OFFICE OF THE UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, D.C. 20301-4000

PERSONNEL AND
READINESS

JUL 18 2024

The Honorable Jack Reed
Chairman
Committee on Armed Services
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

The Department's response to section 743 of the James M. Inhofe National Defense Authorization Act for Fiscal Year 2023 (Public Law 117–263), "Updates to Prior Feasibility Studies on Establishment of New Command on Defense Health," is enclosed.

This report provides updates to past feasibility studies on establishing a new command on Defense Health. The Department considered multiple potential structures, including a unified combatant command and a specified combatant command, before concluding that establishing a joint medical command is not currently advantageous. The Department believes that the Military Health System should be given time to mature into its new structure before more reorganization.

Thank you for your continued strong support for our Service members, veterans, and their families. I am sending a similar letter to the House Armed Services Committee.

Sincerely,

[redacted]

Ashish S. Vazirani
Performing the Duties of the Under Secretary of
Defense for Personnel and Readiness

Enclosure:
As stated

cc:
The Honorable Roger F. Wicker
Ranking Member

[redacted]

OFFICE OF THE UNDER SECRETARY OF DEFENSE
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WASHINGTON, D.C. 20301-4000

PERSONNEL AND
READINESS

JUL 18 2024

The Honorable Mike D. Rogers
Chairman
Committee on Armed Services
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

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Sincerely,

[redacted]

Ashish S. Vazirani
Performing the Duties of the Under Secretary of
Defense for Personnel and Readiness

Enclosure:
As stated

cc:
The Honorable Adam Smith
Ranking Member

[redacted]

Report to the Committees on Armed Services of the Senate and the House of Representatives

Updates to Prior Feasibility Studies on Establishment of New Command on Defense Health

July 2024

The estimated cost of this report for the Department of Defense is approximately $20,000. This includes $0.0 in expenses and $20,000 in DoD labor.
Generated on 2023Nov19 RefID: 9-6D4E61B

Executive Summary

This report is in response to section 743 of the James M. Inhofe National Defense Authorization Act for Fiscal Year 2023 (Public Law 117–263), "Updates to Prior Feasibility Studies on Establishment of New Command on Defense Health." The Department of Defense (DoD) considered multiple potential structures, including a unified combatant command and a specified combatant command. The Secretary of Defense (SecDef) recommends the Military Health System (MHS) be provided time to mature into its current organizational structure, given the recent reforms and perturbations to military medicine.

1.0 Introduction

This report provides updates to prior studies regarding the feasibility of establishing a new Defense Health command under which the Defense Health Agency (DHA) would be a joint Component. In conducting such updates, DoD considered a unified combatant command, specified combatant command, and other structures that DoD determined appropriate for consideration.

DoD primarily used findings from the study, "Defense Health Command: Organizational Options and Assessment," provided as an appendix to the report, "Report on the Feasibility of Establishing a Command as a Superseding Organization to the Defense Health Agency," in response to section 711(c) of the John S. McCain National Defense Authorization Act for Fiscal Year 2019 (Public Law 115–232) to reassess the potential for a new organizational structure. DoD also interviewed and collected recommendations on the feasibility of a command structure from senior medical leadership in the Office of the Secretary of Defense (OSD), Department of the Army, Department of the Navy, Department of the Air Force, the Joint Staff, DHA, the National Guard Bureau, and the Uniformed Services University for the Health Sciences to make a final determination. That study, "Defense Health Command: Organizational Options and Assessment," is included for reference at the Appendix.

These updates include: how, and to whom, a potential command would report and be overseen; its relationship to the SecDef, Military Departments, Combatant Commands, and the Joint Staff; how it would differentiate new authorities from those already residing with the Director, DHA; the chain of command; the incorporation of specific sub-organizations of DHA; and headquarters locations.

DoD also provides an overview of how DHA supports training and clinical proficiency of medical personnel and how a command would not necessarily or directly improve clinical proficiency beyond the current organizational structure of the MHS. While DoD does not need additional legislative authorities to establish a unified command, Congress would need to rewrite recent statute that reorganized the MHS in order to implement the restructuring.

