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A REVIEW OF THE DEPARTMENT OF DEFENSE HEALTH PROGRAM

BRIEFING

BEFORE A

SUBCOMMITTEE OF THE

COMMITTEE ON APPROPRIATIONS

UNITED STATES SENATE

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A REVIEW OF THE DEPARTMENT OF DEFENSE HEALTH PROGRAM

TUESDAY, MARCH 7, 2023

U.S. SENATE,
SUBCOMMITTEE ON DEPARTMENT OF DEFENSE,
COMMITTEE ON APPROPRIATIONS,
Washington, DC.

The subcommittee met at 10 a.m. in room SD–192, Dirksen Senate Office Building, Hon. Jon Tester (chairman) presiding.

Present: Senators Tester, Durbin, Baldwin, Shaheen, Murphy, Collins, Murkowski, Moran, and Hoeven.

OPENING STATEMENT OF SENATOR JON TESTER

Senator TESTER. I want to call this hearing to order.

Good morning all. Welcome Dr. Martínez-López, General Crosland, General Dingle, General Miller, Admiral Gillingham, thank you all for joining us today.

I want to especially welcome Dr. Martínez-López, and General Crosland, this is your first time briefing this committee and we look forward to hearing your brief.

I also want to recognize Admiral Gillingham who is retiring later this month. I think, thank you for your service, is not quite adequate. We appreciate everything you have done over your career to keep this country the greatest country on Earth. And so we appreciate you. We wish you much luck in your next phase of your life. And just know that Maine or Montana; are great places to retire to.

Admiral GILLINGHAM. Yes, sir. Thank you.

Senator TESTER. Look, the Defense Health Program accounts for roughly $39 billion, or 5 percent of the DoD (Department of Defense) budget. The Defense Health Agency is charged with providing Health Care Services to 9.6 million servicemembers or families, and retirees through TRICARE. Its mission also includes managing the DoD Medical Research Program. And I want to acknowledge that the Defense Health Agency has not been immune from challenging trends in the national healthcare industry.

These include escalating costs and a shortfall of providers. I hear this firsthand from servicemembers and veterans in Montana who tell me that TRICARE is not working for them in rural America.

So today, I want to have a candid discussion about the Department's delivery of healthcare and medical readiness of our Force. The Defense budget has enjoyed robust top line increases in recent years; however, for this year we have members proposing reduced and outdated funding levels, Congress has repeatedly failed the De-

partment in recent years by putting you on automatic continuing resolutions, and getting you a budget that is late.

It is my hope that in this new Congress we can break through the vicious cycle of CRs (Continuing Resolution), and I wholeheartedly support efforts to get back on track. And I know Senator Collins does too.

So the committee needs to know exactly what reduced funding levels and a CR would mean for the Defense Health Program, including for our servicemembers and their families, medical readiness, and medical research.

We have much to discuss. The Defense Health Agency is in the midst of a significant restructure, we continue to hear about challenges with TRICARE, and I believe mental health is our biggest healthcare problem. There isn't a family in America that doesn't have a mental healthcare problem somewhere in their midst.

So I want to thank you for joining the subcommittee this morning. I look forward to our discussion, before you——

Oh. Go ahead. Senator Collins.

STATEMENT OF SENATOR SUSAN M. COLLINS

Senator COLLINS. Thank you Mr. Chairman, I appreciate your holding this hearing on the Pentagon's Defense Health Program.

To each of our witnesses, thank you for being here, and for your service to our country. I would echo the Chairman's special thank you to Admiral, for all of your years of service.

Providing for the healthcare of our troops and their families is a no-fail mission. Unlike other healthcare providers, the Military Health Care System must support and save the lives of our warfighters in battlefield environments. I look forward to hearing about the Department's investments, both the ongoing and planned, to train and posture medical units to be able to respond in contested environments far away from the safety of large hospitals or military bases.In addition, as the Chairman has indicated, the Military Health System continues to undergo substantial changes intended to improve healthcare. All military hospitals and clinics are now managed by the Defense Health Agency, rather than the individual Military Services. DoD's new electronic health records system appears to be on track to be fully implemented this year, yet problems remain with the interoperability with the Veterans Affairs—Veterans Administration. And the long-awaited awards for the next national TRICARE Managed Care contracts were recently announced as well.

Will these transformations improve the quality and level of healthcare for our troops and their families? That is the bottom line. That depends on DHA (Defense Health Agency) having enough staff, hospitals, clinics, and private sector providers to provide ready access for the physical and mental healthcare needs of the 9.6 million, servicemembers, their family members, and retirees who rely upon the Military Health System.

On this committee, we are also interested if the cost efficiencies promised by some of these changes have in fact, been realized.

The Defense Health Program also conducts the innovative research that benefits our warfighters and the American public. For example, from 2007 to 2018, eleven FDA (Food & Drug Administra-

tion)-approved drugs that benefited from congressionally directed medical research funded programs were prescribed to more than 139,000 times for cancer treatment. And that only includes those prescriptions within the Military Health System. DoD must continue to transform our Health Care System through this impactful research.

It is unfortunate that here we are, in March, and the President has yet to deliver his budget requests for fiscal year 2024. It is a little more than a month overdue.

Nevertheless, I look forward to hearing from our witnesses about how the Department is using the resources provided by this committee for fiscal year 2023, and what resources will be needed to care for our servicemembers, dependents, and retirees in the future.

Again, my thank you to the witnesses and to the Chairman for holding this hearing.

Senator TESTER. Thank you Senator Collins.

The first briefer will be the Assistant Secretary of Defense for Health Affairs, Dr. Martínez-López. You have the floor.

STATEMENT OF DR. LESTER MARTÍNEZ-LÓPEZ, ASSISTANT SECRETARY OF DEFENSE FOR HEALTH AFFAIRS

Dr. MARTÍNEZ-LÓPEZ. Chairman Tester, Ranking Member Collins, and distinguished members of the subcommittee, I am pleased to represent the Office of Secretary of Defense to discuss the Defense Health Program and its contributions to the health and medical readiness of the Department.

I am speaking today in advance of the formal release of the President's Proposed fiscal year 2024 Budget. I will outline, the major activities unfolding in the Military Health System that will inform our soon-to-be released budget proposal.

The National Defense Authorization Act, NDAA, for fiscal year 2017, enacted sweeping reforms to the organization and management of Military Medicine, the expanded responsibility of the Defense Health Agency are now largely completed. The DHA exercises authority, direction, and control over all the MTFs (Military Treatment Facilities) worldwide.

Lieutenant General Crosland, the Director of the Defense Health Agency, will provide further details on specific initiatives that the DHA is undertaking.

This same law directed DoD to restructure or realign the MTFs to support the Department's readiness requirement, however, in fiscal year 2023 NDAA, placed a 1 year moratorium on any changes to the configurations of our MTFs. As requested, we are preparing an update to Congress on our way ahead in the coming month.

The NDAA also included a 5-year moratorium on further Military Medical personnel reductions. Together with the Joint Staff we are updating our medical requirements, as COCOM (Combatant Commands) operational plans are also updated. We are conducting a comprehensive internal review with our OSD (Office of the Secretary of Defense) colleagues and the Military departments on the best configuration of medical infrastructure and personnel for the long term.

We are resolute in our commitment to ensure combatant commanders have the medical resources necessary to protect, treat, and provide long-term care medical services to our men and women in uniform. We are also committing resources and attention to the ongoing challenge of suicide, both among uniformed servicemembers and family members.

