Assistant Secretary Thomas McCaffery
Health Affairs

Defense Writers Group
Project for Media and National Security
George Washington School of Media and Public Affairs,

11 June 2020

DWG: Mr. Secretary, thank you for joining us for this conversation.

A/S McCaffery: I'm happy to be with you day.

DWG: We're delighted and honored to have you with us. We're going to do a one hour Q&A conversation on the record. I think it's timely given your area of work and given, I mean the very fact that we're having this conversation not face to face but instead remotely speaks to some of the issues that you're dealing with.

I'm going to start this Defense Writers Group conversation by just asking you to kind of tell us what you're working on right now as Assistant Secretary of Defense for Health. I presume COVID-19 is occupying most of your time. Is it pretty much all of what you're doing? What are you doing about it? And are there other issues and if so what are they that you're having to spend time on as well?

A/S McCaffery: Thank you.

I should say I came on board at the department August of 2017 so I kind of consider myself a relative newcomer, but I know everybody on our communications teams have always characterized this forum as one of the best ways the department can get out information and have a dialogue, so I appreciate you all spending time with me.

Yes, that's a great opening question. I would say I'm spending probably 80-90 percent of my time on the military health

system's response to COVID. That wouldn't surprise you.

It's interesting, I came on board without really, without any background in the military or the military health system, and one of the things that I found really interesting and somewhat challenging was the fact that in the military and on the active duty side there is continual change at leadership levels. You know, leading a hospital, leading a region. Every two to three years. From my private sector experience I was like wow, that's a challenging dynamic if you're wanting to make long-term change and put something in place, you've got a leader in two years and then he or she is gone.

What I've learned, though, is there's a flip side to that. That is our uniformed leaders and our civilians are exceptionally good at adapting to change. It's not something unique, they're not used to it. It's like part of the culture, part of their DNA. And I found that with the pandemic response that the health system leadership -- it's quite easy for them to quickly pivot and say yeah, we've got a lot of stuff on our plate. Some of the reforms we're doing, the rolling out of our ERR, but now we've got to pivot and adapt to respond to the pandemic.

Obviously you all are aware of what I would say the front line or the headline areas -- our deployment of medical forces for the domestic response; the ability of our folks to adapt. You know, usually our medical forces are deployed, whether it's overseas or domestically, for more like trauma-related efforts. This was vastly different, a very different enemy. As we saw in New York City we had several hundred of our uniformed medical providers actually helping staff civilian hospitals. So that's been a core piece of just that hands-on deploying, having our medical infrastructure help the nation.

The other thing that's really, a show of being able to pivot really a large focus on the military health system's effort with the pandemic is on research and development. I spent over 20 years in the healthcare sector, both private sector and

California state government, so I kind of considered myself fairly educated on healthcare, but it wasn't until I got here to realize just the enormous role that the military health system plays in medical research and development. Obviously for operational military purposes, but it often translates into support of kind of larger social, civilian healthcare sector.

A great example of that is obviously we do research on vaccine, medical countermeasures for military purposes, keeping our troops safe, but we were very quick to pivot and leverage that kind of research that has already been going on for our military purposes to how can we use that and pivot to focusing on vaccine research and development for COVID, therapeutics for treatment. So we are very quickly focusing our energy and effort on that.

So I think in terms of answering your question, it is kind of a COVID all day every day, and what we want to do is be able to figure out how we continue that support while moving some of the other significant changes in the healthcare system forward.

DWG: As a follow up, do you happen to have and could you give us how many cases in the military there are as we speak? How many deaths there may have been, if any, and whether the apparent increases in certain states are having an impact on the military.

A/S McCaffery: As of my latest data, as of yesterday, so total cases for DoD -- when I say for DoD, that's active duty, that's our civilian employees, dependents, contractors. It's just over 11,000 total cases. And then we have 36 deaths in terms of that denominator.

Right now we're hearing about different upticks in different areas. We have existing surveillance programs. Again, nothing to do with necessarily COVID specific but just our normal course of business that we watch that. As of right now we're not seeing anything that we believe we can't address it like we've been addressing it over the last three months. But as you say,

it's something that we have measures and frameworks in place that we're constantly monitoring it. We also are doing regular testing for certain categories of our active duty, you know, based upon mission essential activities so that's another source of our ability to find out if we see any upticks in our forces.

