Senate Armed Services Committee
Advance Policy Questions for Mr. Keith Bass
Nominee to be Assistant Secretary of Defense for Health Affairs

Duties and Qualifications

What is your understanding of the duties and functions of the Assistant Secretary of Defense for Health Affairs (ASD(HA))?

The ASD(HA) is the advisor to the Secretary of Defense and Under Secretary of Defense for Personnel and Readiness for health policy and medical resources as well as leader of the Military Health System (MHS). The ASD(HA) has authority, direction, and control over the Defense Health Agency (DHA) and Uniformed Services University of the Health Sciences (USUHS) and, working with the Military Departments and Joint Staff, oversees all DoD medical capabilities, medical personnel, and medical readiness.

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

If confirmed, I expect the Secretary of Defense to charge me with stabilizing and modernizing the MHS. I will support rebuilding our warfighter ethos by increasing medical force generation and sustainment through improved military and civilian staffing at military medical treatment facilities (MTFs) and more integrated relationships with federal and private sector partners.

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

I spent two decades in uniform, both as an enlisted sailor and officer in the Navy, aboard ships, supporting humanitarian missions, in MTFs, at the White House, intelligence headquarters, and the Navy Bureau of Medicine and Surgery. After retiring from Active Duty, I served in executive leadership roles in the private sector before returning as a civilian hospital leader at the Department of Veterans Affairs. These experiences gave me a deep understanding at all levels of the MHS and military medicine.

Major Challenges and Priorities

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

With the increasing cost of health care, the most significant challenge is improving medical readiness in a resource constrained environment. As briefed recently in open testimony, DoD needs to quickly stabilize the MHS to rebuilding medical capabilities and improve readiness.

If confirmed, how would you address each of those challenges? Please be specific in your responses.

I support continuing to stabilize and optimize the MHS by more appropriately staffing the MTFs

and strengthening our partnerships with other federal health care systems and leading private sector health care organizations. I also believe that we need to improve our medical logistics to better supply equipment, supplies, and pharmaceuticals to our MTFs and operational medical missions.

If confirmed, what would be your top priorities for the military health system (MHS)?

My top priorities for the MHS would be improving medical readiness, stabilizing the MHS, and focusing on mental health and suicide prevention. The MHS underwent tremendous transformation over the past decade. It is now time to use these modernizations to refocus efforts on generating, sustaining, and maintaining medical readiness at MTFs, operational units, and partnerships. I understand that there are significant fiscal constraints in and long-term underfunding of the MHS and my priority will be to ensure we are maximizing the return on investment of current resources.

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?

The relationship to the Members of the Senate Armed Services Committee, and Congress broadly, is one of the most important relationships for the ASD(HA). The House and Senate represent the will of the people, and moreover represent the constituency of millions of TRICARE beneficiaries. In my view, it is vital that the ASD(HA) has a strong, open, transparent, and trusting relationship with the Senate Armed Services Committee and the whole of Congress. If confirmed, I will do everything in my power to ensure this relationship is strengthened, robust, and enduring.

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

If confirmed, I will ensure that the relationship between Congress and the OASD(HA) builds on trust and transparency. I pledge that Congress will have open lines of communication to the OASD(HA), that we provide regular updates, and respond to inquiries or requests for information. If confirmed, I will also continue to participate in regular updates to the House and Senate Armed Services Committee, as I understand is the current practice of the OASD(HA) and the Director of the Defense Health Agency.

National Defense Strategy

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

It is my understanding from earlier testimony that Defense Department has not fully utilized the potential of industrial and innovation bases to deliver necessary military capabilities efficiently

and at the required pace of the National Defense Strategy. If confirmed, I will improve how we resource and staff medical capabilities, including more agile and modernized contracting practices, medical industrial base policy, and holistic assessments of military and civilian medical personnel resources in the MHS.

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

If confirmed, first and foremost I will look at the footprint, policies, and resources of the MHS to ensure it best aligns to the National Defense Strategy. I will overlay the DoD's medical go-to-war, combat casualty, and readiness requirements with opportunities for collectively sharing resources with other federal partners and working with the civilian sector where appropriate. I will then look at all the revenue streams into the MHS to make sure we are most efficiently maximizing the use of all the resourcing opportunities.

Joint Medical Estimate and Combat Casualty Care

The most recent Joint Medical Estimate, required by section 732 of the National Defense Authorization Act of 2019, identified significant concerns related to the Military Health System's ability to provide required care to injured personnel in certain combat scenarios and the Department's contested medical logistics capabilities.

If confirmed, how would you evaluate and mitigate the risks identified in the Joint Medical Estimate within the MHS?

