Prepared Statement

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REGARDING

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Chair McCollum, Ranking Member Calvert , distinguished Members of the Subcommittee, I am pleased to represent the Office of the Secretary of Defense to discuss the Defense Health Program (DHP) and its contributions to the health affairs of the Department. I am honored to represent the dedicated military and civilian medical professionals in the Military Health System (MHS), which provides direct support to our combatant commanders and delivers health care for our 9.6 million beneficiaries.

This hearing is occurring in advance of the formal release of the President's FY22 full budget. My testimony will provide the Subcommittee with information on major activities that will inform our budget proposal for FY22 as well as issues affecting FY21 execution. The most significant issue, looming over all of our projections, is the national response to the COVID-19 pandemic. Our national success in reducing the spread of the virus, and vaccinating our population, will affect every aspect of our health care costs. For that reason, my testimony will begin with the current state of the DoD response to COVID-19.

COVID-19 Response

The past fourteen months have represented a unique and challenging period for our Nation as we've confronted and responded to the COVID-19 pandemic. In line with the President's priorities, Secretary Austin has made clear that the greatest proximate challenge to our Nation's security is the threat of COVID-19. The Department has, and will continue, to act boldly and quickly to support Federal government efforts to defeat this disease. The MHS is providing critical health support worldwide to our military forces, supporting other Federal and

state entities as part of a whole-of-government response to this crisis, and continuing to meet other strategic, global mission requirements, while sustaining high quality health services to our military Service members and their families.

Beginning with the declaration of a global pandemic in March 2020, the MHS provided essential crisis response services in support of military leaders and civilian demands. Though this summary is not all-inclusive, I will briefly mention several critical initiatives that contributed to the national response and also generated additional expenditures for the Department.

Surveillance and Laboratory Testing. Soon after the pandemic began, the Secretary of Defense established the DoD Coronavirus Task Force that included a Diagnostics and Testing Line of Effort. The Department grew its laboratory testing capacity from 16 operational laboratories in late March 2020 to 189 operational laboratories by March 2021, and increased on-hand SARS-COV-2 tests from approximately 200,000 to over 1.8 million. To date, the Department has conducted well over 3 million tests and has tests on-hand to conduct more than 100K tests per week. Testing is a key public health intervention that has helped to limit the spread of SARS-COV-2 within the military. Coupled with other public health measures like social distancing and masking, military installations have consistently lower positivity rates than their surrounding communities.

Even as vaccination efforts continue to increase, testing will remain a key pillar of our public health strategy to battle this disease and maintain a ready force. Screening through antigen and PCR testing using a variety of testing strategies in a post-vaccination environment will continue as part of the Department's COVID-19 risk mitigation strategy to drive cases down toward zero. The Department is also committed to whole genome sequencing and

identification of variants of concern and interest and to understanding their prevalence among our Service members and other beneficiaries. The Department has already committed the resources and funding to more than double the number of specimens the Department can sequence and analyze each week.

Clinical Support for Treatment and Therapeutics. Early in the COVID response, the Defense Health Agency (DHA) developed and released the first *DoD COVID-19 Practice Management Guide (PMG)* to provide clinicians and Military Treatment Facilities (MTFs)- our military clinics and hospitals- with a single document on best practices informed by the latest evidence, and guidance across all clinical care specialties. The PMG has been continually updated and rereleased, with the most recent version (Version 7) published in March 2021. The DHA also established a Joint Registry for COVID-19. Using the Joint Trauma Registry as a foundation for this effort, the COVID Registry collects and assesses clinical information on COVID patients, in order to inform our military medical community on the rapidly evolving science behind this disease. In April 2020, DHA also put forth the *Health Protection Condition (HPCON) Guidance in a COVID-19 Environment*, which contained CDC informed guidance to support MTFs in healthcare delivery in response to COVID-19, based on the locally-determined risk level.

