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MILITARY HEALTH SYSTEM REFORM: A CURE FOR EFFICIENCY AND READINESS?

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BEFORE THE

SUBCOMMITTEE ON MILITARY PERSONNEL

OF THE

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MILITARY HEALTH SYSTEM REFORM: A CURE FOR EFFICIENCY AND READINESS?

HOUSE OF REPRESENTATIVES,
COMMITTEE ON ARMED SERVICES,
SUBCOMMITTEE ON MILITARY PERSONNEL,
Washington, DC, Thursday, December 5, 2019.

The subcommittee met, pursuant to call, at 3:15 p.m., in room 2212, Rayburn House Office Building, Hon. Jackie Speier (chairwoman of the subcommittee) presiding.

OPENING STATEMENT OF HON. JACKIE SPEIER, A REPRESENTATIVE FROM CALIFORNIA, CHAIRWOMAN, SUBCOMMITTEE ON MILITARY PERSONNEL

Ms. SPEIER. Good afternoon, everyone. We will call this hearing of the Military Personnel Subcommittee on Military Health System reform to order.

Today, this hearing is focused on the status of military health reforms Congress enacted in the 2017 NDAA [National Defense Authorization Act] and whether the Department and the military services are working towards achieving congressional intent.

The reform that most impacts service members and their families is the transition of management of the military treatment facilities from services to the Defense Health Agency, which is the focal point of this hearing.

The last time we had a briefing on this issue was in December of 2017. I recall there was some disagreement among the military departments and DOD [Department of Defense] on how to implement these changes. I understand this transition began at least in part as of October 1 this year, but it was painful getting to that point, and it was a very small step towards accomplishing the overall goal of a single military health system instead of three separate service health systems.

There also are many important reforms critical to making the MTF [military treatment facility] transition successful that are lagging behind, such as implementation of the new electronic health records GENESIS, the proper analysis of what medical skills and the number of medical providers are needed to support the warfighters and beneficiaries, the appropriate number and sizes of medical facilities, and reforms that could create economies of scale and effective efficiencies within the MHS [Military Health System].

To be clear, budget cuts are not the same thing as efficiencies in MHS. And many rumored cuts to the military medical workforce, whether primary care physicians or ophthalmologists, lack rationale or evidence that they would actually save taxpayers money.

One of the top concerns many of my colleagues have heard over the past 8 months was about the military medical manpower cuts in the President's fiscal year 2020 budget. This was done to repurpose 17,944 military department officer and enlisted health specialty medical billets and transition them to other manning needs in the military departments.

I was baffled as to why this request was submitted when the services and the Joint Staff had not completed the analysis of the operational requirements for supporting combatant commanders in time of conflict of war. It appeared to me that this proposal prioritized cost cutting over operational needs and common sense.

In February 2019, the GAO [Government Accountability Office] confirmed our concerns when they reported that the DOD has not determined the required size and composition of its operational, medical, and dental personnel who support the wartime mission or submitted a complete report to Congress as required under the NDAA for fiscal year 2017.

We have also heard that there is a defense-wide review underway that is considering a wide variety of cost-cutting proposals, including shuttering major military medical centers, a restructured TRICARE benefit that could significantly increase copays, closure of the Uniformed Services University of the Health Sciences, and the potential destruction of some reforms that we have made into law over the past 3 years.

The goal of military health reform is not to reduce the military's ability to deliver healthcare in times of peace or war. The goal is to find ways to be more efficient so that we can save taxpayers money while providing better quality healthcare for our service members and their families. Private insurance and private providers may serve these goals for some types of services in some communities, but privatization can also threaten worse outcomes and higher costs if done without care and consideration.

The ranking member and I recently visited Madigan Army Medical Center, Naval Hospital Bremerton, and the David Grant Air Force Medical Center, where we spoke with military spouses about quality of life issues. Access to military healthcare came up at every discussion.

At each installation, we heard about challenges with the lack of mental health resources in the local community. We heard about civilian healthcare networks that either lacked the capacity or are unwilling to admit TRICARE beneficiaries. And we have heard about challenges accessing appointments at military treatment facilities.

The larger problem we heard is not that local providers think TRICARE reimbursement rates are low. It is that the healthcare market is already oversaturated, even in large metropolitan areas like Seattle and San Francisco.

It is not all bad news. At Travis Air Force Base we saw a busy military treatment facility working hand in hand with the VA [Department of Veterans Affairs] in collaboration that could, along with civilian providers, create an integrated delivery system. The 2017 NDAA encouraged these types of relationships with local healthcare facilities. We need to see more of this kind of coopera-

tion and hear more from these programs in order to replicate their successes.

Instead, DOD seems intent on gutting our Military Health System and calling it an efficiency. The system is costing less. It has saved billions of dollars, at least $1 billion in just the last year, but there remain urgent coverage needs that should be addressed by reinvesting any savings in the military healthcare system, not continuing to squeeze every last penny out of the system in order to fund other priorities.

Healthcare is a need and right. We must continue to provide for our military families. Weakening the delivery system will only cost us and our service members more down the road. The Department must do better.

Today we will hear from a panel of senior leaders from across the Department of Defense that are responsible for implementing the Military Health System reform. We are seeking to better understand how DOD is implementing major Military Health System reforms, how they are determining TRICARE success and meeting the needs of its beneficiaries, and how DOD plans to repurpose roughly 18,000 medical positions and how that will affect health services.

We will also hear how DOD is balancing readiness with efficiency and how the Joint Staff and the service surgeons general are approaching readiness to ensure that we have the right personnel and the right capabilities at the right time.

I now would like to have Ranking Member Mr. Kelly offer us any opening remarks.

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

STATEMENT OF HON. TRENT KELLY, A REPRESENTATIVE FROM MISSISSIPPI, RANKING MEMBER, SUBCOMMITTEE ON MILITARY PERSONNEL

Mr. KELLY. Thank you, Chairwoman Speier.

And that is as long as I have heard our chairwoman talk on any subject, and mine is going to be lengthier than usual too, and that is because we are very passionate about it in getting this right. This is one of the most important things I think we do on this subcommittee.

I want to welcome our witnesses to today's hearing, and thank you for your service to our service members and their families. The Military Health System is one of the largest healthcare systems in the world, and you all have the critical mission of providing care to one of the most venerated segments of the United States population, our service members, veterans, and their families.

We hold the Military Health System to a higher standard than civilian healthcare, given your important mission, and I know that you share that commitment. That is why this committee has worked continuously with the Department of Defense to ensure that our Military Health System has the resources and systems in place to provide exceptional healthcare.

The 2017 Military Health System reforms are an integral part of improving healthcare delivery. The primary goal of that reform effort was to improve medical readiness, standardize patient experi-

ence in military medical treatment facilities, and where possible, improve efficiency.

I am encouraged by the progress that DOD and the services have made in implementing these reforms, but there remain several areas of concern.

In particular, I am very concerned with the Department's current efforts to restructure and realign military treatment facilities, commonly known as section 703 implementation. I believe the Department may be viewing this as a cost-saving exercise when the actual purpose is to improve efficiency and healthcare quality.

It is crucial that prior to any reductions in MTF services that DOD fully understand the civilian network capability to absorb those patients.

In our visits to military installations around the country, I can tell you that many civilian healthcare networks are oversaturated and will not be able to absorb more patients. I look forward to hearing what analysis has been done regarding network adequacy in preparation for any MTF realignment.

I am also very concerned about the planned reduction in military healthcare billets. The services identified over 17,000 healthcare billets for elimination. While some of these positions are purely administrative in nature, many of them are medical professional billets.

At nearly every military installation I have visited, one of the chief complaints regarding healthcare is that patients must wait weeks in order to get an appointment. That is unacceptable, and I am concerned that further personnel reductions will make the problem worse. I would like to hear more about what analysis was done to support these reductions.

Finally, I am concerned about the state of behavioral healthcare in the military. I have repeatedly heard from medical providers, service members, and their families about chronic staffing shortages and long wait times for appointments. Meanwhile, the rates of suicide in our military continue to increase.

I understand that this is national problem, but I want to know what the services and the Defense Health Agency are doing to fix this problem in the military.

In a recent report, each of the services said that the number one recruiting challenge for behavioral health providers is low pay and the lengthy hiring process. So now that you have identified the problem, what specific authorities do you need in order to fix it?

I want to thank our witnesses for their considerable efforts to improve healthcare and institute the Military Health System reforms. I look forward to a robust discussion that is focused on readiness and quality care.

Thank you, and I yield back, Chairwoman.

Ms. SPEIER. Thank you, Ranking Member. And as you can see from both of our statements, they are fairly consistent, which is a recognition, I think, that we here in Congress are very concerned about what is happening.

We now welcome our distinguished panelists. Mr. Thomas McCaffery is the Assistant Secretary of Defense for Health Affairs. Lieutenant General Ronald Place, Director of the Defense Health Agency. Lieutenant General Dorothy Hogg, Surgeon General of the

Air Force. Lieutenant General Scott Dingle, Surgeon General of the Army. Rear Admiral Bruce Gillingham, Surgeon General of the Navy. Brigadier General Paul Friedrichs, Joint Staff Surgeon.

I will ask unanimous consent to allow any Members not on the subcommittee to participate in today's hearing and be allowed to ask questions after all subcommittee members have been recognized.

Without objection?

Mr. KELLY. Without objection.

Ms. SPEIER. That is granted.

Let us then ask each of you to summarize your testimony in 5 minutes or less. Your written comments and statements will be made part of the hearing record, and each member has the opportunity to question the witnesses for 5 minutes.

We will start with Mr. McCaffery, and you may offer your opening statement.

STATEMENT OF THOMAS McCAFFERY, ASSISTANT SECRETARY OF DEFENSE FOR HEALTH AFFAIRS, DEPARTMENT OF DEFENSE

Secretary MCCAFFERY. Thank you, Chairwoman Speier and Ranking Member Kelly, members of the committee. Thank you for the opportunity today to discuss our combined efforts to maintain and strengthen our Military Health System.

The men and women of the MHS are justifiably proud of what they do. They provide a platform to train our uniformed medical force, and they ensure our Active Duty service members have access to the healthcare they need in order to do their jobs anywhere, anytime.

They support one of the largest and most successful medical research enterprises in the country. They operate a global health surveillance network that monitors for infectious threats to our forces and our homeland. They manage one of the country's largest networks of hospitals and clinics.

They do all that with unfailing professionalism and, I might add, with incredible passion. They and we are grateful for the committee's support of this work.

Our primary mission, as you had indicated, is readiness, the readiness of the medical personnel to support our forces in battle and the medical readiness of combat forces to complete their missions.

And that readiness mission also entails caring for the families of our troops and our retirees. After all, while service members who deploy must be medically ready to do their jobs, they also need to know that their families back home are cared for, and that in retirement they will receive a health benefit that recognizes the value of their service.

Meeting this obligation to our beneficiaries is vital to recruiting and retaining a high-quality force.

In order to advance these goals, we believe the MHS, like the rest of the Department of Defense, must adapt and change in order to carry out our mission in an ever-evolving security environment, and very importantly for us, a consistently dynamic medical landscape.

And we know that Congress shares this belief. In the past three National Defense Authorization Acts, Congress has given the Department very clear direction on the fundamental reforms it expects us to implement. Building off that direction, we are changing to ensure that the system can most effectively meet our mission.

Some of the things that the reforms that we are partnering with Congress on are aimed at: ensuring that the uniformed medical force is properly sized and has the skills to respond to operational requirements; ensuring that our system of hospitals and clinics is optimally sized and shaped to support the readiness of our medical forces, the medical readiness of combat forces, and our obligations to our beneficiaries; better organizing and integrating our direct care system to form a true unified medical enterprise that can improve our effectiveness and efficiency and provide a more standardized, dependable, high-quality experience for our Active Duty, their families and our retirees; and finally, most effectively managing private sector care through TRICARE's managed care networks.

General Place and I outline in more detail in our written testimony each of these reform efforts, but the point we would like to emphasize is that all of these efforts are aimed at ensuring that the Military Health System provides maximum support to the Department as it executes the National Defense Strategy.

It is our privilege to testify before you today on this critical mission of the health system and to provide you information on the status of the numerous reforms Congress has directed us to pursue. Thank you to the members of this committee for their support of that mission and the men and women who carry it out, and we look forward to answering your questions.

[The joint prepared statement of Secretary McCaffery and General Place can be found in the Appendix on page 40.]

Ms. SPEIER. Thank you.

Lieutenant General Place.

STATEMENT OF LTG RONALD PLACE, USA, DIRECTOR, DEFENSE HEALTH AGENCY

General PLACE. Chairman Speier, Ranking Member Kelly, members of the committee, I will add a few comments to Mr. McCaffery's opening comments.

As he made clear, our principal mission is enabling readiness, and within that mission are two distinct responsibilities. First, to ensure every person in uniform is, in fact, medically ready to perform their job anywhere in the world. And then secondarily, to ensure our military medical personnel are individually and collectively prepared to support the full range of military medical operations.

The Defense Health Agency [DHA] serves as the supporting agency in this readiness mission to the combatant commands and to the military departments. The Military Health System's performance on the battlefield is exemplified by historically high survival rates from combat wounds and historically low rates of disease and non-battle injuries. These successes reflect processes in which joint solutions contributed to these outcomes.

Now, the DHA was established to strengthen our health system in both the deployed settings and in the fixed healthcare facilities

around the world. Our combat support responsibilities include a broad range of military health support. They include management of the Armed Services Blood Program, the Joint Trauma System, public health, Armed Forces medical examiners, medical logistics in the operational environment, health information technology in the operational environment, and really a whole lot more.

But as the DHA assumes responsibility for managing all the military's hospitals and clinics, we continue to view these medical facilities as readiness platforms where medical professionals from the Army, from the Navy, and from the Air Force obtain and sustain their knowledge and skills and for which these professionals deploy in support of our military missions.

The DHA approach better enables the MHS to optimize the care we can deliver along with clinical skill sustainment experiences for our medical staff within and across geographic markets.

As DOD leadership evaluates the size of the medical force and makes determinations about the configurations of hospitals and clinics, the DHA is also prepared to ensure our beneficiaries have access to care they need through the management of the TRICARE program.

Now, the Department has long relied on civilian healthcare to provide and deliver care to our beneficiaries in locations where we don't operate medical facilities or when the needs of our patients exceed the capabilities that we have locally.

Over the past three decades, with changes in military basing, reductions in the military force strength, we have successfully increased specific civilian healthcare networks. We are performing those assessments again today and will do so continuously. And we are working with the military departments to ensure military families and retirees continue to enjoy access to high-quality care if military medical capabilities are exceeded.

I am grateful for the opportunity to share our detailed plans to further improve military medical support to combatant commands and to the military departments. Thank you again to the members of this committee for your time and your continuing service to the men and women of our Armed Forces and the families who support them.

Ms. SPEIER. Thank you.

Lieutenant General Hogg.

STATEMENT OF LT GEN DOROTHY HOGG, USAF, SURGEON GENERAL OF THE AIR FORCE, UNITED STATES AIR FORCE

General HOGG. Chairwoman Speier, Ranking Member Kelly, and distinguished members of the subcommittee, thank you for the opportunity to provide an update on Air Force Medical Service reform.

This committee is well aware of the reemergence of great power competition, such as China and Russia, and the Air Force's need to increase lethality, strengthen alliances, and realign resources in preparation of these potential threats. The Air Force Medical Service is evolving in support of these overarching national defense objectives.

Air Force medics continue to answer the call across a broad spectrum of operational, humanitarian, and disaster response missions.

We specialize in aerospace and operational medicine, most notably aeromedical evacuation, while ensuring the readiness and deployability of our warfighters.

Our charge is crystal clear, and I am confident that these reforms will maximize our ability to meet combatant commander requirements and support line of the Air Force operations across the enterprise.

With this renewed focus in operational readiness, we restructured our headquarters by deactivating the Air Force Medical Support Agency and redesignating the Air Force Medical Operations Agency as the Air Force Medical Readiness Agency. This new organization directly supports readiness, aerospace and operational medicine activities, and provides oversight of strategic medical readiness initiatives at Air Force installations.

We are also realigning medical resources at our base installations in order to improve airman deployability and overall wellness. This initiative reorganizes medical groups into two squadrons, an Operational Medical Readiness Squadron, which serves Active Duty, Guard, and Reserves, and a Healthcare Operations Squadron, which serves non-uniformed members and dependents. While these squadrons are interconnected, they have a singular focus which allows each of the squadrons to optimize care for its designated population.

We continue to enhance our ability to save lives both on and off the battlefield by investing in our most vital pacing units, our Critical Care Air Transport Teams and our Ground Surgical Teams. Complementing these efforts is one of my strategic initiatives, called MedicX. This goal is to develop multifunctional medics who can perform duties beyond their primary specialty, which will have exponentially expanded clinical capabilities.

Our partnerships with military, educational, and civilian medical institutions will remain a critical component to maintaining medical airmen's clinical skills and currency. Collectively, these efforts increase our ability and agility to support homeland defense, deployed requirements, and operate in tomorrow's highly contested environment.

I would like to highlight the progress and the collaboration with the Defense Health Agency in transitioning authority, direction, and control of military treatment facilities to the Defense Health Agency.

The Air Force Medical Service will continue to provide direct support to the Defense Health Agency until it can establish its headquarters, markets, and functional capabilities. We are committed to a successful transition that will continue delivering high-quality readiness and beneficiary care.

My testimony gives the committee a clear picture of the Air Force Medical Service and how we are aligning our efforts with Defense Department and Air Force priorities.

As our Nation faces new challenges, preparing for an uncertain future requires bold and innovative thinking. I have no doubt we are moving in the right direction, and our medics throughout the Military Health System will rise to the occasion.

Thank you again for your time, and I look forward to your questions.

[The prepared statement of General Hogg can be found in the Appendix on page 52.]

Ms. SPEIER. Thank you.

Lieutenant General Dingle.

STATEMENT OF LTG SCOTT DINGLE, USA, SURGEON GENERAL OF THE ARMY, UNITED STATES ARMY

General DINGLE. Chairwoman Speier, Ranking Member Kelly, distinguished members of the subcommittee, it is an honor to speak before you today as the 45th Army Surgeon General, representing over 130,000 soldiers and civilians in Army Medicine.

I also would like to thank my Military Health System and my sister service colleagues here today. We all share a common commitment to ensuring our Military Health System is manned, organized, trained, and equipped to meet the needs of our services and the joint force.

The Chief of Staff of the Army states, "Winning matters," and, "People are our number one priority." As the Army modernizes and prepares for large-scale combat operations, it is imperative that our medical force remains ready, responsive, and relevant in order to conserve the fighting strength in the multi-domain battlespace because in combat, winning not only matters but there is no second place.

As required by law, the Army transitioned authority, direction, and control of our medical treatment facilities to the Defense Health Agency. The transfer has been transparent to our soldiers, civilians, and our beneficiaries. Partnering with the Defense Health Agency, we will continue to deliver high-quality and safe care.

The Army is continually assessing the risks with changes to medical end strength. Personnel changes currently under review are a necessary part of our modernization and our force shaping. We will ensure that adjustments are informed and support the operational force as well as the healthcare delivery mission.

As we reform and reorganize, we are committed to providing ready and responsive health services and force health protection. I have established my priorities to ensure that we remain ready, reformed, reorganized, responsive, and relevant. Ready to deploy, fight, and win when called upon. Reformed in accordance with the law. Reorganized to support Army modernization. Responsive to the demands of the multi-domain operations. And relevant to the rapid changes in modern warfare.

Finally, Army Medicine must change at the speed of relevance. This includes modernization of key capabilities, innovation of organizational concepts, advancement of technology, and integration with the joint and interagency community.

In closing, I am committed to meeting the congressional intent and sustaining the readiness of Army Medicine. Further, I am committed to my statutory responsibilities in support of the Secretary of the Army and as the chief adviser to the Defense Health Agency for the Army. I will inform the committee as we make strides in Military Health System reform and Army Medicine.

I want to thank the committee for your longstanding support to Army and military medicine. For the service and sacrifice of our

soldiers and their families, we must get this right. This is our solemn obligation to our Nation.

Thank you for the opportunity to come before this committee, and I look forward to answering your questions. Thank you.

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

Ms. SPEIER. Thank you.

Rear Admiral Gillingham.

STATEMENT OF RADM BRUCE GILLINGHAM, USN, SURGEON GENERAL OF THE NAVY, UNITED STATES NAVY

Admiral GILLINGHAM. Chairwoman Speier, Ranking Member Kelly, distinguished members of the subcommittee, on behalf of the mission-ready Navy Medicine team, I am pleased to be here today with my colleagues to provide you an update on an important issue for us all, Military Health System reform.

As we move forward with systemic changes in the MHS, I want to assure you that the foundation of Navy Medicine is readiness. Our highest priority is keeping sailors and Marines healthy and ready to deploy and ensuring they get the best care possible from trained and confident providers when they are wounded or injured.

The Nation depends upon Navy Medicine's unique expeditionary medical expertise to prepare and support our naval forces.

To this end, our priorities of people, platforms, performance, and power are aligned to meet this commitment: well-trained people, working as cohesive teams on optimized platforms, demonstrating high-velocity performance that will project medical power in support of maritime superiority.

On any given day, Navy Medicine personnel are deployed and operating forward in a full range of diverse missions, including austere damage control resuscitation and surgery teams in U.S. Central Command and U.S. Africa Command; trauma care at NATO [North Atlantic Treaty Organization] Role 3 Multinational Medical Unit in Kandahar; humanitarian assistance aboard hospital ship USNS [United States Naval Ship] *Comfort*; and expeditionary health services support with Joint, Fleet, and Fleet Marine Forces around the world.

A week ago, I had the honor of celebrating Thanksgiving with our Navy Medicine personnel forward deployed at Camp Lemonnier, Djibouti, as part of the Combined Joint Task Force Horn of Africa. I saw firsthand the important work they continue to do to ensure the health and readiness of our service members and multinational partners. All of us can be justifiably proud of the great work that they do.

Collectively, the substantive reform legislation contained in the fiscal years 2017 and 2019 National Defense Authorization Acts represents an important inflection point for military medicine and catalyzed our efforts to strengthen our integrated system of readiness and health. Navy and Marine Corps leadership recognize the tremendous opportunity we have to refocus our efforts on medical readiness while transitioning healthcare benefit administration to the Defense Health Agency.

I want to emphasize that while significant organizational change in healthcare is inherently complex, all of us testifying before you

today know we have a shared responsibility to ensure that both the services and the Defense Health Agency are successful. Our efforts will continue to reflect this imperative moving forward.