We recently received the recommendation from the Suicide Prevention and Response Independent Review Committee and are continuing to implement strategies that can help reverse the heartbreaking trends that we have witnessed both in DoD and in the Nation.

The Department remains grateful for the long-term support from this committee for our Military Medical research in those areas of most pressing needs, and relevance for today's emerging threats. That includes: infectious diseases, combat casualties, and other areas of importance to our warfighters and to Congress.

For the current fiscal year, our mid-year review is underway. As in past years, the MHS (Military Healthcare System) continue a sustained track record in responsibly managing healthcare costs, which remain below the national health expenditure per capita rate. Our fiscal year 2024 budget will present a balanced, comprehensive strategy that aligns the Secretary's priorities.

We look forward to working with you over these coming months to further refine and articulate our requirements. Thank you for inviting me here today to speak with you about the battle of Military Medicine in supporting our national security.

I look forward to your questions.

Senator TESTER. Thank you, Doctor.

Next up, we have Director of the Defense Health Agency, General Crosland.

STATEMENT OF LIEUTENANT GENERAL TELITA CROSLAND, DIRECTOR OF THE DEFENSE HEALTH AGENCY

General CROSLAND. Chairman Tester, Ranking Member Collins, distinguished members of the subcommittee, thank you for inviting me to join Dr. Martínez-López, and the Service's Surgeon Generals, to discuss the Defense Health Program.

I will add to Dr. Martínez-López's remarks by briefly focusing on some of the critical capabilities of the Defense Health Agency in supporting the Military departments in the combatant commands. As Dr. Martínez-López also noted, my comments assess the current state and do not speak to the fiscal year 2024 budget, which is not yet released.

In 2022 and into 2023, the Defense Health Agency has been able to focus its resources to supporting operational requirements of the Department while continuing to manage COVID–19 pandemic. There were a number of important milestones achieved by the Defense Health Agency in the past year that will continue to influence operations in 2023 and into 2024.

For my opening comments I will focus on just two. First, more than 50 percent of our Military Medical treatment facilities have migrated to our new electronic health record known as MHS GENESIS. In a few weeks, we will deploy the system here in the national capital region and that will take us to approximately 75 per-

cent. We remain on track to have the system fully operational, worldwide, by 2024.

This modern electronic health record platform will provide the Department a powerful tool to support our readiness mission, improve interoperability, and record sharing, with care delivered in the private sector, and allow our patients to engage more directly with their providers in managing their care.

The COVID–19 pandemic accelerated the Department's use of virtual health. For the coming year I will build on what we have learned, and how our providers and patients effectively use this technology throughout this public health emergency; I am creating a new digital Health strategy that will expand our use of technology in ways that improve our training, our preparedness, access, and quality of care. I intend to work with the Military Medical leaders and industry partners to focus on what we can achieve now and build on our successes over time.

In late 2022, after a multi-year process, the Defense Health Agency awarded the next generation of TRICARE contracts at a value of over $135 billion over the next 8 years. These contracts will deliver high value, patient-centric care that integrates the military and the private sector care.

In January, protests were filed that will slightly delay this transition. We are closely working with GAO (Government Accountability Office) and we will ensure that the process is carried out in a fair and timely manner.

Dr. Martínez-López noted our current budgetary status and future plans. We appreciate that Congress continues to grant the Department carryover authority, allowing DoD to maintain a better flow of funds to minimize disruption in healthcare services, and our beneficiaries.

I am grateful for the opportunity to represent the men and women of the Defense Health Agency. And I thank you for inviting me here today. I look forward to your questions.

Senator TESTER. Thank you, General.

Next up, we have Surgeon General of the Army, General Scott Dingle.

STATEMENT OF LIEUTENANT GENERAL R. SCOTT DINGLE, SURGEON GENERAL OF THE ARMY

General DINGLE. Chairman Tester, Vice Chairman Collins, and distinguished members of the subcommittee, thank you for the opportunity to speak to you on behalf of the 111,000 that comprise the total Army Medicine Force.

I am privileged to serve as the 45th Army Surgeon General and Commanding General of the United States Army Medical Command. The U.S. Army is the most lethal and capable ground combat force in history. As the Army continues to modernize for multi-domain operations, it is imperative that our Medical Force remains ready, responsive, and relevant to conserve the fighting strength.

The Chief of Staff of the Army, General McConville says that winning matters. I agree. There is no second place in war. From foxhole to the fixed facility, Army Medicine has achieved a high survivability rate for soldiers wounded on and off the battlefield in recent decades. We did this by remaining agile and adaptive. We

applied the lessons from operations and developed a holistic system for future operations in austere locations.

My vision for going forward remains consistent with the Army Medical Modernization Strategy and nested with the Army Modernization Strategy, ensuring our Medical Force is trained and ready as an enabler of combat power. We will synchronize and integrate the medical effort within the Army, the Defense Health Agency Joint Staff, and combatant commands to be responsive and steadfast to teammates of the Joint Force. This will ensure that Army Medicine is responsive and relevant to execute the National Defense Strategy.

We will also build readiness through our investments in people, Army Medicine must be innovative and agile to remain competitive with the healthcare industry on our recruiting and retention practices while partnering with the DHA to deliver high quality and safe care.

Army Medicine remains engaged at Echelon to confront the challenges associated with Military Service and suicide. Each life loss devastates the Force and Congress has spoken loudly. As the medical integrator, we actively support the modernization of the medical effort.

Timely funding this year will expand our expeditionary medical capabilities and ensure that interoperability within the Joint Force. Medical reform will allow us to update our capability, design, and structure to optimize resources for operating and generating forces.

Finally, we are strengthening our alliances and partnerships in order to enhance interoperability with the international community by providing institutional medical training, collaboration on medical research, development, innovation, and Force structure design. Across the globe, we offer solutions to grow capability and capacity.

In closing, I thank the subcommittee for your long-standing support to the Army and Army Medicine, our trained and ready Medical Force depends on timely, adequate, predictable, and sustained funding. Army Medicine is Army strong. I look forward to your questions.

Senator TESTER, Thank you, General.

Next up, we have Surgeon General of the Air Force, General Miller.

STATEMENT OF LIEUTENANT GENERAL ROBERT I. MILLER, SURGEON GENERAL OF THE AIR FORCE

General MILLER. Chairman Tester, Vice Chair Collins, and distinguished members of the subcommittee, it is my honor to brief you today on behalf of 31,000 Medical Airmen.

We respond to our Nation's global needs during peacetime, humanitarian crisis, and hostilities. Our cornerstones are aerospace medicine and aeromedical evacuations, capabilities that have saved thousands of lives and ensure our warfighters come home with the best medical outcomes. Thank you for your past and ongoing support to modernize key readiness capabilities, and sustain our Force.

Last year, I charged my leaders to evaluate and reenvision our readiness force and response structure. The objective is to provide combatant commanders with a well-trained and equipped medical force capable of adapting the rapidly evolving Joint Force require-

ments. I expect a modular growth capability with a smaller footprint than our Expeditionary Medical Support System.

It will increase operational abilities in contested and degraded environments, plus impact future capability requirements, training, sustainment, recruitment needs and changes to the AFMS (Air Force Medical Service) end-strength mix. It will also improve our alignment to the Air Force's ACE construct.