DWG: Thank you.

I'm going to go down the list now of people who signed up for this event. Some of you have already told me you won't have a question but I'm going to ask everybody if they do in this order.

The first person is Michael Gordon of the Wall Street? Michael, do you have a question?

DWG: Yeah, thank you.

Sir, you explained how you pivoted to work on the COVID vaccine for the sort of larger good. I basically have tow related questions.

One, can you please explain how that decision was made? When it was made? Was this something that was done on your own initiative? You were directed to do by the administration? Did you ponder it for a period of time before deciding to pivot that way? If you could just explain that a little bit.

And since COVID is not going away any time soon and it's not clear there will be a vaccine in January. And even if there is a vaccine sometime next year it has to be scaled up. This looks like a situation that might be here to stay for a while.

So what is your longer-term planning in the event that COVID lasts really through next year and perhaps beyond as a phenomena?

A/S McCaffery: Your first question, I probably can't go back

and pinpoint the date, but I would say immediately in the January/February timeframe when everyone was starting to see kind of globally where this was going, that it was really headed to a global pandemic, we kind of immediately were looking to our research folks and saying well what are we doing in this area that can be leveraged? So that was one of the things that was kind of immediately identified. Where are we on our research? How can it be leveraged?

We then brought that to our senior leaders with some ideas about how we could accelerate and redirect research dollars on other areas to the vaccine and therapeutics development.

That is what I would say normal course of business for the department. That was made fairly early on. We are in execution mode of accelerating where we can, you know, different vaccine candidates and different therapeutic candidates.

Your second question, one thing I've learned in my time here is that the military is always planning for the worst case scenario. So while we are hunkered down and focused on as early as possible, getting vaccines and therapeutics available for our active duty, we also know that we don't know where that's going to go. I think right now we have in place a very good comprehensive framework that has been out beginning in the end of January in terms of force health protection guidance. You know, what needs to be in place when we have a pandemic in terms of following the CDC guidelines, issues around travel restrictions, access to bases. Everything that you'd need to have in place if indeed this pandemic becomes somewhat of a new normal.

So I think we're good for the long term and we're pushing really for the quickest and safest way to get that vaccine out there and therapeutics out there.

DWG: Patricia Kime of Military.com.

DWG: Thank you so much.

Before the pandemic began obviously the services were planning to cut the 18,000 military billets in healthcare and administrative folks. Have you all looked at sort of the lessons learned yet and whether those cuts are still needed?

And what are you doing in terms of analyzing the COVID response and rolling that into the planned reforms that are going on at DHA?

A/S McCaffery: I think you've kind of mentioned a couple of different distinct reform lines of effort. One on the military manpower, for the rest of the group. Last year the department proposed repurposing around 17,000 medical billets for, based upon the military department's assessment of what their manpower requirements were and where they could repurpose those to other higher priorities. Congress has directed the department before it can move forward or execute that proposal, it needs to come back to Congress with a very detailed plan. You know, who are those billets, what type of billets, at which of our facilities, and over what time period? They've mandated that we do this this month. The department will be submitting its final proposal that will articulate what we intend to do and over what time.

And obviously part of any implementation of that or other reforms obviously will be tied to what have we learned and what are we learning with regard to the pandemic and its impact on the military health system and the ability of our health system to support the military requirement.

I think you reference, Patricia, similar reform with regard to how we are looking at our MTFs and the scope of services they provide tied to their readiness mission and if we came forward with a proposal for certain MTFs to have that scope of services change, and what's our ability to have that change be absorbed by private sector healthcare networks? And obviously we are

going to need to -- that implementation has always been conditions based.

Our number one priority is making sure whatever we do we maintain access to care for our beneficiaries and obviously if in the local community the COVID response has affected that private sector network, we're going to have to consider that as we implement those changes.

DWG: John Server, are you on? Do you have a question?

DWG: I am, thanks.

