

STATEMENT BY

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REGARDING

THE MILITARY HEALTH SYSTEM: BUDGET OVERVIEW

BEFORE THE

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Madame Chairwoman, Members of the Committee, thank you for the opportunity to discuss the priorities of the Military Health System (MHS) and its budget for fiscal year 2010. We are pleased to be here.

The men and women of America's Armed Forces are our country's greatest strategic asset. Apart from defending the Nation, the Department has no higher priority than to provide the highest quality care and support to our forces and their families.

As Secretary Gates has said, "At the heart of the all-volunteer force is a contract between the United States of America and the men and women who serve ... A contract that is ... legal, social, and sacred.

"When young Americans step forward of their own free will to serve," he said, "they do so with the expectation that they, and their families, will be properly taken care of ..." ¹

MHS Mission and Strategic Plan

Madame Chairwoman, that commitment, which dates back to the Civil War, is engraved in granite on the Lincoln Memorial, along with Lincoln's pledge to care for those who "have borne the battle." We take it seriously. And it encompasses not only the wounded, but all who serve.

Indeed, the Military Health System (MHS) has one overarching mission: to provide optimal health services in support of our Nation's military mission – any time, anywhere.

Today, the MHS serves 9.4 million beneficiaries, including retired military personnel and their families.

In addition to force health protection and family support, the MHS provides humanitarian assistance at home and around the world, and supports world class medical education, training and research.

Our strategic plan, developed in concert with the Surgeons General, and the Joint Staff – supports all of these mission components. It also recognizes the outcomes the American people expect from their investment in military medicine.

In addition to a fit, healthy and protected force, our goals include the lowest possible rate of death, injury and disease during military operations; superior follow-up care that includes transition to the Department of Veterans Affairs (VA); healthy and resilient

¹ From speech delivered by Secretary Gates to the Wounded Warriors Family Summit, *Monday, October 20, 2008, Washington, D.C.*

individuals, families and communities; and the highest quality care at the lowest possible cost to the taxpayer.

We appreciate the support the Congress, and especially this Committee, has provided to help us provide the very best health care for our forces and their families, and in particular for the wounded ill and injured. While there is always much more that must be done, I believe we have made significant progress toward each of our goals, and I would like to tell you where we are, and what we have accomplished.

A Fit, Healthy and Protected Force

Madame Chairwoman, contrary to common assumption, the single largest contributor to loss of forces is not combat, but disease and non-battle injuries. To keep our forces fit and ready, health assessments are performed on accession, annually, and each Service member prior to deployment, following deployment, and again 90 to 180 days after a Service member has returned to home station.

These health assessments not only provide a comprehensive picture of personal health, but highlight areas of concern, provide an opportunity for additional education, evaluation, or treatment, if necessary; and give commanders a view of force readiness down to the individual level.

Vaccinations are another way to protect force health, particularly against serious illness and disease. Smallpox and anthrax, for example, continue to be viewed as real threats, as well as potential bioterrorism weapons that could be used against our forces. After the Food and Drug Administration (FDA) confirmed the Anthrax Vaccine Absorbed (AVA) safe and effective for individuals at high risk, the Department restarted the anthrax vaccination program. We also implemented FDA-approved changes for a reduced number of doses, which will lower both the number of needed inoculations and the cost.

To date, DoD vaccines have protected almost 2.2 million Service members against anthrax, and more than 1.75 million against the smallpox virus. These vaccination programs have an unparalleled safety record, and are setting the standard for the civilian sector.

The Department continues to lead the world in disease surveillance, education and rapid eradication of global epidemics including influenza. Indeed, DoD influenza surveillance assets offer a global perspective of emerging infectious diseases that not only impact the Department but overall national security – and national health.

In the recent H1N1 outbreak, for example, Defense surveillance assets were responsible for identifying the first two cases in California and Texas, and we continue to be actively engaged with other federal agencies to ensure that the Department's response is

consistent with national efforts and guidelines. In addition, the Department has established stockpiles of medications and other materials to ensure its ability to meet mission requirements anywhere, any time.

As a result of these and other measures, the Disease, Non Battle Injury (DNBI) rates for Operation Enduring Freedom and Operation Iraqi Freedom are the lowest ever reported – 5 percent and 4 percent respectively for Operation Enduring Freedom and Operation Iraqi Freedom, as compared with 5.6 percent in Operation Desert Shield/Desert Storm, 7.1 percent in Operation Joint Endeavor (Bosnia), and 8.1 percent in Operation Joint Guardian (Kosovo).