The initial concept was tested in war-gaming tabletop exercises in January. Now, we are refining and moving forward with a test at a joint exercise this summer. We must also focus on the daily readiness care of our Airmen and Guardians to address the challenges of their work environment. Occupational and environmental exposure risk assessments are critical.

A current early-stage study on specific risks to the missileer community is ongoing. We will be transparent during this process as our responsibility is to protect the health and safety of our Airmen and Guardians. We take that seriously. We are moving forward with our operational support teams to optimize performance and readiness using evidence-based strategies.

Access to mental healthcare improve through our targeted CARE Program, members are vectored to the appropriate place for support based on individual needs whether that is a mental healthcare provider or nonclinical support, like group therapy.

Family readiness also impacts member readiness. Those who are part of our Exceptional Family Member Program may now have access to expanded care and support through the Air Force Developmental Behavioral Family Readiness Centers. The program is rolling out as it uses a hub-and-spoke approach to support our members' families. Air Force medics are uniquely ready and capable to safeguard our interests both at home and abroad.

Thank you again for your support to the AFMS and our medics. I look forward to your questions.

Senator TESTER. Thank you, General.

Next, we have the Surgeon General of the Navy, Admiral Gillingham.

STATEMENT OF REAR ADMIRAL BRUCE GILLINGHAM, SURGEON GENERAL OF THE NAVY

Admiral GILLINGHAM. Chairman Tester, Vice Chair Collins, distinguished members of the committee; I am pleased to be with you today to provide an update on Navy Medicine.

On behalf of our mission-ready, One Navy Medicine Team, please know that we are grateful for the support you provide us, as well as the trust and confidence that you place in us. Navy Medicine is best described as well-trained people working as expeditionary medical experts on optimized platforms, demonstrating high reliability performance as highly cohesive teams to project medical power in support of naval superiority.

These priorities guide our deliberate planning efforts, resource allocation decisions, and strategic program investments. We are at a critical and exciting juncture as we pivot from operating military medical treatment facilities, which are now completely under the authority, direction and control of the Defense Health Agency, while our attention is on the operational mission of delivering

manned, trained, equipped, and sustained medical units, who provide enduring support to the Fleet, the Marine Corps and The Joint Force. This operational focus maintains Navy Medicine's requirement to provide health services at sea, and onshore, on our platforms, and in DHA–MTFs.

As you know, the National Security and Defense Strategies make it clear that China represents the pacing challenge against which we must plan our warfighting strategies and investments. For the first time in at least a generation, we have a strategic competitor who possesses naval capabilities that rival our own, and seeks to aggressively employ its Forces to challenge U.S. principles, partnerships, and prosperity.

Similarly, Russia, Iran, and other authoritative states continue to challenge the rules-based international order. Navy Medicine is taking urgent action to support the Navy and Marine Corps, and save lives in contested battle space that is quickly growing in lethality, complexity, and scope.

Last month I released our 2023 Campaign Order, which outlines our strategic direction for the next 5 years and directs foundational changes to our entire enterprise, operates, in order to meet combatant commander and combatant—and component commander requirements for the warfighter.

To get us there we are working on several strategic imperatives including new platforms in development, like the Expeditionary Medical Ship, which will speed to assist casualties, and have 3 operating rooms, and 60 medical beds.

Thank you for the program increase in the fiscal year 23 appropriations bill to procure two additional ships.

I was recently in Mobile, Alabama, representing the Secretary of the Navy as we christened the USNS Cody, which is our first Expeditionary Fast Transport Flight II, with enhanced medical capabilities to augment the EMS.

These platforms truly represent a quantum leap forward for Navy Medicine's ability to meet our mission in future complex conflict on the water.

And another key priority in ensuring our sailors and marines have access to the full continuum of mental health resources, while aiming to utilize the right care, at the right level, at the right time, Embedded Mental Health remains vital for mental wellness by placing mental health as far forward as possible.

Currently, 36.5 percent of active duty mental health providers, and 31 percent of behavioral health technicians serve in operational and training commands. Navy Medicine supports readiness from accession to separation, prioritizing resiliency efforts, suicide prevention, providing mental health services within primary care and specialty clinics, embedded within the fleet, and via virtual health platforms, and deploying disaster mental health intervention.

Navy Medicine is most grateful to the committee for the resources to support our research initiatives, particularly in areas of dental technologies, and human performance. The Ads that you provided will improve overall warfighter readiness in the medical treatments we provide.

In summary, our center of gravity is the commitment to provide expeditionary maritime medical care. Our ability to quickly deploy and support a crisis response around the world makes Military Medicine unique, but more importantly, demands that we are both operationally relevant, and clinically prepared.

Again, thank you for your leadership. And I look forward to today's discussion.

Senator TESTER. Thank you, Admiral. There will be 5-minute rounds, and I will yield to Senator Durbin.

Senator DURBIN. Thank you Senator Tester. Let me say at the outset congratulations to you for leading this important subcommittee, which I have been honored to serve on.

Let me respond to my friend, Senator Collins. It is true that the administration is probably a few weeks late at producing a budget request, but our hope for the budget process this fiscal year lies in the capable hands of five people who were featured in a color photograph on the front page of The New York Times several weeks ago. It was an article that noted that we have reached a historic milestone.

Both the Director of the OMB (Office of Management and Budget), the Chair and Ranking Members of the House and Senate Appropriations Committees are all women.

Senator SHAHEEN. Here, here.

Senator DURBIN. I thought you would like to hear that. I am hopeful. I believe that you are going to set out, as Senator Murray has told me; I know that you are working closely together to make history in that appointment. And I am confident you will. So I wish you the very best, and I want to help you reach that goal.

Senator Tester, I also want to say a word or two in praise, I am sure you have given me an additional time if necessary, in praise of your role as Chairman. I set out 8 years ago to achieve 5 percent real growth in medical research by the Department of Defense and the National Institutes of Health. You were my partner in that effort, as was Senator Blunt of Missouri, with the NIH (National Institutes of Health). And I note that in the fiscal year 2023 Omnibus you have appropriated $3.107 billion for medical research, 5 percent real growth.

Congratulations, Chairman. I hope we can maintain that going forward.

Let me address the issue that we Rear Admiral Gillingham raised at the end, which I think relates to a number of our witnesses in my general question.

I will start with Dr. Martínez-López.

Mental health, mental health counseling is so important for all of us, all of us, and especially important in the Military where they are under stress situations, and face trauma incidents on a regular basis. In the past, let us be honest about it, in virtually every aspect of medicine there was a stigma attached to mental health counseling, and there was a belief that if you conceded that you needed counseling, it was a black mark on your record, which would hold you back come time for promotion and advancement.

Has that changed? Are you changing it?

Dr. MARTÍNEZ-LÓPEZ. Sir, I think, you know, there is movement in the bullpen to really change that. Culture takes a while but the

Department has been very entrenched, and I can speak for Secretary on down, that mental health is health, it is like anything else we need. So we need to really lower that stigma, and people make it very available, close, so everybody, it will be very easy to get just like a sick call for an ingrown toenail, or something like.

But I will tell you, there still is an ongoing challenge that we are really making headways, but we are not done yet.

Senator DURBIN. I can see that point very easily in my own family circumstance. A member of our family served in Vietnam and came back from that Military Service, a changed person. We never could quite understand what happened to him. He did some things, which were not good for his family, for himself, it took him many years to come to grips with his experience in Vietnam.

