Advance Policy Questions for Thomas McCaffery
Nominee for Assistant Secretary of Defense for Health Affairs

Department of Defense Reforms

The National Defense Authorization Acts for Fiscal Years 2017, 2018, and 2019 included the most significant reforms since the Goldwater-Nichols Department of Defense Reorganization Act of 1986.

Do you support these reforms?

Yes. The organizational and operational reforms included in recent NDAAs provide the Department with opportunities for the necessary modernization of the Military Health System (MHS) to ensure both a ready medical force and a medically ready force.

What other areas for defense reform do you believe might be appropriate for this Committee to address?

Once the current set of reforms is implemented it should be clear whether or what additional changes may be needed. I look forward to working with Congress to consider and identify additional areas for reform to strengthen the MHS.

Qualifications

What background and experience do you have that qualify you for this position?

I bring over 25 years of hospital, health plan, and healthcare policy experience both within government and the private sector. In the commercial health care sector, I most recently served as Vice President at Blue Shield of California, California's 3rd largest health plan with four million members. Among other roles I led Blue Shield's CalPERS sector where I was responsible for all strategic initiatives, product development, marketing, pricing and operational functions for the 400,000 member California Public Employees Retirement System account. In my most recent public sector role, I served as Chief Deputy Director of the California Department of Health Services, what was then California's public health and health care services agency. I joined the MHS in my current position as the Principal Deputy Assistant Secretary of Defense for Health Affairs in August 2017.

Are there are any actions you should take to enhance your current ability to perform the duties of the Assistant Secretary of Defense for Health Affairs (ASD(HA))?

Yes. The MHS is in the midst of the most significant change to the system in over three decades. As the Department implements this reform, the MHS has a superb opportunity to assess how it is carrying out its responsibilities to support the medical readiness

requirements of the Joint Staff, Combatant Commanders, and Military Departments. If confirmed, I will evaluate and adjust as necessary the system's organization and governance processes working in collaboration with the medical leadership of the joint staff and Military Departments, the Defense Health Agency (DHA), and the Uniformed Services University of the Health Sciences, to ensure that we are best positioned to carry out our collective responsibilities in the new, changed environment.

Duties

What is your understanding of the duties and functions of the ASD(HA)?

The ASD(HA) is the principal advisor to the Secretary of Defense and the Under Secretary of Defense for Personnel and Readiness for all DoD health and force health protection policies, programs, and activities. The ASD(HA) is also responsible for execution of the Department 's medical mission, including providing and maintaining readiness for medical services during military operations and for ensuring the health of the members of the Military Services, their families and other eligible beneficiaries. To do this, the ASD(HA) is responsible for developing policies, and providing oversight of the health care system. Other responsibilities include effectively governing the management of DoD health and medical programs, the sponsorship and oversight of medical research and development, and medical education and training. Good stewardship of the Defense Health Program (DHP) appropriation and effective use of taxpayer dollars is another major responsibility of the ASD(HA).

If confirmed, what duties and functions do you expect the Secretary of Defense to prescribe for you?

If confirmed, I expect that the Secretary will prescribe duties and functions in accordance with the responsibilities I describe above.

Major Challenges/Priorities

In your view, what are the major challenges confronting the next ASD(HA)?

The biggest challenge facing the next ASD(HA) is continuing to advance the consolidation and modernization of the MHS as directed by Congress and the Department. Consolidation of administration and management responsibilities over the Department's military treatment facilities (MTFs) under the DHA will require continued close coordination with the Military Departments. Moreover, this transformation requires close attention to performance management so that our support of medical readiness requirements are not compromised and our patients continue to receive a care experience that is accessible, safe and of the highest quality. A related major challenge for the next ASD(HA) is overseeing the deployment of MHS GENESIS, the Department's new electronic health record (EHR) as we refine our implementation plans for the next wave of site deployments scheduled for the Fall of 2019.

If confirmed, how would you address those challenges?

If confirmed, I will continue to pay close attention to, and lead the actions required to successfully move the system to its fully integrated end state, while ensuring that we continue to achieve efficiencies as we consolidate functions under the DHA.

If confirmed, what would be your top priorities?

If confirmed, my top priority will be ensuring the continued medical readiness of our Service members and medical teams in support of our national security objectives. I will be actively engaged in directing and overseeing the successful transition of all MTFs from the Military Departments to the DHA, as well as in implementing other transformative actions to modernize the system. Other priorities include successfully implementing our new electronic health record, MHS GENESIS, within DoD. Now that the Department of Veterans Affairs (VA) is implementing the same EHR, I will also work closely with them to ensure that both Departments are successful. Recently, Secretary Mattis and Secretary Wilkie signed a joint statement pledging that the two departments will align our plans, strategies and structures as we roll out the new system—all with a view to ensure that VA and DOD share patient data seamlessly. My third priority is strengthening strategic global partnerships by advancing global health engagement in support of Secretary Mattis's line of effort to strengthen our global alliances.

Relations with Congress

What are your views on the state of the relationship between the Office of the Assistant Secretary of Defense for Health Affairs (OASD(HA)) and the Senate Armed Services Committee in particular, and with Congress in general?

If confirmed, I plan to maintain a close working relationship with our Committees as well as with all Members of Congress. In my capacity as the PDASD(HA), I and our legislative team have had the opportunity to meet and speak regularly with our Committee staff. The open exchange of information that characterizes these meetings has been extremely helpful in understanding the important partnership between Congress and the Department in setting policy for the MHS.

If confirmed, what actions would you take to sustain a productive and mutually beneficial relationship between Congress and the OASD(HA)?

If confirmed, one of my priorities will be to maintain a strong working relationship with Congress. I will continue to provide regular updates to the Committees and will maintain open lines of communication and make myself available to meet with interested Members and Professional Staff on any and all issues involving my areas of responsibility.

National Defense Strategy

If confirmed, how would you position the Military Health System to support more fully the Department's National Defense Strategy?

MHS reforms are aligned to support the National Defense Strategy and the Secretary's three lines of effort.

One of the biggest challenges facing the MHS is the requirement to rapidly expand in the event of a major conflict. The MHS needs access to a large pool of skilled medical professionals in order to generate the medical capabilities required by operational plans. We need to reassess both our infrastructure and health care personnel requirements, and potentially re-balance our active duty and Reserve Component mix. In order to address this matter, a novel approach to accessing highly skilled medical professionals is needed. We must find a way to make military service more attractive to qualified medical professionals.

A key focus area of our reforms aims to sustain a direct care system that best supports the readiness mission – using larger MTFs to provide the clinical training and complex specialty skills sustainment platform. The business reforms we are undertaking to standardize processes and reduce unnecessary duplication of services also provides opportunity to improve performance and return efficiencies to the Department for investment in other areas of military readiness.

If confirmed, I look forward to working with the Military Departments and the Committee as we develop recommendations in support of these efforts.

If confirmed, what immediate changes would you make in the military health system to support the National Defense Strategy better?

If confirmed, I will support Secretary Mattis' National Defense Strategy (NDS) by advancing the reform of the Military Health System that is clearly laid out in the last three NDAAs. Among the specific actions to which I will be committed are: consolidation and reorientation of our investments in the direct care system to better support readiness as its primary focus; improvements in patient experience and efficiencies by leveraging the combined synergy of direct and purchased care; implementation of the necessary changes in policy and resourcing to support the Joint Staff's and Military Departments' assessments of the sizing and mix of the military medical force; and expanded military-civilian partnerships to maximize the readiness sustainment capability to support a more lethal force.

Managing the Cost of Health Care

The President's fiscal year 2019 budget submission requested $54 billion in operation and support funding for the unified medical program. CBO has calculated that those costs will reach $64 billion by 2030 if their growth reflects anticipated national trends in health care costs.

In your view, what is the greatest threat to the long-term viability of the military health system?

