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UPDATE ON THE DEPARTMENT OF DEFENSE'S EVOLVING ROLES AND MISSION IN RESPONSE TO THE COVID–19 PANDEMIC

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ONE HUNDRED SEVENTEENTH CONGRESS

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HOUSE OF REPRESENTATIVES,
COMMITTEE ON ARMED SERVICES,
Washington, DC, Wednesday, February 17, 2021.

The committee met, pursuant to call, at 11:02 a.m., in room 2118, Rayburn House Office Building, Hon. Adam Smith (chairman of the committee) presiding.

OPENING STATEMENT OF HON. ADAM SMITH, A REPRESENTATIVE FROM WASHINGTON, CHAIRMAN, COMMITTEE ON ARMED SERVICES

The CHAIRMAN. Good morning. We will call the meeting to order.

We welcome our witnesses, members, and staff. This hearing will be hybrid. There are a few members here in committee, and most members are participating remotely. So I have a script that I must read to explain how all of that will play out.

Members who are joining remotely must be visible on screen for the purposes of identity verification, establishing and maintaining a quorum, participating in the proceeding, and voting. Those members must continue to use the software platform's video function while in attendance, unless they experience connectivity issues or other technical problems that render them unable to participate on camera.

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Finally, I have designated a committee staff member to, if necessary, mute unrecognized members' microphones to cancel any inadvertent background noise that may disrupt the proceedings.

Well, thank you. We are here this morning to get an update from the Department of Defense on their evolving roles and missions in response to the COVID–19 [coronavirus disease 2019] pandemic. We have had a number of these hearings over the course of the last 9 or 10 months. I very much appreciate the Department's cooperation in that process.

And this morning we have with us Dr. Robert Salesses, who is performing the duties of Assistant Secretary of Defense for Homeland Defense and Global Security; Major General Jeff Taliaferro, who is the Vice Director for Operations for the Joint Chiefs; and Major General Steven Nordhaus, who is the Director of Operations for the National Guard Bureau.

I appreciate all of you being here this morning. And for the record, our witnesses are here in person. We have many members who are here virtually.

And before we get started, I do want to thank our staff, in general, Doug Bush, in particular, who has done an outstanding job of making this process work. It hasn't been easy, but I think it has been very, very effective. We have been able to conduct the business of this committee effectively while still accommodating the needs to deal with the COVID pandemic. So it has been a lot of work, and I definitely appreciate that work.

I also want to thank the Department for their leadership and efforts on the COVID pandemic. There is a number of different layers to this, which we will want to get into today. Obviously, at the top, you know, is the protection of the force, Active Duty, civilian, and guardsmen. How are we able to continue to maintain readiness, maintain performance of the duties, while at the same time protecting our service members from the pandemic and stopping the spread. There has been a lot that DOD [Department of Defense] has done to make that happen.

Learning more about how it is going, how it has gone, is enormously helpful, because I think in many ways the Department of Defense has been a leader in some of that, in guiding all of us into how we can get our work done and still contain the virus. So I appreciate hearing about that.

Also, as we know, the Guard has been called up to help support States and localities in a variety of different ways from the beginning of this pandemic. Most urgently, in some cases, when communities have been overrun, they have set up field hospitals, and they have provided staff to meet those needs.

I remember in my home State of Washington which got their sort of first burst in March. You know, we set up a field hospital at a local stadium. It turned out we didn't need it, which was good, but we definitely needed the support staff that was provided, as I know many other States have as well.

And now as we go forward, it is going to be really important to see how the Department of Defense can help with the vaccine distribution. I would really like to learn this morning more about how you are participating in that, how you are coordinating with FEMA [Federal Emergency Management Agency] and HHS [Department of Health and Human Services] to maximize the most rapid distribution of the vaccine possible.

Also, there are the issues surrounding, you know, production of the vaccine as well. I am curious what DOD is working on in that regard.

And then lastly, there is the industrial base. Now, the industrial base is enormously important for maintaining our national security needs. They obviously have been stressed in all the ways that the rest of us have in terms of maintaining the workforce, in terms of providing safety for their workers. How is that going? How do we feel about the level of production in making sure that we are meeting our defense needs?

And, again, while that may start with a focus, certainly, from this committee and from the Department of Defense's perspective on, you know, how do we protect defense needs, it has larger implications. Many of these companies, obviously, do both commercial and defense work. How are they handling that? Are they adequately protecting their workforce? Are they able to meet their needs? If they are not, how are we adjusting to those shortfalls?

Many questions to be covered in this conversation and discussion. I look forward to the testimony and to the question and answer.

And with that, I will yield to the ranking member, Mr. Rogers, for his opening statement.

STATEMENT OF HON. MIKE ROGERS, A REPRESENTATIVE FROM ALABAMA, RANKING MEMBER, COMMITTEE ON ARMED SERVICES

Mr. ROGERS. Thank you, Mr. Chairman. I appreciate you having this hearing today.

Since the earliest days of the pandemic, the U.S. military has been on the front lines of this response, providing critical support to civilian authorities at Federal, State, and local levels.

They repatriated thousands of Americans; hosted dozens of quarantine, testing, and vaccination sites; deployed two hospital ships and set up military field hospitals to surge healthcare capacity in hard-hit areas; provided thousands of ventilators and millions of respirators and other PPE [personal protective equipment] to civilian authorities; and helped develop the therapeutics in vaccines under Operation Warp Speed that are saving lives and putting an end to this pandemic.

For this, we are eternally grateful. And while we know—while I know there is a desire to see DOD do more to assist civilian authorities, I am primarily concerned with its impacts—that COVID is having on our military readiness.

Over the past year, nearly 200 Navy ships have suffered outbreaks, which in some cases disrupted training and operations. Across the services, hundreds of training exercises have been canceled, curtailed, or altered. This is especially problematic for our service members overseas who rely on international exercises to maintain their proficiency.

At our shipyards and depots, and across the industrial base, COVID workforce reductions are cutting production capacity, delaying maintenance cycle, and pushing planned work back by months.

While the services have done a tremendous job to mitigate these impacts to keep our troops on station, I remain worried about the

cumulative impact they are having on our readiness. I am also very concerned with a lack of progress the DOD is making vaccinating our service members. It is my understanding that since the vaccine only received emergency use authorization from the FDA [Food and Drug Administration], the DOD is reluctant to make vaccinations mandatory at this time.

The Department typically waits until full FDA approval before issuing such orders to vaccinate. However it could be another 2 years before these vaccines receive full FDA approval.

With new variants popping up across the globe, I am not sure we can wait for 2 years. It is critical for our national security that every service member, as well as DOD civilian personnel and contractors, receive vaccines as soon as possible.

I am interested to hear from our witnesses what percentage of our service members have been vaccinated, what the refusal rate has been, and what steps are being taken to get more shots into arms.

Finally, my job is to ensure our service members have the resources they need to successfully carry out their mission. This pandemic is making that mission much harder. I hope our witnesses will explain what more Congress can do to help the services adapt and overcome.

Thank you for being here today, and I thank you, Mr. Chairman. I yield back.

The CHAIRMAN. Thank you, sir. And we will begin testimony now with Mr. Salesses. You may proceed.

STATEMENT OF ROBERT G. SALESSES, PERFORMING THE DUTIES OF ASSISTANT SECRETARY OF DEFENSE FOR HOMELAND DEFENSE AND GLOBAL SECURITY, OFFICE OF THE SECRETARY OF DEFENSE

Mr. SALESSES. Good morning, Chairman Smith, Ranking Member Rogers, distinguished members of the committee, thank you for the opportunity to testify before you today on the Department of Defense's response to the COVID–19 pandemic.

The COVID–19 pandemic has posed an unprecedented challenge to our Nation. Since the start, DOD has protected its people, supported the national response, ensured the readiness of the force to meet its national security mission.

To protect DOD personnel from the pandemic, DOD implemented measures to contain and mitigate the effects on the force, including forced health protection guidance, restriction of movement orders, social distancing, mask wearing, telework on an unprecedented scale, and testing and contact tracing. DOD has also established a tiered vaccine plan, following CDC [Centers for Disease Control and Prevention] guidance tailored to DOD's unique requirements.

As of 16 February, DOD has administered approximately 860,000 doses of the vaccine. DOD support to the national response to the COVID pandemic has evolved over the last 13 months.

DOD assistance began in late January 2020, supporting embassies and consulates around the globe to repatriate U.S. citizens and U.S. persons to the United States. In support of the State Department, USTRANSCOM [U.S. Transportation Command] facilitated the safe return of more than 4,500 Americans. In support of HHS,

USNORTHCOM [U.S. Northern Command] and INDOPACOM [U.S. Indo-Pacific Command] and the military departments aided the quarantine of more than 3,000 individuals at 13 military installations.

As the pandemic spread over the late winter, early spring of 2020, hospitalizations increased rapidly, and State and local demands rose for both medical facilities and medical providers. HHS and FEMA turned to DOD to help meet this demand. NORTHCOM deployed almost 15,000 DOD personnel, including nearly 5,000 Active Duty and Reserve medical professionals to 10 States and multiple locations within those States.

INDOPACOM provided similar support to Hawaii, Guam, and the Northern Mariana Islands. The Army Corps of Engineers designed and constructed 38 alternate care facilities providing additional medical bed capacity in multiple States.

Working with FEMA, DOD also authorized National Guard personnel to carry out FEMA COVID–19 mission assignments in title 32 status. More than 47,000 National Guard supported testing, emergency medical care, medical sheltering, public health communications, transportation, logistics, and first responder support.

DOD also played a critical role in strengthening the supply chain for medical resources and PPE in short supply. HHS and FEMA leveraged DOD's acquisition logistics expertise to reenforce nearly all facets of the national supply chain. FEMA and HHS established the Supply Chain Task Force in late March of 2020 which was led and heavily supported by DOD experts. The task force accelerated acquisition, expended production by generating new capacity, and allocated key resources and supplies to priority hotspots around the Nation. USTRANSCOM supported Project Airbridge which also airlifted millions more of critical PPE and medical supplies to fill the supply chain gaps.

In late March 2020, DOD also established the COVID Joint Acquisition Task Force to serve as the DOD's nexus for supporting Federal acquisition and logistics needs. The JATF awarded nearly $2 billion worth of contracts to restock the national—the Strategic National Stockpile and expanded the domestic industrial base for medical supplies and equipment.

The Defense Logistics Agency also executed more than 25,000 contract actions for medical supplies and equipment. Building on decades of work studying infectious disease such as Ebola and the coronaviruses, research and development efforts of DOD experts helped genetically sequence COVID–19, and established the first treatment protocol for the Remdesivir in March 2020.

Furthermore, DARPA [Defense Advanced Research Projects Agency] funded projects helped lay the groundwork for rapid development of RNA COVID–19 vaccines produced by Moderna and AstraZeneca.

The Joint DOD–HHS Vaccine Task Force established in May of 2020 accelerated the development, the manufacturing, and the distribution of COVID–19 vaccines in record time.

Now at approximately 60 million vaccine doses delivered, 42 million which have been administered, and expecting 600 million vaccine regiments delivered by the end of July of 2021.

As Secretary Austin made clear in Day One message to the Department, DOD must move further and faster to help counter the COVID–19 pandemic. To that end, DOD, with FEMA, has developed plans to support vaccine centers able to administer up to 6,000 vaccines a day.

DOD has also supported our allies and partners through the provision of transport of lifesaving medical equipment, PPE, and humanitarian aid. DOD has provided more than $200 million in assistance to 143 countries, including testing, diagnostic support, infection control, PPE, and contact tracing, and more.

Going forward, DOD is actively implementing President Biden's national strategy, executive orders, and national security policy memorandums and is committed to executing the President and Secretary Austin's direction to defeat the COVID–19 pandemic and defend the force while protecting our Nation.

Chairman Smith, Ranking Member Rogers, distinguished members of the committee, thank you for the opportunity to testify today. I appreciate the critical role and partnership Congress plays in ensuring the Department is prepared to face every challenge at home and abroad.

[The joint prepared statement of Mr. Salesses, General Taliaferro, and General Nordhaus can be found in the Appendix on page 53.]

The CHAIRMAN. Thank you. And I should have asked this up front, but are both of you gentlemen planning on offering opening statements as well?

General NORDHAUS. Yes, Chairman.

General TALIAFERRO. Yes, Chairman.

The CHAIRMAN. Then we will go to General Taliaferro.

STATEMENT OF MAJ GEN JEFFREY B. TALIAFERRO, USAF, VICE DIRECTOR OF OPERATIONS, JOINT CHIEFS OF STAFF

General TALIAFERRO. Thank you, Chairman. Chairman Smith, Ranking Member Rogers, and distinguished members of the committee, thanks for the opportunity to talk about DOD operations in response to the pandemic today.

The joint force has been committed to supporting the national COVID response effort from its beginning in early 2020 and has responded to 374 FEMA mission assignments, 47 requests for assistance from other departments and agencies with many more expected.

In the early days of this effort, DOD provided facilities to house personnel evacuated from overseas, and in March of 2020 began providing support to the States through FEMA mission assignments.

The capabilities needed by FEMA in the States evolved over time, but included everything from direct medical support to hospitals and nursing facilities, to the deployment of field hospitals and hospital ships, to the staffing of alternate care facilities, mortuary affairs, transportation, and sustainment.

As the States and medical community learned more about treating the disease and responding to the pandemic, our primary operational headquarters, U.S. Northern Command, innovated and evolved its response to best meet the needs of our partners.

In our initial response, we deployed traditional military capabilities, like field hospitals and hospital ships. But over time, it became clear our capabilities could be much more effective augmenting existing hospitals with medical personnel, specifically, doctors, nurses, and respiratory therapists. This model met the patients and hospitals where they wanted to be, in the treatment facilities they were used to, and enabled those facilities to handle the increased patient load.

Over the past year, U.S. Northern Command has put more than 15,000 title 10 forces in the homeland in support of COVID–19 response efforts, including at its peak over 45,000 medical professionals. They have supported 63 different hospitals, 9 alternate care facilities across the country, and today have over 200 personnel supporting non-hospitals in Arizona, the Navajo Nation, and Texas.

U.S. Transportation Command has also moved over 900,000 pounds of supplies, helped repatriate over 4,000 American citizens using military or commercially contracted aircraft.

As the Nation's response evolves again towards the focus on vaccine distribution, the joint force is equally committed. Today, we are already supporting two vaccination distribution centers, one in California and one in New Jersey, and have ordered over 4,000 additional forces to prepare to deploy to support the first 25 different centers as needed.

We are anticipating FEMA mission assignments that can come quickly for New York, Texas, and elsewhere, and will stay in lockstep with FEMA as the lead Federal agency for this effort.

The DOD vaccination teams utilize some of the same capabilities from our medical facility support, but also lean more heavily on medics, pharmacists, and more nurses. These teams come in a variety of scalable sizes based on the need of the States.

Just as last year, we will stay agile and continue to innovate and evolve this response as we learn more or the needs of the States change.

Thanks for the opportunity to share experience today and for the work of the committee to support our efforts and our service members over the last year. We look forward to continuing to work with the committee on these important issues going forward. Thank you.

The CHAIRMAN. Thank you.

General Nordhaus.

STATEMENT OF MAJ GEN STEVEN S. NORDHAUS, USAF, DIRECTOR OF OPERATIONS, NATIONAL GUARD BUREAU

General NORDHAUS. Chairman Smith, Ranking Member Rogers, distinguished members of the Armed Services Committee, it is truly an honor to testify before you today on the National Guard support to COVID–19 in defeating it.

I would like to start by highlighting the historic efforts of our National Guard members in our 50 States, 3 territories, and the District of Columbia. These are the same National Guard men and women who spent over 10 million days in 2020 serving their communities and their Nation both domestically and around the world. Four times more than in the previous year.

They helped battle wildfires that damaged over 9.5 million acres. Over 43,100 service members helped maintain order in 34 States, territories, and the District of Columbia last summer when civil disturbances threatened the public's ability to safely protest. And they saved lives and expedited recovery efforts after a record-breaking hurricane season, including 12 named storms impacting the United States.

As you know, the National Guard's primary focus within the homeland has been supporting COVID–19 operations. We currently have over 28,400 soldiers and airmen dedicated to COVID–19 operations across all 54 States, territories, and the District of Columbia, performing a wide range of missions.

In 2020, alone, our National Guard members tested nearly 13 million people, provided medical planning support to local communities, and conducted warehouse operations to support the distribution of personal protective equipment and medical equipment to hospitals and community medical centers.

The National Guard also provided nearly 550 million meals to families in need, disinfected over 9,600 long-term care facilities, and delivered nearly 37 million masks for frontline workers.

General Hokanson, Chief of the National Guard Bureau, has made maximum support to COVID vaccination efforts his number one priority. Since early January, the National Guard has grown from a few civilian vaccination sites to over 350 across 42 States and territories; 33 States and territories are employing National Guard service members to vaccinate citizens; and 9 States provide wraparound services and support to local vaccine centers.

As I speak, Army and Air National Guard members are administering on average over 72,000 vaccines a day to local citizens. We estimate that since the beginning of our vaccination efforts, the National Guard has administered over 1.2 million vaccinations to our civilian population.

Also, vaccinating our National Guard members and their families, and our civilians remains a top priority. To date, over 71,000 have received at least their first vaccination, and that number continues to climb today.

Next, I would like to highlight to the committee the significant use of the dual status command in efforts to fight the virus. In the aftermath of Hurricane Katrina in 2005, the dual status command concept gained acceptance and allowed a National Guard officer to command both Federal and State members—service members responding to a domestic emergency.

Thanks to Congress making the dual status commander a matter of law in the 2012 NDAA [National Defense Authorization Act], Governors are enabled to provide seamless command and control of National Guard, Active Duty, and Reserve service members fighting wildfires, hurricanes, and, of course, this virus.

During the peak of our response in May, we had 47,400 service members supporting COVID operations, with 41 dual status commanders approved, of which 9 were activated for command and control of Active Duty and Reserve service members within their State or territory. Today, there are currently 21 approved dual status commanders with 2 activated in California and Texas.

The continued investment and the readiness of the National Guard has paid dividends both on the battlefield and in our communities. Not since World War II has our National Guard been called upon to serve in such numbers. Last June, we had over 120,000 service members supporting missions in our homeland and overseas.

Every day, we are reminded of the sacrifices of these brave and women and their families, and it is with those sacrifices in mind that we remember the eight National Guard members who died as a result of COVID–19. These soldiers and airmen, while not serving on the front lines of COVID operations, still gave their full devotion to our Nation. Their legacy of service will live on in our memories.

In closing, I want to thank you for this opportunity to tell the National Guard story. On behalf of over 443,000 National Guard soldiers and airmen, I want to express our gratitude to you for your consistent and unwavering support.

We are especially grateful for Congress' support of the TRICARE Transitional Assistance Management Program, known as TAMP, which provides 180 days of premium-free transitional healthcare benefits after regular TRICARE benefits end. This protection is crucial to our transitioning National Guard warriors as they demobilize and return to civilian life.

We will remain laser focused with our interagency partners, civilian and military leaders, and frontline workers to help vaccinate our citizens and defeat COVID–19. Every day, tens of thousands of National Guard members, many of whom left their families and jobs, serve on the front lines of this battle saving lives and minimizing suffering across the Nation. The National Guard remains always ready and always there.

I look forward to your questions.

The CHAIRMAN. Thank you very much. Mr. Rogers alluded to this in his opening statement: What is the plan for vaccinating the DOD workforce? And that is Active Duty, civilian, Guard, Reserve, how are you implementing that and particularly in light of the comment Mr. Rogers made about not being able to actually mandate it?

Mr. SALESSES. Mr. Chairman, the Department has developed——

The CHAIRMAN. Could you pull the microphone just little closer to you there? There we go.

Mr. SALESSES. The Department has—developed a vaccine the material approach to the way that we will vaccinate. For example, in the first year, is medical professionals that are working——

The CHAIRMAN. Yeah. You have to speak up.

Okay. We are having a hard time hearing him in here as well. Are you sure your microphone is on?

Mr. SALESSES. Can you hear me now?

The CHAIRMAN. Yeah. It was off.

Mr. SALESSES. That is the key to success, I guess.

The CHAIRMAN. So, yeah, the key part—and I know the whole you're on a tier, you are going to do all of that.

Mr. SALESSES. Yeah.

The CHAIRMAN. What is your estimate on when, you know, how soon you will get the entire force vaccinated? Are you having prob-

lems with members saying, "Hey, I don't want it"? What is your guess on when you can get basically all of your personnel vaccinated?

Mr. SALESSES. So, just a little bit more perspective. This past week we vaccinated 170,000 members. It includes both military members, civilians, and contract folks, and obviously, beneficiaries; 170,000.

In this tiered approach, again, we are focused on the frontline folks that need the vaccine to care for others, then we move through that process making sure that we are focused on specific high important mission areas, like strategic forces, then we move through that to the most vulnerable ages 65 and above, and operational forces.

