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HEARING TO RECEIVING TESTIMONY ON DEFENSE HEALTH CARE REFORM

Tuesday, February 23, 2016

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U.S. Senate
Subcommittee on Personnel
Committee on Armed Services
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The subcommittee met, pursuant to notice, at 2:31 p.m. in Room SD-G50, Dirksen Senate Office Building, Hon. Lindsey O. Graham, chairman of the subcommittee, presiding.

Subcommittee Members Present: Senators Graham [presiding], McCain, Wicker, Tillis, Gillibrand, Blumenthal, and King.

OPENING STATEMENT OF HON. LINDSEY O. GRAHAM, U.S. SENATOR FROM SOUTH CAROLINA

Senator Graham: The committee will come to order.

I thank everyone for attending.

We meet this afternoon to discuss military health care system reform and to learn how we can redesign an outdated 20th century health care system that has become unsustainable and does not work as well as it should for service men and women and their families.

We are fortunate to have two panels of distinguished witnesses joining us today.

On the first panel, we have Dr. Bernadette Loftus, Associate Executive Director and Executive-in-Charge for Mid-Atlantic Permanente Medical Group; Dr. Mark Fendrick, Director of the Center for Value-Based Insurance Design and Professor in the Departments of Internal Medicine and Health Management and Policy at the University of Michigan; Mr. David McIntyre, President and CEO of the TriWest Healthcare Alliance; Mr. John Whitley, Senior Fellow at the Institute for Defense Analysis.

On the second panel, we have the Honorable Jonathan Woodson, Assistant Secretary of Defense for Health Affairs; Vice Admiral Bono, Director of the Defense Health Agency; Lieutenant General Mark Ediger, Surgeon General of the Air Force; Vice Admiral Faison, Surgeon General of the Navy;

Lieutenant General West, Surgeon General of the Army.

Senator McCain has made this a priority of the committee to try to find a way to reform health care. We made a good effort and I think some breakthroughs in terms of retirement reform. Now it is health care's turn because it is such a big part of the budget.

Last year, the Military Compensation and Retirement Modernization Commission gave us an important report on the military compensation and retirement system, complete with numerous recommendations to modernize that system. Without the commission's great work, we could not have reformed the military retirement system in the comprehensive way that we did. But we have more work to do.

The commission also made recommendations to assure service members receive the best possible combat casualty care to improve access, choice and value of health care for all beneficiaries and improve support for family members with special medical needs.

In the NDAA for the fiscal year 2016, we began the journey to accomplish military health system reform by requiring DOD to establish and publish appropriate access standards requiring DOD to be more transparent in the important areas of health care quality, patient safety, and beneficiary satisfaction by requiring them to publish outcome measures on public websites, mandating a pilot

program that allows TRICARE beneficiaries to get urgent care without needing to get a time-consuming, unnecessary pre-authorization for treatment and requiring the DOD to implement a pilot program on value-based reimbursement whereby health care providers are reimbursed for improving health care economics, outcomes, patient satisfaction, and the experience of care.

Although the commission published this report over 1 year ago, we have seen little progress made by DOD to fix the many problems in their hospitals and clinics. In fact, we continue to get frequent reports of the difficulties military families face every day. Here are two examples.

An expectant mother with a high-risk pregnancy moved with her husband to a new duty station during the 28th week of her pregnancy. Before being assigned to an obstetrician at the new duty station, she had to see her primary care manager and get a pregnancy test, despite the fact that her medical records verified her high-risk status. After going through all of this, she still could not get an appointment with a military obstetrician until the 36th week.

A spouse of a retiree injured her wrist in December and she scheduled an appointment at Walter Reed for an evaluation. At the appointment, the provider spent more time berating the patient for being overweight than examining her wrist. A wrist x-ray was done, but the

provider dismissed the wrist injury as a carpal tunnel syndrome. No follow-up appointment was given. 1 month later, the patient received a letter from the radiology department at Walter Reed advising her that she had a broken wrist. The patient now has a cast on her arm.

In my view, these failures to provide timely quality health care are symptoms of the many ills within the military health care system. Clearly there are problems. There are centers of excellence in the system, but these centers are not large enough and frequent enough. In my view, we have seen a military health care system designed and structured over decades to deliver peacetime health care in a way that is being passed by by time and modernization in the private sector.

On the battlefront, there are many soldiers alive today that would have died in other wars because of the quality of military health care. That has to be acknowledged. To those on the front line of this fight, you have done amazing things.

The purpose of this committee is to learn about how we can make things better, to listen to the private sector of what works there, and see if we can take a 20th century health care system designed to benefit the bravest among us to have better outcomes, more value, and to make it more sustainable.

So with that, I will turn it over to my colleague, Senator Gillibrand, who has been terrific in everything reform.

STATEMENT OF HON. KIRSTEN E. GILLIBRAND, U.S. SENATOR FROM NEW YORK

Senator Gillibrand: Thank you, Senator Graham, for your leadership and the work you do for this committee. I join with you today in welcoming our witnesses as we begin our discussion of military health care reform.

I was pleased to read about the many exciting and good approaches to health care in all of the witnesses' testimony, including Dr. Fendrick's mention of value-based insurance design utilized in my home State of New York and I am looking forward to hearing more about those approaches today.

Last year, the Senate and House fiscal year 2016 National Defense Authorization Act conference report included a commitment to work with the Department of Defense to begin reforming the military's health care system. The conference report called the reforms aimed at improving access, quality, and the experience of care for beneficiaries.

Today's hearing is the Senate's first step to fulfilling this agreement. We begin with a panel of experts from outside the Department of Defense to discuss innovations and best practices in health care across the U.S. From this panel, we hope to learn about the possibilities for improving military health care.

The first panel will be followed by a panel of officials in charge of health care for our service members, retirees, and families. From this panel, we expect to hear about current and prospective future initiatives in the military's health care system, as well as their assessment of innovations and best practices described by the witnesses on the first panel.

As we consider changes to the military health care system, it is critical that we ensure that no service members or their families are left behind and that the care we provide accounts for the unique needs of our military community and that any changes we consider improve access, quality, and experience for beneficiaries.

I am particularly interested in hearing about innovations and best practices to address health care of military families with special needs. I am interested in hearing about the private sector's management of pediatric populations with chronic or complex health problems such as those with autism or other developmental disabilities and how we may be able to adapt these practices to serving our military families.

Specifically, many on this committee are aware of my work to ensure that all military children with autism have access to ABA therapy, which is considered the gold standard treatment to help these kids reach their full potential. I

appreciate that the military has put in place a demonstration program to help military families, and I am pleased with this program's success.

However, I am worried that the proposed changes to reimbursement rates for ABA therapy providers may derail this program. So in your remarks, I would appreciate a discussion of your recommendations and perspectives regarding families with special needs children.

Finally, we have to make sure that our military health care providers maintain the skills and experiences they need to continue to provide world-class health care to our service members wounded on the battlefield, and we have to ensure that those who have served our country bravely return to a health care system that is able to meet their physical and mental health care needs. Our service members, retirees, and their families deserve the highest quality of care.

Again, I thank our witnesses for the time and effort they have put into this important issue.

Senator Graham: Senator McCain?

Chairman McCain: No. Thank you.

Senator Graham: Dr. Loftus, if you would start.

STATEMENT OF DR. BERNADETTE C. LOFTUS, ASSOCIATE EXECUTIVE DIRECTOR AND EXECUTIVE-IN-CHARGE FOR THE MID-ATLANTIC PERMANENTE MEDICAL GROUP

Dr. Loftus: Good afternoon, Mr. Chairman and committee members. Thank you for the invitation to be here today. I am Dr. Bernadette Loftus, Executive-in-Charge of the 1,300-physician Mid-Atlantic Permanente Medical Group at Kaiser Permanente.

Kaiser Permanente is the largest private integrated health care delivery system in the United States providing health care services to 10 million members in eight States and the District of Columbia. Kaiser Permanente is a high-performing health system as recognized by the Commonwealth Fund and the National Committee for Quality Assurance, or NCQA. In 2015, only two systems in the entire U.S. received a 5 out of 5 rating from NCQA for both commercial and Medicare patients, and they were Kaiser Permanente of the Mid-Atlantic States and Kaiser Permanente of Northern California. In fact, no Kaiser Permanente plan received lower than a 4.5 out of 5 rating in 2015, a level that only 10 percent of plans achieved nationwide.

We believe attaining excellent outcomes is based on understanding and relentlessly measuring performance so that opportunities for our improvement are continuously identified. We strategically exploit the full benefits of

our electronic medical record, creating systems of care that make it easy to do the right thing and hard to do the wrong. This is accompanied by clear expectations around behavioral norms and performance for our physicians and staff. The reliable achievement of better results starts with knowledge of current results. We measure all aspects of our care at all levels. We choose metrics for measurement that are evidence-based, nationally recognized, and reasonably comparable across geographies and populations. This minimizes distracting arguments that my patients are so unique, you cannot hold me accountable for any particular outcome. We do believe we can fairly assess performance across diverse populations using these standard measures.

We assiduously measure access to care because, obviously, without access, quality suffers. We have learned from 2 decades of studying correlations between patient satisfaction and the objective speed to access in days that patients have a much higher standard for access than doctors may feel is strictly medically necessary. Because of this, we base our access standards solely on our members' expectations. Our best levels of patient satisfaction with routine specialty care, for example, correlate with a speed to access of significantly less than 10 days from date of referral. We measure and report access to care daily. The expectation for physician managers is that the supply of

appointments will be managed dynamically on a daily basis to adjust to the ebb and flow of demand.

The science of excellent access is just that, a science, although it is a relatively simple one. Supply of available appointments must always exceed historical demand in order to ensure great access. Hence, our physician managers are thoroughly trained on the constant management that must be brought to bear to maintain access.

High achievement in quality requires the same degree of performance measurement, analytics, and reporting. Specific to quality management, we produce monthly variation reports, which graphically display variation in performance on quality metrics on multiple levels. These unblinded reports allow us to identify the high and low performers in similarly situated practices, and this creates the opportunity for dialogue around improvement. Data transparency spurs not only dialogue, but a little competition as well, which in turn engenders more rapid improvement. Data is delivered directly to every physician's desktop. Our primary care physicians can, on a daily basis, check their own performance on quality measures against those of others in their department.

