STATEMENT
BY

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REGARDING

THE DEFENSE HEALTH PROGRAM OVERVIEW

BEFORE THE

HOUSE APPROPRIATIONS COMMITTEE
DEFENSE SUBCOMMITTEE

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Mr. Chairman, Members of the Subcommittee, thank you for the opportunity to appear before you today to discuss the future of the Military Health System (MHS), and in particular, our priorities for the coming year.

This is my first public appearance before this Subcommittee in my role as the Assistant Secretary of Defense for Health Affairs, and I want to first express my deep gratitude for the warm and helpful guidance both you and your staffs have privately offered to me in my first four months in this position.

The people who comprise the MHS have a well-deserved reputation for exceptional professional performance and personal courage. I believe deeply that military medicine has proven itself time and again as a learning organization, capable of self-critical analysis and substantive improvement in those areas where it falls short of its own and others' expectations.

We begin 2011 on a strong foundation. Our medical achievements on the battlefield, in combat hospitals, and in the air continue to set new standards for medical outcomes in war…anywhere in the world.

We are fortunate to have the continued, substantive support of both the Congress and the White House. This support has been greatly enhanced by the very public effort led by the First Lady and Dr. Jill Biden to highlight the contributions of military families to our national security, and to focus on how the broader American community can acknowledge this and support military families on the home front. Within the MHS, we are engaged in this effort, and I will illustrate some of our efforts in this testimony.

Even with our successes, challenges remain. First, we continue to provide medical treatment to Service members in combat in some of the most austere environments on the planet. There is nothing routine about this, regardless of how long we have been at war. I will not waver from my primary focus to ensure the medical readiness of all of our Armed Forces, and the readiness of the MHS to deliver highly trained medical professionals to support them.

International events and ongoing humanitarian crises also remind us that we must be prepared to respond to additional events on a moment's notice at the direction of national command authorities. Readiness is more than the center of our strategic plan; it's our fundamental obligation and reason for being.

A key component of our readiness obligations is to ensure we sustain the confidence of the Service members who we support here at home, and who have borne the greatest burden of war --the service members with serious wounds, visible and invisible, along with their families who sacrifice, who grieve, and who carry their own wounds from this

conflict. We will continue to dedicate our time and resources to our care for wounded warriors and their families.

Finally, we must also operate in an environment that recognizes financial resources are limited. As you know, the Department has put forward specific proposals to address the rising costs of military health care. But, it is important to note that this is not our first step at cost control. Over the last several years, we have taken a number of actions that have produced real savings to the Government and the taxpayer, to include: introduction of the Outpatient Prospective Payment System (OPPS), targeted efforts to increase the use of the TRICARE Mail Order Program (TMOP); a TRICARE Pharmacy Fraud and Abuse surveillance system; and expanded access to urgent and primary care facilities to redirect care away from Emergency Room care whenever clinically appropriate.

Today, I will explain the actions we are taking to address the financial challenges we face, and the process by which we selected the proposals put forward in this budget.

From the broadest overview possible, the proposed total funding for the MHS in FY 2012 – combining both the Defense Health Program (DHP) and other appropriations which fund MHS activities -- is over $52 billion (Table 1). This reflects continued investments in readiness, patient care activities, research and development and medical military construction.

**TABLE 1: MILITARY HEALTH CARE COSTS[1]**

| Program | FY 2011 Request | FY 2012 Request |
|---|---|---|
| Defense Health (DHP) | 30.9 | 32.2 |
| Military Personnel[2] | 7.9 | 8.3 |
| Military Construction[2] | **1.0** | **1.3** |
| Health Care Accrual[3] | 10.9 | 10.7 |
| **Unified Medical Budget** | **50.7** | **52.5** |
| *Treasury Receipts for Current Medicare-Eligible Retirees*[4] | *9.4* | *9.9* |

*1/ Excludes OCO funds and other transfers.*
*2/ Funded in Military Personnel & Construction accounts.*
*3/ Includes health care accrual contributions into the Medicare-Eligible Retiree Health Care Fund to provide for the future health care costs of our personnel currently serving on active duty – and their family members – when they retire.*
*4/ Transfer receipts in the year of execution to support 2.1 million Medicare-eligible retirees and their family members.*