Integral to the MHS-wide transformation is the transition of our military treatment facilities to the DHA. In October, as you know, the DHA assumed authority, direction, and control of all MTFs in the continental United States, including Alaska and Hawaii. As a component of this significant transition, we are continuing to provide defined support to the DHA as it progresses to full operating capability.

In addition, Navy Medicine is making important changes at all levels to support our refocus on readiness. We are streamlining activities that directly impact our capabilities to support operational requirements and ensure we have a trained and ready medical force. We must have the agility to rapidly deploy anytime, anywhere to support Fleet and Fleet Marine Force missions and platforms, including expeditionary medical facilities and units, hospital ships, as well as casualty receiving and treatment ships.

The success of Navy Medicine is inextricably linked to a dedicated and well-trained workforce. We continue to emphasize recruiting and retaining personnel with the proper skill sets to care for sailors and Marines, particularly those with critical wartime specialties.

Thank you for your support both in resources and authorities to help us maintain our most important asset, the Navy Medicine team.

In summary, we continue to make progress in our transformation efforts. However, all of us recognize there is much hard work ahead as we continue to build an efficient and sustainable integrated system of readiness and health.

Once again, thank you, and I look forward to your questions.

[The prepared statement of Admiral Gillingham can be found in the Appendix on page 74.]

Ms. SPEIER. Thank you.

Brigadier General Friedrichs.

STATEMENT OF BRIG GEN PAUL FRIEDRICHS, USAF, JOINT STAFF SURGEON, JOINT CHIEFS OF STAFF

General FRIEDRICHS. Thank you, Chairwoman Speier, Ranking Member Kelly, and distinguished members of the Military Personnel Subcommittee. On behalf of Chairman Milley, it is truly an honor and a privilege to be here this afternoon to provide the Joint Staff perspective on health system transformation and its impacts on the operational readiness of the joint force.

As the 15th Joint Staff Surgeon, I also want to thank you for the strong support you have continuously provided to military personnel, including to me. This support has impacted more personnel than we can acknowledge this afternoon.

But I would like to tell you a little bit about my father, who grew up in southern Louisiana on a farm during the Depression, served at the end of World War II, and through the GI Bill received his college education, went on to help design aircraft carriers at the Brooklyn Navy Shipyard. He inspired me.

Later he met my mother, who was born in Hungary, fought in the 1956 revolution, was tortured by the KGB [Committee for State Security], eventually came to this country to teach, married, and the two of them taught me the value of freedom and the price that must be paid to preserve it. They have inspired me to become a military physician, and I am honored to be here in that role.

I also want to thank you for your continued support of the Reserve Officer Training Program, which allowed me to attend the Louisiana State University and then Tulane, and your support for the Uniformed Services University, which provided a phenomenal medical education and allowed me to be a competent and more than competent surgeon in Iraq when people relied on me to care for them, and they relied on many of us to care for them, whether it was in Iraq or Afghanistan, the North Pole, the South Pole, and all the other places where military service members receive care from military medics.

I am grateful for your commitment to joint medical operations. I met my wife, an Army physician, in the back stairs of the old Beach Pavilion at Brooke Army Medical Center. We have a much better facility today, thanks to you, but we have always had great facilities in which we provided great care for our service members.

As the son of a Navy service member, the husband of a former Army service member, the father of two young men who hope to serve in the Navy, I am fiercely committed to continuing to ensure we provide great care. My wife now works for the Veterans Health Administration and is a constant reminder to me of the importance not only of getting it right while people are serving, but also, as Americans transition from the Department of Defense to the VA, we must continue to improve that interagency collaboration.

As Chairman Milley recently noted, we are in a period of great power competition within a complex and dynamic security environment. The fundamental character of war is changing rapidly, the threats are worsening, and we must evolve to meet them, and thanks to your continued help, we are doing so.

You asked us in section 732 of the 2019 National Defense Authorization Act to develop a Joint Medical Estimate [JME], and our office is leading that effort. We will put the initial draft in coordination next month and plan to publish it in May. That will be an annual report in which, as other functional communities have done, we will describe requirements, gaps, and the risks that those gaps create to the mission and to the force based on the National Defense Strategy, COCOM [combatant command] inputs, the inputs from the services, our interagency partners, and our allies. After the JME is published, if helpful, it would be a privilege to return and brief you on its contents.

The National Defense Strategy describes significant challenges, and the 2019 Capstone Concept for Joint Operations begins to describe how the Department integrates those requirements across the force in order to reshape the force.

In addition, we know our Nation continues to face natural disasters and other events which require a whole-of-government response, and we continue to partner with the Department of Health and Human Services, Department of Veterans Affairs, other Fed-

eral, State, regional, tribal, and local stakeholders to ensure we are ready when our Nation requires us to respond.

But regardless of the technology employed by our warfighters, there is always a human being in that process, and our job as military medics is to maintain that human weapon system. Our job is to ensure that human is ready to deploy and that we are there and ready to care for them when they need us.

I am grateful for your support for our mission and for our service members, grateful for the opportunity to serve as a military medic, and grateful for the opportunity to answer your questions this afternoon. Thank you.

[The prepared statement of General Friedrichs can be found in the Appendix on page 84.]

Ms. SPEIER. Thank you all for your testimony.

Let me begin by asking the question that probably is on the minds of a lot of people. Are there going to be 18,000 billets that are going to be reduced as part of this defense-wide review?

Is that a question for you, Mr. McCaffery?

Secretary MCCAFFERY. Yes. I will start an initial response.

The proposal that you are referring to in terms of the proposed reduction of around 18,000 medical billets is something that was put forward in the President's 2020 budget, so last year. That is distinct and separate from your reference to the defense-wide review, which is something that just started within the last 3 months by Secretary Esper, so the two are separate.

To get to your question about the plans for the 18,000, I will let each of the military departments kind of weigh in in more specifics. But the bottom line, last year each of the military departments determined that their current medical force exceeded the operational requirements they needed, and each military department made a decision to look at a subset of their medical billets and repurpose them for other high priorities tied to the military department's needs in meeting national defense goals.

That is the basis for the proposed reductions. I will defer to the military departments in terms of giving them a little more detail in terms of the numbers and the timing.

The initial planning here is in, I think with some exceptions, in 2020 the plan would be to only make changes to vacant billets, so billets that don't have somebody currently occupying, doing a job.

And right now, our focus, working with the military departments, the Defense Health Agency, is really around what would be the scheduled reductions coming in fiscal year 2021 and what would our plans be to implement that in a way that we maintain the capability in our system, be it through contractors, the TRICARE network, hiring civilians, to restore that capability that could be removed based upon the medical billet reduction.

Ms. SPEIER. All right. Do you have numbers for each of the services?

Secretary MCCAFFERY. I think I will let each of the services get into their particular numbers.

General HOGG. Yes, ma'am.

So every year in the Air Force Medical Service, we go through a process to identify what our operational medical requirement is, and that process is called the Critical Operational Readiness Re-

quirement. And in that process, it identifies what I need in uniform to do my operational mission. And the last year's review of that indicated that I had a little over 4,000 medics that were over my uniformed requirement.

Ms. SPEIER. Okay. I am going to have to—we are going to have to move quickly because I have a number of other questions I want to ask.

Lieutenant General Dingle. So 4,000 in the Air Force, is that right?

General HOGG. Yes, ma'am.

General DINGLE. Ma'am, in the Army, we have 6,935 billets that we have identified for conversion. In our analysis, these do not impact any services or any risk to mission, and we continue to do analysis with the DHA and the other service to ensure that it is not impacting multi-service markets.

Ms. SPEIER. All right.

Admiral.

Admiral GILLINGHAM. Chairwoman Speier, the number for the Navy is 5,386. This was based on a careful analysis of the National Defense Strategy. But as General Dingle stated, we continue to assess this against the DHA requirement.

Ms. SPEIER. All right. I think we are going to need to have you provide us something a little more detailed. So if you would, make a point of providing us the specific specialties that you are extracting these positions, these billets from, and then we will go from there. We may have to do a deeper dive than that.

Ranking Member Kelly, do you have any other thoughts about that?

Mr. KELLY. Just any adds that they have got, because the OB/GYN [obstetrics and gynecology] shortage that we talked about with our female combat surgeons. So I see the subtractions, but if you have any adds, we would like to know those, too.

Ms. SPEIER. Okay. Very good.

Now, my time has expired, but I am going to take the privilege of asking just one more question.

Mental health was an issue we heard about over and over again when we visited the various bases. That initial assessment may be made within 72 hours, but then they wait upwards of 3 months. Now, that is an unacceptable length of time to wait for mental health services.

So I don't know that you can speak to that today, but I think I would like for you to be on notice that I am not confident that we are providing the level of mental health services we need. And I would like for you to each go back and look at the length of time between initial assessment and the ability to actually get the regular services.

And then the oversaturation, I think it is a—we heard it loud and clear in Seattle in particular when we were there. People are—families are not able to access the services in TRICARE, and there is some speculation that TRICARE is paying at a lower rate, which doesn't make sense to me because, ostensibly, it is linked to Medicare and therefore should meet the needs. But if it is not, that needs to be assessed as well.

And with that, I will turn it over to Ranking Member Kelly.

Mr. KELLY. Thank you, Chairwoman Speier.

And I am glad she asked. We are pretty much lockstep on this. And I just want you guys to know, that is a lot of billets that are going away. And you talk about near-peer and future threats.

Let me tell you what. Civilians don't go downrange when we hit them downrange. It takes guys and girls in uniform to get our soldiers to the right level of care in that magic hour. And if they are not there, we have soldiers, sailors, airmen, and Marines that die. And so we need to make sure that we are looking at each and every one, we need to scrutinize every single medical professional we can.

And then going back to my point with Chairwoman Speier, we talk to female combat soldiers, and there is a lack of medical professionals that are able to provide specific, whether it be medics or OB/GYNs or things that can apply specific medical procedures for women, and we need to make sure we are addressing that. So we shouldn't just be subtracting, we should be adding in some areas and saying, hey, we can get rid of these folks, but we need more in this area. So I ask that you do a comprehensive review.

As I mentioned in my opening statement, I am extremely concerned about the lengthy delays for routine behavioral health appointments and the shortage of mental health professionals. The services have told us for years that low pay and complex hiring processes are to blame.

What are the services and DHA doing to fix this issue? And I think if either Mr. McCaffery or Lieutenant General Place can answer this, I will just stick with you so I can get more questions in.

General PLACE. Sir, we agree with you, the challenges, some of it are within the regulations, requirements that we have of hiring civilians into any part of our program. Certainly in high-yield areas like mental health it is even more of a problem.

We do have a wide range of incentives and bonus pays that we apply to them. In some areas, they are relatively effective. In other areas, they are just not.

The reality is across the systems, I can give you examples, I would prefer not to, but in rural America in particular it is very difficult to find these sorts of things irrespective of the incentives that we put against it. So for a worldwide organization, that is the challenge that we face.

Mr. KELLY. We have heard from several families and veteran service organizations that increased copays for specialty care visits, like care for autism, have made this care unaffordable for many military families. In a recent report to Congress, DOD stated that approximately one quarter of military beneficiaries with household incomes below $50,000 reported postponing primary care sometimes, often, or usually.

This is unacceptable. What has the Department done to fix this?

Secretary MCCAFFERY. I am not aware that, you mentioned with regard to increasing cost shares for certain services, that that has been identified as a barrier in terms of seeking primary care appointments, other appointments.

I know one of the things that we have done at DHA last year, we are continuing to look at it, is indeed have there been a difference in terms of utilization of services based upon some of the increased co-shares. I don't believe we have finished that analysis.

But that would, I think, inform what would be the next steps to mitigate.

Mr. KELLY. And I don't want to interrupt you, but you guys owe us an answer on the record. That is definitely, that is exactly and specifically, and if you need me to give you the question again after so we can get specific replies. But we can't afford.

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

Mr. KELLY. Our families of our soldiers and our soldiers or airmen or sailors are the most important things that we have, and we have got to make sure that we don't put any impediments to primary care for those folks.

And for Mr. McCaffery or Lieutenant General Place, I want to ask you about MTF realignment process. Can you explain what you are doing to ensure the civilian healthcare network can absorb the patients that would be displaced from the MTFs? Because I know as early as 2017, I was in Italy, and we were talking about shutting down in Naples where there was no primary care available on the local economy. So tell me how you are going to address that, please.

Secretary MCCAFFERY. Yeah. So what you are referring to is, as you mentioned in your opening statement, one of the things that Congress directed the Department to do in NDAA 2017 was, for lack of a better word, was they asked us to optimize our direct care system. And what I mean by that is to look back and say the essential purpose of our medical treatment facilities is to serve as training platforms for our providers and to provide access to care to Active Duty so that they can do their jobs.

And so the ask was, looking at a particular MTF and the services, the capabilities they have, how does it tie to that? How does it tie to supporting that mission? And part of that is there may be areas where there is no civilian network, and so you need to have an MTF there. But there may be places, not everywhere, but there may be places where the civilian network is robust, we can provide care to non-Active Duty at less cost, and that helps optimize the use of that MTF.

Mr. KELLY. We are over time, Mr. McCaffery, but I do want to make one final point. We were just at Joint Base Lewis-McChord, and we have oversaturated that based on civilian capacity that was there. And so we have sent all our people with problems, with the identical problems there because they had it, and now we have oversaturated the civilian market. We have to pay attention to second- and third-order effects.

With that, I have to yield back, Chairwoman.

Ms. SPEIER. Thank you.

Congresswoman Davis.

Mrs. DAVIS. Thank you. Thank you, Madam Chair.

And thank you to all of you for being here, for your dedication.

We know this is really complex. When any large organization tries to integrate in a different way it is going to be very difficult. But I wonder if you could, for a moment, I think actually, Mr. McCaffery, you sort of just summed up, I think, what the goals, what the expectations were to a certain extent. But what I am hearing, and I think what we are concerned about, is that perhaps

the push for cost savings could overshadow not just efficiencies, but services to beneficiaries.

And my understanding is that there is some difference in the way the different services see this. And could you talk, maybe just going down the line a little bit, was there a difference in what you were trying to accomplish through this, and how were those differences expressed?

Secretary MCCAFFERY. Sure. And, Congresswoman Davis, I appreciate your opening statement about this being hard.

My background is in private sector and public sector healthcare, and what we have talked about in terms of this MTF transition is really, in essence, like a merger, a merger of separate healthcare systems. It is a big, heavy lift.

And anyone that would think, whether it is the military or any other organization, that wouldn't have challenges, wouldn't have contention about that change, they are not speaking realistically.

Have we had those? Yes, we have. But that being said, I believe we are in an excellent spot in terms of how we have managed this. We have already started it. A year ago we moved 31 facilities under the DHA, and as you heard from the panel, we are actually working in direct support relationship with each of the military departments to manage this transition in a way that we don't let it affect our Active Duty or our beneficiaries.

Number two, the issue you mentioned about, is this about cost savings or efficiency? I would say it is about effectiveness. I think Congress recognized in 2017 that we could be more effective as a military medical enterprise if we didn't have four separate systems, but we had a consolidated system that could respond to the mission requirements as an enterprise, that we could have more standardization across the system, not just for our beneficiaries and their experience of care, but most importantly, for how it affects operational missions. Meaning, the fact that you could have the same equipment or devices that our uniformed providers are using in the MTFs are the same ones they are using downrange.

So this is, to me, more about effectiveness, of making the Military Health System even more successful in meeting the mission, as opposed to—do I think there is going to be savings out of it? Yes. I think you get that out of that consolidation and standardization, but the focus is on effectiveness.

Mrs. DAVIS. If anybody else wants to comment on that.

I think the difficult thing is that we are dealing with people, right, employees who have to sort of work through what this is going to mean to them. And so I am wondering a little bit too about how you are messaging for them, because if you are losing that many billets, that is having an effect on people. And I think it does translate into beneficiary services. And I know as well, I mean, having served on the MILPERS [Military Personnel] committee at the height of our wars, I mean, from 2001 until today, there were so many families that were ready to walk because initially they were not getting the support that they needed.

And so talk a little bit more about, I mean what comes together is that there are needs that are difficult and difficult to work through in a very short period of time. What is it today that you

would like to share with us that is going to get this job done perhaps a little faster?

Secretary MCCAFFERY. To get the transition done faster?

Mrs. DAVIS. Well, I think to help with the transition while at the same time respecting the men and women not just who serve, but all the people who are part of the system. How are they going to be part of it?

Secretary MCCAFFERY. So right now, General Place and each of the surgeons general are actively part of this transition of moving administration of the MTFs to DHA is about, well, how do we make sure that that knowledge and their resources that are now in the services get moved over to the DHA. And we are talking about people. It is easier for us to move uniformed people around, but the civilians are different.

And so what we are doing is we are working together to as much as possible allow a clean transfer of folks doing certain responsibilities in the service medical headquarters, bring them over to DHA. And where we are not being able to do that, look at different tools that we can do management directive transfers so that we ensure not only does DHA get that people resource that we need, but it is also at the same time ensuring that those employees that are doing that mission continue to do that mission but under a different management.

Mrs. DAVIS. Yeah. I appreciate that. My time is up. I am going to turn it back to the chairwoman. But just sort of hearing from all of you as well in terms of, like, so what do you have to do to make sure that that happens and we are not just saying we are going to do it, but we are going to act on what we say. Thank you.

Ms. SPEIER. Thank you.

Dr. Abraham.

Dr. ABRAHAM. Thank you, Madam Chair.

Dr. Friedrichs, I listened to your résumé, and I know where you went to medical school, and I know in your heart of hearts you do understand that LSU [Louisiana State University] will be the national champion this year.

General FRIEDRICHS. Absolutely, sir. I strongly endorse that.

Dr. ABRAHAM. On a side note, we were discussing with you ladies and gentlemen that our veterans are being moved to the civilian population, and I still practice pro bono in a medical practice that certainly takes those wonderful people. But we still have problems with TRICARE West and others not being accepted in the civilian—and I have taken this up with the Veterans' Affairs Committee where, of course, jurisdiction lies.

But you need to be aware that when we move these veterans from an active military situation to a civilian situation, it becomes problematic that if that particular insurance is not taken by civilians, those patients, those veterans are denied, unfortunately, care in some places. We, of course, take them regardless, but some practices can't afford to do that.

And toward General Kelly's point, there is a barrier, Mr. Secretary, when that copayment is higher for certain specialties as to those families that may not can afford if it goes from 10 to 25 to 50 or whatever. So that is something that we have to continue to address.

My question, and I will start with all the surgeon generals here, just please explain any inefficiencies or structural difficulties that you have with DHA at this time.

And, General Place, I will start with you, sir.

General PLACE. I don't think there is any structural problems with DHA. I see a private process that enables us to come together to have overlap. One of the problems with overlap is that takes more time. It is crucial to not have gaps and drop a soldier, drop a family member, drop a retiree.

So to Mrs. Davis' point before, and I get that we want to move fast, but not at the expense of one of our service members or their family. So that, if anything, I see that as the problem, that is the challenge, is the timeliness, but it is based on not wanting to drop anyone through the system. I think we are set up well.

Dr. ABRAHAM. General Hogg.

General HOGG. Yes, sir. So I believe we are working well together in trying to address some of the difficulties. This is hard.

Dr. ABRAHAM. I understand.

General HOGG. It is very challenging to bring all us together at one time. And we are working well together.

I would articulate that I like to say, I would like to transition before I transform. So let's get the Defense Health Agency on its feet with 702 to where they can truly take over authority, direction, and control of the military treatment facilities, and then we can start finding those efficiencies that I know we can find. But if we try to do both at the same time, I do have concern that we might, we might miss some very important things.

Dr. ABRAHAM. General Dingle.

General DINGLE. I would echo the same comment. I believe that it has to be focused and deliberate, that we must focus on the medical treatment facilities transferring, and the electronic health record, get that correct before we do anything else. And that is my position.

Dr. ABRAHAM. The EHRs [electronic health records] are problematic, as we know. That is why about half of the gray hair I have on my head is there now, dealing with that.

Admiral.

Admiral GILLINGHAM. Yes, Congressman.

I would say as the new kid on the block, having been in this position for about 5 weeks, I am incredibly impressed by the collaboration that exists with my partners.

I would say in terms of the structure, I think the establishment of the direct support agreements has been a very important step to ease that transition rather than just a complete turn the switch in October.

So I would say that continuing that work, but having clear road map for hand-off of those functions, is a critical step going forward.

Dr. ABRAHAM. General.

General FRIEDRICHS. Thank you, sir.

And I would echo that. From the Joint Staff perspective, one of the great strengths of DHA has been how they have helped us to better collaborate in the combat support arena, things like the Joint Trauma System. We recently hosted a meeting with the combatant command surgeons in which they highlighted the significant

progress that we have made in what was already a world-class Joint Trauma System, making it even better as we continue to work more closely together.

So I think there is great progress. Obviously, much more work to be done. There will always be opportunities for improvement.

Dr. ABRAHAM. Well, I am glad to hear the cohesion.

Madam Chair, I just request we enter into the record this article on Military Times, the military needs for a unified command. And that is from Brad Wenstrup.

Ms. SPEIER. Without objection.

[The information referred to can be found in the Appendix on page 97.]

Dr. ABRAHAM. Thank you.

I yield back. I am out of time.

Ms. SPEIER. General Friedrichs, one of the articles that our good friend Dr. Wenstrup had brought to our attention that was put out by U.S. News & World Report spoke about how surgeons in the military are not getting the kind of experience that they should be getting in order to be more proficient, that they are getting about 20 percent of what a surgeon in civilian workforce would be getting in terms of the number of cases they handle a year.

And you just spoke about the trauma care issue. So I am curious how we are going to address the fact that they are lacking in the opportunities to handle enough surgeries and be prepared then in terms of readiness when they are out on——

General FRIEDRICHS. Thank you, ma'am.

And I would say from the Joint Staff perspective, we define the requirement, we describe what the combatant command requirements are and rely on the services and the Defense Health Agency to organize, train, and equip to meet that requirement.

I believe as a surgeon that the article captured a number of points on which we are already working. One of our responsibilities in the Joint Staff is joint capability development. And we have been working on improving through the Joint Trauma System a number of areas, whether it is expanding opportunities for currency or expanding equipment, improving equipment availability, for several years now.

Those articles capture very valid concerns that are expressed by some surgeons. I can tell you, I was in San Antonio 2 weeks ago at the Committee on Trauma, which is the assemblage of our senior leaders, and I heard a much more optimistic story of progress being made across the services. And so I would respectfully ask if my colleagues from the services could also talk about what they are doing on that.