The greatest threat to the long term viability of the MHS is managing the growth in costs in both our Direct Care and Purchased Care systems. The National Defense Strategy calls for enhanced readiness and increased lethality. Through changes in our business practices we must ensure resources are available to build and sustain medical readiness and combat lethality. The requirements associated with the NDAAs for FY2017 and FY2019 allow us to modernize the MHS so as to lower the cost of operating the system, thereby freeing up resources to invest in readiness and sustain the health benefit our Service Members, retirees, and their families rely on and deserve.

What is your assessment of the long-term impact of the Department's health care costs on military readiness and overall national security?

Every dollar used to fund healthcare costs is a dollar that is not available to support enhanced readiness or increased force lethality. If the costs of the MHS are not managed appropriately we will not have resources to invest in the necessary reforms of the MHS as well as the Department's other priorities in support of the NDS. As we continue to transform the MHS and implement the provisions of the NDAAs for FY2017 and FY2019, we expect to realize efficiencies from the elimination of unnecessary duplication that currently exists. This is why our efforts to wisely manage health care cost growth, among other reforms, is so central to our strategy: unconstrained cost growth occurs at the expense of other investment in military modernization, both medical and other priorities.

If confirmed, what actions would you take to mitigate the effect of the Department's medical costs on the Department's budget top-line while simultaneously implementing programs to improve health outcomes and to enhance the experience of care for all beneficiaries?

If confirmed, I will continue the Department's implementation of the structural reforms directed by the recent NDAAs. These reforms will lower the cost of operating the system, thereby freeing up resources to invest in readiness and sustain the health benefit our Service Members, retirees, and their families rely on and deserve. Other reforms authorized by recent NDAAs facilitate the Department's efforts to promote the reduction in the generators of disease and injury; the encouragement of healthy behaviors; and increased health resilience. In addition, regarding the Department's move toward value-based health care, we are implementing a number of demonstration projects to move our system from simply paying for input and toward payment for quality outcomes.

If confirmed, what would you do to create a value-based military health system – a system that delivers quality health care and improves health outcomes for beneficiaries at reasonable costs both to beneficiaries and to the Department?

Increasing value by improving outcomes, while managing costs, is central to effective management of the MHS. In support of these efforts, the MHS is focused on reducing the generators of disease and injury; encouraging healthy behaviors; increasing health resilience; and decreasing the likelihood of illness through focused prevention. To lower costs, we focus on quality, elimination of waste, and reduction of unnecessary variation or duplication of effort. In the move toward value-based health care, we are considering the total cost of care over time, not just the cost of care at a single point in time.

The DHA is implementing a number of value-based care demonstration projects to move our system from simply paying for input, and toward payment for quality outcomes. I know Congress, through the NDAA, has expressed its expectation that we will move in a timely manner to both implement and evaluate the success of these initiatives. If confirmed, I will pursue both near-term and longer-term opportunities to change the trajectory of cost growth by building value while improving the health of those we serve.

If confirmed, what specific reforms in medical infrastructure, benefits, benefit management, contract acquisition, military provider productivity, military-civilian provider mix, and medical personnel strengths would you implement to improve medical readiness and to help control the per capita costs of health care provided by the Department?

The MHS is executing the most comprehensive transformation of its organization in its history. Through the DHA and its expanded authorities, the MHS is now empowered to standardize activities in a manner that improves support to both our Combatant Commanders and our patients. In the area of acquisition, if confirmed, I will continue to support the establishment of enterprise-wide contracting vehicles to promote an agile response to local needs, simplify processes for front line staff, and reduce overall costs.

If confirmed, I will also engage in a comprehensive review of our medical infrastructure, provider-mix and manpower so as to optimize use of our existing military hospitals, while better integrating military and civilian health care when circumstances require. I will leverage the Congressional direction in recent NDAAs, and the NDS, to design changes in processes and procedures to enhance performance, with input from installation line and medical leadership as well as our beneficiaries.

Has the MHS adopted methods to analyze cost effectiveness relative to clinical and readiness outcomes?

Yes. The MHS has adopted some methods to analyze cost effectiveness relative to clinical and readiness outcomes. But there is more work to do. An example is the Department’s Integrated Resourcing model, which applies a mix of capitation and value-based purchasing concepts to better control costs while simultaneously incentivizing improvements in quality. This model has been shown in studies to improve utilization of lower cost options such as virtual health and to improve targeted quality measures while controlling or even reducing costs.

If confirmed, I will ensure we enhance and refine value-based resourcing decisions. Standardization of accounting practices and managerial accounting procedures will enable better analysis of cost effectiveness between locations, peer groups, and medical disciplines, to assist in determining value as defined by the Quadruple Aim.

I will also work with the Military Departments to advance core measures of medical readiness of the overall force as well as readiness of the medical force. Matching the required "Knowledge, Skills, and Abilities (KSAs)" of our medical teams to the most cost-effective means of delivering those KSAs will offer important avenues to effectively maximize our readiness posture.

Medical Provider Productivity

The Services established a very low provider efficiency (productivity) standard for military physicians – 40% of the Medical Group Management Association median, and most of the Services' physicians fail to achieve this very low efficiency standard.

If confirmed, what would you do to improve provider productivity in the military health system?

I recognize that the MHS needs to improve its provider efficiency. In Fiscal Year (FY) 2018, the MHS increased the active duty provider productivity target to 50 percent of the Medical Group Management (MGMA) median; however, not all MHS providers are meeting this standard. If confirmed, I will ensure the DHA leads MHS efforts to improve provider productivity. The DHA has codified guidance for all MTFs to establish productivity and empanelment standards for providers, identify standard appointing and specialty referral processes to maximize the delivery of healthcare within the direct care system, and enhance patient experience by ensuring appointments are scheduled on days and at times most convenient for our beneficiaries. In addition, the DHA is developing processes to ensure that providers have adequate support staff, optimized operating room resources, and enhanced telehealth capabilities, which will expand the reach of our providers and allow them to provide care to our beneficiaries wherever they may be located. Finally, the DHA will ensure providers are assigned to locations with the greatest beneficiary demand to best support medical readiness and maximize MHS provider productivity and clinical currency.

How does low provider productivity impact beneficiaries' access to care?

The MHS productivity standards were established to meet requirements identified in the Section 709 of the NDAA for FY2017 and are codified in the DHA-Interim Procedures Memorandum (IPM) 18-001 on standardized appointing processes. Our standards are adjusted to account for the necessary and unique medical readiness training obligations our teams must complete. The provider productivity standards are based on industry norms and identify the expected number of appointments that each provider must schedule to meet beneficiary demand for care within MHS Access Standards. Each full-time primary care provider is expected to empanel a minimum of 1,100 beneficiaries and

plan at least 100 appointments available per week, on days and at times most convenient to those beneficiaries. Specialty care providers are expected to meet or exceed the MGMA median number of encounters per year, adjusted based on whether the provider is active duty, a government employee, or a contractor. Provider productivity is one of several measures that the MHS leadership team reviews regularly, and data is available to leaders, commanders and staff to monitor productivity performance on an enterprise, Military Department, and MTF levels. If confirmed, I will direct the DHA to ensure compliance with provider productivity and access to care standards, and ensure these measures remain a leadership priority across the MHS.

In your view, is low provider productivity impacted by the Services' inability or failure to provide adequate administrative or ancillary clinical resources to relieve providers of administrative burdens that may limit their time for patient encounters?

There are many reasons for low provider productivity. These include, but are not limited to, non-standard specialty care administrative support staff ratios, and non-standard adjustments for administrative, training, or leadership time. To maximize provider productivity and eliminate variance among the Military Departments, the DHA has established guidance for standard primary care support staff ratios, support team role processes to reduce the administrative burden on primary care providers, and standard primary care provider adjustments to empanelment and productivity targets, to account for administrative and leadership duties. DHA guidance also establishes adjustments for specialty care providers by type to account for administrative and leadership duties and is establishing specialty provider support staff ratios. If confirmed, I will ensure DHA guidance is adhered to, and that productivity measures are closely monitored and managed.

In your view, how does medical procedure volume and complexity relate to the readiness of military medical providers to provide casualty care in a deployed environment?

