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ARMED SERVICES

UNITED STATES SENATE

TO RECEIVE TESTIMONY ON STABILIZING THE MILITARY HEALTH SYSTEM TO PREPARE FOR LARGE-SCALE COMBAT OPERATIONS

Tuesday, March 11, 2025

Washington, D.C.

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U.S. Senate
Committee on Armed Services
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The committee met, pursuant to notice, at 9:36 a.m., in Room SD-G50, Dirksen Senate Office Building, Hon. Roger Wicker, chairman of the committee, presiding.

Committee Members Present: Senators Wicker, Fischer, Cotton, Rounds, Ernst, Sullivan, Cramer, Scott, Tuberville, Mullin, Budd, Schmitt, Banks, Sheehy, Reed, Shaheen, Blumenthal, Kaine, King, Warren, Peters, Rosen, and Kelly.

OPENING STATEMENT OF HON. ROGER WICKER, U.S. SENATOR FROM MISSISSIPPI

Chairman Wicker: The hearing will come to order.

The Committee has convened this hearing to discuss the state of the Military Health System. We hope to shine a light on the challenges facing that system and begin working toward solutions.

Our witnesses are experts in the field of military medicine. Dr. Douglas Robb is a retired Air Force Lieutenant General and the former director of the Defense Health Agency, DHA. Dr. Paul Friedrichs is a retired Air Force Major General and the former Joint Staff Surgeon. And Dr. Jeremy Cannon is a retired Air Force Colonel and trauma surgeon who currently serves on the faculty at the University of Pennsylvania School of Medicine.

I look forward to their testimony. I want to hear their recommendations about what Congress and the Department of Defense should do to provide long-term stability to the Military Health System.

Military medicine often follows a familiar but regrettable cycle. During peacetime, medical teams focus on the treatment of ordinary illnesses. When conflict erupts, military medicine is frequently caught unprepared, resulting in unnecessary casualties.

This interwar erosion of our unique military medical

skills is known as the "peacetime effect." To disrupt the "peacetime effect," Congress enacted sweeping reforms of the Military Health System. These reforms, now nearly a decade old, were designed to refocus military medicine on its primary purpose: combat casualty care and medical readiness.

We elevated the Defense Health Agency to a combat support agency and tasked it with administration of all military hospitals and clinics, relieving the military departments of that mission. The goal was to have the military services focus exclusively on the medical readiness of their forces. These ideas were recommended by an independent, bipartisan commission embraced by Pentagon leadership, and signed into law in 2017.

Unfortunately, opponents of these reforms have delayed implementation and undermined the effectiveness of the legislation. For example, in 2019, the military departments implemented drastic cuts to military medical personnel on the faulty assumption that it would be easy for DHA to hire civilians to take their places.

This assumption was misguided, which became evident during the COVID pandemic. During that crisis, the existing national physician shortage accelerated. To this day, private sector health systems seek out and hire away doctors from the military, not the other way around. We

have all seen this in our states.

In 2020, Congress ordered a halt to any additional military medical reductions, but it was too late. A significant number of reductions had already occurred, severely reducing the capability of military hospitals. In many locations, the private sector was unable to handle the additional patients, sending more servicemembers to private sector care. This has proven more expensive and has sapped the military doctors' experiences that are vital to maintaining proficiency.

Even worse, DoD has refused to request adequate funding for DHA, which would allow DHA to staff adequately and equip its hospitals and clinics. Since 2015, the budget for military hospitals has decreased by nearly 12 percent. The water damage at Walter Reed this January is an example of the antiquated infrastructure that military medical teams work with around the world.

In addition to the problems I have just explained, I would like our witnesses to highlight how bureaucratic delays within the Department of Defense have prevented the Military Health System from preparing for the next potential conflict.

Combat casualty care is the primary purpose of the Military Health System. When servicemembers are exposed to danger or are injured, they need to know that they will

receive the best care possible. We know that troops in combat are more comfortable taking the risks necessary to accomplish their mission if they have confidence in military doctors.

We cannot go back to the way things were before 2017. We must stop scapegoating the Defense Health Agency. The Department of Defense must request adequate resources to ensure the Department's hospitals and clinics are properly staffed and equipped. This is the best way to ensure the Military Health System is ready for the potential demands of large-scale combat operations in the future.

I thank the witnesses for being willing to testify and now recognize Ranking Member Reed for his remarks.

STATEMENT OF HON. JACK REED, U.S. SENATOR FROM RHODE ISLAND

Senator Reed: Thank you very much, Chairman Wicker, and welcome to our witnesses. General Douglas Robb, General Paul Friedrichs, and Colonel Jeremy Cannon each bring important perspectives from their extensive careers in military medical fields. We are fortunate to have such a distinguished panel before us.

Throughout history, military medicine has often represented the leading edge of modern health care. Many of the lifesaving practices common in today's emergency rooms and clinics were born out of necessity on the battlefield hospitals of the Civil War, World Wars I and II, Vietnam, and the wars in Afghanistan and Iraq.

Professional expert health care, both in combat and peacetime, is a vital component of our military. Our service men and women, and their families, deserve nothing but the best in this regard.

I am concerned that our military health care system will be challenged to meet the demands of a potential large-scale future conflict, particularly in the Indo-Pacific. We have seen the terrible challenges of health care in austere environments, like the front lines of Ukraine, where supplies and medics are often cut off from the troops in contact. These risks would be compounded in

the Indo-Pacific where contested logistics and the tyranny of distance would be major factors.

Congress has dedicated considerable attention to reforming the Military Health System in recent years, with an eye toward any potential future large-scale conflict. The primary objective of these reforms has been to improve combat casualty care, assume quality medical care for servicemembers and their families, and ensure that military medical professionals are able to deliver the world's best care on the battlefield, at field hospitals, and at medical centers and clinics.

However, until relatively recently, the Military Health System was inadequately designed to meet these missions. For decades, the individual military branches managed their own military treatment facilities and the Defense Health Agency, or DHA, was tasked with managing Defense Department health care via civilian providers. This system was hampered by unnecessary complexity, a lack of standardization, inefficiency and redundancy in the system, and inflated costs. The Military Health System was too focused on beneficiary care while insufficient attention was paid to combat casualty care.

To address this, the fiscal year 2017 National Defense Authorization Act included provisions restructuring much of the system. This legislation transferred responsibility

for operating the military treatment facilities entirely to DHA. This change was intended to allow the military services and surgeons general to focus on medical readiness for the force and its health care providers.

Unfortunately, implementation of this legislation has been difficult. The military services have not implemented the changes readily, and they have failed to staff the treatment facilities with the military personnel needed to provide timely care. The Department of Defense made progress to break through the inertia in 2023, when it issued a memorandum with specific direction to save lives and improve the Military Health System, to include adequate manning of military treatment facilities, and this effort marked a major milestone in modernizing the system.

More work remains to be done, and I hope that the Trump administration will continue the momentum in this area. During today's hearing, I would ask for our witnesses' views on the key challenges remaining for successfully reforming the Military Health System and how Congress can help equip the Department and our warfighters with the medical support needed for any future conflicts.

Thank you again to our witnesses, and I look forward to your testimonies. Thank you, Mr. Chairman.

Chairman Wicker: All right. We will begin with 5-minute testimonies from each of our distinguished

witnesses.

Lieutenant General Robb, you are recognized.

STATEMENT OF LIEUTENANT GENERAL (DR.) DOUGLAS J. ROBB, USAF (RET.), FORMER DIRECTOR OF THE DEFENSE HEALTH AGENCY

General Robb: Chairman Wicker, Ranking Member Reed, and distinguished members of the Committee, thank you for this opportunity to testify on the urgent need to restore and sustain our military medical readiness in the face of large-scale combat operations, and thank you both for what I would believe is spot-on comments. So thank you very much.

Just a little background on where my perspective of the Military Health System originates from, I started my military career as a boots-on-the-tarmac operational flight doc, both stateside and overseas. I have served at the Air Force Squadron hospital, clinic, and medical centers in commander positions, and at the headquarters level.

I have also had the honor and privilege to serve our joint forces as the U.S. Central Command surgeon, joint staff surgeon, and as the first Director of the Defense Health Agency.

