

**U.S. House Armed Services Committee
Military Personnel Subcommittee Hearing
“Military Health System Overview and
Defense Health Program Cost Efficiencies”
Tuesday, March 15, 2011, 10:00 a.m.**

Members Present

- Joe Wilson (R-SC-2nd) – *Chairman*
- Susan Davis (D-CA-53rd) – *Ranking Member*
- Walter Jones (R-NC-3rd)
- Niki Tsongas (D-MA-5th)
- Joe Heck (R-NV-3rd)
- Chellie Pingree (D-ME-1st)
- Allen West (R-FL-22nd)

Witnesses

- The Honorable Clifford L. Stanley Ph.D. – Under Secretary for Defense for Personnel and Readiness
- Dr. Jonathan Woodson – Assistant Secretary of Defense for Health Affairs
- Lieutenant General Eric Schoomaker, USA – Surgeon General, U.S. Army
- Vice Admiral Adam Robinson, USN – Surgeon General, U.S. Navy
- Lieutenant General Dr. Charles Bruce Green, USAF – Surgeon General, U.S. Air Force

Focus of the Hearing

This was the first in a series of hearings to analyze the Administration’s Fiscal Year 2012 for military health programs with the Department of Defense. The Subcommittee heard testimony on the Defense Health Program cost efficiencies and the Military Health System (MHS).

Chairman Joe Wilson Opening Statement

- Today the Subcommittee meets to hear testimony on the Military Health System (MHS) and the Defense Health Program for Fiscal Year 2012.
- The Subcommittee remains committed to ensuring that the men and women who are entrusted with the lives of our troops have the resources to continue their work for future generations of our most deserving military beneficiaries. Even in this tight fiscal environment, the MHS must continue to provide world class health care to our beneficiaries and remain strong and viable in order to maintain that commitment to future beneficiaries.
- The Department of Defense (DOD) has proposed several measures aimed at reducing the cost of providing health care to our service members and their families and military veterans. While I appreciate that your plan is a more comprehensive approach than previous cost cutting efforts, the challenge here is finding the balance between fiscal responsibility while maintaining a viable and robust MHS. We must be sure to remember these proposals have complex implications that go

'beyond beneficiaries.' They will also affect the people who support the defense health system, such as pharmacists, hospital employees and contractors.

- The Subcommittee has a number of concerns about DOD's initiatives. To that end, we would expect DOD's witnesses to address our concerns, including that:
 - The proposed TRICARE Prime fee increase for Fiscal Year 2012, while appearing to be modest, is a 13 percent increase over the current rate. DOD proposes increasing the fee in the out years based on an inflation index. You suggest 6.2 percent, but it is unclear exactly which index you are using.
 - You plan to reduce the rate that TRICARE pays Sole Community Hospitals for inpatient care provided to our active duty, family members and retirees. Several of these hospitals are located very close to military bases; in fact, some are right outside the front gates, especially important for 24-hour emergency care. What analysis have you done to determine whether reducing these rates will affect access to care for our beneficiaries and, in particular, the readiness of our armed forces?
- I would also like our witnesses to discuss the range of efficiency options that were considered but not included in the President's budget. I would appreciate hearing your views on the recent GAO recommendations included in their report on federal duplication, overlap and fragmentation. GAO made recommendations regarding establishing a unified medical command and for DOD to finally jointly modernize their electronic health records system with the VA.
- In addition, I would like to hear from the military surgeons about efforts they are taking within the military departments to increase the efficiency of the MHS and reduce costs. I would also like the military surgeons' views on areas where additional efficiencies can be gained across the DOD health system.
- DOD recently announced that they have hired Governor John Baldacci, former Governor of Maine, to undertake a full scale review of military health care and the impacts of military health care on the force. I would appreciate hearing from Dr. Stanley the considerations for this review and what the Department hopes to gain from Governor Baldacci's efforts. Why is having a 'Military Health Care Czar' not a duplication of the duties already assumed by Undersecretary Stanley and Assistant Secretary Woodson?
- Finally, I would like to make it clear that in an effort to reduce the cost of military health care and find efficiencies in the MHS, we must never lose sight of the population that the military medical system serves. The members of the Armed Forces and their families who currently serve and those who served as veterans for a full career in the past warrant the best health care available. Reducing cost must never result in reduced quality or the availability to the health care they earned and they deserve.
- I hope that our witnesses will address these important issues as directly as possible in their oral statements and in response to Member questions.