As I understand it, the Defense Department recently implemented new policy to take an enterprise-wide perspective to address, analyze, and mitigate risks identified by the Joint Medical Estimate. This would be a significant evolution for the MHS. I believe continuing to implement these new policies will increase the effectiveness and efficiency of planning, programming, and budgeting for the Unified Medical Budget and Defense Health Program. If confirmed, I will use these policies to drive strategic change to improve the allocation of taxpayer resources to rebuilding military medical capabilities to support our warfighters, including the world's most advanced aeromedical evacuation and medical logistics.

In the September 16th, 2020 issue of *JAMA Surgery,* Dr. Jeremy Cannon, a retired Air Force trauma surgeon, and current faculty member at the University of Pennsylvania School of Medicine, warned of the "peacetime effect" that happens when the military medical establishment returns home at the conclusion of a major conflict. He wrote, "Once fighting ends, wartime surgeons and medical specialists disperse, casualty care systems dismantle, military-specific publications in the medical literature significantly decline, and the focus on injury-related education and training wanes. During these times, Military Health System (MHS) leaders prioritize the mission of wellness among active duty members and other beneficiaries over combat-relevant training. Then, when the military mobilizes for the next war, the MHS is ill-equipped for combat and its members are unprepared to manage casualties." We see this occurring now at the Walter Reed National Military Medical Center, the Department's premier military hospital.

Do you believe the MHS is adequately focused on combat-related medical capability?

We know that the peacetime effect is very pronounced across the MHS. As described above, I believe the MHS needs to rebuild medical readiness and combat-related medical capabilities. The MHS really needs to refocus its strategy and modernizations to improve support to the Combatant Commands and our warfighters downrange.

If confirmed, how will you ensure the MHS is properly prepared to avoid the consequences of the "peacetime effect" in the next major conflict?

Section 735 of the Servicemember Quality of Life Improvement and National Defense Authorization Act for Fiscal Year 2025 established the Indo-Pacific Medical Readiness Program. In recognition of the importance of medical readiness in this Combatant Command area of responsibility, as well as the vast geographical distances involved, this section provides for accreditation of foreign medical facilities and procedures to facilitate access to such facilities by U.S. personnel. This new initiative also reflects the need for effective partnering with allies to improve medical readiness.

If I am confirmed, I would need to understand why we are unable to fully generate and sustain our medical forces. From recent testimony and reports, I know that DoD's largest medical platforms do not have the staff, supplies, and resources to reattract complex care. Without these complex patients, our providers and health care teams will naturally lose their skillsets. We have an opportunity as a Nation to train our medical personnel with our Allies and partners while simultaneously sustaining and maintaining clinical skills by partnering with medical facilities in these host countries. Doing so gives our medical forces training nearer to the fight, an understanding of the challenges they may face, and helps our Allies and partners advance their own capabilities.

Will you commit to working with the Joint Staff, the Combatant Commands, and other DoD components to implement effective collaboration and partnering with medical systems of allies to improve medical readiness?

Yes, I commit to working closely and better integrating health policy and medical capabilities with the Joint Staff, Combatant Commands, Military Departments, DHA, and USUHS to improve collaboration across the DoD, the federal government, and our Allies and partners, especially those across the Indo-Pacific's vast geography. We need to make sure that military medical personnel understand and can work inoperably with these Allies and partners, and we must also ensure that our Allies and partners can work with us without degrading the high-quality clinical care we provide to American men and women in uniform.

Managing the Cost of Health Care

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

From my time in uniform and as a civilian health care leader, I believe the greatest threat to the MHS is fiscal instability. Rising health care costs are directly impacting the Department. The MHS must manage growth in health care costs while ensuring medical readiness and the care of our service members, retirees and family members are not compromised. Like other large health systems in the United States, the MHS is confronting significant medical inflation and labor shortages. Unlike other health systems though, the MHS is also confronting the rise of China as a near-peer threat to our military. Getting the funding and resourcing right is the biggest challenge and most important step to rebuilding readiness in the MHS.

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

Rising health care costs are a national problem. The Department will continue to provide a robust health benefit to attract and retain military personnel as well as for those who dedicate their lives and careers to the military. As these costs rise above the average growth rate of the Department's topline budget, there is the real risk that rising health care costs will compete with resources needed to invest in other warfighting platforms and Department-wide organizational reforms. To alleviate these burdens, DoD must continue to transform and modernize the MHS to improve effectiveness while realizing efficiencies by reducing less productive and unnecessary redundancy.

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

If confirmed, I will lead the ongoing modernization of the MHS with renewed focus on effectiveness, infrastructure, and staffing. I will advocate for the appropriate budget while searching for efficiencies to ensure we are good stewards of the taxpayer's funding. There is a delicate balance between maintaining a focus on professional development, quality of care goals, and the primary focus of combat casualty care.

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?

We need a MHS that delivers on its unique value to the Nation: a health care system that sustains fighting forces, deploys into combat and contested environments, receives combat casualties, and provides day-to-day health care for 9.5 million beneficiaries. If confirmed, I will accelerate efforts to become a value-based care system by ensuring accurate requirements and resourcing strategies based on readiness and health outcomes for both direct care and private sector care.