Moving forward, a refocus on our ability to support large-scale combat operations, I believe, will require a recalibration of current and future resources to support large-scale casualty flow, from the battlefield or the sea battle to definitive care, rehabilitation, and eventually

reintegration. All this in the face of incremental pressures from OSD, OMB, and the military departments, resulting in a decade-plus of flight line actually declining defense health program budgets, personnel reductions, erosion of our mission-critical military treatment facilities, and intense competition for quality health care professionals with the private sector.

One of the key Military Health System organizational elements in support of the Military Health System strategy is the evolving and maturing Defense Health Agency, designated as a combat support agency. It was established over a decade ago. Recently, the DHA's justification, and specifically the DHA's designation as a combat support agency, has been challenged and questioned.

In 2011, the Deputy Secretary of Defense issued a memo titled "Review of Governance of Model Options for the Military Health System." That was driven by the Department's significant growth in health care costs. Fast forward a decade later -- sound familiar?

The Task Force on Military Health System Governance Reform was then established -- and this is key -- that included co-chairs from the Joint Staff, OSD, and flag and SES representation from the Joint Staff, OSD P&R, CAPE and Comptroller, and the service surgeons general, for a total of nine voting members. And I think it is also important

to recall the task force overwhelmingly recommended a Defense Health Agency organizational model, with a final vote of 7 for the Defense Health Agency, 1 for a unified medical command, and 1 for what then was called a single-service model.

The recommendations were briefed through both Joint Staff and actually through two chairmen, and Office of Secretary of Defense and actually through two Deputy Secretaries of Defense, with the Defense Health Agency construct signed off by the DEPSECDEF with the Chairman's support.

Another decision that has come into question in recent years was the designation of the Defense Health Agency as a combat support agency. The designation was initiated by the Director of the Joint Staff, with the Chairman's concurrence, when reviewing the proposed DHA organizational structure and the relationships with both the Chairman and the OSD. The CSA designation was then codified.

Now, a decade later, do I still believe the original analysis and the recommendation to stand up a Defense Health Agency as a combat support agency remain valid? And the short answer is yes. But does a recalibration of the Defense Health Agency supporting relationship with its combat support agency responsibilities to the supported entities of the military departments and the joint forces

need to be readdressed? And again I would say yes.

I share with you several lines of effort that I believe are essential as we strive to further achieve a more tightly integrated Military Health System to support our national military strategy and our national security strategy.

Number one, reemphasizing, with clear articulation and execution, of the Assistant Secretary of Defense of Health Affairs' authority, direction and control of the Defense Health Agency.

Number two, I believe we need to establish a direct organizational linkage at the Defense Health organizational structure level, with the Chairman of the Joint Chiefs of Staff and the commands through the Joint Staff Surgeon, to ensure that the responsibilities are prioritized with the DHA's execution.

And finally, NDAA '19 directed the Department to establish joint force medical requirements process to synchronize the Military Health System's already established joint operational requirements governance process. And I think that is key, that the medics need to play with the Joint Staff's process for determining requirements.

In closing, I would like to thank you, and look forward to support you in assisting the Military Health

System's ability to accomplish our mission of ensuring a medically ready and a ready medical force in support of our military departments and combatant commands through the provision of care to our 9.5 million beneficiaries. Thank you.

[The prepared statement of General Robb follows:]

Chairman Wicker: Thank you very much, Dr. Robb. Major General Friedrichs.

STATEMENT OF MAJOR GENERAL (DR.) PAUL A. FRIEDRICHS, USAF (RET.), FORMER JOINT STAFF SURGEON

General Friedrichs: Chairman Wicker, Ranking Member Reed, and members of the Committee, thank you so much for the opportunity to be here. I had the opportunity in my very last briefing to some members of this Committee in May of '23 to give you a classified assessment of MHS readiness, and I will start with a recommendation that if you have not had an update since May of '23, I would implore you to schedule that so that the Joint Staff Surgeon can give you the most current classified assessment, because what we will provide today is an unclassified assessment.

Second, I will give a disclaimer that the views that I express are my own, not those of any organization with which I have been affiliated.

I provided a detailed written statement to you, and I would respectfully ask that that be entered into the record of this hearing.

Chairman Wicker: All of the statements will be added to the record at this point, without objection.

General Friedrichs: Thank you very much, Chairman.

I have two disclaimers. The first, this is my family business, so I will speak both from my experience and because my dad served in the Navy -- 98, still alive -- at

the end of World War II. Multiple other relatives in the Navy. My wife is a former Army physician who now works for the VA. We are very proud that one of our children is a Marine. I care about this not only because of all of the others but because this is what my family has done for generations.

My second disclaimer, like General Robb, is I have had the privilege of serving our country now for 39 years, and the majority of those years I have spent in joint roles. Congress got it right in 1986, with the Goldwater-Nichols Act, but the one thing I wish you would change is to include medics as part of the military. As long as we preserve this false narrative that the Military Health System is separate and not covered by the same expectation of jointness as the rest of the military, we are going to continue to have these fruitless, bureaucratic buffoonery actions that distract us from taking care of patients. I encourage you to treat the Military Health System like a part of the military.

We have had tremendous accomplishments over the last 20 years, with the lowest rate of deaths among injured ever seen in conflict, and we should be incredibly proud of that. When I deployed, I had what I needed, when I needed it, air-evac available. I flew air-evac missions. I operated on casualties. I never lacked for what I needed.

I cannot offer you the assurance that my successors will have that same environment in the next conflict, and I am grateful that you are holding this hearing today.

I have several very specific recommendations. First, as I touched on before, we must prioritize the patient over the patch, put a nail in the heart of this discussion about reorganizations and what the role of the Military Health System actually is. We need to commit, and we need your help in the next NDAA, to clearly articulate , just as both the Chairman and the Ranking Member said, the Military Health System exists as part of the military to ensure that we deter those who might seek to harm our nation and defeat them if they try to. The military's role is to take care of the human weapon system. The health care benefit delivery is part of how we do that, and part of a commitment that we make. But I implore you to address that in the next NDAA.

As I said before, I think that you got it right with Goldwater-Nichols, and I would encourage you in the next NDAA to clearly articulate that you view the Military Health System as part of the military and not exempt from the requirements that the rest of the military faces. A joint casualty stream requires a joint casualty care team. That seems relatively straightforward, and yet that is still something that we are arguing over, whether medical

units should be interoperable, whether they should have the same equipment or the same training. The answer is yes.

Look at Israel. Look at almost every other country with a large military. They have already made those changes, which you rightfully began and appropriately began in 2017. We do not need another reorg. What we need is execution of the vision that you laid out.

The next point that I bring up is resourcing, and both the Chairman, the Ranking Member, and Dr. Robb touched on this. Health care is not cheap. The mistaken belief that somehow military medicine can be done at a lower cost than in the civilian sector, and be ready for conflict, is just that. It is a mistake and it is a discredit to those who state that they care about our patients.

Finally, I am deeply concerned about our growing vulnerability to biological threats. The decisions to take down our overseas partnerships to build better biosurveillance, the decisions to take down research in biological threats, the decisions to take down multiple other programs that we had built as a result of the 2018 National Defense Strategy, which President Trump signed in the first administration and President Biden updated, put us at greater risk. And we must continue to address those risks of the evolving biological threats, both naturally occurring and deliberate threats. The confluence of AI,

biotechnology, and compute is dropping the bar dramatically for biological threats. We should be working on mitigating that.

I thank you again for the opportunity to be here and for your interest in this.

[The prepared statement of General Friedrichs follows:]

Chairman Wicker: Thank you, Dr. Friedrichs.

Colonel Cannon.

STATEMENT OF COLONEL (DR.) JEREMY W. CANNON, USAFR (RET.), PROFESSOR OF SURGERY, PERELMAN SCHOOL OF MEDICINE, UNIVERSITY OF PENNSYLVANIA

Colonel Cannon: Chairman Wicker, Ranking Member Reed, and distinguished members of the Committee, thank you for the opportunity to testify. These comments are my own and do not reflect an official position of my employer, Penn Medicine, or of the Hoover Institution, where I current serve as a Veteran Fellow.

As a practicing trauma surgeon, I have cared for injured warfighters in both Iraq and Afghanistan. I have directed the DoD's only Level I trauma center, and now I need a Penn Medicine Navy partnership for trauma training. I know firsthand what it takes to save lives on the battlefield and what happens when we fail to sustain medical readiness.