DoD could expect standing up a Unified Medical Command (UMC) to add implementation costs, at least in the short term. Establishing a new unified combatant command generally requires an investment in personnel. A UMC would likely increase headquarters full-time

equivalent employees to staff additional echelons of military and civilian leaders (e.g., O-7 through O-9 and Senior Executive Service personnel). Cost neutrality in the long term is ambiguous given on-going medical reforms and modernizations. The primary headquarters of a potential Defense Health Command (DHC) would be in Falls Church, Virginia, where DHA and Services' medical headquarters currently reside, with satellite headquarters likely in San Antonio, Texas and Aurora, Colorado to build upon the existing DHA footprint.

The report provides a summary of the responsibilities for the conduct of health operations among operational units of the Armed Forces; administration of military medical treatment facilities (MTFs); and administration of the TRICARE program by potential construct. In all constructs, the UMC would coordinate requests to support the National Disaster Medical System, not unlike U.S. Northern Command does today. Research and education activities would still be centralized under DHA or would transfer wholesale in UMC constructs without a DHA.

2.0 Updates to Past Feasibility Studies

The most recent study in 2019 found a clear determination on a UMC challenging. Four years later, and further along into the transition of MTFs to DHA, DoD determined that the overall value of creating a UMC is still somewhat ambiguous and not appropriate or recommended at this time.

To update or confirm that past findings are still applicable today, OSD reviewed the feasibility of establishing a new UMC under which DHA would be a joint Component. OSD added additional feedback from senior medical leadership across the Departments of the Army, Navy, Air Force; Joint Staff; DHA; and the Uniformed Services University of the Health Sciences to confirm updates to feasibility.

OSD considered unified combatant command structures, specified combatant command structures, and others as appropriate. A unified combatant command has broad continuing missions and is composed of forces from two or more Military Departments. A specified combatant command has broad, continuing missions and is normally composed of forces from a single Military Department.

Assuming Congress intends to maintain the reforms to MHS governance and structure enacted into law since 2013, the Government has a range of plausible options, from the current DHA mission set, all the way to a single Military Department or Military Service or UMC. For context, DHA presently has authority, direction, and control over military medical and dental treatment facilities (MTFs and military dental treatment facilities (DTFs), respectively) in accordance with the 10 U.S.C. § 1073c.

The comprehensive study completed in 2019 started by reviewing over 50 years of studies and analyses on the organization of military medicine and the MHS. These past studies were mixed in whether the readiness and health benefit missions are synergistic or in tension with one another. Some studies find the missions inextricably linked, while others did not. These studies found that the command structures were feasible without significant legislative or regulatory change. Table 1 summarizes the most recent studies of a UMC completed in the past 20 years.

Table 1: UMC studies since the start of the Global War on Terror in 2001 to the most recent study delivered in 2019.

Year	Study Title	Requestor	Author	Recommendation	Outcome
2019	Feasibility of Command to Supersede the DHA	NDAA FY19, Sec. 711	Johns Hopkins University Applied Physics Lab	Do not establish a health command	Reassess in 3-5 years after DHA reaches full operating capability
2011	Review of the MHS Governance	Deputy Secretary of Defense	Internal Task Force	DHA	DHA
2007	MHS Governance, Alignment and Configuration of Business Activities	Deputy Secretary of Defense	Internal Working Group with Defense Business Board	UMC	Further consolidation but no UMC
2003	Reorganizing the MHS	Under Secretary of Defense for Personnel and Readiness	RAND National Defense Research Institute	Modify structure to unify health plan management	Established multi-Service markets

The Department uses the tension between readiness and health benefit delivery synergistically to support a ready medical force: active duty medical forces generate and sustain clinical skills needed to support military operations when they deliver care to DoD beneficiaries. A UMC would not likely immediately or directly improve medical force readiness.

DHA does not provide forces to Combatant Commands. The Military Departments recruit, train, and equip uniformed health care personnel to provide medical services to the Combatant Commands. The MTFs and DTFs under the authority, direction, and control of DHA provide platforms for health care training, education, and skills maintenance opportunities for the Military Departments to support medical force generation and sustainment. A UMC would not have any new authorities to guarantee capacity or access to care levels needed to reattract beneficiaries and complex care necessary to generate, maintain, and sustain medical forces beyond the current authorities and responsibilities of the Secretaries of the Military Departments and DHA.