Actually just to continue on that thread on the MTF restructuring. The GAO view on this seemed to have been that the list that you initially published in February was based on just way insufficient data on private sector care availability. So to what degree to you concur with that? How much more data do you think you'd need to bather before you actually moved to implementation of some kind?

A/S McCaffery: We've looked at the GAO report and want to make sure we address some of the issues they've raised. We think on the private sector piece, again, when we submitted this report in February we made it very clear that that was the key driver here. That we have to, whatever change we make, we've got to maintain access to care for our beneficiaries. So obviously that only works if that private sector network is available and can absorb that. We've even stated in our report that this change is conditions based and it may not, in some communities it could very well take two or three years.

We've also said that if we had a plan for a change as we started to execute that plan the conditions or the assumptions we made changed, that we're going to have to revisit our plan.

But to the network question, you know, one of my prior lives is working for a health plan. So we had very similar issues we'd

have to deal with in terms of access to care, adequacy of provider networks.

I believe the department did a very solid job in terms of how many of those determinations -- we looked at three different sources of network adequacy. We worked with our own TriCare program, and their knowledge of what's in our TriCare network. We did ask the local MTF commander and installation commander their experience on the ground. And we used a commercial too, a tool that other health plans use to evaluate network adequacy. So I think we did do good due diligence in data before we made our recommendations on change.

DWG: A quick follow-up, if I could. Based on the analysis that you've done so far, do you have a sense of when the first of those 40-something closures and restructurings could actually be implemented?

A/S McCaffery: That's a good question because because of COVID, we were on the path before COVID of likely having at least for some -- there's like 48 facilities and these are largely out-patient facilities that we had proposed for some level of scope of service change, that we were looking probably at the September timeframe for some of those early facilities to actually have a developed implementation plan. That's unclear n ow if we're going to have that in September because of the requirement of the health system that we really have been diverting more time and resources to the COVID response.

So it could be something more towards the end of the year that we'd have a better idea, out of those 48 which ones do we think are going to be earlier in implementation versus later?

DWG: Army Magazine, Jen? Are you there? Do you have a question?

DWG: No question for me. Thank you.

DWG: Ellen Milhiser, Synopsis?

DWG: Hi, a couple of things. First of all with the COVID pandemic [inaudible], is this making y'all rethink the idea of moving medical research over to DHA or does the Secretary still want to keep it in the Army?

Second of all I see that WRAIR, the Walter Reed Army Institute of Research, has announced today that they're advancing a vaccine candidate. I was wondering if you would like to speak on that?

A/S McCaffery: On your first question, right now the way the department does medical research and development it's really kind of across several entities. So each of the services does have a little bit of their own funding where they will fund kind of certain service-unique efforts. But the lion's share of the medical R&D funding for military purposes that the department gets actually comes to my office. So Health Affairs under our Defense Health Program appropriation. And what we do is we then work with the rest of the department and the services to determine based upon priority requirements of the combatant commands, the military services, where do we allocate those dollars? And oftentimes we'll allocate it to, for example, to the Army to carry out research that benefits the entire department but also the Army.

We think that approach works well. We're going to continue that and I can't tell you which one of the vaccine candidates you mentioned from Army. That one that was funded by kind of the DoD pot versus the Army pot. But I can tell you across the board we're looking at about five or six different vaccine candidates in terms of the DoD and that's one of them.

DWG: Terra Kopf, are you on? Do you have a question?

Shaw Naylor, Yahoo News.

DWG: Hi. I want to talk to you about Operation Warp Speed which obviously has a significant DoD component. There's been a lot of expert skepticism about the guarantees that have been given by senior leaders about a vaccine being widely available on the first of January.

So my question, did DoD and the medical experts inside DoD have any input into that date? What were your scientists telling you? And if not, how did that date come about?

A/S McCaffery: I think your overall question, what's interesting, what I've learned coming on board here is that Operation Warp Speed is really kind of formalizing the ongoing natural working relationship that HHS has with other parts of the government that are doing medical research and development. I mean Operation Warp Speed is really under the tutelage of HHS. What we're doing in terms of our own R&D no vaccines and therapeutic treatment is we're making sure that we simply are linked up with that HHS effort in support of the goals that have been identified in terms of getting a vaccine and therapeutics out there.