In June 2020, DHA began an effort to collect donated units of plasma from patients who had fully recovered from COVID-19 to support development of an effective treatment against the disease. Again, the DHA relied on the COVID-19 registry to identify potential donors, as well as capture the use of, and outcomes from, convalescent plasma on hospitalized COVID patients. In August 2020, after receiving Emergency Use Authorization (EUA) from FDA,

COVID-19 convalescent plasma was made available to MTFs for investigational treatment of COVID-positive patients who met established criteria in accordance with approved protocols.

The MHS worked closely to implement other FDA-authorized treatments for COVID. In September 2020, shortly after Veklury® (remdesivir; first FDA-approved treatment for COVID-19) received an expanded EUA, the medication was rapidly pre-positioned throughout DoD to ensure availability to hospitalized patients with suspected or laboratory-confirmed COVID-19, irrespective of their severity of disease. Similarly, in November 2020, after receiving an EUA from FDA for COVID-19 monoclonal antibody treatment, DHA developed and disseminated specialized guidance to assist MTFs and healthcare providers regarding patient care considerations when administering this treatment for mild and moderate cases.

Individual Medical Readiness. COVID-19 did affect medical readiness within the military. The Department uses a concept called Individual Medical Readiness (IMR) to measure medical readiness, which consists of six elements. These are Dental Readiness, Immunizations, Medical Readiness Labs, Deployment-Limiting Medical Condition (DLMC) Status, Periodic Health Assessment (PHA), and Individual Medical Equipment. In 2015, the DoD Total Force Medically Ready (TFMR) goal was set at 85%. Since 2015, the Total Force has consistently met or exceeded the 85% goal. With COVID-19 pandemic beginning in the 2nd quarter of 2020, TFMR decreased below the Department's 85% goal. As of the 4th Quarter of Calendar Year 2020, TFMR compliance was 82.2%; Active Component IMR compliance was 82.4% and Reserve Component IMR compliance was 81.7%.

The COVID-19 pandemic most affected Dental Readiness and Immunizations. These IMR requirements can only be completed via in-person clinic visits. Of note, throughout the

pandemic, medical readiness for deploying Service Members was prioritized and all personnel are required to be fully medically ready prior to deployment. Capabilities such as virtual and telephonic medical appointments allowed MTFs to continue to provide access to medical readiness support services. We expect IMR rates to quickly recover and return to pre-COVID levels as our vaccination campaign proceeds through spring and summer 2021.

Healthcare Delivery and Deferred Medical Care. In both the direct care system and the TRICARE network, the Department has worked to ensure beneficiaries receive medically necessary and readiness-related care throughout the pandemic and we are currently working to address delayed or deferred care. In addition to guidance for MTFs on standard processes to provide medically necessary care that could not be delayed, the Department significantly expanded the use of Virtual Health (VH) to meet beneficiary demand while minimizing unnecessary risks for patients and staff.

MTFs and Markets are increasing the number of available appointments to meet patient demand for care and schedule previously delayed care. Despite additional workload associated with COVID-related deployments and vaccinations, MTF appointment availability is approaching pre-pandemic levels and access to appointments for routine and follow-up care averages 4.8 days, which is better than the standard of 7.0 days or fewer. Likewise, specialty referrals are up from spring 2020 levels and are approaching pre-pandemic rates. While direct care performance on cancer and other preventive screening is lagging compared to strong pre-pandemic performance, MTF staff members are actively reaching out to beneficiaries to encourage and facilitate screening appointments.

For network care, DHA worked with the managed care support contractors to develop strategies to ensure our beneficiaries' ability to access care in the network, ensured resources were monitored to confirm provider availability, expanded availability of VH and eased beneficiary access to providers by extending referral and authorization limits and adjusting rules impacting beneficiary cost shares.