We do not, however, leave prevention and quality achievement solely to our primary care physicians. It is our cultural expectation that every physician, regardless of

specialty, addresses the prevention and chronic disease needs of every patient she sees. This means that dermatologists and orthopedic surgeons are as responsible for ensuring that each diabetic gets his hemoglobin A1c measured timely or that a woman gets her mammogram that is due, as are those patients' primary care physicians. We continually collect and analyze data about our patients' health status and other findings and use that to create extensive population health registries that in turn inform decision support software in our EMR so that every physician is alerted at every visit to every patient that is due for a prevention or treatment measure. We believe high achievement of quality is everyone's job.

Again, thank you for today's invitation. I hope the information provided about Kaiser Permanente will be useful to you as you consider changes to the military health system and the TRICARE program. Kaiser Permanente would be honored to provide further assistance to you in the future and to serve this population in any way we can.

[The prepared statement of Dr. Loftus follows:]

STATEMENT OF DR. A. MARK FENDRICK, DIRECTOR OF THE CENTER FOR VALUE-BASED INSURANCE DESIGN AND PROFESSOR IN THE DEPARTMENTS OF INTERNAL MEDICINE AND HEALTH MANAGEMENT AND POLICY AT THE UNIVERSITY OF MICHIGAN

Dr. Fendrick: Good afternoon and thank you, Chairman McCain, Chairman Graham, Ranking Member Gillibrand, and members of the subcommittee. I am Mark Fendrick, a primary care physician and professor at the University of Michigan.

Mr. Chairman, I applaud you for holding this hearing on defense health care reform because access to quality care and containing costs are among the most pressing issues for our military personnel and our national well-being.

Yet, moving from a volume-driven to value-based delivery system requires a change in both how we deliver care and how we engage consumers to seek care. Reforming care delivery and payment policies are important, as you just heard. However, less attention is paid to how we can alter consumer behavior. Today I propose that clinically driven consumer incentives, through the creation of benefit designs that promote smarter decision-making, can assist us in achieving our clinical and financial goals.

The most common approach used by payers to impact consumers in the United States is cost-shifting. With some notable exceptions, most health plans, including TRICARE, implement cost-sharing in a one-size-fits-all way, in that

beneficiaries are charged the same for every doctor visit, every diagnostic test, and every prescription drug.

People frequently ask me if TRICARE members' co-payments are too high, too low, or just right. The answer, of course, is it depends. Asking TRICARE members to pay more for all services, despite clear differences in clinical value, results in decreases in both non-essential and essential care, which in certain clinical circumstances lead to adverse health outcomes and higher overall costs. I see this approach as pennywise and pound foolish.

Does it make sense to you, Mr. Chairman, that my TRICARE patients pay the same out-of-pocket cost for essential visits such as a cardiologist after a heart attack or a therapist for opioid addiction or autism? They pay the same amount to see a dermatologist for mild acne. They pay the same for drugs that are lifesaving for cancer, diabetes, and depression as drugs that make their toenail fungus go away or their hair grow back.

So realizing that TRICARE members avail themselves to too little high-value care and too much low-value care, we endorse smarter, clinically nuanced cost-sharing as a potential solution, one that encourages TRICARE members to use more of the services that make them healthier and discourages them away from the services that do not. We refer to these plans that use clinical nuance as value-based

insurance design, or V-BID. V-BID simply sets cost-sharing to encourage the use of high-value services and providers and discourages the use of low-value care.

For the record, I support high cost-sharing levels but only for those services that do not make TRICARE members healthier. The fundamental idea of buy more of the good stuff and less of the bad stuff has made V-BID one of the very, very few health care reform ideas with broad multi-stakeholder and bipartisan political support. Led by the private sector, V-BID has been implemented by hundreds of private and public employers, several States, and most recently the Medicare program. It is common sense. When barriers to high-value services are reduced and access to low-value services are discouraged, we attain more health for every dollar.

So, therefore, I recommend incorporating V-BID into TRICARE plans in the following ways.

First, TRICARE plans should vary cost-sharing for services in accordance to who provides them, such as high-performing providers, as Dr. Loftus mentioned, or the location of care based on quality, as well as cost.

Second, TRICARE plans should implement V-BID programs that combine reductions in high-value services but also include increases in cost-sharing for low-value care. As we think about fiscal sustainability, it is important to point

out that immediate and substantial savings are accumulated from waste identification and elimination.

And last, TRICARE plans should vary cost-sharing based on information such as clinical risk factors, special needs, and disease diagnosis.

So the successful practice of precision medicine requires precision benefit design. As cost-sharing becomes a necessity for TRICARE's fiscal sustainability, I encourage this committee to take a common sense approach of setting member co-payments based on whether a clinical service makes a TRICARE member healthier instead of the status quo, which is basing contributions exclusively on what they cost. If such an approach encourages the utilization of high-value care and discourages only low-value services, these TRICARE plans can improve health, enhance consumer responsibility, and reduce costs.

I am honored to support the men and women of the U.S. military and their families and am happy to provide the committee further assistance. Thank you very much.

[The prepared statement of Dr. Fendrick follows:]

STATEMENT OF DAVID J. McINTYRE, JR., PRESIDENT AND CEO OF TRIWEST HEALTHCARE ALLIANCE

Mr. McIntyre: Good afternoon, Chairman McCain, Chairman Graham, Ranking Member Gillibrand, and members of the Personnel Subcommittee of the Senate Armed Services Committee.

It is a privilege to appear before you today at this initial hearing on defense health care reform, and I hope that my participation in today's hearing will be of assistance to you and the Defense Department as you seek to ensure that the military health system is strengthened and is able to continue to provide optimal support to those who wear the cloth of this Nation, their families, and those who earned a retirement benefit due to their career of service.

I believe any framework for reform needs to begin with an assessment of what is working and not working, what the environmental conditions are likely to look like in the future, including the "go to war" capabilities and needs, and what approach will likely ensure success in the future.

For my nearly 20 years of privileged service at the side of DOD and now VA, I believe there are four fundamental questions worthy of exploration.

First, does DOD have the optimal footprint and most effective, efficient management structure and tools and system to deliver on the needs? And is the investment in

the direct care system being optimized? There is a great deal of expense inherent in the physical footprint, the equipment that has to be purchased and kept current and the personnel required to effectively staff the footprint. There is great efficiency and effectiveness to be gained when sizing a system, when making "make versus buy" decisions and collaborating appropriately, and perhaps even when leasing versus traditional ownership of plant and equipment is broached.

I also believe that telehealth and data and analytics tools and the corollary personnel investments need to be maximized, especially in this day and age.

As for management structure, there has been much written, proposed, and discussed on this topic over the years. It would seem that there is an opportunity in this space as well to achieve savings and enhance effectiveness, just as has been done with the evolution in the way in which the military medical community now supports the warfighter in theater. While not easy, streamlining the number of players and consolidating functions will also make the organization more agile and fiscally efficient.

Second, does the benefit available to the population make sense and is it priced properly?

The individual that testified just before me spoke eloquently of one component part that ought to be

considered. As we all know, the TRICARE benefit has evolved greatly in the last 20 years. Having said that, one challenge that remains constant is what to do with the pricing structure which was previously addressed. I believe that part of that needs to include indexing. And one of the challenges often with programs that are developed is that we fail to index them. And I think a simple, actuarially based and automatic triggered index would be worthy of consideration.

Third, is access to care easy, and what is the optimal approach to providing the direct care system with the needed elasticity to ensure that access to quality providers is available to meet the needs that the direct system cannot meet itself?

My understanding is that an electronic authorization system that allows workflow to efficiently and effectively move between the direct system and the TRICARE contractors and providers still does not exist. I would say that needs to be remedied, and it needs to be grounded in processes that are effective and efficient, to include supporting how to make sure that appointments work effectively and accurately.

Lastly, I would say that the networks built by those that support the DOD as contractors need to be constructed to match the need that exists for care in the community.

One size does not fit all. And in order to optimize the DOD budget, those networks should be priced at market rate.

And fourth, are we optimally promoting health and effectively and efficiently supporting those whose unmanaged health issues are both bad for the individual and presenting avoidable expense to the taxpayer?

Optimally promoting health starts with effectively supporting the patient, which my colleagues have addressed previously. If done right, it also results in cost avoidance, so the two go hand in hand. Segmenting the population and focusing in on those who benefit most from assistance in the management of their conditions is just smart and annually reviewing the analysis of the population's health is critical to doing this right.

Developing and deploying an integrated approach to disease management for that specific profile of conditions is also critical, something that we tried in TRICARE when I was doing it and we failed to focus in on the right spaces where opportunity exists. You want the treatment to be coordinated and well managed, regardless of where the care is delivered, whether it is in the direct system or in the community.

There should then be the development of a customized treatment plan for the individual patient and the modification of the design of the TRICARE program to provide

a series of incentives and disincentives for compliance with that treatment plan.

And lastly, provider payment models that appropriately reward providers for quality outcomes and reduce an overall spend need to be adopted as they are the key partner in delivering care. I would suggest doing pilots to continue to test this, but then deploying it effectively and quickly is important.

Senator Gillibrand, I would like to draw your attention to one prototype that I was privileged to be a part of with one of the next panel's participants. And that is at the side of the first lady then of the Marine Corps, Annette Conway, who was a special educator. We had the privilege, then-Captain Faison and myself, now the Navy Surgeon General, to prototype how to put a special needs program together to serve the families at Camp Pendleton. And I believe, sir, that that worked extremely effectively. So there are some clues there from a while ago, and there are probably clues from current pilots that could be rolled out and made available as you map the final policy.

In closing, I want to thank you for the invitation to appear before you today. It was an honor and a privilege for my colleagues and I at TriWest Healthcare Alliance and our nonprofit owners to be of service to the beneficiaries of the military health system at the side of the ladies and

gentlemen who wear the cloth of the Nation. That is work we will not return to because we have the awesome privilege now of leaning forward at the side of the VA in the current furnace, and that is where we will stay focused until our job is done.

I hope that my testimony today has been helpful to you as you contemplate the way ahead as it relates to continuing to refine the military health system and the important TRICARE benefit. And I look forward to answering any questions you might have. Thank you.

