SEC. ___. REPEAL OF REQUIREMENTS TO ESTABLISH DEFENSE HEALTH AGENCY RESEARCH AND DEVELOPMENT, TO ESTABLISH DEFENSE HEALTH AGENCY PUBLIC HEALTH, AND TO DESIGNATE DEFENSE HEALTH AGENCY AS A COMBAT SUPPORT AGENCY.

Section 1073c of title 10, United States Code, is amended—

(1) in subsection (d), by striking "as a combat support agency under section 193 of this title";

(2) by striking subsection (e); and

(3) by redesignating subsections (f) and (g) as subsections (e) and (f), respectively.

[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 requirements 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 that 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 and efficient manner. If this proposal is

not adopted, the Department incurs substantial risk in both the transition of the Military Medical Treatment Facilities (MTFs) to the DHA and fielding equipping solutions and materiel to the warfighter.

Background on 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 MTFs 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 MTFs from the original date of October 1, 2018, to September 30, 2021. Transferring medical research and 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 and 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 statutory language transfers both Army organizations responsible for medical research and 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 materiel functions that support readiness, combat

[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 medical 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.

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 capabilities employed in MTFs are developed by civilian medicine industry; whereas, capabilities developed by Army's research, development, acquisition, and logistics are inherently oriented toward 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, thereby complicating research, development, and acquisition within the Military Services and eliminating other essential Service specific capabilities.

Impact of Transfer of Research and Development Capabilities to DHA

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-17-499) and contrary to previous Department of Defense reform initiatives, these layers will produce greater inefficiencies in medical research and development 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 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 subsection (e) of section 1073c of title 10, United States Code, which required the transfer of 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.

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 (5), 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) provision and delivery of health care within each such facility;

(B) management of privileging, scope of practice, and quality of health care provided within each such facility;

(C) budgetary matters;

(D) information technology;

(E) health care administration and management;

(F) supply and equipment;

(G) administrative policy and procedure;

(H) military medical construction; and

(I) 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 identify the capacity of each military medical treatment facility to support clinical readiness standards of health care providers established by the Secretary of a military department or the Assistant Secretary of Defense for Health Affairs;

(E) to determine total workforce requirements at each military medical treatment facility;

(F) to determine, in coordination with each Secretary of a military department, manning, including joint manning, assigned to military medical treatment facilities and intermediary organizations;

(G) to select, after considering nominations from the Secretaries of the military departments, commanders or directors of military medical treatment facilities;

(H) to address personnel staffing shortages at military medical treatment facilities; and

(I) 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) on behalf of the military departments, ensuring the readiness of the members of the armed forces at such facility; and

(B) on behalf of the Defense Health Agency, furnishing the health care and medical treatment provided at such facility.

(4) If the Secretary of Defense determines it appropriate, a military director (or any other senior military officer or officers) of a military medical treatment facility may be a commanding officer for purposes of chapter 47 of this title (the Uniform Code of Military Justice) with respect to military personnel assigned to the military medical treatment facility.

(5) 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.

(6) 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 the education and experience to perform the responsibilities of the position.

(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 at military medical treatment facilities.

(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 at military medical treatment facilities.

(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) 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) 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.~~

(~~f~~e) TREATMENT OF DEPARTMENT OF DEFENSE FOR PURPOSES OF PERSONNEL ASSIGNMENT.— In implementing this section—

(1) the Department of Defense shall be considered a single agency for purposes of civilian personnel assignment under title 5; and

(2) the Secretary of Defense may reassign any employee of a component of the Department of Defense or a military department in a position in the civil service (as defined in section 2101 of title 5) to any other component of the Department of Defense or military department.

(~~g~~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.

(3) The term "military medical treatment facility" means—

(A) any fixed facility of the Department of Defense that is outside of a deployed environment and used primarily for health care; and

(B) any other location used for purposes of providing health care services as designated by the Secretary of Defense.