Public Health Planning. The COVID-19 pandemic has highlighted the importance of integrated DoD and interagency public health planning, which includes conducting realistic exercises with federal, state and local public health partners. However, the MHS pivoted quickly and effectively in responding to the pandemic across a wide range of requirements, both internal to DoD and across the public health universe. In the process, we learned lessons and developed associated recommendations that can have an immediate and sustained impact on the ability of the MHS to support the ongoing pandemic and to prepare for future major public health emergencies. Chief among these actions is developing even tighter integrated coordination with interagency partners within the Departments of Health and Human Services (to include the Centers for Disease Control and Prevention (CDC), the Food and Drug Administration (FDA), the National Institute of Health (NIH), and the Office of the Assistant Secretary for Preparedness and Response), Homeland Security, Veterans Affairs and State, and other organizations regarding global medical surveillance of cases and variants of concern. As a primary partner in the interagency scientific community, DoD shares genetic sequencing findings, seroprevalence information and other relevant surveillance data with interagency partners.

Medical Education & Training. The collaborative leadership efforts of the Medical Enlisted Training Campus and the Services resulted in minimal disruptions in training by maximizing the interoperability and capabilities of alternative learning modalities and

technology adoption. The MHS kept graduation rates on target, and the end-strength of enlisted medical career fields healthy and ready to support Combatant Commanders. Additionally, the MHS expanded support for continuing education credits (CE) for 16 healthcare specialties and awarded over 90 thousand continuing education/medical credits. Continuing education credits are required for health professional licensure and certifications. The Defense Medical Modeling and Simulation Office recognized an opportunity to provide immediate support in meeting COVID-19 related simulation training gaps/needs of the transitioned Markets and associated Military Medical Treatment Facilities.

COVID-19 Vaccine and Immunization Implementation. Since December 2020, the Department introduced a global immunization campaign to deliver expanding supplies of vaccines approved for use under an EUA. In December 2020, DHA issued an Interim Procedures Memorandum to implement instructions, assign responsibilities, and prescribe procedures for the COVID-19 Vaccination Program. DHA continues to publish updates on the coordinated strategy for prioritizing, distributing, and administering the COVID-19 vaccine, with the most recent DoD Vaccination Plan modification (MOD-12) released in April 2021.

As of May 21, 2021, the Department had administered over 3.3 million doses of the three vaccines authorized by the FDA under an EUA. Adapted from the CDC tiered framework for prioritizing individuals for vaccination, the DoD population schema includes persons in critical national security positions and deploying forces in the Tier 1 priorities. Vaccinations are being administered at 369 DoD sites around the world, in addition to access to civilian sources for our beneficiaries. On April 19, 2021, the Department fully opened vaccine appointments to all eligible individuals, consistent with the President's direction to all jurisdictions.

The vaccine remains voluntary for all eligible persons to include active duty Service members. The Department has implemented a comprehensive outreach and communications effort to encourage all eligible persons seek out these highly safe and effective vaccines. We are encouraged by the trends in vaccine acceptance, and are confident that all individuals over the age of 15 who want the vaccine will be fully vaccinated by mid-Summer. On May 14th, following the CDC Director's acceptance of the Advisory Committee on Immunization Practices' recommendation, the Department expanded administration of the Pfizer COVID-19 vaccine to beneficiaries, ages 12-15. As of May 21st, the Department has already vaccinated over 12,000 adolescents in this age cohort in MTFs and through our retail pharmacy networks.

Defense Support to Civilian Authorities. In addition to the comprehensive response in support of the military mission, the Defense Department has provided significant expertise, logistics support, and personnel to civilian communities. Early in the pandemic, the DHA coordinated the delivery of critical inventory from existing strategic reserves to FEMA for redistribution to civilian communities. This support included delivery of five million N-95 masks and over two thousand ventilators. The US Navy deployed the USNS Comfort and USNS Mercy to civilian ports on the east and west coasts to provide hospital bed surge capacity for cities in crisis. Throughout 2020, Army, Navy and Air Force personnel deployed as units to civilian hospitals around the country to augment local staff. Military medical personnel took on key positions with Operation Warp Speed, and infectious disease experts and medical researchers from DoD medical research and development offices collaborated closely with the broader American medical research community.