So I would characterize it as this is a formalizing the natural relationship we have with HHS and others. I think the added thing here that HHS is doing is they're bringing on board the private sector kind of to help partner there. So that's where we are on our piece of Operation Warp Speed.

DWG: That doesn't actually answer my question, though, which is what input did DoD and your scientists have to this first of January date? And what are they telling you about the plausibility of that?

A/S McCaffery: I think that's a question in terms of, that I'd really ask you to, I would kind of refer you to HHS in terms of the specifics of the date and the target, the dosages and all that.

What I can tell you is our researchers, not just because of COVID, but our researchers in vaccines always are communicating with HHS and all the entities over there in this area. So definitely what we're doing, where we are, progress on our candidate, what our expected outcomes are has all been put on the table with HHS so that they have that data and information to come to their conclusions about which candidate fits the target, what the appropriate goals are. But indeed, everything we have and what we're doing was part of that equation.

DWG: John Harper, National Defense Magazine.

DWG: Thank you. Obviously right now the big focus is on COVID, but as you look ahead to the possibility of new epidemics in the future, to what extent will DoD be adjusting its biodefense enterprise? Do you need more funding for these types of programs? Do you need to do any restructuring? What do you see as kind of the road map or the vision for the future in this regard?

A/S McCaffery: That's a great question and really it's a good linkage to, I don't believe right now with regard, if you're talking about non-COVID where we have obviously with Congress we've gotten additional funding for a lot of COVID-related efforts including R&D. But putting that to the side, and you're talking about other threats, be it natural or manmade, that's an ongoing, that's kind of part of our core baseline R&D focus. Those investments have been made over the years. That's actually what put us in a place to eb able to leverage research and pivot to COVID.

So I'm comfortable that what we have in place allows us to pivot to -- our folks are always looking at what's the next thing on the horizon? What is it that we need to start researching now that we think may be an issue a year from now or two years from now or five years from now. That is normal operating procedure for the department. That's ongoing.

DWG: Just a quick follow-up in that regard. What are they looking at right now? You said there's sort of a lag time in what you're doing in a given period pays dividends down the road. Beyond COVID, what are they turning their attention to now that could be helpful in the future? Is there anything specific that the R&D folks are looking at in terms of threats?

A/S McCaffery: One of the areas that we were looking at that actually was able to be leveraged in part of the research with Remdesivir which recently got approved for usage in terms of a treatment for COVID. That was part of research that we were looking at at kind of Ebola-like viruses. So I'd have to get back to you in terms of giving you a specific what virus strain are we, have we identified as the next potential Ebola-like virus that we need to be ready for? On the chem/bio line which is more kind of outside of my area at the department, I would have to kind of get back to you. Number one, what are the things that we're looking at? And what are the things we can actually share that we're looking at just because of the normal intelligence security issues.

DWG: Gotcha. And you noted you've been given a lot of funding for COVID but do you anticipate that in the future you'll need more funding than you've been given in the past to deal with bio threats now that this is kind of maybe a higher priority issue for the department given what's going on now with COVID?

A/S McCaffery: That's one of the things that we're actually looking at, based upon our experience to date with COVID are there other areas, other requirements for additional resources? But we haven't come to a final conclusion about what those areas may be and what amounts. That definitely is something that we're looking at.

DWG: Lauren Williams, SCW. You're next. No?

Okay, Karen Jowers, Military Times. Do you have a question?

DWG: Thanks for doing this.

What is the asymptomatic COVID rate among troops? And have you drawn any conclusions about why the Air Force's infection rate is so much lower than the other services?

A/S McCaffery: No, we have not drawn conclusions on that. We're looking at all the data to see what the commonalities are between that, but we have kind of different pots of data.

So I think one of the best places to go would be to be looking at what came out recently from the Joint Navy CDC Surveillance Study from the carrier Roosevelt. There what we saw was from their sample that volunteered for the testing we saw about 20 percent that were infected but had no symptoms.