I want to start by sharing the story of the unexpected combat casualty survivor that I took care of in 2010. Note, I will use a pseudonym throughout my comments for patient privacy.

U.S. Army Sergeant Erik Ramirez was on patrol in Afghanistan when I sniper's bullet tore through his chest, just above his body armor. His injuries were truly catastrophic. But thanks to decades of investment and innovation in combat casualty care, a military trauma team

pulled him up out of his certain death spiral by placing him on heart and lung bypass, on the battlefield. Days later, I had the honor of caring for Sergeant Ramirez in the U.S., as he reunited with his family.

This unequivocal display of medical supremacy was not accidental. It was built on years of research, training, and policy reforms. But I fear that if Sergeant Ramirez suffered this same injury now, he would die a preventable death on the battlefield.

Today, only 10 percent of military general surgeons get the patient volume, acuity, and variety they need to remain combat ready. We are actively falling into the trap of a peacetime effect.

Meanwhile, as the MHS struggles, our enemies continue to grow stronger. Projections estimate a peer conflict could produce as many as 1,000 casualties per day, for 100 days straight, or more, a scale not seen since World War II. Neither the current MHS nor the civilian sector can absorb this impact. What's more, many of these patients will have survivable injuries, yet 1 in 4 will die at the hands of an unprepared system.

How can we meet this living threat? First, we must clearly articulate the root problem of our failed readiness efforts. No one in DoD truly owns combat casualty care. In 2017, the Joint Trauma System, or JTS, was codified in

law. This Committee must now strengthen the statutory language to affirm that JTS owns combat casualty care and to provide this precious resource with both top-down authority and bottom-up support.

Then we must push the MHS to refocus on forward-deployed care, the one thing that only military medicine can do. For this I recommend three lines of effort.

First, clinical training. In order to train the way we fight, we must establish five to six high-volume military treatment facility centers of excellence for both trauma and burn care. These centers must undergo civilian accreditation and fully integrate into a national trauma and emergency preparedness system.

We also need to strengthen and expand our military-civilian partnership sites where military trauma teams manage critically injured patients on a daily basis, like my partnership program at the University of Pennsylvania. To do so, Congress must reauthorize PAHPA and fully appropriate the Mission Zero Act.

Second, combat casualty research. To succeed on complex future battlefields, DoD medical research must refocus on pre-hospital care, team training, bleeding control, battlefield blood transfusions, regenerative medicine, and long-term outcomes. In order to fully understand the effects of battlefield treatments we must

link DoD Trauma Registry data with VA records.

Finally, we need to unify military trauma system strategy. We must urgently develop and implement a whole-of-society roadmap, aligning military, VA, and civilian systems for both peacetime readiness and large-scale combat operations.

The bottom line, if we maintain the status quo and enter a peer conflict unprepared, we will condemn thousands of warfighters to preventable death. Without urgent intervention, the MHS will continue to slide into medical obsolescence. To restore the medical supremacy that saved Sergeant Ramirez, we must act now. Mr. Chairman, members of the Committee, our warfighters and our nation deserve medical supremacy.

Thank you for your time, and I look forward to the comments.

[The prepared statement of Colonel Cannon follows:]

Chairman Wicker: Thank you, Dr. Cannon, and I commend each of you for your excellent testimony.

Let me just get quick answers here from all three of you. I think what I am hearing from all three of you is that this is going to require more than simply good management of what we have on the books now. Each of you is recommending changes in the statute that need to come in this coming NDAA. Is that right, Dr. Robb?

General Robb: Yes.

Chairman Wicker: And Dr. Friedrichs?

General Friedrichs: Yes, sir.

Chairman Wicker: And Dr. Cannon?

Colonel Cannon: Yes, Mr. Chairman.

Chairman Wicker: All right. Let's talk about military surgeon readiness for combat care. There was a study out in 2021. It found that the population of military general surgeons meeting necessary readiness standards decreased from an already low 17 percent in 2015 to about 10 percent in 2019.

We will let all three of you take a brief chance at answer this. Why is this happening, and what specifically can DoD do to reverse this trend? And we will just start with Dr. Robb and go down the table.

General Robb: We will try to share different perspectives here. I think it comes back to the system to

be able to resource the requirements that we need. So, for example, if you want to look at what Dr. Cannon referred to as the 5 to 8, what we call critical military treatment facilities, in order for us to provide a higher volume, high acuity care, they need to be resourced. And I think that is the challenge that we all face right now, is what is that strategic reserve with our military treatment facilities, and then how you augment that with the VA and the Department of Defense partnerships, and then how do you augment that with the military --

Chairman Wicker: Is that what he called the centers of excellence?

General Robb: So I would call them -- that is one way to call them, but I, coming from the airlifter world -- in fact, General Friedrichs and I would both say follow the casualty flow. And the casualty flow comes in from INDOPACOM to primarily we will be coming to two or three military treatment facilities. From SOUTHCOM they will be coming into the National Capitol region. And then from Europe, CENTCOM and AFRICOM, they will be coming into primarily National Capitol region and then with a popoff at Portsmouth.

Chairman Wicker: Okay. Dr. Friedrichs, is this 10 percent number a concern, and why do we have 10 percent of military surgeon readiness?

General Friedrichs: Mr. Chairman, it absolutely is a concern. When I did my training in the military, I trained at the old Wilford Hall, that was a Level I trauma center. I took care of trauma patients because it was a 36 on, 12 off schedule every other night. Or I took care of vascular surgery patients. Or I took care of cardiothoracic patients. We de-scoped our facilities to the point that they take care of low-acuity community hospital patients, not trauma patients.

So I would reiterate the point that you have heard all three of us make. We need our key hospitals to be Level I trauma centers in partnership with the American College of Surgeons in the communities in which they are located.

But to do that we must address the elephant in the room, and that is resourcing. The medical inflation rate, on average, since 1938, is 5.1 percent per year, and the military has seen a net 12 percent reduction in funding. There is no way to fix these problems if the Military Health System is viewed as a bill payer and not something worth investing in.

The second point that I would make is we have got to reiterate the intent that you and the Ranking Member mentioned. I spent 4 years as the Joint Staff Surgeon. Almost every meeting in which I participated in that role focused on roles and responsibilities and patches, not on

patients. Please, again, I implore you, kill this narrative that somehow there is a belief that we can unwind things and go back to the good old days. We need to go forward towards a more integrated system that focuses on patient care and, as you said, on readiness, not continuing to focus on bureaucratic buffoonery.

Chairman Wicker: Dr. Cannon.

Colonel Cannon: Mr. Chairman, it is shocking, astonishing, and awful, and it has to be reversed. That 10 percent number results from inadequate, actually grossly inadequate, patient numbers, volume. They are not doing the cases. They are not doing the procedures. They are not doing what they were trained to do, and that is because they do not have the patients in the facilities. They are, in many cases, not designated or verified trauma centers, so they are scrounging around, trying to get cases, and it has been, frankly, an uphill climb. So we have got to provide them the patients, the cases, the experience to right that 10 percent number.

Chairman Wicker: Thank you very much, gentlemen. Senator Reed, you are next.

Senator Reed: Thank you very much, Mr. Chairman, and gentlemen, thank you for your excellent testimony.

In the 2023 memorandum by the Deputy Secretary of Defense, one of the key points, I believe, is the direction

to reattract beneficiaries to the MTFs, which would increase the patient flow, increase the demands on physicians, et cetera, and also save money, they believe.

Dr. Friedrichs, your response to this approach.

General Friedrichs: I strongly support the vision that Deputy Secretary Hicks laid out, which is very similar to the vision that Deputy Secretary Norquist laid out in the previous administration, and almost every administration prior to that. Again, to do that we must have resources.

I will offer one other option which I think you have heard all three of us touch on briefly. Every single patient in the Veteran Health Administration started in DoD. I had the great privilege of commanding the DoD/VA joint venture facility in Anchorage, and I can tell you that when the patient walked in the door, they were taken care of by a joint team. It was far more efficient than building duplicative adjacent facilities. Instead, we built integrated adjacent facilities.

There is a $10 billion, unfunded recapitalization bill in the DoD, $100 billion, unfunded recapitalization bill in the VA. There are real opportunities to bring those higher acuity patients from the VA into the DoD facilities, or bring DoD medical personnel into the VA facilities, so that we are not wasting money on duplicative buildings and

instead focusing our resources on the patients who need our care.