[The prepared statement of Mr. McIntyre follows:]

STATEMENT OF DR. JOHN E. WHITLEY, SENIOR FELLOW AT THE INSTITUTE FOR DEFENSE ANALYSES

Dr. Whitley: Mr. Chairman, members of the committee, it is a privilege to participate in this panel. The views I express are my own and should not be interpreted as reflecting any position of the Institute for Defense Analyses.

The military medical community is a dedicated force trying to provide beneficiaries a high-quality benefit and maintain their readiness to provide lifesaving care on the battlefield. But this community works within a military health system that often fails to encourage these outcomes and, at times, actually hinders their ability to succeed. I commend the Congress for addressing these challenges.

I make three primary points in my written testimony, which I will summarize briefly here.

First, TRICARE reform is not simply raising beneficiary cost-shares. TRICARE reform is a chance to fix a program that has become out of step with current trends in health care. It is not simply raising costs on retirees to save DOD money. It should be able replacing a system of 5-year, winner-take-all, largely pass-through, largely fee-for-service contracts with a modernized system that improves the quality of the benefit for our families and retirees while saving the taxpayer money.

Second, TRICARE reform is an opportunity to bring an increased focus on readiness to the military health system, in particular on how to retain the capability built during the wars. As the Compensation Commission reported, quote, research reveals a long history of the military medical community needing to refocus its capabilities at the start of wars after concentrating during peacetime on beneficiary health care.

Well before the wars in Iraq and Afghanistan began, GAO was reporting that, quote, since most military treatment facilities provide health care to active duty personnel and their beneficiaries and do not receive trauma patients, military medical personnel cannot maintain their combat trauma skills during peacetime by working in these facilities.

Although there were a lot of improvements made during the war, military physicians are still reporting, quote, today the service that the physician was referring to has less than a dozen pre-hospital physician specialists and about the same number of trauma surgeons on active duty. By comparison, that service has roughly the same number of radiation oncologists and nearly three times the number of pediatric psychiatrists and orthodontists in the force. This is largely because the medical specialty allocations are based on traditional peacetime beneficiary care needs.

Refocusing on wartime needs could populate key institutional and operational billets with a critical mass of trained pre-hospital and trauma specialists and drive further advances in battlefield care during peacetime. End quote.

This focus on the beneficiary care mission brings me to my third point. TRICARE reform is also an opportunity to reform the entire military health system. The MHS is a complex, interweaving set of missions, delivery systems, benefits, and funding streams. It involves duplicative management layers and fails to incentivize unity of effort on the key system-wide outcomes of readiness, high-quality benefit delivery, and cost control.

A prime example of these MHS problems is the military hospital network. The MHS direct care system includes over 50 inpatient hospitals and over 300 outpatient clinics. The purpose of having a DOD-run hospital system is to provide the clinical skill maintenance platform for the operationally required military medical force. But the day-to-day workload and operations of these hospitals are almost exclusively focused on beneficiary health care. As an example, I show in my written statement how different the inpatient workload in the direct care hospitals is from the deployed inpatient workload.

This puts military hospital commanders in an almost impossible situation, and it creates a climate of confusion

within the MHS that affects everything from staffing decisions to major investment decision-making.

And these military hospitals are expensive and a key driver of excess cost -- of health care costs within the DOD.

Many of these incentive challenges and the mission confusion in the MHS are driven by a lack of transparency in funding. The line service leadership, the Office of the Secretary of Defense, and Congress cannot identify how much is spent on beneficiary care and how much is spent on readiness, reducing the effectiveness of resource allocation decision-making and reducing accountability.

I offer suggestions on potential reform options for each of these challenges in my written testimony, and I would very happy to elaborate on them in the question and answer period.

I would just like to close by, again, commending you for taking on these important and complex issues and for including me in this conversation.

[The prepared statement of Dr. Whitley follows:]

Senator Graham: Thank you all.

I will lead this off and let other members ask questions. I want to thank my colleagues for attending.

I am going to make a general statement and see if you agree with it. The battlefield medical care provided in the last 14 years has produced outcomes historic in terms of warfare. Does anybody disagree with that?

[No response.]

Senator Graham: The answer is you all agree. Nod your heads. Everybody nodded their head.

So let us make sure we do not break the one thing that is working.

Now, Mr. Whitley, you said that military hospitals are skewed toward basically family care and not battlefield medicine readiness. Well, how do you explain that in light of my first statement?

Dr. Whitley: So it is a very sensitive issue and I want to be very careful in how I describe it, Senator.

So you said that the survival rates on the battlefield have reached unprecedented heights, and that is true. And I think that is a great testament to everybody involved in that situation.

What I would caution, though, is using that as a measure of success of the clinical currency, the clinical readiness of the medical force prior to deployment,

particularly at the start of the wars in 2001 and 2002 and 2003. That measure of the overall survival rate was contributed to by many things. We fought the war differently. We organized the battlefield differently. We moved patients differently, and we had some of the best men and women in uniform providing medical care down-range that we could have ever possibly had. That measure is the cumulative effect of all those things.

So I think what we are asking here when we talk about the military hospitals, we talk about the readiness of the medical force, we have get down to more specific measures that get at the question of --

Senator Graham: Here is my concern. If you a uniformed doctor or nurse, you can be deployed. TRICARE network physicians are not going to be deployed. What I want to do is make sure that in trying to fix a system that I think is very much in need of repair that we do not destroy the one thing that seems to work very well. So I am going to look at your reform measures, but I also want to make sure that anything we do in the military hospital systems enhances the battlefield medicine. So if we need that footprint, even though it may not be the most efficient way to deliver health care, because these doctors and nurses will do something nobody else will do -- they will go to the battlefield themselves, and they are going and they are

going to practice in an environment where they can be shot at. So let's don't miss that boat.

Dr. Loftus and Dr. Fendrick, when you look at TRICARE for families, for the retiree community and family members and active duty members, how antiquated would you say it is on an A to F rating?

Dr. Loftus: Well, that is a difficult question.

Senator Graham: That is why I asked it.

Dr. Loftus: Yes. I would say that I have seen aspects or observed from the outside aspects that I think do --

Senator Graham: What grade would you give it overall?

Dr. Loftus: A grade on an antiquated basis? I would give it a B.

Senator Graham: So we are starting with a B.

What about you, Dr. Fendrick?

Dr. Fendrick: I would say B-plus actually.

Senator Graham: Dr. McIntyre?

Mr. McIntyre: I would say somewhere around a B-minus in terms of keeping up with where we need to be.

Senator Graham: Dr. Whitley?

Dr. Whitley: I will be the odd man out. I give it a C at best.

Senator Graham: What is the 30-second answer to get us to A?

Dr. Loftus: I think that the military health system

needs to do a better job of measuring its actual performance and trying to compare itself to internal and external benchmarks and to work continuously to improve that care.

Senator Graham: Dr. Fendrick?

Dr. Fendrick: I would pay providers more for providing the services that make military members healthier. There is a very strong evidence base that backs that up and go further to make it easy for those members to do that. It is very straightforward.

Senator Graham: Mr. McIntyre?

Mr. McIntyre: I would ensure that providers are getting paid for their performance and their quality.

Number two, I would make the patient in part responsible for their care from an incentive and disincentive perspective.

Third, I would index the benefit so that it properly keeps pace with inflation.

And fourth, I would focus on the question of alignment of the providers that are in the direct care system with the providers that are downtown both in terms of requirements but also in terms of what their focus is for the patient.

Senator Graham: Dr. Whitley?

Dr. Whitley: I would focus with respect to the TRICARE contracts -- I would focus on increasing greater competition, having annual contracts with multiple winners

per location. I would focus on making those contracts risk-bearing, and I would focus on increasing the flexibility to the contractor to manage the care.

Senator Graham: If you have not done so, could you provide in a three- or four-page report to the committee how you would go from C to A and B-plus to A? Be specific.

[The information follows:]

[SUBCOMMITTEE INSERT]

Senator Gillibrand?

Senator Gillibrand: Thank you, Mr. Chairman, and thank you all for being here.

Our country has a shortage of mental health providers resulting in many patients receiving mental health care from their primary provider. What do you see as the solution to this problem? And Mr. McIntyre, specifically how does TriWest ensure that mental health providers in its network have experience with unique needs and experience with service members and their dependents, including military children? And last, does TRICARE require this type of experience?

Mr. McIntyre: So I will start. We no longer do the work in TRICARE, which was probably partly why I am here because I do not have a conflict in that regard.

When we did that, we built out a mental health network that was mapped to the needs of the population, both those that are close to a military installation but also those that served in the Guard and Reserve, mapped to ZIP codes where they reside.

What we currently do is relevant to that topic, and that is we are doing exactly the same thing, and we are looking at the ZIP codes as to where people live. We are looking at what the direct care system actually has in the way of footprint, which I believe is applicable to the DOD,

and we are in the process of going back to something that we did at the start of the wars, and that is to train the mental health providers and the primary care providers in how do you recognize where a threat is for your patient from a mental health perspective, how do you be relevant, and where do you turn people to if they are in distress.

Senator Gillibrand: Others?

Dr. Fendrick: I would just say very quickly that if we really were serious about changing our conversation from how much we spend to how well we spend, we would see a serious investment in infrastructure for mental health and also incent providers and patients to do those evidence-based services.

Senator Gillibrand: What infrastructure changes would you make?

Dr. Fendrick: The problem is that most medical services that are most profitable are not producing a lot of health for the money you spend, and as long as you continue to allow a fee-for-service payment system, they will go to those services that produce lots of revenue. And they have never been measured on the health that has been produced, which are points made by folks to the right and left of me. I think if we again get to this point and you say I am going to still pay a lot of money for military health care but insist that it goes to services and providers for things

that are actually needed, so whether it be mental health, opioid abuse, or other types of things that are away from the standard cardiology, orthopedic surgeon, other types of things that are needed but deemed to be overused in the system -- we have enough money there. It just takes the courage to make the shifts that may be going upstream against some interests who may not want that to happen.

