BRAD R. WENSTRUP, D.P.M.
2ND DISTRICT OHIO

COMMITTEE ON WAYS AND MEANS

PERMANENT SELECT COMMITTEE ON INTELLIGENCE

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CHAIRMAN

WWW.WENSTRUP.HOUSE.GOV

Congress of the United States
House of Representatives

2335 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515
(202) 225-3164

170 NORTH MAIN STREET
PEEBLES, OH 45660
(513) 605-1380

4350 AICHOLTZ ROAD
SUITE 110
CINCINNATI, OH 45245
(513) 474-7777

475 WESTERN AVE SUITE B
CHILLICOTHE, OH 45601
(740) 672-7040

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The Honorable Mike Rogers
Chairman
House Armed Services Committee
Washington, D.C. 20515

The Honorable Adam Smith
Ranking Member
House Armed Services Committee
Washington, D.C. 20515

AS PREPARED FOR DELIVERY

Dear Chairman Rogers and Ranking Member Smith,

Thank you for the opportunity to testify before you today regarding the Fiscal Year 2024 National Defense Authorization Act. In my written testimony, I would like to discuss three issues that I feel are necessary for this Committee to address in the FY24 NDAA:

1. The role of podiatric surgeons in the Armed Forces
2. The *Patriot Retention Act*
3. The continued evolution of the Military Health System

The role of podiatric surgeons in the Armed Forces

I want to express my personal, strong support for an amendment submitted by Representative Lisa McClain for this year's NDAA, which would revise the Defense Health Agency's policy regarding credentialing and privileging under the Military Health System to expand the recognition of board certification for physicians to a wide range of additional board certifications in medical specialties and subspecialities.

Recruiting and retaining the best and brightest physicians to the Armed Forces is of utmost importance to the health and wellbeing of our military's greatest asset: our people. Every medical professional serving in uniform must have the knowledge, skills, and abilities needed to serve our people well and engage fully in the operational mission.

Specifically, I'd like to express my support for the amendment language that includes "Certifying boards recognized by the Council on Podiatric Medical Education" under Singular Specialty Organizations, including the American Board of Podiatric Medicine and the American Board of Foot and Ankle Surgery.

Podiatric education, training, and practice have evolved considerably over the past four decades. Podiatrists now complete four years of graduate medical education at one of many colleges of

podiatric medicine. Doctors of podiatric medicine receive basic and clinical science education that is comparable to medical doctors. Podiatric residency curriculum is also comparable to M.D. and D.O. residency training and a minimum of three years for civilian podiatrists. All of the Services also require a three-year surgical residency.

The present-day podiatric surgeon is trained in all aspects of surgical principles, patient admissions, performing history and physicals, and taking emergency call. Today, the military faces a tremendous shortage of surgeons, and it is essential that podiatric surgeons in the Armed Forces meet the highest possible standards and have the training and certification needed to indicate that they are prepared for the operational mission. Both in uniform and as a Member of Congress, I have recommended that all specialties review which knowledge, skills, and abilities are necessary for the operational mission as we recruit and retain medical professionals to serve in our military.

For now, I'd like to focus on my specialty.

I served as the Chief of Surgery with the U.S. Army's 344th Combat Support Hospital in Abu Ghraib, Iraq, from 2005 to 2006. The 344th cared for our Soldiers, Marines, and Iraqi civilians, and we were also responsible for detainee healthcare throughout the Iraqi theater, with the heart of the mission taking place at Abu Ghraib Prison Hospital. Because of my training, I was well prepared to execute our medical mission.

As podiatric surgeons, our careers track along the lines of their M.D. and D.O. counterparts in the civilian world and in the Department of Veterans Affairs. I appreciate Representative McClain's effort to ensure that podiatric surgeons in our Armed Forces have these same opportunities and urge this Committee to support the inclusion of her amendment in the final Committee product.

The *Patriot Retention Act*

Last Congress, I introduced the *Patriot Retention Act* with my friend, colleague, and member of this Committee, Representative Jimmy Panetta. This legislation aims to provide our Armed Forces the needed authority to retain specialty positions that are in critical shortage in the Ready Reserve.

Currently, the Ready Reserve is facing a significant shortage in dozens of critical wartime specialty positions, which threatens our ability to meet combat-ready mission requirements. Should conflict occur, we cannot afford to be undermanned in the positions that require the highest levels of specialization.

Our military invests heavily in the education and training of special skills personnel. Upon reaching eligibility for retirement, if a qualified servicemember in a critical specialty would like

to continue their service by joining a Reserve capacity, he or she would be uniquely suited to fill the positions that are needed most.

Unfortunately, current law imposes restrictions on a retiree's ability to simultaneously collect distributions from their already-earned pension and receive pay for Reserve service, disincentivizing qualified personnel from serving in the Ready Reserve upon retirement from active duty.

The *Patriot Retention Act* would provide a pathway for certain qualified, retiring specialists to be placed into the Ready Reserve without financial disincentives. Specifically, should a Service Secretary find that a servicemember with more than 20 years of creditable, active duty service possesses a skill in which the Ready Reserve has a critical shortage, that servicemember will be able to serve without forfeiting portions of their pension or Reserve pay. Consistent with current Reserve retirement rules, a member serving under this authority would not be eligible for additional pension from service in the Ready Reserve until age 60 and/or full separation.

