery:** I will have the experts here correct me from wrong. What I referenced was…the focus of the review was only in CONUS, so only U.S.-based facilities. And, I mentioned "over 300-plus", I believe the figure is 348, there about. Again, this is U.S.-based, so it's not including anything overseas. Out of that initial review, based upon data on workload and readiness requirements, 77 merited an actual deep dive assessment. And, from those 77, we concluded 50 warranted a change in the scope of their services.
**Dr. Smith:** Just to further clarify on the numbers, we can provide you with the specifics, offline, but often, it depends on how you're counting. In this case, we were looking at just the medical clinics. We were not looking necessarily at the dental clinics or the veterinary clinics. So, it will depend on

what number you're looking at, but we can provide you that breakdown.

**Question:** I was wondering, two things. One, did you actually speak to these 250,000 (sic) patients affected? Did any of them say whether or not they would like to move or don't want to move? Did you take them into account in your decision-making process in any way, they're their feelings on their own provider and whether or not they want to stay with their own provider? And, secondly, back to Travis's question, there has to be some estimate beyond the $36 million. I mean, obviously, if you're trying to return 50,000 people to change doctors, you would hope that you have some projected savings. Otherwise, you know, that's a lot to go through and potentially a lot of inconvenience for the families if there's not really some chunk of change at the end of that. So, I was hoping you might be able to address that.

**Hon. McCaffery:** So a couple of things. Number one, our review included a lot of different data sets and efforts, one of which was actually for many of the facilities that warranted this deeper dive, actually an on-site team going to the installation, to the MTF leadership, engaging them personally in terms of what would this mean, based upon their knowledge of that local market, what they thought the local market could absorb in terms of new patients, our work with the TRICARE contractors and their knowledge of the local provider network in terms of what would the potential impacts on beneficiaries. We did not contact these 200,000 people. This is basically our assessment of where we are making proposed changes, who are our enrolled beneficiaries in those markets in terms of the potential universe of beneficiaries to be impacted.

On your question about savings and the focus on savings, while we definitely believe, as Dr. Smith indicated, that this realignment will indeed produce savings over several years, the focus of this review was about readiness. The focus is to ensure that the way we operate, and the services we provide at our military hospitals and clinics, are directly in support of that MTF being a training platform for our medical force, and ensuring our active duty get the medical care they need to be medically ready to do their jobs. That is the focus of the directive. And, as a byproduct of that, we anticipate there will be savings to the overall system.

**Question:** But you don't have a number?
**Hon. McCaffery:** The number that we have the most confidence in is in FY ‘21. We do not, as I indicated … because this is going to be an MTF-by-MTF implementation over different time periods based on MTF markets, we do not have a solid projection beyond FY ‘21.

**Question:** If we're having these family members change hospitals, how does that actually help readiness, in practice? It sounds like it could be unfairly shifting a huge burden on military families which ultimately falls on the service number. And then, is this just to save a couple of bucks in the grand scheme of the Pentagon massive budget overall. And, it could just end up costing a lot of time and travel on the service member, ultimately.
**Hon. McCaffery:** So, a couple of couple of comments. Number one, again, this is tied to the readiness requirement. What I mean by that is, if you look at the 50 facilities, in two of those 50, we are actually recommending enhancement in the services they provide, again, to support the readiness requirement. But number two, what we found in our review is that many of these facilities do not have the type of patient caseload volume acuity that we need for our providers to have access and to be proficient to do what they do downrange. And so, by limiting the scope of services, that will allow us to take some of those providers, and place them in other MTFs, that indeed have that kind of patient caseload volume and acuity, that is a direct match for their readiness requirements. So, that is the connection to readiness. With regard to costs and impacts to active duty service members and their families. Our proposal would not have any impact in terms of increased costs, with one exception. What I mean by that is, active duty and their family members, even if they need to go downtown for care, will not be required with additional copays. The exception being if they fill their prescriptions off-base at a retail pharmacy, they will have a copay. But, active duty and their family members are protected from the additional costs from these changes.

**Question:** At a lot of facilities, are they just not getting the volume of patients necessary, essentially, to make it work out?
**Hon. McCaffery:** Correct. It will to make it worth it. With regard to having that MTF be an appropriate training platform for our medical providers. That's correct.

**Moderator:** We're coming up on the end of our time here and I wanted to open it up to Mr. McCaffrey or General Place or Dr. Smith, if you have any closing comments to make.
**Hon. McCaffery:** As I as I mentioned, the focus here is to ensure the central purpose of our direct care system is in support of National Defense Strategy military requirements. That's what this review is about. But very importantly, as we do this, as we implement these changes, as I indicated, we are going to be deliberate. Nothing is changing immediately. This is going to be a multi-year effort, and it is contingent upon, as we get into the actual implementation and we're working with those local civilian health care markets, that they do have the capability to take on new patients. And if, for some reason that changes on the ground, we are going to reassess our plans. We want to make sure our beneficiaries continue to have access to care.

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