As we move through those tiers, tiers one, two, they are segmented in a certain way to get after everybody. The bottom line—your question relative to when do we think we will have everybody vaccinated. It will probably be sometime in late July, August timeframe. And we are making great progress.

As you know, the vaccine delivery has picked up significantly. I mean, the vaccine delivery for the country this past week was 13 million doses. So it is picking up exponentially.

The CHAIRMAN. Yeah, and that leads me to my second question, in terms of the distribution chain, and I know you guys are certainly focused on, you know, DOD personnel and those folks, but you are also involved in speeding up the chain. And it is simple to explain—you need to produce the vaccine, and then you need to get it out to people.

Mr. SALESSES. Yes.

The CHAIRMAN. But there are, you know, a lot of details in that. As you are looking at the distribution chain, is there—how to ask this question?

So, and I have seen the report that basically once we get to July, that is when we are going to get there. What are the bottom—what is the most important thing that DOD can do to speed that up? Where do you think you can be helpful? Where are the bottlenecks here?

Is it, just, we don't have enough of it? Is it it is not getting distributed to the States, once it gets to the States, it is not getting out fast enough? Or is it—or are we pretty much doing the best we can right now"?

Mr. SALESSES. My sense is that we can do better, but we are doing a lot to make it happen. If I can give you a bit of a perspective, and I can talk specifically about what the Defense Department is doing.

Obviously, the Defense Department is working very closely with FEMA to establish these mega and large centers. That will be very helpful. In fact, I visited the center in Glendale, Arizona, about 2 weeks ago. They are providing 8,000 shots a day at a drive-through center out there. That is a tremendous amount of vaccine shots in one day in that area.

Our mega centers that we are working with FEMA on will also be able to provide up to 6,000 vaccine shots. The one is just established in Los Angeles, we have plans to establish them in Texas and New York over the coming days. And that will be very helpful.

But, as you know, if I could just back up, because the vaccine, Pfizer and Moderna, right now we expect 100 million doses by the end of March of each one of those. We expect another 100 million doses from Pfizer and Moderna by the end of May, and another 100 million doses by the end of July. That gives you some perspective of what the supply side is.

On the distribution side, the Defense Department is obviously helping with these mega and large centers. At the same time, there is about 30,000 centers identified the across the Nation with State and local authorities.

As the vaccine becomes more readily available, it will be coming, obviously, in greater quantities. As I just pointed out, yesterday we did 1.6 million doses in arms around the country.

The CHAIRMAN. And that all sounds good, and I apologize. Other members here are going to want to get in. Just quickly, is there a particular chokepoint where you are like, here is what we need to do. This is—I have seen this. We really need to get after this, or is it just sort of all kind of moving forward as you described?

Mr. SALESSES. Sir, I believe it is all moving forward, and it's beginning to ramp up much faster than what we've seen. Again, this started December 14th when we started to take the first doses. I think you are going to see a great acceleration over the next 30, 60, 90, 120 days until we are at the end of July we have delivered over 600 million doses of vaccine.

The CHAIRMAN. Thank you very much. I appreciate it.

Mr. Rogers.

Mr. ROGERS. Thank you, Mr. Chairman. To follow up on that line of question with the chairman, has there been a lack of supply that has held up from vaccinating more members of the service?

Mr. SALESSES. I think, in general, yes, sir, that is reasonable. I mean, it had not been produced. Obviously, we have hundreds of millions of people to vaccinate. If we focus just on DOD, our increase in supply has been growing every week.

Mr. ROGERS. Okay. Well, I was looking at your Joint Staff COVID–19 Update of February 17th and I see that between first dose and second dose you all have administered right at 916,000 doses. And this could be, I guess, for General Taliaferro. I thought I heard you testify there were 860,000. So what is the delta there?

General TALIAFERRO. Ranking Member, I think that certain—just the timeline between preparation of the remarks and products today, there are a lot happening each day. So as of today, 916,575.

Mr. ROGERS. Okay. Do we know how many of those are for service members as opposed to like depot workers, civilian personnel?

General TALIAFERRO. The majority, Ranking Member, focus on the higher tiered members. Tier 1a and 1b which are primarily our healthcare workers, critical personnel. So more heavily focused in those areas.

Mr. ROGERS. Okay. My understanding, this puts us at about 20 percent of the individuals we are trying to vaccinate. Is that about right? That is including civilian personnel and contractors, et cetera?

Mr. SALESSES. Correct.

General TALIAFERRO. That is correct.

Mr. ROGERS. Okay. Do we know how many service members have received the vaccination of that 916,000?

Mr. SALESSES. Sir, I do have the numbers. What I show, and again these numbers, obviously, depending on when they were captured, either yesterday or today. I show 359,000 initial doses for service members. And then fully vaccinated, that means two shots, obviously, 147,000. I also have the civilian numbers and the contract numbers, if you would like those, sir?

Mr. ROGERS. Okay. What about concerns? Have you heard many concerns from service members about apprehensions in taking the vaccine? And if so, what are those concerns and how are you all managing them?

General TALIAFERRO. Sir, Ranking Member, I think we believe that, of course, the vaccine is the right thing to do, it is clearly safe for service members, and we need to continue to educate our force and help them understand the benefits and ensure there is leadership involvement in the discussion of the benefits of the vaccine.

Mr. ROGERS. So do you have a handle, General Taliaferro, what percentage of the service members has declined?

General TALIAFERRO. And so, Ranking Member, I think our initial, initial look—and this, of course, is very early data, is acceptance rates are somewhere in the two-thirds territory. And, of course, it varies by different groups.

Mr. ROGERS. Okay. What about—are they deployable? Somebody who is not vaccinated, is that individual deployable?

Mr. SALESSES. So, Ranking Member, we have—the services and the combatant commands have worked very hard over the last year to make sure that we can operate in a COVID environment. Before vaccines were available, the addition of the vaccine should make us more capable in that environment, but we have already demonstrated over the last year that we are fully capable of operating in a COVID environment.

Mr. ROGERS. So I take that to mean, yes, they are deployable even if they have not been vaccinated?

General TALIAFERRO. Yes, sir.

Mr. ROGERS. Great. Finally, what is the current state of readiness across the services when it comes to COVID, and how has it been impacted by COVID?

General TALIAFERRO. Sir, Ranking Member, I think that the services have been very adaptive and resilient. When larger formation exercises weren't possible, they substituted those with some smaller formations, smaller formations that have allowed them to maintain their basic proficiency and currency and combat readiness.

At the same time, of course, there is some quality lost in those larger formation training and exercises. But I would say the overall C ratings or readiness ratings for all the services and combatant commands have stayed within historic norms, largely because of the adaptive and aggressive action by the services and the combatant commands.

Mr. ROGERS. Thank you, Mr. Chairman, I yield back.

The CHAIRMAN. Thank you.

Mr. Langevin.

Mr. LANGEVIN. Thank you Mr. Chairman. Am I coming across okay?

The CHAIRMAN. Yeah, we got you loud and clear.

Mr. LANGEVIN. Very good. Thank you.

I want to thank our witnesses for your testimony today. Let me begin, sort of on a follow-up to the ranking member's question, I am concerned about, focused on readiness as well.

So we have seen—obviously, COVID–19 outbreaks disrupt our military's operations, especially Navy deployments. And while the Department is doing well in distributing the vaccine, it has a hand—last week Secretary Austin said that the Department does not know how many service members have declined to get vaccinated.

General Nordhaus, what would be the force readiness impacts if fewer than 50 or 60 percent of service members accept vaccinations? And, just for the record, I would assume, but I don't want to assume, I want it to be just for the record, do service members have the right to refuse to get vaccinated? This, obviously, impacts readiness.

So, if you could address both those aspects of the question.

General NORDHAUS. Congressman, thank you for the question. Yes, it is voluntary to receive the vaccination. As far as numbers that we are seeing in the National Guard, it is just like General Taliaferro talked about, very similar to what is out in the population.

In the two-thirds to 70 percent readiness impacts, if they were lower than the 40 to—30 to 40 percent as you discussed, I can't really speak to—we have been able to operate within a COVID environment.

Like Major General Taliaferro talked about, the individual capability of our adjutants general and how they have worked with flexibility and adaptable to make sure that our service members have, one way or another, gotten the training they need to be ready and to deploy. They have been very successful at that.

And to this date, we are able to meet all current and future projected deployments for the National Guard.

Mr. LANGEVIN. Thank you, General.

Mr. Salesses, the Biden administration modified the cost share agreement to fully fund the National Guard in title 32 status at 100 percent and extended the authorization until September 31, 2021. What criteria will the Department use when determining whether or not to recommend any further extension of funding the National Guard in title 32 status after September 31, 2021?

Mr. SALESSES. Congressman, thank you for the question. We are working closely with FEMA. Obviously, the National Guard is filling FEMA mission requirements in support of FEMA. And so as we work through this together, we will make a determination as we get closer to the September whether the continuing efforts of the National Guard, obviously, is necessary. And if that is the case, obviously, we would be supporting 100 percent reimbursement going forward for that too.

Mr. LANGEVIN. Thank you. And I understand that the Department is responsible for, obviously, supporting civilian efforts for vaccine distribution and tracking.

Mr. Salesses, can those responsibilities be taken over by large companies, like Amazon, for example, who are experienced in last mile delivery, what would be best in terms of actually function of how do we get this, get this out? Is it best in the National Guard, or should we be looking at the private sector like Amazon?

Mr. SALESSES. So, Congressman, if we are talking about distribution from the manufacturers, that is being done right now by FedEx and UPS and those kinds of organizations to the State level. And they are maximizing the commercial capability to do that. Is that helpful, Congressman?

Mr. LANGEVIN. So, give me a—take it from there what the National Guard is doing versus what the private sector is then doing?

Mr. SALESSES. So, once the vaccine has arrived at a distribution point within the State, then the State, obviously, the Public Health/Emergency Management State officials take over from there, and as far as making sure that the right resources at that distribution point and at that vaccination point are available.

And I think that is where the National Guard has been tremendously helpful throughout the States with all of the ability to inoculate the citizens in support of their public health and individuals at the State level. But I will defer to General Nordhaus if he wants to add to how the National Guard is exercising that in the States——

The CHAIRMAN. He is going to have to do that in 8 seconds. So why don't we take that for the record, because I think your time is pretty much up. But thank you. I appreciate that.

[The information referred to can be found in the Appendix on page 79.]

The CHAIRMAN. And next up is Mr. Turner, recognized for 5 minutes.

Mr. TURNER. Thank you, Mr. Chairman. I want to thank all of our witnesses today. DOD certainly has been extraordinary in its response in what has been an unbelievably difficult situation for our country, and it has been essential.

General Nordhaus, I have a couple of questions about the National Guard. The Secretary mentioned that we are trying to prioritize the vaccine for those service members who are on the front lines, if you will, or performing functions which are not only essential but in which they might have exposure.

Are the members of the Guard being appropriately prioritized, who are, as you indicated, serving their communities in the COVID response, such as serving in food banks, serving in vaccine supply, assisting their communities in ways in which they are backfilling as part of the COVID response, are they appropriately prioritized?

General NORDHAUS. Congressman, thanks for the question, and I do have to state that I am an Ohio guardsman. First of all, yes, we are in lockstep. We have been fully integrated in a DOD priority schema for the vaccination. We receive our allotment of vaccines, and then we follow right down the list from 1–A through 1–C.

And in that top list of—in the 1–A, our guardsmen that are serving in COVID operations across the 54, and so they have the ability to get the vaccine. And we have been pushing it out weekly to the States so that they can get vaccinated.

Mr. TURNER. Excellent. General, I have one more follow-up with you. Since both of us have, you know, our roots in Ohio, I do want to say that this question is based on information I have actually in other States besides Ohio.

Could you, please, tell me how is the chain of command working when National Guard work with community partners and are embedded in, for example, food banks, supply systems, or vaccine supply where there are community organizations that are actually conducting it? If a member has—a service member has concerns about how it is being operated, or even has recommendations, how does that work with respect to their participation—because they are not just obviously labor, they have great intellectual capability—how are we able to ensure that that is leveraged and that their thoughts or concerns are taken into consideration?

General NORDHAUS. Congressman, across the 54, from the beginning of this, we have been focused on the federally supported, locally managed. And that has been a great opportunity for our guardsmen as they are out and able to assist at the local level to help local communities be able to expedite, whether it is food banks or vaccines, to those in need.

I will give you a for instance, this is a quote from the the Louisiana director of community outreach of testing and vaccination programs, and he talks about that the Louisiana National Guard have been very helpful in assisting them with logistics of all the sites within Louisiana, all the traffic control, and they are helping getting patients registered and really keeping things safe, orderly, and moving properly and efficiently.

And so because our guardsmen are traditional, and they have civilian jobs all across the different entities, they bring those different perspectives and thoughts to every mission set that they go to.

So, in South Carolina, Major General McCarty talks about how those guardsmen are able to come up with creative solutions to help solve complex problems. And so every State is using—is working with our interagency partners, whether it is FEMA, or whether it is the State health department, or whether it is the local community to make sure that we can support them as best as possible.

Mr. TURNER. Excellent. Thank you, General.

Thank you, Chairman. I appreciate you holding this hearing.

Mr. GARAMENDI [presiding]. Thank you, Mr. Turner.

Mr. Courtney, are you participating? Apparently, you are not on, so that would be my turn.

This will be a question to—well first, for all of you. It has been an extraordinary year. And clearly, the U.S. military all across all of the services has been a very, very important part of the American response to the pandemic. And I thank you.

This morning, as I drove into the Rayburn building, I had the pleasure of seeing National Guardsmen here at the Capitol protecting us and doing so all across the Nation.

Yesterday, the Readiness Subcommittee did a briefing to learn from the five services, the impact on readiness. I will just not go through all of that and ask you gentlemen to go through it again. However, I will put it this way. The services have been very creative in addressing the issues, and learning along the way.

If we knew today—if we knew at the beginning what we know today, the impacts across the military would be significantly less. Nevertheless, learning has taken place. There are concerns—and we will go into those concerns in more detail in the subcommittee work.

But my question really goes to the future here. The new administration wants to use the military, particularly, the Defense Production Act.

Mr. Salesses, if you could take this issue up. What is taking place with regard to the Defense Production Act? We are thinking PPEs here, perhaps even the issue of vaccinations being produced and distributed. So if you could talk, generally, and then perhaps, specifically, about some examples of where the Defense Production Act is or is not in operation?

Mr. SALESSES. Congressman, thank you. I am going to ask Brent Ingraham who is with A&S [Acquisition and Sustainment], he actually manages, oversees Defense Production Act, and he is going to speak to that. Brent.

Mr. INGRAHAM. Good morning, Congressman.

Mr. GARAMENDI. You can bring your chair up and have at it. Please introduce yourself for the record.

Mr. INGRAHAM. Good morning. For the record, I am Mr. Brent Ingraham, Department of Defense, Acquisition and Sustainment.

Mr. GARAMENDI. Thank you.

Mr. INGRAHAM. From the Defense Production Act perspective, the Department has used some of our own resources, along with supporting both Health and Human Services and FEMA to execute a number of onshoring of medical resources across the—for the need of COVID, across both PPE, testing and diagnostics, pharmaceuticals, N95 masks.

So to date, the Department has awarded about 885 million Defense Production Act dollars of our own that has been both towards medical resources in the defense industrial base. And then about—we have—about $1.6 billion on behalf of HHS.

So we have seen—we have done medical investments to include $250 million in N95 respirator masks, $10 million in surgical masks to get the production of over 445 units per month, $22 million in glove production for over 38 million units a month, and over $880 million in COVID test production kits to get over 86 million units per month.

Mr. GARAMENDI. Are you able to—does the Defense Production Act allow for the prioritization of both the purchases and then the distribution in the—in 2020, it was principally left up to the States to try to acquire the necessary equipment, PPEs, and others.

Are you now using the Defense Production Act to coordinate and to acquire and then distribute necessary equipment, PPEs, for example?

Mr. INGRAHAM. We use Defense Production Act to acquire material. I will say Department of Health and Human Services using the Strategic National Stockpile and FEMA are the ones that are actually distributing, that are actually distributing that PPE to the States and using their rating systems to be able to prioritize for the States.

Mr. GARAMENDI. So there remains across the Nation a shortage of equipment. And you are relying—it is the Department of Health and Human Services and FEMA that are setting the pace, and then you administer from there?

Mr. INGRAHAM. We supply them the products. Right? So we were doing from an assisted acquisition providing the contractual and acquisition support to procure the items and stand up the industrial base to be able to produce to their requirements.

Mr. GARAMENDI. My time having expired, I want to go into this in more depth, and we will have some written questions for you about how the Defense Production Act works.

I will now yield and call on Mrs. Hartzler. You are up next.

Mrs. HARTZLER. Thank you, Mr. Garamendi. And I appreciate everyone here and all that you are doing for our country. I wanted to just follow up on what my colleague just asked about.

Even before the pandemic, Representative Garamendi and I had introduced a bill to bring back pharmaceutical production to America because of the vulnerabilities that we had discovered with China being a major source of our pharmaceutical ingredients.

And I have been pleased that in January of this year, the Department of Defense, in coordination with HHS, awarded a $69.3 million contract to continue pharmaceuticals to develop a domestic production capability for critical active pharmaceutical ingredients and final dosage from medicine using a proprietary integrated continuous manufacturing technology. And last September, DOD and HHS also signed a $20 million contract with OnDemand Pharmaceuticals to develop a domestic production capability for critical active pharmaceutical ingredients.

And so, my question is what capability has been provided here in the United States for standing up our pharmaceuticals, and what additional work is the Department of Defense doing to secure the medical supply chain for our troops through the use of the Defense Production Act?

And are there any additional authorities for the Department of Defense that you need for Congress to help with in this effort? So can you kind of expand a little bit on the pharmaceutical production that has been stood up through the Defense Production Act and give us an update on that?

Mr. INGRAHAM. Thank you, Congresswoman. I would like to take that action for the record. We provided those—both of those capabilities were on behalf of HHS to provide that capability. And so as those products are starting to be developed, I would like to get back to you with the results on how those are being—working out.

Mrs. HARTZLER. Do you know of those capabilities that are being developed, what percentage of those new pharmaceuticals we provided and set aside for our men and women in uniform versus just the general public?

Mr. INGRAHAM. Both of those capabilities would be for HHS for the general public. Those have not been specific for DOD.

Mrs. HARTZLER. And are the capabilities just in general or are the—has this money been dedicated just to COVID-related medicines?

Mr. INGRAHAM. Based on the continuous award, that was focused on COVID–19-related medicines.

Mrs. HARTZLER. Okay. So we are not using the Defense Production Act just to expand our general pharmaceutical development here in the United States. That could be helpful for our soldiers, so we are not depending on China. Is that correct?

Mr. INGRAHAM. We currently have no Defense Production Act awards in that area.

Mrs. HARTZLER. Okay. Are you aware of any additional capabilities that we need here as a committee to enable you to help with this? Because we need to certainly address this pandemic. But Representative Garamendi and myself, and I believe our colleagues who are on this call, have a lot of concerns for our underlying dependence on China with our medicine.

So do we need to do any more through the NDAA or legislation to get this production developed here so our troops aren't so relying on China for some of our basic medicines and vaccines?

Mr. INGRAHAM. I would recommend that Brigadier General Paul Friedrichs from the Joint Staff Surgeon General talk about what specific additional medicines we may need to support our troops.

Mrs. HARTZLER. Okay.

General FRIEDRICHS. Congresswoman, this is Brigadier General Paul Friedrichs, the Joint Staff Surgeon. And first, I want to thank you and the members of this committee for the work that you have done in this area. Because this is an absolute concern of ours, and we are grateful for the precedent that you have set in relooking at this.

We have gone back through based on the original language that you all had drafted and looked at those operational medications that we rely on in our deployed assemblages and identified which ones rely on ingredients from other countries. We are working with the FDA to obtain ingredients for those where we have not been able to identify the source of origin.

And to your question about what other steps need to be taken, that is really the next step is to understand fully through the global supply chain where all of the ingredients come from, and ensure that pharmaceutical companies are able to share that information with us so that we can then identify what risk there is to those medications in our deployable assemblages. We continue to work closely with the Food and Drug Administration and the Department of Health and Human Services on this as we identify those risks and then identify opportunities to mitigate them.

Ma'am, I hope that answers your question.

Mrs. HARTZLER. Thank you. It is very helpful, and I look forward to working with you and try to get this information as quickly as possible.

But thank you for your time there, Mr. Chairman. I yield back.

Mr. GARAMENDI. Well, thank you very much, Mrs. Hartzler. Thank you, General, for your response on that. In the larger context, we have discovered that much of what we depend upon for the military and for our domestic use in this pandemic and beyond is not produced in America. This is one example of that problem, and there are numerous other examples.