Space Available Care

Federal law generally limits the authority of the Secretary of Defense to provide access to military treatment facilities (MTF) to military personnel and covered TRICARE beneficiaries. In certain circumstances MTFs may provide care on a "space available" basis

when such care would not interfere with access to care for covered beneficiaries.

What is your view of the availability of space available care for non-covered personnel (e.g. civilian employees, contractors, their families)?

The MHS exists first and foremost to provide, support, and promote military readiness. ASD(HA) has a role in providing medical capacity for the Total Force, including civilian employees and contractors who work at military installations in rural, remote, and austere locations. However, the MHS continues to remain focused on our Service members, their families and dependents, and retirees, while increasing volume to the maximum extent possible to maintain the appropriate skills for our providers and staff. As always, the MTFs will remain available to provide emergency care on military installations.

Do you believe the Department of Defense should expand the availability of space available care for non-covered beneficiaries?

With on-going medical personnel labor shortages across the United States, I am hesitant to recommend expanding availability of space available care without looking into this further. I believe the Department could increase space available care to non-covered beneficiaries where it makes sense from a readiness perspective. Brooke Army Medical Center in my home state of Texas is a good example of a partnership with the local community to provide trauma services for non-covered beneficiaries to generate, sustain, and maintain ready medical forces.

How should the DHA account, and in what circumstances should it waive payment, for the provision of space available care to non-covered beneficiaries?

I believe that waiving payment for space available care to non-beneficiaries should be limited to those whose health care directly contributes to medical readiness or those who are truly uninsured and unable to pay. This perspective supports the intent of the James M. Inhofe National Defense Authorization Act for Fiscal Year 2023, Section 716, "Improvements to processes to reduce financial harm caused to civilians for care provided at military medical treatment facilities."

Medical Provider Productivity

If confirmed, what would you do to improve provider productivity in the MHS?

If confirmed, I will ensure manpower models are realistic and standardized, especially with respect to provider-to-support staff ratios by specialty area. I will ensure we have the proper support staffing to help facilitate care, reduce administrative burdens to focus on patient care, and reduce burn out. These manpower models must also support determinations of the optimal military and civilian medical force mix required to support deployments while also maintaining continuity of operations within our MTFs.

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

Provider productivity is very complex. I believe the biggest issues with access to care for DoD

beneficiaries are staffing shortages, administrative processes, and cumbersome technology. Without whole teams and state-of-the-art support, we cannot expect our providers and clinical staff to be optimally effective and efficient. We must ensure we have proper support staff.

In your view, is provider productivity impacted by the Department's 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?

From my own time in uniform and experience as a health care leader, administrative and ancillary support is critical to provider productivity. There are far too many examples of physicians triaging their own patients or even surgeons wheeling patients into surgery. We need to allocate the workforce to improve the efficiency of health care across the MHS, which starts by establishing accurate, realistic requirements and resourcing the right personnel to best fill those requirements.

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?

Medical procedure volume and complexity is critical to ensuring the readiness of military medical providers and health care teams. Studies show that providers who have higher medical procedure volume and complexity achieve better patient outcomes. We want providers to practice the full scope of their credentials and privileges to maintain their clinical skills. If confirmed, I will ensure the Department continues efforts to increase the volume and complexity of care provided in its military medical treatment facilities to support case mix in critical wartime specialties.

In your view, do all current MTFs serve as operational medical readiness training platforms? Please explain.

Yes, in my view as a hospital leader and a retired Naval officer, I believe MTFs support the mission as training platforms. It is my understanding that the Department continues to focus on medicine and surgical specialty capabilities at its largest MTFs to ensure sufficient volume and case mix are available to support providers and health care teams with critical wartime clinical currency. If confirmed, I will continue the Department's efforts to optimize primary and specialty care at MTFs worldwide to better meet readiness requirements.

Medical Quality Assurance for Operational Clinical Care

In December 2024, the Government Accountability Office issued a report entitled "Military Health Care: Departments Should Update Policies for Providers in Operational Settings Like Field Hospitals and Aircraft Carriers." This report highlighted the failure of the Military Services to implement requirements of DoD Instruction 6025.13, "Medical Quality Assurance and Clinical Quality Management in the Military Health System," issued in July 2023. The Defense Health Agency and the Services promised corrective actions.

If confirmed, what actions will you take to ensure that clinical quality assurance

requirements are implemented in operational clinics?

The MHS went through an enormous transformation and there are likely many policies that require updating to conform with the new way of managing and administering military medicine across the DoD. Assuring quality in the deployed environment is a critical task and, if confirmed, I will work towards standardizing clinical quality management across the whole Department no matter where the care is delivered.

