DEPARTMENT OF THE AIR FORCE

PRESENTATION TO THE COMMITTEE ON ARMED SERVICES

SUBCOMMITTEE ON MILITARY PERSONNEL

UNITED STATES HOUSE OF REPRESENTATIVES

SUBJECT: The Military Health System: Health Affairs/TRICARE Management Activity Organization

STATEMENT OF: Lieutenant General (Dr.) James G. Roudebush
Air Force Surgeon General

April 29, 2009

NOT FOR PUBLICATION UNTIL RELEASED
BY THE COMMITTEE ON ARMED SERVICES
UNITED STATES HOUSE OF REPRESENTATIVES

BIOGRAPHY

UNITED STATES AIR FORCE

LIEUTENANT GENERAL (DR.) JAMES G. ROUDEBUSH

Lt. Gen. (Dr.) James G. Roudebush is the Surgeon General of the Air Force, Headquarters U.S. Air Force, Washington, D.C. General Roudebush serves as functional manager of the U.S. Air Force Medical Service. In this capacity, he 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 Air Force people. General Roudebush 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. He exercises direction, guidance and technical management of more than 43,100 people assigned to 75 medical facilities worldwide.

The general entered the Air Force in 1975 after receiving a Bachelor of Medicine degree from the University of Nebraska at Lincoln, and a Doctor of Medicine degree from the University of Nebraska College of Medicine. He completed residency training in family practice at the Wright-Patterson Air Force Medical Center, Ohio, in 1978, and aerospace medicine at Brooks Air Force Base, Texas, in 1984. The general commanded a wing clinic and wing hospital before becoming Deputy Commander of the Air Force Materiel Command Human Systems Center. He has served as Command Surgeon for U.S. Central Command, Pacific Air Forces, U.S. Transportation Command and Headquarters Air Mobility Command. Prior to his selection as the 19th Surgeon General, he served as the Deputy Surgeon General of the U.S. Air Force.

EDUCATION

1971 Bachelor of Medicine degree, University of Nebraska at Lincoln
1975 Doctor of Medicine degree, University of Nebraska College of Medicine
1978 Residency training in family practice, Wright-Patterson USAF Medical Center, Wright-Patterson AFB, Ohio
1980 Aerospace Medicine Primary Course, Brooks AFB, Texas
1981 Tri-Service Combat Casualty Care Course, Fort Sam Houston, Texas
1983 Master's degree in public health, University of Texas School of Public Health, San Antonio
1984 Residency in aerospace medicine, Brooks AFB, Texas
1988 Air War College, by seminar

1978 Residency training in family practice, Wright-Patterson USAF Medical Center, Wright-Patterson AFB, Ohio
1980 Aerospace Medicine Primary Course, Brooks AFB, Texas
1981 Tri-Service Combat Casualty Care Course, Fort Sam Houston, Texas
1983 Master's degree in public health, University of Texas School of Public Health, San Antonio
1984 Residency in aerospace medicine, Brooks AFB, Texas
1988 Air War College, by seminar
1989 Institute for Federal Health Care Executives, George Washington University, Washington, D.C.
1992 National War College, Fort Lesley J. McNair, Washington, D.C.
1993 Executive Management Course, Defense Systems Management College, Fort Belvoir, Va.

ASSIGNMENTS

1. July 1975 - July 1978, resident in family practice, Wright-Patterson USAF Medical Center, Wright-Patterson AFB, Ohio
2. July 1978 - September 1982, physician in family practice and flight surgeon, USAF Hospital, Francis E. Warren AFB, Wyo.
3. October 1982 - July 1984, resident in aerospace medicine, USAF School of Aerospace Medicine, Brooks AFB, Texas
4. August 1984 - September 1986, Chief of Aerospace Medicine, 81st Tactical Fighter Wing, Royal Air Force Bentwaters, England
5. September 1986 - July 1988, Commander, USAF Clinic, 81st Tactical Fighter Wing, Royal Air Force Bentwaters, England
6. August 1988 - June 1991, Commander, 36th Tactical Fighter Wing Hospital, Bitburg Air Base, Germany
7. August 1991 - July 1992, student, National War College, Fort Lesley J. McNair, Washington, D.C.
8. August 1992 - March 1994, Vice Commander, Human Systems Center, Brooks AFB, Texas
9. March 1994 - January 1997, Command Surgeon, U.S. Central Command, MacDill AFB, Fla.
10. February 1997 - June 1998, Command Surgeon, Pacific Air Forces, Hickam AFB, Hawaii
11. July 1998 - July 2000, Commander, 89th Medical Group, Andrews AFB, Md.
12. July 2000 - June 2001, Command Surgeon, U.S. Transportation Command and Headquarters Air Mobility Command, Scott AFB, Ill.
13. July 2001 - July 2006, Deputy Surgeon General, Headquarters U.S. Air Force, Bolling AFB, Washington, D.C.
14. August 2006 - present, Surgeon General, Headquarters U.S. Air Force, Washington, D.C.