Ms. SPEIER. All right. I want to give Congresswoman Trahan her opportunity first. We will come back to this issue. Thank you.

Mrs. TRAHAN. Thank you. Thank you, Madam Chairwoman.

I am going to switch gears. I am not sure this is going to really fall with the 5 minutes, but I am going to give it a shot, given that I have got so many surgeon generals and military healthcare professionals in front of me.

I wanted to talk about suicide for our Active Duty members. Data shows that there are approximately 60 percent of military

personnel who are experiencing mental health problems and they are not seeking help.

And when I reviewed the medical standards for appointment, enlistment, and induction, it precludes things like sleep disorders, ADHD [attention deficit hyperactivity disorder], depressive disorder, anxiety disorders. So I don't think it is any surprise that there are studies that suggest that many are skirting the rules to enlist.

And I am wondering, can you briefly touch upon maybe the cognitive assessments taken on service members as they join? And also what is preventing service men and women to self-report potential risk factors like sleeplessness and depression?

Ms. SPEIER. It is not a good sign that none of you are responding here.

Secretary MCCAFFERY. The reasons, just in terms of some of the questions that you are asking with regard to military department processes, in terms of accession, standards, I think one of the surgeons would be most able to kind of respond to some of those specifics.

General DINGLE. I will start.

Yes, ma'am, it definitely is a very important aspect. So at the point of accessions, behavior health screenings, physical screenings are very important, and you are absolutely correct that we can improve it to make sure that we are not missing it and then taking it on when they come on to Active Duty.

In reference to why are they not reporting, it has been a challenge in removing the stigma. It is imperative that we educate and that we change the climate and cultures of commands and organizations so that soldiers, sailors, and airmen are not afraid to report because of retribution or impact on their career.

And so that is the bottom line why service members do not report. They do not want it to impact their careers.

However, one of the greatest things I saw at the DOD/VA Suicide Prevention Conference this summer was that we have to move to prevention, getting ahead of the act, by changing the culture, and we change that culture by removing the stigma and education and a holistic approach from the command itself.

General HOGG. Yes, ma'am.

So in the Air Force, we are actually seeing an increase in people coming to mental health because of the outreach that we are doing. We are embedding our mental health into units where they can build the relationship with those providers and they feel more comfortable coming in to get care.

The other thing that we are doing is, a lot of this is really giving people the capability to handle stress without crisis. And so in our basic training military capacity, we are actually providing classes to our new recruits on how to handle stress and what are the ways to seek care if needed and reach out and touch people.

Admiral GILLINGHAM. And, Congresswoman Trahan, I would just say from the Navy perspective, we very much endorse embedding mental health personnel at the deckplate and in stressful training commands. So one-fourth of our mental health professionals are actually in the operational force. And so we have seen a commensurate increase in access and decrease in stigma.

The other benefit is that those mental health professionals do tremendous training for the senior officers in those, for example, submarine squadrons, so that they are extenders in terms of identifying those at risk. And similar to the Air Force, we are piloting teaching meditation to new recruits at boot camp as a way to help deal with stressful situations.

Ms. SPEIER. Congresswoman, was your question actually answered? I thought what you were asking was, when recruits are reluctant to identify these conditions, how do you—how are you able to assess that as they are going through the training process? Is that what your question was?

Mrs. TRAHAN. Yes. So, one, I think it is great to sort of diagnose and help embed and to treat people who are suffering from mental illness. And culture, some organizations do it better than others when it is time to change culture.

My question is—and certainly we have got generations of young people who are taking medication to prevent sleep disorder, to prevent ADHD. They are working. Is there any discussion around—my fear is that people are going off their medication when they enlist because that is a requirement, and that can cause great mental—that can obviously cause harm and mental disorders to flare up in nontraumatic situations even.

So I am wondering if there has been any discussion around revisiting some of these protocols or if there has been any sort of study or a discussion around that being a root cause for some of the mental health problems and suicide rates that we are seeing in our nondeployed Active Duty service men and women.

General HOGG. So not to my knowledge, but it is certainly something that we can take back and take a view and see if we have something that we can improve upon.

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

Ms. SPEIER. You know, Mrs. Trahan, I think that you have touched on an issue that probably deserves having a briefing on, because there is an ability for people to be very functional on drugs to combat ADHD. And yet I am sure that if that was identified in an application before a recruiter, that person would be declined the opportunity to serve.

So maybe we need to just have a generalized discussion on whether or not the basis on which individuals are allowed to enlist meets the medical technology and advancements we have made relative to drugs and other things.

Mrs. TRAHAN. I would love to attend that hearing. Thank you, Madam Chairwoman.

Ms. SPEIER. All right.

Congressman Bacon.

Mr. BACON. Thank you, Madam Chair.

I want to thank all the witnesses for being here today and for your commitment to the health and readiness of America's most important weapon system. That is our warriors and their families.

I would like to focus for a moment on a medical readiness challenge that concerns me; perhaps an opportunity as well.

Most Americans would be surprised to learn that World War I more soldiers actually died due to disease than to enemy action, largely as a result of the 1918 influenza epidemic or pandemic.

Today we know that our enemies are relentlessly pursuing ways to kill Americans in large numbers. We also know that naturally occurring infectious diseases in our increasingly interconnected world have the ability to spread faster than ever. The risk of infectious diseases is significant and growing, not only for our general population, but also for our defenders in the Armed Forces and our first responders.

So as these threats grow, I am concerned our capacity to prepare, detect, and respond with specialized care for chemical, radiological, biological infectious disease is far less than we need and may actually be declining.

So my question is to General Friedrichs. If we have time, we will come back to others.

But my question to you, General Friedrichs, is as you contemplate the 21st century force health protection threats facing our military and the shrinking of our uniformed medical service, how do we better position the military and our civilian health systems to work together to address this mission?

General FRIEDRICHS. Sir, thank you very much. And I would offer several observations.

First, absolutely agree with your points about the rapidly evolving threats. There is no question that the threats that we faced in previous conflicts are not the threats we will face in the future, and we must continue to evolve our detection capability, our attribution capability, our ability to prevent the effects of those agents that are being used, and then to treat those once they are exposed.

All of that has worked. It must continue. And it will require a robust, whole-of-government cooperation, partnering across the Department of Health and Human Services, the Department of Homeland Security, and the Department of Defense.

But more importantly, we are grateful that we have partners at the State level who have recognized these threats and have joined in those partnerships to develop new capabilities. That sort of partnership is imperative because the threat is not just somewhere else. It is not just in another continent. It can just as easily happen here. It can be a pandemic that occurs on our own soil or an attack on our own soil.

To your specific comment about the capabilities that we need, as these threats evolve we must develop new detection capabilities, we must develop new training capabilities for our medics, we must develop the ability to have better treatments that allow us to function wherever that new agent is used as we go forward. And that is important work which is going to require partnership, as I said, across the whole of government and with key State partners.

Thank you, sir.

Mr. BACON. So we have facilities in Omaha like the University of Nebraska Medical Center [UNMC] that is the world's center of excellence for Ebola, as an example. So let me just follow up and ask you, how do you take advantage of civilian centers of medical excellence, like UNMC, in developing solutions? Do you see a role

for more creative public-private partnerships like we now are doing in communities like Omaha with the new VA medical center?

So appreciate your insights on that.

General FRIEDRICHS. Sir, first, thank you for the question. And more importantly, thank you for the community support across the State of Nebraska. That was not just an Omaha initiative, that was a statewide initiative that in many respects is a model of public-private partnership.

The work that has occurred across the agencies in order to work with the Nebraska community does set a model that we can use in the future going forward because this is not solely a military problem. We are part of our Nation's response, but we cannot be the only response.

It begins with local capabilities, local leaders who recognize the threat, and then partner with State and Federal experts to develop those capabilities that we can use, whether it is a local event or a national event or, unfortunately, as may occur in the future, an international event.

I think that the capability that has been developed for Ebola, the partnership for the VA hospital, some of the cutting-edge research that is being done there in Nebraska is exactly the sort of work in collaboration that we need to move forward in the future.

Mr. BACON. Thank you.

And, Madam Chair, I see an opportunity for public-private partnerships working together to benefit the whole country and beyond just the military.

I have a follow-up for General Hogg, if I may. Don Bacon is going to ask her a question here. We have been working off and on together for a long time.

So have we already had cuts made at the bases at the medical centers? Have those cuts already occurred?

General HOGG. No, sir, they have not.

Mr. BACON. Because I have been getting more and more reports from concerned constituents, retirees primarily, that feel like they are being pushed out, made to go to the VA, and not allowed to do their TRICARE.

So these phone calls I am getting are not related to the proposal that is going on here. Is that what I am hearing?

General HOGG. Right. Yes.

Mr. BACON. Okay. Thank you.

Ms. SPEIER. All right. We are going to do a second round for those that are interested in staying to ask more questions.

I would like to go back to that question that I asked about surgeons and their ability to have enough experience with cases and what we are doing to try and—if, in fact, the average surgeon has 500 cases a year and the average surgeon in the military has only 20 percent of that, that is a real vacuum, I think.

So let's start with you, Lieutenant General Hogg.

General HOGG. Yes, ma'am.

In the Air Force we have for a long time had what we call training affiliation agreements where we send out our medics to civilian or other Federal institutions to get those touches, what I like to call volume acuity and diversity of cases, because we know in our direct care system we won't have that.

And so for a long time we have been sending our specialized medics, trauma surgeons, orthopedic surgeons, nurses out into civilian facilities to get that. Nellis is a good—UMC [University Medical Center of Southern Nevada] is a good example of that, Baltimore Shock Trauma is a good example of that, and many others.

We are also now having some success in getting our enlisted medics into those treatment facilities in order to have the touches that they need.

One of the difficulties that we have is gathering the data on exactly how much——

Ms. SPEIER. All right. So I would like to get to the other services.

Could you just provide that data to us? Because in part, General Friedrichs, I think what I would like to see is a response to those articles as to where we are falling short and where we have actually made some advances.

General Dingle.

General DINGLE. And ma'am, we are coming on a critical point, because what we have also done as a collective joint work group, we have identified what is called those knowledge, skills, and attributes that are required for surgical proficiency; and not just surgical proficiency, but all of our specialties across the militaries.

Within the Army, we then build on top of that with what we call ICTLs, Individual Critical Task Lists. So for that trauma surgeon, how many procedures do you need, as you mentioned? And then we, for the first time in our history, are tracking and documenting those as it goes towards readiness. And we will continue to build upon those internally with the MHS.

Ms. SPEIER. So you recognize that there is an issue.

General DINGLE. Yes, ma'am.

Ms. SPEIER. And you are attempting to address it.

General DINGLE. Yes, ma'am.

Ms. SPEIER. Admiral.

Admiral GILLINGHAM. Chairwoman Speier, I would agree, yes, we do. We are approaching this in two different directions.

Internally, within the direct care system, you may be aware that Naval Medical Center Camp Lejeune was designated a trauma center, and we are seeing tremendous value, both within Lejeune and also to the local community.

And then externally we also have existing partnerships, which also include our corpsmen, which we all recognize at the tip of the spear are some of the most important part of the trauma response.

Ms. SPEIER. Okay. Thank you.

What we have seen since the budget year 2015 is an actual reduction in the cost of providing military health by about at least a billion dollars.

So I guess to you, Mr. McCaffery, where is that money going?

Secretary MCCAFFERY. So is the question with regard to a change from fiscal year 2019 to what the President's budget proposed for 2020 or——

Ms. SPEIER. No. I think staff has looked back at the Defense Health Program spending since 2015, and the program has had a decrease in funding and appears that it is costing less money and that the savings, whether it is a billion or 3 billion, we have seen

different figures, there is a savings of about a billion to 3 billion, and I want to know where that money is going.

Secretary MCCAFFERY. So some of the data I am looking at right now, and I am looking at the Defense Health Program [DHP] appropriation, so that is what is funding our direct care system, the purchase care system, some of the R&D [research and development], what I am looking at for fiscal year 2015 shows that DHP plus military construction for health facilities is about 33 billion. It dipped a little bit in 2016, 33 billion in 2017, 34 in 2018, and just under 35 in 2019.

So I am not sure if we are looking at different numbers or——

Ms. SPEIER. We will have our resident expert.

Mr. DIEHL. Mr. McCaffery, the question is really the unified medical budget at the DHP.

Secretary MCCAFFERY. Oh, okay.

So I am looking at that now for the same figure. Unified medical budget in 2015, I have 48 billion. It then dipped a little under 48 billion, then 49 billion in fiscal year 2017 and 50 billion in 2018, and a little over 50 billion, at least enacted, for fiscal year 2019.

Now, I know in the fiscal year 2020 proposed budget, the President's proposed budget has it down at 49 billion. But my understanding, and I could be wrong, is every year Congress adds in roughly a billion, between, I think, 800 million and a billion, in additional R&D dollars. That is not in the base budget proposal in the President's budget and so that probably is one explanation for a delta between what was actually enacted in fiscal year 2019 versus what the President proposed in 2020. But I can go back and double check and confirm that.

Ms. SPEIER. So the question becomes, if it is basically stagnant, is that actually savings, because we are not seeing a cost of living increase? I don't want to take any more time. Maybe we can have a subsequent conversation on that.

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

Ms. SPEIER. Ranking Member Kelly.

Mr. KELLY. Thank you, Chairwoman Speier.

And just real quick, and I think you answered this, Admiral Gillingham, but the embeds you were talking about on behavioral health, you are also doing that with your corpsmen with the Marines that are forward. Is that correct?

Admiral GILLINGHAM. Yes, sir, that is across——

Mr. KELLY. Very good. I am satisfied with your answer. I just want to make sure we are taking care of our Marines.

Admiral GILLINGHAM. Yes, sir.

Mr. KELLY. And then, Lieutenant General Dingle, I didn't hear the Army talk about embeds at all. And I would argue that the people who are the hardest and need that the most are the Army and the Marine Corps, based on the duties and the unit types that they have. So what are we doing?

General DINGLE. Mr. Kelly, you are spot on. We did embeds many years ago and we continue to champion that as part of our behavioral health system of care. Embeds are a very important part of our brigade combat teams forward.

Mr. KELLY. So we are doing that?

General DINGLE. Absolutely, yes, sir.

Mr. KELLY. But is there a shortage there of behavioral health? Because my experience in the Army, and especially in the Guard and Reserve, is that there is an extreme shortage of professional behavioral health specialists that are in the Army units that are filling those MTOE [modification table of organization and equipment] slots. We have got the slots, but we don't have the docs.

General DINGLE. And what we are doing, again, improving the recruitment to try to get those specialties in there. In addition to that, within the Army, in addition to those bottoms-up—we did a bottom-up review where we looked at the mental health requirement and identified even more.

So as we are looking at H2F, holistic health and fitness, it is from a mental health perspective as well as a physical therapist and occupational therapist also augmenting our brigade combat teams and our divisions forward.

Mr. KELLY. Have you been down to Bragg lately and seen what they are doing down there with our special operators at Bragg as far as psychological health and just total package?

General DINGLE. Yes, sir.

Mr. KELLY. We need to do that across the services, because that is all services, and we need to figure out how we can do that better across the entire services. I am sure you have been down there, too, General, but I just want to make sure that we are doing that.

Second, real quickly, what authorities do you guys need to help you assess behavioral health experts? Because we have asked you and you guys need to give us what authorities or what things do you need in order to get this to where we need to be, for accessions of behavioral health specialists.

Secretary MCCAFFERY. Right. I don't believe there is authorities in terms of statute or policy direction. I believe you have kind of heard a common theme from everybody, and it is also common in the private sector, is resources, resources to be able to hire. And even if you have resources, there are going to be certain areas that you are going to have a hard time recruiting, even if you can pay them, recruiting mental health providers.

But I would say it is probably more around resources and what else we can do to entice folks to join and provide that service.

Ms. SPEIER. Will the gentleman yield?

Mr. KELLY. Yes.

Ms. SPEIER. When you say mental health providers, are we also talking about marriage and family counselors? I mean, we are talking about the whole gamut, it is not just psychiatrists and psychologists?

Secretary MCCAFFERY. Correct. Correct. I can't speak to kind of each service in particular, but I know in certain classification of mental health providers, we are pretty good. I think it is hit and miss based upon the classification of provider.

Mr. KELLY. And then the final thing I want all you guys to look at is we are a total force, but docs can make a lot more money on the civilian world than they can in the Army, Navy, Air Force. I mean, there is a lot more money to be made. It is kind of like being in Congress. There are a lot better ways to make money than do this job. So you guys do it because you love it.

But there is an opportunity out there in our Guard and Reserves, for the Air Force and Navy and Army, there is an opportunity because these guys want to serve. I mean, the reason people are doctors is because they want to help people. It is not about money. But there is a point where they have other obligations.

So let's make sure that each of our services are looking at our Reserves and our National Guards and saying, do we pay them better? How do we get them in the rotation so that they fill behavioral health specialties? Maybe we have those seeing soldiers or airmen at Joint Base Lewis-McChord on the weekends or maybe they do their 2-week AT [annual training] there and we schedule them in.

So as a whole, as an Air Force or as an Army or DHA, how are we integrating, especially behavioral health specialists, into the Guard—I mean into the total force—so that we are using that to our benefit?

And maybe we need to pay them a little more, maybe we need to make their incentives a little better so that when a guy comes off Active Duty or a doctor who wants to serve—everybody likes to wear a uniform. I mean, they do. I mean, because it is the same thing that makes people want to be doctors that make them want to be soldiers. They want to serve. So how do we get those guys so they can serve in a capacity and help our total force?

And with that, Chairwoman, I yield back.

Ms. SPEIER. Thank you.

Congresswoman Davis.

Mrs. DAVIS. Thank you, again.

I think what I know I am hearing and what I really wanted to ask you about as well is, what is the strategy? What is the plan? How do we make certain that as we move further into TRICARE for beneficiaries that there is a "there" there for them and they are not going to lose in the benefits that they have already had.

I know that it is a great source of anxiety for our families. And certainly when we go on a full OPTEMPO [operations tempo] and deployment, all the pediatricians go to war, right, so we don't have them. And it is important that we figure that out.

So for mental health, I mean, one of the questions that I was interested in is, we talked a lot while a number of our troops and our corpsmen were coming home from the war, some of them had developed a real aptitude for being able to help one another in the mental health field.

And I hope, and, again, part of this really thinking ahead about it is, how do we make sure and identify those people—and I think the ranking chair mentioned this—that are coming out of the service that perhaps at another time they would have never thought about going into the behavioral health field, but they are now.

We talked a lot about social workers a number of years ago. How does the military identify those people who, with proper training and with loan forgiveness, that they can do that?

And so I am hoping that perhaps we think a little bit more about the future, because there is no way in the world that we are going to be able to rely on the civilian world to satisfy the needs that we are going to have.

And the other thing is, just quickly, finding a better way—and we have some wonderful folks in San Diego that have really looked

into this because of a family suicide. How do we, within our system of privacy, HIPAA [Health Insurance Portability and Accountability Act], whatever, make certain that families can be more involved in the mental health of their loved ones? It is a deep, dark secret sometimes that somebody needs help and it shouldn't be that way.

As a parent you feel like I want to be a partner here, but I don't know how. And there are some men and women in the services who are not going to call their families and tell them they are struggling. But maybe there is a better way of doing that. And I know the VA has been working on that. So thinking about how do we do a better job.

But certainly our spouses, and I remember talking to so many spouses about this, yeah, they were afraid to share the fact that their husbands were screaming in the night, because they were afraid that they would be kicked out of the service. They need to be involved as well. And certainly having good practitioners to help them out as well.

So I hope that all those issues will be looked at. And we were talking about that, the issue that I think, Admiral Gillingham, you would be aware, too, in San Diego, we really did not have the patients for our surgeons to be able to help there, and so they go to L.A. County Hospital. That is where they go for gunshot wounds, honestly. And that is what we have to do sometimes in partnering.

But just as it has been difficult for you all to work together to have this change, it is not so easy for them as well, although our military has often been trained in the civilian world and back and forth, and we train them very well.

Sorry. I think my time is almost up. Maybe you gave me more time.

Ms. SPEIER. You have another minute.

Mrs. DAVIS. Okay.

Ms. SPEIER. You can actually have them answer you.

Mrs. DAVIS. Yes, please, please.

So is there that kind of planning that we are really looking at all the parameters possible to be able to serve our men and women?

Secretary MCCAFFERY. Let me start with one of the first questions you asked, in terms of where does the TRICARE program, where does our partnership with the civilian sector fit in to where we are going in terms of reforming the whole system, because that is a key, it is a linchpin.

And even though the current TRICARE contract is only a little less than 2 years on board, we are already starting the effort in terms of the next generation, the next procurement, because just for what you said, it has to be critical to support the change in the system.

So if we are going to be consolidating all of our MTFs under one management under the same roof that manages the TRICARE program, we need to make sure that we are requiring more from our contractors, both to make sure we get what I would call the readiness-related caseload we need into our system, for all the reasons we have talked about in terms of keeping our surgeons, our providers current, so we need to be able to do more of that, we need to make sure that we do have the adequate networks to support

our families and our beneficiaries when, indeed, we are making changes to the system and we realign services in certain areas in terms of what MTFs are providing, we need to make sure that we have that partnership with those contractors to make sure that that capability doesn't go away. You may not get something from a uniformed provider, but we have to make sure you get it from a provider.

So I think those are some key things that we are looking at as to what we need to do to support the reform going forward.

Mrs. DAVIS. And looking at increased pay obviously is going to be an issue.

Ms. SPEIER. All right.

Dr. Abraham.

Dr. ABRAHAM. General Friedrichs, educate me, sir, please. You said Lejeune has been designated a trauma center?

Oh, I am sorry, Admiral. Is that true? Is it a Level 1?

Admiral GILLINGHAM. Level 3, sir, with aspirations for Level 2.

Dr. ABRAHAM. And so you are seeing civilians in that capacity?

Admiral GILLINGHAM. Yes, sir. That is correct.

Dr. ABRAHAM. You have worked out getting the ambulance through the gate, insurance, and all that stuff? Okay.

Admiral GILLINGHAM. Yes, sir.

Dr. ABRAHAM. The reason I ask is I know that the armed services' surgeons are not getting enough cases or certainly as many as they desire. And I know that in some cases you are meeting some headwinds from the civilian docs taking their cases. And so we understand the dynamics there of there is just a set number of trauma patients and everybody wants to have their gloves on and hands in fixing that patient.