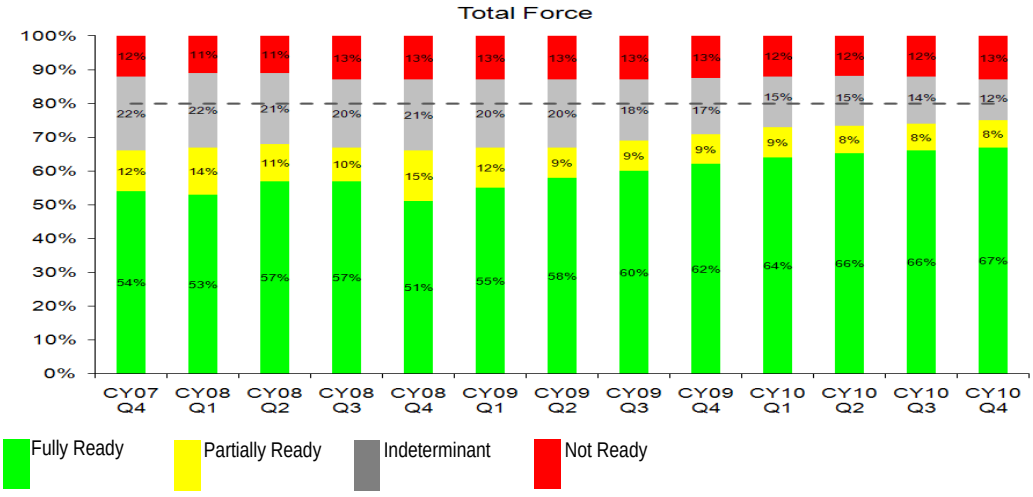
In the pages that follow, I will outline our programmatic priorities for the FY12 Defense Health Program. I have organized this testimony and our priorities around the MHS' strategic framework – the Quadruple Aim. This framework best captures the core mission requirements of our unique system: Assure Readiness; Improve Population Health; Enhance the Patient Experience of Care; and Responsibly Manage the Cost of Care.

Undergirding these four priorities are our Learning and Growth requirements, and I will outline our efforts in these areas as well.

## I. Assure Medical Readiness

Within the MHS, we have established an Individual Medical Readiness (IMR) metric to determine the medical preparedness of each Service member to deploy. Overall, the medical readiness of our forces remains sound, and for the last two years we have seen continuous improvement in readiness each quarter, across both the active and reserve components (Figure 1). Within the Reserve Component, medical readiness is below our benchmarks. We find that, in general, the individual Reservists can quickly be elevated to a prepared status during the pre-deployment period (e.g., complete health assessments and by ensuring minor dental procedures and immunizations, etc. are quickly performed). We are in the process of engaging with commanders, particularly in the Reserve Component, to focus attention and corrective action on these matters within their units.

**Figure 1: Individual Medical Readiness (IMR)**




In addition to our focus on the medical readiness of our current force, we are also building upon our medical research and development programs that are essential to our future readiness posture. We are advancing our understanding – and the understanding of the broader American and global health community – of how to prevent, diagnose, and treat scores of military related illnesses and injuries. We are transferring our knowledge from the research bench to the battlefield, and lives are being saved.

The MHS medical research and development investment priorities for FY12 are focused on early Diagnosis and Treatment of Brain Injury; Polytrauma and Blast Injury Diagnostics and Treatments; Countermeasures against Operational Stressors and Optimizing Health, Performance, and Fitness; Definitive and Rehabilitative Care Innovations Required to Reset our Wounded Warriors; Psychological Health and Well-Being for Military Personnel and Families; Prevention, Diagnosis and Treatment of

Wound Infections and Militarily Relevant Infectious Diseases; and Military Medical Training Systems and Health Information Technology Applications.

It is not possible to reflect on every research project or program initiative in our portfolio, but I would like to highlight just a few high-interest areas and point out where we are seeing particularly promising results and programs that will continue to maintain high-level interest and oversight in the coming year.

Our Service members continue to incur more than 20,000 cases of Traumatic Brain Injury (TBI) every year. Although the vast majority of TBI incidents are diagnosed as "mild" and resolve with rest, the Department of Defense has implemented numerous programs within the last 3 years to provide early identification, diagnosis and treatment for those who sustain a traumatic brain injury.

TBI research continues to be fast-tracked to bring findings from research being done into clinical practice as soon as possible. Key areas of promise include understanding injury related blast dynamics, rapid field assessment of mild TBI to include identification of objective biomarkers to be used in the identification and diagnosis of concussion, and TBI innovative treatment modalities such as the ongoing clinical trials for neuroprotectants.