We used to, euphemistically; refer to them as the Vietnam generation. And I won't go into detail, but you know what I am speaking of. Contrast that with those who served in Iraq. I noticed, many times these young military veterans would come home and be very open and honest about the need for help and counseling. What a dramatic reversal that was over the Vietnam generation. I hope that is the spirit that the military is looking at this issue moving forward.

Dr. MARTÍNEZ-LÓPEZ. Senator, absolutely. I mean we are committed for the overall wellbeing of all servicemembers, and mental health is one of those issues that, thanks to God, now we can talk and put it on top of the table and address it the way it should be addressed.

In the Vietnam days, for whatever the reason we didn't talk openly about these kind of issues that needed to be spoken about. So stigma is one of the issues of mental health, but obviously, it is very complex and we are taking the public health approach to deal with the mental health crisis. And what that really means is, it is not just a medical issue, it is an issue that encompasses personal actions, it is an issue that encompasses financial issues.

So anything that brings more stress, we need to figure out how to level that load on the service member. So everybody has to own, everybody, has to own on this exercise, on this issue.

Senator DURBIN. Thank you, very much.

Thank you, Mr. Chairman.

Senator TESTER. Senator Collins.

Senator COLLINS. Thank you, Mr. Chairman.

Dr. Martínez-López, let me follow up on the mental health issues that are of such concern to this subcommittee; you mentioned the Department's Suicide Prevention Response Independent Review Committee, which recently released a report with the numerous recommendations aimed at reducing the number of suicides.

I want to make a couple of observations about that report before asking you a question. First, it is evident that the Department needs to reduce the time that is required to recruit behavioral health specialists. In one example cited in the report, it took, on average, a-year-and-a-half to hire civilian psychiatrists, and almost a year to hire psychologists at Walter Reed. So it is not a big surprise that half of the psychiatrists, ultimately, declined the position after that long delay. Undoubtedly, they went elsewhere. And that

is unacceptable, that we are losing people because it takes so long to bring them on board.

Second, TRICARE's policy guidance is that 98 percent of the claims submitted by providers should be completed within 30 days. Yet, the report found that behavioral health providers were reluctant to serve military beneficiaries because it took so long for TRICARE to pay them. One provider cited in the report said, "It takes forever to get paid a pittance, if you get paid at all." So obviously, our Military Force will be stronger and healthier when more providers are available, and more of them are willing and eager to accept TRICARE coverage.

So here is my question, will the upcoming budget requests include funding to implement the committee's recommendations?

Dr. MARTÍNEZ-LÓPEZ. Senator Collins, first, the Secretary and myself are very grateful to the members of the committee for spending their time to come out with the recommendations, you know study it out, and helping us out with this big issue.

Second, it is the Secretary right now has a team, and we are looking, leaning forward each of the recommendations, and we are looking at ways to, first, which one we are going to be able to accommodate first, and which ones are going to come—and in that process there will be issues of budgetary requirements.

So I am not prepared to tell you what those look like right now, but I am telling you, we, as a Department, we are looking at all the—one by one, and addressing (a) are they viable to how much—what it would take to implement those measures.

So as we are ready to do that, we will come back to you with the specifics, ma'am.

Senator COLLINS. Thank you. General Crosland, just yesterday, I met with a group of veterans from Maine who told me that the rollout of the new electronic health records system within the VA (Veterans Affairs) is still very problematic. Obviously, even if DoD is going to have its new system in 75 percent of its hospitals, as you testified, by the end of the year, if the VA is not in sync we are still going to have a problem with transferring medical records once someone retires from the active duty military. And the veterans were telling me example after example of where they had difficulties in chasing down records, getting them to the VA.

So how is DoD collaborating with the VA on the electronic health records rollout, and ensuring that once it is fully implemented that there is the interoperability that we have been talking about for years, for years?

General CROSLAND. Senator Collins, thanks for the opportunity to comment. First, ironically last week I spoke with a senior leader within the VA and offered up the opportunity for them to come and witness our rollouts and to learn from our lessons on how we are able to execute our rollout, and potentially, things we can offer for them by sharing the lessons learned.

With respect to that value of the record, there is a lot of value with the data, as I mentioned in my opening comments, having the right information, being able to follow servicemembers from the time they are assessed, all the way to the time they transition. And obviously, if there is a further delay in the VA's rollout we would have to work through how we would—in our MHS GENESIS, the

electronic record that we are going to be on by the end of the year to the VA, we haven't gotten that far yet.

Senator COLLINS. Thank you. I am sure the Chairman is going to solve that problem in his dual role.

Senator TESTER. No problem whatsoever. Moran is going to help me do it too.

Senator, right?

Senator MORAN. Yes, sir.

Senator TESTER. Okay, good. Look, it is a very good question, and I will just say that I don't know that there is anybody that is not frustrated with the whole electronic health record, the billions of dollars that are being spent, and it doesn't appear that we are moving the ball. So we have got some work to do.

I want to start my questioning on TRICARE. I just had a town hall meeting in Montana, things were brought up that I thought were solved, like providers that couldn't get into the network. That offered up, but couldn't get Montana. I think you see this about everywhere in the country. Providers are something we need more of, not fewer of.

And then the payments for those providers were not being done on time, so the providers that did sign up weren't getting their checks when they should have.

So the question is, who has oversight of—it will be TriWest—who has oversight to make sure, number one, that they are bringing on the providers they need—and this is for you General Crosland—they are bringing on the providers they need, and that the providers are getting paid, and by the way, that the money isn't—it is actually going out to provide services and not being pocketed by somebody in one of these third-party providers' pockets?

General CROSLAND. So Senator, the oversight of the TRICARE Program is executed out of the Defense Health Agency, so that that would be my responsibility.

Senator TESTER. Okay

General CROSLAND. To engage with TriWest to make sure they are honoring the aspects of the contract. We do have a pretty aggressive auditing for the last part of the concern that it is actually not going to the provider, but there is this potential fraud. We do have a very robust program that looks in and audits with timeliness, working harder with TRICARE West is what I owe you, and the team in Montana, to make sure that they are meeting their contractual obligations.

With respect to signing up providers, the Managed Care contractors are given targets, they meet those targets. I acknowledge that when they meet those targets, for the beneficiaries that doesn't always translate that appointment is available. So specifically, if you sign up it doesn't translate that we have actually put appointments out. So in the T–5 contract we have added that as a criterion not just to sign up providers, but to make sure that there are appointments available for the patients to book with the providers.

Senator TESTER. So this was a small sample size, but I had providers there that had contracts with TRICARE, and I had ones that would like to get contracts with TRICARE that couldn't, these were mental health providers. So I don't know what the contract says about the numbers of people you need. I don't know if it is based

on population, or geography, or what it is based on, but I was shocked by what I heard. I was just absolutely shocked.

At a time when mental health has been already brought up here several times, when mental health is such a huge issue in this country, and we are not bringing on as many folks as we can, doesn't make a lot of sense to me.

I want to move on. I want to talk about China. It may strike you as an odd discussion in DoD Healthcare, but we have troops in Japan, and other places, where a number one readiness concern we hear about is lack of healthcare for the dependents and their families, and DoD civilians.

Apparently, the Defense Health Agency recently barred DoD civilians from receiving care at hospitals—military hospitals, forcing them to use local hospitals. Wow. I think it is a disaster. And by the way, I think it is going to, if it hasn't already, end up being an incredible recruitment challenge.