The visualizations, tables, and summaries below are organized similar to the "Report on Feasibility of Establishing a Command as a Superseding Organization to the DHA" provided to Congress in 2019. The main challenge set forth by the study team in 2019 was the concept of

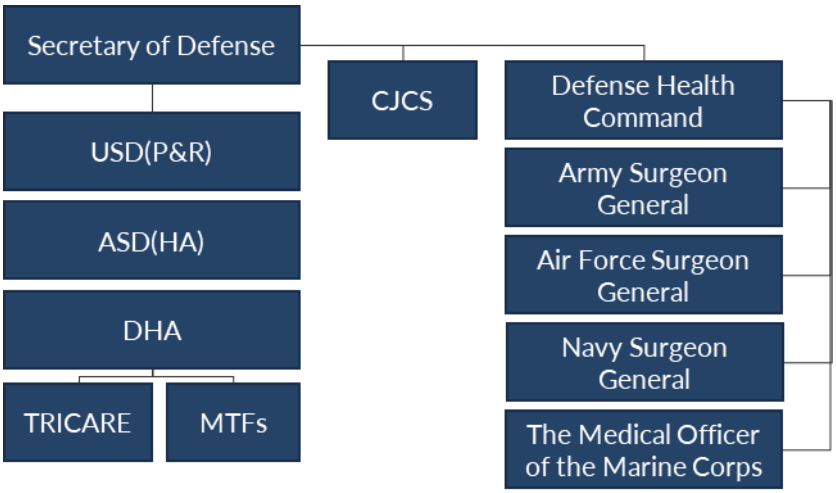
feasibility. The UMC options presented all have pros and cons associated with them in the 2019 study; this update did not find material changes to the pros and cons identified in the 2019 study. Feasibility of an option supports decisions based on the risks and benefits of each option framed by specific evaluation criteria:

- Clear decision authority
- Stakeholder integration
- Medical readiness of the force
- Operational medical support
- Ready and deployable medical forces
- High quality care to beneficiaries
- Impact on medical personnel
- Cost savings via reduced duplication
- Cost and ease of implementation
- Enhance operability

2.1 UMC with DHA

In this construct, visualized in Figure 1, DHA manages TRICARE and MTFs, including clinics and other infrastructure, and reports to the Assistant Secretary of Defense for Health Affairs (ASD(HA)). The UMC would be named the DHC, and report directly to the SecDef, and is supported by a Military Service Component structure.

Figure 1: UMC with DHA.



The DHC would have responsibility for managing readiness-related missions and addressing Combatant Command mission requirements in coordination with DHA and the Military Departments and Military Services. The DHC assumes some specific training responsibility for medical personnel, and DHA has tactical control of personnel assigned to MTFs. The Defense Health Program (DHP) splits between DHA and DHC. For example, DHA receives resources for TRICARE management while the DHC receives resources associated with readiness-related missions and man, train, and equip requirements. Authorities and evaluations are delineated in Table 2.

Table 2: Authorities delineated in a UMC with DHA.

Authorities	Military Departments	Agency	Command
Recruiting, promotion, etc. (i.e., administrative control (ADCON))	X		
Specialty selection and training			X
Force provision to Combatant Commands			X
MTF management		X	
Operational control (OPCON) on MTF military personnel			X
OPCON of embedded military medical personnel	X		
Research and development		X	
Management of purchased care		X	
Immediate supervisor of the Commander, DHC	Service-specific	ASD(HA)	SecDef

Section 743(c)(4)-(8) require delineation of specific functional responsibilities between the various part of the command, some of which are broad or exist on the continuum of military health care delivery. The specifications and placement of these responsibilities in Table 3 envisage where each would reside. The definitive assignment of these responsibilities requires further analysis and scenario-based modeling should a UMC with DHA be established. Similar tables are included for each construct.

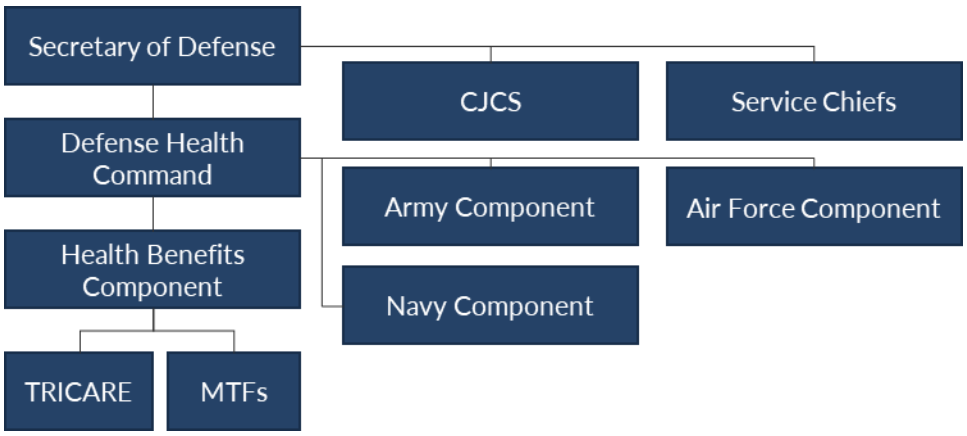
Table 3: The most likely delineation of specific responsibilities in the proposed construct. In accordance with DoD Directive 5136.13, "Defense Health Agency," DHA executes the DHP appropriation and MHS funding from the Medicare Eligible Retiree Health Care Fund as directed by the ASD(HA).

