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STATEMENT BY

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Mr. Chairman and distinguished members of the Committee, thank you for the opportunity to come before you today to discuss the care of injured and wounded service members serving in Operations Enduring and Iraqi Freedom. The efforts of the Army Medical Department are extraordinary in this arena.

Let me begin by addressing the Medical Holdover Program or MHO as we refer to it. MHO status specifically applies only to our Reserve Component (RC) Soldiers who are mobilized in support of the Global War on Terrorism. These are Soldiers who need to remain on active duty following a medical evacuation or redeployment to receive medical care. Our experience to date is that about 8 percent of the mobilized force enters the Medical Holdover System. About 2 percent come in during pre-deployment training, another 3 to 4 percent as medical evacuations from the theater of operations, and 2-3 percent enter the MHO system upon redeployment. That translates to approximately 1,000 new MHO patients every month. We finalize their care and out process about the same number as enter the system each month.

Since November 1, 2003, we have processed nearly 16,000 medical holdover patients. About 10,000 of these service members were treated and successfully returned to their units. We performed Medical Evaluation Boards (MEB) on the remainder, and assisted them through the Physical Disability Evaluation System (PDES).

As you are aware, we initially had serious problems with our MHO program in the October/November 2003 time frame. I would like to spend just a moment letting you know how far we have come since then.

One of our first “fixes” was the establishment of the 25-day rule. This tool allows us to release Soldiers from active duty during the first 25 days of mobilization if they have pre-existing conditions that make them non-deployable. Since November 1, 2003 we have successfully identified approximately 9,000 non-deployable RC Soldiers. Another immediate “fix” was to ensure all MHO Soldiers are housed in facilities equal to that of permanent party Soldiers. The Army has met that standard 100 percent of the time for more than a year now. Additionally, the Army Surgeon General immediately ordered enhanced access to care standards for MHO patients: 72 hours for specialty referrals, one week for magnetic resonance imaging and other diagnostic studies, and surgery within two weeks. Our health care professionals meet those standards 89 percent of the time...we strive to do even better.

In the months following November 2003, many MHO Soldiers came to the end of their mobilization orders. At the time we had only one mechanism available to keep them on active duty to receive treatment: Active Duty Medical Extension (ADME). ADME, however, was never meant for the large numbers of Soldiers who entered MHO in late 2003. The Army quickly recognized this problem, and in less than 90 days published a policy establishing the Medical Retention Processing program (MRP), allowing rapid administrative entry into MHO. The Army is currently in the process of converting all remaining RC Soldiers mobilized for the Global War on Terrorism who are on ADME orders to MRP orders.

It takes people to effectively carry out these processes, and since November 2003 the Medical Command (MEDCOM) has mobilized or hired nearly 800 medical professionals solely for MHO care. Consequently, each MHO

Soldier is assigned to a nurse case manager whose role is to assist the Soldier through treatment and all associated processes and events. Additionally, at those Veteran's Health Facilities in which we have a significant number of Soldiers, we are also placing case managers to assist the Soldiers and their families.

In addition to manpower increases at the MEDCOM, the Physical Disability Agency (PDA), which falls under the Army's Human Resources Command, established an additional (fourth) Physical Evaluation Board (PEB) to decrease Board processing time. HRC also placed noncommissioned officers (NCO) at every mobilization station to assist the physical evaluation board liaison officers (PEBLO) and others assist MHO Soldiers with orders and administrative processing.

The Army has long recognized that it is sometimes beneficial to patient recovery to have family members close by. If a Soldier is seriously or very seriously ill or injured, the Reserve component family members are afforded the same considerations family of regular active component service members receive. They are brought to the bedside of the injured or ill Soldier when the attending physician and the commander of the MTF determine that the presence of the next of kin is necessary and will contribute to the recovery of the Soldier. Department of Army casualty officers are responsible for authorizing the Casualty Area Coordinator to use an open allotment fund for invitational travel orders for next of kin. These travel orders cover the cost of travel, lodging and per diem for a pre-determined time period, and extensions are possible and decided on a case-by-case basis.