Ranking Member Susan Davis Opening Statement

- I look forward today particularly to hearing about the TRICARE program.
- The last 10 years of conflict have taken a toll on our forces, and in particular, those who serve in our MHS. The constant demand on the system and the successes that we have seen both on the battleground and back at home have been remarkable.
- While I suspect that the majority of this hearing will focus on the DOD's health care proposals that were included in the budget, this hearing will probably be one of the only ones that we'll have on health care prior to the Subcommittee and Committee markup, so it's important that Members have an understanding of all of the challenges that the MHS is facing, not just the budgetary constraints.

- Our military personnel and their families are under constant pressure, and access to quality health care should not be on that list of concerns.

Witness Opening Statements

Clifford L. Stanley

- For service members wounded in combat, their likelihood of survival after a medic arrives remains at historic and unmatched levels.
- We're working ever more closely with our colleagues in the Department of Veterans Affairs to ensure that our activities are better coordinated to include a disability evaluation process, sharing of personnel and health information, and collaboration on our future electronic health record.
- In addition to the efficiencies we will discuss today, I've asked former Governor John Baldacci to help us work at a deep dive review of health care and wellness; this review will focus on readiness, improved health population, patient experience and care, and cost.
- Turned to Dr. Woodson for the second half of the joint-testimony.

Jonathan Woodson

- This MHS has shown time and again that it is a vibrant learning organization capable of self improvement and rapid incorporation of lessons learned.
- Thanks to the ongoing support of Congress, we are continuing to invest deeply in the most challenging medical issues we're facing as a result of war.
- We're making important investments in how we deliver care to all of our beneficiaries; patient-centered medical home is a transformative effort in our system; we have enrolled more than 655,000 beneficiaries today with promising results.
- In addition to our investments in readiness and improved population health, we also have proposed some changes that will allow us to more responsibly manage our costs. Our efficiency initiatives share the responsibility for cost controls among all of the participants.
- Throughout our proposals we have taken steps to protect those who are enrolled in existing programs or those who have special circumstances that must be considered and protected.
- Our proposed budget helps keep fidelity with our core principles. We will never lose our focus on our commitment to the men and women who serve in the armed forces, their families, those who have served in the past and present, and those who will serve in the future.

Eric Schoomaker

- Despite over nine years of continuous armed conflict for which Army Medicine bears a heavy load, every day our soldiers and their families are kept from injuries, illnesses, and combat wounds through our health promotion and prevention efforts; are treated in a state of the art fashion when prevention fails; and are supported by an extraordinarily talented military medical force including those who serve at the side of the warrior on the battlefield.
- We are focused on delivering the best care on the right time and place. I would like to talk about our work through the lens of the Five E's:
 - Enduring care through initiatives such as the Warrior Care and Transition Program and the Soldier medical Readiness Campaign Plan. We have brought about a soldier medical readiness campaign that was brought about because of rising cost of health problems in our forces, especially in the reserve components; we identify the medically non-ready soldier component and work to deploy healthy, resilient and fit soldiers. Also, DOD and VA have jointly designed a new DES, the Integrated Disability Evaluation System (IDES); began in 2007 at Walter Reed and is now in 16 of our army medical treatment facilities; it will be the DOD and VA replacement for the legacy disability evaluation

system; but even with this improvement DE remains complex and adversarial; our soldiers still undergo dual-adjudication, which is confusing to soldiers; IDES doesn't change the fundamental nature of the dual-adjudication process; under leadership of Army Chief of Staff, we continue to forge the consensus necessary for a comprehensive reform of the physical disability evaluation system

