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**DEFENSE HEALTH AGENCY: BUDGETING
AND STRUCTURE**

HEARING

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SUBCOMMITTEE ON MILITARY PERSONNEL

OF THE

COMMITTEE ON ARMED SERVICES
HOUSE OF REPRESENTATIVES

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DEFENSE HEALTH AGENCY: BUDGETING AND STRUCTURE

HOUSE OF REPRESENTATIVES,
COMMITTEE ON ARMED SERVICES,
SUBCOMMITTEE ON MILITARY PERSONNEL,
Washington, DC, Wednesday, February 24, 2016.

The subcommittee met, pursuant to call, at 5:01 p.m., in room 2212, Rayburn House Office Building, Hon. Joseph J. Heck (chairman of the subcommittee) presiding.

OPENING STATEMENT OF HON. JOSEPH J. HECK, A REPRESENTATIVE FROM NEVADA, CHAIRMAN, SUBCOMMITTEE ON MILITARY PERSONNEL

Dr. HECK. Let me go ahead and call the subcommittee meeting to order. Today the subcommittee meets to continue our discussions on the military healthcare system, to help inform our efforts to reform military health care. I know the timing of our hearing is a little unusual for the Military Personnel Subcommittee. I appreciate everyone's participation even at this late hour. Just too much to get done and not enough time to get it done in.

The Defense Health Agency [DHA] was established in October 2013 to manage the activities of the Military Health System [MHS], which includes integrating clinical and business processes across DOD [Department of Defense] and the military services. A key element was establishing shared services to eliminate the need for each of the military medical services to manage functions that are common across the MHS.

At the time the DHA stood up, DOD estimated that the shared services would generate significant savings by eliminating redundancy and variability. I am interested in hearing how much the DHA has saved DOD since 2013. I am also interested in hearing about the DHA's role in medical readiness, and in particular, how the DHA assists the Army, Navy, and Air Force medical services to provide a medically ready force and ready medical personnel to combatant commands.

In the fiscal year 2017 budget the Department of Defense has proposed several measures aimed at reducing the cost of the defense health program by reforming TRICARE. While I appreciate the Department's efforts to simplify the health benefit, the proposal still shifts the cost burden through TRICARE fee and cost share increases to our Active Duty family members and our retirees.

What is not clear from the Department's proposals is how this reform addresses the concerns we have heard from our beneficiaries. Does it improve access to care and reduce the hassles of

the referral process? Will the anticipated savings generated by the reforms be used to improve the beneficiary's experience?

Lastly, I am interested to hear your views on the MHS structure and function especially as it compares and contrasts with civilian hospital systems. I hope that our witnesses will address these important issues as directly as possible in their oral statements, and in response to member questions.

Before I introduce our panel, I would like to offer our ranking member, Mrs. Davis from California, an opportunity to make her opening remarks.

[The prepared statement of Dr. Heck can be found in the Appendix on page 25.]

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

Mrs. DAVIS. Thank you, Mr. Chairman. I also want to welcome our witnesses, especially Admiral Bono. I believe that this is your first hearing before our subcommittee in this capacity.

And Dr. Woodson, I hope that this will certainly not be the last time we are able to hear from you this year. And I look forward to working with you on these reform efforts. And I know that you have worked very hard on this for quite some time.

The committee has held several roundtables and hearings over the past several months to try and better understand the Military Health System. And our goal is to find the most appropriate way to reform the military healthcare benefit in order to provide the best, the most cost-effective benefit, while maintaining, of course, the appropriate level of medical readiness for the force.

Your written statement details the initiatives that you have taken on your own as well as the legislative reform proposals that you have submitted once again for our review.

And I look forward to discussing how we can move forward together to continue to provide access to quality health care for your beneficiaries as well as ready and capable providers to care for our force.

Thank you very much, Mr. Chairman, and I know we have a number of objectives with this hearing today, and I hope that we are able to work through those. Thank you.

Dr. HECK. Thank you, Mrs. Davis. I would respectfully remind the witnesses that we desire that you just summarize, to the greatest extent possible, the high points of your written testimony in 5 minutes. As a reminder, you see the lighting system in front of you. At 4 minutes gone it will turn yellow and when your time is up, it will turn red.

At this time without objection, I ask unanimous consent that additional statements from The Fleet Reserve Association and The Military Coalition be included in the record of this hearing. Without objection, so ordered.

[The information referred to can be found in the Appendix beginning on page 53.]

Dr. HECK. Let me welcome the panel. I am pleased again to welcome back the Honorable Dr. Jonathan Woodson, Assistant Secretary of Defense for Health Affairs, and for the first time wel-

coming Vice Admiral Raquel Bono, Medical Corps, United States Navy, Director of the Defense Health Agency.

With that, Dr. Woodson, you are recognized for 5 minutes.

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

Secretary WOODSON. Thank you very much. Chairman Heck, Ranking Member Davis, members of the committee, thank you for placing the issue of Military Health System reform high on your agenda for 2016.

The Military Health System takes great pride in its performance in combat medicine over the last 14 years, with a greater than 95 percent survival rates for those wounded in battle. Our ability to prevent disease through exceptional primary care and preventive medicine services produced equally historic outcomes and reduction of disease and non-battle injuries. The challenges we face in medicine and national security, however, continue to evolve and require new approaches so that we are prepared for the future.

We have undertaken a number of initiatives to strengthen the Military Health System in all facets of its responsibilities, and they have been organized around six principal lines of effort which we have spoken about in previous testimony. I was, therefore, encouraged that last year's Military Compensation and Retirement Modernization Commission reviewed and supported many of the initiatives that we had already set in motion in the Department.

Let me briefly describe those efforts. First, we have modernized our management system with an enterprise focus. We established the Defense Health Agency that Vice Admiral Bono leads. The Agency is entrusted with providing common business processes and standards in support of the military departments and the combatant commanders, an approach that provides greater operational efficiency and ensures joint solutions to our customers. We identified multiservice markets and developed 5-year business plans to promote common solutions and optimize the use of the military treatment facilities, while providing required care to beneficiaries in the purchased care sector.

In addition, we have acquired and are now preparing to deploy a new electronic health record using commercial off-the-self products. Together with the Surgeons General and Vice Admiral Bono we have established an enterprise-wide dashboard to actively manage our performance in readiness, access to care, quality, safety, patient satisfaction, and cost. The Defense Health Agency achieved a milestone of full operating capability on 1 October 2015 and in its first 2 years saved over \$700 million.

Second, we are defining and delivering the medical capabilities and manpower needed in the 21st century. With the services the Department has embarked upon a thorough process to define essential medical capabilities and metrics to monitor readiness.

Third, as a result of the modernization study, we have analyzed infrastructure needs and rightsized several military treatment facilities, as well as made adjustments to move skilled medical personnel to markets where the MTFs can recapture care, they can maintain their skills, and reduce overall costs.

The fourth line of effort is perhaps the main focus of today's discussion. That is our plan for reforming TRICARE. We are appreciative of the input from the beneficiaries and the service organizations that in recent testimony have expressed their support for TRICARE. The TRICARE benefit was named the number one health plan in the country for customer experience by Temkin in 2015, owing in no small part to the comprehensive coverage and low costs to the beneficiaries. But we also heard loud and clear from our beneficiaries that access to both primary and specialty care needs attention, particularly in the MTFs.

In response, we have implemented a number of access improvements last year to open up appointments and resolve appointment issues on the first call. We are improving access to after-hours care, particularly childcare, whether that is through evening clinics, weekend clinics, the ability to email providers with questions through secure messaging, the availability of a 24/7 nurse advice line that is integrated into our appointment system, streamlining the referral process, and implementing urgent care demonstration programs that Congress requested in last year's Defense Authorization Act. Our T2017 contract which will be awarded in 2016 includes provisions that further improve upon the experience of care for our beneficiaries. The PB17 [President's budget for 2017] proposal provides choice and incorporates the feedback of our stakeholder groups.

The fifth line of effort has been to expand the strategic partnerships with the civilian health organizations to enhance our ability to meet and exceed our responsibilities in readiness, quality, safety, and satisfaction. Partnerships with the organizations such as the American College of Surgeons and the Institute for Healthcare Improvement are providing tangible benefits that offer us ways to sustain our trauma system, improve clinical quality, and become a high reliability organization.

Finally, the sixth line of effort is about the global health engagement where DOD is deeply engaged with other partners in reducing threats posed by emerging infectious diseases and building bridges through health care around the world. We have contributed to surveillance, prevention, diagnosis, and treatment strategies to combat well-known outbreaks of Ebola and now Zika, as well as ongoing efforts to prevent outbreaks in other areas.

We enter 2016 confident that the reforms in the MHS and health benefits can be further strengthened through a combination of legislative and operational reforms.

I am grateful for this opportunity to be here today, and look forward to your questions.

[The joint prepared statement of Secretary Woodson and Admiral Bono can be found in the Appendix on page 26.]

Dr. HECK. Thank you. Admiral Bono.

**STATEMENT OF VADM RAQUEL C. BONO, MEDICAL CORPS,
USN, DIRECTOR, DEFENSE HEALTH AGENCY**

Admiral BONO. Chairman Heck, Ranking Member Davis, and members of the subcommittee, thank you for the opportunity to appear here today. I am pleased to represent the Defense Health Agency and explain how the DHA is contributing to the moderniza-

tion of the Military Health System. In November, I was honored to become the Defense Health Agency's second director. Only a month earlier the Agency had reached full operating capability. After 2 years of collaborative work with Army, Navy, Air Force, medical leaders, and the Joint Chiefs of Staff, it established the concept of operations for many of the functions of the Agency.

Our responsibilities center on supporting the military departments and the combatant commanders in the execution of their missions. The Defense Health Agency was created in the recognition that most healthcare delivery is common across the Army, Navy, and Air Force; what we need, what we buy, and what a best practice entails in both the clinical and administrative environment. The Defense Health Agency helps bring together common support functions into a new enterprise-focused organizational structure.

We are able to help Dr. Woodson and the Surgeons General see and manage across the MHS in a more unified way. One of the principal ways in which we deliver the support is through this operation of shared services. Critical enterprise support activities include TRICARE, pharmacy operations, health information technology, medical logistics, public health, medical R&D [research and development], education and training, health facilities, contracting, and budget resource management.

In addition to the 10 shared services that have been implemented, the DHA has also brought in joint activities that had previously been distributed to the services that acted as executive agencies. These include the Armed Forces Health Surveillance Center, the Armed Forces Medical Examiner System, the DOD Medical Examination Review Board, the Defense Center of Excellence for Psychological Health and Traumatic Brain Injury, and the National Museum of Health and Medicine.

The DHA offers value, however, to more than our COCOMs [combatant commanders] and services. We serve as a single point of contact for many intra-agency, interagency, and external industry matters, simplifying the process for our partners and outside colleagues to work with the Department of Defense in support of a number of our imperatives: research, global health engagement, adoption of emerging technologies, healthcare interoperability, and more.

The existence of the DHA has streamlined engagement with the Defense Logistics Agency, Defense Information Systems Agency, and other field agencies. External to the Department, the DHA provides a single point of contact for operational matters with the VA [Department of Veterans Affairs], a number of agencies within HHS [Department of Health and Human Services], to include the Centers for Medicare and Medicaid Services, the Food and Drug Administration, the Centers for Disease Control and Prevention, the Public Health Service, and more. We have successfully collaborated with the Justice Department on the prosecution of healthcare fraud cases, most recently with highly suspect activities around compound medications.

We work with Treasury, State, and the GSA [General Services Administration] on a number of critical functions that directly support our healthcare mission. I would like to focus on one shared

service in particular, the operation of TRICARE, the military's health plan. TRICARE modernization is part of the MHS modernization plan that Dr. Woodson just outlined. We have a number of TRICARE initiatives already underway in 2016. Later this year, we will award the next round of TRICARE contracts known as T2017, which is when health care will become operational under the new contracts.

We are simplifying the contracts, reducing management overhead in both government and contractor headquarters by moving from three regions to two regions. We are expanding the means by which we manage the quality of our networks to ensure that they meet the expectations for quality and safety that we expect for our beneficiaries whether in the direct care system or in private sector networks.

We also will introduce innovative models for value-based purchasing in the coming year. My staff, in close collaboration with the services, is also crafting the contract amendments to permit TRICARE enrollees to use urgent care centers without preauthorization. And our analytics team provides the Department's civilian, military, and medical leadership at the headquarters and field level with the ability to assess enterprise-wide performance of the Military Health System using agreed upon joint measures for readiness, health, quality, safety, satisfaction, and cost.

The DHA is now an integral and integrated part of the Military Health System. We are proud to contribute to the modernization of this system through a joint collaborative solution and responsible management approach.

I am honored to represent the men and women of the Defense Health Agency and I look forward to answering any questions you may have.

[The joint prepared statement of Admiral Bono and Secretary Woodson can be found in the Appendix on page 26.]

Dr. HECK. I thank you both for your testimony. So, my first question is how does DHA relate to, and interact with, the service Surgeons Generals in carrying out shared services and in the relationship of facility management, staffing of facilities, and things along those lines?

Secretary WOODSON. Thanks for that question. And there are two parts, of course, to the revised enterprise management scheme, if you will, that we have outlined and carried out over the last few years.

So first is the Defense Health Agency that has the 10 shared services. And so in regards to your question about facilities, the Defense Health Agency provides the common business processes for managing those facilities. As it relates to governance and how the DHA interacts with the services, there is a governance system that is made up of medical operations group, and most importantly, the medical deputies advisory group, which looks at the enterprise priorities and helps set those priorities with Admiral Bono.

Dr. HECK. So then can you provide some examples of how DHA has achieved integration of clinical and business processes at the MTFs, across the services, and what are the additional opportunities for expanding common activities and functions across the MTFs?

Secretary WOODSON. So maybe I will start and then certainly Admiral Bono will want to chime in. I think the biggest example is in health information technology. Prior to the DHA separate activities in the three services, a lot of money goes into health IT [information technology], whether it is in DOD or it is in any private health system. Bringing it into enterprise focus, you can reduce the redundancy. You can actually develop the enterprise tool. I don't think we could field a new electronic health record without an enterprise focus on health IT. It is allowing us to make changes in the network, at lower cost, that will save billions of dollars going into the future.

Admiral BONO. A couple of additional areas, they would also be in pharmacy, where jointly working with the services we can create a uniform formulary that makes that available to all of our patients. We can also through this pharmacy shared services and working with the military services, have been able to move to almost 100 percent electronic ordering, order entry, not only within the MTFs, but from our providers, or from providers that are seen out in the network in the civilian world.

One other area is in medical logistics, in ordering the equipment that we use in the MTFs, and what we use even down range. So being able to collaborate and consolidate some of those purchases has saved us money as well as created less variability, or more standardization in the acquisition of those products.

Dr. HECK. So is all purchasing for durable equipment then purchased through DHA for the individual MTFs, or is there like a blanket purchase order that an MTF can buy off of at DHA-negotiated rates?

Admiral BONO. Yes, sir. We work very closely with the Defense Logistics Agency and so they have created an e-catalog which contains all that and all MTFs can order off of that catalog.

Dr. HECK. My next question is probably going to take longer to answer than a minute-30, so I am going to yield back my time and wait for the second round and recognize the ranking member.

Mrs. DAVIS. Thank you, Mr. Chairman, and I think we all recognize there are a lot of layers to this. And at the same time, I think you have made an attempt to simplify the proposals from what we had seen initially. And I am very pleased to see that. I think that is great.

But I am also wondering as we boil it down a little bit, I think the chairman mentioned earlier about shifting the cost, and the perception at least, and the reality for some, that there is a shifting of cost from the DOD to the beneficiary.

So I wanted to, you know, I guess to just echo, perhaps, what constituents might be asking. I am paying more for my health care, but what do I get in return?