Dr. Loftus: I would add that integrating mental health care into primary care is actually important. I do not mean that mental health care is provided solely by primary care physicians, but breaking down the barriers in referral and in sharing information about patients with behavioral health problems is actually important. There are great privacy concerns about behavioral health, but when primary care physicians and others treating the same patients are not aware of those issues, we cannot bring to bear all of the power of the entire multi-specialty power that we have in front of us to the care of those mental health patients.

Dr. Whitley: I have nothing to add. I agree with all my colleagues. I think they said it very well.

Senator Gillibrand: Another major concern is the care for service members' special needs dependents, which I mentioned in my opening. Military families move frequently and that means that moving to and from locations with different levels of service provision.

From your private sector experience, how do we ensure that the continuity of care for these special needs are met whenever service members might be moved? And, Mr. McIntyre, how does TriWest handle provision of this specialized service?

Mr. McIntyre: I think that is a fundamental question in this space. And the thing that Captain Faison and myself learned at the time -- then-Captain Faison -- through the lens of the Marine Corps was you need to come to understand what the needs are and you need to pay attention to them and meet them while they are in your midst, and then you need to prepare and plan for their change geographically so that as they move from place to place, you are actually thinking about not only them moving forward but the receipt of them on the other side. The same thing applies, I would say, to those that are injured and those that have mental health needs as they move within the system in the military and as they also move between the military and the VA.

The last thing I would say, if I can go back for a second to the mental health piece that you raised previously. Very few providers in this country are trained in evidence-based therapies. And we have a network of 25,000 mental health providers now built across 28 States. And we are in the process of looking at that issue market by market. We are doing a test in Phoenix actually this

weekend. We are doing something together with the private community as well as those that serve in the Federal space.

The bottom line is it is possible to go through and do that training. And the expertise of it exists in the DOD and the VA spaces. And so it is getting those that bring those networks to the table to narrow in on the populations that need services, how many there are, what types of EBTs you need, and then make the investments to actually ensure that they are trained. And so we are going to be testing that in the chairman's hometown of Phoenix, Arizona starting this weekend.

Senator Graham: With that, Senator McCain.

Chairman McCain: Dr. Whitley, I am very interested in your recommendations, one of them, MTF management layers should be reduced. Are you talking about one service?

Dr. Whitley: I think there are many options to do that. One option that others have talked about is consolidating the military hospital system into the existing Defense Health Agency. Another would be a single service. I think there are many options of ways you get there, Senator.

Chairman McCain: Would you do me a favor and send that to me in writing?

Dr. Whitley: I would be very happy to, sir.

Chairman McCain: You also say that MTFs should be

professionally managed. Does that mean you contract out to a management group? Is that what you are saying?

Dr. Whitley: I think that should be an option that is on the table and used in appropriate situations, Senator.

Chairman McCain: Does that mean like in a pilot program? Would you recommend a pilot program where we contracted out for a non-military associated organization to conduct some of these functions?

Dr. Whitley: I would add, Senator, I think that should definitely be an option to consider. I would add that there are outpatient clinics that are operated that way today within the direct care system. And then I would add that --

Chairman McCain: How is that working?

Dr. Whitley: My understanding is that the beneficiaries that use them are very pleased. I think the next panel can talk about their experiences with that from a management perspective.

Chairman McCain: MTFs should face competition. This is pretty much along the same line of what we are talking about.

Dr. Whitley: Yes, Senator. I mean, the best way to motivate people to improve is to make sure that they know they are not the only game in town.

Chairman McCain: So how do you do that? The same way? A pilot program?

Dr. Whitley: Yes, sir. You could take specific markets and you could allow beneficiaries to choose among plans or choose between venues for where they are going to receive their care. And it would be interesting to see what happens in those pilots. It would be interesting to see where the beneficiaries choose to go. It would be interesting to see what happens to costs in those markets, what happens to outcomes in those markets.

Chairman McCain: For example, who would be the option?

Dr. Whitley: I am sorry, Senator.

Chairman McCain: You say there would be other options that they would pursue. What would those options be?

Dr. Whitley: Civilian provision of the health care, Senator.

Chairman McCain: Would that be in a private hospital or a private provider or a private insurer?

Dr. Whitley: I mean, all of the above. So they could decide where to go for their primary care -- that would be a primary care practice -- where to go for their acute care. Yes, Senator.

Chairman McCain: MTFs that cannot succeed in their mission should be downsized or closed. Has there ever been an MTF downsized or closed?

Dr. Whitley: There have been many, Senator. The direct care system is about half the size it was about 25

years ago.

Chairman McCain: 25 years ago, one was --

Dr. Whitley: It is about half the size. We are at about 55, 56, ballpark, bedded facilities, and we were close to 100 probably 20 years ago, Senator. Our folks coming in the second panel would have the numbers better than I would.

Chairman McCain: So to some degree, I think what you are talking about overall is competition.

Dr. Whitley: Yes, Senator.

Chairman McCain: And right now there is none?

Dr. Whitley: There is some, and it manifests itself in various ways. But I think it could be made much more explicit and it could be made much more of an effective tool for managing and for improving outcomes and the cost control in the system. Yes, Senator.

Chairman McCain: Well, Mr. Chairman, I wonder if we ought to look at some of these recommendations at least as pilot programs as a beginning.

Finally, Dr. Whitley, do you think we should have a one-service medical corps or should we maintain three or four separate ones?

Dr. Whitley: I have to apologize, Senator. I am going to punt on that. I am willing to take a stand on competition. I have never personally studied the joint question. So I have to punt on that one, Senator.

Chairman McCain: But does each service not have a medical staff?

Dr. Whitley: Yes, sir, they do.

Chairman McCain: Thank you, Mr. Chairman.

Senator Graham: Senator Tillis?

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

Dr. Fendrick, I want to ask you a question. You in your testimony, both written and what you delivered before the committee, talked about value-based insurance design. That is something I got involved with down in North Carolina as a matter of public policy when I was speaker.

I want to talk a little bit more about that and how you think maybe State health plans that have done it, to the extent that you can and any member of the panel, have benefited from it.

And if you could -- it may not be related, but in the briefing materials, one thing that jumps out at me -- and I would be interested in any of the panelists' opinions on this -- are the discharge. The medical health system average annual inpatient discharges per 1,000 are some 61.7 for enrollees in the medical health plans and about 36. There seems to be a really big gap. Do you think that V-BID helps narrow that gap, or are there legitimate reasons why the gap is so great?

Dr. Fendrick: So I will first take the first half of the question about what is going on in the States, and maybe my fellow panelists can chime in about the level of optimism that V-BID might have to be part of the solution of this very important hospitalization problem.

So first off, I think you pointed out that V-BID programs have reduced financial barriers to high-value services and providers in many of the States represented by this panel. I think it is important to point out that in the State of South Carolina, the Medicaid program has reduced cost-sharing for high-value drugs for the most vulnerable populations there. As Senator Gillibrand pointed out, the Empire State has highlighted V-BID in the State's innovation plan and its very important role in the State innovation $100 million grant model. It is also highlighted in the Maine State innovation plan and is a very important part of the private sector Maine Business Coalition there.

You pointed out and we are very proud of the fact that V-BID plans are now offered to State employees in 13 States, including North Carolina. And of note, one voluntary V-BID plan was taken up by over 98 percent of State employees, and after 2 years, we saw marked increases in healthy behaviors, increases in preventive screenings, much clearly delineated consumer satisfaction. And the good news is we are seeing emergency room visits and specialty visits decline.

I do not have information on hospitalizations because you know they tend to occur in a very compressed portion of the population. Those are often the people we are focused on more often and why we were so pleased to see a bipartisan, bicameral political support for a V-BID demonstration in Medicare Advantage, and we hope to be able study rigorously a V-BID program to actually lead to the reduction in re-admissions that you mentioned.

But I think over the long term, we will see modest impacts on ER visits and hospitalizations, but I think much more importantly, you will be able to tell your constituents and the American taxpayers that the American health care financial situation is moving not to things that make people money but are finally moving in a very systemic way to services that make them healthier.

Mr. McIntyre: I would agree that providing incentives and direction for value-based incentives is the right thing to be doing.

You know, the thing that is interesting about TRICARE and about the DOD system is that not all the care is provided in one domain. And that makes it uniquely challenging. And the chairman of the full committee is not here at this juncture, but the Air Force went through a pretty massive re-footprinting process back at the beginning of TRICARE about 20 years ago. It did an amazing job of re-

footprinting its installations. And I think some focus on the question of what the sizing and the structure ought to look like and then what do you actually have to supplement it with to give elasticity from a provider perspective and then what types of providers and systems do you want. And if you are going to have an integrated system that is in the private sector in a certain market, how do you plug that in? Because some of those delivery systems -- their models really need to take care of the entire patient not just part of the patient's needs.

What I would also offer is that some of the prototypes of design that have been done over the last 20 years are worthy of exploration and assessment. And there may be some new prototypes that need to be done, but I think there is probably a lot that has already been tested. And figuring out what its application might look like to end up making change as you go forward from here would be smart.

And I will tell you I am particularly intrigued with the notion that you take the Defense Department for a population that it has need for and you take the VA for a population that it has need for, and in the same community, you are melding that together. And there is a series of prototypes that have been in place for almost 20 years now that do that in different ways in about eight different markets. But the Chicago approach kind of threads it all

together. And then how do you bring the third leg to the stool?

Then you could go out to Gerald Champion in New Mexico. When Senator Domenici was a Senator here, there actually was a prototype that actually took a small community hospital in an Air Force location and actually took the airmen and put them in that hospital, took the VA folks, had them in that hospital delivering services in that environment doing operations there. And then the private sector was the third leg of the stool. It was the only prototype that was ever done like that.

But you know the incentives in communities that are smaller or on their own -- they ought not to be doing everything themselves -- offers some real interesting assessment. And I think you might find that there is a lot of fodder already there to step back and say how do we do this right. What are we missing in models, or do we have most of them already tested? And how do we footprint forward with the right kind of make/buy requirements of folks before they start doing design and construction?

Senator Tillis: Thank you, Mr. McIntyre. I think that was a great model.

And, Dr. Loftus, I am out of time. But a part of what I was going to lead to is how would a high-performing health care system like Kaiser Permanente kind of play into that

integrated solution. I think that that is a model that we have got to look at and develop, as Chairman McCain said, maybe through pilots. But I do believe that helps us. I serve on the Veterans Committee. It is a very important topic. I think it is a way to target a lot of the needs in certain areas of the country.