We have recently teamed with the Department of Veterans Affairs and academia on the Military Suicide Research Consortium to better understand the interventions that are most successful in our suicide prevention efforts.

We are also planning a comprehensive research effort, spread across three fiscal years (FY11-13) to study the indicators / predictors of violence in service members. We envision a retrospective and a prospective effort, that will examine DoD populations and develop a scientifically based list of behavioral indicators of potential violence.

Our efforts in regenerative medicine are now starting to focus on taking our products out of the science and technology realm and into clinical trials. These efforts focus on limb and digit salvage, craniofacial reconstruction, scar-less wound healing, burn repair, and compartment syndrome.

Lastly, we are focusing our efforts on innovative combined pharmacologic and psychotherapeutic approaches to treat Post Traumatic Stress Disorder.

## II. Improving population health

The Department continues to seek ways to mitigate the development of mental health disorders, and to reduce the number of suicides in our Armed Forces. We engage in a number of preventive, diagnostic and treatment approaches to reduce the incidence of these disorders, if possible, and to identify and treat those impacted.

Together with the line community, both officer and enlisted, we have undertaken a Department-wide effort to reduce and eliminate the stigma associated with seeking mental health care. There are indications that this effort is working. For example, we are seeing that significantly more Service members who are referred for mental health care seek it out, and stay in treatment. We are encouraged by this trend and will continue to do our part to ensure that these trends continue.

We know that mental health conditions, like most medical conditions, are treatable. Most patients with Post Traumatic Stress (PTS) symptoms recover without treatment in a few months, and many recover with medication and/or psychotherapy. With your help, over the past two years we have made a tremendous investment in behavioral health care, adding nearly 2,000 behavioral health providers to our military hospitals and clinics, and 10,000 more to the networks (Table 2). By embedding mental health providers in our primary care clinics, we have improved access to mental health services for all of our beneficiaries.

The mental health workload has increased across the Military Health System (MHS) for both active duty service members and family members. Among the reasons for this increased workload are PTSD, TBI, earlier identification of mental health issues, increased suicides and suicide attempts, and reduced stigma of seeking mental health care. This workload has increased the need for mental health providers. Currently, throughout the MHS, there are a total of 7,662 military, civilian, and contract employees (full time equivalents) providing mental health care. This reflects a shortage of 1,025 which puts the MHS at 88 percent fill compared to requirements. We are pursuing efforts to assist the Services in recruiting and retaining these critical mental health provider positions. These efforts include using Direct Hire Authority and Expedited Hiring Authority that Congress provided the Department to help recruit providers. Additionally, we are implementing the Physician and Dentist Pay Plan (PDPP) which will ensure we can pay critical shortage specialties, such as psychiatrists, salaries competitive with the private sector.

## TABLE 2: MENTAL HEALTH STAFFING

### MENTAL HEALTH STAFFING

| | Needs | Assigned | Shortage in Red font | % Filled |
|---|---|---|---|---|
| **ARMY** | | | | |
| Psychologist | 1,393 | 1,205 | (188) | 86.5% |
| Psychiatrist | 563 | 436 | (127) | 77.4% |
| Social Worker | 1,772 | 1,486 | (286) | 83.9% |
| MH Nursuing (include NP) | 489 | 426 | (63) | 87.1% |
| Other licensed MH Provider | 103 | 24 | (79) | 23.3% |
| Tech/Counselor | 703 | 818 | 115 | 116.4% |
| **TOTAL** | **5,023** | **4,395** | **(628)** | **87.5%** |
| **NAVY** | | | | |
| Psychologist | 361 | 307 | (54) | 85.0% |
| Psychiatrist | 191 | 158 | (33) | 82.7% |
| Social Worker | 242 | 205 | (37) | 84.7% |
| MH Nursuing (include NP) | 160 | 151 | (9) | 94.4% |
| Other licensed MH Provider | 58 | 50 | (8) | 86.2% |
| Tech/Counselor | 651 | 536 | (115) | 82.3% |
| **TOTAL** | **1,663** | **1,407** | **(256)** | **84.6%** |
| **AIR FORCE** | | | | |
| Psychologist | 425 | 321 | (104) | 75.5% |
| Psychiatrist | 164 | 150 | (14) | 91.5% |
| Social Worker | 437 | 416 | (21) | 95.2% |
| MH Nursuing (include NP) | 109 | 102 | (7) | 93.6% |
| Other licensed MH Provider | - | - | - | |
| Tech/Counselor | 866 | 871 | 5 | 100.6% |
| **TOTAL** | **2,001** | **1,860** | **(141)** | **93.0%** |
| **MHS -WIDE** | | | | |
| Psychologist | 2,179 | 1,833 | (346) | 84.1% |
| Psychiatrist | 918 | 744 | (174) | 81.0% |
| Social Worker | 2,451 | 2,107 | (344) | 86.0% |
| MH Nursuing (include NP) | 758 | 679 | (79) | 89.6% |
| Other licensed MH Provider | 161 | 74 | (87) | 46.0% |
| Tech/Counselor | 2,220 | 2,225 | 5 | 100.2% |
| **GRAND TOTAL** | **8,687** | **7,662** | **(1,025)** | **88.2%** |