FLIGHT INFORMATION

Rating: Chief flight surgeon
Flight hours: More than 1,100
Aircraft flown: C-5, C-9, C-21, C-130, EC-135, F-15, F-16, H-53, KC-135, KC-10, T-37, T-38, UH-1 and UH-60

BADGES

Chief Physician Badge
Chief Flight Surgeon Badge

MAJOR AWARDS AND DECORATIONS

Distinguished Service Medal
Defense Superior Service Medal with oak leaf cluster
Legion of Merit with oak leaf cluster
Meritorious Service Medal with two oak leaf clusters
Air Force Commendation Medal
Joint Meritorious Unit Award
Air Force Outstanding Unit Award with oak leaf cluster
National Defense Service Medal with bronze star
Southwest Asia Service Medal with bronze star
Air Force Overseas Long Tour Ribbon with oak leaf cluster

Air Force Longevity Service Award with silver oak leaf cluster
Small Arms Expert Marksmanship Ribbon
Air Force Training Ribbon

PROFESSIONAL MEMBERSHIPS AND ASSOCIATIONS
Society of USAF Flight Surgeons
Aerospace Medical Association
International Association of Military Flight Surgeon Pilots
Association of Military Surgeons of the United States
Air Force Association
American Medical Association

EFFECTIVE DATES OF PROMOTION
Second Lieutenant May 15, 1972
First Lieutenant May 15, 1974
Captain May 15, 1975
Major Dec. 8, 1979
Lieutenant Colonel Dec. 8, 1985
Colonel Jan. 31, 1991
Brigadier General July 1, 1998
Major General May 24, 2001
Lieutenant General Aug. 4, 2006

(Current as of May 2008)

Chairwoman Davis, Representative Wilson, and esteemed members of the Committee, thank you for inviting me here today to discuss the organizational structure of OSD Health Affairs (HA) and the TRICARE Management Activity (TMA). This is an important issue that should be jointly addressed by OSD and the Service Surgeons General, as the stakes for our beneficiaries are very high. I carefully considered the issues you identified and will seek to address them in my testimony.

In reviewing whether the HA/TMA structure is appropriate to the roles and responsibilities of the office, we identified what we view as strengths and weaknesses. The current structure of HA is generally conducive to its role in developing policies, crafting strategic plans, aligning financial plans, and integrating Military Health System (MHS) functions to create synergistic effects. Of concern is the growth in HA and DASD "dual hat" responsibilities to include oversight of selected execution activities within TMA. Also of concern, TMA has broadened beyond its traditional role of MCSC oversight and DHP budget execution to include oversight of MTF-level financial and business plan execution as well as aspects of readiness (Service Title X responsibilities). Within this broad portfolio, TMA has significant challenges in executing health plan management and managing growth in Private Sector Care (PSC) cost. Although TRICARE benefit expansion and Operations ENDURING FREEDOM and IRAQI FREEDOM can be cited as contributing to rising costs, private sector care costs have grown rapidly over the last 13 years. The amount of care delivered in the private sector, as highlighted in the Task Force on the Future of Military Health Care Final Report (December 2007), is substantial. "In 1996, the DoD obligation for medical service contracts was $1.6 billion, and by 2005 this obligation had increased to $8 billion—a 412 percent increase."

As of Fiscal Year (FY) 2007, total PSC costs were $11.4 billion. According to 2009 Defense Health Program Private Sector Care Trend data, actual costs for PSC in FY 2008 increased to $12.3 billion, and the projected requirement for FY 2009 is $14.2 billion. Despite significant PSC cost growth, TMA remained focused on Military Treatment Facility (MTF) oversight. As previously noted, TMA provided extensive oversight of MTF level performance by financial and business execution tracking to enhance efficiency, which duplicates Service Medical Department's Title 10 responsibility. We believe the MHS would be better served by TMA efforts focused on control of PSC costs and augmenting the direct care system where possible.

During the past few years, TMA's staff in the National Capitol Region grew from 360 (does not include contract staff—data unavailable per TMA) in 2000 to 1,430 in 2009 which includes 861 contractors. Beyond the 1,430 staff working in Washington, D.C., TMA also employs 206 staff (does not include contract staff—data unavailable per TMA) at four TRICARE Regional Offices (TRO). Although part of the TMA staff growth can be attributed to new program responsibilities (i.e. TROs, Joint Medical Information Systems Office, Military Medical Support Office), and a percentage of the PSC growth can be attributed to an expansion of legislated TRICARE benefits, the continued PSC cost escalation remains a significant concern.