As we examined our practices, we recognized that we medically could – and should - allow MHO patients to live at home when possible. Consequently, the Army launched the Community Based Health Care Initiative (CBHCI) in Dec 03, and created five Community Based Health Care Organizations (CBHCO). This effort began as a pilot project in Arkansas, California, Florida,

Massachusetts, and Wisconsin. Their mission was – and is – to provide command and control for MHO Soldiers while they live at home, work near home, and receive medical care in their communities. The existing CBHCOs now cover Soldiers from 23 states.

Soon we will open three additional sites, and provide coverage for the entire United States. One very tangible benefit of the CBHCOs is that they allow us to better leverage the capabilities of the TRICARE Network, the Veterans Health Administration, and Navy and Air Force medical treatment facilities (MTFs). For instance, CBHCO patients who live in the catchment areas of Navy and Air Force MTFs are enrolled to those military service MTFs, regardless if they are Army, Air Force, Navy or Marine service members.

To evaluate the success of these solutions, the Army sent review and assessment teams to every site that cares for MHO Soldiers. Led by the Assistant Secretary of the Army for Manpower and Reserve Affairs, the teams included members from Forces Command, Army Surgeon General's Office, Installation Management Agency and Human Resources Command. Results confirmed that we have made progress, and that we need to continue our efforts to improve this system. To that end, the teams begin a second round of assessments in March 2005.

Of the lessons learned, they found that MEBs and PEBs may not be welcome events in a Soldier's life if he or she wishes to remain in the Force. Since 35 percent of our MHO Soldiers undergo a medical evaluation board (MEB) and go on to a PEB, we continually work to improve the experiences of Soldiers who enter the Physical Disability Evaluation System.

The Soldier enters the Physical Disability Evaluation System when the medical community makes the determination that the Soldier falls below medical retention standards. This requires a Medical Evaluation Board. This Medical Evaluation Board then refers the Soldier to one of three fixed Physical Evaluation Boards, which are located at Washington, D.C., San Antonio, Texas and Fort

Lewis, Washington or to the recently establish fourth mobile PEB. The PEB, without the Soldier present, renders an informal decision which indicates a disposition and conveys this decision to the Soldier, usually within two days. The Soldier can accept these findings or request a formal board with a personal appearance and representation by legal counsel. Formal boards on mobilized Reserve and National Guard Soldiers are held within thirty days of the Soldier's request. Following the final board, the case is forwarded to the Physical Disability Agency (PDA) located at Walter Reed Army Medical Center for final processing. The Physical Disability Agency reviews all cases in which the Soldier disagrees with the findings. When the case is complete, the PDA notifies the commands and the transition center of the Soldier's disposition; fit, return to duty, separate without benefits, separate with benefits, placement on the Permanently Disabled Retired List (PDRL), or Temporary Disabled Retired List (TDRL). The Soldier is given up to thirty days to comply with these orders. During this process, the Soldier can submit his application to Continue on Active Duty (Reserve). If that occurs, then this request is forwarded to the Soldier's Command (either State or HRC St Louis) for action. This description only hints at the complexity of this process as the multiple commands assemble sufficient medical information to make a fitness/disability determination, sufficient administrative information to process the Soldier for separation or retirement, and sufficient counseling information so that the Soldier can make an informed decision and be aware of the rights to appeal during these proceedings.

You asked us to also provide information on the role of TRICARE in support of injured and wounded service members. Fortunately, the TRICARE system has been built to assure access to health services for active duty personnel and their families, regardless of location – whether they live on or near a military installation or in a remote area. Because of the widespread TRICARE networks, contracts with health care providers, access policies and procedures are already established. We have a solid foundation on which to make modifications to suit the unique requirements of the large numbers of returning Soldiers and their family members.

CBHCOs are managing the care for Soldiers at or near their home locations. Additionally, use of TRICARE assistance lines allows for the identification of TRICARE providers, access to care and claims process management. A tremendous amount of coordination is still required, but the availability of the TRICARE system helps ensure a reasonably smooth access to care for these Soldiers.