Mr. Chair, the only comment I wanted to make -- it may be something I bring up in the next panel, but there is just one more detail level thing I wanted to get on the record. And, Senator Gillibrand, I think this is something you may have looked at as well. But the ABA treatment for persons with autism and the proposed rate cut is something that I am concerned with, the timing of it. I hope that either in this committee or in my discussions with the panelists outside of this committee that we go back and maybe be a little bit more methodical. I think that we may be making a mistake potentially cutting treatment options down below the national average and produce a bad outcome for something that I think has been proven to be highly effective and highly beneficial to those who take advantage of the treatment.

Thank you.

Senator Gillibrand: Thank you all.

Senator Graham: Thank you. That was excellent.

Next panel, please. Thank you all very much for

participating. It was very helpful.

[Pause.]

Senator Graham: Thank you to the first panel. This is the second panel, and we will start with Mr. Woodson. I am going to have to run to another subcommittee hearing. I will turn it over to Senator Gillibrand, and I will be back as quickly as I can. But let us go ahead and get started. Mr. Woodson?

STATEMENT OF HON. JONATHAN WOODSON, M.D., ASSISTANT SECRETARY OF DEFENSE FOR HEALTH AFFAIRS

Dr. Woodson: Chairman Graham, Ranking Member Gillibrand, members of the committee, thank you for placing the issue of military health system reform high on your agenda for 2016.

The military health system takes great pride in its performance in combat medicine over the last 14 years with greater than 95 percent survival rates for those wounded in battle. Our ability to prevent disease through exceptional primary care and preventive medicine services produced equally historic outcomes in reduction of disease and non-battle injuries.

The challenges we face in medicine and in national security, however, continue to evolve and require new approaches to be prepared for the future.

We have undertaken a number of initiatives to strengthen the military health system in all facets of its responsibilities, and they have been organized around six principal lines of effort, which we have spoken about in previous testimony. I, therefore, want to encourage that last year's Military Compensation and Retirement Modernization Commission reviewed and supported many of the initiatives that we have already set in motion in the Department. Let me briefly describe these efforts.

First, we have modernized our management systems with an enterprise focus. We established the Defense Health Agency that Vice Admiral Bono leads. The agency is entrusted with providing common business processes and standards and support of the military departments and combatant commanders, an approach that provides greater operational efficiency and ensures joint solutions to our customers.

We identified multi-service markets and developed 5-year business plans to promote common solutions and optimize the use of military treatment facilities while providing required care to beneficiaries in the purchase care sector.

In addition, we acquired and are now preparing to deploy a new electronic health record using commercial, off-the-shelf products. Together with the Surgeons General and Vice Admiral Bono, we have established an enterprise-wide dashboard to actively manage our performance in readiness, access to care, quality, safety, patient satisfaction, and costs. The Defense Health Agency achieved the milestone of full operating capability on 1 October 2015 and, in its first 2 years, saved over $700 million.

Second, we are defining and delivering medical capabilities and manpower needed in the 21st century. With the services, the Department has embarked upon a thorough

process to define essential medical capabilities and metrics to monitor readiness.

Third, as a result of the modernization study, we have analyzed infrastructure needs and right-sized several military treatment facilities, as well as made adjustments to move skilled medical personnel to markets where MTFs can recapture care, they can maintain their skills and reduce overall costs.

The fourth line of effort is perhaps the main focus of today's discussion, and that is our plan for reforming TRICARE. We are appreciative of the input from beneficiaries and service organizations that in recent testimony have expressed support for TRICARE. The TRICARE benefit was named as the number one health plan in the country for customer experience by Temkin in 2015, owing in no small part to the comprehensive coverage and low cost to our beneficiaries. And by the way, we jockeyed for that position since 2011 with Kaiser Permanente.

But we also have heard loud and clear from our beneficiaries that access to both primary and specialty care needs attention, particularly in the MTFs. In response, we have implemented a number of access improvement initiatives last year to open up more appointments, resolve appointment issues on the first call. We are improving access to after-hours care, particularly for child care, whether that is

through evening and weekend clinics, the ability to email providers questions through secure messaging, the availability of 24/7 nurse advice line that is integrated with our appointing system, streamlining the referral process, and implementing an urgent care demonstration program that Congress requested in last year's Defense Authorization Act.

Our T-2017 contract will be awarded in 2016 and includes provisions that further improve the experience of care for our beneficiaries. The PB-17 proposal provides choice and incorporates feedback from our stakeholder groups.

The fifth line of effort has been to expand strategic partnerships with civilian health organizations to enhance our ability to meet and exceed our responsibilities of readiness, quality, safety, and satisfaction. Partnerships with organizations such as the American College of Surgeons and the Institute for Health Care Improvement are providing tangible benefits that offer us ways to sustain our trauma system, improve clinical quality, and achieve our goals as a high reliability organization.

Finally, the sixth line of effort is focused on global health engagement where the Department is deeply engaged in national security threats posed by infectious disease and building bridges through health care around the world. We

have contributed to the surveillance, prevention, diagnosis, and treatment strategies to combat well known outbreaks to include Ebola and now Zika, as well as ongoing efforts to prevent other outbreaks from occurring.

We entered 2016 confident that the reforms in the military health system and the health benefit can be further strengthened through a combination of legislative and operational reforms. I am grateful for this opportunity to be here today, and I look forward to your questions.

[The prepared statement of Dr. Woodson and Admiral Bono follows:]

STATEMENT OF VICE ADMIRAL RAQUEL C. BONO, USN, DIRECTOR OF THE DEFENSE HEALTH AGENCY

Admiral Bono: Chairman Graham, Ranking Member Gillibrand, and members of the subcommittee, thank you for the opportunity to appear here today. I am pleased to represent the Defense Health Agency and explain how the DHA is contributing to the modernization of the military health system.

In November, I was honored to become the Defense Health Agency's second Director. Only a month earlier, the agency had reached full operating capability after 2 years of collaborative work with the Army, Navy, Air Force medical leaders, and with the Joint Chiefs of Staff that established the concept of operations for many of the functions of the agency. Our responsibilities center on supporting the military departments and the combatant commanders in the execution of their missions.

The Defense Health Agency was created in the recognition that most health care delivery is common across the Army, Navy, and Air Force, what we need, what we buy, what a best practice entails in both the clinical and administrative environments. The Defense Health Agency helps bring together common support functions into a new enterprise-focused organizational structure. We are able to help Dr. Woodson and the Surgeons General see and manage

across the MHS in a more unified way.

One of the principal ways in which we deliver the support is through the operation of shared services. Critical enterprise support activities include TRICARE, pharmacy operations, health information technology, medical logistics, public health, medical R&D, education and training, health facilities, contracting, and budget resources management.

In addition to the ten shared services that have been implemented, the DHA has also brought in joint activities that had previously been distributed to the services that acted as executive agencies. These include the Armed Forces Health Surveillance Center, the Armed Forces Medical Examiner system, the DOD Medical Examination Review Board, the Defense Center of Excellence for Psychological Health and Traumatic Brain Injury, and the National Museum of Health and Medicine.

The DHA offers value, however, to more than our COCOMs and services. We serve as a single point of contact for many intra-agency, interagency, and external industry matters simplifying the process for our partners and outside colleagues to work with the Department of Defense in support of a number of imperatives such as research, global health engagement, adoption of emerging technologies, health care interoperability and more.

The existence of the DHA has streamlined engagement with the Defense Logistics Agency, Defense Information Systems Agency, and other field agencies. External to the Department, the DHA provides a single point of contact for operational matters within the VA, a number of agencies within HHS to include Centers for Medicare and Medicaid Services, the Food and Drug Administration, the Centers for Disease Control and Prevention, Public Health Service, and more. We have successfully collaborated with the Justice Department on the prosecution of health care fraud cases, most recently with highly suspect activities around compound medications. We work with Treasury, State, and the GSA on a number of critical functions that directly support our health care mission.

I would like to focus on one shared service in particular, the operation of TRICARE, the military's health plan. TRICARE modernization is part of the MHS modernization plan that Dr. Woodson just outlined. We have a number of TRICARE initiatives already underway in 2016. Later this year, we will award the next round of TRICARE contracts known as T-2017, which is when health care will become operational under the new contracts. We are simplifying the contracts, reducing management overhead in both government and contractor headquarters by moving from three regions to two regions. We are expanding the means by

which we manage the quality of our networks to ensure they meet the expectations for quality and safety that we expect for our beneficiaries whether in the direct system or in a private sector network.

We also will introduce innovative models for value-based purchasing in the coming year. My staff, in close collaboration with the services, is also crafting the contract amendments to permit TRICARE enrollees to use urgent care centers without pre-authorization. And our analytics team provides the Department's civilian, military, and medical leadership at the headquarters and field level with the ability to assess the enterprise-wide performance of the military health system using agreed upon joint measures for readiness, health, quality, safety, satisfaction, and cost.

The DHA is now an integral and integrated part of the military health system. We are proud to contribute to the modernization of the system through joint collaborative solution and responsible management approach.

I am honored to represent the men and women of the Defense Health Agency, and I look forward to answering any questions you may have.

STATEMENT OF LIEUTENANT GENERAL NADJA Y. WEST, USA, SURGEON GENERAL OF THE ARMY AND COMMANDING GENERAL U.S. ARMY MEDICAL COMMAND

General West: Chairman Graham, Ranking Member Gillibrand, and distinguished members of the subcommittee, thank you for this opportunity to provide the Army medicine's perspective on defense health care reform.

It is an honor, first I would like to say, to serve as the Army Surgeon General and Commanding General of the U.S. Army Medical Command.

Since 1775, Army medicine has supported our Nation and our Army whenever and wherever needed. However, today I would like to focus on our more recent history.

For the past 14 years, we have supported an all-volunteer force engaged across the globe and supporting the joint campaign fighting in Iraq and Afghanistan and responding to national disasters and other contingencies such as the U.S. Government response to the Ebola outbreak in West Africa. We have accomplished this while continuing to attract, educate, and train the next generation of Army medicine. We are collecting what we have learned over the past 14 years and ensuring that we are using these lessons to inform our daily efforts and how we prepare for the future.