Studies have reported a correlation between providers with higher medical procedure volume and complexity with better patient outcomes. If confirmed, I will work to ensure optimal outcomes for patients and to maintain sufficient patient volume and case complexity to ensure that our providers maintain clinical readiness as required in the deployed environment. Currently, there are multiple efforts to increase the volume and the complexity of cases to our MTFs by increasing access. Additionally, many of our MTFs have entered partnerships with VA and civilian hospitals to give our providers access to more complex patients and caseloads.

In your view, do all current military treatment facilities (MTFs) serve as operational medical readiness training platforms? Please explain.

In many respects, the answer is yes. Operational medical readiness requires the DoD to maintain medical capabilities across the spectrum of health services–from public health

and preventive health measures, to trauma skills, to advanced surgical and rehabilitative care. For instance, more than half of the medical conditions treated in deployed environments are for primary care services, including musculoskeletal, mental health, acute illness and chronic medical conditions. These are the same health services on which our MTFs focus; thus, it can be said that in providing primary care services, our MTFs acts as clinical readiness platforms. Conversely, not all MTFs see a sufficient number and variety of specialty cases to sustain specialty (e.g., surgical) clinical readiness. If confirmed, I will continue to enhance system-wide efforts underway to match clinical readiness requirements to requisite case volumes and acuity.

In addition, we are continuing to conduct the analysis directed in section 703 of the FY 2017 NDAA. We will soon complete a comprehensive assessment of the Department's medical facilities capabilities against the demand for clinical readiness. Once complete, we will be able to detail how and where we need to realign the Department's medical facilities to meet warfighter and medical force readiness requirements. These efforts will help us to better ensure that the primary focus of our MTFs is to serve as a readiness platform.

Based on your analysis of the Department's data, which facilities have sufficient workload and case-mix complexity to be considered as readiness training platforms?

We are continuing to conduct the analysis directed in section 703 of the FY2017 NDAA. We will soon complete a comprehensive assessment of the Department's medical facilities capabilities against the demand for clinical readiness. Once this analysis is complete, we will be able to detail how and where we need to realign the Department's medical facilities to meet warfighter and medical force readiness needs, while ensuring that our beneficiary experience is sustained or improved.

In your view, does the Air Force Medical Service's RESET initiative improve provider productivity and efficiency? Are there data available to show that RESET improves patient outcomes?

The MHS welcomes innovations from the Military Departments and individual MTFs. If a process is validated for clinical or administrative lines of business, the MHS will consider it for standardization across the MHS. DHA is currently evaluating the RESET program. If confirmed, I look forward to reviewing the results of this evaluation,

Military Health System Reorganization

Section 702 of the National Defense Authorization Act for Fiscal Year 2017 transferred direct oversight and management of military hospitals and clinics from the Services to the Defense Health Agency (DHA).

If confirmed, would you strive to ensure an effective, rapid, and efficient transfer of the operations of military medical facilities to the DHA?

Yes, if confirmed, I am committed to this transformation as necessary to meet future MHS requirements. In my role as the PDASD(HA), I have been deeply engaged in the development and implementation of the Department's plan. On October 1st of this year, 8 MTFs and their associated clinics transferred to the authority, direction, and control of the DHA. Under the Department's plan, by October 1, 2019, we will transfer over 50 percent of all MTFs to the DHA. If confirmed, I will continue to devote my efforts to overseeing and managing the transition to meet Congress's clear direction that we establish a more effective and efficient MHS to meet both warfighter and beneficiary needs.

In your view, is it possible and advisable to hasten the transition of military hospitals and clinics from the Services to the DHA?

I believe that acceleration is possible. I am already working with the DHA, Military Departments, and across OSD to define the conditions that must be in place for acceleration to be considered. Our priority is to avoid adversely impacting the care that our warfighters and other beneficiaries receive; we must carefully address all key risks associated with any acceleration plan. If confirmed, I will keep the Committees informed regarding any planning for acceleration.

What outcome measures has the Department developed to help determine the timing of this transition?

The MHS has a robust performance metrics system. We have leveraged this system to identify 19 metrics that are related to the transition. These metrics are focused on making sure that we anticipate any potential adverse impacts of the transition to the warfighter, our beneficiaries, and the medical readiness mission, and that we mitigate those risks before they occur. We will continue to monitor the full range of MHS metrics to make sure that the overall system continues to meet its goals supporting our Quadruple Aim throughout the transition.

Sections 711 and 712 of the NDAA for Fiscal Year 2019 enhanced the authority of the DHA to administer, direct, and control most aspects of the military health system and further defined the roles and responsibilities of the Services' Surgeons General.

If confirmed, how would you ensure that the Services reduce their medical headquarters staffs and infrastructure (including eliminating regional command staffs and associated infrastructure) to reflect the more limited scope of the roles and responsibilities of the Surgeons General?

We have completed manpower reviews of the DHA and Military Department medical headquarters, including regional requirements. We are still in the process of adjudicating manpower transfers between the Military Departments and DHA. If confirmed, I will work to ensure that DHP-funded manpower needs be based on validated requirements. If confirmed, I will continue to work with the Military Departments, DHA, and OSD leadership to articulate a single, integrated vision of the future of the direct care system,

both at the headquarters and at the market level that will determine manpower requirements and will ensure that Service medical headquarters staff and infrastructure are not duplicating functions of the DHA.

What is the total number of military, civilian, and contractor personnel required to manage the military health system's headquarters functions?

This continues to be a work in progress for the Department as we complete the deliberations during the Department's annual program and budget review. We are still intent on meeting or exceeding the 10% target for reduction in headquarters manpower that was provided to Congress in our final implementation plan for section 702 of the FY 2017 NDAA.

Section 703c Study

Section 703c of the NDAA for Fiscal Year 2017 required the Department to update the previous MHS Modernization Study accomplished in 2015, to address the restructuring or realignment of MTFs. Recently, the Department briefed the Committee on the updated study.

Are you concerned that the study found considerable variance in methods used by the TRICARE Regional Offices to assess provider network adequacy (capability and capacity)?

Our TRICARE Regional Offices (TROs) are required to assess network adequacy through the lens of the ability of the network to meet access and quality requirements for the patients currently seen by network providers. I believe these assessments meet these requirements and provide insight into the ability of the networks to meet current workloads.

The Modernization Study asked a slightly different, but equally important, question about the ability of purchased care to meet a proposed future workload. In this case, I accept the findings that the responses of the TROs demonstrated variance in developing this answer. Given that what the Modernization Study analysis was asking for is different from what our TROs and their contractors normally accomplish/evaluate, it's not surprising that there was variance.

As a result, it is clear that we need to engage in the difficult work of developing methodologies for assessing the adequacy of the network around our MTFs relative to various use case scenarios. I understand that this will be included in the report required under section 703 (d) of the NDAA for FY2017.

Why is there an inconsistent approach to assessment of network adequacy in the MHS?

The Department has assessed network adequacy through different prisms, depending on the issues under consideration.

Our TRICARE Regional Offices are required to assess network adequacy through the lens of our ability to meet access and quality requirements for our patients. We assess network adequacy in a consistent manner across the two US-based TRICARE contracts.

The Modernization Study looked at network adequacy through a different lens – our ability to meet a proposed future workload with different military medical infrastructure models. This study underscored the need to develop methodologies for assessing the network adequacy around our MTFs, relative to various use case scenarios. If confirmed, I will undertake to further that work, with a view to providing a consistent analysis in the future. I understand that this is will be included in the report required under section 703 (d) of the FY 2017 NDAA.

If confirmed, what would you do to shift more beneficiary care to the private sector in locations where direct care costs are significantly higher than private sector care?

If confirmed, I will focus on using a transparent, data-driven process that addresses the readiness of the warfighter, the readiness of our uniformed medical personnel, and the needs of our beneficiaries to determine where our direct care system can be optimized and where greater use of private sector resources should be pursued.

