SECRETARY OF THE ARMY
WASHINGTON

20 DEC 2019 15:00
OUT

INFO MEMO

FOR: DEPUTY SECRETARY OF DEFENSE

FROM: RYAN D. MCCARTHY

SUBJECT: Status of Medical Reform Efforts

I am concerned about the lack of performance and planning of both the Defense Health Agency (DHA) and DoD Health Affairs with respect to the MTF transition. Both have failed to provide a clear plan forward with respect to policy and budget. Until the DHA provides a detailed budget strategy by location and Budget Activity Group (budget template attached) AND a clear plan to transition the functions from the Services, I recommend we halt transition of MTFs from the Services to the DHA. Secondly, I request your support for the Army's legislative proposal to repeal the portion of the NDAA FY 19 legislation, which transfers Army Public Health and Medical Research and Material to DHA (legislative proposal attached). Until DHA can demonstrate they can manage our hospitals, I have serious concerns about their ability to lead our public health, research and development, and operational logistics assets.

COORDINATION: NONE

Enclosure

Prepared by: Ms. Jennifer Daugherity, 703-697-3844; LTC Scott Mras, 703-614-1952

1 **SEC. ___. REPEAL OF THE REQUIREMENT TO ESTABLISH THE DEFENSE**
2 **HEALTH AGENCY RESEARCH AND DEVELOPMENT AND DEFENSE**
3 **HEALTH AGENCY PUBLIC HEALTH.**
4 Section 1073c of title 10, United States Code, is amended—
5 (1) in subsection (d) by striking "as a combat support agency under section 193 of
6 this title".
7 (2) by striking subsection (e); and
8 (3) by redesignating subsection (f) as subsection (e).

[Please note: The "Changes to Existing Law" section below sets out in red-line format how the legislative text would amend existing law.]

Section-by-Section Analysis

This legislative proposal would repeal the requirement for the Secretary of Defense, acting through the Director of the Defense Health Agency, to: 1) establish a subordinate organization comprised of the Army Medical Research and Materiel Command (MRMC) and other medical research organizations and activities to be called the Defense Health Agency Research and Development; 2) establish a subordinate organization comprised of the Army Public Health Command, the Navy–Marine Corps Public Health Command, Air Force public health programs, and other related defense health activities to be called the Defense Health Agency Public Health; and 3) designate the Defense Health Agency (DHA) as a Combat Support Agency. This proposal does not affect continuing with the designation for creating the Center of Excellence for Joint Biomedical Research, Development, and Acquisition Management.

Risk if Legislative Proposal is not adopted.

This proposal is necessary to ensure that the Secretaries of the military departments are capable of performing those functions which are in direct support of Operating Forces to execute the U.S. National Security and Defense Strategies. These responsibilities include control over Military Service-specific medical research, product development, acquisition, and medical logistics programs involved with battlefield casualty care. Ensuring that these programs are synchronized and integrated with other warfighting functions to ensure proper combat casualty care, military medical readiness, and lethality as well as to ensure a continued synchronized response to emerging Public Health threats in a timely manner and efficient manner. If this proposal is not adopted the Department incurs substantial risk in both the transition of the Military Medical Treatment Facilities to the DHA and fielding equipping solutions and materiel to the warfighter.

Background on the Transfer of Military Healthcare capabilities to DHA.

The Military Health System (MHS) is currently undergoing a historic transformation as the DHA assumes authority, direction, and control for military treatment facilities (MTF) around the globe. The DHA should be focused on building a world class healthcare delivery system by merging the three service medical departments. There is enormous complexity merging three global health care systems, complicated by the cultural and organization differences between these systems. Additionally, the DHA is already responsible for implementing the Electronic Health Record across the enterprise. As a result of the complexities involved in this process, the National Defense Authorization Act for Fiscal Year 2019 extended the transfer of the administration of military treatment facilities (MTFs) from the original date of October 1, 2018 to September 30, 2021. Transferring medical research & development and public health to the DHA during an already complex reform effort poses significant risk to systems that serve both our warfighters and their beneficiaries.[1]

DHA's role as a Combat Support Agency (CSA) has created uncertainty regarding responsibility and authorities. Removing the CSA designation in statute will allow the Secretary of Defense to determine what functions are aligned to the military services and what functions are aligned to DHA. The CSA designation also creates redundancy with the services who provide ready, trained, and equipped medical formations. Appropriately aligning capabilities and responsibilities will unburden DHA and allow it to focus on MTFs while streamlining the services ability to generate ready medical formations.