We have also heard concerns about a lack of mental health care for dependents in Japan. This stops servicemembers from deploying there, puts tremendous stress on military parents, these reports are concerning and were repeatedly delivered with a sense of urgency from senior Military leaders on the ground.

It has already been pointed out, China is our number one pacing threat, so this impact on military readiness is alarming. I understand the DoD is now going to make some changes with this policy, but quite frankly, it should have never happened to begin with.

General Crosland, was the impact on military readiness taken into consideration when announcing this change?

General CROSLAND. So Senator, the change I believe you are referencing was a policy put out on the 22nd of December, and the policy limited the space available access to the system so that we could preserve readiness for the Force, specifically saying that Space-A would have to call in after 10 o'clock, and they would only receive acute care.

I have since issued guidance, and the policy was released last week that added clarity to that policy, which expanded care to the Space-A. So the policy never targeted or short access for dependents and their family members, it was meant to make sure that they got the priority that they were supposed to get, at the expense, potentially, of Space-A.

So we have removed the barrier for chronic conditions to open up at the community level, access within our MTFs for our beneficiaries to include the DoD civilians, and signed that out last Thursday or Friday.

Senator TESTER. Okay. And so do you believe this fully addresses the concerns of the commanders in the field?

General CROSLAND. No. I do not believe this fully addresses the commands—the field. I think the concerns are broader than the care that the Defense Health Agency is resourced to provide. So specifically, in Japan, if you have a hospital then all beneficiaries, active duty, active-duty family members, in partnership with TRICARE–ISOS, receives care from the host nation. I believe that that is also part of the concerns that are being raised.

Senator TESTER. Okay. Senator Moran.

Senator MORAN. Mr. Chairman, thank you. These discussions don't seem to leave us, whether we are in the Veterans or in Defense Appropriations. And the same challenges that have been described, particularly with electronic health records, are ones that we are facing in that arena as well.

I want to focus my few minutes on a challenge that I have had in getting information from you going back to October. There was a period of time, and it continues, in which just military retiree after military retiree sought me, my staff, to tell me about a significant change in their pharmacy benefit. And they were now traveling much further or would have to travel much further than previously.

Then, that was followed up by the pharmacists who have struggled to keep their contracts with your agency. Or the story of a number of major pharmacy chains who have declined to continue dealing with the Defense Health Agency.

So in Kansas, a pretty darn rural state these—perhaps you will tell me that the requirements are being met for the amount of travel time or distance that you must meet; but the inconvenience to veterans is significant, and the complaints are real and continuing.

In October, I tried to get information from you. I was told this morning that the letter is in the mail, not quite those words, but in the phrase that we often use. But I and a handful of my colleagues who were experiencing the same thing, have sought the analysis that was done a long time ago that would explain the decisions that you made. And 6 months later we still don't have that information.

I have submitted requests for information through letters, and through RFIs (Requests for Information) to the Department, I went and visited with General Milley seeking his help to get answers from the Defense Agency, Health Agency, but I am disappointed by the lack of cooperation that has been extended to me and to my constituents in an oversight responsibility that I have.

I have heard the Department blaming pharmacists for leaving the TRICARE network, but I also think that narrative is unfair and not accurate. There were winners and losers in the initial solicitation of contracts, some pharmacists were continued in network and never received an amendment, while others received rates lower than the cost to fill the prescription, effectively, removing them from the network.

A question—perhaps to you General Crosland—how did the contractor decide which pharmacies received an amended contract at a much lower reimbursement rate, and which ones did not?

General CROSLAND. Senator, I will first acknowledge the delay in getting back to you. And the letter is in the mail and my apologies for that. I am not read on to what the contractors process for negotiating rates are, what I am aware of is what the decision process was, and how many to include into the network.

I understand that some of the independent pharmacies, specifically, in the initial bid, felt like they did not have an opportunity to compete for the TRICARE. We released another opportunity on 1 January, I believe, and received a response from another round of independent, and grew those numbers of the independent phar-

macies. Specifically for Kansas, 55 percent of the pharmacies are chain pharmacies, and 45 percent of the pharmacies that——

Senator MORAN. That are contracted with?

General CROSLAND [continuing]. Are contracted with ESI are independent pharmacies. Acknowledge that in rural areas the burden, or the field, when we say 98 percent of individuals are 15 minutes from a network contract, that will be in the letter that we sent you, 98 percent. And so the change for drive time for Kansas beneficiaries, is 95 percent of them are within 15 minutes of a pharmacy. And that leaves about 3,000 of your constituents that have to travel a little bit beyond 15 minutes. 99 percent is the overall number once we go outside of 15 minutes, within 30 minutes.

Senator MORAN. I would push back, or just make the case that a pharmacy is not just a commodity, it is a relationship, and our servicemen and women have had that relationship with their pharmacists for a long time, and to be told that it is no longer an option, and the pharmacists indicating they had no option to continue, is still problematic to me.

The transition, apparently, was driven by a 2019 independent analysis that the Department seems to be unwilling to provide to me. Is there a reason you cannot share that analysis so that I and others can analyze the methodology by which you reached these conclusions?

General CROSLAND. I actually don't have that answer.

Senator MORAN. Okay.

General CROSLAND. But I will get back to you, for sure.

Senator MORAN. All right. And Dr. Martínez, my time has run, but I held your nomination, I put a hold on your nomination because of lack of cooperation from the Defense Health Agency. I lifted that hold with—it served its purpose. Well, it presumably fulfilled its purpose. I lifted that hold and voted for your confirmation. The commitment was that I would have the answers that I have been seeking since October, and often since then, by March the 1st. March the 1st has come and gone. I would ask for your help in fulfilling that commitment to me.

Dr. MARTÍNEZ-LÓPEZ. Sir, I thank you. And I thank all the members of their supporting my confirmation process. And yeah, hold me up to that. As Ms. Mullen said, that response will be fairly soon.

Senator MORAN. I may be satisfied, but let us see what the response is.

Dr. MARTÍNEZ-LÓPEZ. Yes, sir.

Senator MORAN. Thank you.

Senator TESTER. I just want to touch on this. I am very proud of this committee, because there are some really good people in this committee. One of our jobs is oversight. I don't need to tell you guys over half the money we appropriate goes to the Military. If somebody on this committee wants an answer, unless there is a classified reason for not having that answer, we should get that answer, and we should get it in short order.

And so I don't think there should be any reason for a Senator, and this goes for you guys, and anybody else listening, on this committee, when we are appropriating the money, not to get the answers we need, it is unacceptable.

Senator Baldwin.

Senator BALDWIN. Thank you, Mr. Chair.

Dr. Martínez-López, as the Department is well aware, the National Guard has become an integral part of our Total Force, one on which we have relied very heavily for the past 20 years for the global war on terror, and a long list of other missions. Increasingly, we have seen the National Guard activated on short notice to support national priorities such as pandemic response, domestic unrest, and securing our southern border.

The increasing reliance on short notice deployments makes readiness a very key concern, for both the National Guard, and for this committee. According to the National Guard, over 66,000 Guard members do not have health insurance.

Would you agree that providing health coverage to all National Guard members would be an important part of improving readiness?