Primary responsibility for:	Services	Agency	Command
Medical treatment, advanced trauma management, emergency surgery, and resuscitative care		X	
Emergency and specialty surgery, intensive care, medical specialty care, and related services		X	
Preventive, acute, restorative, curative, rehabilitative, and convalescent care		X	
Collaboration with medical facilities participating in the National Disaster Medical System established pursuant to section 2812 of the Public Health Service Act, the Veterans Health Administration, and such other Federal departments and agencies and non-governmental organizations as may be determined appropriate by the Secretary			X
The conduct of existing research and education activities of the Department of Defense in the field of health sciences		X	
The conduct of public health and global health activities not otherwise assigned to the Armed Forces		X	
The administration of the Defense Health Program		X	

2.2 U.S. Transportation Command-like UMC

In this construct, visualized in Figure 2, the DHC reports to the SecDef. The DHC Commander develops medical requirements with the Army, Navy, and Air Force Components. The Health Benefits Component Commander is responsible for establishing health mission requirements and managing MTFs.

Figure 2: U.S. Transportation Command-like UMC.



The Military Departments maintain ADCON of medical personnel. The DHC Commander assumes OPCON for those personnel assigned to MTFs. The Military Departments and Military Services remain responsible for addressing requirements of the DHC and other Combatant Command mission requirements through the joint planning and force generation processes. The DHP is allocated to the DHC by the ASD(HA) and aligned to key missions as defined and prioritized by the DHC Commander.

Table 4: Authorities delineated in a U.S. Transportation Command-like UMC.

Authorities	Military Departments	Command
Recruiting, promotion, etc. (i.e., ADCON)	X	
Specialty selection and training	X	
Force provision to Combatant Commands	X	
MTF management		X
OPCON on MTF military personnel		X
OPCON of embedded military medical personnel	X	
Research and development		X
Management of purchased care		X
Immediate supervisor of the Commander, DHC	SecDef	

Section 743(c)(4)-(8) require delineation of specific functional responsibilities between the various part of the command, some of which are broad or exist on the continuum of military health care delivery. The specifications and placement of these responsibilities in Table 5 envisage where each would reside. The definitive assignment of these responsibilities requires further analysis and scenario-based modeling should a U.S. Transportation Command-like structure be established.

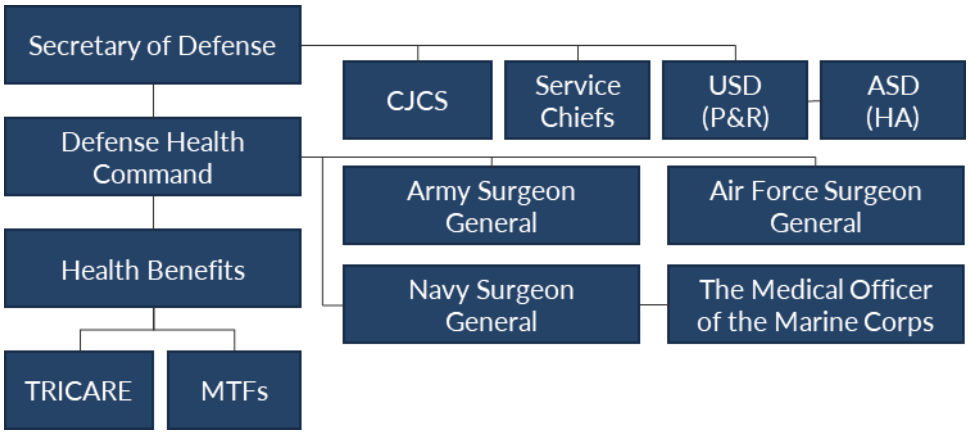
Table 5: The most likely delineation of specific responsibilities in the proposed construct.