Secretary WOODSON. Well, that is a great question, and so let me see if I can explain this from a number of perspectives. PB17 really offers a simpler system. We have boiled down a lot of different programs into basically a managed care variety which is the HMO [health maintenance organization] variety, and a self-manage which is preferred provider organization variety, or fee for service, which is the ability to go anywhere, any time to receive health care.

The issue brings into sharp focus, then it gives choice, because if you want to use the PPO [preferred provider organization] product or the fee-for-service product, you have the ability to go and see physicians that you want, when you want to see them. And particularly with the PPO product, no longer are you paying a percentage of the fee, but you are paying a fixed amount so you can predict your costs better.

We did the analysis, let's say, for a family of four. The actual rise in total out-of-pocket costs rises from about 8 percent to about 10.4 percent. And this needs to be seen in the context of when TRICARE was originally put forth where the cost share was 27 percent. So it modestly increases that cost, but it gives greater freedom. And of course, with the PPO product, the referrals go away, which was a major dissatisfier for many of our constituents.

There is no change for Active Duty. There is this participation fee, but again, because we have moved to a fixed copay, the actual increase in out-of-pocket expenses is only from about 8 percent to 10.4 percent. Notably also, is that our catastrophic caps are low. So your expenses will accrue against your catastrophic cap, and the issue really is that this is a major benefit of TRICARE versus other commercial products where the catastrophic cap is much, much higher.

So although there is a slight rise in that catastrophic cap, remember, those caps were reduced back in 2001 and have not risen over a decade and nearly a half. There is also the second payer option that we have put forward which lowers the fees for those who have other health insurance. We have also set the fee structure so that it incentivizes for those who are around MTFs really to receive care at very low cost or no cost if they receive care in the MTFs.

So I think there is great value there. There is a very modest increase in cost, again, to this average family of four, but it is in the context of having had a diminished cost share that has progressively gone down over the years.

Mrs. DAVIS. I don't know, Admiral Bono, if you want to—I actually wanted to sort of throw something else in there about an FEHBP [Federal Employee Health Benefits Program] option that might be along a continuum in terms of what people could look at. I would suspect that that would only be for people who would choose to have increased costs that would, you know, have a higher share of that option, but it would be possibly part of a continuum. And I think that folks have thought about that a little bit. We will probably have a chance to get into that in terms of whether you think it would be a good idea or not.

But it certainly would continue to do that. I think that my time is up. But I think what you had to say is very helpful. I think we also have to find ways of doing it in a quicker elevator speech, so that people have an understanding immediately of what it means to their family. And maybe that additional percentage is the best way to talk about that.

But I know that there is a lot of concern out there that nevertheless, people are going to be paying a little bit more. And when you think in terms of the benefit, they want to know that they are really getting something for that. So thank you.

Dr. HECK. Mr. Knight.

Mr. KNIGHT. Thank you, Mr. Chair. So I just have a couple of questions on kind of the timing of this. I know this was established in 2013. Can you give me an idea of what happened before that, why we have had these problems, why it has taken a little bit long to figure out these problems? And because we are doing this kind of this purchasing power of getting the three services together, are there any audits that are going on out there that we can figure out if this is actually everything that we can do, or if there are other issues that we can handle?

Admiral BONO. So part of the evolution of the DHA was when we identified these shared services which were brought together and designed by the services. And the conditions for successful performance was identified there. What we realized was in bringing the services together, that in many times we each had different business processes to accomplish similar end goals. And so being able to standardize that, and understand what nuances or what specific service concerns were being addressed took some time to do that.

In addition, as we brought people together, we also had to understand what our own infrastructure had available to support some of this. And so it has been an adjustment but we have been able to watch that and look at it.

I think at FOC now, full operating capability, we now have the ability after 2 years of actually measuring what our baseline performance is, and now being able to measure our progress towards goals. So I think that was probably the primary issue in standing up the DHA, was bringing three services with different business processes.

Mr. KNIGHT. Do either of you believe that this might be a model to move forward with other services that the branches are doing, that maybe at some point they are going in three different directions, and they have to go in three different directions in certain aspects because they do certain missions. But in other missions they don't because, you know, a hurt soldier is the same as a hurt marine or sailor. So could we use this as a model to help in other situations in the military?

Secretary WOODSON. So the short answer is yes. If you look at medical as you have suggested in your statement, 85 percent of what the services do in regards to delivering care is alike. As a surgeon, I always say that the outcomes you want when you do a procedure, the resources you bring to having to do that procedure, the standards you want to apply are all the same no matter whether you are wearing an Army uniform, a Navy uniform, or an Air Force uniform. So 85 percent is alike. And that relates to the operational environment as well as the garrison environment.

There is that 15 percent which is service unique. So what Navy brings to a float platform and undersea medicine, what Air Force brings to aerial platforms, needs to be respected because they made great advances, and what Army brings to land-based projection of force, but the majority is alike, and so that is the underlying concept.

And I would remind the committee members that prior to the DHA establishment we had 19 studies that suggested that we needed to come together. And when we conducted the task force

back in 2011, it was pretty clear that we could achieve economies of scale and efficiencies, and so I think the issue is that we really have delivered on that at this point.

Mr. KNIGHT. Thank you. Thank you, Mr. Chair. I yield back.

Dr. HECK. Mr. O'Rourke.

Mr. O'ROURKE. Thank you, Mr. Chairman. Dr. Woodson, what do we know about available or excess capacity at military treatment facilities since this proposal would drive more customer use? Maybe I will just start there and I might have some other questions based on your answer.

Secretary WOODSON. A great question. So we need to look at it in two ways: outpatient capacity and inpatient capacity. Inpatient capacity we clearly have excess capacity particularly in many specialty areas. And we need to be able to utilize the MTFs more effectively.

In the outpatient, as is true throughout the country, there is less of a capacity in primary care. However, having said that, we have done analysis through the modernization study and we do have a significant capacity there, particularly if we drive up productivity. If we increase panel size, if we create capacity by use of telehealth and other mechanisms to interface with patients who don't require a face-to-face appointment, and just better management strategy. So there is capacity there.

Mr. O'ROURKE. And have you measured that capacity and is that a number that you have at the top of your head or one that you could get to the committee?

Secretary WOODSON. So I can get that to you, and I would rather take that for the record in terms of numbers, but let me just tell you that we conducted this modernization study which looked at just that. So I think we do have substantial data.

[The information referred to can be found in the Appendix on page 73.]

Mr. O'ROURKE. Okay. And then if I heard you correctly, part of the capacity will be developed by forcing efficiencies and modernization, or were you saying that that has already happened and it has created the capacity?

Secretary WOODSON. So that is in progress and as I mentioned in my opening statement, things like secure messaging, streamlining the referral process, increasing panel size, urgent care, things that increase our ability. You know, weekend and night clinics, pre-school clinics for children, all of these things increase your capacity. So we are carrying out those reforms as we speak.

Mr. O'ROURKE. Great. So when you provide those numbers for the committee, I would love to know what established capacity we have and then the capacity we project forward if we are able to follow through on these great initiatives that you talk about.

So one of the concerns that I hope your numbers will answer is whether there is any threat to current, you know, service members, Active Duty service members receiving care at military treatment facilities in terms of compromising capacity for their priorities and their care. And then I have another question related to that.

Secretary WOODSON. So I don't believe there will be any compromise to the services.

Mr. O'ROURKE. Because that capacity exists, great. And then the other question, Admiral Bono brought up care for veterans. Does the capacity then also exist to complement care provided at the VA where you have unacceptable wait times, especially in specialties like behavioral health and mental health, and should we avail ourselves of that capacity within military treatment facilities for veterans who may not be TRICARE beneficiaries?

Secretary WOODSON. So the short answer to that is yes. The longer answer is that we already have a number of sharing agreements with the VA around the country. And the issue really needs to be analyzed on a local level because all of the markets are different. And the capacity to take care, of particularly, behavioral health individuals, will be somewhat market dependent.

So the short answer is yes. But the more involved answer and we have got data to look at the distribution of the facilities and what is available in each market.

Mr. O'ROURKE. Great. I look forward to seeing that and to the degree that you can localize that capacity, I would love to know, for example, William Beaumont Army Medical Center in El Paso at Bliss, what we have and what we project going forward. Maybe other members would like to know that for their districts as well. Thank you very much. I yield back.

Dr. HECK. Ms. Stefanik.

Ms. STEFANIK. Thank you, Mr. Chairman, and thank you to the panelists for testifying today and for your service. I wanted to direct my question to Admiral Bono. I want to discuss the General Temporary Military Contingency Adjustment Program which, as you know, exists to offset the lower reimbursement levels provided under the Medicare payment model to sole community hospitals that provide care to large volumes of service members and military families.

In my district Fort Drum does not have a full MTF on post so soldiers and their families depend on community hospitals, one of which is the Carthage Area Hospital. Outpatient services to our military and their families represent anywhere from 30 to 35 percent of this hospital's outpatient services and unfortunately, Carthage is still being reimbursed at the Medicare levels. And although they have applied, they have not received relief from the General Temporary Military Contingency Adjustment Program. And this appeals process has been going on for 2 years, since September of 2013.

So my question is, what is DHA doing to alleviate these bureaucratic challenges facing facilities like Carthage Area Hospital?

Admiral BONO. Thank you for the opportunity. I confess that something like that is something I am still getting a better understanding. But your broader question about what DHA is doing to address some of these bureaucratic or these administrative challenges is something that I am taking into real strong consideration as we are going forward in the modernization of our healthcare plan.

In looking and in arriving at the DHA one of the first things that I realized is that many times we have policies or operations in place that need to be brought into a more modern approach, to be a little bit more agile, and to look at some of the processes we are

doing. This was particularly evident with some of our referral management operations and our processes there.

So I would like to take that for the record, and look at it a little bit more closely so that I can better understand where the opportunities are. But I share your concern on that that administratively, part of what I feel my responsibility to do is to make sure that the DHA is looking at our administrative processes and streamlining them to the best of our ability.

[The information referred to can be found in the Appendix on page 74.]

Ms. STEFANIK. Great. I appreciate that and I look forward to working with you to alleviate those bureaucratic challenges. But I would also like you to take for the record the specific case of Carthage Area Hospital, the uncertainty for 2 years since September of 2013.

[The information referred to can be found in the Appendix on page 74.]

Ms. STEFANIK. We are working with their office. We are trying to work with DHA, and we need to get more understanding of the decision, which brings me to my next point.

What actions have been taken to ensure that these reimbursement levels are determined in a transparent manner, so bringing more transparency to the decisionmaking process? Have you put any thought into that from your position?

Admiral BONO. I have, as a matter of fact, and I realize that being able to be more transparent is more helpful to everybody. So you will see that in many of our discussions. We are bringing that to the table, being more transparent about our conversations, being more transparent about our analysis as well.

Ms. STEFANIK. Okay, great. Bringing greater transparency would not only help this specific case of Carthage Area Hospital, but in terms of who qualifies for this program because there has been an independent audit of Carthage that basically says that they are beyond the 10 percent requirement; that outpatient services make up 30 to 35 percent, so they should qualify for this program. So we need transparency and clarification. And I am sure this isn't the only hospital that is facing this issue.

And I yield back the rest of my time.

Dr. HECK. Thank you. Mr. MacArthur.

Mr. MACARTHUR. Thank you, Mr. Chairman. I applaud you for thinking through how to simplify the TRICARE plans and I think the intended move to an HMO and a PPO makes some sense.

But the PPO, which is where I want to focus, still relies on your current networks. And as I read and I just read it again last week, the Military Compensation and Retirement Modernization Commission's overall assessment, they were pretty critical of the adequacy of the provider networks within the TRICARE system.

So I want to get into the weeds on this a little bit, but for starters, I would like to ask if you agree with their assessment of your networks. And if not, where do you differ? And I will, maybe I will start with you, Mr. Secretary.

Secretary WOODSON. Thank you very much for that question. And I don't agree with the assessment that the Commission made

about the adequacy of the network. There are several things I think that they considered in making that assessment.

So first of all, let's start with some big numbers. We have 424,000 physicians in the TRICARE network. And we have got virtually all of the 5,000 hospitals that are available to take care of our patients. But the issue is that, some of the assessments that were made relative to, let's say the Fort Bragg or the Fayetteville area, didn't take into account that when we considered the network development, we consider what is available in the MTF as well as what is required. So we have formulas that we use for trying to decide the adequacy of the network.

And the issue is that you may not need as many orthopedic surgeons in your network if you have got a lot of orthopedic surgeons in the MTF, particularly in that 30-mile area around the MTFs. You know, there are some other formulas that every insurance company uses to determine adequacy. It turns out that the average insurance company will have a ratio of particularly primary care providers to population of about 1 to 528. TRICARE's is 1 to 24.

Mr. MACARTHUR. If I can stop you there, though, because it is an interesting comparison. The difference is when you are talking about private insurers, if they are wrong, if their formula might be right overall, but in particular communities around the country there are gaps, their beneficiaries can walk. And they can go to a different insurer, a different plan, and remedy their own situation. The difficulty is under TRICARE, that remedy doesn't exist.

So let me just finish, my question then because I have only got another moment to try to unpack this, if we made the networks in the FEHBP available to our military personnel, what would that do in your opinion? Pro and con, what would that do?

Secretary WOODSON. So first of all, probably many of those physicians that are in these other plans are in our network. I mean, because physicians are in multiple plans. But to the issue of if there is inadequate, let's say, specialty in one area, two things: one, if you have a private insurance program, you are going to have to travel to get that care because the providers are not there. TRICARE has to pay for you to travel to get that care because we have a requirement to provide the care.

So one of the issues that you are addressing is very real, but it is a ubiquitous issue that in certain rural communities there aren't enough providers of a variety of specialties. But TRICARE must pay for that beneficiary to travel, which is not true in other plans.

Mr. MACARTHUR. But is it possible that there might be a closer service provider in a different network other than yours that perhaps they wouldn't have to travel quite as far?

Secretary WOODSON. And so, conceivably that could be a case, and certainly for Active Duty and Active Duty family members, they can actually go and see those providers without the added costs. So for the retiree, they may have to get a waiver, basically, but we have a requirement to provide care, so either there, or have them travel.

Mr. MACARTHUR. I thank you. I yield back.

Dr. HECK. Mr. Coffman.

Mr. COFFMAN. Thank you, Mr. Chairman. I am on health care on both sides of VA and DOD. Can you tell me, I know that the Vet-

erans Administration would certainly like to do more DOD work. To what extent is that occurring?

Secretary WOODSON. Thanks again for that question. We, too, would like to do more business with Veterans Administration. And as I mentioned before we have a number of sharing agreements and we are looking more closely how we can craft more mutually beneficial sharing agreements across the country.

One of the interesting things that has happened with the rollout of the VA Choice product, is that the way it was, I guess, outlined, it put in conflict our ability to, in fact, operate under the sharing agreements and we are actually trying to unpack that right now and resolve those conflicts so that we can be at liberty to do more work with the VA.

Mr. COFFMAN. Well, let me just say, I have had, obviously, problems with the VA in my district in the building of a hospital that happened to be \$1 billion over budget. And so during the process before I didn't know whether I could get funding for it, and obviously, we stripped the VA's ability to build another hospital again.

But I remember going to the University of Colorado Health System and saying, would you take over this project and work with the VA and somehow purpose this for veterans? And I remember during those discussions that were occurring when I was concerned about not getting funding and what I was going to do with this half-built building, they said something very interesting. They said, you know what, we will not have VA employees in this hospital because we have got two separate cultures and it would result in a separate standard of care. And I believe that the military medicine and the VA, I believe is two separate cultures. And I am very concerned.

We need to reform the VA. But until it is reformed, as a veteran of 21 military years of service, I don't want to see them taking care of our Active Duty. And I don't want to see them taking care of our Active Duty families. And I think that is absolutely important. And so I am going to push back the other way. And in fact, we had flag officers from other branches of the service that testified before us in an earlier hearing and essentially said the same thing: different standard, two different cultures, different standard of care, and they were not supportive. And so I would ask you to relook at that. And I think I am going to visit it for the National Defense Authorization Act coming up.