Civilian Healthcare Providers

The recently enacted National Defense Authorization Act for Fiscal Year 2025 included a provision that extended until 2030, the Secretary of Defense's ability to utilize exceptional hiring and compensation authority available to the Department of Veterans Affairs under title 38 of U.S. Code. This authority has been available to the Department of Defense for more than two decades, yet this authority has never been implemented despite staffing shortages across the MHS.

If confirmed, how will you utilize so-called "title 38" authority to more effectively recruit and hire civilian health care personnel to staff MTFs?

I understand the DoD is already applying many of these title 38 authorities to establish special salary rates in specific geographies as well as pay setting for physicians, dentists, and podiatrists. I also know from personal experience at the VA that title 38 is expensive and that there is more to recruiting and retention than pay scales alone. If confirmed, I will continue implementing title 38 authorities where it makes the most strategic sense to reduce the difference in salaries between the DoD, other federal agencies, and the private sector.

Based on your experience with the Department of Veterans Affairs, is there anything else the Department of Defense should be doing to better recruit and retain civilian health care personnel?

Based on my experience, I think DoD needs to offer competitive compensation and incentive packages, streamline the hiring process, provide enhanced training opportunities for our providers, and we must continue to evaluate their work-life balance.

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, how will you enhance DHA's operations to ensure the medical readiness of military forces and the readiness of the military medical force?

If confirmed, I will work with key stakeholders to assess and evaluate staffing methodologies and

operations to ensure we optimize medical readiness.

In December 2023, the Department of Defense required the Defense Health Agency to reattract "at least 7 percent of available care from the private sector back to MTFs" by December 31, 2026 as the "effective way" to "take care of our people, support the National Defense Strategy, increase clinical readiness, mitigate risk to requirements, and reduce long-term cost growth in private sector care"

What is your opinion of the directive to reattract significant numbers of TRICARE beneficiaries to the direct care system?

I agree with this wholeheartedly. It is crucial to have the necessary volume and complex patients required to maintain skills for a medically ready force. If confirmed, I will evaluate staffing levels and the capacity across our MTFs. I think it is a worthwhile effort to reattract TRICARE beneficiaries to the MTFs. If confirmed, I will ensure that DoD policies support process improvements to MTF manpower requirements as well as making access to care at MTFs easier and more patient centered.

In your judgement, how should the MHS determine what services are offered at MTFs rather than in the private sector care network?

The MHS is becoming a requirements-driven organization, much like other warfighting and combat supporting capabilities and organizations in the DoD. Those requirements for combat support are sometimes incongruent with health care delivery on a day-to-day basis. MTFs should offer services where there is an overlap with combat support and readiness as well as the full spectrum of care at MTFs on installations in austere or remote locations. The MHS can also take advantage of its scale by better deploying virtual health tools to provide care at a distance and across time zones.

The same December 2023 directive required the Secretaries of the Military Departments to "primarily prioritize assignment of uniformed medical and dental personnel to MTFs, with the Director of the DHA exercising "operational control over such personnel for the primary duties for which they are assigned."

Do you support prioritizing MTFs for the assignment of military medical personnel?

I support prioritizing the assignment of military medical personnel where it makes sense from a readiness perspective to improve generating and sustaining ready medical forces and maintaining a medically ready force. If confirmed, I will work with medical manpower subject matter experts in the Office of the Secretary of Defense, the Military Departments, and DHA to fully assess the policies regarding the assignment of military medical personnel.

If confirmed, how would you attempt to balance the staffing needs of the MTFs under the DHA and operational medical needs under the military departments?

If confirmed, I would take a collaborative approach with DHA, the Services, the Joint Staff Surgeon and Combatant Commands to ensure staffing needs are properly aligned to support the

National Defense Strategy.

Military Medical Treatment Facility Restructuring

According to the Defense Health Agency, "There are not enough Active Duty medical personnel, civilian employees, or contractor personnel…to meet mission requirements effectively and efficiently for wartime and peacetime operations, contingency planning, and preparedness." This medical manpower shortage combined with a constrained Defense Health Program budget is forcing DOD to identify potential actions to realign medical manpower to MTFs with more clinical demand, and reduce the scope of services at MTFs on installations where there is sufficient private sector capacity to meet the health care needs of the beneficiary population.

Section 1073d of title 10, United States Code, requires the Secretary of Defense to notify the Committees on Armed Services of the Senate and the House of Representatives at least 180-days prior to any modification of the scope of medical care provided at any MTF.

If confirmed, do you commit to keeping the Armed Services Committees informed of any changes to medical care offered at particular MTFs as required by law?

If confirmed, I commit to keeping the Armed Services Committees informed of any changes to medical care offered at MTFs as required by law.

In your view, when considering whether to modify the scope of services at an MTF, what factors should be of primary importance?