Senator Reed: Thank you. And General Robb, or Dr. Robb, or both, do you think the Military Health System is adequately focused on the combat-related medical capabilities? I have heard comments by all the panel suggesting that they are diverted into things that are not effective in a combat situation.

General Robb: Well, I think, in fact, I would kind of like to challenge the misnomer that there is a separation between care beneficiaries and medical readiness. And I would argue, the way that we get our skills -- primary care, specialty care, and just as important, our allied health, pharmacy, x-ray techs, logistics -- we get that by taking care of our beneficiaries.

So what I think is so, so, important is that we use -- not use, but that we care for our patient population to best achieve medically ready, in a ready medical force. And what I think is really important is that, again, we have to create a capability. It has to be an enterprise approach. And when we talked about it, again, I will go back to the point of follow the casualty flow, and you look at those critical hospitals that we believe are important, we must staff those. And we must staff those to the fullest extent possible.

You cannot reattract patient care into our MTFs unless you staff them, and I think that is what is key. If I cannot get an appointment, then I cannot get an appointment. So that is what is key.

So if you talked with Walter Reed, for example, they may have enough surgeons, but for various reasons the support staff does not exist, so they do not have the throughput that they need for surgical cases. The case load is there.

So what I think we need is an enterprise approach, and how do we resource, okay, the full spectrum of support for our critical care hospitals, and then make up the delta with our military VA partners and with our military-civilian partnerships.

Senator Reed: Thank you. Dr. Cannon, your comments, please.

Colonel Cannon: Senator, I think it is vitally important to have highly functioning, premier medical centers that we can be proud of, that our surgeons and other specialists and allied health members want to be a part of. Right now, many of these facilities are shells of what they used to be. You heard about Wilford Hall. That was an amazing facility that did so much good for so many decades.

The new incarnation, Brooke Army Medical Center, the

San Antonio Military Medical Center, is also amazing, but it is sort of out on the vanguard by itself. We need other premier flagship centers. And I think we can do it. We have got the pieces in place, but we have got to commit to keeping the combat casualty at the center of our focus, and make it happen.

Senator Reed: Thank you. My time has just about expired, but a yes, no, or perhaps answer. I am concerned about the ability to mobilize medical professionals for an all-out fight. Is that a valid concern? Yes or no, please.

General Robb: Yes.

General Friedrichs: It is the billion-dollar concern. The Israelis have proved that. And we have a shell game right now with our Guard and Reserve and civilian facilities. We are going to pull them out, deploy them, and assume that civilian facilities, which during COVID required 70,000 military medics to take care of the surge in demand, instead lower their staff and then take care of a surge in demand. The math does not work, even for a Louisiana Public School grad.

Chairman Wicker: Dr. Cannon, go ahead and answer the question. Take the time.

Colonel Cannon: Yes, I agree. It is a concern.

Chairman Wicker: Thank you. Senator Fischer.

Senator Fischer: Thank you, Mr. Chairman. Thank you all for being here today.

I really appreciate the information that you are giving us, and also the concern you have with the direction that we are not headed yet. In the NDAA for fiscal year 2020, a pilot program was established to assess the National Disaster Medical System, the NDMS, and hopefully that it would increase not just capability but also capacity within that. In a conflict, you know, we have touched on that already. We have to be able to quickly disperse and absorb casualties throughout the United States.

Dr. Friedrichs, why is it so important for the NDMS to maintain this surge capacity?

General Friedrichs: Senator Fischer, first, thank you for the role that you and your colleagues from Nebraska played in championing this and highlighting this. It is important because the Military Health System does not have the capacity to care for every casualty coming back. We do not have the capacity to care for the people in peacetime right now. So to think that somehow we can do this on our own is another mistaken belief.

During the Cold War, we recognized that if our nation went to war, we would go to war together, and that we would do it with an integrated system with the DoD, the Veterans

Health Administration, and civilian partners. We must rejuvenate the NDMS, not let it continue to atrophy.

Senator Fischer: So what is the next step in this pilot program?

General Friedrichs: So the next step is to make this not a pilot program but to reiterate that this is, indeed, the intent of Congress, that the NDMS is the framework in which we integrate our ability to deal with either surges in military patients or, in the event of a natural disaster, surges in civilian patients. But that is the framework.

A subset of that are the Respect Centers, which you are very familiar with, the regional Emerging Special Pathogen Centers that are designed to take care of patients exposed or infected with high-consequence infectious diseases. And another subset of that is the trauma system that Dr. Cannon so nicely described.

We need your help to articulate in law that we must work as a nation and as a team. We are short 300,000 nurses nationally. The projections are we will be short 130,000 doctors by 2035. There is no way that we can do this individually. We must do it together, and I urge you to codify the NDMS pilot and make that the intent, moving forward.

Senator Fischer: Dr. Cannon, Dr. Robb, anything to

add on that?

Colonel Cannon: Senator, I would just advocate for what my colleague, General Friedrichs, just said, but we need to put our foot on the gas. We do not have 5 years, 10 years, 20 years. We need the solution really now.

Senator Fischer: Dr. Robb?

General Robb: Yeah, I concur with both their comments. And going back, the fact that we dual-purpose these assets, these expensive assets, to solve problems both in the military and civilian sector, but they are mutually synergistic. So absolutely, we need to press forward.

Senator Fischer: Thank you. Dr. Friedrichs, you mentioned the University of Nebraska Medical Center and working with an academic institution. Can you explain to the Committee the benefits of those partnership with academic institutions in particular, and what that can yield for the Military Health System?

General Friedrichs: Thank you very much, Senator Fischer. The first benefit is we share and exchange information. University of Nebraska has established, without a doubt, one of the premier programs for treating casualties or patients who are exposed to highly contagious infectious diseases, and they have got remarkable onsite training, which they built in partnership with the United

States Air Force. This is a great example of a military-civilian partnership in which the exchange of ideas improves care, both for military and civilian patients.

But the other thing that we can learn from our civilian partners is something that I offer to the Committee to consider, the CHIP IN Act, which was originally passed to allow for blending of funding to build new VA facilities. It should be expanded to include the DoD. We cannot afford to keep building duplicative facilities, and the CHIP In Act was a great way to allow the blending of Federal, state, local, and philanthropic funds so that we can most efficiently care for this diverse patient population.

Again, I commend the University of Nebraska for the pioneering work that they have done in showing what a good mil-civ partnership looks like.

Senator Fischer: Thank you for the shout-out on the CHIP IN Act. That bill was written in my office, so thank you very much.

Dr. Cannon, as a professor of surgery, do you have anything to add on that?

Colonel Cannon: I would just comment that these mil-civ partnership sites can be incredible assets for force generation, for building up that next generation of future leaders in surgery and other combat-relevant specialties.

And these are epicenters of academic excellence where we can truly inspire that next generation.

Senator Fischer: Thank you. Thank you, Mr. Chairman.

Chairman Wicker: Thank you, gentlemen. It seems to me that the state of Nebraska must have excellent representation in the U.S. Congress.

Senator Shaheen.

Senator Shaheen: Thank you all very much for being here today.

Dr. Robb, you discussed the impact of declining budgets on the Defense Health Agency. As a former director, can you talk about how late budgets and operating under continuing resolutions, continued budget uncertainty affects the readiness of the Military Health System?

General Robb: When I look back -- in fact, I will go back in history, because I was part of that. When we initially stood up to the Defense Health Agency in response to the perception that we had 10 percent of the DoD's overall budget, and then fast-forward to 12 years later and now we are actually less than 10 percent. And we were meeting not quite but most of our demands b ack then. But as I watch, we have had increasing combatant command requirements with a decreasing defense health program.

And what that has forced us to do is we have seen a couple of challenges, and there are multiple things going

on. But the military departments, their end strength has gone down, and the way we man those hospitals is with a certain percentage of military members. And as Dr. Friedrichs said, you just cannot buy health care professionals off the streets.

So when we cut the end strength then we apportion this care downtown, and then that increased TRICARE budget, but then we have to pay with bag one money, which is direct care money, to pay direct care. So now we actually have an internal shrinking of our budget. So it has been challenging for the Defense Health Agency to manage a set of military treatment facilities with that to be the current business process.