So I think it is a wonderful concept of designating as many camps as we can as trauma centers so we can get that expertise that you people need with your doctors in play, so it is a good concept.

Mr. Secretary, just one question for you. Do you see value in placing the DHA under a unified operational command?

Secretary MCCAFFERY. I mean, I think one of the things that Congress has asked us to do and we are in the kind of final stages was actually to look at, is it feasible to morph DHA into a unified health command, a defense health command. And we are putting together what we think could be feasible options.

The key thing is what would we want to get out of that. I mean, it could be is it because we want to have more clear command authority over all medical forces across the services? Is it efficiency? And that is the thing that I think you have to determine first before you can assess whether that is the right direction.

But the one thing I think there is unanimity within the Department is we don't believe this is the time for us to go down that path, only in that you have heard us all talk about the enormous change we have already launched. And our feeling is, it is better to see how does DHA function with their new responsibilities before we were to talk about would you convert that or change the Defense Health Agency into an even larger command across the Department.

So we do think it is worthwhile looking at, but we want to revisit that in probably the next 3 to 4 years once we have some more stability in the system.

Dr. ABRAHAM. Thank you.

Madam Chair, I yield back.

Ms. SPEIER. Thank you.

I think it was you, Lieutenant General Hogg, who said that it is really important for us to bring all of these services together under one roof before we start moving forward on some of these other aspects. I am presuming you mean these billets as well. Is that correct? Or is that something you are going to implement while this process is going on?

General HOGG. So the billets are from the Air Force, higher Air Force level. And the plan right now is, while they are there, we will not reduce the faces until the system can handle the workload.

Ms. SPEIER. All right.

And how about you, General Dingle?

General DINGLE. Yes, ma'am. We, likewise, the billets have been identified, and we are coming together working with the DHA to see impacts of billets. However, we also have a large number of unfilled billets that we are looking at this fiscal year.

Ms. SPEIER. Are you going to hold off reducing the billets or are you going to reduce the billets, is what I am asking.

General DINGLE. Our unfilled billets, ma'am, have already been converted over. There will be no further reductions until we do the complete analysis with the DHA.

Ms. SPEIER. Well, what happens if those billets are mental health professionals? I mean, one of the issues that we have talked about a lot today is the fact that we need more mental health providers. So arbitrarily, if you are just going to not fill these unfilled billets, don't you have to make an assessment as to whether or not they are important to be filled?

General DINGLE. Yes, ma'am. And one thing, a little more detail, as we have done conversion of billets, some of the billets we have converted are, in fact, goes towards holistic health and fitness, mental health providers, but on the operational force side of the house.

The empty billets that are in the MTF side of the house, again, are unfilled, and as we move them to the operational force we have done bottoms-up review in which we have, in fact, identified more medical requirements for our operational force that we will move to recruit to fill those billets in.

Ms. SPEIER. All right.

Admiral.

Admiral GILLINGHAM. Yes, ma'am. For the Navy, the faces remain in the billets and looking very carefully at the impact on DHA.

I will say to your point about mental health, very few of the planned reductions were in mental health billets.

Ms. SPEIER. All right.

Mr. KELLY. Would the gentlelady yield?

Ms. SPEIER. Of course.

Mr. KELLY. I just want to make sure, I get the unfilled billets, but from a lot of years of experience, the unfilled billets are gen-

erally the low-density, hard-to-get billets. And I just want to make sure that those aren't the behavioral health and the OB/GYNs and all the areas we have trouble getting enough people that we are not just, because those billets aren't full, that those are the slots or the people that we are going, so we are not going out and recruiting those. If that makes sense.

We have got to make sure that we are not, just because we don't have a filled billet with a behavioral health specialist, that we don't do away with that slot. We have got to fill that slot. We have got to do away with another slot when it goes away.

And I yield back.

Ms. SPEIER. Let me also make note of the fact that when we were visiting the bases, it was astonishing to both of us that there was such a high incidence of autism among the families of service members, many of whom were officers as well.

I actually think we need to do a review and determine if this is just isolated or is it reflective of the general population or is there something environmentally or something else that is creating this incidence of autism and our ability within the military system and the health system to provide the services to these families.

And finally, there is a lot of talk today about effectiveness and readiness and efficiency. What was left out of all of those terms is the fact that it is not just for that. The families are a huge component of the healthcare system within the military. And if we don't have a robust system that provides the services, I think we are going to have a problem with retention.

And so, it is really important that we have the quality of healthcare that each of these families deserves. And if we are falling short there, we are falling short in many other areas as well.

So with that, if there are not any further comments to be made, thank you very much for your service and for your participation here tonight. And we stand adjourned.

[Whereupon, at 4:56 p.m., the subcommittee was adjourned.]

A P P E N D I X

December 5, 2019

PREPARED STATEMENTS SUBMITTED FOR THE RECORD

DECEMBER 5, 2019

Statement of
Representative Jackie Speier
Military Health System Reform:
A Cure for Efficiency and Readiness?
Military Personnel Subcommittee
December 5, 2019

The hearing will now come to order. I want to welcome everyone to this hearing of the Military Personnel subcommittee on Military Health System reform.

Today's hearing is focused on the status of military health reforms Congress enacted in the 2017 NDAA, and whether the Department and the Military services are working toward achieving Congress's intent.

The reform that most impacts servicemembers and their families is the transition of management of the Military Treatment Facilities from the Services to the Defense Health Agency, which is the focal point of this hearing. The last time we had a briefing on this issue was in December 2017.

I recall there was some disagreement among the Military Departments and DoD on how to implement these changes. I understand this transition began at least in part by the October 1, 2019 deadline; but it was painful getting to that point and it was a very small step toward accomplishing the overall goal of a single Military Health System instead of 3 separate service health systems.

There are also are many other reforms critical to making the MTF transition successful that are lagging behind, such as the implementation of the new electronic health record Genesis; the proper analysis of what medical skills and number of medical providers are needed to support the warfighter and beneficiaries; the appropriate number and sizes of medical facilities; and reforms that could create economies of scale and effective efficiencies within the MHS. To be clear, budget cuts are not the same thing as efficiencies in the MHS. And many rumored cuts to the military medical workforce—whether primary care physicians or ophthalmologists—lack rationale or evidence that they would actually save taxpayers' money.

One of the top concerns many of my colleagues have heard over the past 8 months was about the military medical manpower cuts in the President's FY 2020 budget. This was done to repurpose 17,944 Military Department officer and enlisted health specialty medical billets and transition them to other manning needs in the Military Departments. I was baffled as to why this request was submitted when the Services and the Joint Staff had not completed the analysis of the operational requirements for supporting combatant commanders in time of conflict or war. It appeared to me that this proposal prioritized cost cutting over operational needs and common sense.

In February 2019, GAO confirmed our concerns when they reported that "the DOD has not determined the required size and composition of its operational medical and dental personnel who support the wartime mission or submitted a

complete report to Congress, as required by the National Defense Authorization Act for Fiscal Year 2017."

We have also heard that there is a Defense Wide Review underway that is considering a wide variety of cost-cutting proposals including shuttering major military medical centers, a restructured TRICARE benefit that could significantly increase copays, closure of the Uniformed Services University of the Health Sciences, and the potential destruction of some reforms that we've made into law over the past 3 years.

The goal of military health reform is not to reduce the military's ability to deliver health care in times of peace or war. The goal is to find ways to be more efficient so that we can save taxpayers money while providing better health care for our servicemembers and their families. Private insurance and private providers may serve these goals for some types of services in some communities. But privatization can also threaten worse outcomes and higher costs if done without care and consideration.

The Ranking Member and I recently visited the Madigan Army Medical Center, Naval Hospital Bremerton, and the David Grant Air Force Medical Center, where we spoke with military spouses about quality of life issues. Access to military health care came up in every discussion.

At each installation, we heard about challenges with the lack of mental health resources in the local community. We heard about civilian health care networks that either lack the capacity or are unwilling to admit TRICARE beneficiaries. And we heard about challenges accessing appointments at Military Treatment Facilities.

The larger problem we heard is not that local providers think TRICARE reimbursement rates are low, it is that the health care market is already oversaturated, even in large metropolitan areas like Seattle and San Francisco.

It's not all bad news. At Travis Air Force Base, we saw a busy Military Treatment Facility working hand in hand with the VA in a collaboration that could, along with civilian providers, create an integrated delivery system. The 2017 NDAA encouraged these types of relationships with local health care facilities. We need to see more of this kind of cooperation and hear more from these programs in order to replicate their successes.

Instead, DoD seems intent on gutting our military health system and calling it an efficiency. The system is costing less; it has saved $1 billion and been a smaller budget item over the last couple of years. But there remain urgent coverage needs that should be addressed by reinvesting any savings in the military health care system, not continuing to squeeze every last penny out of the system in order to fund other priorities. Health care is a need and right we must continue to provide for our military families. Weakening the delivery system will only cost us, and our servicemembers, more down the road. The Department must do better.

Today, we will hear from a panel of senior leaders from across the Department of Defense that are responsible for implementing Military Health System reform.

We are seeking to better understand how DoD is implementing major Military Health System reforms, how they are determining TRICARE's success in meeting the needs of its beneficiaries, and how DoD's plan to repurpose roughly 18,000 medical positions will affect health services.

We will also hear how DoD is balancing readiness with efficiency and how the Joint Staff and the Service Surgeons General are approaching readiness to ensure that we have the right personnel and the right capabilities at the right time.

Prepared Statement

of

The Honorable Thomas McCaffery
Assistant Secretary of Defense (Health Affairs)

And

Lieutenant General Ronald Place, M.D.
Director, Defense Health Agency

REGARDING

MILITARY HEALTH SYSTEM REFORM

BEFORE THE

HOUSE ARMED SERVICES COMMITTEE
SUBCOMMITTEE ON PERSONNEL

December 5, 2019

Not for publication until released by the Committee

Chairwoman Speier, Ranking Member Kelly, members of the Committee, thank you for the opportunity today to discuss our combined efforts to maintain and strengthen our Military Health System (MHS).

The mission of the Military Health System (MHS) is to support the National Defense Strategy by: assuring the military has a trained uniformed medical force ready to deploy at any time to provide medical care in a combat environment; ensuring service members are medically ready to carry out their duties around the globe; and providing quality health care to active duty service members, their families, and retired military personnel. The MHS pursues this mission through a combination of military and civilian medical personnel, DoD operated military treatment facilities (MTFs), and contracted private sector care. The MHS annual budget is approximately $50B and is supported by the Defense Health Program (DHP) appropriation.

The men and women of the MHS are justifiably proud of what they do. They provide the platform to train our uniformed medical force, and care for 9.6 million service members, retirees and their families. They support one of the largest and most successful medical research enterprises in the country. They operate a global health surveillance network that monitors for infectious threats to our forces and our homeland. They manage one of the country's largest networks of hospitals and clinics. They perform all of these missions with unfailing professionalism. We are grateful for the Committee's support of our work.

MHS Guiding Principles

As leaders entrusted with maintaining and strengthening this unique medical enterprise, we are guided by foundational principles. Our primary mission is readiness – the readiness of medical personnel to support our forces in battle, and the medical readiness of combat forces to

complete their missions. Readiness also entails caring for troops, retirees and their families. As our service members deploy around the world, they need to know that their families back home are cared for. Meeting this obligation to our beneficiaries is vital to recruiting and retaining a high-quality force.

In order to advance these goals, we believe the MHS, like the rest of the Department of Defense, must adapt and change in order to carry out our mission in an ever-evolving security environment. Congress, in successive National Defense Authorization Acts, has also given us direction to reform the MHS in order to optimize the system so that it can most effectively meet our mission. Today we will discuss the reform efforts now under way in the MHS and their role in sharpening our focus both on warfighting readiness and on the needs of military families, both active and retired.

The MHS is guided by the National Defense Strategy, and it has a critical role to play in each of the three elements of the strategy – building a more lethal force, strengthening relationships with allies and partners, and reforming business practices to build a more effective and cost-effective organization.

We are strengthening the MHS to better prepare for future conflicts with a highly trained, well-equipped medical force. And to be good stewards of the public's resources, we are working to derive the maximum potential benefit for every dollar we spend. We are incorporating the findings of decades of reviews and studies that suggest ways to address the MHS' siloed nature that has produced undesired variability and too little standardization among the institutions operated by the DoD. That fragmentation serves neither our readiness mission nor our ability to provide the patient experience our families deserve.

Our reforms are aimed at:

- Ensuring that the uniformed medical force is properly sized and has the skills to respond to operational requirements.
- Ensuring that our system of hospitals and clinics is properly sized and shaped to support the readiness of our medical forces, the medical readiness of combat forces, and our obligations to our beneficiaries.
- Better organizing our direct-care system to improve its effectiveness and efficiency and to provide a more standardized, dependable, high-quality experience for our service members, their families, and our retirees.
- More effectively managing private-sector care through TRICARE's managed care networks.

Reforming MTF Management and Administration

In 2018, we launched the most significant change to the MHS in over three decades, initiating the transfer of authority, direction and control of military medical and dental facilities to the Defense Health Agency (DHA). This was done to comply with the direction provided by Congress in the 2017 National Defense Authorization Act to consolidate the separate health systems of the Army, Navy and Air Force under a single agency that also oversees our civilian TRICARE networks. Congress' action accelerated a path the Department had already begun in 2013, when we established the DHA as a means to strengthen jointness and drive greater standardization in order to more effectively carry out the mission of the MHS.

This reform will allow the military medical enterprise to:

- Improve readiness by allowing the Military Departments to place additional focus on their medical man, train, and equip responsibilities (rather than management of separate healthcare facility networks)
- Improve readiness by expanding the clinical opportunities for Military Department medical teams across a unified military medical enterprise
- Further strengthen our ability to ensure high quality, accessible care for our active duty service members, retirees and their families
- Lower the cost required to operate the system, and ensure overall costs remain below National Health Expenditure inflation rates

DoD has long recognized that the readiness of our total force and our medical teams are inextricably linked with the operation of our direct care system. Ongoing, active clinical practices across all specialties continuously sharpen our teams' clinical skills. The MTFs where our medical professionals work serve as readiness platforms. In this respect, DHA serves as a supporting agency to the Military Departments who, in turn, are supporting the requirements of our combatant commands. DHA's management of the MTF platform in support of Military Department requirements supports the MHS mission to ensure ready medical forces can deploy in response to command authorities worldwide, and to ensure appropriate backfill of government, contract or network providers are available to maintain continuity of care to our beneficiaries provided by those MTFs.

The transition of MTFs to the DHA is a multi-year process that will conclude by the end of 2022. On October 25, the DoD Deputy Secretary directed DHA to undertake administration and management of U.S. MTFs. In the early stages of the transition, the Service medical organizations, working under DHA's management direction, will provide direct support to MTFs

while the DHA continues to build its capacity to oversee the direct care system,. Working with the Services, the DHA has established a rigorous, conditions-based process for transitioning to a market-based management approach.

In the long run, our patients will see significant benefits from this reform: better standardization of quality, safety, access and business practices among our MTFs; more effective spread of best practices across our facilities; better integration and coordination of our direct and purchased-care systems. In the immediate term, this change should be seamless for our patients. While it is a major change for how the Department's medical enterprise is organized and managed, the reforms will not disrupt day-to-day operations, and our patients will continue to receive the same great care.

Medical Facilities Reform

We are also completing work on a review of our medical facility infrastructure – the hospitals and clinics we operate on installations around the world. This review was mandated by Congress in the 2017 NDAA in recognition that some of our facilities may not generate significant readiness value for medical competency.

Our analysis has assessed the contribution of each facility to our readiness requirements. Our focus has been to identify those areas where we could expand capacity at MTFs that offer potential for building the skills and knowledge of our medical force, while re-sizing some facilities that do not offer a platform for maximizing ready medical capabilities. A critical part of our analysis has been an assessment of the ability of the local civilian medical community to accommodate additional MHS beneficiaries.

As required by statute, the Department will provide Congress a detailed report on our specific recommended MTF re-sizing actions. Any re-sizing decisions that emerge in our final report will be implemented being mindful of our mission and the people we serve. We expect that for many of the recommendations, if approved by Congress, will be phased-in over a 2-3 year period. We anticipate submitting the report to Congress early next year.

Medical Manpower Reform

The Department's FY2020 budget proposal includes plans by each Military Department to reshape their uniformed medical force. We know this is an issue of concern for Members of Congress and for some of our beneficiaries, and we want to share information on how the Department is implementing these changes.

Each Military Department conducted an assessment of its medical readiness requirements and determined that a smaller military medical end strength was feasible and that the potential risk to their missions was manageable. The Department is proposing the medical end strength reductions to enable each of the Military Departments to utilize those resources for required operational/modernization priorities that support the National Defense Strategy. These proposed reductions are planned to start in Fiscal Year (FY) 2020 with initial reductions expected to consist largely of vacant positions.

The Department is carefully assessing the impacts of the proposed reductions by location and specialty to ensure that we maintain access to quality care for our beneficiaries. That assessment will continue throughout the implementation process to ensure that any impacts to readiness and beneficiary care are identified and addressed in our planning. We will work with our TRICARE contractors and local health care providers, where appropriate, to mitigate

potential impacts to healthcare. We will continue to refine the necessary analyses related to location and timing of reductions. Details of the timing of the reductions of military medical personnel by specialty and location are in the process of finalization. Prior to any reductions occurring, we will fully inform our beneficiaries on any changes to the location of their care and support their transition as needed. We will continue to monitor the pace of the reductions to identify and address any issues as they arise. While the location of where our beneficiaries receive care might change, our commitment to provide that care has not.

TRICARE Reform

Our private sector system is another area where we have made significant strides in modernization, and we are determined to continue on a path of reform. Congress has provided significant support for this effort, including provisions in the FY17 NDAA that helps bring TRICARE management more in line with best practices from civilian health plans.

The DHA, in its management of TRICARE, has instituted additional reforms to improve our beneficiaries' access and experience of care around the world. We have improved our use of virtual health capabilities through programs such as the integrated 24/7 Nurse Advice Line / appointing system, secure online messaging, mobile apps and expanded telehealth. We have streamlined the referral management process in certain markets to ensure specialty care needs are met effectively. We are scaling these process improvements for implementation across the enterprise in the coming year. We have expanded access to preventive care and reduced referral requirements for urgent care.

While the current TRICARE contracts have been in place for less than two years, work has already begun on designing the next-generation contracts. One area of focus will be to

strengthen the TRICARE Network to support the readiness requirements of the direct-care system. We will also improve on testing and evaluating the ability of the Network to accept additional patients during contingency operations. We also intend to expand our use of value-based care models, paying not merely for the number of services provided, but for better outcomes, and to incentivize better information exchange between DoD and the private sector. As we go forward, our goal is to further integrate the direct and purchased care systems on behalf of our beneficiaries. We will continue to expand transparency so that beneficiaries can better evaluate access, quality, safety, and costs to them and their families.

MHS GENESIS

In parallel to our organizational changes, we are continuing our deployment of a modern, standard electronic health record (EHR). MHS GENESIS will replace a disparate collection of legacy system with a single, off-the-shelf health record ready for use wherever a military professional delivers care. This new EHR will give our patients and providers the health record system they need and deserve.

As you know, we deployed MHS GENESIS at the first of four Initial Operating Capability (IOC) sites in the Pacific Northwest two years ago. And as we have discussed with the Committee, we learned much from that initial test deployment that then informed how we initiated the next steps to roll out the EHR to the rest of the MHS. We learned important lessons about how to most effectively train front-line users; timing around the build-out of the IT infrastructure required to support the EHR; and how to best support our people in the challenging first few weeks of deployment.

In September, we deployed MHS GENESIS at four facilities in California and Idaho, incorporating lessons learned from our IOC deployments, which clearly paid off. These successful deployments have cleared the way for an accelerating schedule of site deployments and for on-time deployment of MHS GENESIS throughout the MHS over the next 2-3 years. This success not only positively impacts our beneficiaries, but on Department of Veterans Affairs (VA) patients. Once the VA completes its deployment of the same EHR, our Service members will have a single medical record that follows them from the first day they are sworn in, through their time in the DoD and VA systems. We're working hard with our VA partners to share knowledge from the first MHS GENESIS deployments to ensure the successful deployment within both Departments.

Conclusion

It is our privilege to testify today on the critical role the MHS plays in support of the National Defense Strategy and how the reforms we are pursuing will better position us to meet our mission. We thank this Committee for its support of that mission and the outstanding men and women who carry it out.

Mr. Thomas McCaffery
Assistant Secretary of Defense for Health Affairs

Mr. Tom McCaffery was sworn in as the Assistant Secretary of Defense for Health Affairs on August 12, 2019.

In this role, Mr. McCaffery is the principal medical advisor to the Secretary of Defense. He administers the Military Health System (MHS) $50 billion Defense Health Program (DHP) budget and is responsible for ensuring the global delivery of quality, cost effective health care to 9.4 million Service Members, retirees, and their families. Mr. McCaffery oversees the Defense Health Agency and the Uniformed Services University of the Health Sciences.

Mr. McCaffery has extensive experience in the health care industry. Most recently, he served as Vice President, California State Partnerships at Blue Shield of California. In this capacity, he led the day-to- day activities governing Blue Shield's post-acquisition integration of the Care1st Health Plan, a 500,000 member health plan serving Medicaid and Medicare members. Prior to that role, he served as Vice President of Blue Shield's CalPERS sector, where he led a team responsible for all strategic initiatives, product development, marketing, pricing, and operational functions for the 400,000 member California Public Employees Retirement System (CalPERS) account.

Prior to his tenure at Blue Shield, he served as Chief Deputy Director of the California Department of Health Services, California's public health and health care services agency. Mr. McCaffery also served as Senior Vice President / Chief Operating Officer at the Alliance of Catholic Health Care, the public policy and advocacy organization representing California's Catholic health systems and hospitals. Earlier in his career, he served on the staff of the Washington, DC Office of the Governor of California.

Active in many community organizations, Mr. McCaffery has served on a number of healthcare, education and children's program non-profits in the Sacramento area.

Mr. McCaffery graduated from the University of Notre Dame with a degree in Government and International Relations and holds a Master's Degree in Public Policy from the University of California at Berkeley.