In my view, there are three critical factors to consider when modifying the scope of services at an MTF: opportunities to generate ready medical forces, operational requirements, and local availability and capacity of private sector care.

In your judgement, how can the MHS meet its stated goal to reattract beneficiaries to the direct care system if the DHA is also likely to recommend downsizing or eliminating medical services available at MTFs?

While I am not aware of specific actions to downsize or reduce medical services, there is a delicate balance between reattracting care and optimizing available services at MTFs. Yes, we need to reattract care. We must maintain the strength of the referral network, staffing to adequately care for patients, and assess and analyze the details to make an informed decision. There are many factors that must be considered when evaluating medical services for downsizing or elimination. The decision is not made lightly. I understand there are significant medical personnel shortages across the MHS. The MHS cannot sustain these shortages and gaps in the long run and will need to make decisions about where best to place limited resources. I do support reattracting beneficiaries where it makes sense, especially in markets with severe access to care issues in the private sector and when such care generates medical readiness

In your view, how could the MHS better match military provider assignments to

requirements that may change quickly in a given medical market?

From what I understand, DoD has a new policy to evaluate human capital distribution across the MHS every year aligned to the planning and programming cycle. From my own experience in uniform, this is a welcome policy change. DoD can now evaluate local market conditions and historic workload trends enterprise-wide to inform its requirements and resourcing of a particular billet. I also understand that the same policy gives more TDY/TAD authority to local leaders to mitigate unexpected staffing gaps.

TRICARE Contract Administration

The Department's new TRICARE managed care support contract, known as "T-5," began health care delivery on January 1, 2025. This contract should improve the accuracy of provider networks, expand patient access to telehealth services, improve the beneficiary appointment process, and provide more overall access to care. Including all eight option years, these contracts are valued at $136 billion.

In your view, is the Defense Health Agency adequately resourced to effectively supervise and oversee contracts of this complexity and value?

If confirmed, I would evaluate the DHA headquarters broadly to determine its resourcing needs. Right now, I do not have enough information to judge whether DHA has the right personnel to supervise and oversee contracts as large and complex as the next-generation T-5 TRICARE contracts.

If confirmed, what metrics will you prioritize to ensure the contractors are delivering the promised T-5 improvements?

As a retired Navy officer, improvements to T-5 are near and dear to me and my family. The improvements promised also directly impact recruiting and retaining our Active Duty Service members. If confirmed, I will prioritize monitoring access to care, including timely referral management and network adequacy, to deliver on promised T-5 improvements.

Section 705 of the National Defense Authorization Act for Fiscal Year 2017 requires the Department of Defense to implement a "TRICARE Competitive Plans Demonstration Project" in order to create an opportunity for competition for the larger managed care support contracts and to assess a variety of other value-based incentive for the provision of heath care services to covered beneficiaries.

What do you believe is the potential value to the MHS of the TRICARE Competitive Plans Demonstration Project?

I believe in the power of free markets and theory of competition to drive improvement and innovation in the United States. Done right, the TRICARE Competitive Plans Demonstration Project would provide more opportunities for innovation in private sector care delivered to DoD beneficiaries.

If confirmed, how would you ensure the DHA is adequately awarding contracts and supporting the implementation of the TRICARE Competitive Plans Demonstration Project?

If confirmed, I would look first at any potential shortcomings in the awards to make sure that the requirements are in the best interest of DoD beneficiaries and the Department. Once those shortcomings or gaps are addressed, I would continue implementing the project and track these lessons learned to inform the next generation of TRICARE contracts.

What factors would you consider to determine whether the TRICARE Competitive Plans Demonstration Project should be expanded beyond the two locations currently planned?

Based on my experience, I would consider beneficiary populations, patient experience, access to care, and costs to the government when considering expanding the TRICARE Competitive Plans Demonstration Project.

TRICARE Dental Program (TDP)

Section 701 of the National Defense Authorization Act for Fiscal Year 2023 required the Defense Health Agency to make numerous improvements to the TRICARE Dental Program, including increasing the number of plan options, establishing a third-party administrator contract for managing plan administrative features, new enrollment options, and a reduction in cost-sharing requirements for junior enlisted personnel. The 2023 provision required the DHA to implement these improvements no later than January 1, 2026. That deadline has been extended by one year in the recently enacted National Defense Authorization Act for Fiscal Year 2025.

If confirmed, how will you ensure that the DHA delivers, without any further delay, the modern, innovative TRICARE Dental Program required by law?

If confirmed, I will closely monitor the DHA's implementation of these improvements to the TRICARE Dental Program. Dental expenses can quickly mount, and the ASD(HA) must ensure that readiness of our Service members to deploy is not hampered by medical or dental expenses.

MHS Genesis

The Department of Defense recently completed its deliberate phased deployment of MHS Genesis, the new electronic health record system (EHR). This careful deployment involved operational testing that identified and facilitated the correction of implementation challenges, facilitating subsequent successful deployments to different health care settings, where other challenges are identified and addressed.