Thanks to the dedication of the men and women who rapidly reach, evacuate, and treat the wounded, the Death to Wounded Ratio has also dropped. In the past, battlefield medicine was a tricky business. Reaching the wounded warfighter in time to impact his chances of recovery was uncertain at best, and most did not survive the process. Today, every US soldier, sailor, airman and Marine – regardless of location– can rely on state-of-the-art treatment and equipment within the first hour of injury. As a result, the battlefield survival rate now stands at 97 percent, as compared with 75 percent in World War II and 81 percent in Vietnam.

Using aeromedical intensive care units (Critical Care Air Transport Teams) and the latest technology, US medics have significantly reduced the amount of time it takes to evacuate the wounded, moving personnel from forward deployed surgical units on the battlefield to the highest quality care in the United States in as little as 48 hours.

With regard to environmental health protection, Service Occupational and Environmental Health (OEH) specialists routinely monitor air, soil, water and other aspects of the environment in theater to detect and prevent hazardous exposures before they occur. To date, more than 11,000 environmental samples from Iraq and Afghanistan have been collected and analyzed, and new samples are constantly reassessed. Findings to date indicate a low risk to our forces for any long-term health effects from environmental exposures.

In addition, through a multinational agreement (Chemical Biological Radiological Memorandum of Understanding) with Australia, Canada, and the United Kingdom, the MHS is now also sharing this data with our allies to increase their situational awareness of OEH threats in deployed locations, reduce redundancy and duplication of effort, and strengthen their ability to protect deployed forces.

Superior Follow-up Care, including Wounded Warrior and Transitional Care

In addition to prevention, follow-up care is also paramount, particularly for Service members with psychological health needs or traumatic brain injuries (TBI).

The Department is committed to ensuring that every wounded or injured Service member, especially those with psychological health or traumatic brain injuries, receives consistently excellent care across the entire continuum of care – from prevention, protection and diagnosis to treatment, recovery and transition from the Department of Defense to the Department of Veterans Affairs.

In 2007, the Department embarked upon a comprehensive plan to transform our system of care for psychological health and TBI. The plan was based on seven strategic goals:

- Building a strong culture of health leadership and advocacy;
- Improving the quality and consistency of care, across the country and around the world;
- Creating easy and timely access to care, regardless of patient location;
- Strengthening individual and family health, wellness, and resilience;
- Ensuring early identification and intervention for individual conditions and concerns;
- Eliminating gaps in care for patients in transition; and
- Building a network in which to leverage and/or direct medical and cross-functional research, including new and innovative treatments, technologies, and alternative medicine techniques.

Throughout 2008, we made significant progress toward achieving each of them.

We established the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (DCoE) to lead the effort to develop excellence in prevention, diagnosis, practice standards, training, outreach, and direct care for those with psychological health and TBI conditions, and to provide the nexus for research planning and monitoring.

Since its inception, the DCoE has focused its efforts on the development and continuous improvement of a patient-centered network dedicated to all issues related to psychological health and TBI. Approximately \$58.2 million was obligated in FY 2008 to establish the DCoE and supporting networks.

To improve the quality and consistency of mental health care, DoD, in full partnership with VA, continue to develop and update clinical standards and guidelines, share lessons learned and best practices, and establish evidence-based care as the enterprise standard for acute stress disorder, posttraumatic stress disorder (PTSD), depression, and substance use disorders. Over the past year, the Clinical Practice Guideline for depression has been revised, and the existing “Guideline” on PTSD is being updated.

A new evaluation tool, the Military Acute Concussion Evaluation tool, was introduced in USCENTCOM to assess the likelihood of mild TBI. Clinical guidelines for its use in operational settings were also published. TBI certification programs in military medical

treatment facilities were established and standardized protocols for determining if a member should return to full duty or to the United States for further treatment were implemented.

The Department also joined with the VA to implement a standardized training curriculum on evidence-based psychotherapy for PTSD, and trained more than 2,700 providers in evidenced-based treatments for PTSD and TBI.

To recognize the challenging diagnoses and unique requirements that can accompany psychological health and TBI wounds, the DCoE worked with the Intrepid Fallen Heroes Foundation to support the design of a new facility, the National Intrepid Center of Excellence (NICoE).

The new Center will provide an interdisciplinary team of clinicians and scientists dedicated to a holistic evaluation and treatment approach for Service members with mental health and TBI conditions, and provide advanced diagnostics and comprehensive treatment planning for those whose mental health conditions or traumatic brain injuries are not responding to traditional methods. When the new Center is complete, we expect that there will be no finer care available in the country, or perhaps the world, for wounded warriors with these conditions.