In fact, this Committee has previously supported including such language in the NDAA as **Section 703 of the House-passed FY22 NDAA** contained this language, structured as a pilot program, to place certain members of the Armed Forces in the Ready Reserve. While the language did not survive Conference, I urge the Committee to reconsider this language for this year's NDAA and work towards a viable solution that aims to improve recruitment and retention for our Armed Forces.

The continued evolution of the Military Health System

The Military Health System (MHS) is a vital component of our national security strategy, and the Defense Health Agency (DHA) is a critical element of the MHS that was established as part of a larger effort to reorganize military healthcare programs and services. Since its inception in 2013, DHA was established to serve as a combat support agency (CSA) to enable the medical services to provide a medically ready force and ready medical force to combatant commands. But since its inception, as Congress has asked DHA to take on an increasingly larger role in the MHS, DHA remains limited by its construct as an integrated Combat Support Agency (CSA).

Prior to the FY22 NDAA, I submitted testimony outlining five key areas of concern regarding the DHA and the limitations of the current system, summarized below:

1. Lack of clarity of authority within the current DHA structure. In November 2019, the Department of Defense (DoD) transmitted a report to Congress, pursuant to Section 711(c) of the Fiscal Year 2019 NDAA, on the feasibility of establishing a Defense Health Command (DHC). In this report, researchers found that "[i]nterviewees invariably lamented a lack of clarity in the assigned responsibilities of DHA as a source of concern." Additionally, "[a] separate clarity issue raised by multiple interviewees was the need to identify a clear decision-making authority to ensure that authority is recognized."

The use of a CSA to support combatant command requirements, the Services' medical training requirements, and delivery of a healthcare benefit is organizationally limited. While a CSA will be able to communicate with the Services to identify personnel gaps and coordinate manpower adjustments (i.e., joint staffing models or TRICARE network providers), the Director of the current model, by nature, lacks the proper authority to make centralized personnel adjustments.

2. Need for better integration and communication across the Services. Under the current construct, DHA is unable to execute joint deployment solutions. For example, if an Air Force Reservist wants to deploy, but the Department of the Air Force has a policy not to deploy Reservists, or is absent a service-specific requirement for that individual or skillset, the servicemember would be denied such an opportunity to deploy. Alternatively, the servicemember could transfer to another Service in order to take advantage of another Service's deployment opportunities. In this scenario, which did occur, an overseeing Health Commander could more easily coordinate with the Joint Staff and facilitate personnel deployments based on identified need and servicemember availability. Joint deployment flexibility is an area of need that the current system, with or without the involvement of a CSA, is unable to efficiently accomplish.

3. Enhanced Military-Civilian Trauma Training Opportunities. There is a broad need for a unified expansion in military-civilian medical combat readiness training opportunities for both active and reserve medical personnel, especially for trauma. Servicemember and public reports indicate that active duty medical personnel stationed on safe, stateside installations are still not getting the exposure to and repetitions of trauma care that are needed in theater and that this has been observed in field hospitals. In addition to medical combat readiness, these military-civilian partnerships provide critical relationships for population health in the event of a mass casualty event where DoD medical capabilities may need to be engaged domestically.

   The Fiscal Year 2017 NDAA directed the Secretary of Defense to establish a Joint Trauma System within DHA, establish a Joint Trauma Education and Training Directorate that will include a personnel management plan for certain wartime medical specialties, and establish high-performance military-civilian integrated health delivery systems in collaboration with the Service Departments. In the context of the current combat support agency model, DHA will be able to negotiate military-civilian partnership agreements in regional markets at the enterprise level on behalf of the Services, as well as conduct research and incorporate the resulting standards of care within the enterprise.

   However, this framework and the integration of trauma standards to meet combat readiness requirements is occurring outside of the Services' medical departments. While the Surgeons General rightfully retain the ability to determine their operational readiness

requirements and whether their respective Services will be included in DHA's trauma integration efforts, this model ironically blurs the lines of responsibility about the extent to which the DHA owns readiness.

4. Decoupling the MTFs from the Services. Although MTFs are not the sole source of training, they are and have been an important link in the readiness and deployment pipeline controlled by each Surgeon General. In the context of how the integrated healthcare delivery system relates to Service-specific operational medicine, this realignment presents a concern with the extent to which DHA is responsible for readiness, and it decentralizes management decisions.

4. Separating Research Programs from the Services: The Fiscal Year 2019 NDAA built on DHA's research integration authority and directed the transfer of the Army Medical Research and Materiel Command, among other medical research and public health programs across the Services, into a new Research and Development Directorate at the DHA. While DHA should have a role in streamlining and coordinating research activities, ensuring that efforts are not unnecessarily duplicated, there are also reasons to keep Service-specific research, and research tied directly to combat readiness, within the Military Departments.

Last Congress, **Section 743 of the FY23 NDAA** required the Secretary of Defense to update prior studies regarding the feasibility of establishing a new defense health command under which DHA would be a joint component. Included in such update would be a review of the following potential structures:

1. A unified combatant command;
2. A specified combatant command; and
3. Any other command structure the Secretary determines is appropriate for consideration

As the Committee looks develops the policies that will ensure DoD continues to operate a beneficial healthcare integrated delivery network with no adverse effects on readiness, I am eager to read this forthcoming report and urge this Committee to continue to take a look at the reforms that may be needed to ensure we have a ready medical force, a medically ready force, and high-quality beneficiary care.

I appreciate the Committee's consideration of these three issues and look forward to working with my colleagues on the House Armed Services Committee to support our warfighters and their families.

Sincerely,

Brad R. Wenstrup, D.P.M.