Written Statement

The Honorable Paul Friedrichs, Maj Gen (ret)., MD, FACS

Before the Senate Armed Services Committee
Hearing on *"Stabilizing the Military Health System to Prepare for Large-Scale Combat Operations"*
March 11, 2025

Chairman Wicker, Ranking Member Reed and distinguished members of the Committee, thank you for the opportunity to testify on this topic. My last Congressional engagement as the Joint Staff Surgeon in 2023 was with several of you to provide a detailed, classified update on the gaps between Combatant Command requirements for medical support and the readiness of the force elements which the Services organize, train and equip, with support from the Defense Health Agency (DHA), in its role as a Combat Support Agency. It is an honor to be back to share some additional observations on this very timely topic on which Congress needs to act, in order to address critical gaps in our readiness to care for ill and injured Servicemembers.

The opinions and advice I share in this statement and in my testimony are my own; I am not speaking on behalf of any organization with which I am or have been affiliated.

I need to acknowledge several conflicts of interest related to this hearing:

First, and foremost, this is my family's business…and I care deeply about it. I am the proud son of Seaman Third Class Al Friedrichs, who turned 98 this past January and who served in our Navy at the end of WWII. Multiple other relatives served in the Navy. One of the few really great decisions I have made in my life was to propose to my wife more than thirty years ago, when she was serving as a doctor in the Army. Our kids thought it was incredibly cool that their mom really did wear combat boots. After separating from the Army so that our family could stay together, she has worked for the Veterans Health Administration for decades, continuing her commitment to care for those who volunteer to serve their nation. And one of our children is now a Marine.

Second, I am deeply grateful to have had the opportunity to serve our nation in uniform for 37 years, including three tours as a Commander, as well as service as the Command Surgeon for Alaskan Command, Pacific Air Forces, Air Combat Command and United States Transportation Command, where I oversaw the global aeromedical evacuation system. My last assignment was for four years as the Joint Staff Surgeon, attempting to integrate and synchronize medical support to military operations and family members on every continent and in multiple conflicts and disasters. These experiences have taught me that the rest of the military deploys and fights as a Joint Force, not as individual Service forces. I believe to my core that the military health system is a part of the US military and should adopt the same commitment to joint, integrated capabilities and readiness that the rest of the military has embraced, and I commend Congress for the actions they have taken to try to break down stovepipes and enable greater standardization, interoperability, and integration.

Nearly 250 years ago, our nation was born out of the American Revolution. Historians estimate that between 25,000 and 75,000 members of the Continental Army died during this conflict, with three deaths from illness for every one death from injury. Roughly 1,400 medical personnel served in the

Continental Army, but only 10% had any formal medical training. Since then, we have been on a journey to continue improving the care we provide to America's sons and daughters who serve their nation in uniform and this has resulted in a steady and continuous decline in the percent of injured Service members who died of their wounds. Numerous innovations in both pre-deployment care and the care we provide to deployed personnel have enabled military medics to successfully treat and return to duty more and more ill Service members, enhancing combat capabilities. And for those who sustained injuries in Operational Iraqi Freedom/Operation Enduring Freedom, fewer died than in any conflict in history. This is an extraordinary testimony to the work of countless military doctors, nurses, pharmacists, Corpsmen and other military medics. And it was shaped by Congressional direction in the annual National Defense Authorization Acts (NDAA) and annual appropriations which translated that guidance into reality. Thank you for all that you and your predecessors have done to enable these remarkable results.

As proud as we should be of these unparalleled accomplishments, every organization committed to excellence knows the importance of asking "What could we have done better?" High performing healthcare systems know that "Good enough" is not acceptable, especially when it comes to the health of America's sons and daughters who choose to defend our nation. Some of our military medical colleagues reviewed the available data on every single Service member who died in recent conflicts and what they found is remarkable: even with nearly total air superiority, unfettered communications, aeromedical evacuation on demand, and largely unhindered supply chains, roughly 25% of those who died prior to 2012 had injuries which should have been survivable. This is an incredibly important – and painful - lesson: We could have done even better.

Unfortunately, we have made insufficient progress towards minimizing preventable battlefield injuries and death. In some cases, we have mistakenly confused loyalty to the patch on our uniforms over our commitment to our patients. We have confused efficiency with effectiveness. We have argued for years about roles and responsibilities and competing interpretations of Congressional intent. Thankfully, because the United States is not involved in large scale combat operations at this time, we have the opportunity, with help from the members of this Committee, to refocus efforts to ensure that, in the next conflict, military members will be medically ready before they deploy and military medics will be well-prepared to care for those Service members who become ill, or who are injured.