Our methodologies will be described in the Section 703 report, and will focus on support for medical readiness requirements. Decisions will be driven by a comprehensive assessment of mission support requirements, the ability of our direct care system to produce ready medical forces, the adequacy of the civilian network in given markets to meet our patients' expectations, and cost.

If confirmed, I will keep Congress apprised of our progress and the analysis underpinning any recommended shifts in health care delivery by individual MTF(s).

In your view, how could the MHS better match provider assignments to demand signals that may change quickly in a given medical market?

The Department considers population served and local direct care capability and capacity when making provider assignments. Yet, more must be, and is being done in this arena.

We are now implementing an approach—the Quadruple Aim Planning Process (QPP)--for assessing the readiness value of the MTF workload to ensure that providers are placed at the appropriate facilities. Through the QPP, the demand (beneficiary care and readiness) will be matched with the supply (provider and staff requirements). Concurrently, we are implementing a market-based strategy, by which market leaders will be empowered to manage all MTFs in a given geographical market and integrate the care provided by those MTFs with private sector care. If confirmed, I will work to ensure that the QPP is used effectively to facilitate the assignment and reallocation of resources in a manner that is responsive to external changes in a given market.

Does this study demonstrate that the MHS must re-think assignment of certain specialty providers to locations where demand is consistently high so that those providers with critical surgical skills required in combat can maintain their proficiency?

Yes. The 703(c) work refined the previous Modernization Study methodologies, but the results remain the same: we need to continue to develop and standardize our processes for assigning uniformed providers and staff to locations that support their clinical readiness.

We are pursuing a plan for doing this that leverages the guidance provided by Congress. Our opportunity is to redesign the way in which we match Military Department readiness requirements and beneficiary demand with DHA supply. We will clearly need to further leverage and increase our partnerships with civilian healthcare systems and the VA so as to resolve long standing barriers to providing robust clinical experiences for our enlisted force—the medics and corpsmen who are our frontline heroes. If confirmed, I will advance our existing efforts in accomplishing these goals.

Should the Department establish specialty care centers of excellence in specific markets with high demand for those specialty procedures?

Yes, this is one of the options the Department is seriously considering and one in which I have experience from the private sector. Such an approach is ideally suited for DoD-VA collaboration. I am aware that the Department has been in preliminary discussions with Veterans Health Administration leaders on an effort to refer some of VA's specialty care in the community (e.g., for surgical and orthopedic procedures) to certain MTFs. The goal of such an effort would be to enhance military medical readiness while providing Veterans with greater choice in the provider they select for their specialty care. If confirmed, I will rigorously explore this and related initiatives through established bodies like the Health Executive Committee, which I co-chair with the VA Under Secretary for Health. This work, coupled with identification of appropriate civilian partnerships to support military clinical readiness requirements, will help identify the appropriate distribution of specialties and specialty care centers across the MHS portfolio.

<u>TRICARE Contract Acquisition</u>

Section 705 of the National Defense Authorization Act for Fiscal Year 2017 requires the Department of Defense to develop a new medical contract acquisition strategy that: 1) ensures maximum flexibility in provider network design and development; 2) integrates medical management between military medical treatment facilities and network providers; 3) maximizes use of telehealth services; 4) uses value-based reimbursement methods that transfer financial risk to health care providers and managed care support contractors; 5) uses prevention and wellness incentives to encourage beneficiaries to seek health care services from high-value providers; 6) implements a streamlined enrollment process and timely assignment of primary care managers; 7) eliminates the requirement to seek authorization of referrals for specialty care services; 8) uses incentives to encourage certain beneficiaries to engage in medical and lifestyle intervention programs; and 9) uses financial incentives for contractors and health care providers to receive an

equitable share in cost savings resulting from improvement in health outcomes and the experience of care for beneficiaries.

Do you believe the DHA's current managed care support contracts fully adhere to the acquisition strategy required by Section 705?

The current managed care support contracts, awarded before October 1, 2018, were modified to enable value-based care initiatives The contracts provide for an Integrated Process Team approach to demonstrate and measure value-based care initiatives. DHA is implementing ongoing pilots to investigate how high-performing health plans and systems operate and employ value-based reimbursement methodologies and incentives. Three such projects are underway: Lower Extremity Joint Replacement and Reattachment; Medication Adherence; and the Performance Based Maternity Payments Pilot. Seven other projects are in development under this strategy including a demonstration project in the East Region to explore capitated per member, per month payments in a high-performing network partnered with the region's Managed Care Support Contractor.

If confirmed, how would you ensure that implementation of these new requirements in future contracts comply with the law and meet the suspense date prescribed in section 705?

DHA has formed a Project Management Office to integrate requirements into the next generation of contracts. If confirmed, I will oversee the activities of the Project Management Office to ensure that future contracts allow for more competition among innovative providers.

The Department is interested in a new approach to contracting for health care services, informed by our VBC initiatives now underway, and our experience with almost 25 years of managed care support contracts. We will better align incentivizes for both wellness and outcomes, and incorporate proven technologies (such as telehealth) into our system in a more agile, and customer-sensitive manner. If confirmed, I will seek input from all of our stakeholders – line leaders, beneficiaries, our military medical community, the private sector, and Congress. The DHA is already planning to issue a "Request for Information (RFI)" to begin this process of stakeholder input.

In your view, do the current managed care support contracts create value for DOD and its beneficiaries?

The TRICARE benefit–along with the TRICARE contracts that implement the benefit for DoD–serve as a highly effective recruitment and retention tool. Beneficiaries find value in the TRICARE benefit and its supporting contracts through low (or no) fees, ease of use, access to a high quality provider network worldwide, timely claims processing and exceptional protections from catastrophic health care costs. Nonetheless, our TRICARE contracts and the incentives within these contracts for both network provider and benefit contractor performance need to be modernized. If confirmed, I will oversee a

comprehensive review of the next series of TRICARE contracts and solicit input from a broad range of subject matter experts. My objective is to improve performance in measures that matter and better support the readiness and health for everyone served by the MHS.

Performance of Managed Care Support Contracts

The transition of the health care contract in the West region, which began in January 2018, has not gone smoothly. Transition issues have included inability of the call center to handle call volumes; inability to complete requested beneficiary and provider enrollments; inadequate network development; inaccurate network provider directories; issues with referral backlogs, accuracy, and denials; and clear and legible admission and discharge reports.

What is the DHA doing to address these shortfalls in contractor performance in the West Region?

Our West Region contractor, Health Net Federal Services (HNFS) did experience performance issues; however, most requirements have shown improvement since the contracts got underway. For those requirements for which HNFS remains non-compliant, ongoing contracting remedies are being applied, including the imposition of financial penalties and the execution of formal corrective action plans. We are committed to documenting all performance issues and imposing additional contract remedies as appropriate. If confirmed, I will continue to utilize all appropriate contract remedies to address performance issues, and work closely with DHA leadership to ensure effective contract oversight and meaningful contractor accountability.

How will the Department prevent similar problems in future managed care support contract transitions?

Transition risk management remains one of the greatest tasks associated with the Managed Care Support Contracts. Lessons learned and improvements to transition plans and evaluation criteria from the T2017 transition have already been captured and will be incorporated into the next generation of contracts. Additionally, the MHS has invested in a TRICARE Program Management Office designed to deliver Managed Care Support Contracts that achieve best-in-class contract terms for fees and performance, and deliver best-in-class clinical care. If confirmed, I will work closely with DHA leadership to identify challenges in the implementation of necessary changes in today’s contracts and ensure that the MHS incorporates lessons learned into our next series of contracts to avoid similar challenges in the future.

MHS Genesis

The Department of Defense has implemented MHS Genesis in Pacific Northwest military treatment facilities.

What important lessons has the Department learned from this initiative?