Primary responsibility for:	Military Departments	Command
Medical treatment, advanced trauma management, emergency surgery, and resuscitative care		X
Emergency and specialty surgery, intensive care, medical specialty care, and related services		X
Preventive, acute, restorative, curative, rehabilitative, and convalescent care		X
Collaboration with medical facilities participating in the National Disaster Medical System established pursuant to section 2812 of the Public Health Service Act (42 U.S.C. 300hh–11), the Veterans Health Administration, and such other Federal departments and agencies and non-governmental organizations as may be determined appropriate by the Secretary		X
The conduct of existing research and education activities of the Department of Defense in the field of health sciences		X
The conduct of public health and global health activities not otherwise assigned to the Armed Forces		X
The administration of the Defense Health Program Account under section 1100 of title 10, 23 United States Code		X

2.3 U.S. Special Operations Command-like UMC

In this construct, visualized in Figure 3, simplistically the DHC reports directly to the SecDef for OPCON and OSD for ADCON, supported by Military Service component commands. The Health Benefits Commander is responsible for establishing requirements for the health care mission, including direct care and private sector care contracts and MTF management. The Military Departments remain responsible for ADCON for medical personnel. The DHC assumes responsibility for some title 10 functions, such as specialty training and selection.

Figure 3: U.S. Special Operations Command-like UMC.



The DHC Commander assumes OPCON for personnel assigned to MTFs and authority to address medical related mission requirements from Combatant Commanders. The Military Services remain responsible for supporting the DHC Commander to address Combatant Command mission requirements, with the Medical Officer of the United States Marine Corps fulfilling a role like the Service Surgeons General. The DHP is allocated to the DHC by the ASD(HA) and aligned to key missions as defined and prioritized by the DHC Commander.

Table 6: Authorities delineated in a U.S. Special Operations Command-like UMC.

Authorities	Military Departments	Command
Recruiting, promotion, etc. (i.e., ADCON)	X	
Specialty selection and training		X
Force provision to Combatant Commands		X
MTF management		X
OPCON on MTF military personnel		X
OPCON of embedded military medical personnel	X	
Research and development		X
Management of purchased care		X
Immediate supervisor of the Commander, DHC	SecDef	

Section 743(c)(4)-(8) require delineation of specific functional responsibilities between the various part of the command, some of which are broad or exist on the continuum of military health care delivery. The specifications and placement of these responsibilities in the table below envisage where each would reside. The definitive assignment of these responsibilities requires further analysis and scenario-based modeling should a U.S. Special Operations-like structure be established.

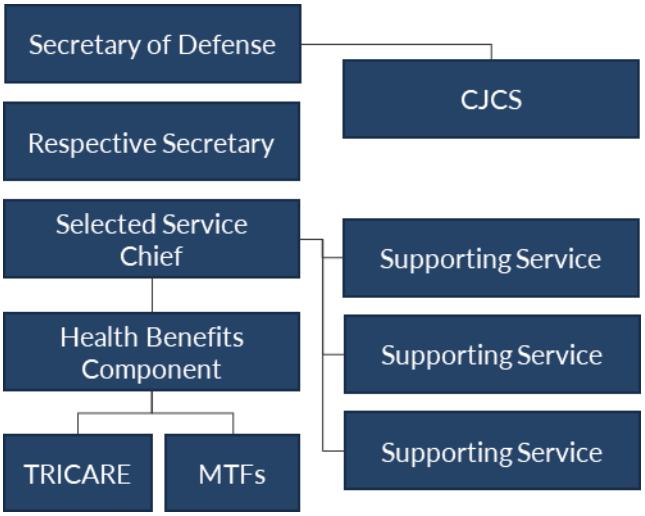
Table 7: The most likely delineation of specific responsibilities in the proposed construct.