- Early prevention – Our second strategic aim is to reduce suffering, illness and injury through early prevention. We're doing this through things like promotion of healthy lifestyles; implementation of the patient-centered medical home; focus on BMI and childhood obesity. The Army is also leading the way in recognition and treatment of concussion through a train-treat-track strategy.
- Effective – Our third strategic aim is the use of evidence based practices. We call this the comprehensive behavioral health system of care. We've launched a comprehensive pain management strategy to address chronic pain that is holistic, multidisciplinary, multimodal and is focusing on non-pharmacological practices such as incorporating acupuncture and massage therapy.
- Efficient – Fourth strategic aim is optimizing efficiencies. We do that through leading edge business processes and partnerships with the other Veterans organizations. Ultimately, the principle efficiency and cost saving step in health care is the maintenance of health, promotion of good health and the focus on good clinical outcomes and evidence-based practices. But we're also working with DOD and VA to create a single electronic health record seamlessly transferring patient data to improve efficiencies and continuity of care. No two health organizations in the nation share more non-billable health information than the DOD and VA.
- Enterprise Approach – Our fifth strategic aim is the Enterprise Approach. We've reengineered Army medicine, created a public health command, and reengineered our regional medical commands to align with the TRICARE region so that we can more efficiently provide health care in a seamless way to our TRICARE partners. We also have at each regional medical command a deputy commander who's responsible for readiness and can even reach out to our reserve component elements to ensure that all medical and dental services are being provided and our reserve units are optimally ready.
- This is my last Congressional hearing cycle as I am about to retire; thank you for allowing me the opportunity to highlight our work.

Adam Robinson

- I want to thank the Committee for your tremendous confidence and unwavering support of Navy medicine, particularly as we continue to care for those who go in harm's ways.
- Force health protection is the bedrock of Navy medicine; it is what we do and why we exist. It's our duty to promote, protect and restore the health of our sailors and marines. This mission spans the full spectrum of health care from optimizing the health and fitness of the force to maintaining robust disease surveillance and prevention programs to saving lives on the battlefield.
- I traveled to Afghanistan last month and witnessed the stellar performance of our people. At the NATO Role 3 Multinational Medical Unit, Navy Medicine is currently leading the joint and combined staff to provide the largest medical support in Kandahar with full trauma care to include 3 operating rooms, 12 intensive care beds and 35 ward beds. The state-of-the-art facility is staffed with dedicated and compassionate active and reserve personnel who are truly delivering world-class care. The Navy Medicine team in working side-by-side with Army and Air Force medical personnel and coalition forces deliver outstanding health care to US military, coalition forces, contractors, Afghan national army, police and civilians, as well as detainees. The team is rapidly implementing best practices and employing unique skill sets with specialists such as an

interventional radiologist, pediatric intensivist, hospitalist and others in support of their demanding mission. I'm proud of the manner in which our men and women are responding.

- We spend a lot of time discussing what constitutes world class health care; the trauma care being provided to our casualties is truly world class, as are the men and women delivering it.
- We also visited our Concussion Restoration Care Center (CRCC) which the Marine Corps opened last August to assess and treat servicemen with concussions or mild TBI or musculoskeletal injuries, with the goal of safely returning as many service members as possible to full duty following recovery of cognitive and physical functioning. CRCC is supported by an interdisciplinary team. The CRCC along with other programs like the Operational Stress Control and Readiness (OSCAR) program reflect our priority of positioning our personnel and resources where they are most needed.
- Preserving the psychological health of our service members and their families is one of the greatest challenges that we face today.
- Nearly a decade of continuous combat operations has resulted in a growing population suffering from TBI; we're doing a lot but there is still much we do not yet know about these injuries and their long-term impact on the lives of our service members.
- We also recognize the importance of collaboration and partnerships, and our efforts include those coordinated jointly with the other services, the Department of Veterans Affairs, Centers of Excellence, as well as leading academic and research institutions.
- Turning to patient and family centered care – Medical Homeport is Navy Medicine's patient-centered medical home model. It's an important initiative that will significantly impact how we provide care to our beneficiaries; emphasizes team-based, comprehensive care and focuses on the relationship between the patient, provider and health care team. Critical to its success is leveraging all our providers and supporting IT systems into a cohesive team that will provide primary care and integrate specialty care. We continue to move forward with the phased implementation of Medical Homeport and our Medical Centers, and initial response from our patients is very encouraging.
- Both force health protection and patient and family centered care are supported by robust research and development capabilities and outstanding medical education programs. These are truly force multipliers. The work that our researchers and educators do is having a direct impact on the treatment we're able to provide our wounded warriors and helping to shape the future of Military Medicine.
- Finally, I want to address the proposed Defense Health Program Cost Efficiencies. Rising health care costs within MHS continue to present challenges. The rate at which health care costs are increasing can't be sustained. Department of Navy fully supports the plan to better manage costs moving forward and ensure our beneficiaries have access to quality care that is the hallmark of Military Medicine.
- In summary – I am proud of the progress we're making but not satisfied; we continue to see groundbreaking innovations in combat casualty care but all of us remain concerned about the cumulative effects of worry, stress and anxiety on our service members and their families brought about by a decade of conflict. Regardless of the challenges ahead, I'm confident that we're well-positioned for the future.