Title X of the United States Code charges the military Services with the responsibility to organize, train, equip, and provide forces. The Service Medical Departments execute the medical component of this responsibility in support of line and combatant commanders. We view the role of HA, and, TMA, respectively, as defining and establishing policy for the MHS

and managing the TRICARE MCSC, both of which support the Services' ability to execute Title 10 responsibilities.

It is our position that HA and TMA organizational structures should be clarified to concentrate efforts on their specific roles. HA should be organized to focus on policy issues and the strategic direction of the MHS. TMA should be organized and staffed to control PSC cost growth, oversee TRICARE MCSC, and partner with the Services to take advantage of Direct Care System capabilities, as recommended by the Task Force on the Future of Military Healthcare.

The Service Medical Departments do play a role in HA/TMA. Along with HA, we serve as stakeholders in a board of directors-style management of the MHS and the Defense Health Program (DHP). With HA and TMA, the Service Medical Departments oversee funding strategies to support the provision of peacetime health care delivery. Each Service Medical Department advocates for their specific peacetime health care resourcing needs and manages the resources provided to meet mission requirements. We are each represented in various HA and TMA management divisions and on committees striving to improve MHS peacetime health care delivery effectiveness. Service SGs ensure Service-specific requirements and standards are met. Service Line leadership is directly engaged in reviewing MHS policy and metrics to ensure optimal health services anytime, anywhere for our warfighting forces and military families.

Health Affairs (HA) supports the requirements of the Services at the policy and strategic planning level. HA and TMA complement the Service Medical Departments in the delivery of peacetime health care around the globe for more than 9.2 million beneficiaries. They serve as advocates when defending, resourcing, and clarifying policy decisions (i.e., National Defense

Authorization Act, POM) with senior DoD and congressional officials (i.e., congressional oversight subcommittees, Office of Management and Budget). HA and TMA have also worked with Service Medical Departments to plan, program, budget, and execute their Defense Health Program portfolios in support of the military mission.

I defer to the Assistant Secretary of Defense for Health Affairs regarding any plans to reorganize Health Affairs or the TRICARE Management Activity. We recommend that any new HA organization continue to be structured and staffed much as it is today. TMA should reduce the breadth of their portfolio, reduce contract support to minimize costs and focus their efforts on controlling PSC cost. Moreover, as outlined in the Task Force on the Future of Military Health Care Final Report (December 2007), the MHS should develop an integrated strategy between the DCS and PSC which will "permit the maintenance and enhancement of the DCS's support of the military mission while allowing for the optimization of the delivery of health care to all DoD beneficiaries." Ultimately, savings generated by streamlining the size of TMA, reducing the PSC wedge, and implementing an integrated DCS/PSC strategy could be recapitalized into the DCS for the benefit of our beneficiaries and American taxpayers, or could be returned to the DoD for allocation to DoD priorities.

Finally, I will address plans for the "Joint Medical Command Headquarters." First, I would note the use of the term "Joint Medical Command Headquarters" can be misunderstood. The 2005 Base Realignment and Closure Law Recommendation 198 requires the "**collocation** of the Navy Bureau of Medicine, Office of the Surgeon General of the Air Force, the Air Force Medical Operating Activity, the Air Force Medical Support Activity, Office of the Secretary of Defense (Health Affairs), TRICARE Management Activity, Office of the Army Surgeon General and US Army Medical Command to a single, contiguous site that meets the current Department

of Defense Anti-Terrorism/Force Protection standards for new construction at either the National Naval Medical Center, Bethesda, Maryland, Bolling Air Force Base, D.C., or federally owned or leased space in the National Capital Region and consolidate common support activity."

In compliance with the 2005 Base Realignment and Closure law, the Air Force plans to relocate 541 personnel to the new co-located DoD medical headquarters. A two-star-level Implementation Team and an action officer-level Transition Team to develop collocation and shared services plans for the DoD medical headquarters functions should maximize operational effectiveness between the Service Medical Departments, HA, and TMA.. The Implementation Team initiated this effort by targeting several opportunities to create synergies and leverage economies of scale within the following functions: clinical operations, financial management, administrative support, maintenance, information technology, and consolidation of administrative support contracts where possible to harvest additional savings. We believe and are hopeful this collaborative partnership will create new synergies which will strengthen the MHS for the future.

In conclusion, there is clearly much work to be done as an enterprise on identifying the right organizational solution. The Air Force Medical Service remains committed to working with HA, TMA and our sister Services to ensure the MHS is organized in the most effective manner to provide quality health care to military families, while being good stewards of American taxpayer dollars. I thank you for your continued support.