Lt. General Ronald J. Place
Director, Defense Health Agency

Lieutenant General Ronald J. Place is the Director, Defense Health Agency (DHA), Defense Health Headquarters, Falls Church, Virginia. He leads a joint, integrated Combat Support Agency enabling the Army, Navy, and Air Force medical services to provide a medically ready force and ready medical force to Combatant Commands in both peacetime and wartime. In support of an integrated, affordable, and high quality military health service, the DHA directs the execution of ten joint shared services to include the TRICARE health plan, pharmacy, health information technology, research & acquisition, education & training, public health, medical logistics, facility management, budget resource management, and contracting. The DHA administers the TRICARE Health Plan providing worldwide medical, dental and pharmacy programs to more than 9.5 million uniformed service members, retirees and their families.

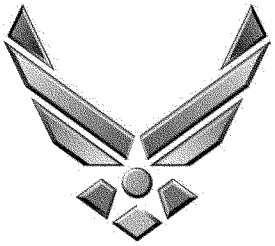
LTG Place hails from South Dakota, graduating from the University of South Dakota with a Chemistry Degree, a member of the Phi Betta Kappa Honor Society and ROTC commission. A member of Alpha Omega Alpha honor medical society, he then graduated from Creighton University School of Medicine. LTG Place completed his General Surgery internship and residency training at Madigan Army Medical Center (MAMC), Fort Lewis, Washington, and fellowship training in Colon and Rectal Surgery at the University of Texas Southwestern, Dallas.

LTG Place's staff surgical assignments include Martin Army Community Hospital, Ft. Benning, Georgia, and MAMC. His combat surgical experiences began in October 2001, when he deployed as a general surgeon with the 250th Forward Surgical Team (FST) (Airborne) to Afghanistan. He subsequently deployed with the 67th FST during Operation Iraqi Freedom I, Task Force Med Falcon IX to Kosovo, and "A Detach" 249th General Hospital (task organized to the 173rd Support BN) for Operation Enduring Freedom VI.

His medical leadership positions began with his assignment to Landstuhl Regional Medical Center (LRMC), Landstuhl, Germany, as the Chief of Surgery in 2002, and then Deputy Commander for Outlying Clinics. LTG Place returned to MAMC as the Deputy Commander-Clinical Services, then responsible for the day-to-day operations of the Medical Center as the Principal Deputy Commander. He served as Commander of USA MEDDAC Fort Knox/Ireland Army Community Hospital, Kentucky, then USA MEDDAC Fort Stewart/Winn Army Community Hospital, Georgia. His flag officer positions include Assistant Surgeon General (Force Projection) at the Office of The Surgeon General, transitioning to the MEDCOM Deputy Chief of Staff (Quality and Safety). After serving as the Commanding General of Regional Health Command-Atlantic, LTG Place led the Military Health System National Defense Authorization Act 2017 Program Management Office. LTG Place previously served in the Defense Health Agency as the Director, National Capital Region Market (J-11), Director, Transitional, Intermediate Management Office (TiMO) and the Acting Assistant Director, Healthcare Administration.

LTG Place is a graduate of the Army Medical Department (AMEDD) Officer Basic and Advance Courses, the Command and General Staff Officer Course, and National War College. He is board certified in both general surgery and colorectal surgery, the author of over 40 peer reviewed articles and book chapters, and an Assistant Professor of Surgery, Uniformed Services University of Health Sciences. His awards include the Distinguished Service Medal with oak leaf cluster, Defense Superior Service Medal, Legion of Merit with three oak leaf clusters, Bronze Star Medal with oak leaf cluster, Navy Presidential Unit Citation, Combat Action Badge, Combat Medic Badge, Flight Surgeon's Badge, The Surgeon General's "A" Designator for clinical excellence, the Order of Military Medical Merit, the Army Staff Identification Badge, and others.

United States Air Force



Presentation

Before the House Armed Services Committee, Subcommittee on Military Personnel

Military Health System Reform

Witness Statement of

Lieutenant General Dorothy Hogg
Surgeon General of the Air Force

December 5, 2019

Lieutenant General Dorothy A. Hogg

Lt. Gen. Dorothy A. Hogg is the Surgeon General, Headquarters U.S. Air Force, Arlington, Virginia. General Hogg serves as functional manager of the U.S. Air Force Medical Service. In this capacity, she advises the Secretary of the Air Force and Air Force Chief of Staff, as well as the Assistant Secretary of Defense for Health Affairs on matters pertaining to the medical aspects of the air expeditionary force and the health of Airmen. General Hogg has authority to commit resources worldwide for the Air Force Medical Service, to make decisions affecting the delivery of medical services, and to develop plans, programs and procedures to support worldwide medical service missions. She exercises direction, guidance and technical management of a $6.1 billion, 44,000-person integrated healthcare delivery and readiness system serving 2.6 million beneficiaries at 76 military treatment facilities worldwide.

Prior to her current assignment, General Hogg served as Deputy Surgeon General and Chief, Air Force Nurse Corps, Office of the Surgeon General, Falls Church, Virginia.

General Hogg entered the Air Force in 1984 and has commanded at the squadron and group level, and served as the deputy command surgeon for two major commands.

She has deployed in support of operations Enduring Freedom and Iraqi Freedom.

EDUCATION
1981 Bachelor of Science degree in Nursing, University of Southern Maine, Portland
1986 Squadron Officer School, by correspondence
1987 Women's Health Nurse Practitioner, School of Healthcare Sciences, Sheppard Air Force Base, Texas
1992 Master of Public Administration, Troy State University, Troy, Ala.
1996 Air Command and Staff College, by seminar
1997 Master of Science in Nursing, Sigma Theta Tau, Medical University of South Carolina
2002 Air War College, by seminar
2007 Executive Development Intern, SDE in-residence equivalent
2010 Interagency Institute for Federal Healthcare Executives
2012 Joint Medical Executive Skills Medical Executive Skills Capstone Course
2014 Capstone, Fort Lesley J. McNair, Washington, D.C.

ASSIGNMENTS
February 1984 – September 1986, Staff Nurse, OB/GYN Nursing Unit, U.S. Air Force Regional Hospital, Eglin AFB, Fla.
September 1986 – March 1987, Nurse Practitioner Student, School of Healthcare Sciences, Sheppard AFB, Texas
March 1987 – September 1989, Women's Health Nurse Practitioner, 410th Medical Group, K.I. Sawyer AFB, Mich.
September 1989 – December 1992, Women's Health Nurse Practitioner, 52nd Medical Group, Spangdahlem Air Base, Germany
December 1992 – August 1996, Women's Health Nurse Practitioner, 18th Medical Group, Kadena AB, Japan
August 1996 – July 1997, AFIT Master's Student, Medical University of South Carolina, Charleston, S.C.
July 1997 – December 2001, Maternal-Infant Flight Commander, 366th Medical Group, Mountain Home AFB, Idaho
December 2001 – May 2002, Family Practice Flight Commander, 314th Medical Group, Little Rock AFB, Ark.
May 2002 – July 2004, Clinical Medicine Flight Commander, 314th Medical Group, Little Rock AFB, Ark.
July 2004 – June 2006, 22nd Medical Operations Squadron Commander/Chief Nurse Executive, McConnell AFB, Kan.

June 2006 – June 2007, Executive Development Intern, Manpower and Organization/SDE equivalent, Headquarters U.S. Air Force/SG, Bolling AFB, Washington, D.C.
June 2007 – July 2008, 79th Medical Operations Squadron Commander, 79th Medical Group, Andrews AFB, Md.
July 2008 – August 2010, 9th Medical Group Commander, Beale AFB, Calif.
August 2010 – June 2012, Deputy Command Surgeon, Air Force Central Command, Shaw AFB, S.C.
June 2012 – July 2013, Deputy Command Surgeon, Air Force Materiel Command, Wright Patterson AFB, Ohio
July 2013 – September 2014, Chief, Air Force Nurse Corps/Assistant Surgeon General, Medical Force Development, Office of the Surgeon General, Falls Church, Va.
September 2014- June 2015, Chief, Air Force Nurse Corps/Director, Medical Operations and Research Office of the Surgeon General, Headquarters U.S. Air Force, Falls Church, Va.
June 2015 – June 2018, Deputy Surgeon General/Chief, Air Force Nurse Corps, Office of the Surgeon General, Falls Church, Va.
June 2018 – Present, Surgeon General, Headquarters U.S. Air Force, Arlington, Va.

MAJOR AWARDS AND DECORATIONS
Defense Service Medal
Legion of Merit
Bronze Star
Meritorious Service Medal with silver and two oak leaf clusters
Air Force Commendation Medal with two oak leaf clusters

CURRENT NATIONAL CERTIFICATION
Women's Health Nurse Practitioner National Certification Corporation

EFFECTIVE DATES OF PROMOTIONS
Second Lieutenant Dec. 29, 1983
First Lieutenant Jan. 14, 1986
Captain Jan. 14, 1988
Major Aug. 1, 1995
Lieutenant Colonel June 1, 2001
Colonel Nov. 1, 2006
Major General Aug. 9, 2013
Lieutenant General June 4, 2018

(Current as of June 2018)

Chairwoman Speier, Ranking Member Kelly, and distinguished members of the Subcommittee. Thank you for this opportunity to update you on our progress implementing the numerous reforms underway in the Air Force Medical Service.

The Air Force Medical Service provides a unique and critical set of medical capabilities to our warfighters. Our specialty is aerospace and operational medicine, most notably aeromedical evacuation. Delivering this vital support to those who defend our nation remains our primary mission, even as we engage in ongoing Military Health System reforms. Air Force Medicine must continue to promote fit, healthy, medically ready Airmen postured to fly, fight and win in air, space and cyberspace.

Air Force medics answer the call across a broad spectrum of operational, humanitarian, and disaster response missions. In August, our medics participated in a life-sustaining aeromedical evacuation mission, transporting a critically injured Soldier directly from Bagram Air Base, Afghanistan to Brooke Army Medical Center in San Antonio. This dedicated team provided en route care for the entire 8,000 mile, 20-hour non-stop flight, sparing no effort to bring this Soldier home, alive. While the distance and duration of the flight were exceptional, this is the level of care and expertise Air Force medics deliver on a daily basis. We are proud of our 98% survivability rate and we do whatever it takes to get our wounded warriors back to their loved ones.

In fall 2017, devastating hurricanes hit the Virgin Islands and once again our Air Force medics were at the forefront. A 23-person team from the 375th Medical Group at Scott Air Force Base were among the first medical personnel on the ground in St. Croix to administer aid

and evacuate injured victims. The team quickly established an En Route Patient Staging facility, supporting nine aeromedical evacuation missions over seven days and evacuating 135 patients. The deteriorating conditions in St. Croix demonstrated Air Force medics' agility and adaptability in executing our mission under the most challenging circumstances.

To best support the Air Force Medical Services' renewed focus on operational readiness, this summer I deactivated our Air Force Medical Support Agency and redesignated our Air Force Medical Operations Agency as the Air Force Medical Readiness Agency. This brings us into compliance with section 712 of the 2019 National Defense Authorization Act, which requires the military department surgeons general to restructure their headquarters organizations to undertake statutory duties supporting readiness. We reduced headquarters management redundancy while improving our ability to execute our medical readiness mission in support of Air Force operational requirements.

The Air Force Medical Readiness Agency delivers operational medical capabilities to support combatant commander requirements while providing oversight of strategic medical readiness initiatives at Air Force installations. Additionally, it will directly support readiness, aerospace and operational medicine activities at military treatment facilities, downrange, and throughout the Air Force. We designed the organizational structure to deliver the operational medical capabilities the Air Force needs now and in the future.

The Air Force Medical Service also reorganized our military treatment facilities with the goal of modifying how we deliver mission support to our operational forces. The Air Force Medical Reform Model, launched this summer, optimizes the medical readiness of our Airmen

and the delivery of healthcare to our beneficiaries. Based on a 2018 pilot conducted by the 366th Medical Group at Mountain Home Air Force Base, the model reorganized our military treatment facilities into two squadron types, an Operational Medical Readiness Squadron, serving our active duty beneficiaries (including Guard and Reserve) and a Healthcare Operations Squadron, serving our non-active duty beneficiaries. At larger military treatment facilities, a third squadron, the Medical Support Squadron will continue to provide ancillary health services such as laboratory, X-ray, and administrative functions for both active and non-active duty patients.

The new two squadron model delivers a more focused approach to ensure Airmen are fully mission-capable and rapidly returned to duty. The initial roll out of this model has been completed at 41 military treatment facilities in the United States, plus the pilot location, with remaining facilities projected to transition by summer 2020. This phased approach allows us to identify any potential challenges and refine the model accordingly. We will continue to work closely with the Defense Health Agency during initial implementation to ensure we are collectively supporting readiness and the delivery of healthcare.

Under the new construct, operational squadrons are empaneled to a single provider team. This facilitates better relationships between patient and provider, and allows the provider to develop a better understanding of Airmen's medical needs. This also enables medical teams to work hand-in-hand with wing and Squadron leadership to gain a better understanding of the physical and mental stressors for each unit. Medics assigned to the Operational Medical Readiness Squadron devote time each week to proactive case

management of Airmen with limiting medical restrictions to maximize their employability and availability.

In today's Air Force, we must prepare for peer competitors while continuing to deter and defeat rogue states and terrorist threats across multiple domains. In support of these strategic objectives, the Air Force Medical Service is aggressively enhancing our ability to operate in these highly contested environments. A major initiative underway is the MedicX program, which expands the basic clinical capabilities of all Air Force medics. MedicX develops multi-functional medics who can perform some clinical functions beyond their primary job duties. For example, when we deploy an Expeditionary Medical Support System (a modular field hospital) to a contingency area, a significant portion are non-clinical positions such as logistics, administrative, and lab personnel. We need to strengthen this cohort's clinical skills so that in the event of a mass casualty or all-hands-on-deck scenario, they are equipped to perform skills beyond their primary job.

The Ground Surgical Team platform recently replaced our Mobile Field Surgical Teams, offering enhanced capabilities. Designed to be flexible platforms that undergo robust training and have a scalable, modernized equipment augmentation package, Ground Surgical Teams provide ground force commanders with enhanced capabilities for damage control resuscitation, combat damage control surgery, life, limb and eye-sight saving care, and post-op critical care. As forward deployable medical assets, their mission is to improve survivability for injured service members in denied environments without access to higher levels of care.

Increasing our Critical Care Air Transport Team capability, which turns an aircraft into a flying Intensive Care Unit, was identified as a requirement in the 2017 Air Force Aeromedical Requirements Analysis Study. We are taking short-term and long-term steps to expand this capability by training additional active duty, Guard and Reserve Critical Care Air Transport Team crews. We grew from 130 authorized teams in fiscal year 2018 to 196 in fiscal year 2019 and expect to have 221 teams by the end of fiscal year 2021. Supporting these emerging requirements presents resourcing, posturing and training hurdles, but we have made significant strides in overcoming these obstacles. It takes considerable time to recruit, train and equip new Critical Care Air Transport Team crews, but I view this as an essential long-term investment in our aeromedical evacuation capabilities.

The Air Force participated in the tri-service working group that led efforts to implement section 703 of the 2017 National Defense Authorization Act which required a systemic review of military treatment facility readiness support requirements at military treatment facilities. A final report to Congress, with the recommendations of that working group should be released soon. Analysis of Air Force military treatment facilities was grounded in guidance from Congress found in section 703, and a standardized processes to gather and validate data developed by the working group. A critical component in assessing the appropriate scope for these facilities is the capacity of the local TRICARE network to take on additional patients. Many Air Force installations are located in communities with limited health care resources where expanding the local network capacity would be challenging.

It is crucial to sustain and strengthen our partnerships with civilian, educational and other government health systems to ensure our maintain medics maintain their currency and competency in their primary specialty. Military treatment facilities are our primary readiness platforms, but their typical case mix is not always adequate to sustain the skills our teams require in a deployed environment. Partnerships with hospitals, like the Level I Trauma Center at the University Medical Center of Southern Nevada, the R Adams Cowley Shock Trauma Center in Baltimore, and the St. Louis University Hospital, are increasingly important for preparing our surgical teams to treat complex combat injuries. In addition to these national level partnerships, medical group commanders are empowered to pursue partnerships with local health facilities. This allows commanders to adaptively build the necessary partnerships needed to maintain the clinical currencies and skills appropriate for their facility in conjunction with their mission. This is critical as we evolve our medical force and possibly decrease the scope of care we deliver in military treatment facilities.

Recent months have seen the Military Health System achieve significant milestones in implementing section 702 of the fiscal year 2017 National Defense Authorization Act. In October, military treatment facilities in the U.S. moved under Defense Health Agency management. The Air Force Medical Service is working closely with the Defense Health Agency and sister services to ensure the success of these efforts. The Defense Health Agency is still building its headquarters structure and capabilities. Until this process is complete, and the Defense Health Agency can begin to assume day-to-day management responsibilities, it is premature to judge the long-term success of the transition.

Earlier this year, the services and Defense Health Agency took a clear-eyed look at our progress and identified significant risks in the geographically phased approach of previous implementation plans. We needed clearer communication and adjudication channels, and plans to build out the Defense Health Agency functional capabilities and markets, which were underdeveloped and did not have a mechanism to validate their maturity. Jointly, we assessed these risks necessitated a new implementation plan to meet the intent of the law without harming our readiness and patient care missions.

In response, the Defense Health Agency, with significant input from the services, developed what we call "Plan 3", which included highly developed implementation plans and annexes for building Defense Health Agency functional capabilities and the market construct, including an outline for the human capital strategy required to bring them online. Critically, it laid the blueprint for developing quantifiable, specific metrics to evaluate and validate when the Defense Health Agency is ready to take on aspects of military treatment facility management from the services.

Plan 3 called for the Defense Health Agency to assume administration of all U.S. military treatment facilities in October 2019. We are supporting the Defense Health Agency in executing administration through a direct support memorandum of agreement. Once Defense Health Agency functional capabilities meet conditioned-based metrics, we will discontinue the memorandum. Today, we retain many of our existing military treatment facility support functions. The phone numbers have not changed, nor in most cases, have the people answering the phone. We will provide this continuity while the Defense Health Agency develops its own

management capabilities. This will ensure a smooth transition and reduce risk of mission failure in both our readiness requirements and delivery of the benefit.

This relationship is very much like the relationship between an instructor and student pilot. The more experienced pilot keeps their hand on the stick, as the less experienced pilot demonstrates that they are ready to take the controls. We are helping to guide the Defense Health Agency as it takes on a new mission set. Once they develop the organizational capability to manage a large, complex and geographically diverse direct care system, we will step back and they will take on full day-to-day management activities. The culminating point of this transition will be a system where the services and the Defense Health Agency mutually support one another in our complimentary readiness and health benefit missions.

We are working closely with the Defense Health Agency, Army and Navy to develop a highly reliable Military Health System. In 2015, Air Force Medicine began our Trusted Care journey to being a Highly Reliable Organization, evolving into a continuous learning and improving organization that partners with patients and families in a single-minded focus on safety and Zero Harm. Since then, we have achieved a 50% reduction in serious patient safety events in the 30 months prior to October 2019. We will blend our Trusted Care culture with our sister services and the Defense Health Agency patient safety cultures to take what works best from each service, and apply it enterprise-wide. Trusted Care will remain our culture as we shift our focus to readiness and operational medicine.

In September, MHS GENESIS, the new Military Health System electronic health record was deployed to the 60th Medical Group at Travis Air Force Base and the 366th Medical Group

at Mountain Home Air Force Base. The Defense Health Agency and the Defense Healthcare Management Systems Program Executive Office deployment team applied the many lessons learned from our initial operating sites to deliver a much smoother launch. Travis and Mountain Home report accelerated adoption of MHS GENESIS by their staff and a significant reduction in time spent using the electronic health record per patient. We have also seen a 50% drop in remedy tickets compared to the earlier waves. In addition, Travis and Mountain Home have nearly returned to their pre-"go live" levels of productivity in just eight weeks. The next deployment wave of MHS GENESIS will impact many Air Force sites starting in June 2020, I am pleased the Defense Health Agency is already surging additional IT staff to help with implementation.

The capabilities offered by MHS GENESIS help position the Air Force Medical Service and the entire Military Health System to better accomplish our Quadruple Aim goals (Better Health, Better Care, Lower Cost, Improved Readiness) over the long term. We continue to work with the Defense Health Agency to evaluate staffing requirements for deploying MHS GENESIS and will mature the manning requirements to ensure timely and successful rollouts.

As we continue down the road of simultaneous reforms and modernizations, we will work closely with our partners in the Defense Health Agency, Army Medical Command, and Navy Bureau of Medicine and Surgery to develop the best possible medical system for our warfighters and beneficiaries. We will continue to innovate and find new ways to push the limits of what is possible in military medicine. Medical Airmen are incredibly talented and totally dedicated to their missions and their patients. I hear their remarkable stories every day,

like the flight nurse on a trans-Pacific aeromedical evacuation flight who held an oxygen mask up to a 5-year old burn victim for seven hours because wearing the mask irritated her burns; or about the New Horizons Medical Readiness Training Exercise, where Air Force medics treated 9,575 Guyanese patients while practicing vital deployment skills; or the Air Force International Health Specialist in Uganda who applied his clinical skills to save a tourist who was mugged and assaulted with machetes, then stayed in touch and coordinated follow-up visits and travel home. These stories, and many more like them, are emblematic of what makes Air Force Medicine, it's what makes military medicine a national treasure.

Chairwoman Speier, Ranking Member Kelly, thank you again for the opportunity to address the Subcommittee. I hope my testimony gives the committee a clear picture of your Air Force Medical Service and the challenges we face. It will not be easy to meet these goals but I don't know anyone who signed up to be in medicine or the military because it would be easy. Our success will be a result of the hard work and tireless resolve of medics at all levels of the Military Health System. Their talent, skill and commitment to our patients, in uniform and out, inspires me every day.

I look forward to your questions.

RECORD VERSION

STATEMENT BY

LIEUTENANT GENERAL R. SCOTT DINGLE
THE SURGEON GENERAL, UNITED STATES ARMY

BEFORE THE

HOUSE COMMITTEE ON THE ARMED SERVICES
SUBCOMMITTEE ON MILITARY PERSONNEL

FIRST SESSION, 116TH CONGRESS

ON MILITARY HEALTH SYSTEMS REFORM

DECEMBER 5, 2019

NOT FOR PUBLICATION UNTIL RELEASED BY THE
HOUSE ARMED SERVICES COMMITTEE

Chairwoman Speier, Ranking Member Kelly, distinguished members of the subcommittee, it is an honor to speak before you today, representing the collective voices of the more than one hundred and thirty thousand Soldiers and civilians serving in the United States Army Medical Department, as the 45th Army Surgeon General. It has been my privilege to serve over thirty years with this incredible group of Americans dedicated to the health and readiness of our Soldiers and beneficiaries, from the battlefield to our medical treatment facilities around the world. I also would like to thank my colleagues on the panel with me today. We share a common commitment to ensuring our military health system is manned, organized, trained and equipped to meet the needs of our Services and the Joint Force.