Charles Green

- I'm here today representing the men and women of the Air Force Medical Service (AFMS). We couldn't achieve our goals of better health without the support of this Committee, and we thank you.
- MHS achievements have changed the face of war. We deploy and set up hospitals within 12 hours anywhere in the world; we have achieved and sustained a less than 10 percent rate of those

who die from wounds. We move our sickest patients in less than 24 hours of injury and get them home to loved ones within three days to hasten recovery.

- The AFMS has a simple mantra – Trusted Care Anywhere. This means creating a system that can be taken anywhere in the world and be equally effective whether in war or for humanitarian assistance. Medics at Air Combat Command have developed an e-med deployable hospital that is capable of seeing its first patient within one hour of arrival and performing its first surgery within three to five hours. Our systems are linked back to American quality care.
- AFMS focuses on patients and populations. Patient-centered care builds new possibilities in prevention by linking patients to provider teams that both the patient and provider can be linked to an informatics network dedicated to improving care.
- The Air Force supports the DOD strategy to control health care costs and believes it is the right approach to managing the benefit while improving quality and satisfaction. By the end of 2012, the Air Force Patient-Centered Medical Home will provide 1 million of our beneficiaries new continuity of care via single provider-led teams at all of our Air Force facilities. We will do all in our power to improve the health of our population while working to control the rising costs of health care.
- The AFMS treasures our partnerships with the OSD, Army, Navy, Veterans' Administration, civilian and academic partners. We leverage all of the tools you have given us to improve retention and generate new medical knowledge.

Question & Answer Session

Chairman Wilson – Dr. Stanley, knowing your military and medical background I have faith in you and Dr. Woodson as to the oversight of MHC, so it was a surprise to me that last week there would be a MHC czar appointed, Governor Baldacci. I understand he is to conduct a one-year review. I believe that is a duplication. Just two weeks ago, GAO said our government suffers from duplication and fragmentation. I am also concerned that in light of this GAO study, why should Congress enact what you're proposing, which are the Defense Health Cost Efficiencies, if this work could be overturned by another major reform by another party?

- Dr. Stanley – The efficiencies we're talking about today are not directly related to what Governor Baldacci will be doing. His charge by me is to have an objective, outside look. I had a Member of Congress help by looking at the holistic viewpoint of readiness, wellness, patient satisfaction and cost. So duplication is not what I see right now; I'm asking Dr. Woodson to work very closely Governor Baldacci as we look at the objective assessment of this.
- Dr. Woodson – I think in part with the delay in my confirmation and the inconsistent leadership within health affairs, there was a need to look at how business was conducted within health affairs. I don't see Governor Baldacci's mandate as interfering with my statutory authorities and the efficiencies that we need to roll-out. To the extent that Governor Baldacci conducts his studies and informs me as to what additional reforms need to be made, I look forward to his work.

Chairman Wilson – General Schoomaker, it's so important to talk about the Walter Reed-Bethesda "merger". I'm concerned about the level of support provided for the wounded warriors. Will it be equal to the current world-class support that we know at Walter Reed?

- General Schoomaker – All of the services have worked very hard to ensure that will occur. We've had very tight schedules and some unexpected hurdles that we'll have to overcome. Honestly, there will be some patients in a new system that will face unfamiliar terrain, but I can say we're working as hard as we can to meet the deadlines as well as the standards of our high quality care.