Our readiness to serve when needed is my number one

priority. In assuring our readiness, Army medicine must maintain medical capabilities that are ready to deploy and support our warfighters.

During the past 14 years of combat operations, we have achieved a survivability rate, as you heard Dr. Woodson mention, of 92 percent, the highest in the history of warfare despite the changing tactics of our adversaries and the increasing severity of battle injuries. And we are not going to lose the knowledge and the best practices that helped us achieve the survivability rate. These advances in combat casualty care resulted from our integrated health services that span the continuum of care from prevention to treatment of illness and injury and to recovery and rehabilitation in both the garrison and the operational environments.

We cannot, however, focus exclusively on sustainment of combat trauma, surgery, and burn capabilities. Our experience shows that the Army must be agile and adaptable and therefore must maintain a broad range of medical capabilities to support the full range of military requirements.

To that end, we see our medical centers, hospitals, and clinics as health and readiness platforms. They ensure we maintain trained and ready medical personnel by exposing them to a diverse and broad range of patients with a wide

variety of illnesses and injuries.

Our medical centers also serve as platforms for our Army graduate medical education programs. These programs are the primary means for transferring the knowledge from this generation of military providers to the next. While we focus on our readiness mission, we must also ensure we provide our soldiers, their families, and our retired population with access to high-quality health care that meets their needs and encourages health.

Improving access to care is a priority for Army medicine, and I have directed actions to rapidly improve access to care.

First, we will enable our beneficiaries to book an appointment up to 6 months in advance, and we have already piloted that at some of our installations. WOMAC Army Medical Center is one example. We will increase the number of available appointments by increasing the time our providers are available to see patients and reducing the number of unfilled appointments and also working on the no-show rate, which leaves a large number of our appointments unfilled and unutilized.

Additionally, we are opening three new community-based medical homes and we will evaluate where after-hour or urgent care clinics are necessary.

As part of the health services enterprise, we will also

continue to expand our telehealth program. We are currently conducting a pilot to treat low acuity patients in the emergency department at Fort Campbell as one example. We are also expanding remote health monitoring programs and leaning forward to expand our telehealth to the home. I would like to thank Dr. Woodson for recently signing the policy to help us expand that facility to home telehealth initiative.

I understand reforms are necessary to ensure the long-term sustainability of TRICARE. However, reforms must not increase the financial burden on our active duty soldiers or their active duty family members and must minimize any impact to our retired population. Reforms should encourage beneficiary use of our direct care system to ensure our medical military skills are maintained and should also encourage healthy behaviors, as you have heard our colleagues mention previously.

But reforms must not degrade our combat-tested system or readiness in an environment where we must remain rotationally focused and surge ready as the next large-scale deployment could be tomorrow. General Milley states that the Army's fundamental task is like no other. It is to win in the unforgiving crucible of ground combat.

Now, Army medicine does not literally fight wars. I understand this. We are, however, a critical enable to

ensure our Army achieves this end. Our Nation's mothers and fathers know that when their sons or daughters become ill or injured, we are there, we are ready, and this gives them the confidence to send them into harm's way if called. This is a truly sacred trust, and our readiness to support the warfighter can never, will never be in doubt.

So I want to thank you all for your continued support to our soldiers and to military medicine, and I look forward to your questions. Thank you.

[The prepared statement of General West follows:]

STATEMENT OF LIEUTENANT GENERAL MARK A. EDIGER, USAF, SURGEON GENERAL OF THE AIR FORCE

General Ediger: Chairman Graham, Ranking Member Gillibrand, and distinguished members of the committee. Thank you for the opportunity to come before you today to discuss the future of the military health system.

We fully support the committee's work to enhance the focus on value and delivery of the health benefit to those we serve, consisting of sustained good health, streamlined patient experience, readiness of the force we support, and the readiness of our medical force.

Strong health systems must continuously improve. Changes to the Air Force performance management process implemented in 2015, as part of the coordinated action plan following the military health system review, are producing continuous improvements in safety, quality, and timeliness of care. Recent evidence includes the joint commission of our hospital at Joint base Elmendorf-Richardson for outstanding performance on key quality measures, the Keesler Medical Center's top 10 percent ranking among all U.S. hospitals participating in HCAP's measures of patient perspectives, and favorable system-wide performance against national benchmarks in perinatal outcomes, diabetes management, and well child care. We know our performance as a health system is integral to our readiness, and we remain

committed to continual improvement.

Today we have 683 medical airmen deployed around the world providing medical support to contingency operations, including the trauma team at Craig Joint Theater Hospital in Bagram, Afghanistan, mobile surgical teams at various sites, and aeromedical evacuation teams with critical care capability.

Our success in support of deployed operations is inextricably linked to the care we provide in our hospitals, our clinics, and our many partner institutions. The bedrock of our readiness is the military hospital. Of the 76 Air Force military treatment facilities, only 13 today are hospitals. I would add that 30 years ago in 1986, we had 73 hospitals. So over the past 30 years, the Air Force has closed and converted 60 hospitals.

Our capability to meet combatant command requirements with deployable medical teams hinges primarily on our eight largest hospitals. The broad scope of care we provide to retired military members, their families, and veterans is key to our readiness. The Air Force has a number of agreements with the VA under which we provide specialty care to veterans. As we consider changes to the military health system, we believe it is very important to facilitate retiree access to specialty care in military hospitals and provide tools enabling more agreements with the VA and other

Federal health systems.

To ensure our readiness, we have evolved to a model in which Air Force surgeons and critical care specialists devote a portion of their time to provision of care in partner institutions, such as VA medical centers and level 1 trauma centers where more complex care and trauma are prevalent. I would offer as an example the medical group at Nellis Air Force Base in Las Vegas where the surgeons on staff at Nellis, vascular surgeons, orthopedic surgeons, and general surgeons, do a significant portion of their cases in the VA medical center in Las Vegas but also at the University Medical Center in downtown Las Vegas, which is the only level 1 trauma center for Las Vegas. This provides the needed balance of complex cases for a proficient, deployable clinician.

An additional key point pertains to primary care support for active duty families. Experience has shown that primary medical support to active duty families from our military treatment facilities enhances commanders' efforts to support families under stress and strengthens the resilience of families. As changes are considered, we strongly recommend sustaining care for active duty families in military treatment facilities.

I thank the committee for its steadfast support and dedication to the welfare of the airmen, soldiers, sailors,

marines, their families, and our veterans. Thank you.

[The prepared statement of General Ediger follows:]

STATEMENT OF VICE ADMIRAL C. FORREST FAISON III, USN, SURGEON GENERAL OF THE NAVY AND CHIEF, BUREAU OF MEDICINE AND SURGERY

Admiral Faison: Ranking Member Gillibrand, distinguished members of the committee, it is my honor to represent the men and women of Navy medicine, 63,000 dedicated professionals who every day honor a trust in caring for those who have sacrificed to defend our freedom. We are grateful for your strong and unwavering support of our service members and their families.

As you consider potential changes to the military health system, I thank you for that, but I would like to highlight important considerations that I believe are central to any discussions.

Military readiness and combat support are our mission. Navy medicine protects, promotes, and restores the health of sailors and marines around the world at home and deployed and in all warfare domains. We are equally privileged to care for their families.

In an increasingly complex world, as our Navy and Marine Corps stand ready and engaged around the globe, Navy medicine stands there as well to protect and to care for them. As an agile, rapidly deployable medical force, this is what sets us apart from civilian health care. No civilian health care company in the world routinely leaves

their families and home on a moment's notice to willingly go into harm's way to care for those in need. No health care company in the world daily puts their lives on the line in battle to defend and care for their patients, as the young hospital corpsman 2nd class was privileged to see awarded the Silver Star 2 weeks ago did without thinking. No health care company in the world experiences the staff deployments and turnover we routinely experience and still delivers world-class care. And finally, no health care company in the world is daily and singularly focused on the combat readiness of its staff.

And the proof is on the battlefield, the highest combat survival in recorded history. Wounded warriors are alive today who, in any previous conflict, would have died from their injuries. They are the testament to the effectiveness of the military health system because every one of them, from point of injury on the battlefield to advanced treatment in our medical centers, received their care from men and women who got their training, their experience, and their preparation in our military treatment facilities. Those facilities are the foundation of battlefield survival. And in my opinion, as a former commander of a deployed expeditionary combat medical facility, a robust military health system is critical to future battlefield survival. Unparalleled combat survival in our Nation's longest

conflict is proof that a robust military health system that also serves as our training and search platforms for our battlefield providers from corpsman to physician is essential to both combat survival and agility in rapidly supporting our deploying operational forces.

These three facts are not in dispute.

One, we have the highest combat survival in recorded history.

Two, many wounded warriors alive today would have otherwise died of their injuries in any previous conflict.

Three, every wounded warrior received their care from injury on the battlefield to recovery in our medical centers exclusively by men and women who receive their training, their clinical experience, and preparation in one of our military treatment facilities. This is a system that works and has proven itself time and again in the thousands of men and women alive today.

It is also a system that is not perfect, and I appreciate your attention to this much needed area of reform and improvement. The services are working hard to improve access, care continuity, convenience, and satisfaction with the care and benefit that we deliver in peacetime. We have made important strides in each of these areas while concurrently increasing enrollment, network recapture, staffing realignments, and other efforts to ensure we

provide the clinical experience our staff needs to preserve skills, competencies, and ultimately combat survival in the next conflict.

And it is more than just trauma. 70 percent of the evacuations in the most recent conflict were not trauma-related. Every single person on our team, every single person wearing a uniform in the Navy today matched to an operational platform is assigned to an operational platform. We do not have people in uniform for peacetime care. All of them have necessary roles and responsibilities in the next conflict.

More needs to be done, and none of us underestimates the effort required to improve our peacetime health care services. We are committed to continuing those necessary reforms which will improve our patients' experience and, most importantly, their health. However, we must do so without putting at risk the very system which has yielded such unprecedented survival. We will need your help in this effort, and for your tireless support, I thank you for helping us to ensure that those sailors and marines who will stand the watch in the future will have the same or better survival than today's wounded warriors have had. In our hands is a sacred trust to do all in our power to return home safely America's sons and daughters who have sacrificed to defend our freedom. I thank you for helping us to honor

that trust today and tomorrow.