What is your assessment of MHS Genesis?

I understand MHS GENESIS is deployed to 100% of garrison locations across DoD both in uniform as well as a civilian outside the DoD. From what I understand, each successive implementation of MHS GENESIS went better, faster, and more efficiently than the last. While there is always room for improvement, I do believe that MHS GENESIS today in the DoD is on a better glidepath than in years past.

In your view, how can the Department offer its testing and evaluation capabilities to the VA as it continues to struggle to implement its version of the EHR that is based on the same platform as DOD's EHR?

DoD learned a lot from its successive deployments of the EHR. If confirmed, I would ensure that the lessons learned from the DoD's implementation are cataloged, shared, and transmitted to the VA to help propel its implementation forward. The VA's adoption of the federal EHR will improve the transition from Active Duty to Veteran status and more effectively integrate health service delivery across the government.

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?

If I am confirmed, one of my key responsibilities will be overseeing the Defense Health Program (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 portfolio and align investments to the highest operational medical priorities. In addition, to address requirements and to avoid duplicative efforts, if confirmed I will coordinate DHP RDT&E funded activities with the Combatant Commands, Military Departments, Defense Agencies, and other DoD Components using formal governance structures.

How will you ensure that the research portfolio represents research areas based upon current military requirements?

DoD needs a diverse and well-balanced research portfolio to support military readiness and mission requirements. The DHP invests in a diverse research portfolio, including combat casualty care, traumatic brain injury, mental health, and other relevant areas that will support current and future military requirements. If confirmed, I will ensure the Department continues to conduct annual reviews and analyses and hold regular governance forums that include the Military Departments, Defense Agencies, and other DoD Components. These efforts leverage formal processes to develop joint requirements and would help the Department align its medical research portfolio with military and mission requirements.

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

I understand that the Department works hard to ensure that DHP-funded research efforts are coordinated with other DoD research activities and linked with efforts of other federal agencies. The Department has several formal partnerships with other agencies, such as those with the VA, National Institutes of Health, and the Food and Drug Administration. If confirmed, I will ensure we work within the Department and through our external partnerships to ensure 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.

Existing law requires medical research activities of the military services to transition to the DHA. Some of the services retain some readiness related research capabilities.

If confirmed, how will you ensure a smooth transition with ongoing research? How will you manage research priorities?

If confirmed, I will ensure that research is prioritized based on warfighting needs in close collaboration with the Joint Staff and Military Departments. From what I understand, the research and development capabilities that were Joint or possibly duplicative transferred to the DHA to create an economy of scale. Transitioning these activities was done by function, which means that we would not stop on-going research simply because those leading the work move – everything about the project transfers. I also believe that consolidating these functions creates opportunities for more efficient research aligned to Joint warfighting requirements.

The Department of Defense has established a cross-functional team tasked with care, collection, and research related to Anomalous Health Incidents (AHI) in servicemembers stationed abroad.

If confirmed, what will your role be to ensure the continuation of the work of this cross-functional team at DOD?

If confirmed, I would ensure that DoD continues researching Anomalous Health Incidents (AHI). I understand that DoD has improved clinical intake processes for AHI patients. Like other important medical research and development in the DoD for new and novel issues, we rely on cross-functional expertise and have a long history of working collaboratively across Components.

Pursuant to a Secretary of Defense memorandum dated August 8, 2024, entitled "Department of Defense Requirements for Managing Brain Health Risks from Blast Overpressure," the Department of Defense is taking steps to mitigate blast exposure during combat and training.

If confirmed, how would you work with the Services to assess and address the health effects of new weapons systems as they are developed?

I understand the DoD has made tremendous strides in advancing information and knowledge of blast overpressure. If confirmed, I will continue working with the Military Departments to ensure we are assessing risks for blast overpressure from new weapons systems while simultaneously mitigating and treating Service members who are exposed to blast overpressure from today's

weapons systems.

Medical Devices and Technology Acquisition

The Department of Defense uses 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?

If confirmed, I will evaluate whether existing authorities are sufficient to meet our long-term needs and facilitate collaboration with commercial innovators in medical devices and technologies. I intend to engage the DHA's Chief Information Officer and the Component Acquisition Executive on any needed reforms that can speed acquisition and implementation of secure commercial solutions for existing or emerging MHS requirements. I will also seek out new opportunities to leverage new or unique authorities, like those of the Defense Innovation Unit, to acquire innovative commercial products, and technologies while still meeting the cyber security standards and intent of free market competition.

Quality and Safety of Medical Care

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

If confirmed, one of my priorities would be ensuring sufficient military staffing at MTFs that generate readiness with high volume, clinical complex surgical cases. Doing so also involves resourcing infrastructure and closing gaps in deferred maintenance to make sure that medical personnel have robust, modern places to deliver care to DoD beneficiaries.