We're looking at that data. We're looking at the data from each of the services as they do more testing for operational purposes. We have started, in May we actually down at the Marine Recruitment and Training down in Paris Island we're doing a research protocol that would be doing the same thing. You know, before they start the training get a sense of how many have the virus, and then follow them through a three or four month period of their training to get a sense of how that, how things develop in that population.

I guess we don't have all the data right now to say we know exactly what that infection rate is across the board, how much of it are folks that are asymptomatic, but that's what we're continuing to do with all the data we are collecting.

DWG: And have all of the MTFs, the Military Treatment Facilities, returned to full service status?

A/S McCaffery: I would have to check because I think what you're referring to is back in March/April we like the rest of the country directed our facilities to suspend elective non-emergent procedures. And we have lifted that prohibition but

it's really tied to what's the condition of that local community, that local base to make that decision. So I'd have to go back and see how many of our MTFs have gone back to providing those elective surgeries and how many still are not doing that. But none of our facilities ever closed or weren't providing services during this time, it was just this elective procedures issue.

DWG: If you could get that, that would be great.

DWG: Travis Horton, Bloomberg Government.

DWG: Sir, I just wanted to go back and clarify some of your earlier statements and make sure that I understood what you were saying.

What I heard you say is that the restructuring of the MTFs is going to be delayed due to the pandemic and also the DoD is sticking with its plan to move the 200,000 beneficiaries to private care.

Also can you just remind me, do you need any further congressional authorization to do that restructuring? Then I have a follow-up, thank you.

A/S McCaffery: On your first questions, let me just kind of go back.

When we submitted the report that Congress required of us in February we very clearly articulated this isn't a, we present the report and we implement changes across these 50 facilities in a uniform way. It's very clear that it's going to be MTF by MTF based upon their local network conditions, and we were very clear to say that as we implement, and some of things, again, it's based upon the ability of that local network to absorb additional patient caseload. This could be a two or three or four year implementation. Again, unique to the MTF and their community. That's number one.

Being that it's conditions based and based upon the ability of that local provider network to absorb care, of course the pandemic is going to affect the timeline as to when that happens because if one of the key things is you need to be able to partner with the local provider network on taking additional cases and develop a plan for that, they may not be able to. Depending on where they are in the country and their experience with the pandemic on the ground, they may not be able to engage with us at this moment.

So I can't give you an across-the-board one size fits all answer. It's going to be MTF by MTF.

Then your second question in terms of additional authority. No, we don't need additional authority to proceed. This was a congressional requirement that the department do this analysis and make a recommendation. We had to wait, we had a certain period after submission of the report before we could take action so that time has passed, but again, we are grappling with the pandemic's impact not just on our health system but the local private healthcare system before we can start executing these implementation plans.

DWG: And if I could just follow up, I wanted to ask you about the billets. You said that DoD is wrapping up the assessment on the 17,000 billets and expect to deliver that to Congress this week. I'm wondering about that number, the 17,000, 16,000 to 17,000. Do you expect now that you're probably seen parts of this assessment or what is near a finished product, do you expect that number to change? To increase or decrease? Thank you.

A/S McCaffery: We are still in the final stages of coming to conclusion on what the department's final plan is going to be, what our final proposal is both on numbers, scope and timing. So I don't want to get out in front of the Congress on that or the department. We're taking all the data that we have, that we

had before COVID, what we have now, and that will be reflected in what we put forward publicly to Congress by the end of the month.

DWG: Richard Burgess, Sea Power Magazine. Do you have a question?

DWG: Yes, thank you.

My question is, several years ago Defense Secretary Gates talked about how the health portion of the defense budget was eating the budget alive. So my question is, in the current situation do you feel like the health portion of the budget is slowing down in the sense -- pre-COVID I'm talking about here I guess. But is it still eating the defense budget alive or has it been brought under control to an adequate level do you think?

A/S McCaffery: I would say based upon data, and I'm kind of going off the top of my head which probably is dangerous, but if you look at the cost of our private sector care budget. So this is the dollars that we contract with for our TriCare providers to provide care to our beneficiaries, and you look at the overall healthcare budget. Over the last five or six years, that budget has stayed fairly stable. Maybe a little bit of an increase. I think that's a reflection of changes the department's made, changes that Congress has supported with regard to the benefit. And as compared to the private sector healthcare costs it's much better performance. Again, I'm going off the top of my head in terms of how significant that difference is.