Senator Shaheen: And is it fair to say that budget uncertainty exacerbates that problem --

General Robb: Oh, absolutely.

Senator Shaheen: -- that continuing resolution exacerbates that problem?

General Robb: Absolutely. Yes, ma'am. Yes, ma'am.

Senator Shaheen: Thank you. Dr. Friedrichs, you mentioned the National Guard, and one of the things I know, the National Guard, as we all know, is assuming a greater role in actual deployments and picking up work for the regular military. I could probably say that more eloquently, but they are taking on a much bigger role than

they did 30 years ago. Yet the National Guard does not have the same coverage for health care that our regular military does. Despite the challenges that you all have identified, it is even a greater problem for the National Guard.

Can you speak to what we ought to be thinking about as we are thinking about how do we ensure that the Guard actually has the health care they need so that they are ready to go if they are called to deploy or called into combat?

General Friedrichs: Thank you, Senator Shaheen, and I will start, if I may, first with your premise that there is an increasing demand signal. The decision to take down the United States Agency for International Development and most of its capabilities is almost unquestionably going to drive more demand on the Department of Defense. USAID provided countless services for disaster response and for work with allies and partners around the world.

Senator Shaheen: And for global health.

General Friedrichs: And for global health, and for biosurveillance, and many other roles. In the absence of USAID, we either agree that when Americans are caught in a disaster they are on their own, or we are going to turn to the only other organization that has those kinds of capabilities, and that is DoD. So we should, I am afraid,

expect to see more demand on DoD as a result of those changes.

To your point about health care preparedness, when we look back at why people, shortly after deployment, have to be pulled off the line, interesting it is dental care primarily among the Guard and Reserve, who do not have ready access to that. I think if we are serious about a smaller force that must be ready on a moment's notice, we are going to have to address how to ensure that force is ready, when needed, to go forward, and that is medically ready, as well as ready and proficient with whatever their assigned task is.

Senator Shaheen: And we are learning a lot of lessons on our industrial base side, from the war in Ukraine right now, and a lot of lessons about the conduct of war today. Are we learning anything about the health care system and what we ought to be thinking about from what is happening in the war in Ukraine? Anybody.

General Friedrichs: If I may, I will just quickly say, having just been with the Ukrainian Surgeon General, absolutely. What they have found, first and foremost, is they are in the kind of conflict we will likely be in, and in the absence of air superiority, contested logistics, you must have a functioning system that is integrated. And this gets back to Senator Fischer's question about the

National Disaster Medical System.

They are also learning the importance of supply chains. When we looked at this at the Joint Staff, we found that a significant percentage of the pharmaceuticals in our deployable assemblages actually rely on ingredients from countries that may or may not be willing to continue to provide those in the next conflict. Same song, next verse, with medical equipment.

I urge you, as I said in my written statement, to require the Department to give you an accounting for our vulnerabilities in that area and a plan to address them. There are ways to do that. We need a strong push, I would submit, to actually accomplish that.

Senator Shaheen: Thank you very much. Thank you all.

Chairman Wicker: Thank you, Senator Shaheen.

Dr. Cannon and Dr. Robb, do you want to elaborate on what Dr. Friedrichs said about USAID?

Colonel Cannon: Sure. That is out of my domain so I do not have anything.

Chairman Wicker: Very well, then. Yes.

General Robb: I would concur, one, with his comments, but number two, again it is mostly out of my domain currently.

Chairman Wicker: All right. Thank you very much. Senator Cotton.

Senator Cotton: General Friedrichs, I would like to continue with the answer you just gave to Senator Shaheen about our dependence on other countries for drugs and precursors, specifically Communist China. The United States relies heavily on Communist China for basic drugs and so-called APIs, active pharmaceutical ingredients. Providers obviously need this, not just in the civilian world but in the military world, especially to treat combat casualties. China, for instance, has 80 percent of the global supply chain of antibiotics.

How could Communist China use this dependence of ours to its advantage if there were a major conflict in the Pacific?

General Friedrichs: Thank you very much, Senator Cotton, and I think we have seen examples of this with rare minerals and other things that China largely controls the supply chain for, in that they will choose to titrate that supply chain based on their satisfaction or dissatisfaction with those trying to purchase those items.

I had the great privilege in my last role of working with India, the EU, Japan, and Korea on a consortium in which we began to identify ways to leverage new technologies to change and to broaden our supply chains. And I encourage this Committee to direct the Department of Defense, in partnership with the Department of Health and

Human Services, to continue exploring those options.

What we found was in many cases, as in the case of antibiotics that are based on penicillin, the Japanese have already made a tremendous investment in the ability to produce those APIs within Japan. We should be partnering with them and creating an environment in which at least the DoD and the VA purchase from Japan to help sustain that production base and ensure that we have the access that we need.

There are many more examples. I touched on some of them in my written statement. But there are ways to mitigate this.

Senator Cotton: And your answer to Senator Shaheen said that Congress should push the Department of Defense to catalog all of these dependencies. It sounds like you are saying we also need to push to eliminate, or at least significantly curtail, these dependencies, as well. Is that right?

General Friedrichs: Absolutely.

Senator Cotton: And you mentioned four different sourcing options -- South Korea, Japan, the EU, and India. Those first three are advanced industrial democracies, just like ours. If they can produce these items, like acetaminophen or ibuprofen or penicillin, at a reasonable cost, surely the United States could do so, as well, right?

General Friedrichs: I believe that is the case. And what we found is that particularly in these countries they have created an environment in which it was financially possible for companies to produce these items within their country. We have not done that here in the United States. But a thoughtful industrial policy that was focused on resilience and national security, as well as economic security and health security, could do that for us, as well.

Senator Cotton: It is fair to say that between the two of them, the Department of Defense and the Department of Veterans Affairs, sure does have a lot of purchasing power to create a domestic market for the production of these fairly basic and longstanding medicines, right?

General Friedrichs: Absolutely. About 8 percent of the market -- and it get back to Senator Shaheen's point about continuing resolutions and predictability. If companies know that they have a predictable demand signal, they will build to it. If they have an episodic or random demand signal, they will let somebody else deal with that.

Senator Cotton: General Robb, I have noticed you nodding your head vigorously, so please get off your chest everything you wanted to add to General Friedrichs' answers.

General Robb: Yes. Also, and I am sure you are

aware, and this has been the direction from questions asked by our Congress, the Center for Health Services Research at the Uniformed Services University has been tasked, along with the Defense Logistics Agency, to catalog and specifically look at what, and define the problem what is, the Department of Defense's reliance on the medicines that we have talked about that are primarily sourced from China and from India, which would then help what I would call inform the decisions a way ahead of whether you, what I call it, ally-shore, or near-shore, or on-shore, as Dr. Friedrichs discussed, in looking at a way forward.

But they are creating that, you know, what is the data to drive the decision and the investment. Thank you.

Senator Cotton: Thank you, gentlemen, both, for your answers. It has long been the case that the Department of Defense, acting at congressional direction, has mandated the domestic purchase of many uniform items, so I think surely we should make sure that our troops have the medicines they need to stay healthy, or to recover, as needed.

Chairman Wicker: Thank you, Senator Cotton. Senator Kaine.

Senator Kaine: Thank you, Mr. Chairman. Thank you to the witnesses. I want to particularly recognize Dr. Cannon. I know you are very well-prepared for this hearing

today because one of the leaders that is with you, Kristin Malloy, used to be on my staff, and she made sure I seemed a lot smarter than I was at any hearing that I attended.

You know, I think I want to focus all of your attention on the workforce issues, because I am on the Health, Education, Labor, and Pension too, and if I go to my hospitals and health care providers they are singing the blues about workforce, tight labor market, difficulty hiring and retaining folks.

I went to the grand opening of the new VA clinic in the Fredericksburg area two Fridays ago, and we built it to the tune of about $350 million. And we built this state-of-the-art clinic, with one step down from a hospital, because there were multiple clinics in the area, and veterans were having to go from pillar to post to get care rather than a single place.

But when we opened it, and I was there for the opening, I had staff say, "We are on a skeleton crew." The three VA hospitals in Virginia -- Salem, Richmond, and Hampton -- are laying people off. There are hiring freezes. There are plans for even more layoffs. So the estimates I was getting at that grand opening is they are probably 20 to 50 percent staffed. There is another sizeable clinic similar that is going to open in Chesapeake, supposed to, on April 11th. If it does open on

time, I am suspecting that it will be a similar thing. And you saw the announcements about more cuts coming in the VA.