Ranking Member Davis – Dr. Stanley, I understand that DOD analyzed a number of options before it considered what proposals to put forward to try to address the growing health care budget. Please share what other proposals were considered and subsequently rejected by DOD.

- Dr. Stanley – We did look at other options from curtailing certain studies to doing curtailment on research. Over the years before I came, there were actually higher costs looked at which were rejected by Congress as well as internally when they looked at ways to be more efficient while having minimal impact on our troops. So we looked at things that would have minimal impact on active duty while not affecting our retirement community or reserve and guard. That's where we came down with these minimal efficiencies that we're looking at.
- Dr. Woodson – Producing efficiencies and reduction in cost in health care is an ongoing effort both in MHS and in the civilian sector; since 2007, \$1.65 billion have been saved in MHS by introducing mail-order pharmacy products, going after federal price ceiling, using outpatient prospective payment systems, enhanced fraud detection and standardizing medical supplies and equipment. We have endeavored to streamline our practices, such as the Patient-Centered Home as a method for managing chronic disease which reduces cost and improves quality of care; we have undergone consolidation; we centralized procurement of medical equipment and devices; we have reduced service contracts and we continue to look at this as a source of efficiencies; and we streamlined TRICARE management activity operations. So there have been a number of initiatives that have been implemented and continue to be implemented. Between 2001 and 2008, the rise in cost of health care was 11.8 percent per year, and we are desperately trying to bend that curve and produce all sorts of efficiencies, so that's why we've considered a balanced approach in FY2012 to bending that cost curve.

Ranking Member Davis – One of the things I was wondering was if the Surgeons General could talk about your engagement and whether you feel there was adequate opportunity for you to weigh in on these opportunities.

- Admiral Robinson – All of us (Surgeons General) have been brought into the whole efficiency movement; coming from health affairs, we've all been tasked to look not only at what we're doing externally but also the internal approach. We all leverage the efficiencies that are occurring in the Medical Home Model, and I think that will be one of the major efficiency moves in terms of quality of care.

Representative Jones – Admiral Robinson and General Schoomaker, I have visited Walter Reed and Bethesda on a regular basis. It seems that in the last year I have visited, the severity of the wounds is deeper than ever. My concern is for those who are still in the military who are severely wounded, as well as when they leave the military. Are you satisfied that we are where we need to be as it relates to psychiatrists in the Army and the Navy? Does the government need to try to encourage those who are graduating from schools with degrees in psychiatry to look more at coming into the military? My concern is not only the young injured, but if they have a family that also needs mental health care.

- General Schoomaker – We've also recognized the same thing about the recent deep, complex injuries, and I started a task force last month to look in greater detail at the data and the magnitude of the injuries that we're now seeing. We think this is the dark side of a good story because soldiers are surviving more than they have in the past. As far as psychological care, this is a moving target; we've seen an increase in behavioral health across all of our units. We've increased the number of behavioral health specialists and the Army has allowed us to put more of them into battalions and brigades; but we continue to chase that because the need is still there.
- Admiral Robinson – I would say what General Schoomaker said is correct. We don't have enough mental health workers in the sense that I can always use more. If you look at the retention rates, the Navy is at 72 percent. With that said, we have spent about \$240 million in behavioral health contracts. We look at each facet of behavioral health and we embed our mental

health professionals with our OSCAR teams so we can get care to people immediately. On the home-front we have focused on families overcoming stress (FOCUS). So we're putting together across the MHS a comprehensive look, but we can always do better.