The first priority of the military health system must always be our commitment to provide the right care at the right place for every American who volunteers to serve. We must continue to demonstrate to Servicemembers and their families that the military health system will be ready to provide the care they need before they deploy, while in combat, and when they return, and that we will care for their families and for those who have retired from the military. To do so, structural, fiscal and policy changes are needed. After studying this for most of my career, I urge the members of this Committee to reject any recommendations to revert to stovepipes and siloes of care. There is no data to support the premise that any one Service delivered better care in garrison or down range and ample evidence from multiple conflicts that the best outcomes for patients occur when medics work together (like the rest of the military does when it deploys). I am dismayed that some colleagues continue to assert that some members of Congress appear to question the merits of integrating medical capabilities as directed in 2017; this perception has complicated efforts to focus as a Joint medical team on improving care to Servicemembers who rely on military medics to be ready when needed. I strongly oppose any recommendations for another large-scale reorganization of the military health system; these take years

to implement and will continue to distract my colleagues from the important job of improving care by requiring them to instead focus on building new bureaucracies. I believe the DOD has the capabilities it needs, although, as I will address below, not the resources, to truly achieve the vision of great care, anywhere for our those who go in harm's way in defense of our nation. Attachment One, National Defense Authorization Act Recommendations, summarizes recommended language for the Committee's consideration. (NOTE: For any recommendations which fall outside the purview of this Committee, I respectfully request that Committee staff share the recommendations with the appropriate Committee, and, if possible, convey the intent of this Committee related to the recommendation.)

1. **Roles and Responsibilities:** In 39 years of government service, and especially in military health system "governance" meetings, I have been dismayed at the amount of time and energy dedicated to this topic at the expense of discussing how to improve the effectiveness and efficiency of care. I remain deeply grateful for and supportive of the changes directed in the 2017 National Defense Authorization Act (NDAA). Congress wisely recognized that Servicemembers' anatomy and physiology do not vary based on the patch they wear and that we can deliver better care if we work as an integrated system, rather a system of competing systems. Other than a few niche environments (e.g., care in low gravity environments, undersea medicine, etc.), **the Senate should direct standardization of equipment and training for deployable medical force elements, as recommended by the Joint Trauma System (JTS) and also that medical force elements must be interoperable (i.e., a Role 2 medical force element from one Service can combine with a Role III 3 medical force element from another Service, when directed by the Combatant Commander in order to provide the right combination of capabilities to care for ill and injured Service members).** Almost every other modern military has already done so, and, as our Israeli and German and other colleagues have repeatedly shown, military medics deliver more effective care more efficiently if we standardize and integrate capabilities. **The only structural changes I recommend are:**
    a. **Dual-hat the Joint Staff Surgeon as the Defense Health Agency Deputy Director for Combat Support and align key operational support capabilities under this two-star leader, as described below and in Attachment 1.**

    b. **Require the Combatant Commands to implement the Combatant Command Trauma System staffing requirements to ensure readiness to collect, analyze and share data on ill and injured in their Area of Operations in order to continue to improve the care our nation's defenders receive.**

    c. **Require the Defense Health Agency (DHA) to reinstate Defense Health Agency Procedural Instruction 6040.06, *Combatant Command Trauma Systems.***

2. **Evolving Threats:** Care for ill and injured is challenging and there are clearly opportunities to improve that care. And the range of threats to which military medics must be prepared to respond is growing.

    a. Disease, Non-Battle Injury (DNBI): Military service is a challenging calling, and many medical conditions impact the ability of an individual to perform his or her duties. The military asks those seeking to enlist or to become officers to voluntarily identify pre-

existing medical conditions and, based on that information, determines whether the member is likely to be medically qualified to perform their assigned duties. The introduction of electronic health records has made it easier to validate the information provided by those seeking to serve in the military and, in some cases, has identified medical conditions which the applicant did not voluntarily report. Some have claimed that this additional visibility into pre-existing medical conditions is contributing to lower enlistment rates, although there has been limited data to support this assertion. These pre-existing, chronic medical conditions may degrade the member's readiness and frequently increase the military health system costs once the member is on active duty. Clarifying the impact of identifying pre-existing medical conditions on both recruiting and on military health system costs can help inform decisions about whether to continue to seek this information. Furthermore, roughly 80% of deployed service members who require medical care have medical conditions unrelated to traumatic injuries. The most common medical conditions which cause a Service member to no longer be "medically ready" include dental, musculoskeletal and mental health conditions. Across the Services, more than 7% of the force is not medically ready prior to deployment, immediately decreasing the effectiveness of combat units. To preserve the fighting force, military medics must be able to rapidly diagnose these conditions and safely and effectively treat them as close to the front lines as possible. **This committee should:**

i. **Require an annual report on actions taken to reduce the number of uniformed personnel who are not medically ready to no more than 5% of the force and the actions taken to improve the ability to care for deployed Servicemembers with DNBI as close to their deployed location as possible in order to sustain the operational capabilities of their unit.**

ii. **Require the Services to provide an annual report to Congress on the number and type of medical waivers granted to those enlisting in the military (e.g., accession waivers), the number of personnel who receive accession waivers and are later determined to be medically unfit for duty, including the number and type of accession waivers granted as a result of the use of the Military Health System Genesis application (i.e., the military's electronic health record) and any data on the impact of the use of GENESIS on accession rates.**