* NOTE: These numbers include military (officers and enlisted), civilian, and contract employees (Full time equivalents).
These numbers do not include the 49, 807 mental health providers in the TRICARE network.
As of 31 December 2010

To enhance services available to National Guard, Reserve, and Active Duty families who live in remote areas without easy access to installation-based psychological support, military and civilian providers are collaborating to educate local healthcare providers on military culture and treatment of psychological problems that military families encounter. We have also introduced the TRICARE Assistance Program (TRIAP), which offers 24/7 web chat with a licensed counselor, recognizing that family stress can often occur outside of normal provider hours, or in locations that do not have readily accessible counseling services. And we continue to fund an initiative with the Department of Health and

Human Services to place 200 Public Health Service officers, who are credentialed mental health clinicians, in our military treatment facilities (MTFs).

We are also working to improve the health and lifestyle behaviors of our beneficiaries, and we will be using funds in FY12 to advance this goal. Our focus is to lower the rate of obesity, tobacco usage, and binge drinking, and, more generally, help beneficiaries make healthier choices. As an example, obesity efforts will target children, active duty members nearing retirement (retirees experience marked increases in weight upon separation from the military), and patients with identified illness (e.g., diabetes, certain cancers) who will benefit from weight management. This effort includes initiatives with patient-level incentives to encourage healthy behaviors as well as partnerships with military bases and communities to create healthier work environments and help motivate other beneficiaries to make the healthier choice the preferred choice.

## III. Enhance the Patient Experience of Care

The MHS is fully engaged in implementing a new approach to primary care in our MTFs. Known as the Patient-Centered Medical Home (PCMH), the principles focus on developing a cohesive relationship between the patient and the provider team. We view the PCMH as a transformative effort within our system, with the potential to positively affect all aspects of our strategic focus – readiness, population health, patient experience and per member cost. With approximately 655,000 patients enrolled in developing PCMH practice sites, the results have been very promising – various sites have reported improved preventive service compliance, reduced use of the emergency room, and more timely care provided. Continued investment in and implementation of the PCMH is a top priority for the MHS.

One major new program that emerged from the NDAA for fiscal year 2011 is a new and important benefit in TRICARE – extension of TRICARE coverage to adult dependents up to age 26. This provision in the NDAA ensures that TRICARE now complies with all elements of the Patient Protection and Affordable Care Act, or the national health care reform law.

The MHS continues its important commitment to upgrade our health care facilities in the Continental United States and throughout the world. Table 2 provides a summary of both appropriated and requested military medical construction funds from 2008-2012.

The new Walter Reed National Military Medical Center, the new San Antonio Military Medical Center, and the new community hospital at Fort Belvoir will open their doors in 2011. These facilities will serve as showcases for leadership in patient-centered care, patient safety standards, environmental responsibility and sustainability, and medical quality and outcomes. These achievements could not have occurred without the sustained interest and investments by the Congress.

**Table 3: Medical Military Construction / Clinical BRAC Funding (FY08-12)**

| Fiscal Year | Medical MILCON ($M) | Clinical BRAC ($M) |
|---|---|---|
| Pres Bud Request, 2012 | $1,116 | $ 0 |
| Pres Bud Request, 2011 | 960 | 410 |
| Appropriated * 2010 | 1,011 | 1,455 |
| Appropriated * 2009 | 2,472 | 1,105 |
| Appropriated * 2008 | 1,358 | 1,097 |

*May include ARRA and Supplemental funding

This year's budget request includes funding for 14 patient care and 3 non-patient care projects. It includes the replacement of one of our largest, oldest, and most critical overseas hospitals, the Landstuhl Regional Medical Center. This project consolidates Landstuhl and Ramstein medical facilities into one convenient location, closer to the Ramstein flight line. The new facility will support three theaters and is sized to serve the peacetime beneficiary population with an expansion capability to address surge from medium intensity conflicts similar to the current Overseas Contingency Operations.