In a similar manner, the DCoE, the National Institutes of Health (NIH) Office of Research on Women's Health (ORWH), and VA, are working to identify and explore the existing science on trauma spectrum disorders (such as PTSD and TBI) related to military deployment, and the DoD and VA are working together to foster partnerships between suicide prevention experts in government, medicine, and communities.

To improve access to mental health care, regardless of location, we provided funds to the Military Departments to hire additional mental health and other specialty providers, and implemented a policy that requires first appointment access within seven days for mental health concerns.

Approximately \$32.6 million was obligated to improve the quality and consistency of mental health and TBI care in FY 2008.

Under DCoE, the Department also initiated a telehealth network for clinical care, medication monitoring, support and follow-up for individuals with TBI or stable mental health conditions, including a number of Web-based applications that deliver real-time mental health services, and telehealth-delivered services – especially important to those in rural and underserved locations – to improve and augment access for those concerned about stigma. A new anti-stigma, pro-resilience campaign entitled “Real Warriors” will be launched nationwide this month. Approximately, \$227 million was obligated to improve access to mental health and TBI care in FY 2008.

The Department is working with its federal and private sector partners to eliminate gaps in care as patients transition through the various health systems, or to different duty locations.

For example, we recently established an assisted living pilot program in Johnstown, Pennsylvania to improve functionality and independent living after TBI, and to provide valuable insight for replication in other areas where appropriate. We helped establish the Federal Care Coordination program and stood up a TBI care coordination system to integrate Federal, State and local resources.

A new program, *In Transition*, will be launched early June to maintain the continuity of mental health care for Service members transitioning between military treatment facilities and affiliated healthcare systems such as TRICARE and the VA.

The *In Transition* program proactively facilitates a Service member's transfer from one healthcare system to another, and bridges potential gaps in health service, by assigning each Service member to a Transitional Support Facilitator. The facilitators, licensed behavioral health clinicians who specialize in coaching, remain with the Service member (with a 24/7 network back-up) until the transition to a new provider is complete.

Two studies have been designed to increase the basic knowledge of issues important to the psychological health of Service members. The first, which is currently underway, will identify the various factors that contribute to a mental health professional's decision to either enlist or leave military service. This study will inform the development of policies to successfully mitigate losses in active duty providers. The second is a study to improve deployment-related primary care assessments of PTSD and mental health conditions. Preliminary approval for this study has already been received.

Approximately \$6.1 million was obligated to help eliminate transitional gaps in care in FY 2008.

To ensure early identification and intervention of mental health and TBI issues, the Department enhanced post-deployment assessments and reassessments, and in July 2008, also began conducting baseline neuro-cognitive assessments on Active and Reserve personnel prior to deployment.

To facilitate the continuity of care for veterans and Service members, we implemented a common DoD/VA post-deployment TBI assessment protocol, which will allow clinicians across the enterprise to collect and access the same information.

We also designed and implemented the Mental Health Self Assessment Program, which offers Service personnel and their families the opportunity to identify their own symptoms and access assistance before a problem becomes serious. The self-assessments

address PTSD, depression, generalized anxiety disorder, alcohol use, and bipolar disorder, and may be taken anonymously online, over the phone, or at special events held at installations. After completing a self-assessment, individuals receive referral information that includes services provided by TRICARE, Military OneSource, and VA Vet Centers. More than 37,000 military and family members have accessed the anonymous web- and phone-based mental self-assessment program since it was introduced in 2006.

Approximately \$59.9 million was obligated for early identification and intervention of mental health issues in FY 2008.

Improving care and outcomes associated with traumatic brain injuries and PTSD requires a commitment to research in funding breakthrough prevention, detection, diagnostic and treatment modalities.

The Department is building a network in which to leverage and/or direct medical and cross-functional research that will enhance outcomes of psychological health and TBI patients.

For example, at the request of the Service Vice Chiefs of Staff and the Surgeons General, the MHS will sponsor an expedited, intramural (DoD facilities), multi-center randomized clinical trial of hyperbaric oxygen (HBO2) therapy in chronic and mild-to-moderate TBI.

The study, which is in the advanced development phase, will answer important questions regarding efficacy in this population, including whether HBO2 therapy should be provided to service members when indicated. Currently, the study is awaiting approval by the Food and Drug Administration (FDA).

We also participated in blast mitigation studies through and with the United States Army Medical Research and Materiel Command, and are working with external groups, such research universities as the Massachusetts Institute of Technology and Virginia Tech, and the National Football League, to explore new ways to mitigate the effect of blast and blunt trauma on our populations.