The President has established a Buy America policy, and that is for the military as well as all other government purchases. And so we will be following that along closely.

We would appreciate some more detailed information on this pharmaceutical issue.

Our next witness is—excuse me, our next questioner, Mr. Carbajal, you are up.

Mr. CARBAJAL. Thank you, Mr. Chairman.

General Nordhaus, in the weeks since the National Guard mobilized to respond to the January 6th violent extremist insurrection mob and for the Presidential inauguration, there were reports that hundreds of Guard members on duty in DC tested positive for COVID–19.

What procedures did the Guard have in place to test members before arriving in DC, while in DC, or before returning home? Did the Guard conduct contact tracing for members who tested positive?

And the reason I asked is because I think it goes to the heart of our readiness. Do we already have the infrastructure and procedures and protocols in place to protect our service members as well as those that they are around?

General NORDHAUS. Congressman, thank you very much for the question. We follow all CDC guidance. And as those folks deployed, you know, they do testing and screening from a standpoint of temperature and checks to make sure that they are healthy, they pass questionnaires, and then they deployed into DC.

I will say that the positives, once we tested somebody, they would go through the normal health requirements there to get tested. If they tested positive, the DC National Guard and their organization worked through the contact tracing to make sure that they identified members that needed to go into restriction of movement. And they continued that over the last, you know, month now.

And I will say that from the numbers I have seen, they've done a really good job and they've continued to reduce that to be able to find where those positives are and then do the contact tracing, do appropriate restriction of movement to ensure that they can minimize any impacts to the mission.

Mr. CARBAJAL. Thank you. General Taliaferro, if I heard correctly, one-third of our service members are refusing the vaccination. What is the Department doing to reach out to our service members to encourage them to be vaccinated? And, you know, when I served in the Marine Corps, I don't think I was ever given an option about my vaccinations. We just got in line, and they zapped us, and everybody got it, that was just the way it was. Are you saying that now we have a new approach to vaccinations for our service members?

General TALIAFERRO. Congressman, I wouldn't say we have a new approach. There is still a variety of vaccinations that are mandatory. The fact that this is authorized under emergency use authorization is what puts it in the category of being a voluntary vaccination.

And, you know, I think it is most effective to think about the numbers that have accepted. Certainly service members can accept or—you know, we don't precisely know why an individual has not received a vaccine. We think it is important that the Department continue to communicate to our service members the value of the

vaccine, the safety of the vaccine, with continued leadership involvement to help our service members understand that.

Mr. CARBAJAL. Thank you.

Mr. Salesses, I appreciate the support the Department has provided to States throughout—providing personnel for testing sites, food distribution, and designating alternate care facilities.

I understand the Department has announced that it will send Active Duty service members to support five FEMA vaccination sites and are currently evaluating additional requests. What criteria does the Department use when evaluating these requests?

Mr. SALESSES. Congressman, we obviously look at a number of factors. First of all, obviously, because of the demand for vaccine support, that is the priority for the Nation, and obviously we want to support that. We also look at the types of people that we are providing—medics, corpsmen, nurses—and, obviously, evaluate the impact on the Department.

The Department is ready, prepared to support all of these vaccine centers that we have identified and are working with FEMA—the ones in California, as you mentioned; we have ones planned for New York and Texas. And we will work very closely with FEMA going forward, depending on the availability of medical people—nurses, medics, corpsmen, and those types of things. We weigh all of those things.

But we understand this is a priority for the Nation, and the Department is ready and postured to support these vaccine centers.

Mr. CARBAJAL. Thank you.

Mr. Chairman, I yield back.

Mr. GARAMENDI. Thank you.

Mr. Wittman, you are up next.

Mr. WITTMAN. Thank you, Mr. Chairman. And I appreciate our witnesses' joining us today.

I wanted to go to Mr. Salesses and ask him specifically what Department of Defense is doing for our critical civilian support structure for the military.

And I will give you an example. Newport News Shipbuilding is one of our contractors that requires individuals to work in close quarters, and, therefore, vaccinations are critically important for them. Last week, they didn't receive their allocation of vaccines from the Virginia Department of Health. When that happens, that interrupts their ability, obviously, to build ships.

And that is, I know, common with a number of other folks that provide critical support services for the United States military, building systems, that are required to work in close quarters, and vaccinations are key.

What is the Department of Defense doing to assure that there is not interruption of those efforts there and making sure that the federally acquired vaccines are distributed to Federal contractors, who, again, by the very nature of their work are required to work in close quarters, and making sure that they are doing their job to support our brave men and women in the military?

Mr. SALESSES. So, Congressman, again, the Department has worked very closely to look at our beneficiaries, our military, our civilian, and specific contract support that is directly provided to

the Department. For example, the Newport shipyard, as you indicated, that is being supported by the State allocation.

And so, as we look to the future, obviously, any of these critical areas, we are willing to and are obviously going to talk to these organizations to see how and what we can do to assist.

But as we see the increase in vaccination capability from Pfizer and Moderna, we will be able to provide more support collectively to these critical essential workers that have been identified. In each one of the States, following the CDC guidance, again, essential workers are identified. So I am optimistic that the Newport shipbuilding community will be receiving their vaccine in short order.

Mr. WITTMAN. I just hope to follow up with not just with Newport News but other companies that perform critical functions for our military to make sure that there is no interruption in vaccines there. Because what it does, it is a workforce interruption, and that is not what we need to be doing.

One other question, too, is about health protection condition levels. What latitude do local commanders have in changing health protection condition levels? In other words, are you giving them the flexibility to determine conditions on literally a day-by-day basis? Because they know best about what is needed to protect the health of their people under their command.

Mr. SALESSES. Congressman, there is that flexibility to do that. I will turn it over to the Joint Staff. But it is obviously dependent upon the positivity rate within the community, the hospitalization rate. And, obviously, those are the indicators. But the local commanders at the installation set the health condition levels.

General TALIAFERRO. Congressman, this is General Taliaferro.

We think you are exactly right, that nobody knows better than the local commander what is happening in that local area, especially connections to local leaders, whether that is leadership or medical facilities. And while DOD instructions give general guidance of things to consider, it is fully within the hands of local commanders to make that decision.

Mr. WITTMAN. Very good. Well, listen, I appreciate that. That is key. I know as I have spoken to some local commanders——

Mr. GARAMENDI. Mr. Wittman, we seem to have lost you.

Mr. Wittman?

We will move on. And if Mr. Wittman comes back, he is late.

Our next witness is—excuse me—our next questioner is Mr. Brown.

Mr. BROWN. Thank you, Mr. Chairman.

And thank you, gentlemen, for being here today.

So we have heard during the testimony that the Department can mandate a vaccine if it is formally licensed by the FDA.

Is that authority to mandate a vaccine, let's say, for example, influenza or when a service member deploys to an area where a vaccination is required, is that express authority granted in statute by Congress, or is that the power of the President as Commander in Chief?

General TALIAFERRO. Congressman, I am going to defer to General Friedrichs, the Joint Staff surgeon.

Mr. BROWN. Okay.

General FRIEDRICHS. Congressman, this is Brigadier General Paul Friedrichs. Thank you very much.

That is authority vested in statute. And the statute is written to state that those drugs which are not under an emergency use authorization can be mandated. Those which are under an emergency use authorization may not be mandated except in certain extraordinary circumstances laid out in the statute.

Does that answer your——

Mr. BROWN. So which—no, no, I really appreciate that. I want to kind of flesh that out so that Congress, that we make sure that you have the tools you need.

Is there, in the planning, in the forecasting for when it comes to the take-up rates of the vaccine, is there a scenario in which the Department might exercise the authority to mandate the COVID–19 vaccination under this emergency use authorization?

General FRIEDRICHS. Congressman, from a medical standpoint, I believe the legislation which you and your colleagues have written is sufficient to address the circumstances that we are facing today.

And it is very clear legislation. We have worked closely with our Office of General Counsel to understand the intent and the specifics of the legislation. So we believe that you have given very——

Mr. BROWN. So, essentially, the Department could mandate that a service member receive the COVID–19 vaccination under the statutory authorization provided by Congress?

General FRIEDRICHS. No, sir. The Department could not mandate that. The Department could not——

Mr. BROWN. Okay. But you said under certain circumstances. Give us an example of what would be that circumstance where, even with the emergency use authorization from the FDA, which is not the formal license, you could mandate the COVID–19 vaccination. What would be a circumstance?

General FRIEDRICHS. Sir, there are no circumstances where the Department of Defense has the legislative authority to do that. And we can provide in a written response back to you the specific language on that. The certain circumstances would require action outside the Department of Defense.

Mr. BROWN. Okay. No, I understand that. And thanks for clarifying that.

Mr. SALESSES. Congressman, can I add to that discussion, though? This is Bob Salesses.

I do think that we are in the beginning phases of this vaccine. And as General Taliaferro pointed out, I do think the opportunity to educate, inform, and make sure that our service members, our civilians and contractors really understand the benefit of this going forward, I think, will reduce——

Mr. BROWN. Thank you.

Mr. SALESSES [continuing]. Significantly.

Mr. BROWN. Thank you.

Are you keeping data, are you surveying the force on, by demographics, who is accepting the vaccine and who is not, either by gender, race, ethnicity, or any other relevant factor?

And I ask that because there is a lower take-up rate in many communities around the country in communities of color. Are you

gathering or collecting that data? Are you making those observations?

General FRIEDRICHS. Congressman, this is Brigadier General Friedrichs from the Joint Staff again.

So we are collecting that data on acceptance rate. And as General Taliaferro and General Nordhaus mentioned, our experience mirrors the preliminary data that we are seeing in other communities.

We are actually digging into that and continuing to collect more data as we administer more vaccines. As we mentioned, the first priorities are healthcare workers. And that is the group for which——

Mr. BROWN. I mean by race and ethnicity. Are you collecting data by race and ethnicity?

General FRIEDRICHS. Yes, sir, we are. And——

Mr. BROWN. Okay.

Thank you, Mr. Chairman. I yield back.

Mr. GARAMENDI. Thank you, Mr. Brown. Thank you for those questions. I think we have gone through this issue of vaccination and required or not required.

Mr. Scott, you are next.

Mr. SCOTT. Thank you, Mr. Chairman.

And, gentlemen, thank you for being here.

My question revolves somewhat around data as well. Mine is specifically geared towards the infection rates. And are the infection rates that we are seeing in the DOD different from the infection rates that we are seeing in the general public? If so, what are the trends that we are seeing?

We obviously have a more controlled environment than the general public does. So infection rates and the trends with regard to those rates versus the general public, what are we seeing?

General FRIEDRICHS. Congressman, this is Brigadier General Friedrichs, the Joint Staff surgeon. Thank you very much.

So we have aggressively implemented those public health measures that the CDC has recommended, and, as a result, we have seen a lower percent positive test rate in our population than in the general public over the last year. And that has been very consistent for the Active Duty force as we have gone forward.

Our overall number of cases has risen and fallen as the number of cases across the United States has risen and fallen, so we have mirrored what is happening in the communities where our bases are located. But the percent of our force which has tested positive has been lower than what we have seen in other communities.

In addition, we have seen a lower percent of the force who require hospitalization. And although we have had a few members of the force who have died as a result of COVID infection, that is a smaller number than in the general public, in part because we have a younger population and, in general, they are fairly active and healthy and able to serve.

[Audio interruption.]

Mr. SCOTT. All right. So Jim Banks is chiming in on my time.

How much difference are you seeing in the ranks versus the general public?

General FRIEDRICHS. Congressman, I am sorry. Could you repeat the question, sir?

Mr. SCOTT. Are we 10 percent better? Are we 20 percent better? What is the difference in the infection rate between DOD personnel and the general public?

General FRIEDRICHS. Congressman, the data that I am most familiar with is the percent positive rate. And we have typically had about a 1 percent lower rate of tests which were positive compared to the general population. But that has varied from week to week as we look at it.

I would be happy, if I may, to respond for the record with specific data on that. But it has been consistently at least a percentage point below the general population.

[The information referred to can be found in the Appendix on page 79.]

Mr. SCOTT. Okay. I am interested in that data, and I do think that it is extremely important that we keep it. We don't know how long these vaccines are going to work, and so we don't know when the second round of vaccinations is going to have to happen. And I think that the data, especially in the more controlled environment—although it is not perfectly controlled, it is more controlled than the general public—is going to be a benefit to all of us as we push forward.

I am concerned—and I mentioned this yesterday in the hearing—I am concerned about our teams, for example, our ODA [Operational Detachment-A] teams that are out in Africa that work in these train-and-equip missions where they are in very close proximity, in order to do their job, with people from other countries. I would be interested in how you intend to handle that with regard to what I would refer to as partner forces.

Are we testing those partner forces? Are we checking fevers before we do a training mission with them? How are we handling ODA missions, for example, with partner forces?

General TALIAFERRO. Congressman, this is General Taliaferro.

I would say, in general, the forces in those areas are practicing good force health protection measures of distancing, mask wearing, in some cases distributed operations, distributed training by an ODA team in an area like that, hygiene awareness.

And we believe that the forces we are partnering with are generally following the same procedures we are, but I don't have the details at present on those specific ODA teams.

Mr. SCOTT. Okay.

I am almost out of time.

General Nordhaus, Tom Carden and Tom Grabowski would want me to tell you hello. They have done a great job, especially months and months ago they were out there in our nursing homes with the Georgia Guard helping them kill this virus. And certainly appreciate all that the Guard is doing in Georgia and in Washington as well right now.

Gentlemen, thank you. And my time has expired.

The CHAIRMAN [presiding]. Thank you.

Mr. Kim.

Mr. KIM. Thank you, Chairman.

Thank you, everyone, for joining here and talking with us about this incredibly important issue.

I wanted to shift a little bit here in terms of the questioning. Many of us represent military bases and installations in our districts. I represent Joint Base McGuire-Dix-Lakehurst, and that joint base is really an anchor to an entire community—a community not just of the service members but outside around it. I want to just ask two or three questions about this.

I had a townhall last night, and on the townhall there was a veteran, a veteran who lives just outside the joint base, who said he is dependent upon access to the commissary for his food. You know, he is someone who does not have a lot of money. He was telling me just the struggles he has had financially because of this. But he has had a tremendous amount of difficulty getting onto the base because of COVID restrictions.

So I guess I just wanted to ask you what work has DOD done to try to think about just the broader community here, how we are looking out for veterans in particular, many of them who settle down and live right around the bases where they retire from. Is there anything else we can be doing to help them get access to the commissary and other services on the base, and other ways we can integrate them into some of our thinking of COVID response from DOD?

Maybe we can hand that over to Major General Taliaferro.

General TALIAFERRO. Thanks, Congressman.

I would say that, in the setting of the health protection condition measures, I think not just at the local level but certainly at the Department, we are aware of the dependencies in the community. There are a lot of linkages to the local community that commanders need to be aware of when they are going to the more extensive measures like, say, Health Protection Condition Delta, where some of those people would not be allowed access to the base.

There are lots of linkages at those levels, whether it is contractors, different support that comes from off the base onto the base, certainly the support the base provides to dependents, veterans, or other beneficiaries in the area.

So I know that our commanders are aware of that. When they reach circumstances that require those kinds of drastic measures, they take them, but I know they are conscious of them.

Mr. KIM. Well, look, I appreciate that.

And one thing I will just say here is, open communication and just, kind of, transparency on that front goes a long way. I think a lot of the problems here—I mean, I will tell you, I get more calls about this than almost any other issue from the veterans community right now. And I think just some open communication about, you know, the timing or the reason for the restrictions at my base as well as around the country I am sure would be helpful.

A last question here, just kind of on a different side of this coin. I have talked with a number of service members in my district that are young parents. They have little kids, like I do. I have a 3-year-old and a 5-year-old. I know the struggles about childcare right now, and I know that a number of our service members have struggled with this.

It has put an enormous burden upon them and their ability to do their work, as well as their spouses. And we already put way too much burden upon military spouses as well. As we know, unemployment for them is through the roof.

I wanted to just kind of hear from you, just, what is your thinking about what it is that we can do to support service members, their families, their spouses when it comes to childcare and other elements for their children? Is there more that we can do, as I know many childcare centers have been closed or have big restrictions on that front?

Over to you.

Mr. SALESSES. Congressman, this is Bob Salesses.

So, in the Defense Department, we have over 200 child development centers and currently have about 180 open. Obviously, they are not open at full capacity, but we are always looking at the kind of mitigation measures that could be put in place to ensure that we can maximize those child development centers. I think the broader issue within the community is the same thing.

There is a lot of good work that has been done within the Defense Department to come up with the procedures so that we can have safe and effective child development centers open. Certainly willing to share that kind of information with the community and others.

I think that is the key to success, is working together both inside the community and with the installations, those local installations, to gain a better knowledge and understanding of the best practices that we could share amongst each other to make sure that we can maximize the childcare capabilities both on the DOD installations and outside the DOD installations.

The CHAIRMAN. Thank you.

The gentleman's time——

Mr. KIM. Thank you.

The CHAIRMAN [continuing]. Has expired.

Mr. DesJarlais.

Dr. DESJARLAIS. Good afternoon. And thanks to the panel for the great testimony today.

For any of those who are at the Capitol—and I think most of you are—you probably experienced a much different city than you are used to, as you tried to enter through one-way lanes, through razor wires and gates.

And so, Mr. Salesses, I wanted to reference your internal email dated January 20 of 2021 where you were discussing the National Guard's presence in DC at least through the fall of 2021.

First, how many guardsmen nationally are responding for the COVID effort right now?

Mr. SALESSES. So, Congressman, it is 23,000 or 24,000—what is the number right——

General NORDHAUS. For COVID?

Mr. SALESSES. For COVID.

General NORDHAUS. For COVID, it is 28,430.

Dr. DESJARLAIS. Okay. Thank you.

And so the extended role at the Capitol, would that, in your opinion, divert valuable personnel and resources away from providing further COVID-related assistance?

Mr. SALESSES. Congressman, that would depend on what level of National Guard was needed to support the Capitol security.

Dr. DESJARLAIS. Right. And what is there, roughly, about 6,200 still deployed?

Mr. SALESSES. Within the NCR [National Capital Region], that is about the right number, Congressman. We have about 4,900 on the Capitol Grounds. We also have National Guard members supporting Secret Service and currently supporting MPD, the Metropolitan Police Department.

Dr. DESJARLAIS. And we certainly appreciate their service. I have had the opportunity to talk to many of them, and they are doing an admirable job.

Major General Nordhaus mentioned in his opening remarks that we have not seen National Guard called upon to serve in such numbers since World War II and that military officials have already estimated that the cost of the Capitol deployment will near a half a billion dollars just through mid-March.

So now more than ever is it important to continue to devote these resources? Or can you share with the committee some credible threats that would require us continuing to have such a presence in the Nation's capital?

Mr. SALESSES. Go ahead.

General NORDHAUS. Sir, if that question was to Major General Nordhaus, sir, right now we are scheduled to end the National Guard on roughly 12 March. And pending any other information, we will work with our interagency partners like we always do, the Office of Secretary of Defense, to continue to support if things change.

Dr. DESJARLAIS. Okay. So, as of now, you can't share with the committee any credible threats that have been identified, so you are planning on sending the 5,000 guardsmen home?

Mr. SALESSES. Look, Congressman, we obviously work with our law enforcement partners to determine that threat, and that is obviously continuing to evolve. At this time, I am not aware of a threat that is out there, but that evolves all the time, Congressman. So we have to work closely with our Federal law enforcement partners to understand that.

Dr. DESJARLAIS. Here at the Capitol, which some have dubbed "Fort Pelosi," it is really discouraging to see the razor wire, the fencing, the image that it sends to the world. So, if that threat no longer exists, I would hope that we can return to normal and that these guardsmen, who have served so admirably, could possibly be utilized in other ways and help with the COVID effort.

If anyone has any further response, that is great. If not, I yield back.

The CHAIRMAN. Thank you.

I do want to emphasize that point. I mean, I have some sympathy—other than the unnecessary shot at our Speaker, I have some sympathy for the concern that is being explained there that I hope you gentlemen will take seriously. And I have raised this issue with the Pentagon as well.

As I understand the threat environment right now, it is very hard to justify the current security presence around the Capitol based on the threat environment that we now see. And my great

fear is that this becomes permanent. Because there is always a threat. I mean, you know, I have been here for 24 years and certainly bad things have happened. Certainly the insurrection took that to a whole other concerning level.

And I know you guys don't make the decision on this. I just want to amplify Mr. DesJarlais's point. This is the United States Capitol. People are supposed to be able to come here and petition their government, all right? And I can barely get in at this point.

So I just hope we balance the risk with the job it is that we are all supposed to be performing here, understanding that COVID is part of this as well. And I have had conversations with the Speaker about this and conversations with General Honoré about this. I hope we think about the balance.