Progress continues on vital chemical/bio-defense facilities at Ft. Detrick, MD and Aberdeen Proving Ground, MD. The first National Capital Region (NCR) Comprehensive Master Plan project in support of world-class standards begins in FY 2012. All of our new clinical construction projects will comply with world-class standards and evidence-based design principles.

I am grateful for your unwavering support of our construction program through the last several years that will allow our wounded, ill & injured service members to be treated in the finest medical facilities in the world.

## IV. Responsibly Manage Costs

Today, we are cognizant that the federal budget deficits and long-term debt require all federal agencies to be even more responsible stewards of the taxpayers' dollars. As Secretary Gates and Chairman Mullen have repeatedly declared, we in this Department must tighten our belts just as so many Americans have done over the last several years. We share the Secretary's concerns that the exponential growth in DoD health care costs can pose a long-term threat to our defense capabilities.

In our proposed budget, we have included a number of specific initiatives that, viewed as a whole, can set us on the right path to long-term financial health. Secretary Gates, Chairman Mullen and the Joint Chiefs have all spoken on this issue consistently and with clarity – we will continue to provide the finest health benefit in the country for our active and retired Service members and their families.

Table 4 highlights each of the major initiatives we proposed, along with their projected savings over the FYDP. Our initiatives acknowledge there is a shared responsibility for cost control in our system – starting with our own internal operational efficiencies, and then including both the provider and beneficiary communities. I will explain our rationale for each of these provisions below.

**Table 4: FY12 MHS Management Initiatives**

| | ($M) | | | | | |
|---|---|---|---|---|---|---|
| Issue | FY12 | FY13 | FY14 | FY15 | FY16 | FY12 16 |
| #1 Internal Defense Health Program Efficiencies | -183 | -255 | -295 | -266 | -297 | -1,296 |
| #2: Increase TRICARE Prime Fees for < 65 Retirees | -31 | -60 | -87 | -114 | -142 | -434 |
| #3: TRICARE Pharmacy Co-Pay | -95 | -556 | -601 | -634 | -669 | -2,555 |
| #4: USFHP Age Out of Medicare-Eligible Retirees | - | -739 | -783 | -826 | -866 | -3,214 |
| #5: Use Medicare Rates at Sole Community Hospitals | -31 | -71 | -92 | -98 | -103 | -395 |
| **Potential Cumulative Savings** | **-340** | **1,681** | **-1,858** | **1,938** | **2,077** | **7,894** |

**Internal Efficiencies**. We have benefited from lessons learned in previous efforts to control rising military health care costs. First, the Department has looked internally as our number one priority to find and implement efficiencies. In the coming year, we will reduce TRICARE Management Activity contractor overhead by a substantial amount – over $183 million in savings in FY12 alone. Our actions will be carefully considered, and will not detract from any activities that directly support patient care, although some management programs will either be eliminated or significantly reduced.

This is in addition to other actions we have undertaken that include more aggressive monitoring and pursuit of fraud, waste and abuse; redirection of prescription drug purchases to more economically advantageous outlets through mail order or MTF pharmacies; and redirection of medical care from Emergency Rooms to urgent care centers. In FY12 we plan to introduce a national nurse advice line that will further assist us in this effort, and provide an alternative access point for information and referral for our beneficiaries.

Together with the Surgeons General, we will continue to identify and rapidly implement other initiatives that take advantage of joint purchasing, greater optimization of our medical supply chain, and increased shared services.

**Equity in Programs and Provider Payment.** Second, we are pursuing a more equitable management of benefits across all health care programs.

Congress has long directed us to align our reimbursement policies with those of Medicare. We will continue to make the necessary regulatory changes to follow the law. In 2012, we will adjust our payments for care provided by facilities designated as Sole Community Hospitals to also align with Medicare reimbursement levels, saving almost $400 million over five years. DoD recently adopted a similar change with the implementation of the Outpatient Prospective Payment System (OPPS), and successfully implemented a phased-in approach to reduce the impact on our civilian provider network.