It would be wrong for our military personnel to subject them to that system. I want to clean it up. We owe it to our veterans to do that. But until we do, it would be wrong. My father was in military medicine and I can remember during Vietnam how those soldiers that came home from Vietnam severely wounded, were stabilized in the military system and were transferred to the VA for their rehabilitation. Thank God we don't do that right now. We keep our military personnel in the military system throughout the rehabilitation; only if they opt for the VA do they go to the VA. And so I want to caution you on the direction that you are taking. Do you have a response to that?

Secretary WOODSON. No, I appreciate your concern, and I appreciate your service and certainly your commitment to ensuring quality care.

And we will take that under advisement. I think the issue is that we will be absolutely certain. Some of these sharing agreements have been in place for a while, but we will relook at the quality of care in the organizations that we have the sharing agreements with.

Mr. COFFMAN. Thank you, Mr. Chairman. I yield back.

Dr. HECK. Thank you. We will continue with a second round of questioning. If you could, you know, compare and contrast the differences between the Military Health System and its MTFs with civilian hospital systems and the best practices that are perhaps on the civilian side. I think you have alluded to some of them and how you try to increase capacity by increasing operational hours, increasing panel size, increasing productivity.

How is that going to go? I mean, having worked in an MTF, certainly during my time there we did not have a taxing schedule of patient flow. Whereas if you were in a civilian hospital, you were expected to see many more patients in the same period of time. And as we have heard, you know, one of the issues that we hear from beneficiaries is the difficulty in getting an appointment slot.

So I understand, you know, you have alluded to implementing some of those things. How do you expect those to roll out and what is the role being pushed by DHA or does that have to be pushed by the Surgeons Generals? How does that actually get down to the MTF and implemented?

Secretary WOODSON. So the Surgeon Generals have a real role to play in this because under the current system they actually operate the hospitals. But I think the issue is that the leadership with Admiral Bono and the Surgeon Generals have made it clear that we need to pivot to a full patient-centric, customer-focus delivery system. So in answer to your question about compare and contrast, there are many things that are the same.

So we have to do hospitalization, we have to ensure access, quality, patient safety. We have to provide trained specialists. We have to organize and equip the hospital to provide those services and pay attention to all of those metrics that are important.

The contrast is, again, that the MTFs are medical force readiness platforms. They are soldier-focused readiness platforms, and the people who are in those MTFs tonight, or tomorrow, may be called to deploy somewhere in the world.

And so there is going to be some difference in operations and maybe some cost to the efficiency. Now, you can rightly push back at me and say, well, what is that cost? And I wouldn't have an answer for you today, but I can tell you that that is what we are working on now to define what is the readiness cost so that we can produce the efficiency and the productivity to the highest level it can be at.

Dr. HECK. And I appreciate it and I have said in just about every hearing that we have had on this issue that there is a cost to readiness and we have to be ready to assume that cost if we want to have a ready, deployable medical force and then a ready deployable combat force. So there is that intangible cost that the civilian sector does not have to deal with.

So transitions to the readiness issue as you just alluded to, as well as in your written testimony about how TRICARE supports

the readiness mission of the MHS with the military treatment facilities as a readiness training platform for medical forces. So how does DHA expand choice to the beneficiaries with their ability to choose either a military or civilian provider while making sure we recapture the right mix of patients to ensure that we do have that medically ready force as you mentioned, incredible strides in combat casualty care, but we have also got to be ready to do the humanitarian mission and take care of that elderly patient with CHF [congestive heart failure] in some far-off land? So how does DHA look at getting that patient mix.

Secretary WOODSON. Let me start the answer and then maybe Admiral Bono can chime in. So the issue, again, at a basic level is, we need to have a good flow of patients through the hospitals to ensure that we keep the skills current. And that is not only for the docs, but it is for the nurses, it is for the OR [operating room] teams, the medics, the x-ray techs, the pharmacy folks, you know, the respiratory therapist. We need to have flow.

And as you have indicated that when we get into the fight and particularly the medical fight, it is more than just trauma care. We actually have to take care of disease and non-battle injuries. And one of, again, our great statistics is the reduction in disease and non-battle injuries. So we need full-service platforms.

Now, to answer your last question about the issue of the right flow. First of all, let me just pivot a little bit to PB17 because I think what we have done in PB17 is set a fee structure that encourages folks to use the MTF. We have got to deliver on the customer care, the experience of care, clearly, but we have set a fee structure that that is the lowest cost option, and incentivizes individuals to use the MTFs.

But again, a lot of the detailed analysis relates to the geographic areas and what is available. So we can't put every subspecialist at every camp, post, and station, but we have got great centers and we have got great community hospitals that can be used more effectively. I don't know if the admiral wants to comment.

Admiral BONO. I think just to piggyback on that, by making sure that the direct care system is the more attractive option, we incentivize patients to come in, but that also means that we need to be prepared to take them. And so working with the Surgeons General we realize that we have to be able to make sure that it is easier for our patients to get in.

And some of the things that we have also put in place are single appointing centers, where the patient only has to call once, and also putting a first call resolution so with that first call the patient gets their appointment that they need.

What we have also put in place is the nurse advice line and this is something that we have implemented across all of the MTFs with the services. And so patients can receive that advice from the nurses, and be able to get some counsel on whether or not they need to go in to see somebody, or whether they can take care of that.

And then of course, Dr. Woodson mentioned asynchronous type of care through telehealth and secure messaging. All of that kind of combines to making sure that we have that capacity and that flow for our patients.

Dr. HECK. Mrs. Davis.

Mrs. DAVIS. Thank you, Mr. Chairman. I know, Dr. Woodson, you responded to Mr. MacArthur and trying to, what would, you know, is it even feasible to think about having an additional option for constituents? And I know that that was what the Commission brought to us, and they were interested and I think that you have done a good job of trying to lay out the piece as it relates to MTFs.

I raise it just because I think that there might be a very small percentage of people that would have an interest in it. I can't imagine that there would be a great deal because it would be more costly.

No other constituent should subsidize that interest on the part of someone who perhaps has some special needs for some reason or other within the family that they would choose to do that, just like people would choose more expensive options within, you know, their company plan.

Does, does that play a role somewhere? And I think partly what we are dealing with, of course, there is all of these regions whether urban, rural, I mean, so that people don't always experience the same health care where they go because it is a more limited ability of the community to respond, at least within a very short time span.

Secretary WOODSON. So thanks again for that question. So within the realm of possibilities, it is possible. The question is whether or not it is feasible and makes sense to do.

Because here is the issue: Number one, you would have to decide which benefits are going to be assigned to the health plan that they are going to get in the commercial market. So if you take the Commission's outline, they had OPM [Office of Personnel Management] setting up sort of a special exchange market where people could go and pick from 250 plans.

But the Department of Defense was still responsible for dental, vision, pharmacy, and many other aspects of the program. And so there were going to be many more touchpoints that any beneficiary would have to coordinate on their own in order to get their full set of benefits.

The biggest issue is, what would be the incentive? So TRICARE is a very robust comprehensive benefit. We have the best autism coverage, bar none, in the country. The question is, who would go and pay now a \$6,000, \$7,000 premium with maybe total out-of-pocket costs of \$9,000 as opposed to the \$1,700 that exists today? And then what would be our responsibilities if they are not happy with that insurance product about coordinating their care?

So, in the realm of possibility? Yes. Feasibility for a small percentage, frankly, they have that right, right now. They can do that. Right? Because all you have to do is not use your TRICARE benefit, and you can buy a commercial product or if your husband or wife works for an employer and they offer other health insurance, you can take that. So that option is there right now.

Mrs. DAVIS. I wondered about that. And part of the, I guess, transparency of this may be that it is helpful for people to see that. Even alongside the options that they have so that they know that, in fact, they really are getting great, great care at certainly a reduced cost.

And people, you know, might know that. They might go on the Net [Internet] and see that. But there might be some reasons, and I guess it is just part of trying to say to people, we want you to be sure that you have all of the information. And part of the process that we will be going through is providing people with good information.

So do you think that that would be information that would be important to people as in part of this education process? And I know my time is up. How are we going to go about making sure that people do get good information so they can make those decisions?

Secretary WOODSON. So that is an excellent point. We need to communicate effectively. We can certainly make people aware that as things stand today, they can exercise their option not to use TRICARE and buy commercial insurance and provide cost estimates so that they have a basis of comparison.

Mrs. DAVIS. Yeah, that might be helpful to do. Okay. Thank you, Mr. Chair.

Dr. HECK. Mr. MacArthur.

Mr. MACARTHUR. Thank you. I am going to actually continue that for a moment. I think we have to be careful when we talk about this because in that discussion I think we were conflating the Commission's recommendation of a private healthcare model with 250 plans, with what I started with, and what Mrs. Davis started with which was FEHBP [Federal Employee Health Benefits Program], which was not a, you know, such an involved and dizzying, frankly, set of options.

Personally, I don't think moving to a commercial system is advisable. I don't think it is necessary. And I was asking a much more directed question about a single option FEHBP which is currently run by the Federal Government and includes many networks which have been less criticized, frankly, than the Commission certainly was of yours. So I think we have to be careful.

And I also think complex systems are difficult to manage. You have got 9.8 million lives in TRICARE. It is a \$50 billion system. It is difficult to manage. And you have got the MTFs and the private contracts you have, but they are even more difficult to predict. And that is why I raise the question because I don't know whether people would opt for it. I have no idea.

All I know is the Commission was critical of the current networks. And I heard you, Secretary, that you have a large number of physicians in the network, 424,000, 5,000 hospitals, but this may be a problem of geography more than volume.

You may have plenty of providers. I am sure you do. The question is, do you have them where the beneficiaries have the need? And it is hard to predict that. And that is why I ask about whether another option allows people to make that judgment for themselves instead of all of us trying to make it for them, which is impossible to do.

That is a comment. I am going to ask another question, though, and that is, Admiral, you mentioned the plan to go from three to two regions in TRICARE. So I am going to take a little different direction now. I am always concerned that when we talk about a change we don't confuse motion for progress. And I would like to

ask you why is two better than three? These are still massive service providers, now each one gets even larger. How does that improve either service or cost?

Admiral BONO. With going from three to two, I think this is a great question and something that bears fleshing out a little bit. What we realized is we needed to be able to offer a more standardized benefit across all of our MTFs and across our services. And in looking at our geography and our current configuration where we had three, we realized that we could already, geographically, work with two main contractors and be able then to kind of standardize and reduce some of the variability that we saw in having three plans.

And so that was why we went ahead. We also looked at the overhead costs, not only within the contractors, but also within managing those from the DHA. And so we saw some great efficiencies by doing that by going to two.

Mr. MACARTHUR. I need you to be a little more specific. Because economies of scale can be deceptive. You have already got massive scale on all three of your regions today. So what further economies do you expect to get out of just two?

Specifically, I mean, you can't unpack all of that, but give me three, four very specific things that will be less costly in two regions than they are in three?

Secretary WOODSON. Administrative process, setting up the contracts, two versus three. You are going to have more standardized processes, easier flow as our beneficiaries move from one region to the other. We can standardize the automating process. We can standardize the communications to the beneficiaries and providers. We can leverage the use of their data systems without having to go to more data systems to do population management, quality management. So there are actually multiple benefits to moving to—

Mr. MACARTHUR. Then if that is true from three to two, why not go to one?

Secretary WOODSON. Well, that is a good question. I think it is about the issue of risk if you put all of your eggs into one basket. But that is a good question. But I would also make this historical note. You know, we didn't arrive at this overnight. Remember, there was a time when we had 12 and then 6, and then 4. And so we have been progressively getting here.

The ability to coordinate when you have four, five, six contracts is just a nightmare. The updates in the manual when these contracts roll out, so they are always out of sequence, administratively it is just a lot easier.

Mr. MACARTHUR. I would stay all night if I could, but my time has expired. Thank you.

Dr. HECK. Thank you. I got one last question because I didn't see it addressed in PB17. The fate of TRICARE Reserve Select [TRS]. So what happens to Reserve members? Are they going to be moved into either a TRICARE Choice or TRICARE Select plan, or do we maintain TRS?

Secretary WOODSON. So as a product it will be TRICARE Choice. But I think the larger question you are asking has to do with what are the optimum products for the Reserve Components? And that

is really under study because there are a couple of different, there are several different solutions that might be applied to the Reserve Component.

The real issue with the Reserve Component is that when they are mobilized, how do you prevent turbulence in terms of families having to switch doctors and insurance plans. The answer for the Reserve Component might be one of several options. One would be if everybody took TRICARE Reserve Select or now TRICARE Choice, they would have that PPO product and then they could use, and of course the member comes on Active Duty and nobody has to change doctors.

Another solution might be something similar to the Commission recommendation, which is to give BAHC [basic allowance for health care] when the reservist comes on Active Duty, and then they don't have to switch their insurance plan, but you just give them a basic allowance for health care.

Another solution might be to offer TRICARE Choice into the employer insurance plans, which might work for the employer and might work for the reservist because it might be a lower-cost option and get greater acceptance of TRICARE Reserve Select.

So there are many options, and we need to really poll and assess the Reserve community about what they are doing for insurance now and what the options are. Because we don't have the right answer. We don't have enough data to make the right answer now.

Dr. HECK. I appreciate that. Three very great options, I believe. Do you believe that you will have data in time to make a suggestion through this NDAA [National Defense Authorization Act] process that is going to probably wind up before June?

Secretary WOODSON. We will not have enough data for this cycle. We certainly will have for the next.

Dr. HECK. Okay. I appreciate that. Again, I thank both of you for being here so long at this late hour and answering the questions as effectively as you did.

There being no further business, I will adjourn the subcommittee.

[Whereupon, at 6:05 p.m., the subcommittee was adjourned.]

A P P E N D I X

FEBRUARY 24, 2016

PREPARED STATEMENTS SUBMITTED FOR THE RECORD

FEBRUARY 24, 2016

Opening Remarks – Chairman Heck
Military Personnel Subcommittee Hearing
Defense Health Agency: Budgeting and Structure
February 24, 2016

Today the Subcommittee meets to continue our discussions on the Military Health System to help inform our efforts to reform military health care. I know the timing of our hearing is a little unusual for the Military Personnel Subcommittee and I appreciate everyone's participation even at this late hour.

The Defense Health Agency was established in October 2013 to manage the activities of the Military Health System, which includes integrating clinical and business processes across DOD and the military services. A key element was establishing shared services to eliminate the need for each of the military medical services to manage functions that are common across the MHS. At the time the DHA stood up, DOD estimated that the shared services would generate significant savings by eliminating redundancy and variability. I am interested in hearing how much the DHA has saved DOD since 2013.

I'm also interested in hearing about the DHA's role in medical readiness and in particular, how the DHA assists the Army, Navy, and Air Force medical services to provide a medically ready force and ready medical personnel to Combatant Commands.

In the FY 17 budget, the Department of Defense has proposed several measures aimed at reducing the cost of the Defense Health Program by reforming TRICARE. While I appreciate the Department's efforts to simplify the health benefit, the proposals still shift the cost burden, through TRICARE fee and cost share increases, to our active duty family members and our retirees. What is not clear from the Department's proposals is how this reform addresses the concerns we have heard from our beneficiaries. Does it improve access to care and reduce the hassles of the referral process? Will the anticipated savings generated by the reforms be used to improve the beneficiary's experience?

Lastly, I am interested to hear your views on the MHS structure and function, especially as it compares and contrasts with civilian hospital systems.

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

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

Prepared Statement

of

**The Honorable Jonathan Woodson, M.D.,
Assistant Secretary of Defense (Health Affairs)**

**VADM Raquel C. Bono
Director, Defense Health Agency**

BEFORE THE

**HOUSE ARMED SERVICES COMMITTEE
SUBCOMMITTEE ON MILITARY PERSONNEL**

February 24, 2016

Chairman Heck, Ranking Member Davis and members of the Committee, I am pleased to discuss the Department of Defense's multi-year plan for modernizing military medicine in service to the 9.4 million Americans who rely on DoD for the delivery and coordination of healthcare around the world. I am honored to have Vice Admiral Raquel Bono, Director of the Defense Health Agency (DHA), join me in presenting this plan.