Long story short, I think the department's done a good job managing the healthcare budget. But like any large employer, you're always looking to see, you know, what do you predict or project to be costs in the future and what can you do to better manage those costs?

I think we're in a good spot but we've got to be vigilant and

we're always doing that. That's actually one of the things that we're already in the midst of developing the next procurement for the TriCare program and that's one of the things we're going to be looking at is what do we need for our health plan partners in that next round to continue to manage costs while ensuring we've got good outcomes for our beneficiaries?

DWG: Anybody on the line, any journalist on the line who has not had a chance to ask a question and wants to?

Unless I hear somebody in the next five seconds or so, I'm going to go back to the top of the rotation.

But Mr. Secretary, let me just ask you this. National Guard forces have been used in a number of states to assist law enforcement in the period when there have been largescale protests after the killing of a black man by a policeman in Minnesota. And I've seen some reports suggesting that some of these forces that were deployed have since contracted COVID-19. I'm wondering, are you looking at this at all? Is it a concern?

A/S McCaffery: We definitely are looking at that, and one of the things that we the department get on a daily basis is reports of, and it would include National Guard that are on deployment, what are their positive cases. So we monitor that like we do kind of the regular active duty to see if there are any sentinel events that we think oh, this is an outbreak that we should be concerned about and get on.

Putting that aside, we would treat them like anyone else that we identify with a communicable disease and that is you provide whatever medically necessary care there is, you do the contract tracing to ensure --

DWG: Mr. Secretary, I've lost you.

A/S McCaffery: Are you there? I can hear you.

DWG: Mr. Secretary, you're breaking up.

DWG: We can still hear the Secretary.

DWG: Somebody's typing.

DWG: Somehow I've been blocked.

A/S McCaffery: I can hear the journalists.

DWG: We can hear you. Go ahead, please.

DWG: Just like any other case, we would immediately provide the necessary care and ensure we're doing the contact tracing as appropriate in terms of public health mitigation. I'm not sure if that's responsive to your question or you were looking for something more.

DWG: I'm really just interested in the extent to which you're looking at this, whether there's a concern about the use of National Guard forces or I suppose potentially others in these law enforcement situations or protest situations that are around the country because of this terrible killing in Minnesota.

We're in the middle of a COVID-19 pandemic which is affecting all parts of the United States society, but as the National Guard is asked to come in and be in crowded places with lots of people, is that a concern for you in the health area?

A/S McCaffery: It would be a normal concern whenever we call upon our active duty including National Guard to carry out a mission that they are focused on that their well-being, their training beforehand, what they are doing during that mission, post-mission, we always would make sure that we're doing all we can to protect the force.

For example, we had many people deployed in New York City in a hot spot, so similarly we'd make sure before they got there what

they needed to be prepared for. When they left, you know doing that surveillance and the testing to make sure we knew then what to do when they returned home. So I would put the National Guard deployment in the same category. They're carrying out a mission and our job, our duty is to make sure that in carrying out that mission they're prepared for it and whatever healthcare they need as a result, they're getting as appropriate.

DWG: We have a few more minutes.

Michael Gordon, do you have anything you'd like to ask? Or Patricia Kime?

DWG: I'd just like to follow up on your question. How many specific cases have come to your attention as a result of the deployment of the National Guard all around the country for their recent mission? Since there were so many of them so many places. And did you really have a systematic contact tracing policy to run down all of these deployments throughout the United States and stay on top of possible COVID cases among the National Guard? Or did you leave that up to individual Guard units?

A/S McCaffery: In terms of the number of cases, I don't have it broken down in front of me. We can get you that in terms of National Guard cases.

In my earlier comments about what would be kind of standard operating procedure, it would be right now if an active duty National Guardsman tested positive he or she is required to report that up the chain so we're aware of what's happening on the ground. He or she gets the care. It would be a normal public health response. It may not even be that it's a DoD public health response but if it's a positive case that's going to get reported to the local public health department and they are then required to do what would be the normal follow-up with regard to this kind of an infectious disease.