Our Nation trusts us with the sacred duty to care for their sons and daughters. They do so with the belief that the care we provide in the military health system is second to none. I do not take this responsibility lightly. As the Army Surgeon General, I am responsible to ensure our Soldiers are healthy and medically ready to deploy anywhere in the world at any time. Working with the Army's Training and Doctrine Command, Army Futures Command, Army Materiel Command and Forces Command, I am responsible for ensuring we field a trained and ready operational medical force to ensure health service support in any operational environment. Our ability to transform the military health care system is vital to the life and wellbeing of someone's child, spouse, mother or father. We owe it to our military today and to future generations to ensure we meet this sacred duty.

The Chief of Staff of the Army says, "Winning Matters" and "People are our number one priority." General McConville's vision drives every action within the Army Medical Department. Even as Army Medicine continues to support ongoing operations around the world, including relatively small-scale combat operations, we must refocus our efforts to prepare to support large-scale combat operations and meet the challenges we would face in a near-peer or peer-to-peer fight as described in the National Defense Strategy. Our Chief of Staff of the Army intends for our Army never to be out-gunned, out-ranged, or over-matched. Our medical force must be agile and adaptive – ready to fight and win in the multi-domain battlespace because "Winning Matters."

Over the past eighteen years of sustained combat operations, Army Medicine has evolved and adapted to the nature of warfare seen in Iraq and Afghanistan. We have observed the threat, implemented lessons learned, and implemented advanced training while rapidly fielding enhanced equipment to empower our medical forces to take every action necessary to return our Soldiers, Sailors, Airmen and Marines home to their Families – and once home, we provide care that enables them to remain healthy and ready as they serve our Nation. Over the past two decades, our military achieved a survivability rate greater than 90% for Soldiers wounded in combat – an unprecedented achievement in the history of warfare. This did not happen by accident, but instead by remaining an agile, adaptive medical force that continuously learned and evolved to save lives on the battlefield. It was the result of a holistic system of health services capable of deploying to remote, austere locations and establishing a system to care for our wounded from point of injury to rehabilitative care in our stateside medical treatment

facilities. These successes can be attributed to many factors – the advanced training of our medical personnel, the rapid fielding of equipment such as Combat Application Tourniquets, the implementation of policies to ensure our Soldiers received surgical care within the "Golden Hour." In the current fight, our medical evacuation helicopters were often able to fly directly to the point of injury, evacuate our wounded and fly directly to our Combat Support Hospitals – providing life-sustaining en route care. Our medics carried blood and blood products far forward to sustain life as the wounded were evacuated. We trained non-medical personnel to provide immediate, first-responder medical care at the point of injury. These actions, which coupled with the unfailing commitment and bravery of our Army medical personnel to Conserve the Fighting Strength, ensured our Soldiers entering into combat knew that if wounded, they would receive life-saving care in a timely manner.

We cannot and will not rest on the successes we achieved during the recent fights. Instead, we must take those lessons learned, study evolving threats and train and equip our Army medical forces to sustain the quality of care that our Nation expects for its Soldiers sent into harm's way. Our expertise today does not guarantee success tomorrow, but can shape our efforts to prepare for the future.

Next month is the seventy-fifth anniversary of the Battle of the Bulge. Army historians recount that during eighteen days of fighting, severe weather conditions impacted our ability to provide air support, conduct ground movements and protect Soldiers from the harsh environments of that cold winter. Exhausted Soldiers waded through the snowdrifts and many of our wounded, already in a state of shock from the

intense stress of combat, died from exposure to the harsh elements. Our Army suffered over four thousand combat fatalities in those eighteen days from December 1944 to January 1945 – a number roughly equivalent to the number killed in action during a decade in Iraq. Another forty thousand soldiers suffered various wounds, most from high explosive munitions. It is estimated that up to sixty percent of the total wounded during the Battle of the Bulge resulted from artillery, mortar shell, bombs, and landmines. Our medical force has not experienced causalities of this magnitude in decades.

The Battle of the Bulge is but one example of the type of large-scale combat operations our Army may again face in the future. In the multi-domain battlespace, we must be ready for the reality of treating massive numbers of casualties in the most austere environments. Airspace will almost certainly be contested, limiting our ability to rapidly evacuate casualties to higher echelons of care by air. Our field hospitals may be further from the front lines due to the threat of precision, long-range fires. We must be prepared for the reality of treating casualties in forward, austere environments not just for hours but for days.

The recent National Defense Authorization Acts along with the National Defense Strategy provide guidance to prepare for the potential nature of future combat. Just as our Army and sister Services are doing, Army Medicine will reform and reorganize to achieve readiness and efficiencies necessary to fight and win in large-scale combat operations.

As required by the National Defense Authorization Act, the Army has transitioned authority, direction and control of our Medical Treatment Facilities to the Defense Health Agency. This transfer has been transparent to our Soldiers, civilians and beneficiaries. Partnering with the Defense Health Agency, Army Medicine will continue to deliver high-quality, safe care in our medical treatment facilities and is prepared to provide direct support to ensure we do not fail in this mission. This partnership allows the services to focus efforts on ensuring the readiness of our force – from the medical readiness of the individual Soldier to the ability to project trained and ready medical forces to support the Combatant Commanders.

Army Medical Department personnel continue to serve within medical treatment facilities, providing the same quality healthcare our beneficiaries deserve. Throughout this transition period, our Army Senior Leaders are united in ensuring the quality and continuity of care to those entrusted to our care as we align administrative oversight to the Defense Health Agency.

As The Surgeon General, it is my duty and responsibility to provide expert medical advice to the Secretary of the Army and the Chief of Staff of the Army relating to the organizing, training and equipping of the medical force. We continuously assess risks to the force and missions associated with changes to medical end strength. The Department of the Army, in coordination with the Office Secretary of Defense, Joint Staff, Services and the Defense Health Agency, review all medical manpower transitions to minimize impact on healthcare delivery and to ensure any adjustments to

medical force structure are the result of an informed process that addresses risk and ensures support to the operational force.

Personnel changes currently under review are a necessary part of force shaping. We routinely adjust the medical force to ensure we have the appropriate combination of medical wartime specialties. Still in the planning process, we analyze the impact of personnel adjustments within Army Medicine, we must be mindful to incorporate the requirements of the Services and the Defense Health Agency prior to making future manpower decisions.

As Army Medicine reforms and reorganizes to support our current mission and prepares for future requirements, we remain committed to providing our Army and the Joint Force ready and responsive health services and force health protection. I have established my priorities to ensure we remain ready, reformed, reorganized, responsive and relevant.

Ready – Taking care of people – our Soldiers and our families is at the core of our readiness. Army Medicine will maintain individual, unit and equipment readiness. Our medical units will conduct high-intensity, mission-focused training, maintain capable and reliable equipment and develop competent leaders of character. We cannot sacrifice readiness today for readiness tomorrow. We must prioritize preparedness for war to enable a more lethal force.

Reformed – Army Medicine reforms as mandated by Congress in the National Defense Authorization Act of 2017 and as part of the larger military health system transition.

Reorganized – Army Medicine must effectively reorganize in accordance with the reform requirements and Army Senior Leader directives in order to remain nested with Army Campaign Plan and the Army transformation strategy.

Responsive – Army Medicine must become a more tailored and expeditionary force in order to support multi-domain operations, with Army Health Systems synchronized across the battlefield as part of the Joint Health Service Enterprise.

Relevant – Army Medicine must change at the speed of relevance. This includes modernization of key capabilities, innovation in our operational concepts, advancement of diagnostic, treatment, and patient information technologies and integration with the Joint and Interagency community. Expanded alliances and partnerships with deepened integration are necessary to meet the shared challenges of our time.

I am fully committed to meeting Congressional intent and sustaining the readiness of the medical force. Further, I am committed to fulfilling my statutory responsibilities in support of the Secretary of the Army and as the chief advisor to the Defense Health Agency for the Army. We will keep the committee informed as we make strides to reform the military health system and Army Medicine.

In closing, I want to thank the committee for their long-standing support to Army and Military Medicine. Let me emphasize that the service and sacrifice of our Soldiers and their families demands that we get this right. Today's transformation does not replace the traditions of the past. We are respectfully building upon the legacy of over two centuries of Army Medicine. This is our solemn obligation to our Nation; we will assure our readiness to support our Nation's Army.

Lieutenant General R. Scott Dingle
The Surgeon General of the U.S. Army

Lieutenant General R. Scott Dingle is currently The Surgeon General of the United States Army. Prior to assuming the position, he served as the Deputy Surgeon General and Deputy Commanding General (Support), U.S. Army Medical Command, from April 2018 to August 2019.

His previous military assignments include: Commanding General, Regional Health Command – Atlantic; MEDCOM Deputy Chief of Staff, G-3/5/7, Office of The Surgeon General, Falls Church, VA; Commander, 30th Medical Brigade, Germany; Director, Health Care Operations/G-3, Office of The Surgeon General, Falls Church, VA; Commander, U.S. Army Medical Recruiting Brigade, Fort Knox, KY; Commander, 261st Multifunctional Medical Battalion, Fort Bragg, NC; Chief, Current Operations, Special Plans Officer, Healthcare Operations Executive Officer, Office of The Surgeon General, Falls Church, VA; Chief, Medical Plans and Operations Multinational Corps-Iraq Surgeon's Office, OPERATION IRAQI FREEDOM, Baghdad, Iraq; Chief, Medical Plans and Operations, 18th Airborne Corps Surgeon's Office, Fort Bragg, NC; Executive Officer, 261st Area Support Medical Battalion (44th MEDCOM), Fort Bragg, NC; Ground Combat Planner for Combined Joint Task Force -180, OPERATION IRAQI FREEDOM, Baghdad, Iraq; Assistant Chief of Staff, Plans and Exercises, 44th Medical Command and 18th Airborne Corps Plans Officer, Fort Bragg, NC; Chief, Division Medical Operations Center, 1st Armored Division, Germany; Instructor, Officer Basic and Advanced Courses, Army Medical Department Center and School, Fort Sam Houston, TX; Plans Officer, 3rd Infantry Division Medical Operations Center, Germany; Commander, Charlie Company, 3rd Forward Support Battalion, Germany; Commander, Medical Company and Medical Hold Detachment, Fort Eustis, VA; Chief of Plans, Operations, Training, and Security, Fort Eustis, VA; Adjutant, Fort Eustis, VA; Ambulance Platoon leader and Motor Officer, 75th Forward Support Battalion, 194th Separate Armored Brigade; Fort Knox, KY.

Dingle is a Distinguished Military Graduate of Morgan State University. His degrees include a Master of Science in Administration from Central Michigan University, Master of Military Arts and Science from the School of Advanced Military Studies and a Master of Science in National Security Strategy from the National War College. His military education includes graduate of the Army Medical Department (AMEDD) Officer Basic Course, the Combined Logistics Officer Advanced Course, the U.S. Army Command and General Staff College, the School of Advanced Military Studies and the National War College.

His awards and decorations include the Distinguished Service Medal (Oak Leaf Cluster), Legion of Merit (two Oak Leaf Clusters), Bronze Star Medal, Meritorious Service Medal (seven Oak Leaf Clusters), Joint Service Commendation Medal, Joint Meritorious Unit Award, Army Commendation Medal (two Bronze Oak Leaf Clusters), Army Achievement Medal (one Bronze Oak Leaf Cluster), Humanitarian Service Medal, the Order of Military Medical Merit, Recruiters Medallion, the Order of Kentucky Colonels, the Army Surgeon General's prestigious 9A Proficiency Designator, Expert Field Medical Badge, Parachutist Badge, and the Air Assault Badge.

NOT FOR PUBLICATION UNTIL RELEASED BY
THE HOUSE ARMED SERVICES COMMITTEE

STATEMENT OF

**REAR ADMIRAL BRUCE L. GILLINGHAM
MEDICAL CORPS, UNITED STATES NAVY**

SURGEON GENERAL OF THE NAVY

BEFORE THE

SUBCOMMITTEE ON MILITARY PERSONNEL

OF THE

HOUSE ARMED SERVICES COMMITTEE

SUBJECT:

MILITARY HEALTH SYSTEM REFORM

DECEMBER 5, 2019

NOT FOR PUBLICATION UNTIL RELEASED BY
THE HOUSE ARMED SERVICES COMMITTEE

Chairwoman Speier, Ranking Member Kelly, distinguished Members of the Subcommittee, on behalf of our mission-ready Navy Medicine team which keeps Sailors and Marines healthy and ready around the world, I want to thank you for continued confidence and support. I am honored to be here with my colleagues to provide you an update on an important issue for all of us - Military Health System (MHS) transformation.

As we move forward with important changes in the MHS, I want to assure you that the foundation of Navy Medicine is readiness. We will not waiver from our highest priority of keeping our service members healthy and ready to deploy and ensuring they get the best care possible from trained and confident providers when they are wounded or injured.

Building an Integrated System of Health and Readiness

The imperative to implement substantive reforms within the MHS is reflected in several key provisions contained in the Fiscal Years (FY) 2017 and 2019 National Defense Authorization Acts (NDAAs). Collectively, this legislation represents an important inflection point for military medicine and catalyzed our efforts to strengthen our integrated system of health and readiness. Within the Department of the Navy, our leadership – the Secretary of the Navy, Chief of Naval Operations and Commandant of the Marine Corps – recognizes the tremendous opportunity we have to refocus our efforts on medical readiness while transitioning health care benefit administration to the Defense Health Agency (DHA). While significant organizational change in health care is inherently complex, all of us know we have shared responsibilities to ensure that both the Services and the DHA are successful, and our efforts continue to reflect this overarching tenet as we move forward. With our collective transformation goal foremost in mind, we must continue to drive change and approach these reform efforts with deliberate planning, solid analytics and sound decision-making.

Integral to system-wide organizational transformation is the transfer of the military treatment facilities (MTFs) to the DHA. In October 2018, Navy Medicine transitioned Naval Hospital Jacksonville to the DHA, at which point they assumed administration and management of this MTF. The following year, in October 2019, our MTFs in the continental United States (as well as Alaska and Hawaii) transitioned to the DHA as directed by the Deputy Secretary of Defense. In order to support this significant transition and mitigate risk, the Bureau of Medicine and Surgery (BUMED) established a memorandum of agreement with the DHA which delineates our direct support role as they move to full operating capability. This memorandum of agreement was preceded by a period during which Navy Medicine detailed both military and civilian personnel to the DHA headquarters to directly assist their organizational transition. Similarly, the direct support relationship between BUMED and the DHA provides a bridge as the DHA establishes the MHS-wide organizational structure and acquires the necessary personnel and expertise to accomplish the mission of directly administering and managing the MTFs.

In addition, Department of Navy personnel participated in the Department of Defense-led efforts regarding the assessments and recommendations of health services and infrastructure within the MHS as required by FY2017 NDAA, section 703 (Military Medical Treatment Facilities). We understand that the Report to Congress will be provided in the near future.

Associated with the transition of MTFs to the DHA and Navy Medicine's refocus on readiness, Navy is establishing Navy Medicine Readiness and Training Commands (NMRTCs) which will provide critical command and control structures to meet Navy and Marine Corps missions. This organizational construct will – at the local MTF level – facilitate and reinforce the mutually supportive relationship between Navy Medicine and the DHA.

There will be no organizational growth associated with these commands as existing functions and personnel will be aligned within the NMRTC to support our readiness mission. NMRTCs have mission responsibilities to maintain the readiness of our assigned medical forces, support installation and operational commanders' requirements and provide a structure to execute Service requirements and programs. Since we must have the agility to rapidly deploy our Navy Medicine expeditionary medical force, NMRTCs will ensure the medical force has the clinical and operational currency and competency to support Fleet and Fleet Marine Forces missions and platforms, including expeditionary medical facilities and units, hospital ships, and casualty receiving and treatment ships. To this end, MTFs remain important training platforms for our medical personnel to gain and maintain clinical experience.

An important tool for our NMRTCs will be the Readiness Performance Plans (RPPs) which capture key operational requirements including, medical training and readiness training support. These plans are essential to meeting individual, unit and platform readiness metrics across Navy Medicine. RPPs will also support the Quadruple-Aim Performance Process (QPP) between NMRTCs and MTFs to clearly identify readiness requirements, as well as provide a mechanism for analysis and performance improvement initiatives. We anticipate that NMRTCs will reach full operating capability by October 2020.

Consistent with our refocus on readiness, we are restructuring our BUMED headquarters to better align roles and responsibilities in providing health services support across the full spectrum of Navy, Marine Corps, and Joint operations. These efforts also extend to our three Echelon III commands; Naval Medical Forces Atlantic and Naval Medical Forces Pacific, which will have command and control of the NRMTCs, as well as our Naval Medical Forces Support Command which will have oversight of our education and training commands. We will be

streamlining activities that directly impact our capabilities to support our operational requirements and ensure we have a trained and ready medical force.

Optimizing Navy Medicine for the Warfighter

MHS transformation has provided Navy Medicine an unmatched opportunity to refocus on our true mission – the reason why we have uniformed medical personnel – which is achieving maximum future life-saving capabilities and survivability along the continuum of care. When a Sailor or Marine goes into harm's way, Navy Medicine is with them. The Chief of Naval Operations and Commandant of the Marine Corps have expressed a sense of urgency for Navy Medicine to meet the demands of the rapidly changing security environment.

Navy Medicine recognizes this mandate and our focus remains to provide a ready medical force and operational medical capabilities to save lives at sea and on the battlefield. Our manning, training and equipping for current and future missions must prepare our medical personnel to operate in varied operational environments including distributed maritime operations, which present unique challenges for damage control resuscitation / surgery and patient movement. Correspondingly, we need to continue to re-shape and modernize medical capabilities that are modular, scalable and distributable. Efforts are actively underway to address the validated requirements for Naval Expeditionary Health Service Support afloat and ashore. Given the importance of these efforts, we now have a Navy Medicine flag officer on the staff of the Deputy Chief of Naval Operations for Fleet Readiness and Logistics as the Director of Medical Systems Integration and Combat Survivability.

On any given day, Navy Medicine personnel are deployed and operating forward in the full range of diverse missions including: austere damage control resuscitation and surgery teams in U.S. Central Command and U.S. Africa Command; trauma care at the NATO Role 3

Multinational Medical Unit in Kandahar Airfield, Afghanistan; humanitarian assistance onboard hospital ship USNS COMFORT (T-AH 20) in the Caribbean, Central America and South America; and, expeditionary health services support and force health protection with Joint, Fleet and Fleet Marine Forces around the world. Well-trained providers and optimally prepared platforms are the foundation of our ability to project medical power.

Future conflicts require investments to improve our health services capability to provide optimal combat casualty care, including specialized trauma care, to enhance survivability in dynamic warfighting environments. Our provider teams must be prepared to deliver trauma care across the full range of military operations and it is incumbent on us to ensure they have access to this clinical experience either in our facilities or with civilian partners. The establishment of the trauma center at Naval Medical Center Camp Lejeune, along with our long-standing partnership with Los Angeles County/ University of Southern California Medical Center, allows our provider teams to get direct trauma care experience. Our Hospital Corpsmen, who are so vital to our medical mission, are getting valuable experience through our trauma training course operating at two high-volume trauma centers, John H. Stronger Jr. Hospital in Chicago, Illinois and University of Florida Health Jacksonville, Florida. We are currently assessing the expansion of these important initiatives to other locations.

These partnerships, along with readiness-centric work at MTFs, are imperative to ensuring our personnel have the knowledge, skills and abilities (KSAs) to develop and sustain operationally relevant skills for expeditionary combat casualty care. Many of these skill sets are perishable, requiring innovative approaches to sustain currency. This is a priority for us moving forward as we leverage our capabilities within military medicine, Department of Veterans

Affairs, partnerships and cooperative agreements with civilian health systems, to ensure our personnel have the skills and training to perform their demanding mission.

Our refocus on readiness also affords us the opportunity to apply the principles of a high reliability organization (HRO) – leadership, culture of safety and robust performance improvement – in the operational medical force. We have made solid progress in our MTFs in improving clinical outcomes and coordination of care, enhancing access, leveraging technology and improving patient safety. We will bring that same commitment to our warfighters in the operational environments. Our priority moving forward is to ensure we have an integrated system of capabilities that optimizes our ability to proactively communicate, anticipate, identify, resolve and share to solve problems that threaten warfighter readiness and battlefield survivability. HRO, along with high velocity learning, are important components in driving these changes.

Another priority is ensuring that our Sailors and Marines have ready access to behavioral health support, where and when they need it. As part of our embedded mental health program, Navy Medicine providers – psychiatrists, clinical psychologists, behavioral health nurse practitioners, clinical social workers and behavioral health technicians – are assigned directly in Fleet and Marine Forces units. Embedding our personnel with the operational forces improves access to care, reduces stigma in reaching out for help, and supports commanding officers in strengthening resiliency and mental health fitness. This focus also extends to training commands including Naval Service Training Command, Marine Corps Recruit Depot and Nuclear Power Training commands. In addition, we are keenly focused on suicide prevention efforts in partnership with our Navy and Marine Corps line leadership. All of us have a responsibility to

do everything possible to reduce the incidence of suicide. Its impact is devastating and affects families, shipmates and commands.

The success of Navy Medicine is inextricably linked to a dedicated, well-trained and mission-ready workforce. We continue to emphasize recruiting and retaining personnel with the proper skill sets, particularly those with critical wartime specialties, to care for Sailors and Marines. We are grateful for your support, both in resources and authorities, to help us maintain our most important asset – the Navy Medicine team. We are continuing to work with the DHA regarding currently programmed medical manpower divestures to mitigate impact to health benefit delivery.

Moving Forward

MHS reform presents us with both challenges and opportunities. We can point to progress made to date; however, all of us recognize there is much work ahead. Change of this scale requires careful and deliberate planning, along with ongoing assessment from our stakeholders, to ensure we are meeting the objectives to build an integrated system of health and readiness. A key component will be to ensure that Navy Medicine is resourced to meet our Services' (Navy and Marine Corps) readiness mission. We remain concerned about the challenges and uncertainties presented by the current Continuing Resolution and appreciate your support in timely enactment of the FY2020 Defense Appropriations Act.