b. Antimicrobial Resistance (AMR): One of the risks for Service members with traumatic injuries is developing wound infections, especially in austere environments. Bacteria or fungi which are resistant to multiple antibiotics are growing domestically and globally and this has become an increasing challenge for military casualties in Europe, Asia and Africa. **This Committee should require an annual report on steps taken by the Miliary health system to detect and to mitigate AMR in military personnel and should review the proposed Pasteur Act language to enhance support to develop new antimicrobials to protect our Servicemembers.**

c. Emerging Weapons: Mankind has continued to seek new military capabilities which will afford an asymmetric advantage over competitors and potential adversaries. Recently

develop new technologies like hypersonic missiles and directed energy weapons do not appear to create revolutionary changes in risk, but, overtime, may cause new patterns of injury which military medical personnel must be prepared to treat. Waiting until new patterns of injury are seen to begin planning for appropriate care should be unacceptable. **This Committee should:**

i. **Direct the Intelligence Community to prepare an annual report on new and updated weapons which create risk to Service members;**

ii. **Direct DOD to ensure that the Joint Staff Surgeon and select members of the Joint Trauma System and Service Surgeons' staffs have sufficient clearances to receive these updates;**

iii. **Direct the Joint Staff Surgeon, in coordination with the Services, the Joint Trauma Analysis and Prevention of Injury in Combat program and the JTS, to provide Congress with a classified annual assessment of changes needed to training and other military medical capabilities to ensure military medical personnel are ready to care for casualties from these new or upgraded weapons systems, including actions taken by the Services to address findings from prior years' assessments**

d. Burden Shifting: In 2020, the National Academies of Science, Engineering and Medicine published an analysis which highlighted the lack of resilience and surge capacity in the US healthcare system. The recent pandemic unfortunately validated that lack of resilience and, as part of the mitigation efforts to protect the American public, as many as 70,000 military medics deployed to augment the US healthcare system through Defense Support to Civil Authorities (DSCA) taskings. The National Disaster Medical System, which was designed to integrate DOD, VA and civilian healthcare systems in case of a surge in military or civilian patients has been allowed to atrophy. The Regional Emerging Special Pathogen Treatment Centers, which are funded to care for patients exposed to, or infected with highly contagious infectious diseases (e.g., Ebola), have very limited bed capacity; and the ability to move these patients depended on capabilities in other agencies which apparently have been eliminated. In addition, only the DOD had the contracting authorities needed to enable Operation Warp Speed to achieve so much so quickly. And recent actions that reduce capabilities in other Federal Departments, including the ability to respond to disasters at home and abroad are typically mitigated by shifting those responsibilities to the Department of Defense. Because of this, the Military Health System is likely to see more taskings in the future to compensate for these reduced capabilities in other parts of the Federal government. **I recommend this Committee should:**

i. Require an annual assessment by the Departments of Defense, Health and Human Services and the Veterans Health Administration of the resilience of the US healthcare system and the readiness of the National Disaster Medical System to support DOD operational requirements during Large Scale Combat

Operations, including the readiness to transport, receive and care for military personnel, US government employees and US civilians who are exposed to or infected with highly contagious infectious diseases.

ii. **Require ASD(HA) to provide an annual summary of all healthcare support provided to other Departments and Agencies which was not funded in the DOD budget, as well as any reimbursements received for that support.**

iii. **Authorize ASPR to execute the same contracting authorities that DOD utilized during Operation Warp Speed.**

iv. **Sustain ASPR and CDC programs which help state and local health authorities continue to improve the readiness of their jurisdictions and make that support contingent on a commitment to participate in NDMS and, for those hospitals with the appropriate capabilities, RESPECT.**

e. Biological weapons and other threats: The confluence of artificial intelligence, increasing computational capacity and rapidly evolving biotechnological advances offers incredible potential for new treatments. And there will always be people who will seek to misuse these new technologies for nefarious purposes; these rapid advances significantly lower the bar for state and non-state actors to use good technologies in ways that increase the risk to the American public and to military members in future conflicts. The best deterrent to ensure these weapons are never used is to demonstrate that we will rapidly detect their use, attribute it appropriately, and hold those responsible accountable, while demonstrating the ability of our health system to rapidly mitigate the impact of acute biological threats. The foundational research creating these advances was largely based on research funded by the Federal government through the National Science Foundation, National Institutes of Health, and the Department of Defense. It is critical that the military health system, in collaboration with the Departments of Health and Human Services, Energy, Homeland Security and the Veterans Health Administration continue to invest in research to rapidly develop better tests, treatments and vaccines for new and emerging biological threats, as well as in enhanced domestic and global biosurveillance capabilities. As noted above, the Centers for Disease Control and Prevention and the Administration for Preparedness and Response should continue to help fund state and local preparedness efforts to increase resilience to future biological threats. The Department of State should reinstate funding for programs which enhance biopreparedness capabilities in other countries to improve our ability to detect if a bioweapon or other biological threat is occurring outside the US and to assist in mitigating the impact of those threats. The 2018 National Biodefense Strategy, which was updated in 2022, and the 2023 Biodefense Posture Review outline multiple actions needed to enhance our ability to deter nations and non-nation states from pursuing or considering employing bioweapons. The Bipartisan Commission on Biodefense in 2024 released its updated *National Blueprint for Biodefense.* The 2020 NDAA also wisely tasked the Defense Science Board to "carry out a study on the emerging biotechnologies