If you look at it from the standpoint of, "Well, let's just eliminate all risk," okay, if we were going to eliminate all risk to our individual Members, we would do everything remotely. We would never leave the house, okay? We cannot be afraid of our constituents and do our job. So I hope we will figure out a better balance on how to make that work.

With that, Ms. Houlahan is recognized.

Ms. HOULAHAN. Thank you, Chairman.

And I guess my question might be a good follow-up to that, which is that, in an alternative world where we deploy our National Guard in a different way other than at our Capitol, some States have been successful in getting their National Guard to be able to support vaccine deployment efforts.

And I was wondering if I might be able to ask Major General Nordhaus—I think that probably is the most appropriate person to ask—are there any obstacles that you are aware of to scaling up the use of the Guard in this way? What would that look like if we did that in a larger scaled effort? And has the DOD considered how they plan to scale up the vaccination efforts when and if other vaccine candidates are approved for use?

General NORDHAUS. Congresswoman, thank you very much for the question.

I know of no impediments right now. We have seen the number of guardsmen on 502(f) increase over the last 3 to 4 weeks. We are now up to 28,430, as I discussed earlier. I believe what we are seeing is that increase. So we started out with just a few vaccination sites of our guardsmen vaccinating civilians in early January. And as I brief today, it is 350, and I know those numbers continue to climb as we are supporting those vaccines.

Some States are using—like Washington I know is doing a great job. They have 150 service members out there. They have 30-person teams. They have four static teams that are at specific locations and another mobile team that is going around to long-term care facilities and vaccinating those members. Other States are using smaller teams that are going out to very rural areas that are some underserved populations to make sure that vaccines are available out there.

But I think we will continue to see the States will utilize the guardsmen to be able to get after these vaccine efforts.

Ms. HOULAHAN. Would anybody else like to add to that before I ask my next question?

Mr. SALESSES. Congresswoman, this is Bob Salesses.

I think it is a combination of things. What we are seeing is, obviously, across the country, there are roughly 30,000 points of administration. A lot of those are community based, State based. As you pointed out, DOD is working very closely with FEMA on these mega and large centers that would provide tremendous throughput on vaccines.

The other thing that is going on is obviously the work with the private sector, in particular with organizations like CVS and Walgreens and many others. That is an opportunity, again, to expand the vaccine administration community. And we believe that, moving ahead, that, along with the community based, the State based, the federally supported, and the private sector, will expand that capability to deliver the vaccine.

This is a very positive development, with the increased level of vaccination that is going to be available and the increased number of locations that will be available. And the Department of Defense's role in this is, again, to support these mega centers and obviously to support the National Guard in supporting the States in what they are doing.

Ms. HOULAHAN. So how are you—and I don't know which one of you might be the most appropriate to answer this. But you spoke about the different ways that we are deploying our Guard and the different kinds of rural areas or our mobile areas. How are you choosing the locations in which you offer to support the non-DOD efforts?

Mr. SALESSES. So, for the DOD support, we work through FEMA. FEMA works with the State to make the determination of where those vaccination centers will go.

I will turn it over to General Nordhaus to talk about how the State works with the Guard to support that.

General NORDHAUS. Yes, ma'am. Major General Nordhaus here.

With the State health departments, they really work with FEMA and with the National Guard and the other agencies within the State, and they determine the best places to make sure that they can get the vaccine across their State with the allocations that they receive.

Ms. HOULAHAN. Thank you. I appreciate that.

I have less than a minute, and I am hoping that maybe I could ask Mr. Salesses—I hope I am pronouncing that correctly—a question regarding pregnant Active Duty members.

I understand that we have been talking a lot about our military and our vaccination process for the general population, but people who are pregnant would be in the 1a vaccination group. How is the DOD factoring in pregnancy status into vaccine prioritization across the Active and Reserve forces?

Some of our colleagues have mentioned that they have concerns about getting vaccinated, but what guidance are we giving to healthcare personnel about providing information to women who are pregnant to make this decision about getting vaccinated or not?

General FRIEDRICHS. Congresswoman, this is Brigadier General Friedrichs.

And we are very closely following the CDC recommendations on that and providing the same evidence-based advice that the Cen-

ters for Disease Control has provided on the safety of the vaccines across the general population and in particular for those who are pregnant or have other medical conditions.

The CHAIRMAN. Thank you.

The gentlewoman's——

Ms. HOULAHAN. Thank you.

And I yield back. I have run out of time.

The CHAIRMAN. Thank you.

Mr. Kelly is recognized for 5 minutes.

Mr. KELLY. Thank you, Mr. Chairman.

My first question has do with 502(f) orders for folks who are on COVID—or service members who are on COVID support. And while it is very important that we be able to respond to this, it is also very important that we maintain our operational readiness in the National Guard and Reserves, in COMPO [Component] 2 and COMPO 3.

Currently, under DOD policy, when a service member is on COVID orders and they have an AT period, annual training period—we have the 155th Brigade that is getting ready to go to the National Training Center for a rotation—they have to come off 502(f) orders, which means they go back into National Guard status. They lose their TRICARE benefits for them and their families, and then 3 weeks later they go back on COVID orders.

With the stroke of a pen, we can change that so that it is either waived and they can stay on TRICARE while they go on those other orders or we can just allow them to do AT status during that.

Do any of you have any response, if anyone is looking at this? Because this is going to impact up to 3,500 members of the Mississippi National Guard this year, and it is affecting soldiers all across the Nation.

General NORDHAUS. Congressman, Major General Nordhaus here.

I believe that has been resolved through the FEMA MAs [mission assignments] and that all the State needs to do is let them know which days that they are on military and not performing in support of the mission assignments from FEMA. And then they stay on the orders, and they just complete the reimbursable difference between those days.

Mr. KELLY. That is great. Just make sure that we are following through and that all States understand this. Because I know I dealt with this, I think, last week, and that was in the initial stages, and I knew we sent out an RFI [request for information] on that.

Second, what amount of our special operations forces have been vaccinated, those who are currently—we had Austin Scott talk about those guys downrange. What percentage of our special operations forces have been vaccinated at this point, or do we have that number?

General TALIAFERRO. So, Congressman, we don't have that specific number with us. But each area is working through allocations both at the service level, the combatant command level, and the installation level to work down the population schema of priorities. So, as they reach critical national capabilities, those national response forces would be vaccinated at that time.

Mr. KELLY. And, finally, Mr. Chairman and also the members, I want to ask them: The emergency use of the vaccine on service members and not being allowed them to be mandatory, that just doesn't make sense. If we are saying the process is safe, we need to portray that in our use on our DOD employees to set the standard and to set an example.

So do you guys on the panel, do you think it would be helpful if we changed that in Congress so that emergency use vaccines, that they can be—not shall be; can be—mandatory to service members? Would that be helpful to you?

General TALIAFERRO. Let me pass that to General Friedrichs.

General FRIEDRICHS. Congressman, Brigadier General Friedrichs. Thank you very much.

I think that would be a discussion that we would need to have with the Centers for Disease Control, the Department of Health and Human Services, as well as the Department of Defense. It is going to depend on the specifics of the vaccine in question.

And I very much appreciate the continued concern about this issue. No one is more interested, I think, than, as we know, you and the members of this committee are——

Mr. KELLY. Well, let me interrupt real quickly. My point is, if we say it can be, it allows DOD to look at different diseases. Currently we can't make it mandatory. And I am not just talking about this pandemic but the next one and the next one. Would it be helpful if we said, DOD can, not shall, make mandatory, can make mandatory, so that we could use the science and the CDC as each specific disease, rather than now having our hands tied?

General FRIEDRICHS. Congressman, speaking as a physician, it is always helpful to partner with you and with our colleagues in the CDC and HHS in crafting language that allows us to respond to each pandemic or biological threat as it occurs. As you said, they will each be different. It will be difficult to write language that will cover everything, but we look forward to working with you on that, sir.

The CHAIRMAN. Thank you.

The gentleman's time has expired.

Mr. KELLY. I yield back.

The CHAIRMAN. Mr. Morelle is recognized for 5 minutes.

Mr. Morelle, are you with us?

Okay. I think we just lost him.

So I think, Ms. Jacobs, are you online?

Ms. JACOBS. I am here. And thank——

The CHAIRMAN. All right. You are recognized for 5 minutes.

Ms. JACOBS [continuing]. You, Mr. Chairman. Thank you.

And thank you, everyone, for being here today on this critical topic.

To follow up on Mr. Brown's questioning, I want to thank you for offering to provide us with the specific legal authority that you, in conjunction with the Office of Legal Counsel, are relying on to assess whether or not you can mandate service members to be vaccinated. And I just want to say that I, too, am very eager to see that specific legal analysis and will look forward to you sending it.

Next, I represent a district in San Diego, which, as you know, is the home port of the *Mercy*. And while the *Mercy* was deployed to

Los Angeles earlier during the pandemic, it is my understanding that the ship was not heavily utilized. The ship's mission was to treat patients other than those with COVID, freeing up hospitals to deal with the virus, but it seems as though few medical providers actually made use of the facilities aboard the ship.

I was just wondering if you have any insight as to why this was the case. Is the Department looking at ways to make it easier for both the *Mercy* and the *Comfort* to better assist the homeland should that need rise again in the future?

General TALIAFERRO. Congresswoman, it is General Taliaferro. I can address that.

Most of our fielded medical capabilities are designed to deploy to a wartime environment and do trauma care. That does not make them perfectly equipped for disease control, as is needed during the pandemic.

But, moreover, we found that, due to the low utilization of some of these traditional fielded medical capabilities, we found it much more effective to deploy our personnel to existing infrastructure, whether that be existing hospitals or medical centers. Because, largely, we found that those hospital and centers were not short on physical capacity; they were short on staff, the ability to staff more beds, the ability to utilize the equipment and capacity they had.

And with the addition of DOD personnel, medical personnel, to expand their internal capacity, it actually allowed our personnel to be much more effective in their response, allowed those hospitals to treat people where the people wanted to be treated. And that was an evolution that made our forces much more capable.

Ms. JACOBS. Thank you for that.

And then, just lastly, I want to reiterate what some of my colleagues have said. I have been hearing from service members on the ground just how difficult the childcare options have been for them during this crisis and, even potentially more concerning, that even the childcare facilities that remain open they don't feel are necessarily upholding COVID protocols and keeping the staff and their children safe.

So I look forward to continuing to work with you all to make sure that we address that issue.

With that, I yield back.

The CHAIRMAN. Thank you.

Mr. Green is recognized for 5 minutes.

Dr. GREEN. Thank you, Mr. Chairman.

And I would like to thank you and Ranking Member Rogers for the opportunity to serve together and to continue the great work that you guys have done caring for our brave men and women in uniform.

I would also like to say to Ranking Member Rogers, I have gotten to know him personally while working under his leadership at Homeland Security. Sir, it has been great to work with you there, and I look forward to and am proud to serve with you now.

My time as an Airborne Ranger and an Army physician assigned with some of our Tier 1 special forces units gave me a love for those who stand in defense of our freedoms. They would die for us, and I believe every member of this committee has a similar devotion and dedication to them. So it is a real honor for me to be here.

And also the chance to take care of, in my district, Fort Campbell and the men and women who are serving from that base, kicking doors and taking names across the globe to defend our freedom, is a real, real honor.

As an Army physician who did research both at Walter Reed and USAMRIID [U.S. Army Medical Research Institute of Infectious Diseases] during medical school and research with soldiers and non-soldiers in residency, I would like to put to bed this issue that I keep hearing about, using research medications on Active Duty soldiers.

There is statute passed by Congress previously in National Defense Authorization Acts that prevent—because of Tuskegee Airmen and what happened there, legislation was passed to prevent the use of any experimental medication on an Active Duty soldier. We did research, myself, on pain management in residency and were not able to use anything but an FDA-approved drug for that. It is written into law.

I think it is a bad idea to change it in a blanket statement, because—or a blanket law, because we need the full-blown research done before we saddle our warriors with an experimental medication. And I can help the committee find that NDAA, and the witnesses find that NDAA, if it is necessary.

I do have some questions for our witnesses, and I appreciate you being here.

Can either of you kind of share, you know, the impact of covering the COVID requirements on training and readiness? And, specifically, were there any JRTC [Joint Readiness Training Center] rotations that were canceled? Were there NTC [National Training Center] cycles that were canceled? What are some of the specific examples of the impact? And when we make this training up, what is the impact going to be on OPTEMPO [operations tempo]?

General TALIAFERRO. Congressman, this is General Taliaferro. I can address that.

In the early days of the pandemic, the services did cancel or delay some of the large force exercises like you mentioned, whether that is a National Training Center rotation or a Red Flag or the like.

Overseas, our joint exercises executed by the combatant commands, over the last year, 99 exercises have been canceled. That would have included about 40,000 U.S. and partner forces partnering with 46 different countries. And 37 exercises were postponed, with almost 50,000 U.S. and partners. That would have included 27 countries.

And I think the overseas training and the large force exercise training in the United States are similar, but there are some key differences. The large force exercises in the United States provide that infrequent opportunity to have a very complicated, realistic training scenario that only occurs a few times in a service member's career, and that is the qualitative——

Dr. GREEN. I really hate to interrupt you. Especially having served in the military, I don't like interrupting a two-star general.

But what is the time it is going to take to return to the level of training when we make all this up? I mean, how long is it going

to take us to make all this up? And what is the impact on the OPTEMPO?

I only have about a minute left, so that is why I jumped in and interrupted.

General TALIAFERRO. Yes, sir. So, Congressman, in most cases, it won't be made up. It will be an opportunity lost for that large force training. And the services have done an outstanding job adapting and substituting small force elements during that space.

Dr. GREEN. Okay.

I only have 20 seconds left, so, Chairman, I will yield.

The CHAIRMAN. Thank you.

Mr. Kahele is recognized for 5 minutes.

Mr. KAHELE. Thank you, Chair.

This question is for General Nordhaus. Good morning, General. And thank you to all the participants who are on today's call.

My question specifically has to do with National Guardsmen who are on title 32, 502(f). I suspect this is an issue that is existing in the other 49 States. But, as you are well aware, section 733 of the most recently passed NDAA provided for transitional health benefits for certain members of the National Guard that are serving under orders in response to COVID–19.

What has happened is National Guardsmen currently that are coming off and are eligible because they have been on title 32, 502(f) for the last at least 30 days are unable to get TAMP, or the Transitional Assistance Management Program, which allows them to continue their TRICARE for up to 180 days, as described in the most recently passed NDAA.

Now, after researching it, it seems that there is a disconnect between the inability for TRICARE to manually activate those eligible service members into TAMP. OSD [Office of the Secretary of Defense] has been working with DMDC [Defense Manpower Data Center] to actively fix it, but their expected implementation date is not until March 20, 2021.

I find that unacceptable for our eligible National Guard soldiers and airmen and their families, who since the passage of the NDAA—I don't know if it was retroactive to National Guardsmen who have been on title 32, 502(f) since last March. But for the National Guardsmen that have been on 502(f) orders since the passage of the NDAA, who have been on orders for the last 30 days and have come off those orders, they should be transitioned right into TAMP and not have to wait until March 20 of 2021. There should be no break in their TRICARE Prime healthcare benefits.

And my questions are: What are we going to do to address this? Why is DMDC unable to implement this today for eligible service members? What is OSD currently doing to address this situation immediately? And why is there not a process to manually activate TAMP for eligible soldiers and airmen who have been on title 32, 502(f) orders since the passage of the National Defense Authorization Act until today?

That is my question, sir.

General NORDHAUS. Congressman, first of all, I want to start off by thanking you for your service in COVID–19 in Hawaii. I know you served on State Active Duty.

And this issue that you have just brought up to me, I will have to look more into it. And we will have to make sure that we do everything we can to follow the law that was passed to make sure that we can take care of our service members through TAMP.

I will yield to anyone else on the panel that has further information than I do.

Mr. KAHELE. And we can follow up, sir, if we don't have those answers.

I am just concerned, because I know at least 21 National Guardsmen here in Hawaii, soldiers and airmen, who have performed at least 30 days of title 32(f) since the NDAA has passed that are being told that they cannot—as you all know, the day you come off Active Duty orders is the day you drop out of DEERS [Defense Enrollment Eligibility Reporting System] and you are no longer eligible for TRICARE Prime for you and your families. And they should roll right over into TAMP, and it is not happening. And they are being told they need to wait for at least 5 weeks before that is going to happen. And that is 1 month without these service members and their families, you know, being covered by TRICARE.

So it is an immediate concern for me, because that is a real situation happening here in Hawaii today, and I suspect it is happening in every other State in the country. Like Congressman Kelly in Mississippi mentioned earlier, you know, these benefits are not transitioning to the service member who has earned them.

General NORDHAUS. Congressman, I will look into that today with our surgeon general and our J–1 [Manpower and Personnel Directorate] to make sure that we figure out what the issue is, and we will provide a response back.

Mr. KAHELE. Great. Thank you.

And thanks for acknowledging my service. I was also on title 32, 502(f) orders for almost 120 days, from April to August. And, you know, it was a great service to the State of Hawaii to do that. So thank you.

The CHAIRMAN. Thank you.

Mr. Waltz is recognized for 5 minutes. Mr. Waltz, are you with us?

Mr. WALTZ. Yep. Thank you, Mr. Chairman. I am with you. Can you hear me okay?

The CHAIRMAN. Yes. We got you. Go ahead.

Mr. WALTZ. Yeah. I just—and this is open to anyone on the panel. I wanted to follow up on Congressman DesJarlais's question, in terms of the analysis that has gone on in NGB [National Guard Bureau], how we got to the current number of guardsmen in the Capitol, the threat that then——

The CHAIRMAN. We don't have you anymore. We are not hearing you, Mr. Waltz. I don't know if you accidently hit "mute" or if we just have a connection——

Mr. WALTZ. Nope. Nope. Can you hear me okay?

The CHAIRMAN. We got you now.

Mr. WALTZ. Okay.

The CHAIRMAN. We lost you for about 20 seconds. You might want to start over.

Well, now you are completely lost.

Oh, there we go. We have a picture.

Mr. WALTZ. Okay. How about now, Mr. Chairman? Apologies.

The CHAIRMAN. Yeah, we hear you now. We could do this all day long, but one more shot. Go ahead.

Mr. WALTZ. One more shot. I hope I got it all out: the analysis that is driving the number on the Capitol and the opportunity cost of other domestic support missions. Hopefully I got that out.

The CHAIRMAN. I think his question is: What aren't we doing because of what is happening with the Guard being used at the Capitol?

General NORDHAUS. Congressman, copy your question.

From our guardsmen that have responded to the request for assistance by lead Federal agencies, our guardsmen, you know, have left their jobs and what they were doing back in their States to support this mission set. There is additional training that they could be doing, obviously. And then there are preparations for any COVID response that is within their State that they might be missing out.

To the exact specifics for each State and each individual, I can't speak to exactly what they are missing out on.

Mr. WALTZ. Well, thank you.

And thank you, Mr. Chairman.

I am looking at what is driving the number that is there, the 5,000 to 7,000 number, and then what is the plan going forward.

I can tell you, also serving as a guardsman, the force is exhausted, between COVID, ongoing overseas requirements, the training that is required for those requirements, natural disasters, particularly in States like Florida, Texas, California. I worry a lagging indicator is going to be retention.

So, again, the opportunity cost, what is driving that number of 7,000, and then what is the plan for the foreseeable future so that we can get those men and women back to the States?

Mr. SALESSES. Congressman Waltz, this is Bob Salesses.

What drives the requirement is really the agency, department, Federal law enforcement entity that provides the request to the Department. For example, Secret Service we are providing support right now. We are also providing support to the Metropolitan Police, providing to Park Police.

Specifically to the Capitol, the Capitol Police set the requirement for the number. The number was based on different missions that the National Guard members would be supporting—a response force, perimeter security, those kinds of mission sets.

Again, we are working with them. As you know, the current request ends on March 12. What we are trying to determine with them is what is the right level of security that they need from the National Guard, considering that the circumstances have changed.

Again, the Defense Department, as you know too, is highly dependent upon Federal law enforcement to provide us the insight into what the threat may be, because obviously the Department doesn't do that domestically. So we work very closely with the FBI [Federal Bureau of Investigation] and the Secret Service and others and the Capitol Police to try to determine what they believe that threat is.

And then looking at what they believe is the need for the National Guard or the types of mission sets that they need support

from, we worked very closely with them to try to understand what that is. Obviously, 4,900 is a very large number here on the Capitol.

Mr. WALTZ. Thank you.

And, Chairman, if I—just one quick follow-up.

Look, the Air Force is probably one of the best at this. When it comes to requirements, it is saying, don't tell us what platform to use or what weapon to use; tell us what effect you want us to have. I know, you know, you can't permanently be in a position of just giving every number that you are asked for. There is some analysis on the Guard and on the Pentagon's end of what it takes to actually have that effect.

And I would be interested, if I could ask for a response on the record, in what is the plan going forward past March 12.