I want to thank the leadership of the Committee for placing military health care reform high on the agenda for action this year. There are a number of interconnected features of the Military Health System (MHS) that influence how we are organized, how we deliver and coordinate care, and how we interact with the broader American health system.

Over the last two and half years, the MHS has fully embraced an enterprise management approach to our work. Together with the Service Medical Departments and the Defense Health Agency, we have crafted strategies, policies, enterprise support activities, and leadership development programs that benefit the system as a whole. Our approaches to access, quality and safety are executed in a collaborative, interdependent manner. Operationally, where we work together in deployed environments or in multi-service markets, we increasingly ensure there is an integrated operating model that facilitates support to line commanders, to service members and to our patients.

For our beneficiaries, we recognize TRICARE is an essential and valued piece of that health system. Both military medicine and the US health system are in a period of profound change driven by new discoveries, technological advances, and integrated delivery models aimed at increasing quality and controlling costs. Our proposals for modernization include both operational actions that we are undertaking right now, as well as legislative proposals that we have included in the President's budget.

TRICARE is essential to recruiting and retention and is an integral part of our overarching strategy for the MHS – the Quadruple Aim: Ensure Readiness, Improve Health, Improve Healthcare, and Lower Cost.

As we institutionalize the lessons learned from fourteen years of conflict, and as we implement a series of actions emerging from the Secretary’s Review of the MHS, we must modernize our TRICARE program to better align with how medicine is delivered in 2016, and how patients expect to receive timely and high quality care.

DoD is taking a new approach to our reform efforts in 2016 and 2017. We are focused on defining value from the perspective of the patient. Emerging from the internal MHS Review, we have invested a great deal of time in understanding and evaluating our performance in access to care, clinical quality, and efficiency from our perspective as provider, insurer, and employer. In 2016, we are looking at healthcare delivery through the patient’s lens, and developing systems and processes that are responsive to their needs.

Our starting point in our modernization plan is the recognition that TRICARE is a good health benefit that supports an exceptional group of Americans. Recent testimony by beneficiary organizations to Congress reinforced the view that TRICARE is one of the most comprehensive health benefits offered by any employer in the United States. While valuing the TRICARE benefit, beneficiaries voiced to Congress and to DoD that they particularly want to see improvements in access to care. We have heard their concerns – and our reform strategy upholds the sacred promise we make to those who serve their country and to their families.

Congress and DoD have expanded eligibility, benefits and services under TRICARE over the 22 years it has been in existence. The most notable expansions include: TRICARE For Life – extending TRICARE benefits as second payer to Medicare for dual-eligible beneficiaries,

TRICARE Prime Remote – offering Prime-like benefits to active duty families when they are stationed far from military installations; and TRICARE Reserve Select – offering certain Reservists with the opportunity to enroll in TRICARE with a modest premium payment.

We have tied our MHS modernization plan to our overarching strategic plan. Our MHS strategy continues to use the Quadruple Aim as our north star – Improved Readiness, Better Health, Better Care, Lower Cost. This is the framework I will use to describe the actions underway and those we have proposed.

The Military Health System: Readiness at the Center of our Strategy

Over the last decade, the MHS performed superbly in providing combat casualty care and life-saving treatment, achieving historic outcomes in saving lives and preventing injuries and illnesses. Lessons from fourteen years of battlefield medicine, along with transformative changes in the practice of medicine in the United States, require new approaches to how we ensure medical readiness and how we best meet the expectations of our beneficiaries. We are continuously reevaluating and improving our approach to maintaining the health of the force, sustaining a ready medical force, and delivering quality healthcare to our beneficiaries – on the battlefield, on military installations, or in civilian healthcare settings

The MHS is unique in our national health system. DoD operates a global system of hospitals, clinics, and health team – both fixed and deployable – to meet the health needs of our military force, and to maintain the ability of *our MSH to meet the readiness needs of the force as we continue to assess reform strategies to improve this primary mission.*

When we say “readiness” is at the center of our strategy – we mean: the medical readiness of individual service members, the readiness of medical forces – and the need to build

and sustain the clinical skills of the entire medical team so they are best prepared for whatever mission they are called to perform. Readiness also *refers to family readiness*. The health and wellness of our military families affects service member readiness in direct and indirect ways. In 2016, we look at readiness from this broader perspective -- with consideration for the family members' viewpoint of whether our health system supports their own health goals.

TRICARE directly supports this readiness mission. In 2015, the Military Compensation and Retirement Modernization Commission (MCRMC) acknowledged the important role that MTFs have in sustaining the readiness of our medical forces. We have accepted a number of recommendations from the MCRMC and have launched a process to identify the essential medical capabilities needed to support the full spectrum of military operations.

One of the most important actions that we undertook during the Iraq and Afghanistan conflicts was the establishment of the Joint Trauma System (JTS). This system contributed significantly to the MHS' ability to produce historic survivability rates for those wounded in action, and accelerated our ability to continuously improve combat casualty care research, training and practice. JTS will be embedded as an enterprise-wide system that provides essential support to our combatant commanders around the world.

Of course, not all MTFs include the full spectrum of medical or surgical capabilities. This requires that we augment MTF-provided care by purchasing health services from civilian healthcare networks managed through the TRICARE program.

In 2016, we plan to expand choices for our beneficiaries – allowing them the opportunity to more freely seek care from either military or civilian providers. There are a number of ways by which we can expand our service offerings. For example, retirees who are Medicare eligible can receive care in MTFs. Caring for these types of patients helps ensure military medical

provider readiness. Likewise, resource sharing agreements with the Department of Veterans Affairs allow Veterans to receive care within MTFs, giving our military medical providers exposure to a more complex set of patient health needs. Other unique arrangements, such as civilian access to our Level I Trauma System and burn center at San Antonio Military Medical Center, ensure that our providers remain current with best practices in trauma and burn care – important skills to maintain for military operations. In other external resource sharing arrangements, military providers obtain admitting privileges at nearby civilian institutions, where they can provide a wider range of care for our beneficiaries, also allowing for clinical skills maintenance.

Although the MHS is an indispensable element of national security, the TRICARE feature of beneficiary choice also includes the choice of beneficiaries to receive all of their care from civilian providers. In some circumstances, this choice is driven by necessity – where beneficiaries reside in areas not near a military installation. In other circumstances, beneficiaries simply elect to receive civilian care even when military medical facilities are nearby. Some military retirees use other systems of care beyond TRICARE: the health care afforded to Veterans through the VA, the health insurance product provided through their employer, or the Medicare program. For those beneficiaries who elect to receive all of their care from civilian sources, whether by choice or circumstance, we are interested in exploring ways to direct beneficiaries to accessible, high quality providers.

The MHS is a complex web of relationships that extend beyond DoD to include other federal health partners as well as the civilian community. This integrated system of care requires relentless attention to the development of leaders with skills to operate in the joint environment. We recently reviewed our leadership development programs and identified the need to better

integrate and sequence these programs. I have directed our leadership team to put together a revised curriculum for leadership development in the joint environment that focuses on the development of management skills that further ensure readiness, improve health, access, and quality and responsibly manage cost.

MHS Modernization: Better Health

MHS modernization recognizes that our health system can be made even better; and that the delivery of accessible, high quality care, matched with exceptional customer service, is part of our mission, not secondary to it.

Our multi-year modernization plan offers a significant advancement in how the MHS will be a leader in healthcare delivery and customer service in the country. Our modernization plan raises customer service performance levels; improves health; further expands choice; simplifies the process of getting care and offers additional new ways to access care; ensures access to the latest healthy technology; helps direct patients to the highest quality of care; and continues to offer value at an out-of-pocket cost to our people that is lower than virtually any health plan in the country.

DoD has already begun its multi-year modernization of the TRICARE program. First, we will continue our efforts to prioritize health ahead of healthcare.

TRICARE has always had excellent coverage of important preventive services – and we're making it better. Most of our preventive services are available without any cost share. For example, any beneficiary (Prime / Extra / Standard / TRICARE For Life) can get required immunizations from any provider, to include retail clinics. We are going to expand the ease and

coverage of even more services in the coming year, and ensure our preventive services plan is fully aligned with the Affordable Care Act provisions.

TRICARE Modernization: Better Care

There are a number of components of health care delivery that are focused on better care. Access, quality and safety are among the predominant components in which we will dedicate our energy and resources in the coming year.

Access – Easier, Patient-Centered. We are overhauling every aspect of our how our patients get care – whether primary or specialty care.

Our patients deserve high quality care delivered safely and expeditiously. Yet, we frequently hear about problems accessing health care within the MHS. In our internal review, we heard that patients are concerned about being told to call back for an appointment, and dissatisfied with delays in getting care because of a cumbersome pre-authorization and referral system.

During the MHS Review, we found that MTFs generally meet defined access to care standards on average. However, there was a great deal of variation – there were MTFs that did not meet these standards and others who consistently performed better than the standard. In 2015, we incorporated two measures of access into an enterprise-wide, “Partnership for Improvement” dashboard, which is reviewed monthly by me and the other MHS leaders present today.

The same access standards apply to both MTF provided care and TRICARE Prime care delivered in the private sector. Assessment of purchased private sector primary care access is largely determined from patient experience surveys. According to survey data, individuals who

use TRICARE Standard or Extra are more satisfied with the care provided when compared to those who use TRICARE Prime. In 2016, we will be exploring beneficiary concerns more deeply by engaging focus groups on specific subjects.

Recent Congressional testimony from beneficiary groups suggests that the lower satisfaction with TRICARE Prime is related to the inability to get an appointment at an MTF and to the associated referral and authorization processes. NDAA 2016 called for improving access in the following ways: 1) make it easier for beneficiaries to move among the identified TRICARE managed care support contract regions; 2) allow TRICARE Prime *beneficiaries access to urgent care centers without a preauthorization* requirement under a pilot project; and 3) expand the public transparency of quality, safety and satisfaction information.

We have taken a number of steps to improve access to care. We implemented “first call resolution” policies ensuring that the appointment or referral will be completed during the initial call for beneficiaries enrolled to our patient-centered medical homes. I issued initial guidance for simplified appointing and first call resolution on June 2, 2015. We have already begun to see the positive effect of these changes from the patients’ perspective. Performance monitoring will ensure compliance and survey data is letting us know if our beneficiaries are satisfied with the results.

We are not simply monitoring our performance from this one action. We have put a number of policy and operational actions into motion already this year,

The Services and DHA undertook a listening tour to MTFs and with beneficiaries around the country. We learned a great deal from these visits. The Services and DHA have identified that peak hours of physician supply do not always match patient demand. In response, we are extending hours to evenings and *weekends in a number* of our MTFs. We have increased the

number of urgent appointment by 32% since May 2015, and we have expanded the overall number of appointments by more than 11%.

Part of our enterprise approach is to effectively use the demonstration authority that Congress has provided us and pilot new approaches to patient care delivery. We recognize that patients, particularly those with complex or chronic medical conditions, require ongoing services from a mix of primary care and specialty providers. I am directing demonstration projects in which we evaluate the use of “integrated practice units (IPUs)” into our medical homes. The most important feature of the IPU is that it organizes medical services around the patient’s needs and medical condition rather than organizing medical services from the health system’s perspective.

Contemporary access to healthcare is no longer confined to the four walls of a doctor’s office or dictated by drive time standards. Instead, information technology offers a variety of opportunities for patients to engage the medical system. Providers can extend their reach to treat or advise their patients beyond the clinic’s open hours or without requiring distant travel. Furthermore, many of these modalities offer new opportunities to support the warfighter wherever they are deployed. In January 2016, I expanded our policies to encourage greater use of telehealth, and permit its connection to the patient’s home. The new policy will enhance our abilities to provide telemedicine services and expand access for our beneficiaries.

In 2014, we established a Nurse Advice Line (NAL) for all of our beneficiaries. This new capability now fields 1,800 calls per day (significantly higher than we projected, and higher than most commercial health plans). Call volumes are increasing each month. Many patients, after engaging with the NAL, do not subsequently seek emergency care, but wait to be seen at their Primary Care Medical Home at the MTF. For those whose symptoms suggest a true emergency,

the NAL activates the emergency medical system and stays on the phone until help arrives. Additionally, the 24/7 NAL is integrated with our appointing and referral systems, ensuring beneficiary have round-the-clock access to healthcare advice and appointing services. We plan to expand the services offered by the NAL in the next year to increase convenient access.

The TRICARE program has leveraged web-based technologies to provide beneficiaries with information, secure ways to enroll for health care services, review claims, pay bills, and even make appointments. Patients can communicate with their providers using secure messaging services and download their medical records using Blue Button technology. We are ensuring that all primary care providers and most specialists use and promote the secure messaging capability with their patients. The new electronic medical record will add even more functionality for patients.

In 2016, the MHS will begin to deploy smart phone applications that will make it easy for our patients to contact their providers, access all of the TRICARE Online capabilities, and find useful information about the nearest MTF. We will also launch new telehealth capabilities that will allow providers to consult with their patients using video technology, along with capabilities for providers to securely monitor their patients' health remotely (e.g. blood pressure monitoring or other biometric data).

DoD will also implement a pilot program that allows enrollees to access urgent care centers without requiring a preauthorization, consistent with NDAA 2016. I am confident that these additional means of access – both virtual and physical – will have a significant, positive affect on satisfaction with accessibility and customer service among our Prime population.

For patients who receive referrals from their primary care providers, we are also streamlining referral processes so that patients will be advised of referral approval in a more timely way.

We are also proposing to allow beneficiaries who live more than one hour away from an MTF to enroll for care at those facilities. While we believe that patients should live in close proximity to their primary care provider, we also believe that patients should be able to choose their provider, even if the provider is more than an hour's drive away. However, we will retain contract provisions that require the civilian network to be constructed in such a way as to ensure easy geographical access, to the extent possible, for our beneficiaries, using existing drive time standards.

In our FY17 proposed budget, we introduce a new approach to the DoD health benefit that further simplifies the program for beneficiaries. Patients would be able to choose between a managed benefit that prioritizes care in the MTFs (and continues to offer MTF care at no cost to beneficiaries), and an unmanaged option that sustains the freedom of choice for beneficiaries to seek civilian care without restriction.

Our initiatives are intended to ensure retention of our existing enrollees as well as increase use of military treatment facilities for all beneficiaries. Our customer service enhancements are intended to encourage our beneficiaries who live near a military hospital or clinic to come back to the MTF.

Finally, in 2016, we will also award the TRICARE-2017 (T-2017) contracts, with healthcare delivery slated to begin in 2017, allowing for a 12-month transition period between contractors. T-2017 is another element in our efforts to simplify program management, reduce administrative costs, incentivize value and ensure quality with our network providers. We have

also streamlined processes for portability, helping ease beneficiary transition as they move from installation to installation. We will reduce TRICARE regions from three to two, eliminating unnecessary administrative overhead for both the government and contractors.

Quality of Care. The MHS is *proud of the quality of care we deliver*. The MHS Review found that the MHS performed well along the quality and safety parameters studied. However, similar to our findings on access, we found wide variation across MTFs and across safety and quality measures. Like health systems everywhere, we know we can improve further. And we will.

We have implemented a number of important measures to achieve that objective. In 2015, we standardized quality and safety measures across the enterprise and can now compare performance across all MTFs. We are now amending our TRICARE contracts to establish similar reporting for private sector care. Senior leaders monitor performance on a monthly basis.

MTF commanders are being provided with tools to both educate their staffs and monitor their performance. We are expanding participation in the American College of Surgeons (ACS) National Surgical Quality Improvement Program (NSQIP) to all MTFs with surgical capabilities. This partnership provides these MTFs with insights into improving surgical mortality and morbidity. In the coming months, we will provide the Institute for Healthcare Improvement's (IHI) Global Trigger Tool (GTT) to all MTFs to proactively assist in identifying potential safety concerns.