DWG: It sounds like you're saying there was in fact no special effort directed by DoD to monitor whether there were more COVID cases as a result of this. You're just waiting for this information to percolate up the chain.

But if you could give us into this group the number of cases that have come to your attention, because it is a little different than the New York situation. You have thousands of National Guard all around the country in urban places, pushed together at a time when the country was opening up probably prematurely and not everyone is wearing masks. So it seems like a situation in which there could potentially be a significant number of cases. Granted they would come in over time, but if you could relay that information to us through David I'd appreciate it. Thank you.

A/S McCaffery: We can do that.

DWG: Patricia, do you have anything you'd like to follow up on?

DWG: I do. Can we switch gears a little bit? There's basically a mandate out of Congress from last year about DoD testing all firefighters for PFAS contamination. And I'm hearing that they are not getting tested so I'm trying to figure out if there's a policy forthcoming about how they're going to be tested.

Also currently there's legislation in Congress that would mandate testing of all service members and families, so I'm wondering what approaches you all might be taking to test for PFAS in the blood of beneficiaries.

A/S McCaffery: I'm aware of the requirement with regard to taking a look at this and testing. I would need to get back to you, Patricia, in terms of where we are in that implementation. I have not seen the legislation you've referenced in terms of what's currently on the Hill, so I would need to take a look at that and get back with you.

DWG: Can you talk about the firefighters? Are you testing? Do you have any numbers for how many you've tested? Or is that like service specific? And are they reporting to you?

A/S McCaffery: I don't have those numbers. I'd have to get back to you on that.

DWG: Let me just as you, Ellen Milhiser, since Health is your bag, do you have any follow-ups at the moment?

DWG: Yes, I do. Thank you.

The Atlanta Demonstration Project on using Kaiser-Permanente and basically value-based care payment reimbursement models. Could you say anything about how that's going? I'm hearing that there are issues.

A/S McCaffery: I know we're about six, seven months into that. As you say, it really is one of the areas that we're looking at to test in our population value-based care approaches and how that can work under the TriCare program.

The last I've heard, it was going well. I believe we had maybe 2,000 to 3,000 people enrolled in that partnership with Kaiser. I am not aware, when you reference that there are issues with it, I'm not aware of any. That would be something I can go back to DHA and find out what the current status is and if there are indeed issues and what they are. But those are the types of things that we'd want to do more pilots of. How we can bring that more as a regular part of our TriCare program.

DWG: Jarod Serbew, do you have a question at this stage?

DWG: I do, thanks, David.

Mr. Secretary, I want to go back to Rick's question on cost. I think you said that as a general matter care delivery in the

MTFs is cheaper than in the private sector. If that's right it seems like that's in tension with the decision to move 200,00 people out of MTFs and into the private sector. Can you help clear that up for me?

A/S McCaffery: I want to make sure I'm understanding the question. So my earlier comments with regard to the overall healthcare budget for the department over the last several years being relatively flat. A little bit of growth. That's an aggregate figure. So that's a combination of our running of our direct care, so the care we provide through our own operated facilities in combination with the TriCare program, so --

DWG: I just lost sound.

A/S McCaffery: Can others hear me?

DWG: Yes.

DWG: Yes.

A/S McCaffery: So I'm happy to provide you kind of the data of that overall and then the breakdown between the private sector care piece of it and our in-house care.

So pivoting to your question with regard to the realignment of the MTF. The whole focus there, what Congress asked the department to look at was, in essence it was a reminder that we have DoD hospitals and clinics. We have that system to meet, those are military facilities to meet military requirements. That is the way we train our uniformed providers to have the skills to do what they need to do in a deployed setting and it's also our core ability to ensure that our active duty are medically ready to do their job.

So Congress said we want you, the department, to go back and review to ensure that that is the primary mission of those facilities. And they even kind of gave us criteria to look at.