Dr. MARTÍNEZ-LÓPEZ. Senator Collins said the health of the airmen or reservists are active duty, it is most important to all of us in the Department. And the good news is, because of you they haven't—the first option is the TRICARE Reserve Select, so many of the members of the Guard and the Reserve who have the option to enroll in that program. If we wanted to expand that program, obviously, we are going to have to look more in detail, so what does it imply——

Senator BALDWIN. That brings me to my second question; would you agree that if a Guard member cannot afford TRICARE Reserve Select, and they lack access to other forms of healthcare, that we should find a way to get them covered?

Dr. MARTÍNEZ-LÓPEZ. We need to figure out a way to make the healthcare that they need, available.

Senator BALDWIN. Okay.

Dr. MARTÍNEZ-LÓPEZ. So yes, I agree. I don't know how, obviously, we are going to have to do studies.

Senator BALDWIN. We have a bill for you. But additionally, can you speak to any impact to or cost savings for the Reserve Health Readiness Program if we were to achieve 100 percent healthcare coverage for members of both the National Guard and Reserve components?

Dr. MARTÍNEZ-LÓPEZ. Ma'am, I am not prepared to talk about that. So I really would like to do a study and look at the background, so I can make a formal statement.

Senator BALDWIN. Dr. Martínez-López, in recent years I have sought and achieved increased funding for organizations within the National Guard to hire additional mental health providers, and to expand efforts to educate civilian providers on intervention strategies. We have also worked to include suicide prevention as a topic eligible for funding through the Congressionally Directed Medical Research Program. But despite these efforts, suicide rates have remained stagnant among the Reserve and Guard populations since 2011.

Last month, the Department released its recommendations from the Suicide Prevention and Response Independent Review Committee. I particularly appreciate the report's holistic view of mental

health, and the inclusion of factors that, while not directly related to clinical care, nevertheless, impact prevention efforts.

For example, the report recommends properly funding morale, welfare, and recreation programs, particularly on smaller and remote installations, as well as recommending spousal employment programs. What is your assessment of how we can better apply resources to make progress in reducing the suicide tragedy?

Dr. MARTÍNEZ-LÓPEZ. Ma'am, as I said before, the public health approach is the way to go. Personally, I believe that, as a physician. We need to look at three things: We need to look at the risk factors that are affecting these servicemembers, and figure out a way to relieve them from those risk factors, right; if we are not paying them in time that may increase their risk factor. So we should be able to figure out how to give them payment on time.

If they, say, have family issues, we need to figure out how to deal with those family issues. So we need to look at those risk factors, and we need to look at from the preventive standpoint, look at ways to decrease it, that is issue one.

Issue two, on the treatment side; we need to figure out new ways to deliver the care. The first thing we need to figure out is right care, with the right provider, at the right time. So we have to make that right on target, because we don't have that many, and the——

Senator BALDWIN. And would you agree that zero-cost healthcare to all members of our Armed Forces, regardless of duty status, is an important component of accessing that prevention care and treatment?

Dr. MARTÍNEZ-LÓPEZ. Ma'am, I will have to think and see what are the repercussions of that before I make a statement one way or the other.

Senator BALDWIN. I yield back.

Senator TESTER. Senator Murkowski.

Senator MURKOWSKI. Thank you, Mr. Chairman. And thank you; to all those that are part of the panel here this morning.

I know that there has been discussion about the Suicide Prevention Response Independent Review Committee report on the impact of suicide within the military. This is something that we have been very keenly focused on in Alaska. Our Focus really has been on Fort Wainwright, along with Eielson Air Force Base, both of these were identified for site visits in Secretary Austin's Independent Committee to review the suicide prevention reports. I am sure that you are well aware of that.

I guess this would be a question for you, Dr. Martínez-López, and I am curious to know what level you all will be involved in, in Secretary Austin's Implementation Working Group? And as you answer that, I would ask for your commitment to visit some of our bases in Alaska as you look at that Proposed Suicide Prevention Report.

And I would suggest that starting at Fort Wainwright would be a pretty good place to begin. And then, I don't know if you are a walker, but encourage you to take the three-mile walk from the furthest barrack, it was built back in the '50s, to the outdated and two small dining facility there at Wainwright. The sun is coming on, and it is getting warmer, but I would challenge you to do it in

the dark and at 30-below, as many of our soldiers have to do. So if you can speak to that?

Dr. MARTÍNEZ-LÓPEZ. Ma'am, thank you for the invitation, but I already accepted the distinguished Senator from Alaska when I was doing my hearings, I have two places I need to go.

Senator MURKOWSKI. Okay.

Dr. MARTÍNEZ-LÓPEZ. The same topic, Alaska and North Dakota.

Senator MURKOWSKI. All right.

Dr. MARTÍNEZ-LÓPEZ. I am working at, now in April, so I hope to be able to—I have been there.

Senator MURKOWSKI. Yes.

Dr. MARTÍNEZ-LÓPEZ. I did the Arctic Survival School a couple years back.

Senator MURKOWSKI. Good.

Dr. MARTÍNEZ-LÓPEZ. When I was doing Aerospace Medicine, but also, for a Puerto Rican to be out there in Alaska during those times, it was——

Senator MURKOWSKI. You know we have significant Puerto Rican population out at Fort Greely, and they love it there.

Dr. MARTÍNEZ-LÓPEZ. Yes, ma'am. And I survived, obviously.

Senator MURKOWSKI. Yes.

Dr. MARTÍNEZ-LÓPEZ. Yes. I already told you. I mean, this issue of suicide and mental health it is very important to me. I will be working with the team, and I will be working with the Secretary to address what we can do, short-term, midterm, long-term. This is not done, and we are done, it is going to take us a while. It is a journey. Every day we are going to learn, every day we are going to deploy new ideas, but I am——

Senator MURKOWSKI. So can I ask on that if I can just interrupt there? Because we are going to be seeing the President's budget laid down here in the next day or so, and I don't know if you can speak to whether or not we are going to see any of this outlined or projected in the President's budget. Are we going to see certain military construction projects prioritized, certain programs prioritized that can, perhaps, help make a difference? Because we know we have got to do something, and just doing the studies doesn't necessarily save lives.

Dr. MARTÍNEZ-LÓPEZ. I am on my eighth day on the job. I really don't know the answer to that one.

Senator MURKOWSKI. Okay.

Dr. MARTÍNEZ-LÓPEZ. My assumption is yes, but can anyone else help me? We owe you an answer on that one.

Senator MURKOWSKI. Okay.

General DINGLE. Senator, one thing I will add. Within the Army we definitely have done that. And under General McConville's leadership, we have what is called "Quality of Life", in which the Commanding General, General Eifler, has been able, through a holistic approach, you know, been giving resources, and facilities that we are looking at adding for the manning of the hospital. So we are taking a holistic approach which prioritizes Alaska, and that is one of the Chief's top concerns, priorities.

Senator MURKOWSKI. Well, thank you for that. And we have included in our Arctic Warrior Act Provisions two authorizing provisions for troops stationed there in Alaska, one is for cold-weather

duty pay, the other one is a requirement that servicemembers in Alaska be reimbursed for the cost of a flight home. And when you think about financial stressors, the things that just, people cannot handle anymore if they need to be reconnected with family and they can't afford the $2,000, $3,000 flight home. Or they don't have the cold-weather gear.

Or another issue that we hear is pay systems that the servicemembers are literally victims of outdated technology, they don't get paid on time.