There are four major areas in which lessons learned have been captured:

- Technical Readiness: Network readiness and stability, as well as medical device interface preparation is essential. We must ensure the Medical Community of Interest (MED-COI) network is fully deployed and stable for the implementation sites at least 6 months prior to "going live" with MHS GENESIS. In addition, all medical equipment must be identified and ready to connect to the network in the same time frame.
- Training Methodology: The training approach and content initially provided was not adequate to ensure successful user adoption. Training revisions are in progress and must include a workflow-based approach, better preparation of MHS GENESIS subject matter experts at the deploying sites, as well as a more realistic training environment.
- Change Management: We underestimated the magnitude of the change management challenge. We are building better tools for communicating the new workflows required for the EHR deployment, bridging the transition from old to new processes, and starting earlier in the timeline prior to "going live." We must maintain continuous leadership communication and buy-in throughout the implementation process at all levels.
- Issue Resolution: The process used to address user concerns proved insufficiently effective and hampered adoption and required development of a complete restructured process. DHA is now bucketing "issue" tickets based upon responsibility–functional or technical–and prioritizing issues and incidents to help address or remediate each one. DHA continues to refine processes to communicate trouble ticket status to end users, which we believe will develop and maintain trust in the process and system.

In your view, should the Department delay roll-out of MHS Genesis to other locations until it corrects any major problems encountered during implementation in the Pacific Northwest?

Our plan for Initial Operating Capability (IOC) was intended to provide the Department with a comprehensive look at MHS GENESIS' performance prior to full deployment. We intentionally selected four diverse MTFs from all three Services and with varied in-house capabilities (e.g., clinic, hospitals, and medical center) to provide this broad perspective prior to full deployment. Electronic Health Record (EHR) roll-outs in any health system are, by their nature, disruptive and complex. The Department is continuously adapting and adjusting its approach based on the feedback we received from these IOC sites.

We have addressed the challenges encountered at the Pacific Northwest facilities through a number of initiatives. Our actions resulted in significant improvement to the network, changes in the management structure, user problem resolution, and improved communication. We have also invested substantial effort into refining the content, configuration and training around the system itself.

If confirmed, I will ensure we continue effective implementation of MHS GENESIS across the enterprise based on the lessons learned in the Pacific Northwest and future deployment sites. We will aggressively continue our efforts to improve training, change management, content configuration, as well as policy and procedures in the next year prior to moving forward to additional facilities.

Are military dentists fully using the Dentrix module of MHS Genesis? If not, why not?

The Dentrix module is being used at all sites where MHS GENESIS has been deployed. More than 180 dentists in the Pacific Northwest (Fairchild, Oak Harbor, Bremerton, and Madigan) are using it for all dental patient visits.

Medical Research and Development

What steps will you take to assess the quality and effectiveness of near-term and long-term medical research activities throughout the Department of Defense?

One of my key responsibilities, if confirmed, will be managing and overseeing the DHP Research, Development, Test and Evaluation (RDT&E) appropriation. If confirmed, I will take steps to ensure a rigorous programmatic and scientific review of all aspects of the DHP portfolio and verify the alignment of our investments to the highest operational medical priorities. In addition, to avoid duplicative efforts, we will coordinate DHP RDT&E funded activities with the Combatant Commands, Military Departments, Defense Agencies, and other DoD Components.

How will you ensure that the research portfolio and activities include an appropriate mix of research topics representing a variety of research areas and technical disciplines, an appropriate amount of exploratory, high risk research efforts, as well as near term research efforts driven by current military requirements?

The DHP invests in a diverse research portfolio in a number of areas, including Combat Casualty Care, traumatic brain injury, mental health treatment, and other relevant areas that will support current and future military requirements. The Department has research investments that range from basic research to clinical trials that will influence practice. If confirmed, I will ensure the Department continues to conduct annual Reviews and Analyses and holds regular governance forums that include the Military Departments, Defense Agencies, and other DoD Components. These efforts leverage formal processes to develop joint requirements and helps the Department align our medical research portfolio with military and mission requirements.

How will you ensure that these activities are coordinated with other DOD research activities, such as at the DOD laboratories, as well as activities in other federal agencies?

The Department takes steps to ensure that DHP-funded research efforts are coordinated with other DoD research activities and also are linked with efforts of other federal agencies. The Department has several formal partnerships with other agencies, such as those we maintain with the VA, the National Institutes of Health, and the Food and Drug Administration. Finally, the Armed Services Biomedical Research Evaluation and Management (ASBREM) Community of Interest (CoI) is used to coordinate research activities across the Department of Defense (DoD). If confirmed, I will work with the ASBREM and through our external partnerships to ensure that our research activities continue to be closely coordinated with the activities of other DoD components as well as the research activities of other federal agencies.

Medical Devices and Technology Acquisition

The Department of Defense makes use of a number of commercial industry partners to meet its medical technology requirements.

What, if any, reforms need to be made to DOD acquisition and procurement procedures and policies to ensure that DOD can continue to work with leading commercial innovators in medical devices and technologies?

DoD acquisition and procurement procedures and policies facilitate our collaboration with industry. The Department is increasingly leveraging commercially available solutions rather than developing DoD unique capabilities, allowing us to rapidly deliver affordable solutions. The acquisition of a commercial electronic health record is perhaps the most visible effort to acquire commercial technologies rather than create our own software. If confirmed, I will ensure we take advantage of the Defense Pilot Program Authority set forth in section 879 of the NDAA for FY2017, to acquire innovative commercial items, technologies, and services using general solicitation competitive procedures, while still meeting the heightened cyber security standards that the Department requires. Finally, if confirmed, I will evaluate whether the existing authorities are sufficient to meet our long-term needs and facilitate collaboration with leading commercial innovators in medical devices and technologies.

Protection of Patients' Health Information

Two separate DODIG reports highlighted inadequacies in the protection of patient health information in Army, Navy, and Air Force military treatment facilities.

How concerned are you about the DODIG's findings?

Protecting our beneficiaries' health information from unauthorized access or release is of paramount importance. Any risk of such access or release is of concern. DHA and the Military Departments concurred with the DODIG's findings and are actively working to improve enterprise-wide compliance with DoD security policies and procedures. If confirmed, I will commit my continued focus on this effort and ensure that compliance is achieved as rapidly and efficiently as possible.

What mitigation strategies has the Department implemented to ensure protection of private health information in MTFs?

The Department has issued guidance to Military Department Medical Departments and MTFs identifying next steps and actions to address the DODIG findings. In addition, DoD information technology modernization initiatives will play a significant role in enhancing protection of patient health information.

The deployment of MHS GENESIS will, in large part, address the recommendations in DODIG's reports. MHS GENESIS enables standardizes the desktop, implementing end-to-end control of the network, and centralizing a supporting infrastructure. Furthermore, MHS GENESIS allows for central configuration and access control. These features will strengthen the Department's capabilities in protecting patient data. If confirmed, I will exercise the necessary oversight to ensure compliance and timely deployment of new modernization initiatives to help mitigate potential issues.

Cybersecurity

What steps has the Department taken with commercial partners to ensure the cybersecurity of medical records and critical medical devices currently used in military hospitals and clinics?

Securely exchanging data with our commercial partners is crucial to continuity of care for our beneficiaries and for ensuring compliance with the Department's stringent data security requirements. We leverage DHA Business to Business Gateways, which provide an architecture solution for encrypted and secured communication between DHA and commercial partners, including TRICARE purchased care partners, and nearly 50 different state and local health information exchanges (HIEs).

To help ensure broad understanding of DoD cybersecurity requirements and to gain insight into potential solutions that might aid in the secure achievement of our mission, the Department actively promotes open communication with existing and potential commercial partners through DoD-sponsored industry days and related events.

Quality and Safety of Medical Care

An April 19, 2018, US News and World Report article described a military health system unable "to assure that patients needing challenging and risky operations are referred to centers with practiced surgical teams that perform the procedures regularly." The report quoted an anonymous high-ranking military surgeon who stated: "They've known this and ignored it for decades. What's the solution? Form a task force? It's the same thing over and over. There's a civilian system in place that will help us prepare for war. The real question is whether there should be a Military Health System at all."

In your view, why is it taking so long for the Department to address this significant problem?