Mental Health Care

Section 718 of the National Defense Authorization Act for Fiscal Year 2020 required DoD to "develop and implement a comprehensive policy for provision of mental health care to members of the armed forces." This was to be done within 180 days of the date of enactment, but has not yet been completed. In the meantime, we have seen high-visibility events suggesting shortcomings in mental health care for members. Further, a December 2024 Defense Health Agency report found that in 2023 mental health disorders were involved in over half (54.8%) of all hospital bed days among active component service members, reinforcing the need for a comprehensive policy on mental health care.

If confirmed, what actions would you take to improve access to mental health care by service members and their families?

I take mental health care for our Service members and their families very seriously. I also am keenly aware of the access to care challenges and shortages across the United States. If confirmed, I would explore expanding telehealth services across the MHS and prioritizing Service members and their families in rural, remote, or austere locations around the world. There may also be some "home grown" local innovations or process improvements at MTFs that could be expanded across the MHS to increase access to mental health care.

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

In my view, no, the DoD's current mental health resources are inadequate to meet the needs of Active Duty Service members, eligible members of the Reserve Component, and other DoD beneficiaries. I think we can also do more and find new innovations. Solving for the lack of providers and support personnel for mental health will take collaboration with industry, academy, and governments across the United States.

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 at home station locations with insufficient community-based mental health resources?

If confirmed, I would explore increasing telehealth for mental health care on the battlefield as well as those at home station. I also understand that recent legislation expanded access to telehealth services for mental health care across state lines, making it easier and more convenient for TRICARE beneficiaries living in locations without mental health resources to get care. In addition, I would explore utilizing AI technology to aid in bridging the gap for stateside, OCONUS, or deployed Service members.

If confirmed, how will you ensure the issuance of a comprehensive policy on mental health care for members of the armed forces without further delay?

If confirmed, I would use the oversight authorities of the ASD(HA) to ensure that a comprehensive policy for mental health care access is implemented quickly and efficiently. I would also investigate any anecdotes about access to mental health care issues to ensure that local leaders are following prescribed DoD policy.

Section 714 of the Servicemember Quality of Life Improvement and National Defense Authorization Act for Fiscal Year 2025 authorizes DoD to extend medical license portability to TRICARE network providers providing mental health services to members of the armed forces and TRICARE-eligible dependents. This would allow TRICARE network mental health providers to practice across State lines, subject to terms and conditions to be established by DoD. This could help increase the availability of mental health services for military members and families. This section also requires DoD to issue an Interim Final Rule within 180 days from the date of enactment to implement this new authority.

If confirmed, how would you expand tele-behavioral health services throughout the MHS to improve access to mental health care?

I understand that the DoD has begun expanding telehealth for mental health care. If confirmed, I would leverage the progress to ensure that more Service members, their families, and all other beneficiaries have access to these services because they are convenient and effective, especially for those stationed in rural, remote, or austere locations. I would also ensure that communications are clear for mental health care providers in the network now that DoD has been given authority to provide care across state lines, which is potentially a game changer for our Service members and their families.

Operational Medical Force Readiness

In your view, what is DHA's role as a Combat Support Agency?

As I understand, DHA's role as a Combat Support Agency (CSA) is to enable the Army, Navy, and Air Force to provide a medically ready force and ready medical forces to Combatant Commands in both peacetime and wartime. As a CSA, DHA also directly supports the Combatant Commands by providing joint logistics, joint planning capabilities, and decision-making information. The DHA uses the principles of Ready Reliable Care to advance high reliability practices across the MHS by improving system operations, optimizing the delivery of care, and cultivating a culture of safety. If confirmed, I will ensure DoD's activities are relevant and visible to Combatant Commanders and enhance DHA's integration in Combatant Command plans, exercises, and requirements, including for Role 4 definitive care capabilities.

What can DHA do to provide more medical expertise to the Joint Staff and to combatant commands so that medical concerns are addressed in OPLANs, exercises, and other operational readiness activities?

If confirmed, I would evaluate the relationship between the DHA, the Joint Staff, and Combatant Commands. As the youngest CSA, I am sure there is ample opportunity for improvement through learning and maturation. I think DHA has a lot to offer, especially with respect to data, analytics, and information needed for planning and exercising operational capabilities.

In your view, have the Services and the DHA adequately defined military medical force readiness and developed an appropriate model to determine and project the Department of Defense's costs for medical force readiness?

It is my understanding that the term medical readiness encapsulates both a medically ready force and a ready medical force. In my view, the Military Departments and the DHA are making progress in defining military medical force readiness. The Military Departments and DHA must work together to ensure the medical readiness of the force is maintained. To that end, it is also my understanding that the Department has refined and expanded critical knowledge, skills and ability (KSA) measures to more precisely assess medical readiness. I understand that efforts are currently underway not only to determine the costs of readiness, defined as the cost of sustaining a medically

ready force and ready medical force, but also to express the value of MTFs as readiness platforms.