COVID-19 After Action Review (AAR). The MHS is a learning organization, and we are committed to continuously improving our performance – whether in battlefield medicine, health

care quality and safety, or our COVID response efforts. Consistent with the FY21 NDAA, Section 731, the MHS established a rigorous AAR process, led by the Uniformed Services University of the Health Sciences. This AAR builds on the MHS interim AAR process and report established by the ASD(HA) in May 2020 and completed in January 2021. The Department will submit a substantive, interim report to Congress under Section 731 by 1 June, and submit a final report by the close of 2021.

Effects on the FY21 Budget. We remain deeply appreciative of the FY20 supplemental appropriation of $2.2 billion, as part of the CARES Act, that covered the significant costs incurred during our initial response.

In FY21, however, costs attributable to the pandemic response continue to accumulate. As of March 31, 2021, our mid-year review of the Defense Health Program (DHP) identified likely shortfalls as part of the ongoing pandemic response, which we are working with the Department to resolve. In addition, the financial impact of our military support to the Federal Emergency Management Agency (FEMA) missions, which remain ongoing, continue to be assessed. The most significant cost drivers include higher than projected Private Sector Care costs; additional laboratory testing; personal protective equipment (PPE) expenditures; and numerous other requirements from public health surveillance to antiseptic cleaning of medical facilities.

While there are opportunities to realign funds to meet the operational imperative of the pandemic response, actions will still create additional risk and financial liability at a later date.

MHS REFORMS and TRANSITION

The FY 2017 National Defense Authorization Act (NDAA) enacted sweeping reforms to the organization and management of military medicine. The over-arching direction from Congress was to centralize and standardize many military health care functions in a way that better integrates readiness and health delivery throughout the Department. Included among these reforms: the expanded authority and responsibility of the DHA to manage MTFs worldwide; and the authority to adjust medical infrastructure in the MHS to maintain readiness and core competencies of health care providers.

Following a strategic pause in transition activities due to the initial COVID-19 pandemic response, which was directed and then lifted by the Secretary of Defense in April and November 2020 respectively, the MHS has continued executing the transition of Military Medical Treatment Facilities (MTF) to DHA management in accordance with the Department's approved, conditions-based execution plan that meets the intent of Section 702 of the FY17 NDAA.

In the coming weeks, we expect to certify all remaining Wave 1 Market Offices (i.e, San Antonio, Colorado, Puget Sound, and Hawaii). The Tidewater market transitioned to DHA at the end of April. These critical markets account for 34 percent of the MHS' dispositions, 48 percent of the MHS's direct care expenditures, and 11 percent of the MHS's purchased care expenditures -- providing tremendous opportunities for continued standardization and optimization. Wave 2 Market Establishment planning is underway, and we plan to institute an intermediate headquarters to manage the remainder of our small hospitals and clinics in early June. There are still outstanding personnel transfer issues to resolve, however, that place at risk our ability to complete this transition by the congressionally established deadline of September 30, 2021.

Section 703 of the FY2017 NDAA directed the Secretary of Defense to submit to the congressional defense committees an implementation plan to restructure or realign military medical treatment facilities. This report was transmitted to Congress on February 19, 2020. The report articulated the DoD's decisions to align MTFs to increase the readiness of our operational and medical forces and achieve a proper balance between meeting readiness requirements and managing the total cost of health care in the direct and purchased care systems.

All restructuring efforts were paused on April 2, 2020 as a result of the resources required to respond to the COVID-19 pandemic. The Department is revalidating the assumptions made regarding its readiness requirements prior to the pandemic, as well as the assessment of network capacity to absorb additional patients where we intend to proceed with right-sizing plans. The DHA will take a conditions-based approach to any transition of medical services. In other words, transition will only occur when we are certain that local TRICARE networks can provide timely and quality access to health care. If they cannot, we will revise our plans.