Together with ongoing research activities supported by the Joint Improvised Explosive Device Defeat Organization, and the Institute of Soldier Nanotechnology, we have learned a great deal about how to keep our Service members safe before, during, and after physically traumatic events.

In addition, in FY 2007 to 2008, the Department executed more than \$446.5 million in Research Development, Testing, and Evaluations appropriations to further science in the areas of TBI and psychological health, including:

- Basic research directed toward gaining greater understanding of the brain and how it works;
- Applied research to provide more in-depth knowledge of TBI and psychological health prevention, treatment, diagnosis, and recovery techniques;
- Advanced technology development to create new tools, technologies, pharmaceuticals and devices, and treatment protocols to improve prevention, diagnosis, treatment and recovery;
- Clinical trials to demonstrate the safety, toxicity, and efficacy of candidate pharmaceuticals, prototype medical devices, or protocols benefiting patients diagnosed with TBI or mental health conditions; and
- Complementary and alternative medicine approaches to the treatment of PTSD and TBI, such as yoga or acupuncture.

Of course, despite the significant gains that have been accomplished, more work remains. We will continue to work with our partners to eliminate gaps; ensure the quality and consistency of care; meet the needs of Reserve forces, especially those in underserved areas; improve efforts to recruit and retain high quality mental health providers; reduce the rate of suicide, improve our ability to share and exchange data with the VA; and continually seek new ways to expand our knowledge and improve our ability to care for Service members, veterans and families.

Healthy and Resilient Individuals, Families and Communities

In addition to the measures cited above, the Department is implementing a range of policies to strengthen resilience to psychological stress and traumatic events and create healthy and resilient individuals, families and communities. These policies include removing or mitigating organizational risk factors, bolstering resilience characteristics in our Service personnel, and strengthening family wellness.

To reduce the stigma associated with mental health issues, we mounted a pro-resilience and anti-stigma campaign, and established a number of effective outreach and educational initiatives to increase “psychological fitness” through resilience building programs. We also eliminated the requirement to divulge combat-related mental health history on security clearance forms.

With the assistance of the Service Vice Chiefs, the MHS began development of the *“Real Warriors, Real Battles, Real Strength”* campaign, mentioned earlier², which stresses the impact of war on Service personnel, and emphasizes that seeking help for psychological

² Page 6.

concerns is a sign of strength. Supporting initiatives have been implemented across the Services to target their individual cultures.

The MHS also helped develop educational tools to help families, especially children, cope with deployed parents or loved ones.

One exciting initiative in this area is “SimCoach,” a program currently under development that will allow warriors and families to electronically query top experts in psychological health and TBI, and discuss their injuries with their peers.

Specifically targeted to the Armed Forces younger population, SimCoach will combine the best of simulation, advanced gaming technology, artificial intelligence, and avatar-based computer interaction to encourage warriors and their families to initiate treatment or access educational resources, and to reduce the stigma associated with seeking psychological health care.

Approximately \$32.2 million was obligated to strengthen resilience to psychological stress and traumatic events, and to reduce the stigma associated with mental health issues in FY 2008.

The Department has also initiated a number of programs that address the adverse effects of tobacco, alcohol, obesity, and inactive lifestyles on health.

For example, the “Healthy Lifestyles Initiatives” are evidence-based projects designed to reduce tobacco use, obesity, and alcohol abuse among both active and non active duty beneficiaries.

“Quitline,” is a 24/7 telephone-based tobacco cessation counseling program that offers web-based support, educational program, and pharmacotherapy. Both preliminary and final demonstration study results indicated increases in cessation rates at the end of each quarterly milestone.

The Program for Alcohol, Training, Research and Online Learning, or “PATROL,” is a promising web-based, alcohol abuse pilot project that targeted young, active duty Service members on eight military installations. One month after rollout, participants in one study reported a significant reduction in heavy and binge drinking – results that were sustained in a six-month follow-up.

To help determine how best to encourage MHS beneficiaries to obtain preventive services, the TRICARE Management Activity (TMA) held a summit with experts from both the civilian and government sectors in early 2008. A variety of different pay for performance/prevention initiatives was discussed, along with strategies to determine their overall effectiveness. The National Defense Authorization Act (NDAA) for Fiscal Year

2009 codified these efforts to improve the health status of active duty members, retirees, and their family members.