For Navy Medicine, we are strategically aligned with the Navy and Marine Corps to provide the force medical readiness for our Sailors and Marines and medical force readiness for our medical personnel. To meet our responsibilities to optimize Navy Medicine for the warfighter, our way ahead remains: To provide world-class care, anytime, anywhere and relentlessly pursue

high reliability and a high velocity learning culture in all environments to accelerate Fleet and Marine Corps performance.

Once again, thank you for your support and I look forward to your questions.

Rear Admiral Bruce L. Gillingham
Surgeon General of the Navy, N093/Chief, Bureau of Medicine and Surgery

Rear Adm. Bruce L. Gillingham is a native of San Diego. He holds a Bachelor of Arts in Cultural Anthropology (with high honors) from the University of California, San Diego and a Doctor of Medicine from the Uniformed Services University of the Health Sciences. He is an inductee in the medical honor society of Alpha Omega Alpha.

Gillingham completed a surgical internship and an orthopedic residency at Naval Medical Center San Diego. He also completed subspecialty training as a pediatric orthopedic surgeon at the Hospital for Sick Children in Toronto, Canada in 1995. He qualified as an undersea and diving medical officer.

He has served in various positions throughout Navy Medicine to include director of Pediatric Orthopedic and Scoliosis Surgery; Associate Orthopedic Residency Program director; and director of Surgical Services. While assigned to Naval Medical Center San Diego, he was instrumental in establishing the Comprehensive Combat and Complex Casualty Care Center (C5).

Operationally, he served aboard the hospital ship USNS Mercy (T-AH-19) as staff orthopedic surgeon and as director of surgical services. He deployed in support of Operation Iraqi Freedom II as battalion chief of Professional Services (Forward) for the 1st Force Service Support Group and officer in charge of the Surgical Shock Trauma Platoon, achieving a 98 percent combat casualty survival rate while providing echelon II surgical care during Operation Phantom Fury.

Gillingham also served as deputy chief, Bureau of Medicine and Surgery, Readiness & Health; commander, Navy Medicine West; commander, Naval Medical Center San Diego; deputy commander, Naval Medical Center Portsmouth; commanding officer, Naval Hospital Jacksonville, Florida; Pacific Fleet surgeon, and Fleet surgeon and director, Health Services, U.S. Fleet Forces. While in the Pacific, he led efforts to assist the Vietnam People's Navy in creating an Undersea and Hyperbaric Medical program, and in the re-location of Navy Medical Research Unit-2 to Singapore. In 2011, he served as the Joint Support Force-Japan Surgeon in the aftermath of the Fukushima Nuclear Disaster, ensuring the safety of over 200,000 U.S. citizens, service members and families.

He is a diplomat of the American Board of Orthopedic Surgery, a fellow of the American Academy of Orthopedic Surgeons, and the American Orthopedic Association and a member of the Pediatric Orthopedic Society of North America, American College of Physician Executives, Society of Military Orthopedic Surgeons and Association of Military Surgeons of the United States. He has published over 30 scientific articles and book chapters. In his previous assignment, he served as the director, Medical Resources, Plans and Policy (N0931), Office of the Chief of Naval Operations.

He currently serves as surgeon general of the Navy, N093/chief, Bureau of Medicine and Surgery.

Gillingham's personal awards include the Legion of Merit (seven awards), Meritorious Service Medal, Navy and Marine Corps Commendation Medal (two awards), Navy and Marine Corps Achievement Medal, Iraq Campaign Medal with the Eagle Globe, and Anchor device with bronze star and the Fleet Marine Force ribbon.

Updated: 1 November 2019

HOUSE ARMED SERVICES COMMITTEE, MILITARY PERSONNEL SUBCOMMITTEE

STATEMENT OF

BRIGADIER GENERAL PAUL FRIEDRICHS, US AIR FORCE

JOINT STAFF SURGEON

OFFICE OF THE JOINT STAFF SURGEON / THE JOINT STAFF

BEFORE THE MILITARY PERSONNEL SUBCOMMITTEE

ON ENSURING MEDICAL READINESS FOR THE FUTURE

05 Dec 2019

HOUSE ARMED SERVICES COMMITTEE, MILITARY PERSONNEL SUBCOMMITTEE

Chairwoman Speier, Congressman Kelly, and members of the Military Personnel Subcommittee, thank you for this opportunity to provide the Joint Staff perspective on the Military Health System Transformation and its impact on operational medical readiness of the Joint Force. It is a privilege to serve as the 15th Joint Staff Surgeon and to have this opportunity to meet with you. On behalf of Chairman Milley and all uniformed service members, thank you for the strong support you provide to our women and men in uniform who volunteer to protect and defend our great nation. I would also like to thank you and your predecessors for making it possible for me to be here today. As a result of the GI Bill, my father, who grew up during the depression on a farm in southern Louisiana and who was enlisted in the US Navy at the end of World War II was able to attend college. Years later, he met my mother, who was a Freedom Fighter in the 1956 Revolution in Hungary, then was imprisoned by the KGB before escaping and eventually coming to the US as a teacher and becoming a US citizen. Both taught me the value of the freedoms we enjoy and the high price that some have paid to preserve those freedoms. Thank you also for the continued support of the Reserve Officer Training Program, which enabled me to attend Louisiana State University and then Tulane University, as well as for the continued support of the Uniformed Service University, which provided an exceptional medical education. I am grateful that whether I was operating on a patient in Iraq, coordinating humanitarian assistance to the survivors of a natural disaster, or arranging the aeromedical evacuation of an ill or injured Service member, I have always been able to provide high quality, state-of-the-art medical care. I am also grateful to your long-standing and evolving commitment to joint medical support, as I met my wife, who was an Army physician at the time, when we were residents in San Antonio. Although no longer in uniform, she has continued to serve Veterans as a physician and clinical leader in the Veterans Health Administration and regularly

reminds me of the need for joint, interagency collaboration. Through these experiences and many others, I have developed a firm commitment to sustain and enhance this remarkable military medical system, which serves America's uniformed service members, as well as their families and those who have served in the past.

As Chairman Milley recently noted before this Committee, we are living in a period of great power competition within a very complex and dynamic security environment, and the fundamental character of war is changing rapidly. The employment of precision weapons and military operations in highly dense urban areas requires increasingly dispersed and decentralized operations. American's 21st-century military medics must build on our proud legacy of outstanding care for our nation's Soldiers, Sailors, Airmen and Marines and innovatively adapt and evolve our current capabilities to ensure that Service members are medically ready before the next contingency and, when the next contingency occurs, that we military medics are again ready to provide outstanding care, anytime and anywhere, to those who depend on us.

The National Defense Strategy (NDS) and National Military Strategy continue to inform our efforts to design and develop the military medical force our nation needs today and in the years to come. As directed in the National Defense Authorization Acts (NDAA) of 2017 and 2019, the Office of the Joint Staff Surgeon is working closely with the Combatant Commands, the Services, the Defense Health Agency and other stakeholders to leverage the Capstone Concept for Joint Operations, which is the Joint Chiefs of Staff's vision for a globally integrated and partnered Joint Force, in order to clearly define operational medical requirements, identify gaps and provide threat-informed risk assessments to shape resourcing decisions.

Joint Medical Estimate

Section 732 of NDAA 2019 states, "the Secretary of Defense shall, in coordination with the Secretaries of the military departments and the Chairman of the Joint Chiefs of Staff, develop a process to establish required joint force medical capabilities for members of the Armed Forces that meet the operational planning requirements of the combatant commands." One of the associated requirements was the development of a Joint Medical Estimate (JME) "to determine the medical requirements for treating members of the Armed Forces who are wounded, ill, or injured during military operations, including with respect to environmental health and force health protection." I am grateful to the Committee for the clear direction to begin providing an annual report similar to that provided by other functional communities. Additionally, I am also grateful for my staff, who will complete the JME in time to inform the Fiscal Year 2022-2026 Integrated Program/Budget Review. The JME will leverage recent readiness reviews and evolving Globally Integrated Base Plans, which integrate operational requirements across the Combatant Commands, to further define and integrate medical requirements from a global perspective. The Services, Combatant Commands, OASD Chem, Bio Defense, the Defense Threat Reduction Agency, Defense Logistics Agency and the Defense Health Agency are all contributing to this effort to ensure it provides an objective, threat-informed assessment of risks to mission and risks to force.

The JME will use the critical capabilities identified in the 2015 Joint Concept for Health Services, (JCHS), which I will describe later in the testimony, as well as requirements subsequently validated by the Joint Staff's Joint Requirements Oversight Council, in order to identify health services vulnerabilities and shortfalls that carry the greatest risk to globally integrated operations. It will focus on the challenges described in the National Defense Strategy,

and will highlight gaps and risks for intra-theater health services supporting geographic combatant commands, inter-theater patient movement for those ill and injured who cannot return to duty, and CONUS military medical operations. The NDS and the National Health Security Strategy (NHSS) describe multiple current and evolving threats to our nation's ability to sustain or surge healthcare capabilities in support of large numbers of casualties from overseas events or from natural disasters or other casualty-generating events at home.

With respect to CONUS military medical operations, we are very grateful to this committee, the Department of Health and Human Services (HHS), who is responsible for the National Disaster Medical System (NDMS), and to our interagency partners for their continued support of the NDMS. We are especially appreciative of HHS' Assistant Secretary for Preparedness and Readiness, who is developing much-needed proposals to enhance the NDMS for the 21st century. With the remarkable changes which have occurred over the past thirty years in the US healthcare system, as well as in the Department of Veterans Affairs and the Department of Defense healthcare systems, it is imperative that we objectively assess our nation's healthcare capabilities holistically, recognizing the interdependencies across the components of the US healthcare system.

The JME will also assess risk to our supply chain, including our growing reliance on equipment and pharmaceuticals critical to our operational medical capabilities, which either are no longer produced in the US, or rely on key components produced in other countries. In addition, we will address risks related to evolving naturally occurring infectious threats and rapid technological advancements in capabilities supporting evolving weapons of mass destruction.

The JME will serve as a strategic input to the development of the Chairman's Risk Assessment (CRA), Joint Military Net Assessment (JMNA), future Defense Planning Guidance (DPG), and Program Objective Memorandum (POM) development. After the JME is published, if helpful, it would be a privilege to return and brief you on our key findings.

Joint Concept for Health Services

The Joint Concept for Health Services (JCHS) describes in broad terms the Chairman's vision and intent for the health services capabilities required by the current and future Joint Force in order to execute Globally Integrated Operations on behalf of the Geographic and Functional Combatant Commands. The JCHS provides a framework of key capabilities to guide the provision of health services and to identify solutions to joint capability requirements that will enhance interoperability and global agility. The need for integrated medical support that keeps pace with the operational agility and organizational flexibility requirements supporting Globally Integrated Operations is clear. It is also clear that the JCHS, which was published in April 2015, needs to be updated to reflect the 2018 National Defense Strategy, the 2019 NHSS published by the Department of Health and Human Services, and similar documents. We will undertake a holistic review and will update the JCHS in 2020 in order to provide a more holistic and Globally Integrated Concept to inform future JMEs.

Joint Publication 4-02, Health Services Support

As part of the overarching commitment to inform the design, development and employment of military medical forces, we will also begin updating *Joint Publication 4-02, Joint Health Services* next year. This publication provides doctrine to plan, prepare, and execute joint and combined health services across the range of military operations. The revised JP 4-02, which was last updated in 2018, will be shaped by the Joint Medical Estimate and new Joint Concept of Health Service, as well as the annual Joint Staff Planning System and ongoing work on Dynamic Force Employment.

The current JP-4-02 groups joint medical capabilities under the joint functions of sustainment (health service support) and protection (force health protection). These capabilities form a network of prevention, protection, and treatment that create an integrated health support capability. There are currently five primary joint medical capabilities for our joint force health services, including first responder care, forward resuscitative care, en-route care, theater hospitalization, and definitive care. The updated JP 4-02 will more clearly describe global health engagement as an enabler of the Department's strategic priority to enhance alliances and partnerships.

Conclusion

Nearly two hundred years ago, military surgeons recognized the value of collaborating with the military logistics system to optimize healthcare by leveraging available logistic transport assets. Since then, our military medical predecessors have continued to innovate and adapt to ever-changing threats, resulting in the remarkably high survival rates for casualties in the recent and ongoing conflicts. Regardless of the concepts or technology employed by our warfighters,

there is always a human being somewhere in the process and our job as military medics remains unchanged: ensure the human weapon system is medically ready and ensure that our military medics are ready to provide high quality care, anytime and anywhere. The hallmark of an agile organization is to continually re-evaluate its performance and plan for the future. The topics I have laid out will help the thousands of joint military medics better understand and execute the Chairman's vison for the current and future Joint Force.

Brig. Gen. Paul Friedrichs
Joint Staff Surgeon

Brig. Gen. Paul Friedrichs is the Joint Staff Surgeon, Joint Chiefs of Staff at the Pentagon, Washington, D.C. He is the Chairman's principal medical advisor, responsible for ensuring that the Joint Force is medically ready to deploy and medically sustained in a deployed environment. He supports Combatant Command requirements as the Global medical integrator for the Joint Force.

Prior to the Joint Staff, he served as the Command Surgeon, Headquarters Air Combat Command at Fort Eustis, Virginia.

General Friedrichs received his commission through the ROTC in 1986 and his Doctor of Medicine degree from the Uniformed Services University in 1990. He has served as a Clinical Assistant Professor of Surgery and published 10 peer-reviewed surgical articles. He has commanded at the squadron and group level, and led joint and interagency teams which earned numerous awards, including "Best Air Force Hospital." He led one of the Air Force surgical teams which responded to the Pentagon on Sept. 11. As the Command Surgeon, U.S. Transportation Command, he rebaselined Defense Department global patient movement requirements, published Base Plan 9008, CONUS Patient Distribution Plan and safely moved thousands of ill and injured worldwide, including from combat operations and during multiple disaster responses.

EDUCATION
1986 Bachelor of Science, Biology, Tulane University, New Orleans
1990 Doctor of Medicine, Uniformed Services University of the Health Sciences, Bethesda, Md.
1997 Urologic Surgery Residency, Wilford Hall and Brooke Army Medical Centers, San Antonio
1998 Air Command and Staff College, Maxwell Air Force Base, Ala.
2001 Aerospace Medicine Primary Course, USAFSAM, Brooks AFB, Texas
2003 Air War College, Maxwell AFB, Ala.
2006 Space Operations Executive Course, National Space Security Institute, Colorado Springs, Colo.
2006 Interagency Institute for Healthcare Executives, Washington, D.C.
2008 National War College, Distinguished Graduate, Fort McNair, Washington, D.C.
2010 Medical Capstone Program, Washington, D.C.
2016 USAF Executive Development Program, University of North Carolina Keenan- Flagler Business School, Chapel Hill

ASSIGNMENTS
1. June 1990–June 1991, Surgical Intern, Wilford Hall Medical Center, Lackland AFB, Texas
2. July 1991–June 1992, General Medical Officer, Wilford Hall Medical Center, Lackland AFB, Texas
3. June 1992–June 1997, Urological Surgery Resident, Wilford Hall Medical Center, Lackland AFB, Texas
4. July 1997–October 1997, Assistant Chief, Urology, 89th MDG, Andrews AFB, Md.
5. November 1997–September 1999, Chief, Urology, 89th MDG, Andrews AFB, Md.
6. October 1999–September 2000, Chief, Population Health Management, 89th MDG, Andrews AFB, Md.
7. October 2000–July 2001, Analyst, Health Benefits and Policy Division, Office of the Surgeon General, Headquarters Air Force, Bolling AFB, Washington, D.C.
8. August 2001–June 2002, Chief, Operations Branch, Office of the Surgeon General, Headquarters Air Force, Bolling AFB, Washington, D.C.
9. July 2002–May 2003, Chief, Optimization and Integration Division, Air Force Medical Operations Agency (AFMOA), Bolling AFB, Washington, D.C.
10. May 2003–May 2005, Commander, 56th Medical Operations Squadron, Luke AFB, Ariz. (September 2004–January 2005, Commander, 332nd Expeditionary Aeromedical Operations Squadron, Balad Air Base, Iraq)
11. June 2005–April 2006, Chief, Aeromedical and Clinical Services Branches, Headquarters Air Force Space Command, Peterson AFB, Colo.

12. May 2006–July 2007, Chief, Medical Operations Division, Headquarters Air Force Space Command, Peterson AFB, Colo.
13. August 2007–June 2008, Student, National War College, Fort McNair, Washington, D.C.
14. August 2008–July 2010, Commander, 3rd Medical Group, 3rd Wing, Elmendorf AFB, Alaska
15. July 2010–July 2011, Commander, 673d Medical Group, 673rd Air Base Wing, JB Elmendorf- Richardson, Alaska
16. July 2011–July 2014, Command Surgeon, HQ Pacific Air Forces, JB Pearl Harbor-Hickam, Hawaii
17. July 2014–June 2016, Vice Commander, AFMOA, JB San Antonio, Lackland, Texas
18. January 2015-June 2015, Chair, Joint Task Force on High Reliability Organizations, Office of the Assistance Secretary of Defense for Health Affairs, Washington, D.C.
19. June 2016 – July 2018, Command Surgeon, US Transportation Command, Scott AFB, Ill.
20. July 2018- July 2019, Air Combat Command (ACC), Command Surgeon, JB Langley-Eustis, Va.

FLIGHT INFORMATION

Rating: Senior Flight Surgeon
Flight hours: 294 including 30 combat flying hours
Aircraft: C-17, C-130, C-141, C-21, C-23, KC-135, C-12, UH-60A and CH-47

MAJOR AWARDS AND DECORATIONS

Defense Superior Service Medal
Legion of Merit with two oak leaf clusters Bronze Star
Air Force Meritorious Service Medal with three oak leaf clusters
Joint Service Commendation Medal with oak leaf cluster
Army Achievement Medal
Air Force Achievement Medal with oak leaf cluster
Arizona State Guard Meritorious Service Medal

OTHER ACHIEVEMENTS

National Defense University President's Writing Award
Federal Liaison to the Governor of Alaska's Health Care Commission Presidential Citation, American Urological Association

PROFESSIONAL MEMBERSHIPS AND ASSOCIATIONS

Diplomat of the American Board of Urology Fellow of the American College of Surgeons
Associate Fellow, Aerospace Medical Association Alpha Omega Alpha

EFFECTIVE DATES OF PROMOTION

Second Lieutenant May 17, 1986
Captain May 19, 1990
Major May 19, 1996
Lieutenant Colonel May 19, 2002
Colonel May 29, 2007
Brigadier General June 2, 2018

(Current as of August 2019)

DOCUMENTS SUBMITTED FOR THE RECORD

DECEMBER 5, 2019

Military Times: The military needs a unified medical command, says lawmaker

By: Patricia Kime

The military health system is six years into reform measures that gave management of U.S. military hospitals to the Defense Health Agency and reduced the services' medical command responsibilities to primarily caring for active-duty personnel.

But Ohio congressman and Army Reserve Col. Brad Wenstrup says the reforms, while sweeping, may not go far enough, and he has thrown his support behind a Defense Health Command – one with a single flag officer overseeing DHA and the service surgeons general.

Such a command would have "the authority and flexibility to maximize capabilities, reach stated goals and be able to offer as many training opportunities as possible," Wenstrup told military and federal health professionals attending the AMSUS annual conference at National Harbor, Maryland, on Tuesday.

"I envision the command would include the Defense Health Agency, the surgeons general, the commands of the National Guard and reserves" and more, Wenstrup said, adding that the goals would be to improve training and opportunities for military health providers while bettering care for beneficiaries.

Wenstrup said a single command would help improve coordination between military medicine and civilian health providers, especially in training, where the services could increase the number of programs that put military surgeons and emergency medical clinicians in civilian trauma centers to maintain their combat treatment skills.

And it could improve dialogue with other federal health agencies, state and local public health officials and emergency personnel to prepare for national emergencies and humanitarian missions.

"We have these opportunities. We have to have flexibility and we have to create relationships that will enhance all of medicine," he said.

The idea is not new. In 2015, the Military Compensation and Retirement Modernization Commission recommended the creation of a four-star billet responsible for "joint readiness" that would oversee a subordinate unified joint medical command.

And in 2016, the Senate Armed Services Committee proposed eliminating the Army, Navy and Air Force medical commands and folding them under the Defense Health Agency, currently a three-star billet.

But what emerged from the reform proposals was a reorganization that started with the Defense Health Agency assuming control of the common functions of military health facilities, such as Tricare, military pharmacy programs, health care support, information technology, logistics, acquisitions, training, education, research and development. It morphed, however, into the DHA responsible for every military health facility, with the service medical commands focused on operational medicine.

Wenstrup said the current structure was created with "good, logical intent." But he worries that readiness is being eroded as military physicians struggle to keep up their skills and the services look to trim up to 18,000 uniformed medical billets.

"Some question the need for surgeons general. I see the need. The surgeon medical capabilities must be maintained to specifically meet the needs of the combatant commanders," Wenstrup said.

The fiscal 2019 John S. McCain National Defense Authorization Act required the Pentagon to study the Defense Health Command concept and provide a table of organization for the proposed structure.

But that report, which was due to Congress in June, has yet to be released.

Wenstrup is no stranger to emergency situations. He is a combat veteran who served as chief of surgery for 14 months at Abu Ghraib Prison, Iraq, after a scandal broke over inhumane treatment of prisoners there. He was awarded

the Soldier's Medal in 2018 after helping save the life of fellow Republican congressman Rep. Steve Scalise of Louisiana, shot June 14, 2017, during an early morning baseball practice in Alexandria, Virginia.

Less than a year later, when the Amtrak train in which Wenstrup was riding collided with a truck on the tracks near Charlottesville, Virginia, he rushed out the door to help victims.

He credits proper training, equipment and experience for helping him react and believes the military health system should provide health care to ensure that U.S. forces are deployable but also must provide a "combat ready medical force" that will continue to save lives on the battlefield and in training.

With military physicians having fewer opportunities to practice their skills in combat, bringing together military and civilian medical communities can help sustain training and readiness, he argues.

"Building these bridges is the key to the future of medicine," Wenstrup said.