The MHS is one of the finest health systems in the country. It provides the foundation for sustaining the health and readiness of our military medical forces across the spectrum of care. From prevention to treatment and rehabilitation, it performs its work exceptionally well. As has been well documented over the past years of extended conflict, the MHS achieved the highest level of survival from wounds in history of warfare, and also achieved the lowest level of disease, non-battle injuries in the history of warfare.

Even given that record of performance, however, I do not disagree that we face challenges in ensuring our medical teams maintain their skills when away from the battlefield (in all medical provider positions, from corpsman, to nurse, to doctor). Medicine has changed in this country, and those changes affect military medicine as well. There has been a shift to more outpatient care and outpatient surgery as compared to inpatient hospital care. Increased levels of sub-specialization lead to more and more surgical care migrating to sub-specialists with specific areas of focus (e.g., more and more, physician specialists are characterized not only as orthopedic surgeons, but specialists who focus exclusively on–say–knee replacements).

Understanding of the link between volumes and outcomes in complex surgeries is still emerging. Although the evidence for a link is strong and growing, there is not yet consensus among medical professionals on how to interpret the relationship between volume and outcomes. This challenge is not unique to the MHS. It is an issue commercial health systems are facing as well. Notwithstanding this uncertainty, the MHS is working to incorporate this still-emerging understanding into our policies and procedures. In April, I asked the Defense Health Board (DHB) to review MHS policies and practices regarding complex surgeries and surgical volume and to make recommendations for how the Department can meet its obligations for high quality, safe care for its beneficiaries whether that care is provided in the direct or purchased care sectors.

This review is just one aspect of our broader efforts to monitor, analyze and improve the quality and safety of the care we provide. One of the most significant and transparent steps has been the expansion of MHS participation in the American College of Surgeons' National Surgical Quality Improvement Program (NSQIP), a nationally validated, risk-adjusted, outcomes-based program aimed at measuring and improving the quality of surgical care relative to civilian hospitals. Currently all 48 MTFs eligible are actively participating in the NSQIP program, an increase from 17 MTFs in 2014. MHS performance has been on par or better than the NSQIP civilian benchmark for overall morbidity and mortality.

Why do certain military hospitals continue to perform low-volume, complex surgical procedures that expose patients to higher risks of post-surgical complications or worse?

As stated in the previous question, the link between volumes and outcomes in complex surgeries is still emerging. I have asked the Defense Health Board to review this issue and provide me with recommendations. The nature of the MHS makes it particularly complex to apply this thinking to both our direct and purchased care systems. For example, should the MHS endeavor to reduce the performance of low-volume complex surgeries in our MTFs by sending patients to civilian institutions, we must take care to ensure that the receiving institutions perform complex surgeries in appropriately high volumes, or risk defeating the purpose of such "refer out" policies. By seeking independent review by the Defense Health Board, we hope to arrive at policies and procedures that will maximize the health of our patients and the safety and quality of the care we provide, while addressing the complexities of volume-outcomes connections ain light of the specific requirements of the MHS.

If confirmed, what would you do immediately to ensure that patients get complex surgical treatment from military surgeons providing treatment in high-volume surgical practices?

I asked the Defense Health Board to conduct an independent review of MHS policies and practices for the purpose of developing recommendations regarding:

- How the MHS should make determinations as to where high-risk surgical procedures should be performed
- How the MHS can optimize the safety and quality of surgical care provided
- How the MHS can enhance patient transparency related to surgical volumes and outcomes, and
- How to evaluate the contribution of high-risk surgical procedures to medical readiness.

The Department is also pursuing a multi-faceted effort, using the authorities that the Congress has provided to the ASD(HA) to further increase clinical case complexity for our medical staffs. Ongoing efforts evidence our philosophy that it is important to increase practice opportunities not only for our physicians, but for all members of the medical team, and I anticipate that programs like these will continue to grow. Some of these programs include:

- Maximizing the use of our medical centers that have capability and capacity by attracting patients to use military care;
- Expanding DoD-VA patient sharing, both by treating more Veterans in MTFs, and by reaching agreements to allow military providers to practice in VA facilities.
- Exploring the demonstration program authorities that Congress has provided to treat non-DoD beneficiaries. For example, DoD cared for a number of victims from the Boston Marathon bombing for long-term amputee and rehabilitative care at Walter Reed National Military Medical Center using Secretarial Designee authority; similarly we took care of some civilian patients at San Antonio Military Medical Center after the mass shooting in Sutherland Springs, Texas. These highly successful engagements provided extraordinary treatment opportunities for our medical staffs, and excellent care for the patients served.

- Expanding our public-private partnerships. The Department already maintains highly successful collaboratives with Maryland Shock Trauma in Baltimore; the Center for Sustainment of Trauma and Readiness Skills (C-STARS) in Cincinnati; a collaboration with Cook County Hospital in Chicago to provide hospital corpsmen training, and others.

While serving as the Acting Assistant Secretary of Defense for Health Affairs, you asked the Defense Health Board (DHB) to examine the military's policies on complex procedures since national studies "suggest a relationship between performing certain procedures in small numbers and patient outcomes."

When will the DHB provide its report to you?

The DHB is expected to present preliminary findings and recommendations to me by the end of October 2018, with a final report delivered in April 2019.

If confirmed, what would you do immediately to improve quality of care and patient safety throughout the military health care system?

If confirmed, I will build on the foundation of the high reliability and quality of health care assurance, measurement, and improvement efforts currently underway in the MHS. The MHS is committed to data-driven decision making and resource allocation, leveraging clinical subject matter expertise for clinical quality improvement. I will use our MHS Dashboard, and our enterprise-wide patient safety programs to drive performance improvement in both the direct care and purchased care systems.

If confirmed, how would you eliminate variability in the provision and delivery of health care throughout the direct and purchased care components of the military health system?

Thanks to Congressional guidance, we are on the path toward elimination of unnecessary variability in the provision and delivery of health care. The consolidation of non-deployed medical care under the DHA will help drive standardization that will eliminate unnecessary variability and variation in both clinical and business practices across the MHS. These efforts will be amplified by DHA's efforts to standardize the delivery of the benefit across an integrated system of readiness and health. The deployment of MHS GENESIS will also drive standardization because providers in the MHS will align with evidence-based pathways of care that are standardized across the entire Department. If confirmed, my team and I will continue efforts to implement these programs and I will support the DHA's efforts in driving standardization through implementation of congressional directed reforms.

Graduate Medical Education (GME)

Section 749 of the National Defense Authorization Act for Fiscal Year 2017 requires the Department to establish and implement a process to provide oversight of the graduate medical

education programs of the Services to ensure that those programs fully support the operational medical force readiness requirements for health care providers of the Armed Forces and the medical readiness of the Armed Forces. In July 2019, the Committee received the Department's report on its oversight process, which described how it will form a GME Oversight Council and a Tri-Service GME Integration Board. The Services and DHA will each have one voting member serving on each of these oversight bodies.

How would this "new" oversight process differ from the current process?

Historically, each Military Department followed its own regulations in executing GME. This new oversight process now provides recommendations to the Director, DHA who will make decisions on policy, direction, location and number of GME programs that will apply to all GME programs across the MHS.

Do you believe this "new" process will lead to objective evaluations and recommendations for training physicians and dentists in the correct specialties to support operational medical force requirements of the combatant commanders?

The new GME process will provide objective evaluations and recommendations on GME policy and programs. It will fully support the Military Departments' operational medical force readiness requirements by training physicians in the specialties required for operational success and developing and sustaining the training pipeline from an enterprise perspective.

This new process will improve execution through centralized oversight and joint coordination under the authority of the DHA. A structured and coordinated review will ensure prioritization of programs and alignment with patient numbers and case mix to maximize MTFs as a viable training platform. DHA will develop civilian training opportunities when MTFs do not have adequate patient numbers or case mix.

How would this "new" process make objective recommendations to revise or eliminate existing GME training programs in the Services?

The GME advisory boards will review existing programs and objectively recommend the closure of duplicative programs that do not contribute to the overall goal of the Military Departments and the MHS. Requirements for educational platforms will align to the operational requirements of the Military Departments. If requirements decrease or increase, this new process allows for an objective enterprise evaluation of closures or additions to the GME functional capability through a single decision-making authority.

