Statement by

Ms. Stacy Cummings

Senior Official Performing the Duties of

Under Secretary of Defense for Acquisition and Sustainment

Office of the Secretary of Defense

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

Before the 117th Congress

Committee on Armed Services

United States Senate

February 25, 2021

Introduction

Chairman Reed, Ranking Member Inhofe, 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. We are honored to be here in the company of General Gustave Perna, DoD's lead for the Vaccine Task Force (formerly "Operation Warp Speed").

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, U.S. 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 stressed the need for 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, as well as, carrying out President Biden's direction, that were provided in: Executive Order (E.O.) 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," E.O. 13991, "Protecting the Federal Workforce and Requiring Mask-Wearing," 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 the greatest public health challenges our nation has faced in over 100 years, since the 1918 influenza pandemic. Domestically, most disasters or emergencies either affect a single State or region within the United States In contrast, COVID-19 not only affected the entire United States, but the entire world. (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 has been ongoing for more than one year. 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). Furthermore, when most incidents occur, responders are able to focus on saving and protecting lives, followed by a transition to recovery. Instead, COVID-19 is a persistent incident that only ebbs and flows in intensity without allowing for a true recovery phase of operations yet.

The response to COVID-19 is distinct from previous disease outbreaks, with the exception of the 1918 influenza pandemic, because of the disability and death caused by the virus, the ease of transmission, and its impact 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 23, 2021, there were nearly 28 million confirmed COVID-19 cases and more than 500,000 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 44 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 as significantly affected by COVID-19. As of February 22, 2021, there have been more than 159,000 cases of COVID-19 and 22 deaths due to COVID-19 among DoD's military

[1] CDC COVID Data https://covid.cdc.gov/covid-data-tracker/index.html#datatracker-home, As of February 18, 2021.

[2] CDC COVID Data, https://covid.cdc.gov/covid-data-tracker/index.html#vaccinations, As of February 18, 2021.

population.[3] Across DoD's total population (military, civilian, dependent, and contractor), there have been more than 237,000 cases of COVID-19 and 281 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 delaying non-emergency medical treatments, military training (especially collective training), military exercises with allies and partners, and by complicating recruitment and initial entry training. As is the case with our civilian counterparts, impacts on family life of our force has been disruptive to readiness as well. Persistent physical and mental health effects of COVID-19 are being studied now, with early results suggesting long-term effects, meaning the virus also has the potential to impose additional costs to 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

[3] DoD, *Coronavirus: DoD Response*, As of February 17, 2021: https://www.defense.gov/Explore/Spotlight/Coronavirus//./

[4] DoD, *Coronavirus: DoD Response*, As of February 17, 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.

coordination with DoD's influenza sentinel surveillance program, along with serologic surveillance through the Department's HIV testing program. Collectively, these mitigation efforts were critical to informing DoD senior leadership and allowing leaders to make appropriate risk-based decisions enabling DoD to protect the force, continue operations, and maintain readiness.

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 infected persons. 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 U.S. 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 prioritizing testing across the force for those presenting with symptoms or who had close contacts with infected persons.[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 February 17, 2021, DoD had conducted more than 2.6 million tests for DoD personnel over the course of the pandemic. Moreover, as of early January 2021, DoD was conducting more than 15,000 tests per

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

day. DoD's testing strategy continues to evolve as new diagnostics 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 to maintain readiness, protect the force, and safeguard the communities where we live and work.

DoD views testing as one of several complementary foundational public health measures, including contact tracing, which must be used in concert 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, in order 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 support is in excess of $3.4 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]

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

Repatriation Efforts

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 requested 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 in order to quarantine more than 3,000 individuals from China and two 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, then quickly spreading across the country. Hospitalizations from COVID-19 began to increase rapidly, creating concerns about insufficient medical capacity to treat the rising number of patients, and a subsequent demand from States and local governments for both medical facilities and medical providers. In accordance with the National Response Framework, HHS and FEMA 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.

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

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 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

Beginning in March 2020, but extending throughout 2020 and into 2021, FEMA requested that DoD authorize NG personnel from 52 States and territories[9] to support COVID-19 response efforts. The Secretary of Defense authorized Title 32 duty status – funded by the Federal Government but under State command and control, to support these mission assignments.[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, communicating health and safety information to the public, transportation, logistics, and first responder support. As of

[9] Wyoming has yet to request support from FEMA for the use of their National Guard, and the District of Columbia National Guard always operates in Title 32 when supporting the District of Columbia.