So one of the things was if you are able to maintain that facility or focus that facility's core mission on those readiness objectives, and in that particular case, that community, that MTF, it is less expensive to send some of our patients to the private sector than it is to retain them at the MTF then that's the call you're going to make.

There are certain communities where there is either not a private sector network or it's insufficient and in that case we are not making any changes.

So it's conditions based, it's dependent upon the MTF and the community. But again, the focus there from Congress, which we share, is that the primary purpose of these facilities is to meet military requirements. And that was the guiding force there.

DWG: Just to clarify, it sounds like the bottom line in the cost question is that when you say the MHS is cheaper than the private sector, that includes purchased care and direct care.

A/S McCaffery: Yeah, that's the combined, what we spend on healthcare for our beneficiaries, both what I refer to as in-house through our facilities as well as through the private sector contracts. I'm happy to get you that data that will kind of give you looking back the last several years and how that compares to overall private sector healthcare expenditure.

DWG: That would be useful.

DWG: We just have a couple of minutes left. Shawn Naylor, do you have a burning question?

DWG: Yes I do.

Could you tell us have the Defense Department organizations that are working on vaccine development seen any increase in

attempted cyber intrusions since they began their work on the vaccine? And if so, which organizations? Were the intrusions successful? And who was responsible for the intrusions?

A/S McCaffery: I'm not aware of any attempted intrusions, so obviously we could go back and ask that of our folks but I'm not aware of any attempted intrusions. I do know that like any other of our research, that is one of the areas that we're always vigilant about. That's why we have such extensive cyber security rules and regulations, far more so than anything in the private sector. But we can check if there's anything on that and get back to you.

DWG: Great. Thank you.

DWG: John Harper, do you have a final question?

DWG: Yes, thank you.

Going back to COVID, obviously the goal of Operation Warp Speed is to have a vaccine in place by the end of the year.

If you had to do odds-making on that, do you think it's more likely than not that a vaccine will be ready? Or do you think it's kind of a long shot?

And on a related question, once a vaccine is ready, regardless of when that happens, will DoD personnel be given priority or kind of put at the front of the line to receive that vaccine given their importance for national security?

A/S McCaffery: On your first question, I'm not a scientist or a researcher. I don't want to come to the table and give you an odds on what's the likelihood of when that vaccine will be on the market and in what quantity.

On your second question, we obviously, we, DoD, would need to work very much hand in hand in an all of government effort on

vaccines to make sure what we need to meet mission we have available to us, but in concert with what's going to be the national demand.

So that obviously will be an issue. I can't tell you right now how that's going to play out and what kind of decision-making process to come to those conclusions. But clearly we have a role to play, we'll need to do what we need to do to make sure we can meet that mission. We're going to do it collectively with an all of government response.

DWG: Mr. Secretary, I'm just struck as we end here, kind of fate has intervened and given you, you got this job of running the health sector for DoD at a really historic and difficult time. I'm just wondering what any, have you got any final thoughts? Anything that's really struck you or surprised you as a result of being in the hot seat during this time?

A/S McCaffery: I think what I touched upon at the beginning. I have found this to be a very fulfilling job. I did so when I came on board early, you know, long before COVID hit, and to see an organization that is very much mission driven. Folks committed to the well-being of our warfighters. What has really struck me, as I said early on, is my observation, being a non-military person, the culture of the ability of the organization to quickly pivot and adapt. I mean in the overall military, the m health system. It's very much hey, we might have been on one path. The enemy, so to speak, has changed our direction and we need to be able to adapt accordingly. And to see what happened early on in our ability to deploy our forces, you know, the two hospital ships, to quickly get field hospitals ready to go . It was like clockwork. And it just struck me as a real positive attribute of the military and the professionalism and so it's kind of given me, it's been fulfilling.

As you say, three years ago was I expecting to be dealing with a pandemic? No. But working on it with the rest of the

department has given me confidence and assurance that we, the department, are going to be central to, have been central and will be to the all of government response.

DWG: Thank you very much, sir, for taking time to talk to us today about this important stuff. The COVID-19 pandemic obviously is on everyone's minds.

Before we sign off here, can I just thank Carnegie Corporation of New York, our sort of anchor funder to the Project. Thanks again.

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