- We are within 90 days of fully implementing the change to the TRICARE benefit by removing potential financial barriers to receiving certain preventive services and waiving all copayments for preventive services, including colorectal, breast, cervical, and prostate cancer screening, immunizations and visits for children less than six years of age. This also ensures that non-Medicare eligible beneficiaries pay nothing for preventive services during a year, even if the annual deductible amount has not been met.
- TMA has designed a demonstration project to assess the effects of providing incentives, along with wellness programs and care management, on healthy behaviors and lifestyle practices among non-Medicare eligible retired beneficiaries and their family members.

This project will be conducted in three geographic area of the United States for non-Medicare eligible, TRICARE Prime retirees. Participants will receive a self-reported health risk assessment (HRA), and physiological and biometric measures, that include assessment of blood pressure, glucose level, lipids, nicotine use and weight determination. As an incentive to full participation in this project, enrollees will be eligible to receive a waiver of 50 percent of their annual TRICARE Prime enrollment fee (a \$230/family annual savings).

Information obtained from the project will be used to provide targeted interventions that help prevent, manage and improve any chronic conditions identified in the enrollee throughout the three year demonstration period. Participants will retake the HRA annually to reassess their health behaviors and outcomes.

- In order to establish a comprehensive Smoking Cessation Program under TRICARE that builds upon initiatives that had already begun, and makes available, at no cost to the beneficiary, pharmaceuticals used for smoking cessation through the mail-order pharmacy (TMOP) program, TMA has drafted a change in regulations to allow TRICARE to dispense over the counter medications from the TMOP, and to waive copayments for these medications. In addition, TMA is working diligently to contract for a 24/7/365 quit line that will be accessible for counseling world-wide, and anticipates this will be operational by the fall of 2009.

TMA is obligating a demonstration project, through December 31, 2011, to evaluate the efficacy of providing an annual allowance to members of the Armed Forces to determine if this would increase their use of preventive health services for themselves and their family members. In this demonstration up to 1,500 members from each Service are eligible to participate. Half of the Services members are single; half have

family members. Each Service will pay a preventive health services allowance of \$500 per year to single members, and \$1,000 per year to members with families.

AHLTA, DoD's standard global electronic health record and clinical data repository, is also enhancing efforts to build healthy communities by creating a life-long, computer-based patient record and health information to support the entire continuum of health care.

Since the Departments of Defense and Veterans Affairs share a significant amount of health information for patient being treated by both departments, AHLTA also enhances continuity of care, especially for those in transition.

To keep pace with evolving requirements and advances in technology, AHLTA is being deployed in phases or "blocks" of increasing functionality. Block 1, deployed worldwide in December 2006, provides the foundation of system performance through a graphical user interface for real-time ambulatory encounter documentation. Through AHLTA, the electronic medical records of MHS beneficiaries are retrievable at the point of care, whether the care is delivered at one of more than 880 fixed military medical and dental facilities, on board select ships, or in a deployed medical facility. On average, AHLTA processes over 135,000 encounters per workday. As of May 1, 2009, AHLTA had processed and stored over 107 million outpatient encounters.

AHLTA Theater (AHLTA-T) is operational in Iraq, Kuwait and Afghanistan. AHLTA-T collects outpatient encounters which are sent to the Theater Medical Data Store (TMDS) and AHLTA Clinical Data Repository for use in AHLTA worldwide. As of March 31, 2009, 2.2 million theater outpatient clinical encounters had been documented and transferred to AHLTA. Both DoD and VA health care providers use the Bidirectional Health Information Exchange to access theater medical information.

Currently, DoD and VA share a significant amount of health information for common patients including pharmacy data, allergy data, laboratory results, radiology reports, provider notes and procedures, problem lists, vital signs, family and social history, and digital radiology images at some sites. The Departments expect to achieve electronic health record interoperability by September 30, 2009.

Additional improvements and enhancements of AHLTA are planned for the fourth quarter of FY 2009. Key features will include automated clinical practice guidelines; a faster clinical encounter documentation process; electronic signature capabilities, so that patients can sign consents and other forms electronically; health assessment management tools, to allow patients to self-report patient history information online for storage in AHLTA; and multi-site user account access for mobile providers.

AHLTA Block 2 integrates robust dental charting and optometry support capabilities. The MHS is also developing an enterprise-wide document and image management

capability, targeted for the 2nd Quarter of FY 2010, that will incorporate non-text information into AHLTA.

Currently, AHLTA's inpatient documentation capability is operational at many of DoD's largest military treatment facilities (MTF), and covers more than 50 percent of DoD's inpatient workload. Within one year, DoD plans to deploy to additional inpatient sites which will cover approximately 90 percent of DoD inpatient beds.