[The prepared statement of Admiral Faison follows:]

Senator Gillibrand [presiding]: Thank you all. I am very grateful for your testimony. I am very grateful for your service, and I appreciate this discussion today.

I would like to start with Dr. Woodson. Senator Tillis and I are both very interested in this issue of comprehensive autism care. I am pleased that the Defense Agency initiated the comprehensive autism care demonstration in 2014, and I am very interested in seeing the outcomes of this program.

However, I am concerned to hear that DHA intends to lower reimbursement rates for providers of ABA therapy for autism. I am most concerned that providers of ABA therapy will no longer be able to accept TRICARE because the reimbursement rates are too low.

Are you at all concerned about the impact changing reimbursement rates will have on children's access to ABA therapy, and what steps have you taken to ensure that access to these services will not be adversely affected by changes in reimbursement rates?

And finally, why not wait until the demonstration program is complete so that the results are not skewed by a rate change?

Dr. Woodson: Senator, thank you for that very important question, and let me just assure you that I am, as we all are, very committed to special needs children. And

that has been a major emphasis in terms of many of our reform activities.

In regards to the rate changes, the rate changes were actually delayed a year and a half. We did an internal study on rates because there were no established national rates, and of course, part of our statutes require us to pay Medicare rates. So we set an amount and we studied it for a few years, did an internal review. And then we were about to make rate changes, and in fact, we heard from stakeholder groups, including Autism Speaks and others, convened repetitive conferences to engage them, and then commissioned two outside studies that confirmed that we were overpaying. And I would be happy to share the details of these studies with you.

Finally, just to ensure that in fact we will not negatively impact the services, we reviewed network adequacy almost on a monthly basis and certainly very frequently. So we will be monitoring the situation very closely. And should we find, in fact, in any locality that it has been adversely affected, we will make rapid changes.

The final point in regards to this is that we put in a safety valve in that we are not going to reduce rates right away completely. It is a stepwise progression over a number of years so that we can ensure that we do not lose providers.

Senator Gillibrand: Well, I have some specific concerns with regard to the studies and the methodologies because I do not think they are reflective of the cost. And so I would like to request some follow-up information specifically on that and further consideration because I think it is inadequate. The reason why Autism Speaks spoke so forcefully against the proposed rate changes is because they are the experts on treating children with autism. And so I think your study is misleading in its outcome. So I will follow up with specific questions, but I would like this to be readdressed because I am very concerned that there will be very negative consequences for patients.

My second question is about innovation and different ideas about how to innovate health care for our service members. When I was in Fort Drum earlier this month in upstate New York, I was impressed with their approach to health care. There they have a clinic on the base that provides basic primary care and service to members and their families -- for their members. But their members and families also go off base for their specialty care. The clinics and providers in the community, by virtue of serving the military population, have an excellent understanding of the needs of our men and women in uniform and their families. This is along the lines of questions that Senator McCain asked to the last panel.

So has DHA looked to Fort Drum as a model for providing health care, and how can we better leverage community health care options in serving the military community? Anyone can take the question.

Admiral Faison: Senator, I will share with you a pilot we have in San Diego right now. In San Diego County, one out of every five residents is eligible for military health care. That is 250,000 people. Of those, 662 are what we call high utilizers. These are folks that use anywhere from 15 to 30 times as much health care as anyone else in the county.

We have partnered with county public health to aggressively manage them as a community-based effort. These are folks that the car will break down and so they will call 911 to get a ride to the ER to get medications. Care will be fragmented in a variety different urgent care centers. And so by partnering with county public health and bringing to bear county services, as well as military provider services in a medical home approach, but in a community-based format, we have improved their health, cut their health care costs in the first year for 250 of them by over $4 million, in the second year, by $12 million, and dramatically cut by over 60 percent their hospitalizations. So that is one issue that we are in the process of exporting across Navy medicine.

Senator Gillibrand: Thank you.

General West: Thank you, Senator Gillibrand.

Regarding the innovation of health care in the Fort Drum model, that is a phenomenal model for that area. But we have noticed that it might not fit in all of our demographic areas. The sizes of our MTFs vary from location to location, and that may not be reproducible.

But there are additional things that we are doing such as at Fort Leonard Wood, Missouri, the innovation of using telehealth where they actually have a virtual ICU set up where they have a telehealth arrangement with an ICU in the State of Arkansas to help them with that. So these are leveraging technology using telehealth, using other types of partnerships in order to achieve some of those same ends.

But I agree that for the Fort Drum community, that model that they have works very well.

General Ediger: Senator, I mentioned in my statement that the Air Force has 13 hospitals. That is actually below our operational requirement for deployable medical teams. And so we have had to use some innovative concepts in order to meet our operational requirements. So we have about 2,500 Air Force medical personnel embedded in other services' hospitals, and that is one way we are doing this.

But the other way we are doing it is we have embedded surgical staff into private sector hospitals in Omaha,

Nebraska; Tampa, Florida; Phoenix, Arizona; Oklahoma City; and in Birmingham, Alabama. And they are providing beneficiary care in those hospitals.

I would say, though, that while that model has been successful for us to some extent, I do not think we can go too heavily in that direction because, as I said in my statement, the military hospital remains the bedrock of our readiness because that provides readiness to the entire deployable team, the enlisted, the nursing staff. The embedded operations in private sector platforms tends to benefit the provider staff but not so much the nursing staff.

Admiral Bono: Ma'am, there are some other areas too where we have all been doing some innovative work, and this is in our enhanced multi-service markets. And each of the services has this where we have about 45 percent of our resources and 45 percent of our patients where they need care. What is innovative about that is that between the services, we are able to level-set some of our resources, and depending on where the demand is for care, one of the hospitals can send personnel to other hospitals within that same market where the demand is.

And just as an example, here in the National Capital Region, when we were looking at the demand for physical therapy services, we were able to understand with a baseline

assessment of where the demand for physical therapy consults were coming from, referrals. And by using some of the assets within a couple of the bedded facilities, we were able to send physical therapists to those clinics where there was a high referral rate. And by doing that, we were able to get care closer to the patient in a more timely manner, and it also decreased some of the demand for specialty care down the road. So this is something that all of the services have with the enhanced multi-service markets.

Senator Gillibrand: Thank you very much.

Senator Graham [presiding]: Senator Tillis?

Senator Tillis: Thank you, Mr. Chair.

Mr. Woodson, rather than go back through what Senator Gillibrand brought up on the ABA treatment, I would like to join with Senator Gillibrand in some follow-up.

I think the key there has to do with timing, and the most important thing is to understand the profoundly important value of this treatment for not only the child that may be receiving the treatment, but also the health and quality of life for the active duty personnel, the military personnel, and the spouses.

Admiral Faison, I want to start with you and then probably ask the other Surgeons General to chime in because I think you are making a very important point about the

unique nature of this health system. But I also want to get to military hospitals, clinics produce inpatient, outpatient workload costs about 50 percent higher than what it would cost if the services were purchased in the private sector.

Can you give me some help in trying to rationalize what the real gap is? Because there is obviously some structural cost based on the unique nature of what you are doing. But give me some sort of sense of what you believe may be an attainable goal or some sort of narrowing of the gap. Or is that gap right and proper?

Admiral Faison: Yes, sir, absolutely. So if you look at our costs, our costs break down really into two large buckets. And there are smaller buckets, but the two large buckets, of course, are facility costs of maintaining bedded facilities. And those are important as we get casualties back, the Walter Reeds of the world and places like that --

Senator Tillis: So there is an unused capacity that you may not find in comparable private health care settings.

Admiral Faison: Absolutely. If you look at the civilian sector, they are running bed occupancies of 90-plus percent. We do not do that because our beds are in reserve for contingency operations.

The others are personnel costs. We staff to operational plans of the combatant commanders. I do not staff to peacetime care. So I have in some places more

staff in uniform than necessary for peacetime demand, but that is because there is an operational war requirement. We try and put those personnel in places where can keep their skills current. And as you have heard, sir, from the other Surgeons General, when we cannot do that, then we do out-service rotations at civilian centers and places like that.

Senator Tillis: I am sorry to cut you off. I have just got a couple of questions. I want to make sure I get at least one more.

But is there a good sort of breakdown or something that you all can provide us that really gives that to us in an empirical way? Because if we make decisions about going back and saying that we have narrowed the gap, that it is no longer 50 percent, if that is the right number, then we have to understand the tradeoffs that we have in terms of capacity and what you are preparing to deal with. And I think that that would be very helpful to get back to this committee as we go through and identify maybe opportunities. You in your opening statement said you are not perfect. I want to go find out where those imperfections are and spend the bulk of our time on this committee fixing those rather than going down a path where if we look at the data, we may agree that it is a structural cost that is the cost of doing business and the unique nature of your business.

General, did you have a comment?

General Ediger: Yes, sir.

I think one thing that is always a challenge, when you talk about differentiating the cost of readiness versus the cost of providing care, is as I said in my statement, the two are really inextricably intertwined. And so there is a lot of work we do that is operationally driven that is actually clinical in nature. And so if you look at our primary care operations, for example, things like medical evaluation boards, annual preventive health assessments, post-deployment health assessments, all of these things consume a significant amount of our primary care bandwidth. So it is very challenging to try to look at perhaps the cost of providing care to enrollees to our clinics and cleanly cleave and separate the cost of readiness versus just the cost of providing care. So that is one of the traditional challenges we have always had with answering this sort of question is that the two really are intertwined very significantly.

Senator Tillis: Yes. I think the key is to try and normalize it in some way that people can understand it, again so that we set the priority on the things that we should improve rather than look at things from a purely numerical basis that on the surface may look like an opportunity to drive improvement, but the consequences could be just the opposite of what we want to accomplish on this

committee, which is to work with you and improve.

Mr. Woodson, the TRICARE legislative proposal did not contain, I do not believe, any recommended improvements for Guard and Reserve communities. What is in the offing there? What can we expect?

Dr. Woodson: Thank you very much for that question because that set of proposals really requires some additional studies because I think there are several courses of action depending on what type of reservist we are talking about. So let me just give you some examples to crystallize.