WITNESS RESPONSES TO QUESTIONS ASKED DURING THE HEARING

DECEMBER 5, 2019

RESPONSE TO QUESTION SUBMITTED BY MS. SPEIER

Secretary MCCAFFERY. Both private health insurance premiums and National Health Expenditures per capita rose 25% (or 3.7% annually) from Fiscal Year (FY) 2012 to FY 2018. Over this period, the Department, with concurrence from Congress, instituted a combination of benefit changes, payment savings initiatives, and contract changes to offset underlying increases in health care costs (exceptions were FY 2014 and FY 2015 due to the compound pharmacy anomaly). If not for these actions, it is likely that the Defense Health Program (DHP) would have continued to rise. While continued efforts are being made to contain healthcare cost growth, recent trends in Private Sector Care claims indicate that DHP is likely to experience growth more in line with National Health Expenditure (NHE) in Private Sector Care. Comparing current year President's Budget (PB) requests to prior year enacted budgets can be misleading. As you mentioned in your question, the DHP typically receives about $1 billion dollars above the PB request in our Research Development Test & Evaluation accounts. Comparing PB request to PB request will often provide a more accurate depiction of changes within the portfolio. Comparing prior fiscal year enacted position (which includes Congressional additions) and the current year President's Budget (without Congressional additions) it may erroneously suggest reduced resource requirement. [See page 26.]

RESPONSE TO QUESTION SUBMITTED BY MR. KELLY

Secretary MCCAFFERY. The Department has conducted analyses as to whether increases in beneficiary copayments since January 1, 2018 have triggered barriers to seeking primary or specialty care or if the increased copayments have resulted in significant changes in beneficiary utilization. There are two important factors to consider on this issue. First, TRICARE Select and TRICARE Reserve Select enrollees are required by law to have higher out-of-pocket costs as compared to TRICARE Prime enrollees. Active duty family members who choose to enroll in TRICARE Prime pay $0 enrollment fees and $0 copayments. Second, all military families are protected by the annual catastrophic cap (CATCAP). Our analysis found more active duty family members (0.09%) in TRICARE Select reached their catastrophic cap of $1,000 while fewer retirees and retiree family members in TRICARE Select reached their CATCAP of $3,000. Our analysis of the utilization for "Therapy Services," since the increase in the beneficiary out of pocket expense for such services, revealed there was an inconsistent effect on unique users, visits per user, and median number of visits per user, even for ADFMs enrolled in TRICARE Prime who continued to have $0 copays. As intended with the first increase in the TRICARE Prime retiree copayment since the beginning of TRICARE in 1995, there was a cost-shift from Government to retiree beneficiaries enrolled in TRICARE Prime. Overall, the total out of pocket costs compared from CY 2017 to CY 2018 were neutral for TRICARE Select enrollees, although there were some beneficiaries that would see an increase in costs while others would see a decrease. Any significant changes to the fixed copayment structure for outpatient network visits or the amounts themselves require statutory and/or regulatory changes. The copays for Group B (sponsor joined the military after January 1, 2018) are designated by law, and the Department has no flexibility for both TRICARE Select and Prime copayments. For TRICARE Select Group A beneficiaries (sponsor joined the military before January 1, 2018), the Department is examining options to address "affordability" concerns. These include short term policy changes under current regulatory provisions that allows the Director, Defense Health Agency to decide whether it is practicable to use a fixed amount to determine beneficiary co-pays as well as longer term options such as pursuing changes to statute and/or regulation. [See page 16.]

RESPONSE TO QUESTION SUBMITTED BY MS. TRAHAN

General HOGG. No, the Air Force Medical Service is not aware of any significant trends or evidence which suggests recruits are going off of their medications to enter

the Air Force. We encourage all recruits to be forthright about their medical history and highly encourage them to continue to take any prescribed medications. Full disclosure of all medical conditions and required medications are vital to ensuring the health of our recruits and active duty members. The Tri-Service Accessions Medical Staff Working Group (AMSWG) meets quarterly to discuss and update the accession medical standards that are listed in DOD Instruction 6130.03, Medical Standards for Appointment, Enlistment, Induction Into the Military Services. There have not been any discussions about changing the standards for Attention-deficit/hyperactivity disorder (ADHD) and sleep disorders in the recent working groups. In 2017, Air Force medical waiver policy was adjusted to allow for more opportunities for members with ADHD to enter the Air Force with a waiver. Furthermore, the Defense Health Board is currently conducting an independent review, "Examination of Mental Health Accession Screening: Predictive Value of Current Measures and Processes" that is investigating current policy and protocols on this subject. The Air Force has also embedded a Psychology Research Service at initial Basic Military Training, that conducts screening of all trainees within 72 hours of arrival at Lackland Air Force. The Psychology Research Service's Biographical Evaluation and Screening of Trainees (BEST) program has been effective in identifying recruits who have not previously disclosed recent or problematic mental health history, and then directs those Airmen to obtain an evaluation by a psychologist. [See page 22.]

QUESTIONS SUBMITTED BY MEMBERS POST HEARING

DECEMBER 5, 2019

QUESTIONS SUBMITTED BY MR. GALLEGO

Mr. GALLEGO. LTG Place, I appreciate the Department's submission of the annual and quarterly reports on the DOD Comprehensive Autism Care Demonstration (ACD). I understand that there are some questions about the metrics used in the 2018 ACD annual report to Congress and the two most recent 2019 quarterly reports and whether those metrics are being appropriately applied to determine the effectiveness of health outcomes under the ACD program. DOD seems to acknowledge the shortcomings of the Pervasive Developmental Disabilities Behavior Inventory (PDDBI) in the reports, yet it relies on that flawed data to draw conclusions about the effectiveness of the ACD in these recent reports to Congress. I also understand that some believe that the way in which the Department is applying the PDDBI is also inaccurate, particularly for purposes of determining effectiveness of the ACD.

Are there other measures of effectiveness that do not have the flaws that the Department acknowledges the PDDBI has that can be used for purposes of measuring the ACD? What are those other measures of autism treatment effectiveness? Might those measurements be used in future reports to Congress?

General PLACE. TRICARE currently uses three instruments to measures outcomes in the ACD. In addition to the PDDBI, which is administered at baseline and every six months, the Vineland Adaptive Behavior Scales (Vineland) and the Social Responsiveness Scales (SRS) are administered at baseline and every two years. These three measures were selected after 18 months of consultation with ABA providers, MTF providers, leading researchers in the field, and other stakeholders. Specifically for the PDDBI, a measure aimed at accessing response to treatment, was recommended at the October 2017 ABA Provider Round Table by Dr. Gina Green, CEO of the Association for Professional Behavior Analysts and other leaders in the field. Based on our review of the input received, and research in the field, the PDDBI is an appropriate instrument to use as one indicator of whether beneficiaries with ASD are making progress. It is important to understand what we are reporting in the quarterly and annual reports regarding the outcome measures. DHA is reporting a summary of individual change scores for each beneficiary with two or more outcome measure data points. Meaning, that we are reporting that approximately 70% of children saw no meaningful change after 12 months of ABA services. That data point alone indicates that these individual children require some change to their treatment plan. The "flaws" to the reported data include information to further define the individual child, i.e., age, intensity of services, and duration of total care. Including this information may help us better identify those beneficiaries most likely to benefit, and future reports will include more data points, but it was important to start to report the existing data which shows that for many of the children in the ACD, no meaningful change across the board was occurring. As stated in each report to Congress, the PDDBI data alone is not being used as a stand-alone determining factor of the effectiveness of the ACD. No policy decisions have been made regarding access to or discharge from the demonstration. Proposed manual changes aim to provide enhanced oversight and support for each individual child and family to ensure that after each authorization period (every six months), a clinical review is performed and treatment impact is thoroughly assessed so that ineffective treatment does not continue and services best serve the needs of the individual child.

QUESTIONS SUBMITTED BY MR. GAETZ

Mr. GAETZ. DHS recently released a RFI on utilizing community pharmacies to expand access to the pharmacy benefit for TRICARE beneficiaries. Currently, for brand name maintenance medications TRICARE beneficiaries are required to use mail order or go to a MTF to obtain their prescriptions. If access to these brand drugs at community pharmacies is restored, it would help address long wait times at MTF pharmacies and improve access to other important health care services provided by pharmacists such as immunizations and health screenings. Can you provide an update on the progress of the RFI and a timeline for standing up a pilot program to test outcomes?

Secretary MCCAFFERY. As part of the TPharm5 acquisition strategy, DHA released an RFI in Aug 2019 to garner industry inputs related to a possible preferred network. At this time, however, DHA has not established an approach or timeline for implementing changes to the current TRICARE retail pharmacy network structure nor has there been any decision to conduct a pilot to test outcomes. DHA subsequently released a draft RFP on 2 Dec 2019, which closed out on 17 Jan 2020, to solicit further industry feedback that will be considered when finalizing the TPharm5 requirements. A focus area in the draft RFP is to identify innovative approaches and commercial best practices for Retail Pharmacy Network Access.

QUESTIONS SUBMITTED BY MR. MITCHELL

Mr. MITCHELL. The Defense Health Agency recently released a request for information (RFI) on utilizing community pharmacies to expand access to the pharmacy benefit for TRICARE beneficiaries. Currently, for brand name maintenance medications TRICARE beneficiaries are required to use mail order or go to a military treatment facility to obtain their prescriptions rather than a retail pharmacy. Can you provide an update on the progress of the RFI and a timeline for standing up a pilot program to test outcomes?

Secretary MCCAFFERY and General PLACE. As part of the TPharm5 acquisition strategy, DHA released an RFI in Aug 2019 to garner industry inputs related to a possible preferred network. At this time, however, DHA has not established an approach or timeline for implementing changes to the current TRICARE retail pharmacy network structure nor has there been any decision to conduct a pilot to test outcomes. DHA subsequently released a draft RFP on 2 Dec 2019, which closed out on 17 Jan 2020, to solicit further industry feedback that will be considered when finalizing the TPharm5 requirements. A focus area in the draft RFP is to identify innovative approaches and commercial best practices for Retail Pharmacy Network Access.

QUESTIONS SUBMITTED BY MRS. LURIA

Mrs. LURIA. Last spring, the hospital at Langley Air Force Base was preparing to close their in-patient and OB/GYN services. One third of births in this hospital are by Active Duty women, including me. The inadequate outpatient OB capacity on the peninsula is a direct readiness issue for our service members, especially considering those who may execute permanent change of station orders during a pregnancy. Though transferring care between military treatment facilities is seamless, it is challenging if civilians perform their care.

How will the transition to DHA consider the capacity, efficiency, and efficacy of MTF capabilities when determining which facilities to close under the Section 702 study?

Secretary MCCAFFERY. The Quadruple Aim Performance Process is DHA's strategic planning and resourcing process. It is one mechanism which provides the opportunity to assess capacity, efficiency, and efficacy at the facility-level. The following bullets outline this strategic planning process specific to capacity, efficiency, and efficacy of an MTF.

- MTF Directors identify and communicate capacity issues through their yearly performance plans and their respective mitigation plan to address those capacity issues. These capacity issues can be solved a number of ways—either through organic capacity growth, initiating a partnership with a VA hospital, or leveraging the civilian network (where allowable capacity exists).
- DHA Markets and HQ will review performance of MTFs and Markets through periodic performance reviews to help identify which MTFs and Markets are underperforming key performance measures/metrics. The performance reviews not only review quality and production indicators, but review the financial performance through the Integrated Resourcing (IR) process. The IR process allocates funding to MTFs based on their production outcomes. This helps identify where an imbalance on return on investment could exist. The bi-directional communication and review in the QPP enhances the DHA's ability in making data-driven decisions, based both on enterprise-level dashboard performance and the local challenges from the patient-care perspective on the ground.

Mrs. LURIA. Many of my constituents are noting changes in the medicines carried in local pharmacies, often requiring family members and retirees to use other sources and incur a co-pay.

How will DHA measure and control out-of-pocket costs to these beneficiaries? What assistance or authorities need to you need to help manage these costs?

Secretary MCCAFFERY. The DHA is very much aware of the impact of copays on the beneficiary at the retail and mail order points of service. The copay structure of our benefit is intended to encourage consideration of the most clinically and cost effective agent. The DOD Pharmacy & Therapeutics (P&T) Committee recommends formulary status changes to the TRICARE Uniform Formulary on a quarterly basis. The Uniform Formulary is the list of all TRICARE covered drugs. These drugs are further categorized into three Tiers for the retail and mail order points of service; Tier 1 drugs (generic and preferred brand-name medications), Tier 2 (non-preferred generic and brand name medications), and Tier 3 (non-formulary medications that have associated step therapy and prior authorization requirements). All Military Treatment Facility pharmacies are required to stock a set of core formulary medications, but may stock additional Uniform Formulary items based on the local MTF requirements. For example, a small primary care facility will stock fewer medications than a larger facility with subspecialty clinics as a broader range of medications is required to treat that group of beneficiaries. All MTFs conduct local P&T Committee meetings to determine what medications should be stocked by that MTF. Medications are added and removed based on local requirements and some impacted patients can opt to switch to a medication that is stocked by the MTF pharmacy, or elect to take their prescription to either the retail or mail order point of service and pay the applicable copayment. Formulary status changes and contingent copay changes are constantly monitored and assessed by the DOD P&T Committee to provide the most effective drugs at the lowest copayment level possible. Across all points of service, 42% of pharmacy beneficiaries do not pay any copayments, 43% pay less than $200 per year (~$17 per month), and only 2% of all beneficiaries pay >$600 per year ($54 per month) in copayments. Pharmacy copayments are aggregated with medical benefit copayments and count against the catastrophic cap of $1,500 per individual or $3,000 per family per year. Once a beneficiary reaches the catastrophic cap, they no longer pay pharmacy copayments.

Mrs. LURIA. In my district, a personal connection between a VA medical center provider and a DOD medical provider allowed them to transfer an ailing veteran to the more-capable DOD facility to receive life-saving care. There are several dual-use or partnering facilities, like the VA host–DOD tenant construct in Pensacola, the Federal Healthcare Facility in Great Lakes, and the peer-to-peer co-habitation model in Charleston SC.

How will DHA seek to partner with the VA to improve care, gain efficiency, and broaden the care available to our service members and their families?

Secretary MCCAFFERY. The DOD and VA have constantly sought opportunities for greater sharing of medical resources to include facility space, shared services, and equipment. DHA will continue this effort to expand upon the existing 130 sharing agreements with 472 shared services across 148 facilities. Specifically, the DHA is partnering with the VA on completing Joint Market Assessments, seeking statutory change to allow joint facility planning, and expanding on efforts to support military provider readiness. The VA is currently collaborating with the DOD Market Visioning Studies (Strategic Market Assessments) to complete the VA Market Assessments as outlined by VA MISSION Act (2018) § 106(a). The market assessments provide opportunities for creating high performing healthcare networks by evaluating market demographics, estimating demand/supply, and assessing quality, satisfaction, accessibility, cost, facility condition, and mission impact. Where there is a DOD presence in the VHA Health Care Market, DOD is participating in preliminary analyses, site visits, and market assessment interviews. DOD is also providing capacity data to fulfill the requirements outlined in MISSION Act (2018) § 106(a)(1)(D), which states "Each Market Area Assessment . . . shall include the following . . . (D) an assessment obtained from other Federal direct delivery systems of their capacity to provide health care to Veterans." The outcomes from each of the market assessments will drive market optimization and capital plans that align with the regional Veterans Integrated Service Network (VISN) and National DOD–VA Strategic Plans. The 96 VHA Market Assessments are scheduled for completion in the Fall of 2020, and will then be reviewed by DOD and VA leadership. Subsequently, opportunities that meet the recommendation criteria established by the VA Secretary (MISSION Act (2018) § 203, Due: May 2021) will be delivered to the VA and Asset Infrastructure Review (AIR) Commission for consideration. The VA and DHA are currently establishing a deliberate process to increase VA purchased care patient referrals to military treatment facilities with excess capacity to support Graduate Medical Education and wartime skills maintenance. The VA and DHA are developing a timeline and basic milestones to develop and use a data-driven process to analyze, select, and test one or more sites where the goal to meet military medical provider readiness skills (skill level 1&2) for specific clinical specialties, is achieved through increased VA patient access to care inside an MTF via VA–DOD

collaboration utilizing the healthcare resource sharing program under Title 38, 8111 and Title 10, 1104. The key clinical specialties the group agreed to look at are: General Surgery, Orthopedic Surgery, Cardio-Thoracic Surgery, Neurosurgery, Vascular Surgery, Emergency Medicine, and Ophthalmology.

Mrs. LURIA. The shift to DHA is assumed to deliver an efficiency within DOD by consolidating some functions from the three services into one agency.

What is the size of that efficiency? How many billets have been reduced from the services to establish DHA, and specifically, what is the net change in Flag & General Officer and SES medical and medical service billets since FY14? What is your prediction for the future?

Secretary MCCAFFERY and General PLACE. NDAA 2017 directed the establishment of the DHA's role in oversight and management of MTFs and consolidation of HQs activities. From the FY 2017 PB which began implementation of NDAA 2017 to the FY 2021 PB (five budget cycles) there was a reduction of 833 civilian FTEs in the DHP (not transferred or reprogrammed elsewhere). These reductions covered multiple PEs across all three Services. Two of the senior positions required by the law, Assistant Director for Health Care Administration (AD HCA) and the Deputy Assistant Director for Financial Operations (DAD FO), could not be addressed within existing funded position and were funded as growth over existing senior billets. A review of future changes across the Military Health System, including senior level billets, is underway.

Mrs. LURIA. The shift to DHA is assumed to deliver an efficiency within DOD by consolidating some functions from the three services into one agency.

What is the size of that efficiency? How many billets have been reduced from the services to establish DHA, and specifically, what is the net change in Flag & General Officer and SES medical and medical service billets since FY14? What is your prediction for the future?

General HOGG. I will defer to the Department of Defense regarding specifics on the projected overall magnitude of efficiencies associated with establishment of the Defense Health Agency. To establish the Defense Health Agency Headquarters, 405 military and 79 civilian billets were transferred from the Air Force Medical Service. Since 2014 there has been no reduction in the number of Air Force Medical Service Flag/General Officers. The Air Force Medical Service has no permanent authorized Senior Executive Service (SES) civilians. In the future, we believe the Defense Health Agency will produce savings as the organization matures and duplication of functions between military services are identified, and standardized with best practices.

Mrs. LURIA. The shift to DHA is assumed to deliver an efficiency within DOD by consolidating some functions from the three services into one agency.

What is the size of that efficiency? How many billets have been reduced from the services to establish DHA, and specifically, what is the net change in Flag & General Officer and SES medical and medical service billets since FY14? What is your prediction for the future?

General DINGLE. The shift to DHA is assumed to deliver an efficiency within DOD by consolidating some functions from the three services into one agency.

What is the size of that efficiency? Defer this response to the Defense Health Agency (DHA) and Health Affairs (HA).

How many billets have been reduced from the services to establish DHA? We have divested and transferred 543 billets from medical HQs and regions to the DHA in FY19. These billets provided functions and capabilities for administering and managing MTFs.

Specifically, what is the net change in Flag & General Officer and SES medical and medical service billets since FY14? There has been a net gain of one (1) FO/GO from FY14 to FY20. In FY14 we had 15 FO/GOs and as of FY20 we have 16, the increase accounts for selection of the Director, DHA. There has been a net loss of four (4) SESs from FY14 to FY20. In FY14 we had five (5) SESs and as of FY20 have one (1) SES on hand.

What is your prediction for the future? The Army is committed to supporting the current MTF transition plan but predicts challenges will become apparent from the merger of the multiple service health care systems. The transition is one of the most complex and difficult ever undertaken in healthcare delivery, requiring a detailed transition plan to ensure this critical mission is handed off to DHA successfully without mission degradation.

Mrs. LURIA. Medical readiness is a fleet commander imperative.

How will the shift to DHA change your ability to provide medically ready individuals and service members to the fleet commanders?

What impediments do you see to improving on your current capabilities and capacities to prepare sailors for their missions?

Admiral GILLINGHAM. MHS transformation has provided Navy Medicine an unmatched opportunity to refocus on our true mission of readiness—ensuring Sailors and Marines are medically ready to meet their demanding responsibilities in the Fleet and Fleet Marine Force; and, providing a ready One Navy Medicine force that is trained to achieve maximum life-saving capabilities and survivability along the continuum of care. With the shift you refer to, the military medical treatment facilities (MTFs) are now under the authority, direction and control of the DHA. These facilities, however, remain important training platforms for Navy Medicine personnel to gain and maintain clinical experience. MTFs, along with other partnerships that enhance wartime critical skills, are necessary to maintain the readiness of our assigned medical forces and execute Service requirements and programs. Associated with the transition, I do not anticipate significant impediments associated with our work ahead in meeting operational requirements. I do, however, recognize that an organizational change of this scale is inherently complex. All of us know we have shared responsibilities to ensure that both the Services and the DHA are successful and we will continue to work together to meet our goal of an integrated system of readiness and health. I want to assure you that within Navy Medicine, we will continue to chart a course that focuses on providing well-trained medical experts, operating as high performance teams to project medical power in support of Naval superiority.

Mrs. LURIA. The shift to DHA is assumed to deliver an efficiency within DOD by consolidating some functions from the three services into one agency.

What is the size of that efficiency? How many billets have been reduced from the services to establish DHA, and specifically, what is the net change in Flag & General Officer and SES medical and medical service billets since FY14? What is your prediction for the future?

Admiral GILLINGHAM. I will defer to the Department of Defense regarding specifics on the projected overall magnitude of efficiencies associated with establishment of the Defense Health Agency and the substantive reforms directed in the FY2017 and FY2019 National Defense Authorizations. Collectively, this legislation represents an important inflection point for military medicine and catalyzed our efforts to strengthen our integrated system of health and readiness. Within the Department of the Navy, our leadership—the Secretary of the Navy, Chief of Naval Operations and Commandant of the Marine Corps—recognizes the tremendous opportunity we have to refocus our efforts on medical readiness while transitioning health care benefit administration to the Defense Health Agency (DHA). Within Navy Medicine, we have made important organizational changes including establishing of Navy Medicine Readiness and Training Commands (no personnel growth) and restructuring our Bureau of Medicine and Surgery headquarters as well as our regional commands. With the DHA assuming authority, direction and control of military treatment facilities, Navy Medicine headquarters and our echelon III commands will be smaller by approximately 43 percent and focused exclusively on readiness responsibilities. We are in the process of transitioning 56 military and 269 Navy civilians positions to the DHA, In addition, we anticipate approximately 8,000 civilian personnel at Navy MTFs will be reassigned as DOD employees. Presently, there are fewer Navy Medicine flag officers (both active and reserve components) than in FY2014. These reductions are not the result of the DHA transition.

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General FRIEDRICHS. I defer to the DHA and the services to provide the appropriate response.

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