Representative Tsongas – I want to start by commenting on the Uniform Services Family Health Plan (USFHP). It came about 30 years ago when direct care system needed help to meet health care needs of our military personnel; since then, they have become highest rated health care program in the MHS based on beneficiary satisfaction. Their approach to patient care management with a focus on prevention and continuum of care has decreased ER visits and hospital visits. It's a model for what we have been aiming to do as we all struggle with the rising costs of health care. I would urge that as a body, we give careful analysis to the impact of your proposals to shift the costs to Medicare for retirees. Now, I have a question for Doctors Stanley and Woodson – currently, the over 2 million military retiree families enrolled in TRICARE pay \$460 per family per year for health insurance and an individual pays \$230 per year. These fees have not been raised in 15 years. I do believe Congress needs to take on the difficult task of reviewing this fee structure, but I believe it must be done in such a way as to minimize its impact. For active duty personnel, DOD has different annual deductible rates for TRICARE Extra and TRICARE Standard on the basis of pay grade. Keeping this great gap in benefits in mind, has DOD seriously reviewed any proposals for a stepped increase in TRICARE Prime fees determined on the basis of rank at the time of retirement and retiree benefits earned?

- Dr. Stanley – I'm not aware of any look at step-increase; the amount that was chosen was considered a minimalist approach to addressing a long-standing issue of prices not changing.
- Dr. Woodson – I agree that we haven't looked at stepwise increases because we've introduced very modest changes. As an administrative process, it becomes more difficult to assess income and who should have the stepwise increase because even an enlisted person who retires after 20 years may enter a very good paying job, so what they actually make may not always relate to their retirement pay. I would remind the Committee to reflect on the fact that our proposal suggests modest increases for working-age retirees, so we would have to means test against the issue of what their total salaries are. It's conceivable that following retirement, as talented as our people are, they contribute greatly and get advanced degrees, so it would be administratively tough to means-test. If we were proposing large fee increases I would agree with you strongly.

Representative Heck – Doctors Stanley and Woodson, in your joint statement you referenced the Reserve Health Readiness metric that has been developed. I'm concerned about the Logistics Health Incorporated (LHI) contract and how that service is currently performed for the Army Reserve. We have Mobilization Support Units (MSUs) in the Army Medical Reserve whose job it is to accomplish the medical aspect of soldier readiness processing when they get mobilized. However, they are prohibited from performing that very same service for their own reserve counterparts on a BTA weekend. You mentioned issues with minor dental procedures that could be readily fixed in pre-deployment mobilization, yet they can't examine their own reservists because of the LHI contract. The issues here are multiple – it impacts our medical readiness and our ability to perform real-world training. My questions are – I understand the LHI contract is up for renewal, so who is the formal approval authority for that contract; is the Army considering any other options or modifications to the contract; what is the overall cost; and how can we document whether or not the LHI contract has provided any value-added service to our medical readiness?

- Dr. Woodson – I need to take those questions for the record and get back to you with the specific facts. I think it is probably time for review as we look at individual medical readiness and seeing how we can get added value out of the all of the contracts that we employ.
- Representative Heck – I appreciate that. We need to get back to the point where our Army Reservists can do what they used to be able to do on BTA weekends.

Representative Pingree – I'm proud to represent many active duty members as well as military retirees in my District in Maine. I visited USFHP's facility in Maine and saw their use of Medical Home Model of care, and the beneficiaries tell me how much they like this health care option. In March, I sent a letter to you, Dr. Stanley, stating my support of how this program works and I'm sorry to say I wasn't completely pleased with your response, and now the President's budget proposal includes a plan that future enrollees would not remain on this plan upon reaching age of 65. Destabilization of this program isn't consistent with DOD's stated priorities of improved health management.

- Dr. Stanley – As we look at what we're proposing, we'll be working very closely with each hospital because the changes may be very minimal in some cases as we look at how the Medicare funding is worked out. At the same time, we're trying to address something that hadn't been addressed for a number of years. Bottom line is we'll work closely with them.
- Dr. Woodson – The issues that we need to remind ourselves of is that this is not about taking a beneficiary away from their doctor, because they can continue to see the same doctor, but we pay about \$16,000 per member per year in capitated fees to the uniform services family health plans, whereas the cost to the government for TRICARE Prime is about \$4,500 and for TRICARE Standard is about \$3,500, so just good business practice would suggest that we need to get better value for our dollar. This proposal will save the entire Federal government about \$300 million over about 10 years because right now, we pay about 42 percent higher in cost than we would pay under Medicare fees. Also, most of the individuals that are Medicare eligible have already taken on Part B, so the impact to any individual patient is not likely to be very dramatic. It's a modest change that on balance says we've looked at a number of initiatives to produce efficiencies.