We have heard from some young servicemen that it is taken up to 7 months to get their paycheck situation squared out. I don't know how that works, but you know, when you have that kind of financial stress on our servicemembers, that is not right to them. So I would like that, again, is where we are looking for considerations to be factored in as well.

Mr. Chairman, thank you.

Senator TESTER. Senator Shaheen.

Senator SHAHEEN. Thank you, Mr. Chairman. And thank you, to each of you, for your testimony today, and your service to the country.

Our office is still hearing, fortunately not as often, but still hearing from people who have been affected by anomalous health incidents. I don't know if this is for you, Dr. Martínez-López, but can you speak to how the Department's understanding of those incidents has evolved, and to what extent you believe people who have been affected, both military members and their civilian family, are being treated now?

Dr. MARTÍNEZ-LÓPEZ. Overarches, ma'am, I mean, we need to take care of these people, they are sick. So when they come to our system, you know, we have the interagency agreement, and we have processes to bring them, you helped us out with that, we are going to take care of that. We are still doing research trying to figure out the causality.

Senator SHAHEEN. Right.

Dr. MARTÍNEZ-LÓPEZ. That is going to take time. But the overarching, like with anything, we need to take care of the people first. And then with the best science we have, development that science as we learn more, close that gap, right, but it doesn't stop. So we are going to need the help from you, from you to sustain that effort.

Senator SHAHEEN. And what I have heard from people who have been affected is that they especially appreciate the care they are able to get at Walter Reed Medical Center. Can you tell me if Walter Reed is still open to those people who have been affected by AHIs (Anomalous Health Incidents), not just within the Department of Defense, but across the Federal Government?

Dr. MARTÍNEZ-LÓPEZ. Ma'am, we are very proud of that team. And I think the General can speak about that.

General CROSLAND. Yes, Walter Reed is continuing to care for AHI.

Senator SHAHEEN. Thank you. And it will continue to do that, yes.

General CROSLAND. And it will continue to do that, yes.

Senator SHAHEEN. Thank you. So I maybe want to ask each of you this question; what percentage of your Force are women, Admiral Gillingham?

Admiral GILLINGHAM. I would have to get back to you, ma'am, but I believe it is approximately 30 percent.

Senator SHAHEEN. General Miller?

General MILLER. Right now, Air Force, overall, is 21 percent, and within the AFMS it is 50 percent.

Senator SHAHEEN. Thank you.

General DINGLE. Ma'am, I would have to get back to you with the specific numbers.

Senator SHAHEEN. Dr. Martínez-López, across the entire military, can you tell me what it is?

Dr. MARTÍNEZ-LÓPEZ. I am told 18 percent.

Senator SHAHEEN. 18 percent, and that number is going up; is that correct?

Dr. MARTÍNEZ-LÓPEZ. Yes, ma'am.

Senator SHAHEEN. So that women make up a very important part of those who are serving on active duty.

Perhaps this is you, General Crosland; what contraceptives are currently available to servicemembers?

General CROSLAND. All contraceptives are currently available to our active-duty women. The Defense Health Agency has rolled out a walk-in for contraception in all 133 of our clinics that offer that capability, to include some of the long-acting contraception, so they can walk in and be taken care of without a referral or an appointment.

Senator SHAHEEN. And is that the case for people who are deployed overseas as well?

General CROSLAND. It is a case for the people who are deployed overseas when they have access to the capability within the theater. So if the clinic provides long acting, then they are able to walk in and get long acting.

Senator SHAHEEN. And can you tell me what percentage of women are deployed in places where they can't get access to those contraceptives?

General CROSLAND. I do not have that number, of what locations do not have the capability to provide it.

Senator SHAHEEN. Is that something that someone within the office is able to provide?

General CROSLAND. We will take that for action.

Senator SHAHEEN. Okay. We hear from women on a pretty regular basis who tell us that they are in places where they don't have access to contraceptives. Servicemembers and their families are affected by eating disorders at elevated rates, compared to their civilian counterparts, and the SERVE Act was passed in fiscal year 2022, in the NDAA, and it was designed to expand access to eating disorder treatments for servicemembers and their families. Can you speak to the options that are now available as the result of the passage of that, and has it been fully implemented?

I guess this is for you, Dr. Martínez-López.

Dr. MARTÍNEZ-LÓPEZ. Ma'am, I don't know the answer to that one. I owe you a response.

Senator SHAHEEN. Okay.

Dr. MARTÍNEZ-LÓPEZ. Anyone else knows that? Okay.

Senator SHAHEEN. Well, thank you. I think it would be—I would appreciate hearing that response, as I am sure the full committee would—subcommittee would. And I think as part of that it would be helpful to know if spouses and children of servicemembers are provided the same level of care, as active-duty servicemembers. Thank you.

Thank you, Mr. Chairman.

Senator TESTER. I want to welcome the newest member to our subcommittee. Senator Murphy.

Senator MURPHY. Thank you very much, Mr. Chairman. It is as honor, to join this prestigious subcommittee, and grateful for the opportunity. Thank you all for being here today. I am really grateful for the Chairman, and the Ranking Member's focus on the suicide epidemic, and for all the work that you have put into it.

I wanted to talk to you, Rear Admiral, about a very specific case that I have become intimately and tragically familiar with, and that is the death of seven sailors on the USS *George Washington* just last year. One of them was a Connecticut resident, seaman recruit, Xavier Sandor, took his own life with a service-issued firearm.

And by now you know that the conditions on this ship, and the conditions for these sailors was, you know, frankly just unacceptable. This was, obviously, a ship that was going through a major refueling, and complex overhaul the conditions on board required a lot of these young men to be sleeping in their cars, to be making long trips home to get away from the chaotic scene, and the access to mental health was just completely inadequate.

Sailors who were seeking routine care on a ship that had significant conditions affecting mental health were facing waits of up to 2 months for care, members of Seaman Recruit, Sandor's Division reported that they were often hesitant to seek mental health treatment through Navy channels because they were under the impression that it would affect their future career opportunities.

Obviously, this is exceptional that we had so many individuals take their life in a short period of time. And I know that there is still a final investigation that is outstanding. But what can you tell me today about how were the changing conditions for our seamen who are living under these kinds of conditions, and how we are making sure they have access to Mental Health Services?

Admiral GILLINGHAM. Thank you, Senator Murphy.

From the Secretary of Navy, on down, we have taken this issue very seriously, as we have taken the general issue of mental health and suicide prevention seriously. I can tell you that our immediate response was to send a special Psychiatric Response Team; that was to counsel those who were directly affected by these incidents, by these tragic incidents.

We have learned also that it is important, not only to respond acutely, but to have a prolonged response. And so all of the members of the George Washington are enrolled in what is called "ORION", which is a periodic check-in to assess how they are doing and to ask if they need help.

Historically, when we have done this, on five previous occasions, we have about a 20 percent take rate, and we directly do a warm

handoff for those individuals. But the larger issue, sir, is ensuring that we are creating a resilient Force. GW, certainly, is an example of a challenging situation to be in a shipyard like that, but our sailors and marines face challenging situations worldwide, and so developing Force resilience is key.

Toward that end, all of our recruits now go through warrior toughness training; they learn stress reduction techniques, as well as meditation. These are reinforced through their training.

In addition, for the GW and for the greater Navy we have an Expanded Operational Stress Control Program, this is a train-the-trainer model, in addition as well our office of Navy culture and Force resiliency just rolled out a mental health playbook which provides tools for unit-level leaders and beyond, ways to prevent suicide, ways to recognize an individual in distress.