pertinent to national security," and that report should be released this year. Similarly, the report from the National Security Commission on Emerging Biotechnologies (NSCEB) is scheduled for release next month and both these new reports will provide valuable advice to DOD and to Congress to inform how we best leverage these technologies to enhance our national, economic and health security. Unfortunately, it appears that at least some of the progress made during the past 8 years is being undone by sweeping reductions in resourcing for scientific research, surveillance, medical countermeasures and Federal, state and local all hazards response programs. **This Committee should:**

i. **Direct DOD to provide Congress with a classified and unclassified update on implementation of the 2023 Biodefense Posture Review (BPR) within 6 months, including any remaining gaps in capabilities and mitigation plans to address those gaps.**

ii. **Direct DOD to publish an update BPR which addresses all recommendations relevant to DOD from the 2024 *National Blueprint for Biodefense* and the 2025 NSCEB and DSB reports by the end of Fiscal Year 2025.**

iii. **Direct the DOD to ensure that all DOD hospitals and operational labs, including those located overseas, provide the Centers for Disease Control and Prevention the same data that is submitted by other public health jurisdictions to enhance global and domestic biosurveillance.**

3. **Manpower Constraints:** Enhancing the readiness of the military health system to care for ill and injured Service members relies, in part, on having the right number and type of military medics. The Health Resources and Services Administration (HRSA), in November, 2024, updated the Health Workforce Projections for multiple career fields. For nursing, they estimate that the current shortages in nursing cannot be significantly mitigated until 2037, at the earliest and noted a "significant geographic maldistribution" of nurses. This appears to be largely in rural areas where many military bases are located. For physicians, the projections are even more dire, with 31 out of 35 physician specialties projected to have insufficient supply by 2037 and an aggregate shortfall of 187,130 physicians across the US. Efficiency advocates have asserted that the military health system can eliminate military medical positions and either hire civilian replacements or shift the care to the private sector. In reality, the military health system is able to sustain the current level of care because it trains many of its medical personnel internally. Given the Congressionally-directed restrictions on increasing civilian physician training programs, closing military training programs will exacerbate both military and civilian medical workforces shortages and further degrade readiness due to even greater shortages of uniformed medical personnel. Efficiency advocates have also attempted to eliminate or substantially reduce military medical billets for specialty codes which are not required in Operational or Contingency plans; this seemingly logical action ignores the reality that mission critical training programs for critical care nurses, trauma surgeons and other specialties needed in wartime cannot maintain their accreditation to continue training unless they are in a hospital with pediatric, obstetrical and other "non-mission critical" departments. And all these workforce challenges are reportedly being exacerbated by decreasing retention of key medical officer and enlisted specialists due a

perception that they cannot sustain their medical skills in the current system due to the low volume of ill or injured patients in most military hospitals. **I recommend that this committee should:**

a. **Ensure that any proposed reductions in military medical training pipelines are only implemented if Congress authorizes and appropriates funding for additional civilian training capacity to support military requirements.**

b. **Require the Services to provide updates to ASD(HA) and the Joint Staff Surgeon on recruiting and retention of officer and enlisted medical personnel by specialty code or equivalent designator and an analysis of reasons for separation by specialty code.**

c. **Direct the ASD(HA) and the Veterans Administration Undersecretary for Health to provide an assessment within one year of opportunities to increase physician, nurse and other medical training pipelines by integrating and expanding training programs.**

d. **Direct the ASD(HA) to develop a plan and cost estimate to increase the number of officer and enlisted students trained at the Uniformed Services University to address shortfalls in current training pipelines and to assist the Services in improving recruiting and retention of military medical personnel required to meet operational requirements.**

e. **Require the Services to account for authorizations required for military medical training as operational requirements, including those for specialties which are required to maintain accreditation of training programs for surgical, critical care, and other operational capabilities.**

4. **Logistical Constraints:** The military health system (MHS) prepares and sustains the warfighter, while the defense logistics enterprise (DLE) prepares and sustains the equipment and supplies used by the warfighter. The two are inextricably linked. Almost all resupply of medical units depends on non-medical logistical capabilities and capacity. Almost all deploying medical personnel travel on non-medical commercial or military logistical platforms. And almost all movement of ill and injured Service members who cannot return to the fight is conducted on non-medical logistical platforms. The Joint Staff Logistics Director (J4) routinely performs a "Logistic Feasibility Assessment" of Operational and Contingency Plans to determine if the proposed military operation can be logistically supported. No similar analysis has routinely been performed for medical support. In addition, as part of previous efficiency efforts, the military health system converted from a system which planned for combat to one which prioritized the efficiencies garnered from "just in time resupply." The United States has the highest number of medications in short supply ever recorded; an analysis in 2024 by the Office of Pandemic Preparedness and Response Policy found that these shortages were not consistently found in other key partners (e.g., European countries, Japan, Korea or India), suggesting that policy actions similar to those taken by other countries could mitigate some of these shortfalls. In addition to shortages of finished pharmaceuticals, assessments by the Joint Staff have found that deployable assemblages which are expected to be resupplied during large scale combat