The Department will continue to enhance AHLTA's performance, reliability and usability and work toward our primary goal of creating a virtual lifetime electronic health record to efficiently support the processes and workflow needs of end-users.

Highest Quality and Cost Effective Care

Our final goal – providing the highest quality care and cost effective care at the lowest possible cost to the taxpayer – is every bit as important as the others I've just outlined. Military and civilian leaders, as well as the American people, rightly expect us to simultaneously provide outstanding health care to beneficiaries and efficiently manage the cost of care. While it is impossible to include all of the actions we have taken to reduce the cost of care, I can provide a good overview of the most significant.

BRAC recommendations have improved the use and distribution of military medical facilities nationwide by reducing unnecessary infrastructure, consolidating medical facilities, and providing more robust platforms for Graduate Medical Education.

Other ways we are addressing cost effectiveness include:

- Implementation of Federal Ceiling Pricing of retail pharmaceuticals. This regulation requires manufacturers to refund a portion of the cost pharmaceuticals dispensed in the retail setting. Discounts are approximately 24 percent of the non-Federal average manufacturers' price. The Department will begin receiving these rebates under this provision beginning May 26, 2009.
- Obtaining significant discounts for pharmaceuticals at MTFs and mail-order venue.
- Effective Contracting Strategies. We have reduced administrative costs through effective TRICARE contracting strategies. Efforts to further enhance the next generation of the TRICARE contracts are well underway.
- Additional increases in VA and DoD sharing of facilities, capabilities, and joint procurements.

- Introduction of new prime vendor agreements that will lower the costs of MTF medical and surgical supplies. The MHS has aggressively negotiated preferential pricing with medical-supply vendors across the country, and we project a cost avoidance of \$28.3 million.

Using our strategic planning tool, the Balanced Scorecard, we are identifying the most critical mission activities, and then applying the continuous process improvement methodology to create a data-driven, decision-making culture for process improvement. The Service Surgeons General have aggressively incorporated this methodology into their business operations, and we are already witnessing positive results. We have also hired a nationally recognized expert in Lean Six Sigma to help facilitate integration of the National Capital Area and San Antonio under our BRAC work.

In fall 2006, based on recommendations from local-level MHS leaders, we began the Innovations Investment Program, to identify the best practices in place at select MTFs, or best practices utilized by private-sector health care firms and introduce them to DoD on a global scale. The intent of this program is to accelerate the use of best practices, using a joint-service, interdisciplinary team of experts to evaluate, validate and then implement proven approaches to better health care delivery. We are currently evaluating three initiatives under this program.

The 2009-2011 VA/DoD Joint Strategic Plan will improve the quality, efficiency, and effectiveness of benefits and services to veterans, service members, military retirees, and their families. For example, 113 VA medical facilities partner with 137 MTFs for a total of 323 direct sharing agreements in the delivery of 158 unique services. In FY 2008, VA and DoD joint national contracts for pharmaceuticals avoided approximately \$115 million in costs.

Another example is the DoD/FDA Shelf Life Extension Program (SLEP) for pharmaceuticals. The VA used the program to extend the expiration dates on products in its Emergency Pharmacy Service program at estimated cost avoidance to VA of more than \$214 million in FY 2008.

Beneficiary Satisfaction

Madam Chairwoman, we studiously seek feedback from our MHS beneficiaries, and I'm pleased to say that they continue to give the TRICARE program solid marks in satisfaction in all of our key inpatient, outpatient and population-based surveys. These surveys are based on the Consumer Assessment of Healthcare Providers and System surveys to enable us to compare our results to U.S. civilian health care surveys.

We fared well on the 2007 American Customer Satisfaction Index survey produced by the University of Michigan and other groups who rate satisfaction with the federal

government. Participants rated satisfaction with inpatient care at DoD medical centers at 89 percent, the second highest satisfaction score by federal agencies/departments surveyed in the benefits-recipients segment.

MHS users' overall satisfaction with the TRICARE health plan rose from 44 percent in 2001 to 59 percent in 2008. Considering that the survey covers the entire period the Nation has been at war, with all of its accompanying stress that is a remarkable achievement.

On the monthly TRICARE Outpatient Satisfaction Survey, the six key metrics of outpatient satisfaction all increased slightly, while a survey of MHS beneficiaries' overall satisfaction with providers was 85 percent, higher than the civilian benchmark at 81 percent.