We recognize that adjustments to payment formulas will have an impact on the projected revenue streams of the hospitals covered under this rule change and we are sensitive to revenue projections in planning for large capital outlays for construction and major medical equipment purchases. We determined that four years provides a reasonable time period for phase-in for the payment adjustments.

We also seek to ensure all healthcare providers are reimbursed in the same manner regardless of their geographic location. We propose to amend our Uniformed Services Family Health Plan (USFHP) enrollment policies so that they align with all other TRICARE providers. All current enrollees will be grandfathered into the current program. In our budget, we propose that all future USFHP enrollees will convert to TRICARE For Life benefits upon reaching Medicare eligibility.

Future enrollees will still be eligible to enroll in the USFHP if they are not Medicare-eligible.

Future Medicare-eligible enrollees will be treated the same as all other dual-eligible DoD-Medicare beneficiaries in the country. Upon reaching age 65, Medicare will become the primary payer for these beneficiaries and TRICARE will be second payer. Once Medicare-eligible, these beneficiaries may continue to see the same providers that they do today; the reimbursement process by which both Medicare and TRICARE contribute payments will be the only change.

Through this proposal DoD will achieve greater equity across the TRICARE program – all Medicare-eligible beneficiaries will be treated the same. Second, the US government will save money, not just DoD. DoD currently pays more than the US government will pay jointly under our proposed plan.

**Modest Changes of Beneficiary Out-of-Pocket Costs.** Finally, for working age retirees, we are proposing minor changes to out-of-pocket costs that are exceptionally modest, manageable and remain well below the inflation-adjusted out-of-pocket costs enjoyed in 1995, when TRICARE Prime was first introduced. We have proposed an increase of $2.50 per month (or $5.00/month per retiree family) for enrollment in TRICARE Prime – the first increase in enrollment fees proposed since the TRICARE Prime benefit was

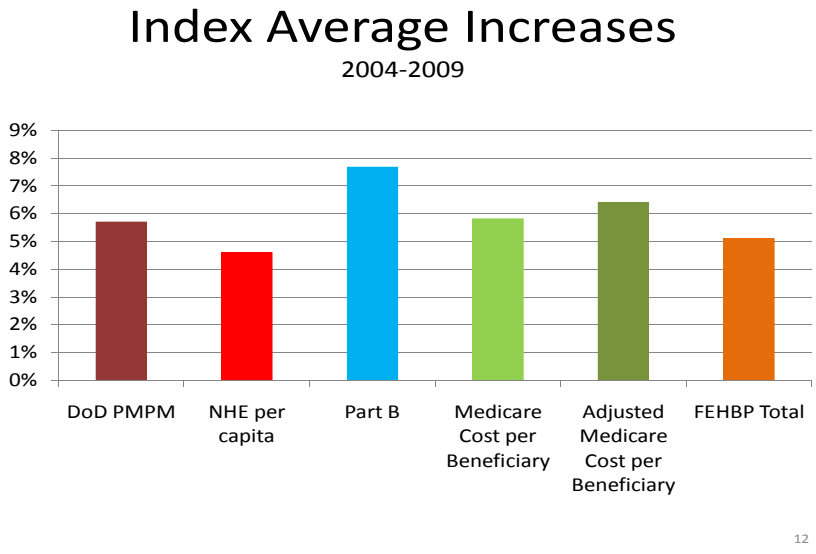
introduced in 1995. For the longer term, we have also proposed to index this enrollment fee in order to establish more predictable and modest fee changes over time.

When these proposals were first introduced with the submission of the President's budget in February, the Administration had not yet selected the appropriate health care inflation index. As part of this process, we met with the beneficiary organizations, and we developed a set of criteria that should be used to determine the right index. These criteria included:

- **Relevance** – an index that most closely aligned with the health care costs experienced by this population
- **Independence** –an index determined by an independent, external agency rather than internally (DoD) established index
- **Transparency** – an index in which the methodology is publicly available
- **Clarity** – an index in which the calculations are understandable to all
- **Fairness** – an index that, when considering all factors influencing health costs, is determined to be a fair and accurate model for the costs experienced by the Government and the beneficiary for services delivered

In recent weeks, working closely with the Office of Management and Budget, we considered and evaluated six separate indices in this process, and believe that the National Health Expenditures (NHE) per Capita model as best meeting the criteria we used above. Figure 4 below highlights the average annual percentage increases in health costs using the various options.