You have talked a little bit about the need to be more integrated between DoD facilities and VA facilities, but then also on the civilian side, what is your vision for how we equip our civilian system to provide a surge capacity or backup capacity when we need it, to perform well in combat situations?

Please, Dr. Cannon.

Colonel Cannon: Senator, thank you for your very insightful comments and questions. I am a veteran. I get my care at our VA in Philadelphia. My wife is a primary care physician and takes care of veterans. So I can speak to your comments about the VA from that perspective.

I do have a role at Penn Medicine as the Assistant Dean for Veteran Affairs for Penn Medicine, but I am quite new in that role and still learning the ropes. So I will speak more from my end user experience.

I would say that certainly there are opportunities for synergy. The partnerships between VA facilities and academic medical centers I think have been partially realized, but in this sort of urgent situation we find ourselves in, we need truly a whole-of-society approach, and where there can be market synergy, where there can be economies of scale we should aggressively pursue that.

I know that our CEO, Kevin Mahoney, has made overtures to the VA, and there have been agreements signed between the VA. I do not have detailed knowledge about that and where that stands. But I think there is an opportunity, and we should push for that. And as a veteran who receives my care, I hope that we can continue to deliver excellent care through better synergy.

Senator Kaine: How about Dr. Friedrichs and Dr. Robb?

General Friedrichs: Thank you, Senator Kaine, and that is a beautiful facility. It will be tragic if it sits there empty while veterans are unable to access care because of shortages of medical professionals in the VA, in the DoD, and in the civilian sector.

We are in a less-than-zero-sum game right now, and that is both a health security issue but also a national security issue.

The first recommendation I would make to this Committee, direct that the Department of Defense does not close any more of our military training programs. For decades, the military training programs have been one of the pipelines that, when people eventually left the military, which all of us do, they go to the civilian sector. We cannot afford to close any more training programs when we have so many shortages of doctors and nurses and dentists and other things.

The second, I implore this Committee, in the NDAA, direct the DoD and in partnership with the appropriate VA oversight committees, the Veterans Administration, to come back with a plan, starting with the D.C. market, to integrate the two systems. We have talked about this since I was a major. I moved here in 1997, and we were talking about this. It is time to stop talking and start doing it. We cannot afford to keep talking about this problem.

That hospital in the VA here is ancient. It has got to be replaced. We just finished a billion-dollar upgrade at Walter Reed. Why in the world are you not demanding that we come back with a plan to do that? It is more efficient, and it helps to pool the resources.

The third point, and the most important one in your Health Committee role, is we must address these pipelines as both a health security and an economic security and a national security concern. As long as the pipelines continue to be insufficient to need, there is no way that any of these problems are going to get fixed. And I think you have a unique opportunity to help bring that into both committees. Thank you, Senator.

Senator Kaine: Thank you. And Dr. Robb, I will ask that question for the record because I am now out of time. I yield back to the Chair.

Chairman Wicker: All right. Actually, these

witnesses will not be taking questions for the record. I will let you follow up for 45 seconds.

Senator Kaine: Dr. Robb, then could you approach that workforce integration question too? Thanks.

General Robb: Yes, and I will go back to where we can share resources, and I will foot-stomp. We have very many successful joint DoD and VA partnerships. Travis Air Force Base is a great example, where the actual VA is inside of David Grant Medical Center, share staffs, but more importantly, share patients. We have others where we are co-located community-based outpatient centers that feed patients into like Anchorage, Alaska. We see that down there at Naval Pensacola.

So those opportunities, because usually what happens is we want access to critical care patients for our proficiency, and the VA wants access to resources, which is either excess capacity on space or in staff. So I think that continued movement forward, not always one size fits all, but that is very, very important. Much like the VA is at all the academic health centers, I think the Department of Defense, especially six or eight strategic places, they would have strategic VA and strategic mil-civ partnerships, sharing staff.

And I will quickly say, not only does the military learn from the civilian opportunities, during OIF and OEF,

actually, the American College of Surgeons made sure that they were with us so they could learn, firsthand, real-time, on how we were treating. So it is a mutually synergistic relationship.

Chairman Wicker: Thank you, Dr. Robb. Senator Rounds.

Senator Rounds: Thank you, Mr. Chairman, and I am going to follow right along that same line because I think what you are laying out is basic common sense when it comes to the integration of these two systems.

My question is, why is it that when we have what is considered to be excellent care with the military system, the MHS, involved, and then we have to transition these young men and women as they leave the armed service into a VA facility, in which we start all over again. And we have different ways of communicating, and, in fact, let me just ask this. In your experiences, how well do we integrate the transfer of information from the MHS back into the VA systems today?

Colonel Cannon: Senator, I can take a crack at that. I believe you are spot on. My experience in transitioning from the DoD to the VA was more of a lukewarm handoff than a warm handoff. I had to sort of navigate my way to the VA. I now have closed that gap and I get my care there, as I mentioned. But it is not a seamless process.

Why is it still the case that the two health care delivery systems are so partitioned? I think you have to go back to ancient history almost, in our country. And if you look at Secretary Gates' comment about his experience as Secretary of Defense, he said, "The one department that gave me the most fits was the Department of the VA."

So there are historic challenges. The VA wants to do it their way. Understandably, most of us do want to do it our way. But I think there are clear opportunities and a clear demand signal to break down those barriers and realize opportunities for synergy. So I think we can do that.

Senator Rounds: I think the focus should be on whether or not we are delivering for the veteran and not necessarily the survivability of the VA itself. And I think that sometimes gets mixed up.

I am just curious, gentlemen. We have talked about trauma centers. We have talked about the reintegration, or integrated health care system, and so forth. We are not, right now, at the same degree of activity and intensity with regard to battlefield casualties as we were just a few years ago, and therefore the opportunity for these surgeons, these battlefield surgeons and others, to actually learn right now is probably not as great.

How do we keep the intensity or the capabilities of

the training, how do we keep that up to date when we do not have those opportunities? And I am not going to say that they are good opportunities. I am glad that we are not in them. But how do you allow that surgeon to keep those skills up to speed when you do not have the types of casualties that you have on a battlefield, that we were experiencing for a number of years?

General Friedrichs: Take care of sick patients, sir. I mean, there is an analog between taking care of a patient who has bladder cancer and needs to have their bladder removed and taking care of a patient who has just had a gunshot wound to the abdomen and needs to have their bladder reconstructed.

We need our military medics taking care of sick patients. They do that at hospitals that are well-staffed and well-resourced to take care of sick patients. And so that is what we have done historically to maintain the proficiency of surgeons or of critical care nurses or of medical logistics staff, is keep them busy during peacetime taking care of sick patients. It is not a perfect analog, but that is the best surrogate, and that requires resourcing the system, making sure that sick patients can get in the door and get the care they need.

And to your point about the VA, I would just say I applaud the VA for accelerating moving forward with their

electronic health record, because that is going to be the secret sauce that enables greater sharing between the two departments and will enable us to track patients from the day they join the military to the day they take their last breath, and really learn how to improve both systems.

Senator Rounds: Is the current system that you use integratable with the VA's new proposed medical records health care system?

General Friedrichs: I am not an expert on the VA's system. When I left the movie they were looking at purchasing the same system that the DoD had purchased. I hope that those with oversight responsibilities will insist that the two systems are integratable, because technologically, there is nothing to prevent that. I mean, civilian health care system integrate Epic and Cerner all the time, or McKesson and Epic. There should be no technological reason why we cannot do that.

Senator Rounds: Thank you. General Robb, anything to add to that?

General Robb: I would share what Dr. Friedrichs said. In fact, what I was excited about is I have had the opportunity for family members to be in civilian hospitals, and they are able to reach into it and see Genesis now. So they know the health care that my family members have been getting in the military.

I know that has absolutely been the vision between the Department of Defense and the Department of VA, and I believe that is still what I would call the true north.

Senator Rounds: Thank you. Thank you, Mr. Chairman.

Chairman Wicker: Thank you, Senator Rounds. Senator King.