Department of Defense Study on Medical Research and Public Health Reforms.

The Department of Defense has been studying the transfer of military public health organizations and medical research & development activities from the military medical departments to the DHA. The assessment and recommended courses of action are not complete due to the intricacies of these systems. For example, the study group determined that medical logistics was outside the scope of the study involving medical research. However, the current language transfers both Army organizations responsible for medical research & development, as well as, operational medical logistics.

Army Essential Responsibilities.

While DHA is assuming control of MTFs, this proposal ensures the Army will remain in control of essential medical research and material functions that support readiness, combat casualty care, and lethality in combat environments across multiple domains with full life-cycle infrastructure (research labs, product development/program management, acquisition, medical logistics, and contracting). These functions are not focused primarily on care at MTFs. Most

[1] In establishing Army Futures Command (AFC), the Army intended to realign elements of the Army's modernization enterprise and bring unity of effort to the future force development process, including medial research and development and public health. AFC will manage all Army Concepts, Capability Development, Science and Technology activities, informed by Army and Joint future force capabilities and requirements. Consolidation of requirements development and science and technology activities will drive the accelerated capability development needed for near-peer competition.

capabilities employed in MTFs are developed by civilian medicine industry; whereas, capabilities developed by Army's research, development, acquisition and logistics are inherently oriented towards operational medicine for warfighters.

The Army research, development, and logistics capabilities inherent in this mission involve funding the Defense Health Program (DHP) and the Chemical and Biological Defense Program. This funding directly provides cutting edge materiel, technology, and capabilities that enhance the readiness of operational units for all Service Members against medical threats while also fulfilling military service and Joint requirements.

Medical programs must also be synchronized and integrated with other warfighting functions to ensure proper combat casualty care, military medical readiness, and lethality. The clearest examples of this synchronization include medical variants of air and ground vehicles, as well as casualty support capabilities for other non-medical vehicles in austere environments. Moving medical research, development, and acquisition will decrease system synchronization and integration away from system developers complicating research, development, and acquisition from the military services of other essential capabilities.

Impact of the Transfer of Research and Development Capabilities to DHA.

Under Title 10 military service responsibilities and system integration requirements, a new DHA Research and Development organization would add additional layers of review. As reported in numerous U.S. Government Accountability Office reports (e.g., GAO-15-192, GAO-17-499) and contrary to previous Defense reform initiatives, these layers will produce greater inefficiencies in medical RDA and impede modernization efforts. Producing the systems and knowledge necessary to care for Service Members will be hampered by these additional layers.

System acquisition of related non-medical warfighting capabilities will also be hampered. Medical research, development, and acquisition responsibilities are co-located within MRMC, which effectively supports both Joint and Military Service activities. Moving it from Army management to agency management will specifically produce inefficiencies for the Army that are contrary to best practices described by the GAO and others. As conditions during war may change rapidly, medical research and development is essential to respond quickly and effectively to support warfighter capabilities and survivability. If MRMC's medical research and development assets are not left with the Army, the Army's ability to fulfill its Title 10 responsibilities and integrate medical capabilities with warfighting systems for Service Members will be degraded and at risk.

Impact of the Transfer of Public Health Capabilities to DHA.

Transferring the Army Public Health Center and other Army Public Health capabilities to the DHA creates an organizational seam between the clients of the Army Public Health Enterprise, our Senior Mission Commanders, and the Public Health service providers. This transfer reduces the agility of the Army Public Health Enterprise to respond to emerging Public Health threats in

a timely manner, and may increase costs and organizational friction, increasing the risks to Army war fighting capabilities.

Conclusion.

In conclusion, the historic MHS transformation is important for standardizing care across the MTFs and creating efficiencies. However, we should not transfer capabilities for military-relevant and field-based military medical knowledge and systems. Army systems and management of medical research, development, and acquisition by MRMC has worked well as evidenced by robust Congressional special interest commitments and engagement. In addition to putting this at risk, moving MRMC out from Army management puts medical readiness, battlefield and operational quality of care, modernization, efficiency, interoperability, and integration with related non-medical Army and Joint weapon system acquisitions, and military service flexibility at risk. The Department requires time to implement the current large scale reforms. This proposal mitigates risks to critical capabilities during the implementation of these reforms.