When serious chronic illness, medical conditions, special needs or injuries require a comprehensive coordination of care across multiple providers, beneficiaries will be assured of a personal case manager who will assist with coordinating care wherever it is provided – with other military hospitals, in the civilian sector, or with the VA.

The Department is going to adopt or introduce value-based payment demonstration projects in 2016. In 2015, we opened discussions with the Centers for Medicare and Medicaid Services (CMS) to explore how we can participate in several of the innovative payment reform initiatives that CMS has introduced over the past several years. By aligning efforts with other federal initiatives focused on value-based payment, we can leverage the extensive research that led to these demonstrations. And, the complex rules related to payment formulas have been incorporated into contractor-operated, federal claims processing systems. Several of the bundled payment demonstration projects – such as the recent CMS demonstration around bundled payments for joint replacements -- hold the most promise for the populations that we serve. We will provide the Committee with regular updates on our progress in this area.

Comprehensive information on service delivery – access, quality, safety and satisfaction – is available online to the public for the military health system as a whole with some limited information visible at the MTF level. Additional information will soon be available at the MTF, consistent with the direction from the Secretary of Defense and the NDAA 2016. We have engaged and will continue to engage our military and veteran beneficiary organizations in how we might present this information in ways that make the information more relevant and easier to understand. And, we encourage our patients to ask us questions about our quality and safety record, and to engage in questions about their own plan for health. And, the DHA is working with CMS to place MHS performance information on Hospital Compare to provide another outlet where our performance information will be publicly shared. We are incorporating beneficiaries into our quality management activities.

The MHS has identified six communities where there is a significant military medical presence by more than one Service Medical Department. We refer to these communities as

“multi-service markets.” Collectively, over 40% of all care we deliver in DoD medical facilities occurs in these markets and an equally significant amount of care is purchased from the private sector in these markets. We have provided senior medical leaders in these markets with enhanced authorities to coordinate service delivery; standardize appointing and referral policies; and reallocate local resources to best meet beneficiary needs. We have achieved some early successes in these markets relative to access to care and patient satisfaction.

These multi-service markets are major deployment platforms, and we similarly plan to use them as platforms for innovation. They reach across Service-specific populations and the lessons we learn from innovating in these markets can be more rapidly shared across the enterprise.

Health Benefits and Technological Advances – Leaning Forward. Healthcare is changing fast. And, with the generous support of Congress, TRICARE has been made more flexible and more adaptive to the changes in technology to advance health. DoD now has greater authorities to approve emerging technologies for coverage. We have already started this process – for laboratory-developed tests and for other promising medical procedures. Where the medical evidence is present, we will look to do more.

We are ensuring that TRICARE’s mental health and substance use disorder benefit meets current standards of care and – like our preventive services benefits -- align with the Affordable Care Act, Mental Health Parity Act and other federal health legislation. We have already eliminated the limit on inpatient behavioral health bed days, and we will finalize policies to ensure parity in other areas in 2016.

One of the most important advances we will introduce in 2016 is the first phase of deployment of our new Electronic Health Record (EHR) in the Pacific Northwest. This multi-

billion acquisition represents a major milestone for the Department. Our decision to purchase a commercial, off-the-shelf product provides DoD with a system that will support our journey to high reliability, allow ongoing private sector innovation to be incorporated into future releases, and support our interoperability objectives in sharing information with both the VA and with private sector providers. The EHR will also feature an advanced patient portal, providing our patients with easier access to their own health data – and improve their ability to manage their care.

Support for Children with Special Needs. Over the last several years, we have modernized TRICARE and the Extended Care Health Options (ECHO) program, expanding services to retiree families and eliminating financial caps on services. We are continuing to improve our complex case management services, with a particular focus on the unique needs of military families and frequent relocations.

TRICARE for Reservists. Issues regarding continuity of care, and continuity of coverage, for Reserve Component families have been raised by both the Reserve community and in the Military Compensation and Retirement Modernization Commission report in 2015. Although the TRICARE Reserve Select program has been well received and offers an excellent health benefit, the Department continues to explore opportunities that can accommodate those Reserve members and families who would prefer to retain their existing provider relationships.

TRICARE Support. In October 2015, the DHA reached Full Operating Capability. The TRICARE Health Plan is one of the principal enterprise support activities – or shared services – for which the DHA is responsible. Working closely with the Service Medical Departments, we are better able to coordinate policy and operational decisions in support of TRICARE changes in a more agile and transparent manner. Our other enterprise support activities – pharmacy

operations, health information technology, medical logistics, health facilities, public health, medical research and development, medical education and training, contracting, and budget & resource management – also provide essential support services to both combatant commanders and the Services.

I would like to highlight just one element of how this enterprise support better enabled critical support in a crisis. In 2015, the MHS witnessed an alarming escalation in prescription drug costs, largely related to increased utilization of compound medications. The DHA monitoring system identified potential fraudulent activity; recommended and concurrently implemented a series of enterprise-wide screening procedures in our military pharmacies, mail order and retail network that precipitously and safely reduced inappropriate fills of compound drug prescriptions; and coordinated with the Department of Justice in the prosecution of fraudulent actors and the recovery of funds.

Cost -- Responsible, Moderate Changes in Beneficiary Cost-Sharing. The full complement of improvements and services that we have put forward also requires investment. Most of these additional costs will be borne by the Department. For example, the implementation of shared services led the Department to reduce defense health costs by \$3.5 billion over five years, savings that have already been decremented from our proposed budget.

Since TRICARE and then TRICARE For Life were introduced, the percentage of care delivered in the private sector rather than in DoD medical facilities has grown. Today, over 60% of all DoD-funded health care is delivered in civilian settings through TRICARE. The integration of care delivered in military and civilian settings is – and will remain -- a necessary feature of military medicine. We will continue to assess our partnership with our civilian network and the impact of its prominence upon our direct care facilities, recognizing cost

efficiencies where possible. Over the last several years, overall defense health program costs have been well managed, with actual costs coming in less than projected at the beginning of the year.

Although costs have stabilized in recent years through both management actions on the part of the Department and a general slowdown in US healthcare inflation, National Health Expenditure projections, a product of the Centers for Medicare and Medicaid Services, anticipate a gradual increase in per capita health care costs to roughly 5 percent in coming years.

The Department has submitted several reform plans since 2005, largely to control health care costs. Last year, the submission of the President's Budget (PB) 2016 benefit reform proposal was relatively well received. The PB 2017 health benefit reform proposal leverages the PB 2016 proposal but makes some important adjustments. Following are the attributes of the PB 2017 proposal.

- A simpler system — provides beneficiaries with two care alternatives and overall less complexity in their health plan. TRICARE Select is an HMO-like (managed) option that is MTF-centric and TRICARE Choice is a PPO-like (unmanaged) option offering greater choice at a modestly higher cost.
- Economically emphasizes TRICARE Select leveraging MTFs as the lowest cost option for care to make full use of Direct Care capacity and also provides needed workload for military providers for readiness training.
- No change for active duty — who would maintain priority access to health care without any cost sharing but would still require authorization for civilian care.
- Copays — will depend on beneficiary category (excluding active duty) and care venue; it is designed to minimize overutilization of costly care venues. There would be no copays

in MTFs to facilitate the effective use of military clinics and hospitals and thereby improve the efficiency of DoD's fixed facility cost structure. There would be fixed network copays for the TRICARE Choice option without a deductible.

- Participation fee — for retirees (not medically retired), their families, and survivors of retirees (except survivors of those who died on active duty). They would pay an annual participation fee or forfeit coverage for the plan year. There is no participation fee for active duty members or their family members. There is a higher participation fee for those retirees choosing the TRICARE Choice option (\$200 higher).
- Open season enrollment — similar to most commercial plans, participants must enroll for a 1-year period of coverage or lose the opportunity.
- Catastrophic caps — which have not gone up in 10 years would increase slightly but still remain sufficiently low to protect beneficiaries from financial hardship. The participation fee would no longer count towards the cap.
- Medically retired members and their families and survivors of those who died on active duty would be treated the same as Active Duty family members (ADFMs), with no participation fee and lower cost shares.
- To ensure equity among ADFMs, the proposal offers all ADFMs a no cost medical/surgical care option regardless of assignment location and zero copays for ADFM emergency room use, including in the network.
- The Department will offer a second payer option with a lower fee for those with other health insurance.
- Fees and copays will be indexed at the National Health Expenditures (NHE) per capita.

There have been no changes to most cost-sharing elements of the TRICARE Program since it was established in 1994. At the time TRICARE was introduced, retiree family beneficiary out-of-pocket payments accounted for approximately 27% of total TRICARE health care costs. Today, retirees and their families only bear 8% of the costs, and our proposal raises that share to 10.5% of total costs. For active duty families, the changes are even smaller, moving out-of-pocket costs from 1.4% of total costs to 1.6%. By any measure, these changes are modest, responsible adjustments that place the Department's health program on a stable, long-term financial footing and preserve the foundation of the health system and its platforms for ensuring a medically ready and ready medical force.

We enter 2016 confident that an excellent health benefit can be further strengthened through a combination of legislative, policy, and operational reforms. Our health benefit plays an important role in readiness as well as recruiting and retaining the men and women in uniform who serve this nation.

The MHS continues to *serve as a unique and indispensable national security asset. It supports our active duty force and it retains its clinical skills through an active clinical practice in both peace and war.* It offers a ready asset to respond to humanitarian assistance needs and disaster response. The full complement of preventive, public health, primary care, specialty and specialty care services that we offer are necessary components for meeting the national security obligations of the United States.

Our *health benefit must continue* to ensure a ready medical force of military providers and support staff able to deploy anywhere, anytime with skills that support combatant commander requirements; provide access, choice and value of the health care benefit, and be fiscally sustainable for the Department.

The MHS reforms we have outlined today will help us meet the appropriately high expectations that beneficiaries have for us. Service members, military retirees and their families are right to expect affordable, accessible quality health care is available to them from both military or civilian providers, wherever they reside. We are committed to increasing value from their vantage point.

Our proposal represents a balanced, comprehensive package of reforms that are directly aligned with and address each element of our Quadruple Aim. We have initiatives that will improve readiness, improve health, improve care, and lower cost. 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 Admiral Bono and me here today to speak with you about the essential linkage between our readiness mission and our health benefit, and about our plans to further improve benefits and services for the long term.

Jonathan Woodson
Assistant Secretary of Defense (Health Affairs)

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

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

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

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

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

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

His prior military assignments include deployments to Saudi Arabia (Operation Desert Storm), Kosovo, Operation Enduring Freedom and Operation Iraqi Freedom. He has also served as a Senior Medical Officer with the National Disaster Management System, where he responded to the September 11th

attack in New York City. Dr. Woodson's military awards and decorations include the Legion of Merit, the Bronze Star Medal, and the Meritorious Service Medal (with oak leaf cluster).

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

Vice Admiral Raquel C. Bono
Director, Defense Health Agency
Medical Corps, United States Navy

Commissioned in June 1979, Vice Adm. Raquel Bono obtained her baccalaureate degree from the University of Texas at Austin and attended medical school at Texas Tech University. She completed a surgical internship and a General Surgery residency at Naval Medical Center Portsmouth, and a Trauma and Critical Care fellowship at the Eastern Virginia Graduate School of Medicine in Norfolk.

Shortly after training, Bono saw duty in Operations Desert Shield and Desert Storm as head, Casualty Receiving, Fleet Hospital 5 in Saudi Arabia from August 1990 to March 1991. Upon returning, she was stationed at Naval Medical Center Portsmouth as a surgeon in the General Surgery department; surgical intensivist in the Medical/Surgical Intensive Care Unit and attending surgeon at the Burn Trauma Unit at Sentara Norfolk General Hospital. Her various appointed duties included division head of Trauma; head of the Ambulatory Procedures Department (APD); chair of the Laboratory Animal Care and Use Committee; assistant head of the Clinical Investigations and Research department; chair of the Medical Records Committee and command intern coordinator. She has also served as the specialty leader for Intern Matters to the surgeon general of the Navy.

In September 1999, she was assigned as the director of Restorative Care at the National Naval Medical Center in Bethesda, Maryland, followed by assignment to the Bureau of Medicine and Surgery from September 2001 to December 2002 as the Medical Corps career planning officer for the chief of the Medical Corps. She returned to the National Naval Medical Center in January 2003 as director for Medical-Surgical Services.

From August 2004 through August 2005, she served as the executive assistant to the 35th Navy Surgeon General and chief, Bureau of Medicine and Surgery. Following that, she reported to Naval Hospital Jacksonville, Florida, as the commanding officer from August 2005 to August 2008. She then served as the chief of staff, deputy director Tricare Management Activity (TMA) of the Office of the Assistant Secretary of Defense, Health Affairs (OASD(HA)) from September 2008 to June 2010. She later served as deputy director, Medical Resources, Plans and Policy (N093), chief of Naval Operations. From November 2011 to June 2013, she served as the command surgeon, U.S. Pacific Command, Camp H.M. Smith, Hawaii. From July 2013 to September 2013, she served as acting commander Joint Task Force National Capital Region Medical. From September 2013 to October 2015, she served as director, National Capital Region Medical Directorate of the Defense Health Agency, and as the 11th Chief, Navy Medical Corps. She currently serves as director, Defense Health Agency.

Bono is a diplomat of the American Board of Surgery and has an Executive MBA from the Carson College of Business at Washington State University. Her personal decorations include Defense Superior Service Medal (three), Legion of Merit Medal (four), Meritorious Service Medal (two) and the Navy and Marine Corps Commendation medal (two).

DOCUMENTS SUBMITTED FOR THE RECORD

FEBRUARY 24, 2016



Statement of
The Fleet Reserve Association
on
Defense Health Agency: Budgeting and Structure

Submitted to:
House Armed Services Committee
Military Personnel Subcommittee

By
John R. Davis
Director, Legislative Programs

February 24, 2016

The FRA

FRA was established in 1924 and its name is derived from the Navy's program for personnel transferring to the Fleet Reserve or Fleet Marine Corps Reserve after 20 or more years of active duty, but less than 30 years for retirement purposes. During the required period of service in the Fleet Reserve, assigned personnel earn retainer pay and are subject to recall by the Navy or Marine Corps.

The Fleet Reserve Association (FRA) celebrated 91 years of service last November 11, and is the oldest and largest enlisted organization serving active duty, Reserves, retired and veterans of the Navy, Marine Corps, and Coast Guard. It is Congressionally Chartered, recognized by the Department of Veterans Affairs (VA) as an accrediting Veteran Service Organization (VSO) for claim representation and entrusted to serve all veterans who seek its help. In 2007, FRA was selected for full membership on the National Veterans' Day Committee.

FRA is a leading advocate on Capitol Hill for enlisted active duty, reserve, retired and veterans of the Sea Services. FRA's mission is to act as the premier "watch dog" group in maintaining and improving the quality of life for Sea Service personnel and their families. The Association is also a founding member of The Military Coalition (TMC), a 31-member consortium of military and veteran's organizations. FRA hosts most TMC meetings and members of its staff serve in a number of TMC leadership roles.

For more than nine decades, dedication to its members has resulted in legislation enhancing quality of life programs for Sea Services personnel, other members of the uniformed services plus their families and survivors, while protecting their rights and privileges. CHAMPUS, (now TRICARE Standard) was an initiative of FRA, as was the Uniformed Services Survivor Benefit Plan (USSBP). FRA led the way in reforming the REDUX Retirement Plan, obtaining targeted pay increases for mid-level enlisted personnel, and sea pay for junior enlisted sailors. FRA also played a leading role in advocating recently enacted predatory lending protections and absentee voting reform for service members and their dependents. More recently the Association played a leading role in abolishing legislation requiring current retirees to get a one-percent reduction in their annual cost-of-living-adjustment (COLA) until they reach age 62.

FRA's motto is: "Loyalty, Protection, and Service."