Representative Allen West – We talk about the visible injuries that we see coming out of combat, but my one of my concerns is the unseen injury of traumatic brain injury (TBI). I visited with a doctor in south Florida who has been offering Hyperbaric Oxygen Treatment (HOT) to several returning veterans, and they have seen noticeable improvements. Three weeks ago I talked to Vice Chief of Staff General Chiarelli to talk about the opportunities of HOT, and one of the things he said was there are obstacles out there to the implementation of this is a viable treatment for our returning officers. Why are there obstacles to using more of that, and what can this Committee do to eradicate those?

- General Schoomaker – I don't think there's anything the Committee can necessarily do; HOT is currently an FDA regulated treatment and it's not currently approved by them for treatment of concussive brain injury or PTSD. We currently have three projects investigating HOT, and the results of the first study show that HOT appears safe at this point for patients with moderate and stable brain injury, but we're awaiting the results of the second two studies. So the summary is that despite a series of anecdotes, there remains no medical evidence that HOT has a therapeutic role in the relief of TBI or PTSD, and until we have that we can't provide care without knowing its ultimate safety and its utility.
- Representative West – Perhaps the Committee should look at if we should send a letter to FDA. We can't take too much time because every day someone is going through an IED blast, so hopefully we can put more emphasis and speed to this issue.

Chairman Joe Wilson – So often we hear the bad, but the good is that military medicine has been the best in the world providing for care of people with brain and trauma injuries. With this, I'd like to know from each Surgeon General what you have done in regard to cost efficiencies. Can you give an example of something you have done on behalf of our taxpayers?

- General Schoomaker – We've focused on standardization of practices, both administrative and clinical. It's been widely discussed that elimination of unwarranted variation in administrative and clinical practices will squeeze out a lot of waste in the system. Also, all of us have embraced the Patient-Centered Medical Home model, and we commend the Air Force for the lead on this.

- Admiral Robinson – Many of the Navy initiatives are along the same lines as what General Schoomaker just said. We've also taken some internal looks at partnering with other groups to look at business and clinical practices in our medical treatment facilities across the enterprise. We're looking at how we can more efficiently work our patients through our system and have standardization of practice. And in the financial world, we have instituted a great deal of effort at standardization of how we do our financial accounting and audits. Those two business practices (industrial engineering and the way we do our finances) have produced efficiencies and savings.
- Dr. Green – We've looked at several things, including decreasing our headquarters; standardizing our practice; implementing the Medical Home model, which has raised satisfaction; and we've had systems looking at our operating rooms and emergency rooms to maximize the efficiency to increase access. The partnerships we're doing are based on bringing care back into the direct care facilities both for currency and to decrease costs. Also, our efforts in disease and case management are reducing care costs.

Ranking Member Davis – I hope we will have the opportunity to look at mental health overall. I want to go back to Representative Pingree's question because the new proposal really could have an impact on our active duty members. In the proposal we're reducing possible payments to Sole Community hospitals. Those hospitals may decide to limit TRICARE participation due to the reduced rates. Has the Air Force engaged with Sole Community hospitals outside of Air Force bases to assess the impact of this proposal on the beneficiaries in those communities? Certain communities are more affected by this than others. What can we anticipate might be the impact?

- Dr. Green – Eight of the 20 hospitals that have over 5 percent of their income based on admissions are from Air Force areas. So about 4 of those facilities are in the 10 to 15 percent range for us. The reality of the implementation is we've had longstanding partnerships with these organizations. We believe the care will still go to these organizations. But as you change the payment we believe the implementation is conservative enough that we can look at it, work with the local facilities, and if necessary work with health affairs to make certain this is sustainable. We believe this is a reasonable approach to bring this back in line with what's going on elsewhere in the nation. There should be no effect on our beneficiaries because their care will still go to the same areas, just at the rate of payment that's provided at every other site where they might go to receive care if they were out of that area. So we'll be watching this issue very closely.
- General Schoomaker – Two of the 20 hospitals are Army-centric, including a hospital in the community that our secretary of the army represented at one point. I think everything General Green says applies to the Army as well.
- Dr. Woodson – We're going to reach out proactively to these hospitals to look at their revenue streams and see how they will be impacted. We do have the ability to pay Medicare rates when practical, and adjustments can be made. We want to be fair and proactive about this, but in this day and age we need to make sure all of our contracts are really looked at carefully and add value as well as quality in terms of the care that is provided.