Budget Implications: This proposal has no budget implications. The repeal of NDAA FY 2019 section 711, transferring Medical Research and Materiel Command and Public Health Command to the Defense Health Agency, will maintain these capabilities within the Army under currently authorized funding and personnel requirements.

Department of Army Priority: This proposal is a critical proposal submitted by the Army for the FY21 legislative cycle.

Resubmission Information: This proposal is being submitted for the first time.

Component Subject Matter Expert: COL Julie Freeman, 703-695-4791, julie.j.freeman.mil@mail.mil

Reviewing Legal Counsel: Ms. Maanvi Patoir, 703-697-8467, maanvi.m.patoir.civ@mail.mil

Reviewing Comptroller POC: COL Todd Handy, 703-693-2893, todd.w.handy.mil@mail.mil

Component Contact for OMB: Ms. Dianne Smith-Neff, 703-697-8174, dianne.m.smith4.civ@mail.mil

Changes to Existing Law: This proposal would make the following changes to section 1073c title 10, United States Code:

§1073c. Administration of Defense Health Agency and military medical treatment facilities

(a) ADMINISTRATION OF MILITARY MEDICAL TREATMENT FACILITIES.—(1) 'In accordance with paragraph (4), by not later than September 30, 2021, the Director of the Defense Health Agency shall be responsible for the administration of each military medical treatment facility, including with respect to—

(A) budgetary matters;
(B) information technology;
(C) health care administration and management;
(D) administrative policy and procedure;
(E) military medical construction; and
(F) any other matters the Secretary of Defense determines appropriate.

(2) In addition to the responsibilities set forth in paragraph (1), the Director of the Defense Health Agency shall, commencing when the Director begins to exercise responsibilities under that paragraph, have the authority—

(A) to direct, control, and serve as the primary rater of the performance of commanders or directors of military medical treatment facilities;
(B) to direct and control any intermediary organizations between the Defense Health Agency and military medical treatment facilities;
(C) to determine the scope of medical care provided at each military medical treatment facility to meet the military personnel readiness requirements of the senior military operational commander of the military installation;
(D) to determine total workforce requirements at each military medical treatment facility;
(E) to direct joint manning at military medical treatment facilities and intermediary organizations;
(F) to address personnel staffing shortages at military medical treatment facilities; and
(G) to select among service nominations for commanders or directors of military medical treatment facilities.

(3) The military commander or director of each military medical treatment facility shall be responsible for—

(A) ensuring the readiness of the members of the armed forces and civilian employees at such facility; and
(B) furnishing the health care and medical treatment provided at such facility.

(4) The Secretary of Defense shall establish a timeline to ensure that each Secretary of a military department transitions the administration of military medical treatment facilities from such Secretary to the Director of the Defense Health Agency pursuant to paragraph (1) by the date specified in such paragraph.

(5) The Secretary of Defense shall establish within the Defense Health Agency a professional staff to provide policy, oversight, and direction to carry out paragraphs (1) and (2). The Secretary shall carry out this paragraph by appointing the positions specified in subsections (b) and (c).

(b) DHA ASSISTANT DIRECTOR.—(1) There is in the Defense Health Agency an Assistant Director for Health Care Administration. The Assistant Director shall—

(A) be a career appointee within the Department; and
(B) report directly to the Director of the Defense Health Agency.

(2) The Assistant Director shall be appointed from among individuals who have equivalent education and experience as a chief executive officer leading a large, civilian health care system.

(3) The Assistant Director shall be responsible for the following:

(A) Establishing priorities for health care administration and management.

(B) Establishing policies, procedures, and direction for the provision of direct care at military medical treatment facilities.

(C) Establishing priorities for budgeting matters with respect to the provision of direct care at military medical treatment facilities.

(D) Establishing policies, procedures, and direction for clinic management and operations at military medical treatment facilities.

(E) Establishing priorities for information technology at and between the military medical treatment facilities.

(c) DHA DEPUTY ASSISTANT DIRECTORS.—(1)(A) There is in the Defense Health Agency a Deputy Assistant Director for Information Operations.

(B) The Deputy Assistant Director for Information Operations shall be responsible for policies, management, and execution of information technology operations at and between the military medical treatment facilities.

(2)(A) There is in the Defense Health Agency a Deputy Assistant Director for Financial Operations.