Other survey results, such as the one for the TRICARE Mail Order Pharmacy (TMOP) show that the military community has been consistently satisfied with the delivery of health care services through our partners, and we will continue to ensure that these private sector providers are rewarded for the outstanding care they deliver to our beneficiaries.

In addition to soliciting general beneficiary feedback regarding use and satisfaction with TRICARE, our surveys are also used to assess specific program performance.

For example, we surveyed National Guard and Reserve members and their families and compared those who purchased the TRICARE Reserve Select (TRS) benefit to those who did not.

We found that TRS enrollees reported the same or better access and satisfaction compared to their Selected Reserve counterparts who use their other health insurance. Specifically, TRS enrollees were more likely to report quick access to care, good communication with providers, and higher levels of satisfaction with overall health plans and health care.

In addition, TRS enrollees who use the TRICARE Standard/Extra benefits option did not differ from regular component Standard and Extra users on most aspects of access and satisfaction.

Despite these positive survey results, the MHS leadership recognizes the continuing challenge of providing timely, consistent access to care at our installations. This is a high priority for the MHS in the year ahead.

Madame Chairwoman, these are some of the more significant accomplishments the Military Health System has achieved with the resources already provided by Congress

and the American people. I'd like to now highlight the key components of our budget request for FY 2010.

UNIFIED MEDICAL BUDGET REQUEST FOR FY2010

The Military Health System (MHS) is uniquely different from any other health care system. The MHS delivers preventive medicine, disease management, treatment, rehabilitation, public health, dental care, medical research, and a host of other services too numerous to list, in virtually every possible environmental condition around the globe. For many of these services, there is no civilian comparison.

The MHS works to enhance its deployable medical capability, the medical readiness of the force, and homeland defense by effectively focusing on products, processes, and services. We strive to anticipate the needs of Commanders and Service members and respond with innovative solutions, new opportunities, and high performance services and products. We have adopted a renewed emphasis on research and development infrastructure to rapidly design, develop, and deploy solutions for the warfighter, and especially to ensure that wounded warriors receive the best possible care, treatment, and support. Achieving these goals is challenging due to stress on the medical force as a result of continuing operations, a growing and aging patient population, and higher than anticipated medical cost growth.

The MHS augments care at military treatment facilities with the TRICARE health benefit. TRICARE provides eligible beneficiaries with access to a global network of private-sector healthcare providers, hospitals, and pharmacies. The MHS provides a world-class health benefit at a reasonable cost to the Department. We continue to see demand for TRICARE benefits grow, with a commensurate increase in the associated costs.

The Defense Health Program (DHP), the appropriation that supports the MHS, is under mounting financial pressure. As a result of the benefits added but Congress and beneficiaries returning to TRICARE as their primary benefit, the DoD health care financing requirement has more than doubled since 2001 – from \$19 billion to \$44 billion in FY 2009.

The majority of DoD health spending supports health care benefits for military retirees and their dependents, not the active force. We project that up to 65 percent of DoD health care spending will be going toward retirees in FY 2011 – up from 45 percent in FY 2001. As civilian employers' health costs are shifted to their military retiree employees, TRICARE is seen as a better, less costly option and they are likely to drop their

employer's insurance. By 2015, at the current trend, DoD health care costs are projected to reach \$64 billion, or 11.3 percent of the DoD budget, versus 8 percent today.

Despite these fiscal challenges, the FY 2010 budget request provides realistic funding for projected health care requirements. I would like to highlight several key attributes of this budget submission. First, the budget does not include any benefit reform savings, and beneficiary enrollment fees and co-pays remain unchanged. Second, Military Treatment Facility efficiency savings previously assumed have been fully restored to the Services Medical Departments. Finally, previously programmed military-to-civilian conversions are being restored in accordance with the provisions of the FY 2008 National Defense Authorization Act. Pursuant to this restoration, the services have submitted memorandums of agreement to restore 5,443 billets in FY 2010.

The FY 2010 Budget Submission reflects several areas of emphasis. While we have achieved outstanding success in managing injuries on the battlefield and preparing wounded Service members to live productive lives, much work remains to be done to help America's injured warriors return to full duty or to move on to the next phase of their lives.

The MHS will continue its efforts to improve diagnosis and provide compassionate care for traumatic brain injury (TBI) and post-traumatic stress disorder (PTSD), illnesses that have presented significant challenges in providing responsive, coordinated, patient-centered healthcare. The FY 2010 budget request includes funding to support organizations, like the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury and Defense Vision Center of Excellence, to overcome these challenges.