Representative Jones – I have more questions about Hyperbaric Oxygen Treatment (HOT). I understand the need for studies, but when would the DOD get to a point after a study that they say that this protocol does work and does help?

- Admiral Robinson – This has been a four-year question for me. We have held double-blinded studies so that we can get away from the anecdotal results of individual patients and we can get down to what we have to have for clinical practice guidelines that can't be influenced by opinions. So we need to employ a scientific method. What we have done now, in my 4th year, is we are beginning to produce data from competent studies that look at hyperbaric oxygen and are finding that it seems to be safe, and now we need to look more deeply at the Air Force study, which has been completed but the analysis has not been done. When we can get some studies on

the record that look at the efficacy of hyperbaric oxygen treatment, we can say that it can be used. We are just months away from getting there. We just have to base it on a scientific method.

Representative Pingree – I understand how well you’re all doing your job and the importance of all of you looking for cost efficiencies. But I’m concerned that we’re going after medical care for our active duty personnel and our retirees when there are other places to make more effective cuts. For me, many of the efficiencies you talk about will reduce the level of medical care to the people who have served us. The only other program that hasn’t been brought up today is the Pharmacy Co-Pay. I’ve seen a little about that and know some of the co-pays will be reduced by using mail-order pharmacies. I believe people get better care when they go directly to a pharmacist in their community rather than using mail-order. How much is DOD doing to negotiate for better prices with the pharmaceutical companies and bringing costs down that way as opposed to this other option?

- Dr. Woodson – We continue to have efforts to negotiate with pharmaceutical companies for cost-cutting of prescription drugs. But I think mail-order advances care because there is a large percentage of retail prescriptions that are never picked up and breaks in terms of the supply of medications. Our proposal reduces the cost and ensures timely supply of medicine. And linked with our concept of patient-centered home, they have a team of health care providers who can coach and monitor medicines, and we have new electronic databases that highlight medications and notify practitioners of medications that may be unsafe. So there are a number of things we’re doing that will enhance the quality of care while reducing the costs.
- Representative Pingree – Back to the question of negotiating, is that an active activity that goes on today to negotiate for cost-cutting?
- Dr. Woodson – I’m told that it’s managed through the Defense Logistics Agency, and I’m told the DOD has some of the most favorable cost profiles of any organization in the US because of leverage and volume.

Representative Heck – I want to go back to the issue of TBI. I appreciate the academic rigor with which you’re reviewing the HOT issue. No matter how that turns out and what treatment process we have in place for TBI, my biggest concern is identifying the military personnel that have TBI. And it seems that it’s the reservists that get lost in the follow-up process upon their return home.

- General Schoomaker – We have come a long way in the last few years. Early in the war we had clinical process guidelines but they weren’t mandatory, and now we have a mandatory screening tool. And with resiliency centers (seven in Afghanistan), we’re seeing rapid turnaround. We’ve done enough studies with ANAM with fresh casualties to be able to know that as a screening tool it’s insensitive and non-specific. We’re now doing a head-to-head evaluation between ANAM and the impact tool that NFL uses. But you’re correct that right now we don’t have a single test for the diagnosis other than the clinical diagnosis of concussion. But we’re being more aggressive and right over the horizon we see biomarkers and other tools that we think will be very useful.
- Admiral Robinson – We also have the micro and the defense center of excellence that is devoting a great deal of research efforts in basic science areas and the areas of how we can diagnose, assess and treat TBI. So we’re not only doing the in-theater assessments, but we’re also compiling and reporting data. With the ANAM and the MACE, with our professionals trained, and with adequate data, we’ll get a look at who has been involved, how we can do a longitudinal look at them, and make sure that we can at least follow them. We don’t understand this completely but we’re not going to let it go.