operations contain medications and/or equipment from potential adversaries, or from a sole source which may not continue provide these items during a conflict. And recent analyses of generic pharmaceuticals have demonstrated variability in the efficacy of some medications. **I recommend that this Committee should:**

a. **Direct the CJCS to include a Medical Feasibility Assessment whenever a Logistics Feasibility Assessment is conducted or updated and ensure the two are deconflicted as part of regular updates to Operational and Contingency Plans and ensure the ASD(HA) and Services review the results to identify gaps which can be mitigated through changes to policy or Defense Health Program or Service Operations and Maintenance funding.**

b. **Require the CJCS to provide an annual report on DOD operational medical supply chain vulnerabilities and actions taken or needed to reduce these vulnerabilities**.

c. **Direct the DOD to provide a report to Congress within one year on options to mitigate gaps in patient movement capabilities and capacity in the Continental United States during execution of the Integrated Continental United States Medical Operations Plan, including leveraging Civilian Reserve Air Fleet assets to execute this mission.**

d. **Codify that all future United States Transportation Command Mobility Capability Requirements Studies include medical transportation requirements for personnel, equipment and patient movement, as validated by the Joint Staff Surgeon.**

5. **Partnerships:** In the operating room, I was part of a team which included nurses and anesthesiologists and other key contributors who cared for the patient who trusted us to cure his or her cancer, or to repair the damage from a traumatic injury. As a flight surgeon on aeromedical evacuation missions, I was part of a team which included medics and pilots and other key personnel who worked together to safely move an ill or injured Servicemember to the care they needed. As a medical leader in our Joint Force, I was part of teams which met Combatant Command requirements by leveraging the best of each Service, and by partnering with key industry and academic and international stakeholders to ensure the next ill or injured Service member was cared for by a military medic who had the appropriate training and equipment and supplies to provide the right care at the right place and time. The American College of Surgeons has been an especially valuable partner for many years, helping to improve care in both the military and civilian healthcare systems by sharing information and research through the *Military Health System Strategic Partnership with the American College of Surgeons* (MHSSPACS), enabled by the Mission Zero Act. The University of Nebraska and the University of Colorado are two examples of the strong academic partners which have helped military medicine continue to innovate and improve how we train, equip and sustain the skills of military medics. In addition, because so many military bases are located in rural areas, DOD relies heavily on community partners to provide care for Servicemembers and other DOD beneficiaries. Finally, our plans to provide necessary medical care in future conflicts and contingencies are currently built on the assumption that we will be joined by allies and partners, as we have been in every major conflict for more than a century. **I recommend this Committee:**

a. **Require the DoD to include medical industrial base partners identified by the Services and DHA in future Defense Industrial Base planning efforts and Joint and Service exercises involving other industry partners.**

b. **Require ASD(HA) to provide an annual report on access to care in rural communities impacted by changes in funding for Medicaid, Medicare or other Federal health programs.**

c. **Direct the DOD to provide a classified report to Congress on any assumptions regarding access to or reliance on allies and partner nations for medical care for US military personnel during future large scale combat operations and the impact on patient care if the United States changes its relationship with these nations.**

d. **Reauthorize funding for the Mission Zero Act for military civilian partnerships.**

6. **Research and Innovation:** The United States has led the world in investments in research which have enabled the United States to be the leader in multiple industries which support military medical care. Academic research centers which have long provided some of the most innovative breakthroughs in medicine are facing significant challenges due to the announced implementation of a standardized 15% Indirect Cost Rate for research funded by the National Institutes of Health, regardless of the complexity of the research performed, as well as the planned 60% reduction in funding for the National Science Foundation, and reductions in research funding from the Veterans Administration and the United Stated Department of Agriculture and the Department of Defense, compounded by the proposed ten-fold increase in taxes on university endowments which might have helped mitigate the impact of some of these changes. Within the military health system, research funding has been divided between the Congressionally Directed Research Program (CDRP), which funds research on topics identified by members of Congress, and the remaining research budget, which should address gaps in knowledge and capabilities impacting care for ill and injured Servicemembers. **I recommend that this Committee:**

   a. **Require the DOD to provide a report to Congress within 60 days of the impact of actual and proposed reductions in Federal research funding on national security and on the ability to continue to pursue innovations and treatments for ill and injured Servicemembers.**

   b. **Direct CJCS to prepare an annual prioritized list of military medical knowledge gaps requiring research, based on Combatant Command and Service inputs, which will be provided to the ASD(HA) to inform research funded by the Defense Health Program.**

   c. **Require the Director of the Defense Health Agency to provide an annual report to Congress showing how research oversight by the DHA addresses the operational gaps identified by CJCS, as well as a summary of any patents awarded and peer-reviewed publications in the past year as a result of military health system-funded research.**

d. **Share the CJCS-identified priority gaps in knowledge impacting care for ill and injured Servicemembers with members of Congress to help inform decisions about new CDRP projects.**