Senator MURPHY. All right. Thank you very much. I will look forward to follow up with you on that.

I just want to sneak in one more question, and that is to you, Mr. Assistant Secretary. We talked a lot about this Independent Review Committee Report; one of their urgent recommendations was to address Section 1057 of the 2011 NDAA, which prohibits the Secretary of Defense from collecting any information regarding firearm ownership by active duty members.

Now, I think this was due to some concerns about overreach, but I don't think that the drafters of that language contemplated the fact that it is just good medical practice if someone is in crisis, to inquire as to whether they have a firearm at home, whether that firearm is properly stored, and locked.

And so I am not going to ask you for your view on the law, that is a question for us, but as a rule is it good medical practice for there to be gag orders on physicians as to what questions they can ask their patients, what information they can try to solicit from their patients?

Dr. MARTÍNEZ-LÓPEZ. As a physician, you know the relationship between my patient and I, it is kind of sacred, I mean, because we talk. And I expect him to be truthful to me so I can help him. So anything that interferes with that interferes with good medical care. So that my position is that, I mean, anything that interferes with a good open discussion between the patient and the physician, or a provider, not necessarily a physician, it is not good for either of the two parties. If I don't know I cannot help you; and if you cannot tell me, even worse. So we need your help to facilitate that process.

Senator MURPHY. Great. Thank you very much.

Thank you, Mr. Chairman.

Senator TESTER. Senator Hoeven.

Senator HOEVEN. Thanks, Mr. Chairman, appreciate it. Thanks to all of our witnesses for being here, and for all you do to keep us safe, and take care of our men and women in uniform.

I want to ask primarily about, well, first some mental health issues, and making sure that those services are available to our members of the Armed Services.

But first, I am going to ask Lieutenant General Miller about the cancer study that is being done in regard to—actually, the German State, the Malmstrom Air Force Base, there were a number of can-

cer cases there, and in response the Air Force has initiated a study on it to determine cause. And of course, make sure that anyone that needs treatment is getting it.

I did talk to General Bussiere. I met with General Bussiere, the Commander of Global Strike Command, to ask him about it. But my first question for you is; how do you determine the cause of cancer, or a group of cases of cancer are attributable to any particular cause?

General MILLER. Thank you, Senator. And yes, there is an ongoing study now based on General Bussiere's request, as he has been offered the initial assessment from our team at USAFSAM (U.S. Air Force School of Aerospace Medicine), and he has elected to conduct a study that will be led by that team at USAFSAM, in cooperation with other important agencies, the VA, the cancer societies, and others.

But what is going on right now, is there is a ten-member team on the ground, just left F.E. Warren, we are at Malmstrom, they are headed to Minot, to assess what—each base is unique and different—what the situation is like in each area. How that study could best be done. Because to get to your question, it is a complicated question especially when you are dealing with multiple different Airman Guardians, different career fields, different bases, different timeframes, and even different cancer types, to determine what might be involved, what the incidence is. And then, if possible, what might be a causative reason that we would then take action on since our priority is a safety for Airmen and Guardians.

So this is a process that will continue to play out over the next 12 to 14 months, as we take this very seriously, and try to get to the bottom of some of these concerns.

Senator HOEVEN. Do you have any sense of time line, at this point?

General MILLER. 12 to 14 months is a reasonable estimate. Now, the study we will plot in stages, and obviously as they get information, if there is something actionable prior to that that will happen. In the same regard it—certain paths may result in more work being done that that could extend this out, but the key is timeliness in trying to get this completed as quickly as possible to best take care of all that might be impacted, whether active, retired, and all beneficiaries.

And once again, partnering with others like the Veterans Administration, understanding all that, potentially, could be impacted.

Senator HOEVEN. Thank you. The True North, Task Force True North is something I have worked on with the Chairman of this Committee, and also with Air Force leadership, Secretary of Air Force, and so forth. In the initiative, the True North Initiative, is there a concerted effort to make sure that you are addressing mental healthcare adequately across the missile bases?

General MILLER. Yes, sir. It is a great question. And True North is the initiative that the A1 community in the Air Force is rolling out with the focus on mental health, in a mirror framework, SG has something called Operational Support Teams that will be at Minot, that will be at every one of our 76 Air Force Bases, knowing that our Airmen and Guardians, the two main reasons that they

are often not deployable, or have issues, it is mental health, and it is musculoskeletal.

So as a part of teams, five-member teams, that will be embedded in the Med Group, will go out to units for short periods of time, eight to nine weeks, develop trust, do prevention, mental health will, absolutely, be a part of that effort.

Senator HOEVEN. And it is addressing family needs too, not just the servicemember, right?

General MILLER. And that is a great question, because family is equally important. OST is based on the active duty members. For the Air Force we have created something called Developmental Behavioral Family Readiness Centers. So there are eight hubs presently throughout the United States that will address; we know that there is quite a few children that are impacted by mental health issues, that these teams go out to bases on a quarterly basis, and then support, virtually, from afar, so that a Wright-Patterson, for example, is a hub that could go out to a location like a Minot, and provide that type of support.

Those teams right now are focused on children, but could be expanded to include adult mental health providers that could take care of dependent family members that have mental health needs.

Senator HOEVEN. Well, with the Indulgence of the Chairman, one final question. And make it short please. I am past my time. But both for Dr. Lester Martínez-López, and also for General Crosland; through TRICARE, are you providing enough mental health services and providers for our service members?

Dr. MARTÍNEZ-LÓPEZ. I will defer to General Crosland.

General CROSLAND. So sir, there is not enough in our country to meet the demand, to be honest with you.

Senator HOEVEN. I will ask him the question.

General CROSLAND. Yes, sir. So we are doing our best with the contract, and as some of our teammates have mentioned, taken a much more holistic approach partnering with other teammates to help folks with their mental health, not just medical.

Senator HOEVEN. And it is a focus?

General CROSLAND. It is absolutely a focus.

Senator HOEVEN. Thank you. Again, thanks to all of you.

Thank you, Mr. Chairman.

Senator TESTER. Just one quick follow-up on Senator Hoeven's question.

This is for you General Miller. What role is the Defense Health Agency playing in the assessment that is being—you know, that the Air Force is doing under General Bussiere?

General MILLER. There is a partnership there, and we are in open communication so the Health Surveillance Division, part of the DHA, is absolutely involved. So it is important to us that this is—and all the key organizations are playing a role. Like, as I mentioned, VA, American Cancer Society, and others, with an interest that once the study is completed we may need to have some civilian organizations to be involved to be another set of eyes based upon the results that we receive.

Senator TESTER. Thank you. We appreciate all of you, your testimony, your opening statements, thank you for being here today.

This was a helpful conversation, covered a number of topics. But our oversight responsibilities will not stop here.

Later this week the subcommittee will receive your budget request, and we will conduct a thorough review. We ask that you provide responses in a timely manner, and continue to keep us apprised of the Department's health policy, decisions, and implementations, similar to what I said earlier in this meeting.

CONCLUSION OF BRIEFING

The Defense Committee will reconvene on Tuesday, March 28, at 10 a.m., for a hearing with the Department of Navy.

We stand in recess.

[Whereupon, at 11:19 a.m., Tuesday, March 7, the subcommittee was recessed, to reconvene at 10 a.m., Tuesday, March 28.]

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