In your view, should dermatology, neurology, pediatrics, ophthalmology, plastic surgery, or vascular surgery be considered readiness tier 1 medical specialties? Please provide an answer for each specialty.

The Department is undertaking a comprehensive review of the type and mix of medical specialties it requires for wartime, and I will await those recommendations before

providing a detailed assessment of each specialty. I believe this comprehensive review will inform the type of GME training programs that will be required to maintain a critical wartime capability. In the future, I would expect all uniformed medical providers to maintain appropriate expeditionary Knowledge, Skills and Abilities needed forward to support a wide range of mission sets. Finally, maintaining a measured capability to allow sub-specialization while in uniform may contribute to overall retention and recruitment.

If confirmed, how would you ensure elimination of those graduate medical education programs that do not directly support the operational medical force readiness requirements for health care providers within the Armed Forces? Would this "new" process accomplish that goal?

Yes, I believe the new process will accomplish this goal. One of our primary goals will be to ensure that those GME programs required to meet our operational mission are Accreditation for Graduate Medical Education (ACGME) accredited. This will require consideration of program interdependency and potential alternative ways to meet operational readiness requirements, such as through partnerships. The new process will provide the DHA Director a more enterprise level assessment and the authority to restructure, realign, and eliminate unwarranted or duplicative programs, while ensuring we have the educational opportunities necessary to meet the readiness mission. If confirmed, I will ensure that this new process is followed and that we rationalize those GME programs that do not directly support the operational medical force readiness requirements.

Mental Health Care

In your view, are the Department of Defense's current mental health resources adequate to serve all active duty and eligible reserve component members and their families, as well as retirees and their dependents?

Yes, I believe that our resources for mental health care are sufficient to the task of serving all of our beneficiaries. With the support of Congress, DoD has roughly tripled outpatient visits from FY2002 through FY2018. Significantly, the number of mental health providers in the MHS has risen to 10,343 in FY 2018—an increase of over 40 percent from FY 2009, and TRICARE assets have been bolstered to better serve Reservists, dependents, and retirees, with a total of 84,029 mental health providers in the network. We have also embedded behavioral health providers in our primary care clinics, allowing for easier access to needed mental health care, and have helped reduce stigmatization with seeking that care. I am not complacent with existing efforts, however, and will continue to ensure all beneficiaries have timely access to this medical service.

If confirmed, what actions would you take to ensure that sufficient mental health resources are available to service members in theater and to service members and

families upon return to home station locations with insufficient community-based mental health resources?

If confirmed, I am committed to ensuring that sufficient mental health resources continue to be available to Service members in theater and at home, and to their families. The provision of mental health care during contingency operations is vitally important. I believe that mental health care is a force multiplier that fosters and sustains force lethality. To that end, I have worked with the components to ensure that embedded multidisciplinary care available from psychiatrists, psychologists and social workers is available to every Service member in theater, on every deployment. Every mental health provider who is not commanding is deployable on short notice.

I support the provision of community-based mental health care for all of our beneficiaries and we have strengthened resources in the TRICARE network such that they now total more than 84,000 mental health providers. Additionally, my staff has worked with their colleagues across the Office of the Under Secretary of Defense for Personnel and Readiness to ensure ready availability of, and access to, non-medical mental health resources. The Yellow Ribbon Reintegration Program promotes the well-being of National Guard and Reserve members and their families by connecting them with resources throughout the deployment cycle, and Military OneSource (MOS) provides confidential, short-term in-person, online chat and telephone non-medical counseling to members of the active force, the National Guard and Reserves, Civilian Expeditionary Workforce members, and their families—throughout their military careers and for up to 365 days after leaving service.

Are the Department's current mental health resources adequate to address the mental health issues of transgender service members?

The MHS has built a robust system of mental health services in both the direct and purchased care systems. All mental health providers must demonstrate basic competencies to treat any disorders listed in the Diagnostic and Statistical Manual of Mental Disorders, including gender dysphoria. Furthermore, we have established Transgender (TG) Care Teams with specialized training in medical treatment plans for Active Duty Service members with gender dysphoria. Providers who believe they do not have sufficient expertise in the care of people with gender dysphoria can leverage the TG Care Teams for consultations. We also developed TG education and training courses for all MTF personnel. Resources to assist in the care and treatment of transgender Service members are readily available to mental health providers, including specialty symposiums, webinars, and other resources.

Suicide Prevention

In your view, is there a correlation between the mental health of service members and suicides and suicide attempts?

It has long been recognized that there is an association between the existence of mental disorders in an individual and that individual's risk for suicide and suicide attempts.

Most individuals who die by suicide have mental health conditions, but the prevention of suicide should not focus solely on mental health treatment. The MHS does outstanding work in treating individuals at highest risk, including individuals with psychosis and severe mood and substance use disorders, but as in the general population, most of these individuals do not die by suicide.

What would you recommend to the Secretary of Defense to reduce suicides among members of the Armed Forces?

If confirmed, I would recommend continuing our investments in research on effective suicide prevention and mental health programs, while operationalizing key research findings from our military suicide research consortium with the Department of Veterans Affairs.

Operational Medical Force Readiness

On December 14, 2015, then-Deputy Secretary of Defense Work signed a memorandum requiring the Services and the Defense Health Agency to define military medical force readiness and to develop a model to determine and project the Department of Defense's cost for medical force readiness.

Have DHA and the Services complied with the requirements outlined in that memorandum? If not, why not?

The DHA and Military Departments have made excellent progress toward full compliance with this memorandum. The measures for sustaining military medical force readiness have centered on expanding and accelerating work on defining the knowledge, skills, and abilities (KSAs) required of the deployable medical force. These KSAs will enable us to measure and sustain the readiness of all medical care providers to perform in an operational context. The Department has established a program office charged with defining the common medical KSAs and developing methods of assessment for use by the Military Departments. The KSA methodology is also being used to measure the potential to generate medical readiness at our MTFs. The volume and variety of workload coming into an MTF are measured, as they relate to the KSAs applicable to each wartime specialty. This results in a determination of what kinds of readiness, and how many specialists practicing in each readiness domain can be supported by that MTF.

If confirmed, how would you ensure that staffing models and associated costs to maintain operational medical readiness skills reflect actual combatant command requirements?

Once the KSAs for operational medical readiness (by specialty) are agreed upon by the Military Departments and DHA, the primary focus of the MTFs will be on maintaining those readiness KSAs for military health care providers and ensuring the medical readiness of Service members. If there is insufficient volume, variety, or acuity of caseload at a particular MTF to meet and sustain the KSAs, the Director, DHA will

establish agreements with civilian or other federal facilities to provide a venue for skills development maintenance. The DHA, in its role as a Combat Support Agency, is a part of the Joint Staff medical planning process, and will revise and update medical skill requirements to reflect current operational planning by the Combatant Commanders.

If confirmed, what would you do to right-size the active medical force requirements of the Department to optimize operational medical force readiness capabilities and to produce cost savings to the Department and U.S. taxpayers?

The active medical force must be adequately sized to be able to rapidly respond to any valid operational medical requirement. The primary advantage of the active medical force is near-real time availability. Reduction in the size of the active medical force will inevitably increase the time required to generate medical capability. Activation of Reserve Component medical forces takes longer, and may pose an unacceptable risk to operations. If confirmed, I will continue the efforts of the OASD for Health Affairs, working in conjunction with the Military Departments, CAPE, and the OASD for Readiness, to establish a DoD process to define the medical and dental personnel requirements necessary to meet operational medical force requirements, in accordance with section 721 of the FY 2017 NDAA. Once the requirements are defined, cost-efficiencies that may be gained, potentially by converting military to civilian positions, or moving medical capability from the active force to the Reserve Components can be reliably assessed. However, the primary goal is to ensure we have a robust medical force that can provide the medical capabilities required by the operational force, when and where needed.