Senator King: Thank you, Mr. Chairman. First, I want to thank you for having this hearing. Very timely and important. Secondly, I want to associate myself with Senator Cotton's comments about sort of Berry Amendment for drugs. The idea that we have to buy Made in America shirts for our troops but we are worried about the availability of crucial drugs, that seems to me that is something that should be pursued. We could even call it the King-Cotton Amendment, but I will pass on that.

Also, Mr. Chairman, before getting into the questions, and these witnesses would not have the answers, but I think in light of this hearing, the Committee should make an inquiry about whether there have been firings or early retirements encouraged within the medical facilities at the Defense Department, because we know there is a lot of that going around, and I would like to know whether that is happening in the Defense Health Agency.

Secondly is the impact of the continuing resolution. That is certainly not going to help this situation in terms

of maintaining demand signals, continuity, pilot programs -- all of that is gone in a continuing resolution. For the first time in my knowledge, I think the first time in American history, we are faced with a year-long continuing resolution, which basically vitiates the entire budget process.

Okay. What we are really talking about, it seems to me, is surge capacity. And it is impractical to maintain a capacity within the Defense Department, or even Defense plus VA, for the kind of casualties that would be generated in a significant conflict. Therefore, I see no other alternative than a cooperative surge agreement with the private sector. That is where capacity is, even though that is fairly limited.

Dr. Friedrichs, isn't that really what we are talking about here is how do we deal with a conflict way beyond what we are seeing now, within the current capacity? Defense Health Agency could not do it. VA could not do it. It has got to be relationships, and should we not have those relationships in advance so this is not something that we scramble to do, as we did during COVID, for example?

General Friedrichs: Senator King, I could not agree more strongly --

Senator King: [Inaudible.]

General Friedrichs: Thank you, sir. So in the Cold War we had what was called the Integrated CONUS Medical Operation Plan, which was essentially what you just described. It was our shared commitment, as a nation, to care for our nation's casualties, if and when our nation went to war. That depended on the National Disaster Medical System as part of the integrating function between the Federal and the civilian health care system. The NDMS has been allowed to attrit.

I echo the recommendations to reauthorize the Pandemic and All Hazards Preparedness Act, because that, in part, enables the NDMS. But I implore you to go further. The Integrated CONUS Medical Operation Plan needs to be updated, and we started that work when I was the Joint Staff Surgeon, and it is continuing today. Having the NDMS in name is not sufficient. We actually have to build out the numbers, by community, of what beds would be available --

Senator King: With preexisting conditions and analysis of --

General Friedrichs: Yes.

Senator King: I just wonder if the Pentagon has war-gamed this issue. They war-game everything else.

General Friedrichs: Absolutely, sir. We actually did a war game on this, that we hosted first when I was the

Transportation Command Surgeon, and again when I was the Joint Staff Surgeon. And what we found was just as you said -- it cannot be done unless it is a whole-of-the-nation effort. And the only way to get to that point is if we do much more detailed planning. Taking down funding for state and local readiness officials, for example, is not going to help them do more planning or preparing.

We need to work together to build and flesh out that plan, and we must bring industry into that. The defense industrial base provides equipment. The health industrial base addresses the points that you bring up.

Senator King: And we have an analog in TRANSCOM, which has agreements with the private sector both in terms of airplanes and ships, in the case of an emergency. That is where our surge capacity is.

So it seems to me, I mean, here we are talking about it, but I think there needs to be some very specific good, new looks at this relationship in order to be ready, so again we are not scrambling.

Dr. Robb, you are nodding. I take it you agree?

General Robb: Yes. I would absolutely concur. And again, I keep going back to the same theme, is we have got to build up those 6 to 8 to 10 strategic military treatment facilities, we have to resource them, and then you create the already established military VA partnerships, and then

you just keep expanding that ring. But you have to have those relationships codified and in place, and that is what Dr. Friedrichs is talking about. You cannot just, all of a sudden when it kicks off, pick up the phone and say, "How is it going?"

Senator King: You have got to have them in place before the crisis hits.

General Robb: Absolutely.

Senator King: Thank you, gentlemen. I appreciate it. Thank you, Mr. Chairman.

Chairman Wicker: Thank you very much, Senator King. Senator Budd. Catch your breath.

Senator Budd: Thank you all for being here. Major General, in your opening statement, whether here or able to watch it on the closed circuit, you identified the importance of the relationship between the Military Health System and the defense logistics enterprise.

So should deterrence fail and war break out in the Indo-Pacific, there are undeniable logistics constraints, particularly given the geography of INDOPACOM. The logistics of replenishing medical supplies and evacuated wounded servicemembers could make all the difference in reducing servicemember casualties. You provide a number of recommendations in your opening statement to address these concerns, including a number of reports and studies, so

thank you for that.

What can our Military Health System do in the short term, like immediately, to address logistical constraints, and how can DoD leverage medical innovation to address some of those constraints?

General Friedrichs: Thank you very much, Senator. I think the most immediate recommendation that I included in my written statement was that whenever we contemplate an operation or we are updating plans, we do a medical feasibility assessment, very similar to the logistics feasibility assessment that the Joint Staff J4 does. We need to ensure that we are informing our combatant commanders about what is and is not possible. That is something that can be done very easily.

The longer answer to your question gets back to the discussion that we were just having about partnering with industry, both on the equipment and pharmaceutical side and on the health care delivery side. We have the Civilian Reserve Air Fleet that allows us to commit money to ensure that we have industry partners willing to provide aircraft and support when we need it. We have no such analog in the health care space, even though we know, as multiple Senators pointed out this morning, that there is insufficient capacity in the DoD and in the VA to care for our casualties.

The NDMS currently is a voluntary system in which hospitals can say, "Yeah, okay," and then when we call them, they say, "I'm busy today. I'm not going to participate." We actually need to codify a system, as we have done with other industrial partners, in which there is a commitment and an understanding of how the reimbursement would work.

The last point that I would make on that going forward is in supplemental planning for future operations we have to build in that cost. There is no question, if we are bringing back thousands of casualties, as Colonel Cannon described, that that is going to displace care, and it is going to increase costs at hospitals. We have to plan for that. That is why this whole planning effort, the Integrated CONUS s Plan, for which NORTHCOM is the lead, in partnership with industry, state, local, and HHS officials, is so important, so we can bring back the requirements for funding and the challenges that we will need congressional help to address.

Senator Budd: Thank you. Following up on that, you said we need to codify that. Do you have the language ready, or has that been written in a way that we could review, either individually or as a Committee?

General Friedrichs: Senator, I took the liberty of including an attachment with suggested language, just in

case anyone wanted to do that.

Senator Budd: We will read it in a few moments. Thank you.

Mr. Robb, as you know, the Department relies on a mix of military personnel, Federal civilians, and contractors to carry out its mission. Talk to me about the roles of physician extenders such as registered nurses, and what role do physician extenders play in ensuring the readiness of the broader force, and what challenges do you see to retention of physician extenders?

General Robb: Thank you for that question, Senator. I think it is key that the same issues of what I call proficiency and currency that exists for physicians, exists for our physician extenders. And the Army does a great job, especially in the way they have manned and equipped their fighting forces, of using those physician extenders, all the way down to the corpsmen, to the fullest extent of their capabilities.

And so I would argue, as we have these discussions about medical readiness and about our ability to care for what we call critical wartime specialties, we must remember, trauma is a small percentage of that, but the majority of the care that is applied to our fighting forces comes from our primary care providers, which would be PAs, nurse practitioners, general practitioners, family

physicians. So we must ensure that they also have the critical thinking skills and the opportunity to practice at the top of their game.

Senator Budd: Thank you all, to the whole panel. Chairman?

Chairman Wicker: Senator Budd, yes indeed, in looking at the statements, which have all been admitted to the record, by unanimous consent, I see on page 14 of Dr. Friedrichs' prepared testimony Attachment 1, Suggested National Defense Authorization Act Language. So we do appreciate him acting as an uncompensated legislative staffer for this Committee. We appreciate that. And thanks for the question.

Senator Kelly.

Senator Kelly: Thank you, Mr. Chairman. General Friedrichs, good morning, and thank you, all of you, for being here today. General Friedrichs, in a recent war game brief to Congress in November of 2024, a hypothetical conflict in the Indo-Pacific resulted in 3,000 U.S. casualties in 3 weeks, and 10,000 across the entire conflict. And I am kind of following up on Senator Budd's line of questioning here.