7. **Fiscal Realities:** The United States Federal budget dramatically exceeds revenues and is unsustainable. The United States healthcare system is the most expensive system in the world on a per capita basis and delivers some of the worst outcomes of any high income country. With the current workforce, the annual US healthcare inflation rate has averaged 5.11%. The Military Health System is a subset of the US healthcare system; 70% of care for DOD beneficiaries is now purchased in the private sector, but the MHS has seen effectively almost no growth in funding for medical care over the past ten years. In addition, numerous new benefits have been authorized without additional funding. Because our current Tricare contracts are "must-pay" bills for the Department, the only way to cover these rising costs is to divert resources from the direct care system and from accounts which should be funding operational medical requirements. Assertions that care can continue to be diverted to the private sector without impacting readiness or access have not been supported by data and the growing shortages of medical personnel nationally and the rapidly rising cost of commercial care appear to make this unsustainable course to enhance military medical readiness. Until this is addressed, we will continue to see declining operational medical capabilities and rising costs as more and more care is shifted to the private sector. Civilian healthcare is expensive; military healthcare, because of its unique additional requirements, is even more expensive. Like other military capabilities, there are no direct analogues in the civilian or commercial sector for all the capabilities needed by the military health system to be able to care for ill and injured Service members during a conflict. All of the Federal healthcare delivery systems (DOD, Veterans Health Administration, Indian Health Services, etc.) face some of the same challenges and all have very large, unfunded infrastructure requirements to sustain their ability to deliver care (e.g., DOD estimates an additional $10 billion is needed to update or replace existing medical infrastructure). In many communities with aging Federal medical infrastructure, there is an opportunity to develop Joint Venture partnerships similar to the ones at Joint Base Elmendorf-Richardson, or Travis Air Force Base. In addition, creative financing mechanisms, like the Communities Helping Invest through Property and Improvements Needed for Veterans ACT (CHIP-IN Act), which pools Federal, state, local and philanthropic resources to fund infrastructure requirements, should be reauthorized and expanded to include the DOD. Finally, as authorized by Congress in the 2017 NDAA, the DHA must ensure accurate tracking and billing for services provided to non-DOD beneficiaries both within the direct care system and when military medical personnel are working in partner facilities. The mistaken belief that the military or other Federal health systems can be funded at lower rates than the civilian sector while achieving similar or better outcomes and be ready for future conflicts is a remarkably optimistic triumph of hope over reality. To begin to address this foundational problem, **this Committee should:**
    a. **Require that any implementation of new benefits which are authorized in an NDAA cannot occur until there is an assessment by CJCS of operational impacts, an independent government cost assessment of the cost of mitigating the operational impacts and of the cost implementing the benefit in both the direct and private care**

system, and sufficient additional funding is appropriated in the Defense Health Program to cover these costs.

b. **Direct that any proposed reductions in services at a military treatment facility can only proceed with an endorsement from the CJCS that there is no impact on operational requirements, and an endorsement from the Services that there is no impact on medical officer and enlisted training pipelines, and an independent attestation that there is sufficient excess capacity to absorb the workload to be shifted to the community , as well as Congressional notification at least 180 days prior to implementation.**

c. **Direct the ASD(HA) to implement the necessary information technology tools and to promulgate policy on accounting for work done by uniformed medical personnel in civilian or Veterans Health Administration facilities.**

d. **Reauthorize the CHIP-IN Act and amend it to include DOD requirements.**

e. **Mandate that the DOD and VA provide a report to congress in six months on how to consolidate inpatient care in communities where one or both Departments are requesting funding for infrastructure investments which exceed $100 million annually.**

8. **Uniformed Military Medical Leadership:** Congress wisely recognized that successful implementation of the reforms mandated by the 1986 Goldwater-Nichols Act required a new type of leader who understood the value of Jointness and who had personal experience in that environment. For a variety of reasons, military medical leaders have been exempted from this requirement, making them the outliers in the Department of Defense, with limited understanding of the opportunities and challenges implicit in the Joint Force. **I recommend that this Committee should:**
    a. **Remove the Goldwater-Nichols Act exception for military medical General and Flag Officers;**

    b. **Require that any future Directors of the Defense Health Agency must have previously served as either the Joint Staff Surgeon, or as a Combatant Command Surgeon and must have commanded a hospital which supported Graduate Medical Education programs.**

ATTACHMENT 1

Suggested National Defense Authorization Act Language

Clarify that the military health system is a part of the military and, to the greatest extent possible, should use the same processes, procedures and measures used by the rest of the military, including:

A. Civilian oversight of the MHS: As in the rest of the military, the MHS is led by civilian leadership nominated by the President and confirmed by the Senate, acting under the authority which the Congress and the President have invested in the Secretary of Defense. The Assistant Secretary of Defense for Health Affairs (ASD(HA):