MHS GENESIS IMPLEMENTATION

The Department continues to proceed with the multi-year implementation of its new, Electronic Health Record (EHR), MHS GENESIS. Although we paused a number of specific, in-person activities during the COVID-19 response, we still delivered the two Waves scheduled for completion in 2020, two currently in 2021, and remain on schedule for enterprise completion in 2023. As of today, MHS GENESIS supports the delivery of safe, high-quality data to patients and providers across 20 MTFs.

The value of MHS GENESIS has become even more apparent during the COVID-19 response. We were able to implement COVID-specific configuration changes in MHS

GENESIS within hours on several occasions that provided senior military and civilian leaders with timely information on COVID laboratory testing results and the health of our force and our beneficiaries; the same changes in our legacy systems took nearly four weeks to implement.

MHS GENESIS' mass vaccination capabilities have produced a significant improved workflow that allows the Military Departments to assess the status of service member inoculations in order to ensure readiness. For example, medical personnel at Twentynine Palms, California successfully screened 700 active duty Marine records within days of going live with MHS GENESIS in September. The process was so successful that Cerner made the solution part of its baseline product for commercial use.

DoD and VA continue to closely collaborate on a fully integrated EHR with the oversight of the Federal Electronic Health Record Modernization (FEHRM) office. The Departments collaborated with the FEHRM to launch the joint health information exchange (joint HIE) in April 2020, creating a single common gateway through which DOD and VA providers can send data to and retrieve data from participating private sector partners. With the FEHRM's leadership, the Departments support a Federal Enclave providing a single, common record with high cybersecurity standards, joint configuration boards to ensure standardized workflows, and shared risks, schedules and lessons learned.

TRICARE 5th Generation Contracts (T-5)

The Department continues to manage the TRICARE Program in a manner that seeks to reduce the growth in health care costs while ensuring our health benefit remains an exceptional tool for recruitment and retention of military personnel and their families. Among the most important strategies we pursue is the development of effective TRICARE contracts that deliver

high-value, patient-centric care designed to seamlessly integrate military and private sector care in support of readiness and health outcomes.

The T-5 contracts represent the next generation of contracts that provide DHA with the flexibility to adjust network requirements, improve professional services support, and adapt care delivery models in support of evolving mission requirements and changes in American health care delivery. After an extensive, multi-year engagement with Department leaders, industry, and other stakeholders, as well as three draft Requests for Proposal (RFPs) shared with industry, the Department issued the T-5 RFP on April 9, 2021. The goals of this procurement support (1) military medical readiness and the readiness of the medical force; (2) beneficiary choice; (3) high value care; and the adoption of Industry Business Standards.

The Department looks forward to healthy competition from industry and the inclusion of new health care delivery models in the coming proposals. As part of the T-5 process, the Department will conduct "Competitive Demonstrations" during the contract's period of performance. Twenty-one potential markets are identified in geographic areas where MTFs may rightsize, downsize or where DHA provides TRICARE Prime but no MTF exists. The RFP also specifies three innovations: Virtual Value Networks, Advanced Primary Care, and Care Collaboration Tools that will start with T-5 initiation and up to seven other demonstrations are planned during the life of the contract. DHA anticipates receipt of offeror proposals no later than August 13, 2021. The new contracts are planned to begin health care delivery in Calendar Year 2024.

MEDICAL RESEARCH AND DEVELOPMENT

The Department is grateful for the long-term advocacy and support for its military medical research program. The DHP research, development, test, and evaluation (RDT&E) focus is to advance the state of medical science in those areas of most pressing need and relevance to today's emerging threats, which includes the COVID-19 pandemic.