On the one hand, of course, we initiated TRICARE Reserve Select to fill the gap in what we thought was medical readiness at the height of the war. And the consequence of that was that the reservist and family would have to switch insurance programs when they came on active duty.

So there is the possibility, frankly, of offering, of course, TRICARE Reserve Select to a larger population or including it in employer-based options, which might be reasonable.

There is the possibility, as the commission talked about, of providing a basic allowance for health coverage when they come on active duty, and we need to sort that out.

And then there are some other hybrid options that are

out there.

The issue with reservists is really about not forcing them to change providers when they come on active duty. So there are different solutions, and we need to work those out and study those a little bit more.

Senator Tillis: Thank you.

Thank you, Mr. Chair.

Senator Graham: Senator Blumenthal?

Senator Blumenthal: Thanks, Mr. Chair.

As you may recall, Dr. Woodson and other members of the panel, in the 2016 National Defense Authorization Act, I advocated for a uniform formulary for improved transition from DOD care to the VA as service members transition out of active service. This measure was successfully passed, and now we are in an implementation stage. This joint formulary I think is critical to the quality of care and, in fact, relates to a variety of related medical issues that may arise when there is a lack of sufficient transition in prescription drugs and other health care.

What is the status of the implementation of the joint formulary from the DOD perspective?

Dr. Woodson: So I think there has been much progress certainly in the areas of mental health medications, pain medications, and some of those other critical medications for conditions in which a gap would create a great deal of

problems. They have been mapped significantly to about the 96 percent level so that we have a single formulary. I know there is just a little bit more work that needs to be done on that, but there has been significant progress on that front.

Senator Blumenthal: On the issue of prescription drugs, particularly pain killers and opioids, is there an ongoing danger in the military as, frankly, there is in the civilian world of over-prescription and over-reliance on pain killers?

Dr. Woodson: Well, there is. That is something that needs to be addressed not only nationally but within the military health system.

But what I would say is I think in that regard, we are a little bit ahead of the curve and the reason being is that for a lot of different reasons, there has been a lot of focus on the use of pain medication. And so we have developed more comprehensive strategies in terms of clinical practice guidelines. We have courses that providers must take in terms of pain management. We have invested in research and integration of alternative methods for pain control. So this has been part of a comprehensive set of programs I think that we could even make available to some civilian health care systems.

Senator Blumenthal: On the issue of mental health

care, has there been progress there, do you think?

Dr. Woodson: I think there has been progress, but you know, mental health care -- the more we study it, the more we try and refine it, the more we find out about it. And if I could break this down into a couple of different issues.

Oftentimes dealing with mental health care, it is more than just delivering mental health care. It is about delivering social services and family supports, and that is one issue.

The other issue about mental health care is that we always have this issue about whether or not we have enough providers, but really what we need is a comprehensive new strategy for how we employ our mental health specialists in a rational way to deliver care. So we never will have enough psychiatrists. We will never have enough pediatric psychiatrists. But if we utilize them to do screening, then we make their time less available for treating complex problems. So what we need to do right now is work on a more rational approach to how we employ, let us say, certified mental health counselors, psychologists, licensed psychological nurses, licensed social workers in a continuum of care that allows us to address all the needs more comprehensively because I am not sure we will ever generate enough mental health providers.

Senator Blumenthal: That is the strategy that you say

has to be developed or is being developed?

Dr. Woodson: I think we are working on that. So the previous panel talked about the issue of embedding mental health care in primary care practices. We have been doing that for years. We have been embedding mental health care technicians and practitioners in line units. So we have already rolled out some of that more comprehensive strategy, but still, I think we need to array the different types of mental health professionals in a better way to take care of many different problems.

Senator Blumenthal: As you know, active duty members of the military who may suffer emotional or mental diseases, some of them emanating from combat, post-traumatic stress and traumatic brain injury, sometimes are given bad conduct discharges or less than honorable discharges, bad paper, and then through a tragic irony are deprived of medical care to treat the very injury that causes their discharge under less than honorable conditions. And I have sought to have those discharges reviewed. And in fact, two Secretaries of Defense, beginning with Chuck Hagel and most recently Ash Carter, have committed to change the policies of the boards of correction review within each of the services.

Has your input been sought on that issue? Because there are medical issues involved in those reviews.

Dr. Woodson: So the short answer, Senator, is yes.

And let me, first of all, thank you for your advocacy in this area. And of course, for the last 2 years, we have actually reached out to individuals who have been discharged with so-called bad paper to let them know that their cases will be reviewed.

But to the last part of your question, we have given mental health professionals to these boards of review so that the cases can be accurately reviewed.

Senator Blumenthal: Thank you. My time has expired.

These subjects are tremendously important, and I want to thank all of the panel members for your hard work, all of the hard work done by the men and women under your commands. And thank you for being here today.

Senator Graham: Thank you.

I will be, it looks like, the last questioner here.

How many casualties have we suffered in Iraq and Afghanistan? Not fatalities but injuries. How many people have been wounded requiring admission to a hospital? Does anybody know?

Dr. Woodson: Senator, it depends on how you actually calculate those numbers, whether or not you include disease and non-battle --

Senator Graham: It does not matter as long as you were in Iraq and Afghanistan.

Dr. Woodson: It is over 100,000.

Senator Graham: Admiral Faison, can you imagine a military health care system that did not have a military hospital?

Admiral Faison: Sir, no, I cannot.

Senator Graham: Okay, because the bed space you have is not designed for everyday activity. It is designed for wartime contingencies. Is that right?

Admiral Faison: That is correct.

Senator Graham: Most of these beds are empty during peacetime simply because they are built to deal with wartime contingencies.

Admiral Faison: Sir, if I may. Those beds are not empty. We work very closely with the managed care support contractor to get care back into our facilities --

Senator Graham: So what percentage of your beds are occupied --

Admiral Faison: In general, we try and maintain a bed occupancy of 80 percent or higher.

Senator Graham: What about the Air Force?

General Ediger: Sir, we have a lower bed occupancy than that. We are more in the 50, sometimes up to 70 percent range.

Senator Graham: What about the Army?

General West: Sir, it varies. Some of our large MTFs, Fort Bragg and San Antonio, have a higher occupancy rate.

Some of our smaller facilities have a low daily patient census, and those are the ones that we are actually looking at to realign capability there.

Senator Graham: So here is my point. If we are going to reform something, we need to understand what we are trying to accomplish here. If you had civilian hospital administrators over military medical facilities, would that create a problem?

Admiral Faison: Sir, military hospitals are just like any other military command. I personally would not put a civilian in charge of a ship.

Senator Graham: That is what you would be doing, would it not?

Admiral Faison: Exactly. Yes, sir.

Senator Graham: So a hospital is a military entity, and the military command structure cannot be substituted.

Admiral Faison: Yes, sir, because the good order and discipline carries over to the battlefield and it starts in the hospital.

Senator Graham: General West, at the end of the day, what would happen if we opened up competition to all these military facilities? Where would the military doc go?

General West: Sir, that is a very good question.

Senator Graham: What would they do?

General West: Sir, again --

Senator Graham: Like a dentist. Like if it is cheaper to pull teeth downtown, which it may be, like how do our dentists stay proficient in pulling teeth?

General West: Yes, sir, exactly. When you say open to competition, sir, I think we are not in the same business as for profit. No one appears they want to be in competition for our deployed environment.

Senator Graham: So you treat family members of active duty personnel, all of you. Right?

General West: Yes, sir.

Senator Graham: And that keeps your skill level up. It is good for retention, good for recruitment.

General West: Yes, Senator.

Senator Graham: Does every member of the military have to through an annual physical? The answer is yes.

Admiral Faison: Yes, sir.

Senator Graham: So is that not primary care, General Ediger?

General Ediger: Yes, sir.

Senator Graham: So that is a primary care activity that is related to readiness.

General Ediger: Yes, sir.

Senator Graham: And those same doctors will be treating kids with a cold.

General Ediger: Yes, sir.

I would add that what we do when we provide care in our MTFs, we are ultimately a mission support activity. And so we are actually supporting commanders who are conducting missions. So in the Air Force, it is global mobility. It is the nuclear mission on its RPA operations, cyber ops. And so by taking care of the airman and the family in our military treatment facility, we are actually helping that commander take care of that family.

Senator Graham: So when you say that a military hospital costs 50 percent more to operate than a civilian counterpart, is that a fair comparison, given the unique nature of military medicine?

General Ediger: I think it is an apples and oranges kind of comparison, sir, because --

Senator Graham: So you agree with me you could make things more efficient.

General Ediger: Absolutely.

Senator Graham: That is the goal. Right?

General Ediger: Yes, sir.

Senator Graham: Do you all agree with me that the people under your command have done historic work on behalf of the Nation?

Admiral Faison: Absolutely.

Senator Graham: I want to tell everybody on this committee, that in this war, which has been going on for 14

years now, there are people alive today that would not be alive in any other war, and you guys are the unsung heroes of this war, as far as I am concerned. I have been to forward-deployed areas where people come in who have been blown up, and it is amazing how you can put people back together again. That whole network from Landstuhl to Walter Reed is just literally priceless, but it needs to be more efficient.

Any last comments?

Dr. Woodson: Senator, if I may make one comment in connection with making sure everyone understands that the maintenance of a military health system is essential to the defense of this Nation. The point I would make and give you an example is that the MTFs are part of the medical force-generating platform. And today in this country, there are 1,000 fewer graduate medical education spots than there are American medical graduates. If we were to eliminate the military treatment facilities and the military health system, we could not generate enough doctors -- and I would say also nurses, but doctors to come on active duty. There just are not enough training slots in this country. So we must preserve this generating platform and we must preserve the graduate medical education program.

Senator Graham: On not a happy note, I think TRICARE, as it is designed, is really antiquated. I would not give

it a B. I am really going to be hard on your guys to come up with reforms, not just premium increases. We are going to look at TRICARE and turn it upside down and make it more transparent and make it more accountable because we are basically using civilian networks when it comes to retirees and their families.

So with that said, this has been a great hearing. Thank you all for your service, and we will stay in touch.

The hearing is adjourned.

[Whereupon, at 4:24 p.m., the hearing was adjourned.]