Certification of Non-Receipt Of Federal Funds

Pursuant to the requirements of House Rule XI, the Fleet Reserve Association has not received any federal grant or contract during the current fiscal year or either of the two previous fiscal years.

Defense out of Sequestration

Before commenting on Defense Health Agency (DHA) budgeting and structure, FRA wants to note with growing concern the long-term impact of sequestration on budgeting. Budget cuts mandated by the Budget Control Act of 2011 pose a threat to national security and will substantially impact member pay and benefits. These automatic cuts, known as Sequestration, require that 50 percent come from Defense, even though Defense only makes up 17 percent of the federal budget. FRA appreciates last year's budget deal eliminates a sequestration mandated \$38 billion cut in the FY 2016 Defense budget, and smaller cuts for FY 2017. However, without additional changes to the law, more sequestration cuts are scheduled for FY 2018 thru 2021 remain, continuing to place national security at risk.

Former Secretary of Defense (SecDef) Chuck Hagel warned in 2011 that future sequestration budget cuts will create a "hollow force." The Services have already canceled deployment of ships, slashed flying hours, renegotiated critical procurement contracts, temporarily furloughed civilian employees, and are in the process of reducing force structure, giving America the smallest military force since before World War II. If sequestration is not ended, additional force reductions will likely go deeper and training and modernization levels will be further impacted. Nearly 86 percent of retirees that participated in FRA's online survey (January/February 2016) are "Very concerned" (the highest rating) about continuing sequestration cuts.

TRICARE Fee Increases

For several years now the Administration has included in their annual budget request fee increases for many TRICARE beneficiaries, and this year is no different. The FY 2017 budget request includes enrollment fee increases for TRICARE Prime far beyond the current mandated fee increases. It includes a new "participation" fee for TRICARE Standard, and a new fee for new enrollees for TRICARE-for-Life. The plan also includes higher pharmacy co-pays and higher deductibles. FRA opposes these proposed fee increases because the Association believes that a military retiree's health care premium, is at least in part, paid for with 20 or more years of arduous military service. In FRA's online survey retirees were asked, "*Do you believe that retired service members have, at least in part, earned their TRICARE services through 20-plus years of military service?*" More than 99 percent of retirees said "Yes." Many of these beneficiaries targeted by fee increases will tell you that they were told that they would have free

health care for life if they endured low pay and arduous service. In FRA's online survey (January/February 2016) retirees were asked "*When you joined the military, were you led to believe that you would have free health care for life if you stayed in long enough to retire?*" Exactly 96 percent answered "Yes."

Nearly 94 percent of retirees see TRICARE benefits as very important in FRA's most recent online survey. FRA advocates that the Defense Department (DoD) must sufficiently investigate and implement other options to make TRICARE more cost-efficient as alternatives to shifting costs to TRICARE beneficiaries, and the Association opposes any indexing of future TRICARE Fee increases beyond CPI indexed to COLA increases. In FRA's online survey of retirees (January/February 2016) finds that more than 81 percent see the cost of TRICARE premiums as "Very important."

TRICARE Reform

The House and Senate Armed Services Committees want to reform the TRICARE program and plan to craft legislation this year to achieve this objective. It seems that the starting point will be the health care recommendations from the Military Compensation and Retirement Modernization Commission (MCRMC) that suggests that TRICARE be replaced with a plan similar to the Federal Employee Health Benefit Program (FEHBP). Beneficiaries would be switched to a plan similar to the FEHBP, except that Military Treatment Facilities (MTF) would be included in the network. Like the FEHBP, beneficiaries could choose from a selection of commercial insurance plans. The plan would be administered by the Office of Personnel Management (OPM) rather than the DoD. Beneficiaries would be required to pay 20 percent of all health care costs. Beneficiary family members would not be covered under the plan and would be provided a Basic Allowance for Health Care (BAHC) to cover the cost of premiums and deductibles for an average health care plan. Reserve Component (RC) members who are mobilized would also receive a BAHC in lieu of TRICARE coverage.

Although there are similarities between the BAHC and the Base Allowance for Housing (BAH), the big difference between the two is that housing costs are predictable but health care costs are not. FRA will oppose this provision. The MCRMC proposal recommends that "Non-Medicare eligible retirees should continue to have full access to the military health benefit program at cost contributions that gradually increase over many years..." These retirees under age 65 would eventually be required to pay 20 percent of all health care costs, and premiums would be increased every year to ensure that beneficiaries keep paying 20 percent. The FY 2013 National Defense Authorization Act (H.R. 4310 – P.L. 112-239) established the MCRMC. FRA notes that no enlisted personnel were appointed to serve on the Commission. More than 75 percent of the current active force is enlisted and therefore should have been represented on this Commission.

FRA believes that a military retiree's health care premium, is at least in part, paid for with 20 or more years of arduous military service. FRA advocates that military beneficiaries incur distinctive and extraordinary physical and mental stresses that are completely different to the service conditions of federal civilian employees, and their health benefits should be significantly better than civilian programs. The military health care system is also called upon to provide combat casualty care, and in recent years has proven to be an efficient system that saves countless number of service member's lives, who would have died in earlier conflicts. So the Association would question the use of the FEHPB as a good model for reforming the Defense Health Agency (DHA). The Association welcomes the review and reform, but is not convinced that TRICARE cannot be fixed. In FRA's current online survey (January/February 2016) retirees were asked *"It has been asserted in Congress that TRICARE is irrevocably broken. Would you support replacing TRICARE with a program that costs more but offers a selection of benefits?"* Nearly 90 percent (89.94) responded "No."

No one should assume that FRA is opposed to changing and improving DHA. The Association has supported the HASC-MP proposals to create a unified medical command that would have substantial cost savings for the system. FRA would also point-out the failure of DoD and VA to create a joint interoperable electronic health record as a major disappointment. FRA welcomes MCRMC recommendation 8 that attempts to improve collaboration between DoD and the Department of Veterans Affairs (VA). FRA supports a joint electronic health record that will help ensure a seamless transition from DoD to VA for wounded warriors, and establishment and operation of the Wounded Warriors Resource Center as a single point of contact for service members, their family members, and primary care givers. The Association is concerned about shifting of departmental oversight from the Senior Oversight Committee (SOC) comprised of the DoD and VA secretaries per provisions of the FY 2009 National Defense Authorization Act (NDAA), to the lower echelon Joint Executive Council (JEC). This change is perceived by many as diminishing the importance of improving significant challenges faced by service members – particularly wounded warriors and their families – in transitioning from DoD to the VA. The recommendation to provide additional authority to the JEC is a step in the right direction.

Further FRA members have expressed frustration with TRICARE Prime referrals. The MCRMC report notes that TRICARE Prime beneficiaries in some locations that have half of the referrals for purchased care network waited longer than the 28-day standard for purchased care network. Even in locations with the highest access to care, 16 percent of referrals still do not get appointments within the 28-day standard. Perhaps a pilot program in a limited geographic location, not currently served by TRICARE Prime, could demonstrate the efficiency of the plan.

The Association supports MCRMC recommendation 7 that seeks to improve support for service members with special dependents. These improvements to the Extended Care Health Option (ECHO) include expanded respite care hours, and consumer directed care. FRA wants to make sure that U.S. Coast Guard personnel are also covered by this program. FRA represents the Sea Services and wants to ensure that the Coast Guard benefits have parity with DoD benefits.

FRA's membership appreciates the following Sense of Congress (SOC) in the FY 2013 National Defense Authorization Act (NDAA): (1) DoD and the Nation have a committed health benefit obligation to retired military personnel that exceeds the obligation of corporate employers to civilian employees; (2) DoD has many additional options to constrain the growth of health care spending in ways that do not disadvantage beneficiaries, and (3) DoD should first pursue all options rather than seeking large fee increases or marginalize the benefit for beneficiaries.

The whole purpose of a unique military health care benefit is to offset the extraordinary demands and sacrifices expected in a military career. FRA advocates that to sustain a first-class, career military force requires a strong bond of mutual commitment between the service member and his/her employer.

CONCLUSION

FRA is grateful for the opportunity to present these recommendations to this distinguished Subcommittee on the important issue of military health care budgeting and structure of the Defense Health Agency (DHA).



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**STATEMENT OF
THE MILITARY COALITION (TMC)
Submitted to the
HOUSE ARMED SERVICES
SUBCOMMITTEE ON MILITARY PERSONNEL**

concerning
FY2017 DoD Budget Proposals on Military Healthcare

February 24, 2016

CHAIRMAN HECK, RANKING MEMBER DAVIS, AND DISTINGUISHED MEMBERS OF THE SUBCOMMITTEE. On behalf of The Military Coalition (TMC), a consortium of nationally prominent uniformed services and veterans' organizations, we are grateful to the committee for this opportunity to express our views concerning the FY2017 budget proposals on military healthcare reform. This statement for the record provides the collective views of the following military and veterans' organizations, which represent approximately 5 million current and former members of the seven uniformed services, plus their families and survivors:

Air Force Sergeants Association
Air Force Women Officers Associated
AMVETS
Army Aviation Association of America
Association of Military Surgeons of the United States
Association of the United States Army
Association of the United States Navy
Chief Warrant and Warrant Officer Association, U.S. Coast Guard
Commissioned Officers Association of the U.S. Public Health Service, Inc.
Fleet Reserve Association
Gold Star Wives, Inc.
Iraq and Afghanistan Veterans of America
Jewish War Veterans of the United States of America
Marine Corps Reserve Association
Military Chaplains Association of the United States of America
Military Officers Association of America
Military Order of the Purple Heart
National Association for Uniformed Services
National Military Family Association
Naval Enlisted Reserve Association
Non Commissioned Officers Association
The Retired Enlisted Association
United States Army Warrant Officers Association
United States Coast Guard Chief Petty Officers Association
Veterans of Foreign Wars

The Military Coalition, Inc. does not receive any grants or contracts from the federal government.

We are very appreciative that you and the Subcommittee are seeking to ensure military health programs sustain medical readiness; deliver timely, top-quality care; and sustain benefit and cost-share levels for active duty, Guard and Reserve, and retired members and their families and survivors that are consistent with their extended and arduous service and sacrifice in uniform.

The Military Coalition understands the current and future national security situation requires us to maintain a balance of investment in equipment, training, operational capabilities, as well as the personnel requirements which have been the cornerstone of the success of our all-volunteer force. There are finite resources for these competing demands and we strongly agree the Military Healthcare System (MHS) needs to evolve beyond what it is today, into a modern, high-performing integrated system, delivering quality, accessible care safely and effectively to its beneficiaries – while simultaneously meeting international health crises and national disasters, and honing its readiness capabilities. No other health care entity in the country is charged with these dual, yet mutually interdependent, mandates.

In our collective pursuit of needed military healthcare reforms, our guiding principle should be the first principle of medical ethics – first, do no harm.

We all share the common goals of sustaining medical readiness, delivering top-quality care, and avoiding damage to the career retention value of the military healthcare benefit.

In that context, we offer this statement for the record, which provides you with our views on the FY2017 DOD budget request.

FY2017 DOD Budget Request Health Care Reform Proposals

The Coalition is disappointed the FY17 defense budget provides only vague statements on planned program improvements, but focuses specifically on adding several new fees and raising a wide array of others, especially for the retired community.

In addition, it would require formal enrollment for DoD care, or coverage would be denied for the year.

The proposal does appear to offer somewhat lower costs for currently serving beneficiaries, but would significantly complicate healthcare programs by renaming them, creating a new network system, and instituting a complex system of different copays for different kinds of services, with different charges for in-network and out-of-network services.

The budget proposals do nothing to resolve inconsistent programs for Guard and Reserve members and families, do not address the dis-continuity of care between mobilization and demobilization, and places them at risk for even higher out-of-network fees for those who don't live near military installations or heavily populated areas.

The proposals would require retirees to pay more for care, and more rapidly escalate those charges in the future, without any assurance of improved access, quality, or wait times. The proposals offer very little specifics, or committed resources, on how the Department will improve military health care or increase its value.

Proposed Reforms That are Favorable

Aspects of the proposed budget which appear favorable in concept center on the issues of access to care and ease of referrals. The budget itself does not indicate much detail, or offer additional resources, but indicates MHS leaders have pledged to bridge gaps and fix problems by instituting and changing existing structures through:

- Issuing MTF appointments on the first call by the beneficiary
- Streamlining the specialty referral process
- Working to improve continuity of care with providers
- Increased Telehealth capabilities
- Improving services for military children
- Reforms to the Patient Centered Medical Home, to include extending hours
- Monitoring beneficiary satisfaction with access to care as the metric for success

Additionally, the proposed lower inpatient copays for TRICARE Standard/Choice and a fee structure which supports active duty military families are improvements. Active duty service members and their families do well, especially if they choose the MTF centric option, and would have no copayment for receiving care in network with a referral, and will have no charge for utilizing an urgent care center or an emergency room.

Areas of Concern on FY17 Budget Proposals

The budget proposes reconstituting TRICARE into two renamed options: TRICARE Select (currently the HMO-MTF centric option, TRICARE Prime) and TRICARE Choice (currently TRICARE Standard and Extra).

TRICARE Select beneficiaries would pay reduced fees and co-payments, and would use primarily military hospitals and clinics. Enrollees in this option would have no cost sharing for care received in those locations. DoD hopes to drive down expenses with this option because it costs DoD less when beneficiaries use military treatment facilities (MTF) compared to receiving civilian care. The reduced cost structure is also designed to incentivize beneficiaries to obtain their care in the MTFs with the goal of maximizing MTF use and enhancing training/professional skills of military providers.

The Coalition concurs with the goal but remains deeply concerned regarding the MTFs' ability to absorb new beneficiary demand with existing capacity. Inflexible appointing processes, readiness requirements and provider un-accountability for open appointing practices all serve

to undermine a MTF or clinic's capacity. It's one thing to say those chronic problem areas will be fixed; it's another thing entirely to ensure those fixes are implemented successfully. The Coalition is very concerned these proposals are built upon so-far-unfulfilled commitments to fix them.

The second option, **TRICARE Choice**, would provide an un-managed plan for the largest share of beneficiaries. It proposes to arrange for PPO-style provider networks, with the stated goal of establishing networks sufficient to provide care for 85% of participating beneficiaries. This arrangement poses the most risk for those in rural areas, including many Guard and Reserve members and families.

In regard to fee and co-payment adjustments, DoD's budget hits retirees under age 65 the hardest, by charging steep enrollment fees for participating in either TRICARE option.

Retirees would be charged an annual enrollment fee of \$350 for an individual or \$700 for a family using TRICARE Select, **a 24% increase from the current fee**. TRICARE Choice – or Standard, which currently has no enrollment fee – would require a \$450 fee for individual coverage and \$900 for families, and still would provide no guaranteed access to care. Of particular concern, the TRICARE program has had a long history of providers reluctant to accept TRICARE's lower reimbursements. This poses significant questions regarding how robust the PPO networks would be.

TRICARE for LIFE (TFL) beneficiaries would also see controversial increases under the budget proposal. For the first time, new TFL entrants as of 1 January 2017 would be required to pay an enrollment fee. The Coalition believes enrollment fees should be reserved for programs like TRICARE Prime, which guarantees access.