We seek to discover and explore innovative approaches to protect and support the readiness, health, and welfare of military personnel; to accelerate the transition of medical technologies to development and acquisition; and to accelerate the translation of advances in knowledge into new standards of care and treatment that can be applied in the field or in military medical treatment facilities.

In the coming years, we hope to leverage new technologies to include artificial intelligence and machine learning, biotechnology, and autonomous systems. The goal is to accelerate the transition of medical technologies to development and acquisition programs, and to further the translation of new standards of care to support and treatment that can be applied in the field or in military medical treatment facilities. We will seek to mitigate deployment-limiting medical conditions for service members by focusing on disease and injury prevention and rehabilitation.

The MHS continue to employ and strengthen our enterprise-wide performance management systems that provide stakeholders – both medical and line leadership – at all levels of the military with visibility into how we are performing on key metrics. These dashboards show longitudinal performance in measures of readiness, health, access, quality, safety and cost. We monitor critical indicators of quality and safety – – that point us toward high reliability as a system of care. Access to primary care and specialty care are measured along with patient satisfaction to ensure we are meeting patient expectations. We have provided Department leadership, MTF commanders and staff with visibility into COVID-19 specific measures that

include, but are not limited to operational hospital bed capacity and surge capabilities, timely laboratory test results, PPE inventories, COVID-19 vaccine target population and vaccine administration data, as well as important private sector care data.

Our dashboards can be viewed at an enterprise level, by Service, by market, and by individual hospital or clinic. We will continue to adapt this management system as the MTF transition progresses. Commanders can assess their performance against expected benchmarks, against peer institutions, and – where possible – against civilian sector performance as well. These dashboards help us to both assess how we are doing in these areas, and where we need to invest resources, training, or management attention in order to achieve further improvement.

OTHER SIGNIFICANT HEALTH INITIATIVES

There are several other health initiatives that merit comment – chief among these is access to timely, high quality mental health services and related activities to reduce the incidence of suicide among our service members, their families, and all beneficiaries. The Department is committed to the health, welfare and safety of our service members and families and we have undertaken a broad-based campaign encouraging service members to seek mental health treatment when signs or symptoms occur, help service members and their families to identify those signs and symptoms, and to de-stigmatize mental health care overall.

The DoD has invested in a number of programs to increase access to mental health care for Service members who are experiencing symptoms of a psychological health condition. Service members are eligible to receive free, comprehensive behavioral health care (including clinical assessment, psychotherapy, and psychiatric treatment) at their local military medical treatment facilities. We also have programs that embed psychological health providers in

operational units to assist Service members in their everyday work environments. The primary care medical homes provide follow-up when Service members disclose psychological health concerns to their primary care provider. Military OneSource is our 24/7 resource to connect Service members to information about their psychological health, non-medical counseling for stress management, and referrals to healthcare providers.

We have witnessed significant improvements in destigmatization and increased use of behavioral health services. Nonetheless, suicide rates remain unacceptably high. Suicide is a very complex issue with many biological, social, and psychological factors that contribute to suicide. In recognition of this complexity, the DoD implements a comprehensive public health approach to suicide prevention and intervention. The DoD is focused on using every available resource to support our Service members.

For example, Service members are screened for symptoms of psychological health conditions throughout their service. All Service members who are deployed in connection with a contingency operation receive a series of deployment health screenings designed to identify psychological health concerns, including posttraumatic stress disorder (PTSD) that may require referral for additional care and treatment. Additionally, all Service members, regardless of deployment status, receive a mental health assessment upon separation from military service to ensure documentation of any psychological health conditions and arrange for appropriate follow-up.

Currently, the DoD and VA are working together in the development of a single Separation Health Assessment that will include a Mental Health Assessment. This effort will make the separation process more efficient and improve the mental health care of our Service

members. Clinical Practice Guidelines have been formulated for all major clinical conditions in mental health, and Joint VA/DoD Clinical Practice Guidelines (CPGs) for mental health care facilitate delivery of evidence-based mental health care practices and strengthen the ability to maintain mental health readiness.