With regard to family members – when a Reserve Soldier is called to active duty for more than 30 days in support of a contingency operation they have full TRICARE coverage up to 90 days before the Soldier starts the tour of active duty. Family members are automatically assigned TRICARE Standard coverage during this pre-mobilization phase, and can enroll in TRICARE Prime, if they reside in a Prime area.

Once the Reserve Soldier starts the active duty tour, the family members retain full TRICARE coverage of their choice: TRICARE Prime; TRICARE Prime Remote; TRICARE Standard; or TRICARE Extra, depending on what is available in the area in which they reside. Incidentally, this is the same coverage for family members of any active duty Soldier. Throughout this entire time, pre-mobilization through tour of active duty, family members are also eligible for the TRICARE Dental Plan with reduced premiums.

After the active duty tour in support of a contingency operation is complete, the Reserve Soldier and family members may continue with full TRICARE coverage of their choice for 180 days under the Transitional Assistance Management Program (TAMP). During TAMP, family members are eligible for readjustment counseling through the Department of Veteran's Affairs. Before a Reserve Soldier's TAMP benefit ends, the Soldier and family members must decide to continue healthcare coverage with TRICARE or not. The choices to continue with TRICARE include the Continued Health Care Benefits Program (CHBP) for up to 18 months following TAMP and the

TRICARE Reserve Select Program – a new benefit for Reserve Soldiers and family members.

TRICARE Reserve Select or TRS, is scheduled to be implemented on 26 April 2005. With this program, TRICARE Standard healthcare coverage for Soldiers and family members is available immediately after the 180 day TAMP period. The length of coverage depends on two things: First, for every 90 consecutive days of active duty in support of a contingency operation, the Reserve Soldier and family members are eligible for one year of purchased TRS coverage. (For example: 90 days service equals one year's eligibility for TRS, one year service equals four year's eligibility for TRS; etc.) Second, the Reserve Soldier must sign a service agreement committing to stay on active Selected Reserve status during the years of TRS coverage.

The family members of a Reserve Soldier called to active duty for more than 30 days, but not in support of a contingency operation are not entitled to pre-mobilization healthcare coverage, TAMP or TRS. However, as long as the orders are for more than 30 days, the Reserve Soldier's family members are entitled to the same full TRICARE coverage as any active component Soldier's family members. When the Reserve Soldier begins an active duty tour, the family members receive full TRICARE coverage of their choice depending on what is available in the area in which they reside.

Taking care of families can mean more than routine TRICARE services. It's recognizing when Soldiers need additional support. In April of 2004, the Army introduced the Disabled Soldier Support System or the DS3, providing severely disabled Soldiers and their families with an advocate -- support in assisting America's sons and daughters as they transition from military service back into their civilian communities.

When a Soldier receives a disability rating of 30 percent or greater, and a special category designation, the Soldier is classified as DS3-eligible. These special categories include loss of sight or limb, permanent and unsightly disfigurement of a portion of the body normally exposed to view, incurable and fatal diseases, established psychiatric condition, or paralysis.

The initial focus of DS3 is to provide support to each Soldier seriously injured during combat operations, but will eventually expand to those Soldiers severely wounded since the beginning of the global war on terrorism. DS3 provides Soldiers and their families with a personal DS3 advocate, called a Soldier/family management specialist. This specialist ensures Soldiers understand the numerous support programs available to them and provides the Soldier with assistance in completing administrative requirements to receive support that is so well deserved. DS3 maintains contact with the Department of Veterans Affairs, Labor Department and other organizations that assist veterans.

The intent is to better integrate existing programs to provide holistic support services for our severely disabled Soldiers and their families from initial casualty notification to the Soldier's return to his or her home station and final career position. DS3 will also use a system to track and monitor severely disabled Soldiers for a period up to five years beyond their medical retirements to provide appropriate assistance through an array of existing service providers.

One of the tenets of the Army's Warrior Ethos is we will not leave a fallen comrade behind. That principle applies both on and off the battlefield. With that thought, let me close with two points. First, the Army has already provided an enormous amount of world class care to injured and wounded members of all the Services, and will continue to do so. Second, the Army could not perform its mission without the Guard and Reserve. They are equal partners with the active component, and when any of them falls ill or injured, we will not leave that Soldier behind. Thank you.