1. Serves as the principal medical advisor to the Secretary of Defense

2. Leads and provides oversight of the MHS and the Defense Health Program (DHP), including developing and executing an MHS Strategic Plan which will:

a. Require endorsement by the Chairman of the Joint Chiefs of Staff (CJCS) and the Secretary of Defense prior to transmittal to appropriate Congressional Committees annually
b. Include measurable goals and objectives by quarter and fiscal year, including:
    i. Readiness metrics approved and monitored by the Assistant Secretary of Defense for Readiness, in coordination with the CJCS, through the process used by the rest of the military to assess readiness of deployable and in-garrison capabilities, including
    ii. All patient movement and Role 2 and above medical force elements
    iii. Any required equipment or other assemblages
    iv. Surveillance for and response to bioweapons
    v. The percent of Service members by unit who are not medically ready.
    vi. Quality metrics for assessing the effectiveness of care provided to DOD beneficiaries both in the direct care and the purchased care system, including access to care.
    vii. Quality metrics developed by the Joint Trauma System, in coordination with the Joint Staff, Combatant Commands and Services, to assess the effectiveness of care provided in deployed locations and in the patient movement system
    viii. Fiscal metrics assessing the efficiency of the direct care and purchased system against established targets, including targets for beneficiary enrollment and leakage to the purchased care system for each Military Treatment Facility
    ix. Patient satisfaction metrics for both the direct care and purchased care systems
    x. Availability of uniformed medical personnel for healthcare delivery, by location of assignment, when not deployed
    xi. Metrics should be trended over time and, where available, should be compared to US national benchmarks
c. Service input to this plan is necessary, but Service concurrence is not required; the plan should clearly identify any goal or objective with which one or more Services does not concur.

3. Establishes necessary policies to ensure the MHS provides high quality care for all DOD beneficiaries; Joint Staff and Service input to MHS policies is necessary; critical non-concurrence with a proposed policy will be adjudicated as follows:

a. Policies affecting medical operational capabilities: Services, Combatant Commands, with support from the Director of the Joint Staff, will bring areas of disagreement to the Tank and then make recommendations to the Secretary of Defense

b. All other policies will be adjudicated through governance structures overseen by ASD(HA) or the Undersecretary of Defense for Personnel and Readiness.

4. Ensures that research funded by the Defense Health Program addresses the CJCS-identified gaps in knowledge impacting care for ill and injured Servicemembers.

5. Serves as the immediate supervisor of the Director of the Defense Health Agency (DHA).

6. Is the final approval authority for all fiscal decisions related to the Defense Health Program (DHP) and communicates to Department of Defense leadership and to Congress the fiscal requirements for providing optimal in-garrison and purchased care, any gaps between requirements and resources and plans to mitigate those gaps.

7. Provides the Services with a template for reporting quarterly on the location, availability for MTF utilization, and other responsibilities of all uniformed and civilian personnel funded or aligned in any way with each Service or sub-component.

B. Chairman of the Joint Chiefs of Staff Oversight of Military Medical Operational Support

1. Operational and Contingency Plans. As defined by the President and the Secretary Defense in the Unified Command Plan, CJCS will ensure these plans clearly define:

a. Operational and training requirements for Role 2, 3, 4 and 5 deployed medical force elements and equipment with the goal of preserving the fighting force in order to win future conflicts by optimizing return to duty as quickly and safely as possible.

b. Operational requirements and resourcing for blood products (e.g., whole blood, freeze dried plasma, etc.) as close to the point of injury as possible using planning factors developed by the Joint Staff Surgeon, in coordination with the Combatant Command, Services and with concurrence from the ASD(HA).

c. Patient movement requirements for ill and injured Service members and other combatants who cannot be returned to duty, including those exposed to or infected with highly contagious infectious diseases.

d. Explicit acknowledgement of any reliance on allies or partners to provide medical care and attestation from Combatant Command that the Ally or partner has affirmed they have the necessary capabilities and capacity to provide this care to US personnel.

e. Ensure that the Integrated Continental United States Medical Operations Plan (ICMOP) includes

i. Requirements for acute and rehabilitative care for ill and injured returning to the US

ii. Requirements for patient movement from Aerial Ports of Embarkation and Debarkation to appropriate levels of care.

iii. Planning factors from the Department of Health and Human Services and the Veterans Health Administration for available beds once the National Disaster Medical System is activated

iv. Planning factors from the Tricare Purchased Care contractors for available beds within the purchased care system.

v. Supplemental funding estimates for sustaining care for in-garrison DOD beneficiaries and any beneficiaries reliant on DOD medical personnel who are tasked to deploy during a contingency

vi. Plans to expand blood collection, processing and delivery to DOD to meet operational requirements.

2. CJCS oversight of medical readiness. In coordination with the ASD(R), the Joint staff will monitor, report and address readiness of all required medical capabilities listed above, using the same processes used for the rest of the military.

3. CJCS oversight of Combat Support agencies: As with other Combat Support Agencies, CJCS will conduct a Combat Support Agency Review to assess the readiness and effectiveness of actions taken by the Defense Health Agency (DHA) to support Combatant Command (CCMD) and Service operational requirements and will provide an annual report to Congress summarizing progress and shortfalls in DHA's performance.

4. CJCS will provide ASD(HA) with a prioritized list of knowledge gaps impacting care for ill and injured Servicemembers derived from input from the Combatant Commanders and Services.