Primary responsibility for:	Services	Command
Medical treatment, advanced trauma management, emergency surgery, and resuscitative care		X
Emergency and specialty surgery, intensive care, medical specialty care, and related services		X
Preventive, acute, restorative, curative, rehabilitative, and convalescent care		X
Collaboration with medical facilities participating in the National Disaster Medical System established pursuant to section 2812 of the Public Health Service Act (42 U.S.C. 300hh–11), the Veterans Health Administration, and such other Federal departments and agencies and non-governmental organizations as may be determined appropriate by the Secretary		X
The conduct of existing research and education activities of the Department of Defense in the field of health sciences		X
The conduct of public health and global health activities not otherwise assigned to the Armed Forces		X
The administration of the Defense Health Program Account under 10 U.S.C. § 1100		X

2.4 Single Military Department

In this construct, visualized in Figure 4, the selected Military Service assumes responsibility for all health-related activities and requirements, to include MTFs, readiness missions, and direct and private sector care. The selected Military Service supports the medical requirements and missions of the other Military Services. The medical element within the selected Military Service reports to the Military Service Chief and is supported by the other Military Services through a Component structure.

Figure 4: Single Service UMC.



The selected Military Service, in coordination with the Chairman of the Joint Chiefs of Staff and the supporting Military Services, is responsible for medical missions, including emergent Combatant Command requirements. The selected Military Service assumes ADCON and OPCON of medical personnel except for those assigned to specific embedded units within the other Services. Medical personnel assigned to operational environments would shift to the OPCON of the receiving command. Title 10 recruit, train, and equip functions for personnel would remain with the managing Military Service. The DHP supports requirements developed and programmed by the selected managing Military Service.

Table 8: Authorities delineated in a Single Service model.

Authorities	Services	Command
Recruiting, promotion, etc. (i.e., ADCON)		X
Specialty selection and training		X
Force provision to Combatant Commands		X
MTF management		X
OPCON on MTF military personnel		X
OPCON of embedded military medical personnel	X	X
Research and development		X
Management of purchased care		X
Immediate supervisor of the Commander, DHC	SecDef	

Section 743(c)(4)-(8) require delineation of specific functional responsibilities between the various part of the command, some of which are broad or exist on the continuum of military health care delivery. The specifications and placement of these responsibilities in the table below envisage where each would reside. The definitive assignment of these responsibilities requires further analysis and scenario-based modeling should a U.S. Transportation Command-like structure be established.

Table 9: The most likely delineation of specific responsibilities in the proposed construct.

Primary responsibility for:	Others	Selected Service
Medical treatment, advanced trauma management, emergency surgery, and resuscitative care		X
Emergency and specialty surgery, intensive care, medical specialty care, and related services		X
Preventive, acute, restorative, curative, rehabilitative, and convalescent care		X
Collaboration with medical facilities participating in the National Disaster Medical System established pursuant to section 2812 of the Public Health Service Act (42 U.S.C. 300hh–11), the Veterans Health Administration, and such other Federal departments and agencies and non-governmental organizations as may be determined appropriate by the Secretary		X
The conduct of existing research and education activities of the Department of Defense in the field of health sciences		X
The conduct of public health and global health activities not otherwise assigned to the Armed Forces		X
The administration of the Defense Health Program Account 10 U.S.C. § 1100		X

3.0 Determination

Although the creation of a UMC is possible, it is not appropriate or recommended at this time. DoD recommends that the MHS's current structure be afforded time to mature following a decade of near-continuous change. DoD recommends reassessing feasibility of a unified medical command in 5 to 10 years (2028 to 2033).

Medical leadership endorsed time to settle and mature into more predictable, routine processes. Repeated restructuring and reorganization can lead to change fatigue, even those that are highly successful. Managers and staff at all levels of the MHS experienced multiple, very significant reorganizations for over ten years, beginning with disestablishment of the TRICARE Management Activity and establishment of DHA.

Medical leadership also recognized the impact of other perturbations to military medicine. Simultaneous to the transition of MTFs to DHA, DoD deployed a new electronic health record (EHR). For any health system, a new EHR brings significant short-term disruption. Their value

is often realized in years, or even decades, in large private sector health service delivery systems. Simultaneously, the national health care economy changed significantly in the wake of the coronavirus disease 2019 (COVID-19) pandemic. Across the country, health delivery systems face demoralized, burnt-out staff. Health systems are rebounding, but rebuilding the workforce, morale, and capacity will take years.

DoD continues to stabilize and improve the effective delivery of health care and medical readiness in the wake of the transition of authority, direction, and control of MTFs to DHA; deployment of the EHR; and the COVID-19 pandemic. Restructuring the MHS into a UMC would bring about yet-another change, likely increasing change fatigue and exacerbating burnout.

4.0 Appendix