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

If confirmed, I would review military medical personnel requirements holistically for both operational missions and institutional forces at MTFs. I will work with the Joint Staff Surgeon, the Military Departments, and the DHA to overlay Combatant Command requirements for military medical personnel with the military medical treatment facility staffing requirements to maintain a medically ready force and a ready medical force. This review would be anchored by KSAs as well as graduate medical education and other professional medical education pipelines. If there is insufficient volume and complexity of caseload at a particular MTF to meet and sustain the KSAs, the DHA should establish agreements with civilian or other federal facilities to provide alternate venues for skills sustainment. Furthermore, the DHA in its role as a Combat Support Agency is a part of the Joint Staff planning process and can inform updates to medical skill requirements to reflect current operational planning by the Combatant Commands.

If confirmed, what would you do to right-size the active medical force requirements of the Department to optimize operational medical force readiness capabilities?

I know from my own experience in uniform that the military medical force must be appropriately sized in order to quickly respond to global operational medical requirements. If confirmed, I will continue ongoing efforts to establish a DoD process to define the medical and dental personnel requirements across the MHS necessary to meet operational medical force needs in accordance with applicable law and policy. I will work with DoD stakeholders to ensure DoD has a robust medical force that can provide the medical capabilities across the full range of military operations 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?

If confirmed, I will continue the Department's efforts to establish an integrated health care delivery system, which includes identifying where it makes sense to defer or outsource beneficiaries' health care needs to the private sector. I will ensure the Department uses established, patient-centered and standard processes to refer care to the private sector in locations where MTFs do not have available specialties or cannot provide care within access standards.

Pain Management and Opioid Medications

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?

Meaningful responses to the national epidemic of opioid misuse and abuse should include policies

and programs that address the root causes of opioid use, overuse, and abuse. If confirmed, I will ensure that MHS pain management capabilities, practices, and policies result in appropriate opioid prescribing. More importantly, if confirmed, I will determine if there are sufficient non-opioid pain management treatments available and that they are applied to pain management care plans for our DoD beneficiaries.

In your view, should alternative and complimentary therapies for pain management be considered as benefits under the TRICARE program?

This is an extremely important question that is directly related to the national epidemic of opioid overuse, abuse and overdoses. There has been a rapid evolution of thought and medical evidence to support the utilization of many pain management treatments that were previously termed "alternative" medical therapies. Now referred to as complementary and integrative health, selected therapies such as acupuncture, mindfulness exercises, massage therapy, and movement therapies like yoga have been recognized as safe and effective for pain management by the National Institutes of Health, VA, and, from what I understand, now the DoD. If confirmed, I would support a deliberate and evidence-based practices to increase the availability of many of these pain management therapies for DoD beneficiaries.

Congressional Oversight

In order to exercise legislative and oversight responsibilities, it is important that this committee, its subcommittees, and other appropriate committees of Congress receive timely testimony, briefings, reports, records—including documents and electronic communications, and other information from the executive branch.

Do you agree, without qualification, if confirmed, and on request, to appear and testify before this committee, its subcommittees, and other appropriate committees of Congress? Please answer yes or no.

Yes.

Do you agree, without qualification, if confirmed, to provide this committee, its subcommittees, other appropriate committees of Congress, and their respective staffs such witnesses and briefers, briefings, reports, records—including documents and electronic communications, and other information, as may be requested of you, and to do so in a timely manner? Please answer yes or no.

Yes.

Do you agree, without qualification, if confirmed, to consult with this committee, its subcommittees, other appropriate committees of Congress, and their respective staffs, regarding your basis for any delay or denial in providing testimony, briefings, reports, records—including documents and electronic communications, and other information requested of you? Please answer yes or no.

Yes.

Do you agree, without qualification, if confirmed, to keep this committee, its subcommittees, other appropriate committees of Congress, and their respective staffs apprised of new information that materially impacts the accuracy of testimony, briefings, reports, records—including documents and electronic communications, and other information you or your organization previously provided? Please answer yes or no.

Yes.

Do you agree, without qualification, if confirmed, and on request, to provide this committee and its subcommittees with records and other information within their oversight jurisdiction, even absent a formal Committee request? Please answer yes or no.

Yes.

Do you agree, without qualification, if confirmed, to respond timely to letters to, and/or inquiries and other requests of you or your organization from individual Senators who are members of this committee? Please answer yes or no.

Yes.

Do you agree, without qualification, if confirmed, to ensure that you and other members of your organization protect from retaliation any military member, federal employee, or contractor employee who testifies before, or communicates with this committee, its subcommittees, and any other appropriate committee of Congress? Please answer yes or no.

Yes.