C. The Service Secretaries (Army, Navy and Air Force) will:

1. Organize, train and equip medical force elements to meet operational requirements defined by the Combatant Commanders through established CJCS and OSD processes.

2. Organize, train and equip medical force elements to perform Joint Trauma System-required activities during contingencies and ensure data collection on all ill and injured personnel in accordance with JTS-defined requirements.

3. Standardize all equipment in deployable assemblages across Services in accordance with JTS recommendations; exceptions to this requirement will require approval by the CJCS and Deputy Secretary of Defense, as well as notification to the Senate and House Armed Services Committees within 30 days of the exception being granted and before any acquisitions for Service-specific equipment is executed.

4. Implement JTS-identified standardized training for deployable force elements (e.g., Role Two ground medical force elements, patient movement force elements, etc.)

5. Report the readiness of all deployable patient movement and Role II and above medical force elements and equipment through processes established by ASD(R) and the Joint Staff.
6. Fund operational medical requirements outside the scope of the DHP and inform ASD(HA) of any unfunded operational medical requirements and planned mitigation measures no later then the beginning of the third quarter of each Fiscal Year.
7. Fund Service-specific research to enhance operational medical readiness and inform ASD(HA) of any unfunded operational medical requirements and planned mitigation measures no later then the beginning of the third quarter of each Fiscal Year.
8. Provide DHA with quarterly updates on all uniformed and civilian personnel as described above.
9. Ensure that Nominees to serve as the Director of the DHA must have served as either the Joint Staff Surgeon, or as a Combatant Command Surgeon and have commanded an MTF with inpatient capabilities and graduate medical education programs.

D. Defense Health Agency as a Combat Support Agency:

1. The Joint Staff Surgeon will be dual-hatted as the DHA Deputy Director for Combat Support and will:

a. Provide direct oversight of the Joint Trauma System Director, in order to ensure the JTS:
    i. Incorporates best practices and Clinical Practice Guidelines into the MHS Genesis and medical education programs for both officers and enlisted military medical personnel
    ii. Provides requirements to the Services for data collection as far forward as possible, with reporting to Combatant Command Joint Trauma System offices.
    iii. Identifies standardized, interoperable equipment for Service-provided deployable medical force elements which support CCMD operational requirements.
    iv. Identifies and provides to the Services standardized, training for Service-provided deployable medical force elements which support CCMD operational requirements.
b. Provide direct oversight of the Director of the Armed Services Blood Program, in order to ensure the ASBP:
    i. Develops planning factors for operational blood component utilization
    ii. In coordination with USNORTHCOM, the Department of Health and Human Services and other stakeholders, plans to expand US blood collection, processing and distribution as needed to meet validated operational requirements.
c. Provide direct oversight of the Director of the Armed Forces Medical Examiner System (AFMES), in order to ensure the AFMES:
    i. Reviews, in coordination with the Joint Trauma System, any deaths of uniformed or civilian military personnel while training, in-garrison or during contingency operations, including those for which a civilian medical examiner performs the forensic pathology exam

ii. Prepares annual reports identifying opportunities to reduce risks to Service members.
iii. Sustains accreditation by the National Association of Medical Examiners

d. Provide requirements to update MHS Genesis and other MHS systems to optimize data collection, analysis and reporting in order to improve outcomes for ill and injured Service members.

e. Provide oversight of public health activities aligned under the DHA as required by 10 U.S.C. § 1073c, as amended.
i. Ensure all DOD hospitals and overseas labs are transmitting the same standardized surveillance data to the Centers for Disease Control and Prevention as do other Public Health Jurisdictions.
ii. Partner with Services to ensure waste water surveillance is implemented at DOD installations.
iii. Implement biosurveillance programs to detect and mitigate the risk of naturally occurring and deliberate biological threats.

2. The Defense Health Agency will reinstate Defense Health Agency Procedural Instruction 6040.06, *Combatant Command Trauma Systems.*

3. Defense Health Agency and Health Care Benefit Delivery- all other functions of the DHA related to healthcare benefit delivery will be executed in a manner which:

i. Enhances readiness of the military health system to care for the ill and injured in future conflicts;

ii. Optimizes access to healthcare for DOD beneficiaries in the direct care system and, when necessary, in the purchased care system, with the objective of caring for those DOD beneficiaries with the greatest medical needs (i.e., the “highest acuity”) in the direct care system, whenever possible;

iii. Optimizes health-related outcomes for DOD beneficiaries as effectively and efficiently as possible.

E. Clarify the intent of Congress related to funding for the Military Health System including:

1. Requiring that any new healthcare benefits are only enacted following:

a. Assessment endorsed by the CJCS of any impact on operational readiness of the proposed new benefit.

b. Completion of an Independent Cost Estimate endorsed by the Managed Care Support contractors and the ASD(HA) which mitigates any operational impacts and validates the cost of implementing the benefit

c. Appropriation of sufficient funding for the proposed new benefit

2. Requiring notification to Congress of resource shortfalls which preclude delivering care in the direct care system which enhances the readiness of the military health system to care for ill and injured during future conflicts, or the care to which DOD beneficiaries are entitled.