Thank you so much, Mr. Chairman. I yield.

The CHAIRMAN. Thank you.

By "on the record," he means submit it in writing.

Mr. SALESSES. Correct, sir.

[The information referred to can be found in the Appendix on page 79.]

Mr. SALESSES. I would just like to add one thing to Congressman Waltz's——

The CHAIRMAN. Sure.

Mr. SALESSES [continuing]. Question there. Simply, we realize that personnel is part of this, but we also understand that infrastructure and technology is a large part of this that can potentially provide the additional security. So it is the combination of those things.

And, as the Congressman rightly points out, it is that kind of analysis that will help us understand what the real personnel requirements are.

The CHAIRMAN. Understood.

Having piped up earlier on this subject, I do want to follow up on just a couple of crucial points.

One—you said this, but I want to make it clear—you are responding to what the Capitol Police and the city of Washington, DC, and the Speaker's office and the majority leader's office in the Senate is asking you to do. This is not your independent assessment; you are responding to that request. So the decisions being made on this are not being 100 percent made by you, taking Mr. Waltz's point that you do have to sort of figure out how to achieve that effect. It is being driven locally.

And the second thing I would say is, in terms of the threat environment, I have looked at it, and I agree that the threat environment is less. But if you want to know what is driving the threat environment, it would be helpful if every single elected official and person in a position of power in this country publicly acknowledged that Joe Biden was the duly elected President in a free and fair election.

The degree to which people are still driving that narrative, that narrative then gets taken and put into really wacky sets of arguments that motivate people to say things. And I am sure everyone is aware of this.

Right now, March 4—and I love this, by the way. Sorry. I have a sense of humor about absolutely everything, regardless of the circumstances. So apparently some of these people have figured out that 75 years ago the President used to be inaugurated on March 4. Okay? Now, why that is relevant, God knows. But, at any rate, so now they are thinking, maybe we should gather again and storm the Capitol on March 4. Okay? That is circulating online, all right?

You know, stuff like that circulates all the time. Does it mean it is going to happen? Probably not. But if you want to help, tell them not to do that. Tell them that the election is over, Joe Biden won, it was a free and fair election, and let's get to work. That, too, would help reduce the—well, I don't know—fear-slash-paranoia that people feel that requires everything that we are seeing around here.

So both sides could be helpful in getting our Capitol back to normal, I guess is what I would say.

All right. I think Mr. Morelle is now with us.

Mr. WALTZ. Mr. Chairman, you certainly have a commitment from me.

The CHAIRMAN. All right. Thank you, I appreciate that.

Mr. Morelle, I think we are going to give you another shot here. Are you with us.

Mr. MORELLE. I am, Mr. Chair.

The CHAIRMAN. You are recognized for 5 minutes.

Mr. MORELLE. Yes, thank you, sir. I will be very brief. I just wanted to thank the individuals who are testifying. Thank you, Mr. Chairman, for a very important and enlightening hearing. And as I am brand new to this committee, I am going to stop talking, yield back, and observe my colleagues in this.

But I do want to thank people. And I also—to the National Guard General Taliaferro, we lost three guardsmen in Rochester, New York, my hometown, when a helicopter crashed just a couple of weeks ago. And I wanted to express my condolences to you and to the members of the Guard who do extraordinary service as do all of our active personnel.

With that, I yield back, Mr. Chair.

The CHAIRMAN. Thank you. I am sorry, Mike, did you have something?

Mr. ROGERS. I said he has got a bright future.

The CHAIRMAN. I am sorry, Mr. Rogers made the comment that Mr. Morelle has a bright future on this committee, and I heartily agree.

Mr. Bice—oh, sorry, Mrs. Bice, you are recognized.

Mrs. BICE. Thank you, Mr. Chairman. My question is really directed specifically as it relates to my congressional district. I am near Tinker Air Force Base, and there are approximately 3,000 military personnel that work on base, but there are 25,000 civilians that work on base.

What is the process that DOD is using to make sure that those civilian base employees are accessing the vaccine? Is that being left up to the local community, or is that something that DOD is working actively to assist in making sure that those folks have access to the vaccine so that they are not potentially exposing the military personnel that are working on base?

Mr. SALESSES. Congresswoman, I will turn it over to General Friedrichs, but the DOD civilians are in our vaccine schema, and depending on what jobs they are performing and what their health conditions are will guide exactly when they get the vaccine.

Let me turn it over to General Friedrichs, Dr. Friedrichs.

General FRIEDRICHS. Thank you, Congresswoman, and thank you. As he was saying, that is exactly right. So as we have been through our organization following those CDC criteria, with identifying those on our bases who are at increased risk, whether by age or reason of other medical conditions, so that includes those critical infrastructure personnel that you just mentioned who work on our bases there. So they are part of our schema. And as the vaccine allocations continue over the weeks and months ahead, we will continue to vaccinate those personnel.

Mrs. BICE. To follow up, how—how much headway are you able to get on how much of the vaccine is being sent to a specific area or a specific community to be able to vaccinate those. And what I am trying to figure out is how long is it going to take you to actually offer that vaccine to the almost 30,000 employees that work on base? Are we looking at several months down the road? How is the delivery process working?

General FRIEDRICHS. Congresswoman, this is Brigadier General Friedrichs again. So we work closely with the Centers for Disease Control. Our Defense Health Agency is the lead for this effort, and so they work with Operation Warp Speed and the Centers for Disease Control on our allocation based on the populations that we have identified for which we are responsible.

As was mentioned earlier in this brief, based on the purchases that the Department—or excuse me, that the country has made, we anticipate having 600 million doses by the end of July. And so that should allow us to vaccinate all of the adults who wish to be vaccinated over the next several months.

Mrs. BICE. Thank you for that. A follow-up question. There certainly have—in many parts of the world, we are relying on our allies as partners on the ground for operational support, intelligence sharing, other critical functions. How has the pandemic impacted those relationships, and what does it mean to mitigate the impact?

General TALIAFERRO. Congresswoman, this is General Taliaferro, I would say our combatant commands are heavily focused on maintaining those critical international relationships, whether that is through exercises, key leader engagements, and they deliberately do so to maintain awareness of what is going on in the region, maintain access basing and overflight during a crisis, and so on.

Mrs. BICE. I just want to say thank you for your service, thank you for taking care of our men and women in the military. In Oklahoma our National Guard is currently activated, not only for COVID relief but also for weather issues that we are experiencing here. So I am grateful for the men and women not only serving in our Air Force and Navy that are here in Oklahoma, but also our National Guard that play an important role.

I yield back, Mr. Chairman. Thank you.

The CHAIRMAN. Thank you.

Mr. Panetta is recognized for 5 minutes.

Mr. PANETTA. Thank you, Mr. Chairman, Ranking Member Rogers, and all the gentlemen there, I appreciate your service and I appreciate your time in preparation today to be here to answer these questions.

Obviously, you know, we are dealing—I agree with the President of the United States that we are dealing with a wartime effort. So I appreciate all of the involvement that the Department of Defense is currently undergoing with this right now. Especially when it comes to the National Guard.

I agree with you, General Nordhaus, especially on my district, I am the central coast of California. The National Guard has played a huge role within the last year, dealing with wildfires, dealing with storms, yes, dealing with COVID. But then, obviously, national, dealing with the attacks on our democracy. But also bolstering our democracy with getting involved in securing many of the election sites around our country back in November. So thank you for that.

Another area that was very beneficial are the food banks that I have in my district. I am sure throughout many of the members' districts on this panel. Every week I try to get out to a food bank, and I can tell you, the ones that have the National Guard members helping out are the ones that run the most efficiently, considering how long these lines are getting at our food banks. So thank you very much.

Now, I read recently that the National Guard has 100 National Guard teams in 29 States with the ability of 200 additional teams for vaccine distribution—at least that was said by General Hokanson the other day.

And so what I kind of want to break down here is, okay, so you got these FEMA national sites, those are going to have Active Duty members. And then you have the State and local government sites, those are going to be run by National Guard members. Am I correct in coming to that simple conclusion?

Mr. SALESSES. Congressman, this is Bob Salesses, yes—yes, you are.

Mr. PANETTA. Okay. Great. And so right now you have FEMA that has 1,100 troops—or they are asking—they have 1,100 troops at 5 vaccination centers. The President has called for a hundred more vaccination centers. That could lead up to 10,000 more service members is what I am reading. Do you expect all of those to be Active Duty members?

Mr. SALESSES. Congressman, that is the current plan is to use Active Duty members to source the hundred mega and large centers. But that will depend, based on, obviously, as we start to provide additional forces, the Joint Staff and the services will look at how best to do that. And the original or at least the initial look is to use Active Component forces. It could then lead to title 10 Reserve forces potentially to support those centers.

Mr. PANETTA. Understood. General Nordhaus, focusing on the National Guard at the State and local level, obviously, we understand the priority of getting more vaccinations out there, especially to rural sites. If you are going to have FEMA at the major population centers, then maybe you help the State and local govern-

ments use National Guard to get the vaccination out there to those areas that aren't in the major population areas.

Do you see that taking away from the food banks? Are you able to up, as General Hokanson said, use those 200 additional teams for that type of vaccination—those types of vaccinations in those types of areas?

General NORDHAUS. Congressman, thanks for the question. I don't see it taking away right now within the States and territories due to the mission assignment from FEMA.

Right now, we are at about 28,000, but there is room to grow within each of the States is a little bit different; up to 56,000 is the authority. So each State will look at what they need, what their critical requirements are.

I know everyone is prioritizing vaccine distribution and vaccine shots to the population. And so that will be within each State to make sure they have the resources, and the guardsmen there able to perform each of those duties and make sure they cover them.

Mr. PANETTA. Okay. Thank you. Completely switching gears right now. Obviously, unfortunately, the *Roosevelt* has been back in the news lately. Three members of the *Roosevelt* came down with the coronavirus. And I know the *Roosevelt* is on a double bump right now, basically doing a second tour.

My question to you is, where the hell and how the hell are these three members contracting the coronavirus? Is that being investigated?

General TALIAFERRO. So, Congressman, this is General Taliaferro. I am sure the command team is looking into the individual cases. I think the broader message is how much improvement the Navy has made over the last year and their procedures on their ships, the way they have identified preplanned responses, the way they have changed flows of personnel, one-way corridors, different things, sleeping arrangements, segregating personnel into cohorts.

The fact that there can be 3 infected personnel on the *Roosevelt* and it stay at 3 until they are evacuated is a credit to the work they have done that would keep it from getting to 1,200. Over.

Mr. PANETTA. Thank you. My time is up. I yield back. Thank you, Mr. Chairman.

Mr. GARAMENDI [presiding]. Thank you, Mr. Panetta.

Mr. Franklin, you are up.

Mr. FRANKLIN. Thank you, Mr. Chairman. And thank you, panel. I appreciate your time that you spent here with us this afternoon. It has been enlightening.

As a junior member of the committee, by the time we get to this point, a lot of the questions that I have had have been already answered, but I do appreciate that we have touched—several folks have asked questions about the opportunity costs of missed training opportunities, the impact on readiness.

As a former career naval officer, I have been on the receiving end of a lot of these missions that come above and beyond your regular OPTEMPO. My question really to follow along, to continue on some of the others, is just dealing with retention. And I am specifically curious to know if—have we seen any drop in retention over the buildup in the OPTEMPO over the last year or so? And are we taking any proactive measures to be on guard against that?

Just in talking recently with senior leadership of our Florida Guard, I know we have concern about a lack of manning to begin with, and then on top of that just the tempo and the impact that it is going to have on our troops.

But I guess that question will be for General Nordhaus.

General NORDHAUS. Sir, Major General Nordhaus. Right now, we haven't seen any dip in the retention at this point. I did hear numbers about our retention, our recruiting throughout the end of the year. And right, now we are on par to be able to meet our end strength numbers through our recruiting efforts from both the Army National Guard and the Air National Guard. And I yield to any—to Major General Taliaferro.

General TALIAFERRO. Congressman, this is General Taliaferro. I would say for the Active Component, retention and recruiting has still been at very high levels, and as you know, it generally follows the economy. And so I think this will bear watching as the economy picks up. But right now, retention and recruiting are at very high levels.

Mr. FRANKLIN. All right. Thank you, gentlemen.

I yield back.

Mr. GARAMENDI. Thank you, Mr. Franklin.

Mr. Veasey, you are up.

Mr. VEASEY. Thank you very much.

I wanted to ask General Nordhaus a question. In my district here in the Dallas-Fort Worth area, there was an announcement that there were going to be two openings of COVID vaccine sites. One was going to be at AT&T Stadium, Dallas Cowboys stadium which is in my district, and then another one in Fair Park which is near my district with the capacity to perhaps serve up to about 10,000 people a day. And I know that the Guard was supposed to be assisting in that effort.

As you know, right now, in this part of the world, we are having record low temperatures. Our grid has been, just, you know, not completely incapacitated, but has been downgraded severely. We have people just literally blocks away from me that have had power sometimes, and other times, they haven't.

Is this going to affect the Guard's effort to be able to mobilize and help in these efforts, because I would imagine that there are guardsmen that are also affected by these storms?

Will you still be able to help in this mission as soon as we are able to get past this, or do you see there being some problems?

General NORDHAUS. Congressman, thanks for question. I will pass it over to Major General Taliaferro. I will say that across the States that are receiving the weather right now, our Guard is helping with, you know, incidents within weather, but then they are right back as fast as possible to supporting the vaccination efforts.

And the Dallas area, I believe that is one of the title 10 efforts, and I will turn that over to Major General Taliaferro.

General TALIAFERRO. Thanks, General.

Mr. VEASEY. Thank you.

General TALIAFERRO. Congressman, those two sites in the Dallas area, one at AT&T stadium and then one at the Cotton Bowl, we both expect to be operational a week from today. Although, I just discussed this with Northern Command this morning, it is not yet

clear whether the weather will create any delays, but they are working through that with FEMA and the State.

Mr. VEASEY. Okay. Okay. Good. What sort of delays might—what would happen—what would make it harder for you to mobilize and be able to have your guys and women ready at those particular sites? Like what would be some of the issues that might come up?

General TALIAFERRO. So, Congressman, I don't believe it would be the issues with our force. It would be issues surrounding the facility, access to the facility, and all the other supporting agencies. Our forces will move and be there in time. Over.

Mr. VEASEY. Okay. Well, no, thank you very much. That is very important to know, because obviously as soon as we get past the storms, I know that people are going to really be anxious to get back and start receiving their vaccines again.

So I appreciate your time and answering those questions. I will yield back the balance of my time. Thank you.

Mr. GARAMENDI. Thank you, Mr. Veasey.

Mrs. McClain.

Mrs. MCCLAIN. Thank you, Mr. Chairman. As we all know, China has become an ever-increasing threat, not only to the Pacific region, but globally. They've built up their armed forces to threaten our allies in the Pacific, used their Belt and Road Initiatives to bring poorer nations under their thumb, and now released viral epidemic upon the world.

My question is for Major General Taliaferro, is has our ability to deter aggressive actions by China related to the construction of the islands in the Pacific region, has it been reduced because of the necessity to protect our forces during this pandemic?

General TALIAFERRO. So, Congresswoman, I would say absolutely has not been reduced. Our forces are very active in the Pacific, in that region, whether conducting freedom of navigation operations, we have deployed bomber task force into region, and continued to project power into that area.

And last spring, the combatant commands and the services worked very deliberately to ensure that we were able to operate within a COVID environment to perform our defense role. And, certainly, we have been active in the Pacific ever since.

Mrs. MCCLAIN. Thank you. I yield back my time.

Mr. GARAMENDI. Thank you, Mrs. McClain.

Mrs. Murphy. Mrs. Murphy, you are up next.

Mrs. MURPHY. Thank you. And thank you all for being here today and for your testimony. And also thank you to all the service members for what they do every day to keep our country safe.

You know, I represent a district in central Florida, and I had a chance to visit with some of the Florida National Guard that were deployed to DC, and also to have had some conversations with the Florida National Guard leadership.

And I think a few things stand out to me. One, it is clear that the multiple deployments and the high OPTEMPO has had an effect on morale and, you know, possibly on retention. And some of the previous questioners talked a bit about that. And I think it may be too early to have the data to say exactly what impact that will have, but I think that is something that we should watch for.

But, you know, we have to understand these are citizen soldiers who have been repeatedly called away from their families and their jobs and put in fairly stressful situations.

And I think in Florida this strain has been really amplified, because despite having one of the largest States, we have a relatively smaller Guard. We are number 53 of 54 in guardsmen to citizens ratio. And during a pandemic, it is not really feasible to borrow guardsmen from other States, as we would normally do in responding to a geographically focused natural disaster.

And I think on top of this, for Florida, the pandemic has disproportionately impacted us because we have one of the highest percentages of more mature Americans as a part of our State population. And those are the Americans who are more vulnerable to the negative impact of COVID and most in need of vaccinations, along with our frontline and essential workers.

And then in the nature of being a superlative, we are also one of the States with one of the greatest incidence of natural disasters.

So I look at all of this, and I see a lot of risk here going into this coming year and into the summer when hurricane season starts for us. I am really worried about the ability to respond to the requirements, and then the impact on the men and women who serve in our Guard.

So, General Nordhaus, two questions for you. In the near term as we look out on this year and Florida's natural disaster season, it is going to put additional operational pressures on our National Guard force.

How is this going to be balanced with the increased vaccination pace this summer, and then in the long term, what efforts are under way to study the proportion of guardsmen to citizens to ensure that we have sufficient forces to support the whole range of needs from disaster response to emerging challenges like COVID support?

General NORDHAUS. Congresswoman, thank you for the question. On the first side, as we get to the summer, hopefully with the number of vaccinations that will be available by June and July, that we get really close to having all of our service members vaccinated, and that will help as we go into that season.

Every year we do get together and we have workshops that bring all 54 together for domestic operations, and we look at the EMACs, Emergency Management Assistance Compacts, between States to help assist in things like hurricane that Florida might be undergoing from other States nearby. As you know, Florida has helped out in other States through hurricanes over the last couple of years.

As far as the force structure per civilian ratio within the State, Major General Eifert, The Adjutant General, will work that through the Army National Guard and the force structure committees to, you know, push that forward and then have any decisions through the service.

Mrs. MURPHY. Well, as he does that, he has the support—my support for sure for us to take another look at making sure that our Guard is appropriately scaled for the size of our State.

Just pivoting to another question, a little unrelated, what—I know that DOD has been looking at the impact of right-wing ex-

tremist ideologies on the ability of DOD to carry out its duties. Has there been a similar effort within the Guard and how have some of these early analyses come out?

General NORDHAUS. Congresswoman, we fall right underneath the Secretary of Defense's new thing that he had just pushed out. It is not tolerated across the National Guard or anywhere within our organization. It goes against our fundamental principle of the oath that we take. And so it can't be tolerated.

And we are working through our services, both the Air National Guard and the Army National Guard through the service programs that come down from the Secretary of Defense and the standdown within the next 60 days, and we will implement those all going forward.

Mrs. MURPHY. Thank you, and I yield back.

Mr. GARAMENDI. Thank you.

Mr. Jackson, you are next.

Dr. JACKSON. Thank you, Chairman. Thank you, Ranking Member Rogers. And thank you to our witnesses who are here today. I want to start by telling the witnesses I appreciate your service to our country. Thank you for everything that you have done.

And I just want to start by saying that, you know, ever since COVID–19 has started, this pandemic has affected our military in a variety of ways. And I do believe that the response from the Department of Defense has not only saved countless civilian lives but has also been really good in regards to ensuring that we have been safe all over the globe from threats elsewhere simultaneously. So thank you for everything you have done.

I want to just state a few facts, and then I want to ask you a question that I have received on several occasions that I don't feel like I have a good answer for. And I will just start by saying that I think with regards to DOD, the response to coronavirus began almost immediately. DOD provided approximately 200 beds at March Air Force Base for State Department officials who were evacuating from Asia, and TRANSCOM worked to bring home nearly 4,000 U.S. citizens who were stranded overseas at the start of the pandemic.

This incredible response continued as the hospital ship *Comfort* and the hospital ship *Mercy* provided humanitarian aid in New York and Los Angeles as cases began to surge.

Later we faced critical shortfalls in PPE. DOD once again answered the call by providing over 2,000 ventilators, 5 million N95 masks, and other critical PPE.

And another well-known aspect that I would like to ask about with regards to DOD was Operation Warp Speed. DOD played an absolute critical role in developing the COVID–19 response as it relates to Operation Warp Speed. These efforts continue. They continue with these types of efforts.

President Biden has now released a 200-page National Strategy for COVID–19 Response and Pandemic Preparedness. However, I think this plan to me looks familiar to what I have seen prior to the Biden administration. The Biden plan aims to fill supply shortfalls by invoking the Defense Production Act, which we have talked briefly here, and I believe that is something that President Trump had already done as well.