These numbers are higher than anything we have seen since the Korean War. In a severely injured servicemember's transition through the care system and make

their way back to the United States for treatment, I am concerned that the number of DoD providers capable of handling trauma will be grossly insufficient. So given that, we are going to need to surge capacity, potentially found in the U.S. hospital system and VA hospitals, meaning civilian hospitals, VA hospitals.

What concerns do you have with relying on U.S. civilian and VA hospitals to provide this trauma care to our servicemembers?

General Friedrichs: Thank you very much, Senator Kelly, and I would start by saying even before we get patients back to the United States, in the past we have relied on our allies and partners to help care for our casualties. And I am deeply concerned if we sever or degrade those relationships we will need to rewrite our plans, and the demands on the U.S. health care system will be even greater.

To your point about the U.S. health care system, the Integrated CONUS Medical Operation Plan that we updated in 1998, and then did not look at until 2020, is the plan that describes how we will surge capacity. But a key part of that gets back to some of the discussions we have had earlier. There have to be doctors and nurses and pharmacists and all the other staff to do that, and I implore that we continue to look at the pipelines that

produce those medics as well as the facilities in which they work.

We had briefly chatted about the opportunity for a medical equivalent to the Civilian Reserve Air Fleet that we use to ensure access to civilian aircraft, when needed. I believe we need some similar construct in the health care system, where we partner with industry and recognized that during surge moments there is a plan, and there is money available, for us to be able to leverage their staff and their facilities.

Senator Kelly: Is there a plan?

General Friedrichs: There is a plan. We wrote the first version of that before I retired, and they are working on an update to that. But it would benefit from additional congressional oversight to ensure that it is on track and it does not get diverted by bureaucratic buffoonery.

Senator Kelly: Are there current efforts in the relationship building with these hospitals?

General Friedrichs: The Defense Health Agency is tasked to have that outreach, and as I have met with hospital CEOs and system owners, there is certainly an opportunity to do more in that space. We must view the health care industry the same way we view the aviation industry or the missile-producing industry, as our

partners. We cannot take care of America's casualties without those partners.

Senator Kelly: Can you talk to the value in the two Navy hospital ships -- I do not know if anybody here is prepared to talk about it. Because I think there is an effort underway to replace those. There is also the training ships for the state maritime academies that I think also could serve a role. I visited one at the Philly Shipyard a few weeks ago, had an operating room on board. Is that part of the system, as you envision it?

General Friedrichs: Yes, absolutely. The hospital ships are integral to our plans for a large-scale combat operation, and the two ships we have are some of the oldest ships afloat. They have to be replaced.

Senator Kelly: I think there is a plan to replace them now. Can you speak to how that is going, if you know?

General Friedrichs: I pushed incredibly hard for that plan as the Joint Staff Surgeon, against intense opposition that we should spend the money in other places. I would defer to the Navy for the latest update on it, because they can give you the most current plan. But my understanding is that we are still years away from having the replacement ships available.

So we will have to extend the current ships, and I believe, the last update I received, which is dated, was

through 2035. But we do need that additional replacement funding to replace those aged ships.

Senator Kelly: All right. Thank you, and thank you, Mr. Chairman.

Chairman Wicker: Thank you, Senator Kelly. Senator Warren.

Senator Warren: Thank you, Mr. Chairman. So we need a medical health care system that works in wartime, but the one we have is failing us in peacetime. And I think we need to do better on this. Fixing TRICARE's prescription drug care benefit is part of that.

Since 2009, TRICARE has outsourced to Express Scripts a massive pharmacy benefit manager, PBM. The Defense Health Agency, DHA, pays Express Scripts to negotiate with pharmacies, deciding where servicemembers can pick up their prescriptions and what price they are going to pay. But Express Scripts also owns Accredo, a massive pharmacy that participates in TRICARE, and DHA has been allowing all kinds of self-dealing between these two entities.

Here is one. DHA used to require Express Scripts to maintain a network of 50,000 pharmacies. But in 2021, Express Scripts negotiated that down to 35,000 pharmacies. Then they turned around and told thousands of pharmacies, that they do not own, either to take money-losing terms or get kicked out of TRICARE.

General Robb, you used to oversee the TRICARE network before this gaming started. Do you have any idea how many pharmacies have left, just since 2022?

General Robb: And Senator Warren, I have been out of this since 2016.

Senator Warren: Okay. I just wondered if you happened to know how many had left. I will take a no.

General Robb: No, ma'am. No, ma'am, I do not.

Senator Warren: Well, it is over 13,000 pharmacies have left this network, and most of them are independent pharmacies, community pharmacies. That forced 400,000 servicemembers and their families to find new pharmacies, and many of them have been pushed to the Express Scripts-owned Accredo.

Even worse, Express Scripts has set up Accredo as the primary off-base pharmacy where military families can fill specialty drug prescriptions. You know, these are the really expensive cancer drugs, rheumatoid arthritis drugs, that make up over half of the $8 billion in TRICARE prescription drug spending. So it is a lot of money here.

It does not end there. As we speak, Express Scripts is facing a whistleblower lawsuit that alleges the company systematically overfilled TRICARE prescriptions at Accredo, saddling DoD with, quote, "billions of dollars in excess dispensing fees and drug resupplies." And this is not a

surprise. Express Scripts has been found to massively overfill and overpay for prescriptions at Accredo, which they own, in other government programs.

So General Robb, since last year, an audit uncovered that Express Scripts was leveraging its contract with the West Virginia Public Employees System to send inflated payments to Accredo for expensive specialty drugs, in some cases inflating the price by 100-fold more than the cost of dispensing exactly the same drug at a competing pharmacy.

I imagine you think this kind of taxpayer overcharging is unacceptable. Is that fair, General Robb?

General Robb: I would agree with that, it would be unfair. Yes, ma'am.

Senator Warren: Okay. DHA is supposed to audit Express Scripts' pharmacy data to make sure that that same thing is not happening at TRICARE, but DHA said it had not completed an audit because DHA had, quote, "no concerns about data accuracy."

You know, talk about being asleep at the wheel here, in just the first quarter of 2023, Express Scripts dispensed 70,000 specialty drug prescriptions at Accredo, but the company only reported about 40,000 to DHA. In other words, Accredo failed to report nearly half of the expensive specialty drugs dispensed at its own pharmacy, which were paid for by DHA. So they get the money, but

they do not tell DHA what is going on here.

General Robb, after completing their investigation, GAO sensibly recommended that DHA periodically audit Express Scripts' reported data for accuracy, which, by the way, is already required in the contract. So this is telling them basically to follow through on the contract.

Do you agree with GAO's recommendation?

General Robb: I would agree that they need to follow what is the business policy and what is the contractual requirements. Yes, ma'am.

Senator Warren: All right. You know, I just want to say, and I will close up here, DHA is paying Express Scripts billions of taxpayer dollars to manage the TRICARE benefit and negotiate with itself, and DHA is not even bothering to check the books. I think that everyone in this room agrees that Express Scripts ought to pass an audit, and that ought to be required in this year's NDAA.

Thank you, Mr. Chairman.

Chairman Wicker: Thank you, Senator Warren.

General Friedrichs: Mr. Chairman, may I add a comment to that? Is there time?

Chairman Wicker: You certainly may, yes.

General Friedrichs: Thank you very much. I would hold up the Veterans Health Administration's exemplary mail order program, which has worked for years, as an

opportunity, again going back to this concept of how do we deliver better care, and where possible, do it more efficiently. There is a real opportunity for this Committee, in partnership with the appropriate oversight committees, to direct a comparison of the two systems and then bring back recommendations for the best practices between the two.

Pharmaceuticals are growing in costs, and that is not going to change. But this is an area in which the Veterans Health Administration actually has done this well for years, with high patient satisfaction, and more importantly, the patients get the meds they need, when they need them. There is a real opportunity to learn from the VA here.

Chairman Wicker: Thank you very much. Thank you, Senator Warren. Mr. Ranking Member, anything more?

Senator Reed: Just let me commend the witnesses. You have given us lots to think about and lots to do, and so we appreciate that. Thank you very much.

Chairman Wicker: We are indebted to you and grateful to all three of you. Thank you very much.

And this concludes the hearing.

[Whereupon, at 11:04 a.m., the hearing was adjourned.]