Figure 3: Average Increases in Medical Inflation Indices



As part of our proposals, we also recommend minor adjustments in prescription drug copayments that include both reductions and increases in co-pays, the increase or decrease dependent upon the outlet selected by beneficiaries. We want to offer incentives to use the most appropriate and cost-effective outlet for their needs, and believe the minor changes to this copayment will be accepted and assist us in this goal. I have been heartened by support expressed by leading beneficiary organizations for this change. We have made progress in the last few years in encouraging beneficiaries to elect prescription drug home delivery, and we believe this proposal will accelerate the adoption of this option as it has demonstrated greater medication compliance while saving on overall costs for the beneficiary.

Our proposals have been carefully considered. We have incorporated numerous safeguards – grandfathering in all current enrollees to unique programs; phasing-in new reimbursement methodologies for providers; and excepting certain beneficiaries (survivors and medically retired Service members) from any changes – in order to protect our most vulnerable beneficiaries and providers. None of these proposals affect the free healthcare we deliver to our active duty Service members.

**Learning and Growth**

The foundation of our success lies with our training and education systems. Chief among these educational institutions is our Nation's outstanding medical university---the Uniformed Services University of the Health Sciences (USU) located here in Bethesda, Maryland. Since the first class graduated in 1980, USU alumni have become an integral part of our military health system and many of USU's graduates are assigned in key leadership positions throughout each of our Service Medical Departments.

The value of a USU education was never more evident than following the recent tragic shooting that occurred in Tucson. In the aftermath of this tragedy, it was the medical education received at USU that laid the foundation in medical training that the University of Arizona Health Science Center's Chief Trauma Surgeon, Dr. Peter Rhee, called upon as he provided the initial care and treatment to Representative Gabrielle Giffords. His extensive military experiences proved extremely beneficial in providing the best care possible to the Congresswoman. And when he needed to consult on her care plan to ensure his approach was optimal for her condition, he called upon his USU classmate, neurosurgeon Dr. James Ecklund and USU's Interim Chief of Neurology, Dr. Geoffrey Ling.

USU is a national treasure and its value to our Nation is seen every day in the battlefields of Iraq and Afghanistan, in the care we provide worldwide to our very deserving service men and women, in the research being carried on in the fields of traumatic brain injury and post-traumatic stress disorder, and in the many laboratories conducting research on emerging infectious disease and many other public health issues.

Our system is also buttressed by a strong and deepening relationship with our federal partners, particularly in our interaction and sharing with the Department of Veterans Affairs. We continue to increase the number of sharing agreements between DoD and VA medical facilities, facilitated by the DoD/VA Joint Incentive Fund. We appreciate that the NDAA for fiscal year 2010 extended this very valuable program until September 30, 2015.

We are also working closely with the VA to enhance DoD/VA electronic health data sharing, and to create a long-term architectural framework that benefits both Departments and the people we serve. Beginning with a December 2010 review, led by the Vice Chairman of the Joint Chiefs of Staff (VCJCS), DoD and VA have made substantial progress in developing a solution that can be implemented in a timely and coordinated manner. The Electronic Health Record (EHR) Way Ahead addresses specific challenges with the current EHR, including outdated legacy technologies; ongoing performance and data availability problems; and difficulty in using healthcare industry standards.

In FY12, we plan to introduce elements of the EHR Way Ahead, our long-term plan to replace our existing electronic health record. The details of the management structure to oversee the Way Ahead, the requirements development process and the outreach and engagement with the private sector will follow the important work that is underway now to finalize the details of our strategy.

**Conclusion**

Our overall proposed budget for FY12 reflects our commitment to readiness, population health, an enhanced patient experience of care, and continued responsible management of costs.

I will never lose our focus on those members of our Armed Forces in combat. I will honor the sacrifices of so many Service members and families. I have always been personally inspired by the commitment and dedication of our soldiers, sailors, airmen, marines, and coast guardsmen. The highlight of my career as a surgeon has been caring for the wounded warrior on the battlefield. These talented young men and women, who have been asked to shoulder the responsibilities for defending this Nation and have suffered the consequences of nearly a decade of war, deserve the best medical care both at home and abroad.

I am both pleased and proud to be here with you today to represent the men and women who comprise the Military Health System, and I look forward to answering your questions.