The Biden plan says that DOD will bring logistical expertise and staff to support the COVID–19 response, which I think is also something that President Trump was quick to do.

The Biden plan says the DOD will support States' efforts to provide DOD resources and personnel. And, once again, I believe that is something that I heard the President say early on that was enacted quickly by President Trump as well.

President Biden has rolled out his groundbreaking plan. He rolled this out on his first full day in office. But with reference to DOD, once again, it sounded to me like President Biden's plan was building on a lot of the great work that happened during the Trump administration.

I think that good work should be acknowledged. I think it has become clear that President Trump and his administration responded effectively and decisively in the face of this pandemic. And I am glad to see the Biden administration, in my mind, is building on the successes of the Trump administration with regard to DOD's approach to this.

The question I have for you is I would like to ask each of you, and we can start with Mr. Salesses, if you would like, I would like to know, with regards to DOD, how are the operations, in the Department of Defense, how have they shifted under the Biden administration? And could you outline what actions are now being taken that were not being taken before, specifically, with regard to DOD under the Trump administration? Thank you.

Mr. SALESSES. Congressman, thanks for the question. The Department obviously has a long history of supporting civil authorities. We continue to do that. A number of the initiatives under President Biden to include the initiative to establish the mega and large vaccine centers, to make sure that we are out, the Department as we have already discussed today there is community-based support that is being provided by the Guard. But the new mega and large centers will produce a lot of vaccine shots at the community level.

We have also got initiatives under way with the new administration to make sure that all the mitigation measures, the mask wearing, the workforce protections, and those types of activities are being implemented effectively.

Dr. JACKSON. Thank you, sir. I don't know if any of the other witnesses have anything to add to that. If not, I will close up here.

Well, I close then. I will just say, I do want to thank you all for what you have done. I do think that the Department of Defense has done an outstanding job in supporting the COVID efforts across the country since the very beginning of this. I have full confidence that you will continue to do an outstanding job for our country and take care of us all. I appreciate everything you have done.

And with that, Mr. Chairman, I yield back.

Mr. GARAMENDI. Thank you, Mr. Jackson.

Mr. Moore.

Mr. MOORE. Thank you, Chairman. Many of the—many of the questions I have are related to training, and it has largely been addressed. So I will just briefly say thank you to the Department of Defense.

Yesterday, I had the opportunity to do an immersion tour in my district at Hill Air Force Base. COVID–19 response was their top item that they briefed me on, and I just had an incredible experience seeing the breadth of what goes on there.

As we explored and discussed the COVID–19 response and where things are at now, I will just say that I am hopeful that, you know, we can have a really strong focus on getting back to training and making sure that we make up for lost time that was required during the pandemic to build on that.

It is a crucial part. It helps with morale and so many different factors, especially interacting with our foreign partners as well. And so that is the piece that I would—I would just want to highlight, but also just comment on, you know, how well they responded.

Our depot work, they were essential workers, they powered through, and they kept operations going. I know that wasn't the case everywhere in being able to do it. And I was just really proud of Hill Air Force Base for being able to do it and across the Department did an exceptional job in handling COVID.

So thank you for all your good work and to the committee. And with that, I will yield back.

Mr. GARAMENDI. Thank you very much, Mr. Moore. Thank you, Mr. Moore.

Mr. Fallon, your turn.

Mr. FALLON. Thank you, Mr. Chairman. When we get down to this level, all the good questions have been asked and answered. I want to thank the witnesses for their testimony.

I do have to say and echo what Admiral Jackson said, Ronny Jackson said. I really do believe the legacy of the Trump administration, their finest hour will be Warp Speed. I think this will get us through this pandemic and be stronger as a Nation because of it. And sometimes you just have to give credit where credit is due regardless of whether or not you agree or disagree with certain administration's policy. I think President Trump's administration did a fantastic job.

I do have one quick question, and it was touched upon, but I just want to get a more specific answer. How was their [inaudible] and/or the cancellations of some of the exercises we would have had with our foreign powers or allies, or our foreign partners and friends, rather, have affected our efforts to strengthen the alliances and build our readiness both between—and really our efficacy and synergy with our allies?

And I just wanted to ask the witnesses how the pandemic has affected this?

General TALIAFERRO. Thanks, Congressman. This is General Taliaferro. In the overseas exercises, the Joint Force Exercise Program, we talked about the exercises that had been cancelled or delayed. And in those opportunities, those training opportunities, we can further develop our partners, we can facilitate interoperability. And we can grow and strengthen relationships with our partners that, as we mentioned, have a wide variety of advantages.

So we need to stay engaged with our partners going forward and strengthen those relationships through a variety of mechanisms.

Mr. MOORE. Thank you.

Mr. SALESSES. Congressman, this is Bob Salesses. I would just like to point out, although the physical engagement with our partners has been limited, a lot of activity continues with our international partners through our combatant commands, through the OSD staff with the allies and partners on a daily basis. So that contact is always there working together in that regard. So that is still very strong commitment from one another.

General NORDHAUS. Congressman, Major General Nordhaus. I would also like to comment. The State Partnership Program which has our 54 States partnered up with other nations throughout the last year, those nations have reached out to State—to country and talked COVID and learned from each other. So that has been very productive as well.

Mr. FALLON. Would it be fair to say that once we have our troops vaccinated, it looks like from testimony that would be around July, that come the fall we are going to be back up to pre-COVID levels as far as training, and will this largely be in the rearview mirror in your professional opinion?

General TALIAFERRO. Congressman, this is General Taliaferro. I would say certainly here in the United States, the services have already adapted and have returned to large training venues. Right now today, there is 3,000 Marines training together down at Twentynine Palms. Large force exercises and training is happening in the United States.

Our overseas exercises frequently are dependent on the participation of our partners and whether they are able to attend, whether they are able to participate. But even in opportunities where they are not, our forces will continue to train and take advantage as best we can of those opportunities.

Mr. FALLON. Thank you, Mr. Chairman, I yield back.

The CHAIRMAN. Thank you. There are, as I understand it, no further requests for time. I know we—and also, we went past the 1:30 hard stop a little bit that some of you gentlemen had.

So with that, I want to say thank you to the witnesses, thanks for the questions. I look forward to continuing this discussion. And I appreciate you being here, and we are adjourned.

[Whereupon, at 1:37 p.m., the committee was adjourned.]

A P P E N D I X

FEBRUARY 17, 2021

PREPARED STATEMENTS SUBMITTED FOR THE RECORD

FEBRUARY 17, 2021

Statement by

Mr. Robert G. Salesses

Senior Official Performing the Duties of

Assistant Secretary of Defense for Homeland Defense and Global Security

Office of the Secretary of Defense

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Vice Director of Operations (J3)

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Before the 117th Congress

Committee on Armed Services

U.S. House of Representatives

February 17, 2021

Introduction

Chairman Smith, Ranking Member Rogers, distinguished Members of the Committee: Thank you for the opportunity to testify before you today on the Department of Defense's (DoD's) response to the coronavirus disease 2019 (COVID-19) pandemic. I am honored to be here in the company of Major General Jeff Taliaferro, the Joint Staff's Vice Director for Operations, and Major General Steven Nordhaus, the National Guard Bureau's Director for Operations.

As President Biden's "National Strategy for the COVID-19 Response and Pandemic Preparedness" states: "The federal government cannot solve this crisis alone. Full implementation of the National Strategy for COVID-19 will require sustained, coordinated, and complementary efforts of the American people, as well as groups across the country, including State, local, territorial, and Tribal governments; health care providers; businesses; manufacturers critical to the supply chain, communities of color, and unions." DoD is a critical part of the Federal response, but DoD's efforts rely greatly on partnerships. DoD's provision of key medical and non-medical capabilities, personnel, and supplies to support the States, the District of Columbia, territories, or international partners, was only possible because of strong, mutually supporting partnerships with our interagency partners.

The COVID-19 pandemic has posed an unprecedented challenge to our nation. In the face of this tremendous challenge, Secretary Austin tasked DoD to defeat the COVID-19 pandemic and defend the force against COVID-19, while protecting our nation. In this fight, DoD is fully committed to achieving the seven goals of the National Strategy for the COVID-19 Response and Pandemic Preparedness and carrying out President Biden's direction, that were provided in: Executive Order 13987, "Organizing and Mobilizing the United States Government To Provide a Unified and Effective Response To Combat COVID-19 and To Provide United States Leadership on Global Health and Security," Executive Order 13991, "Protecting the Federal Workforce and Requiring Mask-Wearing," and the President Biden's "Memorandum to Extend Federal Support to Governors' Use of the National Guard to Respond to COVID–19 and to Increase Reimbursement and Other Assistance Provided to States," and the other Executive Orders and Presidential memoranda related to COVID-19.

Unprecedented Incident

The COVID-19 pandemic is one of the greatest public health challenges our nation has faced in over 100 years, since the 1918 flu pandemic. Domestically, most disasters or emergencies either affect a single State or several States in a region. In contrast, COVID-19 not only affected the entire United States, but the entire world (i.e., historically speaking, no President has ever before declared a major disaster for all States, territories, and the District of Columbia). Additionally, typical incident responses last 1-3 weeks and then transition to recovery, whereas the COVID-19 response is more than a year old. Uniquely, the need to stop the spread of the virus eliminated an entire tier of the national response system (i.e., interstate mutual aid and assistance). Likewise, when most incidents occur, responders are able to focus on saving and protecting lives and then transition to recovery in the aftermath. Instead, COVID-19 is a persistent incident that ebbs and flows in intensity.

The response to COVID-19 is distinct from previous disease outbreaks, with the exception of the 1918 flu, because of the harm caused by the virus, the ease of transmission, and the impact of the disease on an interconnected world. In many countries, including the United States, the virus placed unprecedented stress on the capacity of civilian healthcare systems. As of February 16, 2021, there were over 27 million confirmed COVID-19 cases and more than 485,000 deaths in the United States—more lives than those lost in World War II.[1] Vaccination efforts have begun and are steadily expanding, with more than 39.6 million people in the U.S. having received at least one dose.[2]

In comparison to the general U.S. population, DoD Service members have not been significantly affected by COVID-19. As of February 10, 2021, there have been more than 148,000 cases of COVID-19 and 21 deaths due to COVID-19 among DoD's military population.[3] Across DoD's total population (military, civilian, dependent, and contractor), there

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[1] CDC COVID Data https://covid.cdc.gov/covid-data-tracker/index.html#datatracker-home, As of February 16, 2021.

[2] CDC COVID Data, https://covid.cdc.gov/covid-data-tracker/index.html#vaccinations, As of February 16, 2021.

[3] DoD, *Coronavirus: DoD Response*, As of February 10, 2021: https://www.defense.gov/Explore/Spotlight/Coronavirus//./

have been more than 230,000 cases of COVID-19 and 273 deaths.[4] The age-adjusted mortality rate among military personnel has been lower than that for the general population. The virus has nonetheless had widespread impacts on the force, including by delaying non-emergency medical treatments, military training (especially collective training), and exercises with allies and partners, and by complicating recruitment and initial entry training. Early studies of COVID-19 suggest that it may have long-term impacts on physical and mental health, so the virus also has the potential to impose long-term health costs on the force.[5]

Protecting DoD Personnel

DoD took aggressive actions early in the pandemic to protect DoD personnel. As COVID-19 spread, the U.S. Centers for Disease Control and Prevention (CDC) began recommending cloth mask use, physical distancing, avoiding crowds, and washing hands as key mitigation strategies to help control the spread of the virus. DoD was doing these things from the start of the pandemic as a way to protect the force and maintain readiness. Over the course of the pandemic, DoD developed and implemented several measures to contain and mitigate effects on the force. These included: issuing force health protection (FHP) guidance (DoD issued the first FHP guidance on January 30, 2020); strategically issuing restriction of movement (ROM) orders; requiring social distancing and mask wearing; instituting telework on an unprecedented scale; employing testing and contact tracing; and implementing sentinel surveillance programs in coordination with DoD's influenza sentinel surveillance program, along with serologic surveillance through the Department's HIV testing program. As a whole, these mitigation efforts were critical to informing DoD senior leadership and allowing leaders to make appropriate risk-based decisions to enable DoD to protect the force, continue operations, and maintain readiness.

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[4] DoD, *Coronavirus: DoD Response*, As of February 10, 2021: https://www.defense.gov/Explore/Spotlight/Coronavirus//./

[5] i, Luming, Fangyong Li, Frank Fortunati, and John H. Krystal. "Association of a Prior Psychiatric Diagnosis With Mortality Among Hospitalized Patients With Coronavirus Disease 2019 (COVID-19) Infection." *JAMA network open* 3, no. 9 (2020): e2023282-e2023282; Li, Sophie, Joanne Beames, Jill Newby, Kate Maston, Helen Christensen, and Aliza Werner-Seidler. "The impact of COVID-19 on the lives and mental health of Australian adolescents." *medRxiv* (2020), As of November 2, 2020: https://www.medrxiv.org/content/10.1101/2020.09.07.20190124v1; UNCLASSIFIED; Chen, Qiongni, Mining Liang, Yamin Li, Jincai Guo, Dongxue Fei, Ling Wang, Li He et al. "Mental health care for medical staff in China during the COVID-19 outbreak." *The Lancet Psychiatry* 7, no. 4 (2020): e15-e16; https://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366(20)30462-4/fulltext.

Early in the pandemic, DoD experienced the same shortages in testing supplies as the rest of the nation due to the just-in-time supply chain. Therefore, the Department initially prioritized testing for those who presented with symptoms of the disease. Early global shortages of testing equipment and supplies made it difficult for DoD to conduct a broader range of screening and regular surveillance testing to accurately estimate infection rates among DoD populations and quickly isolate those who contracted the disease. Early testing supply limitations made testing, contact tracing, and isolation less robust than DoD pandemic plans would otherwise have been. To coordinate demand for testing supplies, DoD and the Department of Health and Human Services (HHS) created the Diagnostic and Testing Task Force, which streamlined procurement efforts and developed algorithms derived from U.S. Food and Drug Administration (FDA) and CDC guidance to help ensure evidence-based use of new testing options as they became available.

In April 2020, the Department established a four-tiered COVID-19 testing program that would enable DoD to test a wider segment of the military population, in addition to continuing to test those presenting with symptoms or close contacts, as well as prioritize testing across the force.[6] Tier 1 testing was designated for those forces involved in critical national capabilities such as strategic deterrence or nuclear deterrence; Tier 2 was for fielded forces around the world; Tier 3 was for forces being forward-deployed or those redeploying; and Tier 4 was for all other forces.

DoD's testing capabilities have increased dramatically over time. As of January 31, 2021, DoD had tested more than 2.5 million DoD personnel over the course of the pandemic, and in early January 2021 was conducting more than 15,000 tests per day. DoD's testing strategy continues to evolve as new tests become available, supply chains change, and new guidance is released on how best to employ COVID tests to execute its full testing strategy. The increased testing capability and the four-tiered testing system have been important tools that enabled DoD

[6] Garmone, Jim, "DoD Starts Tiered COVID-19 Testing Process to Ensure Safety," *DoD News*, April 22, 2020.

to maintain readiness during the pandemic and to protect the force and the communities where we live and work.

DoD does not view testing as the sole solution, but rather one of several complementary foundational public health measures, including contact tracing, to be used together to limit the spread of the virus and to improve DoD's overall force availability. To that end, Secretary Austin released guidance across the Department to make mask wearing mandatory in any room or area where more than one individual is present. DoD is now also undertaking a thorough review of all COVID-related guidance documents, to include a full review of workplace safety guidelines, to maximize our effectiveness in stopping the spread of COVID-19.

Support to the National and International Response

Overview of National Response

COVID-19 involved unprecedented support to all 50 States, 3 territorial authorities, and the District of Columbia. Since January 27, 2020, the Department of Defense has received 374 Federal Emergency Management Agency (FEMA) Mission Assignments and 47 Requests for Assistance from other Federal departments and agencies in response to the COVID-19 pandemic. To date, the total FEMA obligation amount for DoD medical support is in excess of $3.21 billion, provided on a reimbursable basis pursuant to the Stafford Act. More than 62,100 military personnel, including National Guard (NG) personnel from all 50 States, 3 territories, and the District of Columbia, have been involved in supporting COVID-19 relief operations. Military personnel have augmented medical staff at hospitals, nursing homes, and assisted living facilities; delivered food to hard-hit communities; supported logistics efforts to supply medical equipment; built alternate care facilities; conducted community-based medical screening; conducted laboratory testing; provided installation support; and assisted with fatality management among other tasks.[7]

Repatriation Efforts

[7] See National Conference of State Legislatures, "National Guard Assists Response to the COVID-19 Pandemic," NCSL homepage, April 28, 2020.

Beginning in late January 2020, U.S. embassies and consulates around the globe assisted U.S. citizens and U.S. persons in returning to the United States.[8] After an initial State Department charter flight in January 2020, two flights arrived on February 5, 2020, at Travis Air Force Base (AFB) and Marine Corps Air Station (MCAS) Miramar, and on February 7, flights arrived at MCAS Miramar and Joint Base (JB) San Antonio-Lackland. HHS turned to DoD to provide lodging at five sites, initially: March Air Reserve Base (ARB), Travis AFB, Miramar MCAS, JB San Antonio-Lackland, and Camp Ashland. By the end of this effort, U.S. Transportation Command (USTRANSCOM), in support of the State Department, facilitated the safe return of more than 4,500 Americans, and U.S. Northern Command (USNORTHCOM) and the Military Departments provided housing at 13 military installations for quarantine of more than 3,000 individuals from China and 2 cruise ships in response to multiple HHS requests. The support ended on April 4, 2020, and was provided on a reimbursable basis pursuant to the Economy Act. Installations were also used as support bases for DoD and FEMA responders and logistics.

Medical Surge Support

By the end of March 2020, COVID-19 infections began materializing in key hotspots around the nation, first in Washington, New York, and California, but then quickly spreading across the country. Hospitalizations from COVID-19 began to increase rapidly, creating concerns about insufficient medical capacity to treat the rise in the number of patients, and a subsequent demand from States and localities for both medical facilities and medical providers. HHS and FEMA, through the National Response Framework, turned to DoD to help meet this demand. In response, DoD deployed two Navy hospital ships, several Navy Expeditionary Medical Facilities, Army Combat Hospital Centers, Army Reserve Urban Augmentation Medical Task Forces, and Air Forces Expeditionary Medical Support units to provide surge medical support on ships, at alternate care facilities (ACFs), and in civilian hospitals and nursing homes. Additionally, 38 ACFs were designed and constructed by the U.S. Army Corps of Engineers (USACE) to provide additional capacity. At the peak of this demand, USNORTHCOM deployed almost 15,000 DoD personnel, including almost 5,000 Active Duty and Reserve medical

[8] https://www.gao.gov/reports/GAO-20-701/

professionals (approximately 580 doctors, 1,190 nurses, 130 respiratory therapists, 180 mid-level providers, and 3,200 support services), to 10 different States and multiple locations within some States. Meanwhile, U.S. Indo-Pacific Command provided similar support in Hawaii, Guam, and the Commonwealth of the Northern Mariana Islands.

National Guard Support to the States

In addition to providing medical personnel and medical facilities, in an unprecedented fashion, FEMA requested, beginning in March 2020, but extending throughout 2020 and into 2021, that DoD authorize NG personnel from 52 States and territories[9] to operate in a Title 32 duty status – funded by the Federal Government but under State command and control.[10] Due to the pervasive nature of the pandemic and its economic consequences, President Biden in his "Memorandum to Extend Federal Support to Governors' Use of the National Guard to Respond to COVID–19 and to Increase Reimbursement and Other Assistance Provided to States" authorized a 100-percent Federal cost-share to the States and territories under the Stafford Act, extended the support through September 30, 2021, directed FEMA to reimburse DoD fully for the cost of pay and allowances for FEMA mission assignments to DoD related to NG support, and directed the Secretary of Defense to maximize the use of Title 32 to support the States and territories. Under this arrangement, States retain command and control of their NG personnel for their COVID-19 response, while FEMA covers the costs of such support. At the peak of such authorizations, more than 47,000 National Guard personnel supported community-based testing, emergency medical care, medical sheltering, communication of health and safety information to the public, transportation, logistics, and first responder support. As of February 16, 2021, approximately 27,500 National Guard personnel were supporting the COVID-19 response in 49 States (excluding Wyoming) and 3 territories.

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[9] Wyoming has yet to request support from FEMA for the use of their National Guard, and the District of Columbia National Guard does not require a FEMA mission assignment to provide COVID support in Title 32..

[10] Section 502(f) of Title 32, U.S. Code, authorizes the President or the Secretary of Defense to request the Governors order to duty their NG personnel to conduct operations or missions for DoD. Operations or missions conducted in a Title 32 duty status are under the command and control of the Governors with funding provided by DoD. DoDI 3025.22, "The Use of the National Guard for Defense Support of Civil Authorities," establishes policy for the use of the NG for DSCA missions, which requires another Federal Department to request DoD support. In this case, FEMA requested that DoD support the States and territories and fully reimbursed DoD for the pay and allowances and other costs associated with the use of NG personnel in Title 32 status.