Of particular concern, TFL beneficiaries would also be subjected to means-testing, with fees initially set at 0.5% of retired pay, rising to 2% of retired pay for a TFL-eligible couple, to be phased in over 5 years. It would be accompanied by a complicated system of fee caps, one for flag officers and one for lower grades. The Coalition does not support means-testing, which imposes financial penalties for longer and more successful service on a population that is already paying the highest fees of any military beneficiaries. ***The Coalition believes strongly in the original intent of Congress, which expressly prohibited a separate enrollment fee for TFL, acknowledging this group already incurs higher costs than other military beneficiaries by virtue of being required to pay Medicare Part B premiums. The proposed new fee is particularly inappropriate since DoD's costs for TFL have declined precipitously, from \$11 billion in FY11 to an estimated \$6.4 billion in FY17.***

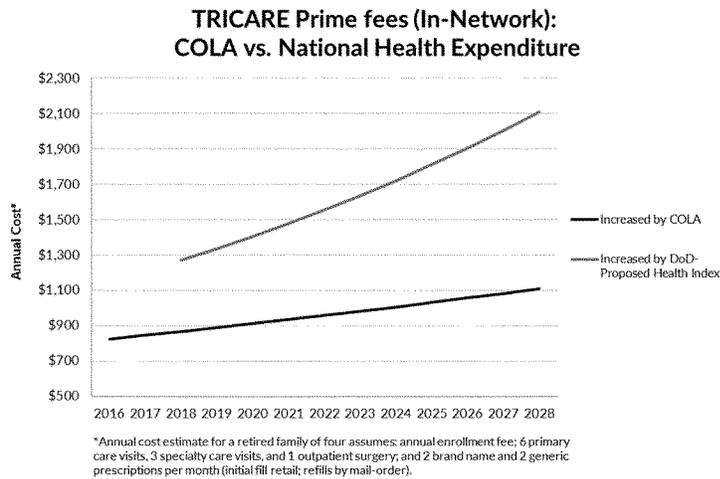
Raising the catastrophic cap (maximum out-of-pocket expenses) to \$1,500 per year for currently serving families and \$4,000 for retired families (vs. current \$1,000 and \$3,000)

Pharmacy co-payments would double over ten years. The budget proposal creates a multi-year schedule which would double most pharmacy copays, which have increased five-fold over the

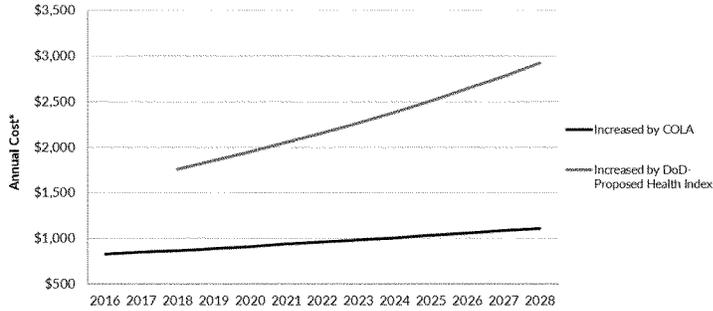
recent few years. In many cases, current copayments already are at or above corporate insurance medians.

Indexing fees to medical inflation is another key component of the DoD proposal. It would provide for annual adjustments of the aforementioned fees and co-payments to the national health expenditure index, which is projected to rise at 5.2% per year. This is noted in the budget in small print – but has very large ramifications for beneficiaries. It would result in both active duty family and retiree co-payment increases of nearly 50% by 2025. This growth rate is significantly faster than the growth in TRICARE payments to providers, which means beneficiaries paying flat fees (rather than the current 20% or 25% of TRICARE-approved charges) likely would end up paying ever-increasing shares of TRICARE-approved charges.

The following charts illustrate how the new proposals would not only impose a significant fee increase immediately, but would rise dramatically in the future compared to current COLA-based adjustments.



**TRICARE Standard fees (Out-of-Network):
COLA vs. National Health Expenditure**



*Annual cost estimate for a retired family of four assumes: annual enrollment fee; annual deductible; 6 primary care visits, 3 specialty care visits, and 1 outpatient surgery; and 2 brand name and 2 generic prescriptions per month (initial fill retail; refills by mail-order).

The Coalition believes strongly that military beneficiary fees should not grow faster than their military compensation does. We agree with the methodology previously approved by this committee that annual increases should not exceed the percentage growth in military retired pay (i.e., inflation as measured by the Consumer Price Index).

The Coalition also is concerned that many cost-shares that are now expressed as a percentage of the TRICARE-approved provider payment would be converted to flat fees, and then adjusted annually by the 5.2% annual health index.

The reality is that Medicare-based payments to providers have increased very modestly over the years as Congress has sought to keep Medicare costs down. Assuming this trend will continue, the proposed schedule would steadily increase the patient’s relative share of the payment.

The chart on the next page shows how this would happen, assuming a 5.2% increase in the flat-fee cost-share vs. a 1.5% annual increase in TRICARE payments to providers (which is actually more than payments have increased over the past decade).

	TRICARE <u>Pays Dr</u>	Patient <u>Pays*</u>	Patient <u>Cost Share</u>
2018	\$ 100	\$ 25	25%
2019	\$ 102	\$ 26	26%
2020	\$ 103	\$ 28	27%
2021	\$ 105	\$ 29	28%
2022	\$ 106	\$ 31	29%
2023	\$ 108	\$ 32	30%
2024	\$ 109	\$ 34	31%
2025	\$ 111	\$ 36	32%
2026	\$ 117	\$ 40	35%
2027	\$ 120	\$ 43	36%
2028	\$ 122	\$ 46	37%

*If adjusted by annual National Health Expenditures index (5.2%/year) as FY17 budget proposes

Imposing an annual enrollment requirement and denying care to those who don't enroll is a key element of the FY17 proposal. According to DOD, failure to explicitly opt in during an annual open enrollment would eliminate coverage for the beneficiary and family for that year. The Coalition strongly opposes this requirement, which effectively would deny a service-earned healthcare benefit. As outlined above, some members may find it preferable to use VA facilities for certain care, but use their earned TRICARE benefit for family care. Others may use spousal or employer insurance for certain care, but TRICARE for things the other insurance doesn't cover. The DoD argument that it needs to be able to plan for who will use DoD care is spurious. DoD knows every claim and every penny spent on each eligible TRICARE beneficiary, and has full capacity to track trends and make future projections. The fact DoD healthcare costs have been flat and DoD is typically able to reprogram funds at the end of the year provide ample evidence of that. The practical reality is Standard beneficiaries are used to just showing their ID card as proof of eligibility. Many would discard notices of a requirement to enroll, especially in the first year, assuming it was junk mail. The consequences in some cases would be far worse than being told at a medical appointment they are not covered. The first time some sponsors could learn of the requirement is upon having a family member suffer a potentially life-threatening injury/illness or require an extended hospital stay, and find they are denied coverage for failure to enroll. That should be an intolerable scenario for DoD as well as the beneficiary. ***In the Coalition's view, no eligible beneficiary should be denied their service-earned healthcare coverage. If there is to be an enrollment requirement, any eligible beneficiary should be enrolled automatically upon seeking care.*** As it has for decades, the military ID card should serve as proof of enrollment.

Net Impact of DoD-Proposed Fee Changes on Military Families

The complexity of the proposed fee changes can be bewildering, especially since all of the program names would be changed as well. The actual impact of the changes on military families could vary widely, depending on the family's usage of various kinds of care.

The following charts show how the changes would affect typical currently serving, retired families under age 65, and Medicare-eligible families compared to the fees they pay in 2016, assuming a specific set of provider visits and prescriptions. For the sake of simplicity and transparency, the charts use the current program names.

In general, the changes would be financially beneficial for active duty families, but far less so for Selected Reserve families.

The changes hit retired families under age 65 the hardest, imposing increases of 50% or more for those using in-network providers and 100% increases for those who don't – or can't -- use network providers. The Coalition believes these fee increases are disproportionately high, especially when there are no guarantees of improved access or service.

Currently Serving - Family of Four			
Fee Component	2016	2018	2018
	TRICARE Standard	TRICARE Prime	TRICARE Standard
Enrollment Fee	\$0	\$0	\$0
Deductible ¹	\$300	\$0	\$0
Network Copays ²	\$0	\$0	\$195
Rx Cost Shares ³	\$188	\$76	\$76
Yearly Total	\$588	\$76	\$271

¹ Under proposal, general deductibles apply for out of network care only

² Assumes 5 network visits per year (3 Primary, 2 Specialty Care, 2 Urgent Care, 1 ER)

³ Assumes 2 brand name and 2 generic prescriptions per month (initial fill retail; refills by mail-order)

Source: FY17 President's Budget Request

TRICARE Prime¹ - Retiree Family of Four

Fee Component	2016	2018 In Network	2018 Out of Network
Annual Enrollment Fee	\$565	\$700	\$700
Annual Deductible	None	None	\$600
Doctor Visit Copays ²	\$72	\$310	--
Rx copays ³	\$188	\$260	\$260
Yearly Total	\$825	\$1,270	\$1,560

TRICARE Standard¹ - Retiree Family of Four

Fee Component	2016	2018 In Network	2018 Out of Network
Annual Enrollment Fee	None	\$900	\$900
Annual Deductible	\$300	None	\$600
Doctor Visit Copays ²	\$338	\$265	--
Rx copays ³	\$188	\$260	\$260
Yearly Total	\$826	\$1,425	\$1,760

¹ Under proposal, TRICARE Prime will be known as TRICARE Select, and TRICARE Standard will be known as TRICARE Choice

² Assumes 6 primary care visits, 3 specialty care visits, and 1 outpatient surgery.

³ Assumes 2 brand name and 2 generic prescriptions per month (initial fill retail; refills by mail-order)

Source: FY17 President's budget request

TRICARE For Life - Married Couple

Fee Component	2016	2018
Annual Medicare Premium ¹	\$2,520	\$2,570
TFL Enrollment Fee ²	None	\$300
Rx copays ³	\$376	\$520
Yearly Total	\$2,896	\$3,390

¹ Assumes 1% annual COLA. Medicare premium based on lowest income bracket fee, many pay more.

² O-5 with 20 years of service turning 65 in 2018 (fee would double by FY2021)

³ Assumes 4 brand name and 4 generic prescriptions per month (initial fill retail; refills by mail-order)

Source: FY17 President's budget request

Mr. Chairman, Madam Ranking Member, and members of the Subcommittee, thank you for this opportunity to present our inputs on these important issues. We stand ready to work with you and your staff in any way that would be helpful.

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

FEBRUARY 24, 2016

RESPONSE TO QUESTION SUBMITTED BY MR. O'ROURKE

Secretary WOODSON. Primary Care: Current MHS capacity targets for primary care are for enrollment of 1,100 per adjusted full time equivalent (FTE) primary care managers (PCMs). Services standardize adjustments per FTE PCM in order maximize clinic provider availability. Current average enrollment per adjusted FTE PCM is 1,053; therefore, Services are open to enrollment overall as long as the MTF is able to provide access to care within MHS standards. The Services are working to increase capacity as follows:

- Reducing the Utilization Rate/Demand: The major variable in increasing capacity size is utilization [(number of duty days per year x 21 encounters per day/ utilization rate). Current MHS utilization or demand is over 4.1 visits per year, which is 187% higher than the national average of 1.43 visits per year in an insured population, per the CDC. If utilization/demand can be reduced, capacity will increase; conversely, if demand increases, primary care capacity will decrease. Numerous utilization/demand reduction efforts are underway. The MHS' main strategy to reduce unnecessary utilization is through optimization of the Patient Centered Medical Home (PCMH) model of care. The primary utilization reduction initiative is PCM continuity; a patient's continuous relationship with his/her PCM reduces demand because the PCM is aware of and can proactively address patient demand for care without multiple unnecessary appointments. In addition, PCMH uses team-based workflow to maximize PCMH teams' ability to meet patients' needs; the Services are ensuring teams have 3.1 support staff per PCM. The PCMH model also includes embedded behavioral health specialists, physical therapists and clinical pharmacists to provide high quality comprehensive care to enrollees. PCMH is also maximizing the use of virtual health opportunities, such as telephone visits, secure messaging and the nurse advice line to meet patients' demand for care beyond face-to-face appointments with the PCM. The direct care system's most mature PCMHs have reduced demand for face to face appointments by using the strategies identified above and have increased capacity above 1,100 enrollees per PCM.
- Increasing number of direct care appointments: Simplified Appointing guidance increased the number of appointments available per duty day by 24% (an additional 11K appointments per duty day.) In addition, the Services hold MTFs accountable to schedule the target number of appointments based on an analysis of demand.
- Expanding Operating hours: MTFs are analyzing demand by day of week and hour of day to determine whether a positive business case exists to expand or implement extended hours in PCMH and/or MTF urgent care. Many MTFs currently offer extended and weekend hours (see below). All Services are exploring extended hours, based on an analysis of patient demand.
- Telehealth: Additional efforts are underway to deploy telehealth initiatives to increase capacity. For example, a pilot is underway to allow virtual PCM appointments using telehealth technology. In addition, a pilot is underway to allow remote home monitoring for patients with chronic disease; remote home monitoring will provide quality care using telehealth technology and increases convenience to the patient who does not need a face-to-face appointment.
- Provider Distribution: The Services are moving primary care managers (PCMs) from areas where no additional enrollment demand exists or where there is excess primary care capacity to areas where there is insufficient capacity to meet appointment or enrollment demand.
- Community Based Medical Homes (CBMHs): The Army is expanding its successful CBMH program, which implements stand-alone primary care clinics in population centers where beneficiaries live. For example, Harker Heights CBMH is located in a town near Ft Hood, Texas, where many beneficiaries reside; referrals generated support the specialty care base at Darnall AMC. The Army has implemented 20 CBMHs and has plans to implement 3 more in FY16 as well as to expand eight existing CBMHs due to their popularity with beneficiaries in FY17. Staffing CBMHs after hours, with overtime GS or active duty rotations, has increased additional capacity, as well (see below).

Specialty Care: The process to standardize specialty care to improve processes and increase capacity is underway through the new Tri-Service Specialty Care Advisory Board (TSSCAB). The TSSCAB is responsible for executing MHS Review Action Plan 2, which outlines MHS requirements to develop standard processes for specialty care in MTFs. Based on the MHS Modernization study, which compared specialty care productivity to 40% of the MGMA standards, there currently is capacity in MTF specialty care; however, making this capacity available will require standard processes and supporting guidance be developed, similar to what was previously done in the MTF primary care product line. Specialty care plans to further increase available capacity include: Deployment of enhanced access tools such as telehealth and secure messaging in specialty care clinics

- Development and implementation of Tri-Service manpower standards for support staff and support staff protocols to increase the product lines' ability to meet the needs of more patients through team-based workflow
- Development and implementation of Simplified Appointing Guidance for specialty care product lines, which will identify the number and types of appointments expected per full time equivalent per day/year. Simplified Appointing Guidance in primary care has increased the number of available appointments per duty day by over 20%.
- Implementation of Specialty Appointing and Referral Guidance, in collaboration with primary care. The guidance is in final coordination with MHS governance; implementation is expected in CY2016. The goal of the guidance is to provide the patient with a confirmed specialty appointment date and time before the beneficiary departs the MTF after receiving a referral from a primary care manager. The guidance includes requiring the use of Tri-Service referral guidelines in primary care, to reduce unnecessary referrals, which will further increase specialty care capacity. [See page 10.]

RESPONSES TO QUESTIONS SUBMITTED BY MS. STEFANIK

Admiral BONO. By law, TRICARE is required to adopt Medicare's reimbursement system to the extent practicable. TRICARE adopted the Outpatient Prospective Payment System in order to comply with this statutory requirement to reimburse like Medicare. However, TRICARE did create a General Temporary Military Contingency Payment Adjustment (GTMCPA) for those hospitals that served a disproportionate share of Active Duty Service Members and Active Duty Family Members.

The process to apply for a GTMCPA is transparent and available to the public through the TRICARE web site at <http://manuals.tricare.osd.mil/pages/Search.aspx>, as well as, education from the facility's respective Manage Care Support Contractor (MCSC). There are no bureaucratic challenges preventing facilities like Carthage from navigating through the process.

Per the TRICARE regulation, 32 CFR 199.14, a GTMCPA is "available at the discretion of the Director..." Carthage submitted their initial GTMCPA request in September 2013. DHA provided a response in December of 2013. While there are no official appeals of the GTMCPA decision, TRICARE has shared detailed claims data on which the decisions are based with hospitals who fail to meet the GTMCPA criteria. DHA met with Carthage and the MCSC in January 2014 to resolve any discrepancies. In addition, on two separate occasions DHA shared the detailed claims data with Carthage and provided an opportunity for feedback. There was no communication/feedback from Carthage for a time period of approximately 18 months. [See page 12.]