(B) The Deputy Assistant Director for Financial Operations shall be responsible for the policy, procedures, and direction of budgeting matters and financial management with respect to the provision of direct care across the military health system.

(3)(A) There is in the Defense Health Agency a Deputy Assistant Director for Health Care Operations.

(B) The Deputy Assistant Director for Health Care Operations shall be responsible for the policy, procedures, and direction of health care administration in the military medical treatment facilities.

(4)(A) There is in the Defense Health Agency a Deputy Assistant Director for Medical Affairs.

(B) The Deputy Assistant Director for Medical Affairs shall be responsible for policy, procedures, and direction of clinical quality and process improvement, patient safety, infection control, graduate medical education, clinical integration, utilization review, risk management, patient experience, and civilian physician recruiting.

(5) Each Deputy Assistant Director appointed under paragraphs (1) through (4) shall report directly to the Assistant Director for Health Care Administration.

(d) CERTAIN RESPONSIBILITIES OF DHA DIRECTOR.—(1) In addition to the other duties of the Director of the Defense Health Agency, the Director shall coordinate with the Joint Staff Surgeon to ensure that the Director most effectively carries out the responsibilities of the Defense Health Agency ~~as a combat support agency under section 193 of this title.~~

(2) The responsibilities of the Director shall include the following:

(A) Ensuring that the Defense Health Agency meets the operational needs of the commanders of the combatant commands.

(B) Coordinating with the military departments to ensure that the staffing at the military medical treatment facilities supports readiness requirements for members of the armed forces and health care personnel.

(C) Ensuring that the Defense Health Agency meets the military medical readiness requirements of the senior military operational commander of the military installations.

~~(e) ADDITIONAL DHA ORGANIZATIONS.—Not later than September 30, 2022, the Secretary of Defense shall, acting though the Director of the Defense Health Agency, establish within the Defense Health Agency the following:~~

~~(1) A subordinate organization, to be called the Defense Health Agency Research and Development—~~

~~(A) led, at the election of the Director, by a director or commander (to be called the Director or Commander of Defense Health Agency Research and Development);~~

~~(B) comprised of the Army Medical Research and Materiel Command and such other medical research organizations and activities of the armed forces as the Secretary considers appropriate; and~~

~~(C) responsible for coordinating funding for Defense Health Program Research, Development, Test, and Evaluation, the Congressionally Directed Medical Research Program, and related Department of Defense medical research.~~

~~(2) A subordinate organization, to be called the Defense Health Agency Public Health—~~

~~(A)(1) led, at the election of the Director, by a director or commander (to be called the Director or Commander of Defense Health Agency Public Health); and~~

~~(B)(2) comprised of the Army Public Health Command, the Navy-Marine Corps Public Health Command, Air Force public health programs, and any other related defense health activities that the Secretary considers appropriate, including overseas laboratories focused on preventive medicine, environmental health, and similar matters.~~

(e~~f~~) DEFINITIONS.—In this section:

(1) The term "career appointee" has the meaning given that term in section 3132(a)(4) of title 5.

(2) The term "Defense Health Agency" means the Defense Agency established pursuant to Department of Defense Directive 5136.13, or such successor Defense Agency.

		Fiscal Year								
		Executed		Budget		POM				
		2018	2019	2020	2021	2022	2023	2024	2025	2026
Large Markets	Central North Carolina									
	Colorado									
	Southwestern Kentucky									
	Southwest Georgia									
	Central Texas									
	El Paso									
	Floriza Panhandle									
	North Carolina Coast									
	Low Country									
	Kansas									
Pacific	Hawaii									
	Guam									
	Okinawa Islands									
	Japan									
	Korea									
Europe	Central Europe									
	Norther Italy									
	Mediterranean / Bahrain									
	Ibera									
	United Kingdom									
Small Markets	Garden State									
	Upstate NY									
	Central South Carolina									
	Central Oklahoma									
	Ozarks									
	Calafornia Desert									
	Central Louisiana									
	Corpus Christi									
	Los Angles									
	Central Kentucky									
	Central Virginia									
	Great Lakes									
	Las Vegas									
	Little Rock									
	New England									
	West Point									
Stand Alone	Stand Alone- Army									
	Stand Alone - Navy									
	Stand Alone - AF									
HQ	DHA									
	Army									
	Navy									
	AF									
Other	Other									
Total			$ 34,000,000,000							