Supply Chain and Acquisition Support

DoD also played a critical role in strengthening the supply chain for medical resources and protective equipment that were in short supply. The effects of COVID-19 made it clear that personal protective equipment (PPE), such as masks, gloves, and gowns, and medical equipment (such as ventilators and respirators), would be critical to protecting medical personnel and for the treatment of patients. Initially, the global demand for these items far outstripped the available supply, due to the just-in-time global supply chain. The primarily overseas nature of PPE and medical equipment supply chains made it difficult to expand production capacity within the United States or use Defense Production Act (DPA) authorities to prioritize domestic COVID-19-related requirements and to expand the industrial base to manufacture critical supplies.[11] The national supply chain, including the supply chain for the Strategic National Stockpile (SNS), was unable to meet demand. In order to bridge this gap, HHS and FEMA turned to DoD to take advantage of its acquisition and logistics expertise to support nearly all facets of the national supply chain.

FEMA and HHS established the Supply Chain Task Force (SCTF), led by Rear Admiral John Polowczyk, to focus on reducing the medical supply-chain-capacity gap both to satisfy demand and to relieve pressure on medical supply capacity. This organization was led by and heavily supported by DoD personnel detailed to FEMA who had expertise in supply-chain management and logistics. This organization accelerated acquisition, expanded production by generating new capacity, and allocated resources to ensure that supplies were prioritized to hotspots. The SCTF also worked with major commercial distributors to facilitate the rapid distribution of critical resources. *A key example of this partnership in action is Project Air Bridge.* FEMA created Project Air Bridge to reduce the time it takes for U.S. medical supply distributors to receive PPE and other critical supplies into the country for their respective customers. USTRANSCOM supported this effort and delivered into the private sector supply

[11] Senate Homeland Security and Governmental Affairs Committee, "Evaluating the Federal Government's Procurement and Distribution Strategies in Response to the COVID-19 Pandemic," June 9, 2020, https://www.hsgac.senate.gov/evaluating-the-federal-governments-procurement-and-distribution-strategies-in- response-to-the-covid-19-pandemic.

chain nearly 1.5 million N95 respirators, 937 million gloves, 112.7 million surgical masks, 39.4 million surgical gowns, more than 2.4 million thermometers, more than 2.5 million face shields, 1.4 million coveralls, 109,000 stethoscopes, 370,000 oxygen masks, and more than 160,000 cannulas.

On the acquisition side of the supply chain the Under Secretary of Defense for Acquisition and Sustainment (USD(A&S)) established a COVID-19 Joint Acquisition Task Force (JATF) to serve as the single DoD entity to support interagency acquisition and logistics needs. The JATF supported the immediate response to the national health crisis, leveraging the Department's authorities in supporting FEMA and HHS in the national response. The JATF helped the agencies identify supply chain constraints and manage the industrial bases of critical medical resources and assisted in acquisitions through Defense Logistics Agency (DLA) to restock the SNS. On October 13, 2020, the JATF transitioned interagency assisted acquisition functions to the Joint Rapid Acquisition Cell (JRAC) Defense Assisted Acquisition Cell (DA2) the permanent office to provide acquisition support to agencies outside of DoD. In total, the DA2 (and previously JATF) has awarded over 35 contracts, valued at $1.8 billion, to expand the domestic medical supply and equipment industrial base and awarded $781 million work of contracts to restock the SNS.

Additionally, DLA has a standing arrangement with FEMA to acquire goods and services during disasters and other incidents, and has been a significant contributor to the pandemic response. DLA used its contracting and logistics expertise to assist FEMA and HHS in their support to States and territories for the COVID-19 response. As of January 12, 2021, DLA has executed more than 25,000 contract actions, obligating more than $3.13 billion worth of medical supplies such as test kits, ventilators, and drugs, as well as masks, gloves, gowns, and other PPE.

Development of Vaccines and Therapeutics

For decades, DoD laboratories have studied infectious diseases of military importance, including HIV/AIDS, Ebola, and coronaviruses such as Middle East Respiratory Syndrome (MERS). In January 2020, DoD began research and development (R&D) on diagnostics, therapeutics, and vaccines for SARS-COV-2, the strain of coronavirus that causes COVID-19.

The U.S. Army Medical Directorate-Armed Forces Research Institute of Medical Sciences led important initiatives to sequence COVID-19 in order to find its genetic "fingerprint." Scientists used this identification information to develop tests and proposed treatments as early as January 2020, and later to help track the transmission chain as the virus evolved over time. The Defense Health Program Medical R&D funds provided the initial infusion required to support early COVID-19 research efforts. Some of these funds were allocated to the Joint Program Executive Office for Chemical, Biological, Radiological, and Nuclear Defense (JPEO-CBRND) and became an important source of funding for early initiatives such as the development of testing and therapeutics in February and March.[12] One of the early successes was the deployment of high-speed COVID-19 testing equipment to Fort Jackson, South Carolina, that would turn around tests in a day and isolate potentially infected recruits quickly, preventing further transmission while allowing training to safely continue. Ongoing research efforts proved useful for the COVID-19 response, which resulted in publication of Clinical Practice Guidelines developed by the Uniformed Services University of the Health Sciences and the Defense Health Agency (DHA). Additionally, based on these research efforts, JPEO-CBRND worked to achieve FDA Emergency Use Authorization for the BioFire diagnostic test on March 23, 2020. The U.S. Army Medical Research and Development Command (USAMRDC) established the first U.S. treatment protocol for Remdesivir on March 17, 2020; and JPEO-CBRND developed antibody treatments to be used by DoD and the larger national response effort.

Additionally, in 2011, the Defense Advanced Research Projects Agency (DARPA) began focusing research specifically on efforts to reduce the timelines for safe development and employment of vaccines and antibodies. DARPA's Pandemic Prevention Platform (P3) program, launched in 2017, focuses on rapid discovery, characterization, production, testing, and delivery of efficacious DNA- and RNA-encoded medical countermeasures against infectious disease.[13] The foundational technology was pioneered by DARPA under its Autonomous Diagnostics to Enable Prevention and Therapeutics (ADEPT) program, which began in 2011. ADEPT funded programs to research how the body could produce antibodies against a new

[12] https://www.jpeocbrnd.osd.mil/coronavirus

[13] https://www.darpa.mil/news-events/2020-11-10

biological threat. These DARPA programs funded projects that laid the groundwork for the development of RNA COVID-19 vaccines produced by Moderna and AstraZeneca, and COVID-19 therapeutics manufactured by Eli-Lilly.

DoD and HHS Vaccine Task Force

The joint DoD and HHS Vaccine Task Force (formerly known as "Operation Warp Speed") was established in May 2020. The Task Force includes the U.S. Department of Agriculture, the Department of Energy, the Department of Veterans Affairs, and private sector companies. The purpose of this partnership is to facilitate, at an unprecedented pace, the development, manufacturing, and distribution of COVID-19 countermeasures. The Task Force coordinates existing HHS-wide efforts, including the National Institutes of Health (NIH) Accelerating COVID-19 Therapeutic Interventions and Vaccines (ACTIV) partnership for vaccine and therapeutic development, NIH's Rapid Acceleration of Diagnostics (RADx) initiative for diagnostic development, and work by the Biomedical Advanced Research and Development Authority. There are three core areas where the vaccine task force has been accelerating the timeframe for countermeasures, including a vaccine, reaching the American public: 1) development; 2) manufacturing; and 3) distribution. The vaccine task force effort is accelerating distribution, now at approximately 60.7M vaccine doses, 42.4 million of which have been administered. The task force expects to deliver the initial target of 300 million vaccine regimens to States by the end of June 2021.

DoD's Vaccination Efforts

DoD established a tiered vaccination administration schema that follows CDC guidance for determining priority groups, modified for unique DoD requirements. As of February 11, 2021, DoD has received approximately 970,000 total doses of the Pfizer and Moderna vaccines, both of which have received an emergency use authorization from the Food and Drug Administration (FDA). DoD is in the expanded distribution phase with vaccine administration occurring at 324 locations worldwide. Due to less demanding supply chain and storage requirements for the Moderna vaccine, only the Moderna vaccine is being used at sites outside the United States. As of February 10, 2021, DHA has administered approximately 800,000 of those doses. More than 373,000 personnel have been partially vaccinated, and more than

200,000 have been fully vaccinated (i.e., having received 2 doses). As of February 10, 2021, 15.9 percent of military personnel have been vaccinated with the first dose, and 5.6 percent have been fully vaccinated.

Support to the National Vaccine Program

As Secretary Austin made clear in his Day One message to the force, the Department must move further and faster to contribute to the Federal Government's efforts to counter the COVID-19 pandemic. One such initiative to meet the Secretary's guidance is planning and resourcing support to FEMA to support States' and territories' vaccination efforts. DoD, in collaboration with FEMA, has developed plans to support vaccine centers that could administer up to 6,000 vaccines/day. This enhanced vaccination support will be provided directly to FEMA to support existing State-run centers or to FEMA's new Federally supported, State-run centers. DoD is actively supporting New Jersey and California with approximately 250 personnel at their State-run vaccine centers. FEMA has provided notice to DoD to prepare to support additional sites in New Jersey, Texas, New York, and the U.S. Virgin Islands, totaling approximately 900 personnel. DoD expects to receive additional requirements from FEMA to support other States and territories in the near future.

International Response Efforts

During the COVID-19 pandemic, the Department of Defense supported U.S. allies and partners through the provision and transport of life-saving medical equipment, PPE, and humanitarian aid. As of January 25, 2021, DoD had provided more than $199 million in assistance to 143 countries to aid testing, diagnostic support, infection control, PPE procurement, contact tracing, and more.[14] DoD's assistance spanned the areas of responsibility for all six Geographic Combatant Commands (GCCs). The first phase of DoD's assistance, from March 2020 until May 2020, focused on supporting countries' immediate response to the pandemic by providing locally procured PPE, medical supplies and equipment, and testing supplies. The second phase of DoD's assistance started in June 2020 and focused on capacity building to support mid- to longer-term pandemic and infectious disease preparedness and response

[14] Jim Garamone, "DOD Uses International Contacts to Help Allies, Partners Combat COVID-19," *DoD News*, October 9, 2020.

capabilities. For example, DoD has provided subject matter expert support to the African Union and the Africa CDC, and has procured 71 field hospitals, diagnostic laboratory equipment, 477 ventilators, and 29 isolation clinics/pods. DoD's Humanitarian Assistance and Foreign Disaster Relief activities are funded by Overseas Humanitarian, Disaster, and Civic Aid (OHDACA) appropriation funds.[15] The advantage of OHDACA is that use of such funds allows DoD to effectuate a transfer of equipment, materials, or expertise, and thus can provide an immediate boost to a partner nation's capacity.[16] Throughout the COVID-19 pandemic, GCCs leveraged OHDACA funds and existing global health assets to undertake "minimal cost projects," which are humanitarian assistance efforts costing up to $15,000, without higher-level approval.[17] The minimal cost project cap was eventually increased to $75,000.

Priorities Going Forward

DoD remains focused on the national vaccination efforts including production, distribution, and administration of COVID-19 vaccines to support the States through FEMA. To protect DoD personnel and safeguard DoD's national defense mission, the Department is continuing to expand its internal vaccine program and refine its vaccination analytics, improving DoD bio-surveillance and testing capabilities, exploring new treatments and testing capabilities through its research and development programs, and continually is refining its school and installation policies for force health protection. The Department is also actively implementing President Biden's guidance, publishing consolidated guidance for COVID-19 at the Department and Service levels, implementing lessons learned from the pandemic, and updating the Global Campaign Plan for Pandemic Influenza and Infectious Disease. Finally, the Department is ensuring it is postured to support the Administration's Global Health Security agenda.

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[15] Defense Security Cooperation Agency, "Security Assistance Management Manual, Chapter 12: Overseas Humanitarian, Disaster, and Civic Aid (OHDACA)"; Assistant Secretary of Defense for Special Operations/Low-Intensity Conflict and Interdependent Capabilities, Policy Guidance for DOD Overseas Humanitarian Assistance Program (HAP), November 2009.

[16] Garamone, 2020.

[17] Defense Security Cooperation Agency, "Security Assistance Management Manual, Chapter 12: Overseas Humanitarian, Disaster, and Civic Aid (OHDACA)."

Conclusion

In conclusion, DoD remains committed to fulfilling Secretary Austin's direction to defeat the COVID-19 pandemic and defend the force against COVID-19, while protecting our nation.

Chairman Smith, Ranking Member Rogers, distinguished members of the Committee, thank you for your support to the Department and the opportunity to testify before the Committee. I appreciate the critical role Congress plays in ensuring that the Department is prepared to face every challenge at home and abroad. I especially thank the men and women of the Department of Defense – military and civilian, Active, Guard, and Reserve – and their families for all that they do every day to protect the people of our nation and to keep our nation safe and secure.

Robert G. Salesses
Performing the Duties of Assistant Secretary of Defense for Homeland Defense & Global Security

Robert Salesses began Performing the Duties of the Assistant Secretary of Defense for Homeland Defense and Global Security on January 20, 2021.

Mr. Salesses currently serves as Deputy Assistant Secretary of Defense for Homeland Defense Integration and DSCA. As the Deputy Assistant Secretary of Defense for Homeland Defense Integration and Defense Support of Civil Authorities, Mr. Salesses is responsible for the development of national homeland defense and security policy. He oversees the implementation of homeland defense and defense support of civil authorities' policy and plans and programs, ensuring the objectives addressing the emerging security challenges faced by the nation are achieved. Working closely with Federal, State, and local leadership, law enforcement, public health, and emergency management, he oversees DoD's response to national emergency operations in support of civil authorities.

Mr. Salesses is a retired United States Marine Corps Officer. His career included global planning and execution of numerous national, significant regional focused projects and contingencies to include: the withdrawal of critical nuclear stockpiles from former Soviet States; the development of multinational counter narcotics policies with Central and South America; and the liberation of Kuwait during the Gulf War, where he was awarded the Bronze Star. Mr. Salesses's military career culminated in his assignment to the Joint Staff where he worked global contingency missions.

Mr. Salesses began his Federal civilian service career shortly after September 11, 2001, serving as the Deputy Special Assistant for the Homeland Security Task Force. During this period, Mr. Salesses supervised strategic planning, military operational support to civil authorities, and the emergency preparedness activities of the Department of Defense. He was appointed to the Senior Executive Service in 2005. He was awarded the Presidential Rank Award at the rank of Meritorious Executive for his decisive leadership and keen program management skills, his contributions to the National Response Plan, and the National Strategy for Homeland Security.

Mr. Salesses graduated from Rhode Island College, with a Bachelor of Arts in Management and Economics. He received his Master of Arts in National Security and Strategic Studies from the Naval War College.

Major General Jeff Taliaferro

Maj. Gen. Jeff Taliaferro is Vice Director for Operations, Joint Staff, the Pentagon, Arlington, Virginia. The Vice Director for Operations serves as the principal assistant to the Director for Operations in assisting the Chairman of the Joint Chiefs of Staff in developing and providing operational guidance and in fostering clear communication between the President, Secretary of Defense, unified commands and services.

Maj. Gen. Taliaferro received his commission from the U.S. Air Force Academy in 1989 and first served in a variety of B-1 flying positions, including U.S. Air Force Weapons School Instructor. He has commanded at the squadron and wing levels and last commanded the 9th Air and Space Expeditionary Task Force-Afghanistan and NATO Air Command-Afghanistan. His staff experience includes various operations, strategy, programming and military planning positions within headquarters U.S. Air Force, Air Combat Command, U.S. Central Command, U.S Northern Command and the Office of the Secretary of Defense. Maj. Gen. Taliaferro is a command pilot with over 2,600 hours, including combat over Iraq, Serbia and Afghanistan.

Prior to his current assignment, Maj. Gen. Taliaferro was the special assistant to the commander at the Headquarters U.S. Northern Command, Peterson Air Force Base, Colorado.

EDUCATION

1989 Bachelor of Science, Human Factors Engineering, U.S. Air Force Academy, Colorado Springs, Colo.
1997 Masters of Organizational Management, The George Washington University, Washington, D.C.
1997 Squadron Officers School, Maxwell Air Force Base, Ala.
1998 U.S. Air Force Weapons School, Nellis AFB, Nev.
2002 Air Command and Staff College, Maxwell AFB, Ala.
2003 School of Advanced Air and Space Studies, Maxwell AFB, Ala.
2007 Joint Forces Staff College, Norfolk, Va.
2008 Enterprise Leadership Seminar, University of North Carolina, Chapel Hill
2008 National Defense Fellow, Center for Strategic and International Studies, Washington, D.C.
2011 Public Policy Seminar, Capitol Hill Club, Washington, D.C.
2015 Joint Force Air Component Commander Course, Maxwell AFB, Ala.
2016 Joint Force Land Component Commander Course, Carlisle Barracks, Pa.

ASSIGNMENTS

May 1989-August 1990, Student Pilot, T-37/T-38, Reese Air Force Base, Texas
August 1990-July 1995, B-1 Instructor Pilot, 9th Bomb Squadron, Dyess AFB, Texas
July 1995-April 1997, Intern, Air Force Intern Program, the Pentagon, Arlington, Va.
April 1997-January 1998, Assistant Flight Commander, 37th Bomb Squadron, Ellsworth AFB, S.D.
January 1998-June 1998, Student, U.S. Air Force Weapons School, Ellsworth AFB, S.D.
June 1998-June 1999, Wing Weapons Officer, 28th Operations Support Squadron, Ellsworth AFB, S.D.
June 1999-July 2001, Flight Commander, U.S. Air Force Weapons School, Ellsworth AFB, S.D.
July 2001-July 2002, Student, Air Command and Staff College, Maxwell AFB, Ala.
July 2002-July 2003, Student, School of Advanced Air and Space Studies, Maxwell AFB, Ala.
July 2003-July 2005, Strategic Warplanner, Strategy, Plans and Policy, U.S. Central Command, MacDill AFB, Fla.
July 2005-July 2007, Commander, 28th Bomb Squadron, Dyess AFB, Texas
July 2007-June 2008, National Defense Fellow, International Security, Center for Strategic and International Studies, Washington, D.C.
June 2008-December 2008, Chief of Staff of the Air Force Fellow, Division Chief, CSAF Strategic Studies Group "CHECKMATE", Headquarters U.S. Air Force, the Pentagon, Arlington, Va.
December 2008-May 2009, CSAF Fellow, Military Assistant to Department of Defense Transition Task Force, Office of the Secretary of Defense, the Pentagon, Arlington, Va.
June 2009-May 2011, Commander, 28th Bomb Wing, Ellsworth AFB, S.D.
May 2011-July 2011, Chief, Combat Forces Division, Directorate of Programs, Headquarters U.S. Air

Force, Arlington, Va.
July 2011-June 2013, Principal Military Assistant to the Secretary of Defense, Office of the Secretary of Defense, the Pentagon, Arlington, Va.
June 2013-June 2015, Deputy Director, Plans and Programs, Directorate of Plans, Programs and Requirements, Headquarters Air Combat Command, Joint Base Langley-Eustis, Va.
June 2015-April 2016, Director, Plans, Programs, and Requirements, Headquarters Air Combat Command, JB Langley-Eustis, Va.
April 2016-April 2017, Commander, 9th Air and Space Expeditionary Task Force-Afghanistan; Commander, NATO Air Command-Afghanistan; Director, Air Force Central Command's Air Component Coordination Element for U.S. Forces-Afghanistan and NATO's Operation Resolute Support; and Deputy Commander-Air for U.S. Forces-Afghanistan
May 2017-July 2019, Director, Operations, Headquarters U.S. Northern Command, Peterson AFB, Colo.
July 2019-September 2019, Special Assistant to the Commander, Headquarters U.S. Northern Command, Peterson AFB, Colo.
September 2019-present, Vice Director, Operations, Joint Staff, the Pentagon, Arlington, Va.