Admiral BONO. The process is very transparent. It is outlined in the TRICARE Reimbursement Manual (TRM) that is available to the public. The starting site for the TRM is at <http://manuals.tricare.osd.mil/pages/Search.aspx>.

Hospitals who serve a disproportionate share of Active Duty Service Members (ADSMs) and Active Duty Family Members (ADFMs) may qualify for the discretionary payment. The exact numbers/requirement is found in the TRM language. Upon request by the facility, TRICARE will provide detailed claims data that was used to evaluate the hospital's GTMCPA request. Further, the TRICARE Regional Office also serves as a liaison between the requesting facility and the MCSC in the event the facility expresses concerns, has questions regarding the process, and needs any assistance regarding the qualifying criteria or their application for a GTMCPA. The hospital has assistance from start to finish if they have questions about the process. [See page 12.]

QUESTIONS SUBMITTED BY MEMBERS POST HEARING

FEBRUARY 24, 2016

QUESTIONS SUBMITTED BY MR. O'ROURKE

Mr. O'ROURKE. During questioning, the Honorable Jonathan Woodson stated that patient capacity at military treatment facilities (MTF) is market-dependent and differs based on whether the care is inpatient or outpatient in nature. Based on this, we have the following questions: First, what is the current inpatient capacity for each MTF?

Secretary WOODSON. The Army has 1,810 current beds. Army inpatient capacity by MTF is provided below:

DMIS ID	MTF DESCRIPTION	FY16
0005	BASSETT ACH FT. WAINWRIGHT	23
0032	EVANS ACH-FT. CARSON	69
0047	EISENHOWER AMC-FT. GORDON	129
0048	MARTIN ACH-FT. BENNING	42
0049	WINN ACH-FT. STEWART	50
0052	TRIPLER AMC-FT. SHAFTER	194
0057	IRWIN ACH-FT. RILEY	24
0060	BLANCHFIELD ACH-FT. CAMPBELL	41
0061	IRELAND ACH-FT. KNOX	25
0064	BAYNE-JONES ACH-FT. POLK	20
0075	L. WOOD ACH-FT. LEONARD WOOD	44
0086	KELLER ACH-WEST POINT	20
0089	WOMACK AMC-FT. BRAGG	110
0098	REYNOLDS ACH-FT. SILL	20
0105	MONCRIEF ACH-FT. JACKSON	24
0108	WILLIAM BEAUMONT AMC-FT. BLISS	113
0109	BROOKE AMC-FT. SAM HOUSTON	376
0110	DARNALL AMC-FT. HOOD	79
0125	MADIGAN AMC-FT. LEWIS	219
0131	WEED ACH-FT. IRWIN	20
0607	LANDSTUHL REGIONAL MED CEN	111
0612	BRIAN ALLGOOD ACH-SEOUL	57
	Grand Total	1,810

Navy: Navy Medicine currently has 842 beds. Navy inpatient capacity by MTF is provided below:

DMIS ID	MTF NAME	Staffed/ Projected Beds from Portfolios
0024	NH CAMP PENDLETON	42
0028	NH LEMOORE	
0029	NMC SAN DIEGO	272
0030	NH TWENTYNINE PALMS	12
0038	NH PENSACOLA	24
0039	NH JACKSONVILLE	28
0091	NH CAMP LEJEUNE	79
0104	NH BEAUFORT	8
0124	NMC PORTSMOUTH	187
0126	NH BREMERTON	33
0127	NH OAK HARBOR	11
0615	NH GUANTANAMO BAY	8
0617	NH NAPLES	8
0618	NH ROTA	9
0620	NH GUAM-AGANA	33
0621	NH OKINAWA	79
0622	NH YOKOSUKA	29
0624	NH SIGONELLA	22
	Grand Total	842

Air Force: Air Force currently has inpatient capacity of 664 beds, which includes staffing 166 beds at Walter Reed and San Antonio Military Medical Center. Air Force inpatient capacity (staffed beds) by MTF is provided below. The second column reflects the results of the Air Force's "staffed beds" analysis. Also, highlighted in "green" are the non-AF MTFs where the Air Force Medical Service staff beds and the quantity. The analysis is based upon the AFMS FY17 PB MPPT file.

DMIS ID	MTF NAME	Staffed/ Projected Beds from Portfolios	SG18S Staffed Bed Capacity Analysis
0006	673rd MED GRP-ELMENDORF	52	45
0014	60th MED GRP-TRAVIS	103	100
0042	96th MED GRP-EGLIN	56	56
0053	366th MED GRP-MOUNTAIN HOME	10	10
0067	WALTER REED NATL MIL MED CNTR	233	23
0073	81st MED GRP-KEESLER	50	50
0079	99th MED GRP-O'CALLAGHAN HOSP	50	46
0095	88th MED GRP-WRIGHT-PATTERSON	58	57
0109	SAN ANTONIO MMC-FT. SAM HOUSTN	376	143
0120	633rd MED GRP LANGLEY-EUSTIS	52	52
0607	LANDSTUHL REGIONAL MEDCEN	111	22
0621	NH OKINAWA	79	6
0633	48th MED GRP-LAKENHEATH	17	18
0638	51st MED GRP-OSAN AB	7	5
0639	35th MED GRP-MISAWA	12	11
0640	374th MED GRP-YOKOTA AB	12	10
0808	31st MED GRP-AVIANO	13	10
	Grand Total		664

DHA (NCR MD): Current NCR MD inpatient capacity is 390 beds. The NCR MD current bed capacity by MTF is listed below.

DMIS ID	Facility	Number of Operational Beds						
		Med/Surg	OB	Bassinets	NICU	ICU	Other	Total
67	Walter Reed National Military Medical Center	151	26	13	18	25	41	274
123	Fort Belvoir Community Hospital	39	18	18	3	6	32	116
	Grand Total							390

Mr. O'ROURKE. How do you expect the inpatient capacity to change for each MTF in the event that the Department of Defense's proposed FY 2017 TRICARE reforms were to be implemented in their entirety?

Secretary WOODSON. **Army:** The Army expects capacity to **decrease** by 150 beds in FY17. Three MTFs are transitioning to outpatient facilities, representing a loss of 69 beds (Ft Knox, Ft Sill and Ft Jackson). Whether additional capacity will be available for new patients will be based on a confluence of both the Choice Act (pulling people away from the MTFs) and TRICARE Reform, which if approved, financially incentivizes beneficiaries to seek care at the MTFs.

DMIS ID	MTF DESCRIPTION	FY16	FY17	Change	Comment
0005	BASSETT ACH FT. WAINWRIGHT	23	21	-2	
0032	EVANS ACH-FT. CARSON	69	69	0	
0047	EISENHOWER AMC-FT. GORDON	129	125	-4	
0048	MARTIN ACH-FT. BENNING	42	48	6	
0049	WINN ACH-FT. STEWART	50	45	-5	
0052	TRIPLER AMC-FT. SHAFTER	194	194	0	
0057	IRWIN ACH-FT. RILEY	24	24	0	
0060	BLANCHFIELD ACH-FT. CAMPBELL	41	41	0	
0061	IRELAND ACH-FT. KNOX	25	0	-25	Transition to Health Clinic
0064	BAYNE-JONES ACH-FT. POLK	20	20	0	
0075	L. WOOD ACH-FT. LEONARD WOOD	44	44	0	
0086	KELLER ACH-WEST POINT	20	20	0	
0089	WOMACK AMC-FT. BRAGG	110	79	-31	
0098	REYNOLDS ACH-FT. SILL	20	0	-20	Transition to Health Clinic
0105	MONCRIEF ACH-FT. JACKSON	24	0	-24	Transition to Health Clinic
0108	WILLIAM BEAUMONT AMC-FT. BLISS	113	108	-5	
0109	BROOKE AMC-FT. SAM HOUSTON	376	378	2	
0110	DARNALL AMC-FT. HOOD	79	79	0	
0125	MADIGAN AMC-FT. LEWIS	219	207	-12	
0131	WEED ACH-FT. IRWIN	20	20	0	
0607	LANDSTUHL REGIONAL MED CEN	111	100	-11	
0612	BRIAN ALLGOOD ACH-SEOUL	57	38	-19	
	Grand Total	1,810	1,660	-150	

Navy: Since the FY17 TRICARE reforms would primarily impact the delivery of private sector care, Navy Medicine anticipates minimal effects to MTF inpatient capacity. MTFs will continue to utilize its eligible beneficiary population enrolled in a managed care option, self-managed option, or TRICARE for Life, to optimize its inpatient and outpatient capacities to sustain critical medical skills and capabilities. The proposed reforms attempt to support military readiness and funnel beneficiary care to the MTF while balancing beneficiary choice, access to care, and cost containment. The proposal expands choice for non-active duty beneficiaries to choose a health benefit option that best meets their needs. The co-pay/cost-sharing structure is also modified to provide incentives to select the managed care option and highlights the MTF as a preferred place of care. Implementing an enrollment fee to participate in TRICARE for Life will also have minimal impact to MTF inpatient capacity and can continue to utilize the TRICARE Plus program and other recapture of care mechanisms to support military medical staff readiness and training.

Air Force: Enacting PB17 would not change inpatient capacity at AF MTFs. If fully enacted, the plan would maintain current workload levels at our facilities by preserving TRICARE Prime as a healthcare option for retirees and their family members. The plan would also continue the practice of not charging copays at for care provided at our MTF to incentivize patients to seek their care at the military facility.

DHA (NCR MD): PB17 should not impact inpatient capacity at Walter Reed National Military Medical Center (WRNMMC) or Fort Belvoir Community Hospital (FBCH)

Mr. O'ROURKE. In what MTFs does the capacity currently exist to potentially accept non-TRICARE Veteran's Affairs patients?

Secretary WOODSON. **DHA:** Currently 97 MTFs (hospitals and clinics) provide care to (have capacity for) VA patients under DOD/VA sharing agreements. Further, Army Medical Winn Ft. Stewart, GA, and Air Force Medical Travis, CA, are examples of 2 hospitals that have provided VA patients mental healthcare through the sharing agreement program. FY17 TRICARE reforms are not the only influencers of VA patients being seen in DOD hospitals. VA is experiencing a budget shortfall in non-VA purchased care funding currently used to pay for DOD hospitals' provided care. Due to this shortfall, VA Directors are making the choice to re-direct VA patients downtown. VA is not authorized to use Choice dollars to pay for DOD provided care unless DOD MTFs become VA Choice (network) providers or legislative relief is given to allow Choice dollars to pay for DOD care. Since implementation of the Veterans Choice Act and VA's funding shortfalls in accounts used to pay DOD MTFs, DOD saw a decrease of referrals to DOD in summer 2015 and in 2016.

Army: The Army currently provides capacity to and \$50M in inpatient, outpatient and/or specialty care to VA beneficiaries. The Army does not anticipate having additional capacity for VA patients beyond current levels. If the VA pulls its referrals from Army MTFs, similar to what is occurring in Air Force and Navy MTFs, inpatient and specialty care capacity will be available, which the Army will fill by inviting DOD retirees back into the MTFs. Army MTFs currently providing care to VA beneficiaries are:

- Tripler AMC
- William Beaumont AMC
- Eisenhower AMC
- Basset ACH
- Womack AMC
- McDonald AHC
- Ireland ACH (Transitioning to an AHC in FY17)
- Keller ACH
- Martin ACH
- Moncrief ACH (Transitioning to an AHC in FY17)
- Reynolds ACH (Transitioning to an AHC in FY17)
- Lyster AHC
- Evans ACH
- Gen Leonardwood ACH
- MEDDAC Korea
- Guthrie AHC
- Landstuhl RMC

Navy: Excess capacity to see VA patients varies based on Navy MTF:

- Navy MTFs seeing the most VA patients include Naval Medical Center San Diego, Naval Medical Center Portsmouth, U.S. Naval Hospital Guam, Naval Hospital Pensacola and have capacity in clinical specialties that support graduate medical education and/or readiness.
- Within the last year, Naval Hospital Bremerton and Naval Hospital Lemoore began seeing VA patients.
- Naval Hospital Camp Lejeune treats small amount of VA patients, while Naval Hospital Camp Pendleton and Naval Hospital Jacksonville have expressed interest and explored the topic, but not yet signed agreements.
- Naval Health Clinic Charleston, Naval Hospital Beaufort, and Naval Branch Health Clinic Key West have entered joint ventures where the Navy provides space and equipment and VA brings in providers and staff who then sees both VA and DOD beneficiaries. Workload generated at joint venture sites are recorded in each agency's respective Electronic Health Record.

Air Force: Currently there are 48 active DOD/VA sharing agreements involving 6 inpatient and 20 ambulatory care facilities. Included in the 48 are 9 Master Sharing Agreements that cover all available services at those sites allowing them to see veterans throughout the available clinical services based on capacity and capability. With the exception of the ambulatory surgical centers most of the sharing agreements at the 20 ambulatory care facilities are for education and training, laundry services, or other administrative requirements. Available clinical services at most ambulatory care facilities are generally for primary/family care and rarely include specialty care clinics. Based on the availability of clinical services, there are at least nine sites that provide significant levels of care to the VA and have capacity to see more. The nine sites include: 10th Medical Group (MDG) at the USAF Academy, 59 MDG (San Antonio Military Medical Center) at Lackland AFB, 633 MDG at Joint Base Langley-Eustis, 673 MDG at Joint Base Elmendorf-Richardson, 60 MDG at Travis AFB, 81 MDG at Keesler AFB, 96 MDG at Eglin AFB, 88 MDG at Wright-Patterson AFB, and 99 MDG at Nellis AFB. The seventeen other sharing agreement sites may see small numbers of veterans but have only minimal capacity to see more with the exception of 779 MDG at Joint Base Andrews who appears to have additional capacity as an ambulatory surgical center.

DHA (NCR MD): Both WRNMMC and FBCH currently provider care and have capacity to accept non-TRICARE Veteran's Affairs patients. NCR MD is actively engaged with VISN 5 to best determine how NCR MD facilities can assist the VA in meeting demand for specialty care and inpatient services.

Mr. O'ROURKE. Highlight specifically as it pertains to capacity in mental healthcare treatment.

Secretary WOODSON. **Army:** The Army does not anticipate having additional mental health inpatient capacity for VA beneficiaries

Navy: Currently, within Department of the Navy, there is limited excess capacity in mental health that could be offered to VA beneficiaries based on current access to care priorities.

Air Force: Information is provided on two MTFs participating in the current DOD/VA agreement:

- Travis—Currently capped at 8 beds due to a temporary nurse shortage (anticipate expanding to full 12-bed capacity by early Apr 2016). There is a VA sharing agreement already in place. Capacity would not change without manning solutions, particularly provider staff. Demand exceeds current capacity. Travis accepts AD and VA patients on a first come, first served basis.
- JBER—Capacity of 10 beds; limited by current provider manning. This capacity exceeds current demand of 2–3 inpatients; therefore, potential exists to provide beds to VA patients. This is also a DOD–VA Joint Venture hospital.

DHA (NCR MD): In the NCR MD, there is little excess capacity in mental health available and would need to be prioritized based on current beneficiary demand.

Mr. O'ROURKE. What, if any, additional facilities would have this capacity in the event that the Department of Defense's proposed FY 2017 TRICARE reforms were to be implemented in their entirety?

Secretary WOODSON. **Army:** Enacting PB17 would not change inpatient mental health capacity at Army MTFs

Navy: Should the proposed FY17 TRICARE reforms be implemented, Navy Medicine anticipates very little impact to current mental health capabilities and capacity. There are currently 62 Navy MTFs with dedicated outpatient or inpatient mental health services.

Air Force: Enacting PB17 would not change inpatient mental health capacity at AF MTFs.

DHA (NCR MD): Implementing PB17 would not have a significant impact on NCR MD capacity.