The Unified Medical Budget, the Department's total request for health care in FY 2010, is \$47.4 billion. This includes the Defense Health Program; Wounded, Ill and Injured Care and Rehabilitation; Military Personnel, Military Construction, and Medicare-Eligible Retiree Healthcare.

Defense Health Program

The largest portion of the request, or \$27.9 billion, will be used to fund the Defense Health Program (DHP), which is comprised of Operation & Maintenance (O&M), Procurement and Research, Development, Test & Evaluation (RDT&E).

- \$27 billion is for Operation and Maintenance, which funds most day-to-day operational costs of healthcare activities;
- The Defense Health Program budget also includes \$0.3 billion for equipment and

systems procurement; and \$0.6 billion for military relevant medical research, double that of last year's request, to advance the state of medical science, and to develop world class medical products and capabilities to improve survivability and quality-of-life.

It is worth noting that we are requesting an additional \$0.4 billion (included in the \$0.6 billion above) in medical RDT&E funding to be used to advance the state of medical science, technologies, and practices in those areas of most pressing need and relevance to today's battlefield experience. Early emphasis will be on psychological health, traumatic brain injury, prosthetics and rehabilitation, restorative eye-care, poly-trauma and supporting medical information and training systems. Research projects will be selected for funding using a competitive process where Department of Defense researchers, industry and academia will submit proposals for specific research and development projects. By using this process we believe the most promising and expedient medical solutions will be developed and fielded for the Joint Force.

Military Personnel and Construction

For Military Personnel, the Unified Medical Budget includes \$7.7 billion to support the more than 84,000 military personnel who provide healthcare services in military theaters of operations and fixed health care facilities around the world. These services include medical and dental care, global aeromedical evacuation, shipboard and undersea medicine, and global humanitarian assistance and response.

Funding for medical Military Construction includes \$1.0 billion for 23 medical construction projects in 16 locations, including two of the Department's highest construction priorities: Phase 1 of a Hospital Replacement Project in Guam, and Phase 1 of a new Ambulatory Care Center at Lackland Air Force Base, Texas.

DoD Medicare-Eligible Retiree Health Care Fund

The estimated normal cost of the Medicare-Eligible Retiree Health Care Fund in FY 2010 is \$10.8 billion. This funding includes payments for care in military treatment facilities, to private health care providers, and to reimburse the Services for military labor used in the provision of health care services.

Wounded Ill and Injured

The Department of Defense has, and will continue to provide, world class health and rehabilitative care for all Service members who are wounded, ill or injured as a result of their service to our country.

The FY 2010 DoD budget request includes \$3.3 billion for enhanced care for wounded, ill or injured Service members, new infrastructure to house and care for them, and research efforts to mitigate the effect of psychological health and traumatic brain injuries.

The DHP budget request includes \$1.7 billion of the total DoD request. A major focus of the budget for FY 2010 is to ensure that all medical requirements associated with wounded warrior healthcare, to include traumatic brain injury and psychological health are addressed.

The Service medical departments, along with the TRICARE Management Activity, presented requirements and the Secretary fully funded all medical requirements requested. No additional requirements are anticipated at this time.

CONCLUSION

Madam Chairwoman, I began my statement with a quote from the Secretary of Defense that epitomizes the Military Health System's commitment to the health and well-being of our forces and their families. I'd like to end by quoting one of the many wounded warriors who epitomize the will and fighting spirit of the men and women who so proudly and selflessly defend the freedoms we enjoy every day.

Lieutenant Jason Redman is a Navy SEAL who was part of an elite Special Ops team in Iraq last year when he took rounds from a machine-gun in his face and arm. Jason posted a bright orange sign on the door of his hospital room at Bethesda National Naval Medical Center. It read:

"Attention to all who enter here. If you are coming into this room with sorrow, or to feel sorry for my wounds, go elsewhere. The wounds I received I got in a job I love, doing it for people I love, supporting the freedom of a country I deeply love.

"I am incredibly tough and will make a full recovery. What is full? That is the absolute utmost, physically, my body has the ability to recover. Then I will push that about 20 percent further through sheer mental tenacity.

"This room you are about to enter," he wrote, "is a room of fun, optimism, and intense rapid regrowth. If you are not prepared for that, go elsewhere."

Madame Chairwoman that is what the Military Health System is all about – Doing the very best we can for these men and women who give everything they have for every one of us. We can never fully repay them for the sacrifices they make for our country and our future as a free people, but we can and will continue to do everything we can to heal their wounds and honor their courage and commitment to the country we all love.

Thank you again, Madame Chairwoman, for the opportunity to be with you today. I look forward to your questions.

[END]