SUMMARY OF JOINT ASSIGNMENTS
July 2003-July 2005, Strategic Warplanner, Strategy, Plans and Policy (JS), U.S. Central Command, MacDill Air Force Base, Fla., as a major
December 2008-May 2009, Chief of Staff of the Air Force Fellow, Military Assistant to Department of Defense Transition Task Force, Office of the Secretary of Defense, the Pentagon, Arlington, Va., as a colonel
July 2011-June 2013, Principal Military Assistant to the Secretary of Defense, Office of the Secretary of Defense, the Pentagon, Arlington, Va., as a colonel
April 2016-May 2017, Commander, 9th Air and Space Expeditionary Task Force-Afghanistan; Commander, NATO Air Command-Afghanistan; Director, Air Force Central Command's Air Component Coordination Element for U.S. Forces-Afghanistan and NATO's Operation Resolute Support; and Deputy Commander-Air for U.S. Forces-Afghanistan, as a major general
June 2017-July 2019, Director, Operations, Headquarters U.S. Northern Command, Peterson AFB, Colo., as a major general
September 2019-present, Vice Director, Operations, Joint Staff, the Pentagon, Arlington, Va. as a major general

FLIGHT INFORMATION
Rating: command pilot
Flight hours: more than 2,600 hours
Aircraft flown: T-38, MQ-9 and B-1

MAJOR AWARDS AND DECORATIONS
Defense Superior Service Medal with oak leaf cluster
Legion of Merit with oak leaf cluster
Defense Meritorious Service Medal
Air Force Meritorious Service Medal with oak leaf cluster
Air Medal with oak leaf cluster

EFFECTIVE DATES OF PROMOTION
Second Lieutenant May 31, 1989
First Lieutenant May 31, 1991
Captain May 31, 1993
Major June 1, 2000
Lieutenant Colonel April 1, 2004
Colonel Sept. 1, 2007
Brigadier General Dec. 3, 2013
Major General Aug. 2, 2017

(Current as of October 2019)

Major General Steven S. Nordhaus

Maj. Gen. Steven S. Nordhaus serves as the Director of Operations (J3/4/7) for the National Guard Bureau. He is responsible for the planning, coordination, and integration of all aspects of National Guard activities relating to Domestic Operations at the national level. Specifically, he provides direct supervision of the National Guard Bureau's Coordination Center, Counterdrug Program, current and future Domestic Operations planning, and joint exercises and training, as well as the Chemical, Biological, Radiological, and Nuclear Response Enterprise. He also advises senior civilian and military leaders at the national and State level on matters related to Domestic Operations.

General Nordhaus graduated from the United States Air Force Academy in 1989 with Bachelor of Science in Engineering. He has flown combat missions in operations Southern Watch, Vigilant Warrior, Northern Watch, Iraqi Freedom and Enduring Freedom.

Prior to assuming his current position, the general served as the Commander, Air National Guard Readiness Center, Joint Base Andrews, Maryland.

EDUCATION
1989 Bachelor of Science in Engineering, U.S. Air Force Academy, Colorado Springs, Colo.
1996 Squadron Officer School, Maxwell AFB, Ala.
2002 Air Command and Staff College, Maxwell AFB, Ala., by correspondence
2006 Air War College, Maxwell AFB, Ala., by correspondence
2013 Fellow, National Security Studies Management Course, Maxwell School of Citizenship and Public Affairs, Syracuse University, Syracuse, N.Y.
2014 Master of Science in Organizational Leadership, Columbia Southern University, Orange Beach, Ala.
2014 General and Flag Officer Homeland Security Executive Seminar, Harvard University, Cambridge, Mass.
2016 Fellow, Capstone General and Flag Officer Course, National Defense University, Fort Lesley J. McNair, Washington, D.C.
2017 Fellow, Program for Senior Executives in National and International Security, John F. Kennedy School of Government, Harvard University, Cambridge, Mass.
2019 Advanced Senior Leader Development Seminar (ASLDS), Warrenton, Va.

ASSIGNMENTS
August 1989 - October 1990, Undergraduate Pilot Training, Sheppard AFB, Texas.
October 1990 - December 1990, Student, Fighter Lead-in Training, Holloman AFB, N.M.
January 1991 - August 1991, Student, F-16 Replacement Training Unit, MacDill AFB, Fla.
September 1991 - August 1992, F-16 Pilot, 309th Tactical Fighter Squadron, Homestead AFB, Fla.
September 1992 - July 1996, F-16 Flight Lead, Instructor, Evaluator Pilot, 79th Fighter Squadron, Shaw AFB, S.C.
July 1996 - August 1997, F-16 Instructor and Evaluator Pilot, Assistant Chief of Standardization and Evaluation, Kunsan Air Base, Korea
September 1997 - September 1998, F-16 Instructor and Evaluator Pilot, Flight Commander, Mountain Home AFB, Idaho
September 1998 - October 2002, F-16 Instructor and Evaluator Pilot, Flight Commander, 112th Fighter Squadron, Toledo Air National Guard Base, Ohio
November 2002 - November 2006, Commander, 112th Fighter Squadron, Toledo ANGB, Ohio
November 2006 - July 2009, Air Sovereignty Alert Detachment Commander, 180th Fighter Wing, Toledo ANGB, Ohio
July 2009 - January 2011, Vice Commander, 180th Fighter Wing, Toledo ANGB, Ohio
January 2011 - December 2013, Commander, 180th Fighter Wing, Toledo ANGB, Ohio
December 2013 - March 2015, Executive Assistant to Chief of the National Guard Bureau, Washington, D.C.
March 2015 - January 2017, Mobilization Assistant to NORAD Director of Operations, Peterson AFB, CO

February 2017 - November 2019, Commander, Air National Guard Readiness Center, Joint Base Andrews, MD
November 2019 - Present, Director, Operations, NGB J-3/4/7, National Guard Bureau, Washington, D.C.

FLIGHT INFORMATION
Rating: Command pilot
Flight hours: more than 3,000
Aircraft flown: T-37, T-38, F-16A, F-16C Block 30/40/42/50/52

MAJOR AWARDS AND DECORATIONS
Defense Superior Service Medal with oak leaf cluster
Legion of Merit with oak leaf cluster
Meritorious Service Medal with two oak leaf clusters
Air Medal with oak leaf cluster
Aerial Achievement Medal with oak leaf cluster

EFFECTIVE DATES OF PROMOTION
Second Lieutenant May 31, 1989
First Lieutenant May 31, 1991
Captain May 31, 1993
Major Dec. 16, 1998
Lieutenant Colonel May 20, 2003
Colonel March 19, 2010
Brigadier General July 27, 2015
Major General July 19, 2018

(Current as of November 2019)

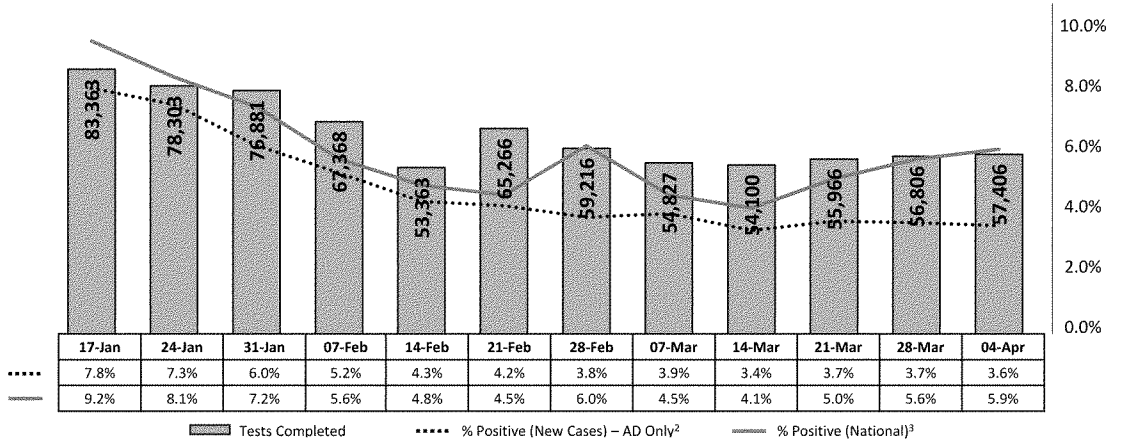
DOCUMENTS SUBMITTED FOR THE RECORD

FEBRUARY 17, 2021

DOD Diagnostics & Testing Update

04 April – 10 April 2021

Weekly Testing Summary		
Tests Completed	**Active Duty Positivity Rate**	**US Positivity Rate**
57,406	**3.6%**	**5.9%**
Tests Completed to Date[1]: 3,077,135		



	17-Jan	24-Jan	31-Jan	07-Feb	14-Feb	21-Feb	28-Feb	07-Mar	14-Mar	21-Mar	28-Mar	04-Apr
·····	7.8%	7.3%	6.0%	5.2%	4.3%	4.2%	3.8%	3.9%	3.4%	3.7%	3.7%	3.6%
———	9.2%	8.1%	7.2%	5.6%	4.8%	4.5%	6.0%	4.5%	4.1%	5.0%	5.6%	5.9%

(75)

Definitions and Calculations

1. **Inclusive Dates:** 02 JAN 2020 – 12 APR 2021
2. **% Positive (New Cases) – AD Only** = Active Duty inclusive of pooled testing numbers for that testing week.
3. **% Positive (National)** is the National weekly average reported from the Department of Health and Human Services (HHS).

WITNESS RESPONSES TO QUESTIONS ASKED DURING THE HEARING

FEBRUARY 17, 2021

RESPONSE TO QUESTION SUBMITTED BY MR. LANGEVIN

General NORDHAUS. Some States involved with vaccine distribution are employing NG members to provide turn-key operations support for Civilian Vaccination Centers (CVC). The operations include providing site security and traffic control at the CVC, in-processing civilians, completing CDC and state-specific paper work, administering vaccines, completing CDC shot records, and post-vaccine monitoring. In other states, the NG is also being utilized to deliver vaccines in very rural and isolated locations. This "last mile" support helps the State to reach citizens in remote areas. [See page 14.]

RESPONSE TO QUESTION SUBMITTED BY MR. SCOTT

General FRIEDRICHS. Over the past 12 weeks, the positivity rate for Active Duty personnel has been an average of 19.5% lower than the national positivity rate. Electronic Health Record data for the week of 04 April–10 April, 2021 shows a 3.6% positivity rate for new Active Duty cases (including pooled testing numbers), 39% lower than the national positivity rate of 5.9%. [See page 24.]

[See charts on page 75.]

RESPONSE TO QUESTION SUBMITTED BY MR. WALTZ

Mr. SALESSES. The Joint Staff works with key DOD stakeholders, such as the Army, the Air Force, and the National Guard Bureau, to identify DOD capabilities and resources that may be sourced to execute an approved request for assistance without adversely affecting military operations or preparedness.

DOD provides support to its law enforcement partners based on their requests for assistance, consistent with the law and mindful of DOD's own mission requirements. On March 4, 2021, the U.S. Capitol Police Board requested the support of 2,280 National Guard personnel, through May 23, 2021, due to a heightened threat environment. On March 9, 2021, the Secretary of Defense approved the U.S. Capitol Police Board request. DOD is meeting weekly with the U.S. Capitol Police to develop, by April 9, 2021, a plan to reduce incrementally the number of National Guard personnel providing support to the U.S. Capitol Police. [See page 37.]

QUESTIONS SUBMITTED BY MEMBERS POST HEARING

FEBRUARY 17, 2021

QUESTIONS SUBMITTED BY MR. MORELLE

Mr. MORELLE. If title 32 mobilizations ended would there be a reduction in National Guard personnel supporting state COVID–19 operations? Second, Are there any capability or capacity gaps within the National Guard that limit or prevent the National Guard from fully resourcing requests for assistance from the states or territories?

General NORDHAUS. The difference in T32 and State Active Duty (SAD) is funding and benefits provided to or by states. Additionally, if states relied on internal funding to combat the virus, they may not be able to sustain the level of response needed or have as robust of a resourcing pool as they do when federal dollars are allocated. T32 is a critical resource for states and any reduction could greatly impact a state's plan to secure its citizenry. The limitations within the National Guard and the Department writ large is the licensure to vaccinate or perform medical treatments. We are able to train non-traditional medical personnel on specimen collection but have relied heavily on general labor to build and staff care facilities, conduct sanitation and fill other critical needs identified by states to keep their economies going. At this time, there are no capability or capacity gaps in the National Guard's ability to fully resource requests for assistance from the states or territories.

QUESTIONS SUBMITTED BY MR. KAHELE

Mr. KAHELE. Section 733 of the NDAA provided for Transitional Health Benefits for Certain Members of the National Guard Serving Under Orders In Response to the Coronavirus (COVID–19) The Hawaii National Guard has service members that are eligible for TAMP per the passage of the recent NDAA as described in section 733 but because of an issue implementing this provision in the NDAA, National Guard service members are not able to initiate their TAMP benefits until the end of March because there is no way for TRICARE to manually activate TAMP for these SMs. OSD was notified by DMDC that they are actively working with TRICARE and DHA with a system implementation date of 3/20/21. This is unacceptable. We currently have eligible National Guard soldiers and airmen and their families that are being denied at least one month of TRICARE through the congressionally mandated NDAA, who have served on COVID T–32 502F orders but are losing one month of healthcare benefits which they have earned.

1. What are we urgently doing to address this?
2. Why is the DMDC unable to implement this today for our eligible service members?
3. What is OSD currently doing to address this situation immediately?
4. Why is there not a process to manually activate TAMP for an eligible national guard service member?

1. What are we urgently doing to address this?

General NORDHAUS. NGB has been communicating to the 54 States and territories about the timeframe to properly implement the automated solution for access to Transition Assistance Management Program (TAMP) healthcare benefits. The Defense Health Agency (DHA) approved NGB's guidance publication on "how to avoid out-of-pocket costs" during the system programming period and "how to file for reimbursement of costs incurred for covered services." Additional guidance was issued to reduce initial out-of-pocket expenses for Service members and family members. Use of military hospitals and those within the TRICARE network are two options to reduce out-of-pocket expenses.

In anticipation of the completion of the software updates, guidance was also proactively provided to ensure accurate reporting would be addressed in the anticipation of the enrollment process. Once software system programming is complete individuals who paid out-of-pocket costs for healthcare services and prescriptions, during the TAMP implementation delay period, may file a claim for expenses incurred that would have been covered under TAMP, less any applicable deductibles, cost-shares, and co-payments.

2. Why is the DMDC unable to implement this today for our eligible service members?

General NORDHAUS. DMDC fully implemented the new benefits on February 27, 2021. Prior to implementation, DMDC manually updated records to provide retroactive TAMP benefits for National Guard personnel who completed their active service on/before February 27, 2021. At this time, this benefit is fully in place for National Guard Service Members who were ordered to Full Time National Guard Duty (FTNFD) as provided in Section 733 of the Fiscal Year 2021 National Defense Authorization Act in support of the whole-of-government response to the Coronavirus Disease 2019 (COVID–19) pandemic.

Implementation of the new benefit required coding changes in DMDC software to both add TAMP benefits for service under Section 502(f) and to enforce the duty release date restrictions specified in the NDAA. DMDC initially estimated this capability would be implemented by 20 March 2021, but through a heightened urgency and prioritization implemented the changes on 27 February 2021. Manual updates were also run to retroactively provide TAMP benefits for eligible National Guard personnel who completed their active service periods before February 27. The first updates were made on February 24, 2021 and applied TAMP benefits to the records of 1,561 personnel and the second set of updates were made on March 1, 2021 and applied TAMP to another 120 personnel. Normal processing began March 1, 2021.

3. What is OSD currently doing to address this situation immediately?

General NORDHAUS. The Office of the Assistant Secretary of Defense issued guidance on February 8, 2021 identifying TAMP eligibility and the parameters. OSD authored and issued new policy and conducted several meetings with NGB, OSD, DMDC and DHA to assist while awaiting the system coding change completion and benefit implementation.

4. Why is there not a process to manually activate TAMP for an eligible National Guard service member?

General NORDHAUS. The DOD benefits determination processes, is very complex. Even minor changes require analysis to make sure changes will both produce the desired result and not introduce unintended consequences to Service Members and their dependent's benefits and entitlements. This change required analysis to determine how the new benefit and its accompanying restrictions should be introduced in order to provide consistent and continuing benefits to affected Service Members.

Manually activating benefits for Service Members requires making changes to specific sections of the individual Service Member's personnel records one record at a time. Such manual manipulations can introduce complications that affect later processing of the record, as well as increasing the possibility of unintentional errors, especially when there are restrictions on the benefit as there were in this case. Hence, DMDC uses manual correction as little as possible when a group of records is involved. Instead, DMDC develops, tests, and implements small program changes termed "sweeps." Sweeps apply the same changes across the entire group of records, thus ensuring that the same rules are applied to generate the intended benefits. The situation was discussed with the Defense Health Agency to minimize the impact to Members and families. The sweeps also applied the benefit retroactively, so that TAMP benefits began as of the end of each Service Member's active duty period. The first sweep was conducted as soon as the sweep logic was tested and approved, roughly two weeks after receipt of the signed OSD guidance mentioned above. The automated implementation of the benefit changes was implemented in DMDC production environments three days thereafter.

QUESTIONS SUBMITTED BY MR. BROWN

Mr. BROWN. The successful rapid development of multiple vaccines to combat the pandemic is due in large part to the foresight of DARPA and other components of the Department in developing mitigation measures to respond to a major pandemic. How is the Department incorporating lessons learned from COVID–19 in its research investments and pandemic preparedness plans to be able to better respond to the next pandemic?

Mr. SALESSES. Throughout our nation's response to the coronavirus disease 2019 (COVID–19) pandemic, DOD continues to document a range of critical lessons learned that, when fully evaluated and prioritized, will guide DOD's efforts to prepare for and respond to future pandemics and other national emergencies.

DOD support of the development of vaccines and therapeutics was a critical enabler to our nation's response. For decades, DOD laboratories have studied infectious diseases of military importance, including HIV/AIDS, Ebola, and coronaviruses such as Middle East Respiratory Syndrome (MERS). In January 2020, DOD began research and development (R&D) on diagnostics, therapeutics, and vaccines for SARS–COV–2, the strain of coronavirus that causes COVID–19. The U.S. Army

Medical Directorate-Armed Forces Research Institute of Medical Sciences led important initiatives to sequence COVID–19 in order to find its genetic "fingerprint." Scientists used this identification information to develop tests and proposed treatments as early as January 2020, and later to help track the transmission chain as the virus evolved over time.

DOD's Advanced Development and Manufacturing capability also provided critical additional capacity to support the manufacture of COVID–19 vaccines and monoclonal antibodies as part of Operation Warp Speed. When companies lacked space to conduct vaccine trials, DOD helped to set up pop-up sites in parking lots. When testing and trials required a particular piece of equipment, DOD helped to acquire it. Defense Advanced Research Projects Agency (DARPA) programs funded projects that laid the groundwork for the development of RNA COVID–19 vaccines produced by Moderna and AstraZeneca, and COVID–19 therapeutics manufactured by Eli-Lilly.

DOD overseas laboratories and Cooperative Threat Reduction–Biological Threat Reduction programs continue to facilitate the detection and reporting of diseases that could affect the armed forces of the United States and its allies and partners. DOD is institutionalizing improvements to programs under its purview. Improvements to a future whole-of-nation response depend on reforms made by other Federal departments and agencies.

Mr. BROWN. As this pandemic approaches its second year, it is clear that COVID–19 will continue to be a factor as it evolves and mutates. What is the Department's long-term strategy for force protection, to include long-term vaccination planning, requirements, and supplies, to ensure that the Department is prepared to combat a persistent presence of the virus at home and is ready for global deployments where we might see mutated strains?

General TALIAFERRO. The department remains committed to supporting the whole of government response, both domestically and internationally, as tasked by the interagency leads (FEMA and DOS). We are fully engaged in planning for potential additional support.

From the beginning of the pandemic, the DOD embraced and implemented CDC and other Federal guidance, and will continue to do so. Our layered approach to force protection continues to evolve as CDC guidance changes, including:

1) Non-pharmaceutic public health measures (e.g., mask-wearing and social distancing)

2) Testing—both when appropriate clinically to determine if someone is infected, as well as to identify people with asymptomatic infections

3) Vaccinations to reduce the risk of becoming infected, including reassessing whether to keep vaccines voluntary at such a time that the FDA grants unrestricted approval

Because we know this is not the last biological threat our nation will face, we are taking the lessons learned from the past 15 months and are in the process of working with USNORTHCOM to update the Global Campaign Plan for Pandemic Influenza and Infectious Diseases. Additionally, the Joint Staff is also coordinating the first-ever Globally Integrated Framework for Pandemic Response. Moreover, we continue to partner with our interagency colleagues to expand global surveillance for new variants and new biological threats so that we can identify them as quickly as possible and, if necessary, develop additional medical and non-medical countermeasures.

Mr. BROWN. First, let me thank you for the service of the National Guard in securing the Capitol during the inauguration. I understand that there were significant outbreaks of COVID–19 within the deployment. What root causes have the National Guard Bureau identified that led to these outbreaks and what corrective actions has the NGB taken to reduce the potential for them in the future?

General NORDHAUS. We determined the carriers introduced the virus to the environment once they arrived. It did not spread and we quickly worked to contain and isolate infected individuals and those in close contact. We reinforced CDC and DOD guidelines and worked through the DCNG Surgeon's office to expand sanitation. Additionally, we increased education to the force as they arrived to keep healthy practices fresh in their minds as they were employed.

○