Beyond individual approaches, the public health approach also includes broader efforts, such as those targeted for our populations of greatest concern (young and enlisted Service members) and developing initiatives to support military families. For example, current efforts include interactive educational pilot programs to teach foundational skills to effectively deal with life stressors and to address help-seeking concerns and encourage use of support resources.

The Department continues to promote initiatives that increase awareness of risk factors for suicide, safe storage of lethal means (e.g., firearms and medications), and communicate how to intervene in a crisis. For example, DoD trained more than 2,000 non-medical military providers to provide Counseling on Access to Lethal Means (CALM) to Service members and families to increase awareness of risk factors for suicide, safe storage of lethal means (e.g., firearms, medications, and other lethal means), and how *to intervene in a crisis*. DoD is expanding on this pilot program for other influencers, such as spouses.

OVERALL FY22 BUDGET

The soon-to-be released budget will prioritize our resource requirements to address the COVID-19 pandemic and also address health care delivery challenges caused by the pandemic.

The Defense Health Program funding level that will be proposed by the Department in the FY 2022 President's Budget re-baselines health care program resources based on FY 2020 execution prior to the onset of COVID. Some residual risks remain, such as the COVID-related

effects of previously delayed care that may return, potentially deleterious impacts on beneficiaries' health due to delaying or forgoing care, unrecognized impacts of COVID-19 among asymptomatic or long-term, persistent disease, and the inherent uncertainty in predicting healthcare costs.

The MHS is not unique in the variability associated with predicting health care costs as all health insurers face these same challenges when forecasting their health expenditures for a given year. Changes in medical practice, demand for services, and new procedures and drugs are hard to predict. COVID has only exacerbated these challenges.

It is important to consider the FY22 budget request in the context of MHS cost control for the last ten years. Over the period of FY 2012 to FY 2018, both private health insurance premiums and National Health Expenditures per capita rose 25% (or 3.7% annually). However, the Department, working with Congress, instituted a series of initiatives that reduced DoD costs well below the rate of civilian growth. A combination of benefit changes, payment savings initiatives, contract changes, and population reductions masked underlying increases in health care costs. Starting in FY 2019, cost patterns returned to normal growth until the COVID pandemic significantly reduced the utilization of health care services beginning in March 2020.

The Department continues to pursue efforts focused on internal business process improvements and structural changes to find greater efficiencies, such as further integrating and standardizing the operation of hospitals and clinics; continuing the deployment of MHS GENESIS; modernizing clinical and business processes; and, streamlining internal operations. The Department is not requesting any additional changes to beneficiary cost-sharing in the FY22 budget.

The Department remains vigilant about variation in year-to-year expenditures, and we are appreciative that Congress continues to grant the Department carryover authority each year. Carryover authority allows DoD to maintain better funding flows to minimize disruption of health care services to our beneficiaries. We are committed to making our health care cost projections even more transparent in the year of execution, providing regular updates to the committee, and providing full visibility to Congress on potential plans for reprogramming funds within the fiscal year should that possibility unfold. Furthermore, we will ensure that available funding is directed toward unfunded medical readiness and health care delivery requirements. Carryover authority is an invaluable tool that provides the Department with needed flexibility to manage issues that emerge during the year of budget execution.

When released, our FY22 budget will present a balanced, comprehensive strategy that aligns with the Secretary's priorities, to include the ongoing response to the COVID-19 pandemic, and continues to fulfill our requirements associated with our congressionally directed transition. We look forward to working with you over the coming months to further refine and articulate our objectives in a manner that improves value for everyone – our warfighters, our combatant commanders, our patients, our medical force, and the American taxpayer.

Thank you for inviting me here today to speak with you about military medicine and our response to the global pandemic, the essential integration between readiness and health, and about our plans to further improve our health system in support of the National Defense Strategy and for our beneficiary population.