If confirmed, would you advocate for outsourcing more beneficiaries' health care services to the private sector when and where it makes sense? How and where would you do that?

Yes, I would support private sector outsourcing where it makes fiscal sense, provided that health care services can be outsourced without diminishing the critical wartime medical readiness skills and core competencies of Armed Forces health care providers, as required by section 725 of the FY 2017. Decisions on how and where to outsource would be informed by market analysis and input from the Military Departments and DHA as to the potential effects of outsourcing on the readiness of Service Members and military medical providers.

If confirmed, how would you collaborate with private sector health care providers to establish government-owned/contractor-operated or contractor-owned/contractor-operated hospitals and clinics?

The Department has several Government Owned/Contractor Owned (GOCO) and contractor-owned/contractor-operated (COCO) clinics presently in operation. Using lessons learned from our current GOCO/COCO clinics, we would continue to enter into such agreements where they make sense. The most likely candidates for GOCO or COCO hospitals would be in situations in which we have made a decision to downsize or

close an MTF. If a contractor could operate the facility in such a way as to be beneficial to the DoD for a lower cost than DoD would otherwise pay, such an agreement would be possible.

Non-Deployable Service Members

Recently, the Department published DODI 1332.45, Retention Determinations for Non-Deployable Service Members. If confirmed, you would be responsible for developing policy recommendations for uniform retention medical standards.

As Acting Assistant Secretary of Defense for Health Affairs, what role did you play in developing this DODI?

Secretary Mattis has been clear that increasing the readiness of our military is one of his top priorities. As the Principal Deputy Assistant Secretary of Defense for Health Affairs, I ensured that my staff provided clear and actionable recommendations during the development of the Department of Defense Instruction, *Retention Determinations for Non-Deployable Service Members*. If confirmed, I will ensure that policies for uniform retention medical standards are developed in coordination with the Secretaries of the Military Departments and in support of Secretary Mattis's priorities.

Do you agree that any and all Service members with Dental Class 3 conditions are deployable?

If confirmed, I will ensure that the MHS is structured so as to provide the dental and medical resources needed by the Services to sustain individual Service member dental and medical readiness required for deployment. I am also confident that military leaders at all levels of command will utilize these resources to attain and sustain Dental Readiness Classifications 1 and 2, and other Individual Medical Readiness requirements, prior to deployment of their Service members. The expectation is that any Service member with a Dental Class 3 condition would be treated and the condition resolved prior to deployment.

In your view, does the Department's new instruction diminish the importance of dental health in overall medical readiness of the Total Force?

Dental health remains a critical element of overall medical readiness. The Department of Defense Instruction, *Retention Determinations for Non-Deployable Service Members,* attempts to categorize dental readiness in a way similar to that of medical readiness: individuals with conditions that can be corrected in less than 30 days are not considered to be non-deployable.

If confirmed, I will ensure that the Department closely monitors the actions directed in the new Instruction, and the actions directed in existing medical readiness-related instructions, to track the combined impact on improving the number of Service members who are deployable.

Pain Management and Opioid Medications

The National Defense Authorization Act for Fiscal Year 2019 includes a requirement for a comprehensive pilot program on opioid management in the military health system.

> **If confirmed, what policies and programs would you implement to improve pain management in the military health system to reduce and eliminate the misuse and/or abuse of opioid medications?**
>
> If confirmed, I commit to continuing and expanding upon our effective policies and programs for pain management. Recently, my staff created a comprehensive policy to standardize MHS procedures to improve pain management and control the prescription of opiates.
>
> This comprehensive policy directs the delivery of pain care under a "stepped" care model, which equips primary care providers (PCPs) to encourage self-care and provide pain control to patients without the use of opiates. Over 10,000 PCPs completed a DoD-developed course on safe use of opiates. Pain and addiction specialty care is available to every Service member, without limits on the length of care or number of visits.
>
> **In your view, should alternative and complimentary therapies for pain management be considered as benefits under the TRICARE program?**
>
> Complementary and integrative pain therapies, such as mindfulness, massage, yoga, chiropractic care, and acupuncture, are essential to managing pain. Indeed, our MTF commanders have been providing these therapies for the better part of the decade.
>
> We are evaluating the addition of certain complementary and integrative therapies, such as acupuncture and chiropractic care, to the TRICARE benefit. This medical benefit determination process involves a review of available evidence and an evaluation as to what extent these therapies are provided in civilian medical systems.

Women's Health

> **In view of the expanded roles of women serving in the Armed Forces, what are the health challenges that the Department of Defense and the Services must address to ensure appropriate health care for female service members in deployed and non-deployed environments?**
>
> Health care for women serving in the Armed Forces is a matter of great importance to the DoD and the MHS. Our challenge is to address health care in a comprehensive way, across the lifespan of female Service members, to ensure they attain and maintain readiness. We are endeavoring to ensure that we are on the cutting edge of physical fitness training, optimal nutrition for neuromuscular function, gender and age-appropriate treatments and rehabilitation for musculoskeletal injuries, access to quality reproductive

care, access to mental health services, and support of personal hygiene in austere deployed environments.

The Department has made significant advancements in areas such as access to contraceptive care for active duty women. Most recently, the Department has established a number of education and training tools addressing active duty women health issues on the Military Department Public Health portals. Subjects include individual self-care in the field and female deployment guidance. Additionally, gender-targeted screening questions were added to the pre- and post-deployment health assessments completed by each Service member preparing for and/or returning from deployment, to ensure health issues such as contraception and menstrual suppression are appropriately addressed. Further, there is a continuing emphasis on collaborative research investments between the DoD and VA regarding gender differences in recovery from concussive injury, post-traumatic stress, and musculoskeletal injuries.

If confirmed, how would you assess the adequacy of current health services for female service members and what steps, if any, would you take to improve them?

If confirmed, I would direct my staff to do a comprehensive look at health care for active duty women. This would allow me to establish a baseline of what is currently being done, apply outcome measures to determining how well the current programs are working, and define any gaps that need to be addressed. Delivering quality, accessible health care is a dynamic undertaking and requires continuous re-assessment to help ensure we are meeting the needs of our military service members in both garrison and deployed environments.

Wounded Warrior Care

If confirmed, what would you do to ensure the Department of Defense continues to advance diagnosis, treatment, and rehabilitation services for wounded, ill, and injured service members?

If confirmed, I will ensure that we continue to advance the diagnosis, treatment, and rehabilitation of Service members, across the spectrum of wounds, illnesses, and injuries, including those that are often considered "unseen," such as traumatic brain injury and post-traumatic stress. We have an ongoing obligation to provide the full range of services to assist with the recovery and rehabilitation of those who have given so much in the defense of our nation. We have worked continuously to ensure that all wounded, ill and injured Service members have access to the specialty care that they require and that the care is delivered in a timely manner. We are increasingly looking to measure and track the outcomes of the services we provide to improve both MTF care for our wounded, ill, and injured Service members, as well as the care we purchase from other sources.

Congressional Oversight

In order to exercise its legislative and oversight responsibilities, it is important that this Committee and other appropriate committees of Congress are able to receive testimony, briefings, and other communications of information.

Do you agree, if confirmed, to appear before this Committee and other appropriate committees of Congress?

Yes.

Do you agree, if confirmed, to appear before this Committee, or designated members of this Committee, and provide information, subject to appropriate and necessary security protection, with respect to your responsibilities as the ASD(HA)?

Yes.

Do you agree to ensure that testimony, briefings, and other communications of information are provided to this Committee and its staff and other appropriate committees in a timely manner?

Yes.

Do you agree to provide documents, including copies of electronic forms of communication, in a timely manner when requested by a duly constituted committee, or to consult with this Committee regarding the basis for any good faith delay or denial in providing such documents?

Yes.

Do you agree to answer letters and requests for information from individual Senators who are members of this Committee?

Yes.

If confirmed, do you agree to provide to this Committee relevant information within the jurisdictional oversight of the Committee when requested by the Committee, even in the absence of the formality of a letter from the Chairman?

Yes.