[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.

February 23, 2021, approximately 28,900 National Guard personnel were supporting the COVID-19 response in 49 States (excluding Wyoming) and three U.S. territories.

Supply Chain and Acquisition Support

DoD also played a critical role in strengthening the supply chain for medical resources and protective equipment, which were in critically short supply at the beginning of this pandemic. COVID-19 created urgent demand for personal protective equipment, or PPE, such as masks, gloves, and gowns, as well as medical equipment, such as ventilators and respirators, all of which are necessary to protect medical personnel and to treat patients. Initially, the global demand for these items far outstripped the available supply, due in part to the just-in-time global supply chain. The U.S. depends on the global supply chain for PPE and some medical equipment necessary to respond to COVID-19, making 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 expand the industrial base to manufacture critical supplies.[11] The national supply chain, including the supply chain for the Strategic National Stockpile, orSNS, was unable to meet the exponential increase in demand as a result of the global pandemic. In recognition of this need, the DoD mobilized its acquisition and logistics workforce to respond quickly and professionally to support HHS and FEMA and meet this National need.

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 and heavily supported by DoD personnel who had expertise in supply-chain management and logistics that were detailed to FEMA. The identified medical supply chain constraints underscored a need to accelerate acquisition and expand production to generate new capacity and allocate resources to ensure that supplies were prioritized to hotspots. The SCTF also worked with commercial distributors to facilitate the rapid distribution of critical resources. *A key*

[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.

example of this partnership in action is Project Air Bridge. Working with the State Department and other partners, 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 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.

To facilitate the U.S. Government's urgent medical resource acquisition efforts, DoD established the COVID-19 Joint Acquisition Task Force, or JATF, on March 25, 2020. The JATF was responsible for creating processes that enabled HHS and FEMA to quickly and effectively access DoD acquisition workforce, expertise, and authorities in support of the U.S Government's COVID-19 response. The JATF's goals were to bring analytic, program management, and contracting expertise from the Services and DoD Agencies to quickly respond to demand from FEMA and HHS; utilize DoD's supply chain expertise to forecast gaps and identify opportunities for industrial base expansion; and prioritize solutions from industry to connect suppliers to FEMA or HHS requirements. Nearly 300 DoD acquisition and supply chain experts responded to this call for support to enable FEMA and HHS to rapidly scale and modify their acquisition efforts, both for procurement of supplies and to expand domestic industrial capacity.

DoD initially provided full-service acquisition support across the Government by establishing product teams in areas where DoD anticipated HHS needs, material shortage, or an industrial base constraint that would require action. DoD acquisition experts conducted the necessary medical industrial base analysis and brought issues highlighted by this analysis to a joint FEMA-HHS decision-making body for direction. As HHS's analytic capacity increased and response efforts stabilized, DoD's interagency acquisition support evolved from full-service to streamlined support responding to HHS requirements and priorities.

In response to HHS' most critical needs, DoD played a key role supporting the immediate response to the national health emergency by replenishing the SNS while

supporting an expanded domestic industrial base. Leveraging the Defense acquisition workforce's supply chain expertise, including its understanding of U.S. reliance on foreign suppliers and the associated impact on producing at scale, HHS expanded both the depth and breadth of the SNS. DoD assisted HHS in replenishing the SNS with a goal of holding a stock level of 90-days based on surge demand for critical medical supplies and PPE while identifying areas of investment that reduce our reliance on foreign suppliers.

DoD has a long history of supporting the national response in support of FEMA and other interagency partners. The Defense Logistics Agency (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 executed new orders to restock the SNS and deliver critical COVID-19 related medical supplies and test kits across the nation to support nursing homes, assisted living facilities, and schools and universities. 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 February 16, 2021, DLA executed more than 27,000 contract actions, obligating more than $3.2 billion in critical medical resources for the Whole-of-Government response, including nearly $800 million to replenish the SNS. These procurements include 168 million rapid antigen tests, 8.9 billion gloves, 54 million N95 respirators, 201 million surgical masks, 111 million gowns, and 5,800 ventilators.

With the passing of the CARES ACT, the Congress recognized that the National response to a global pandemic would require industrial manufacturing capacity to enable long-term domestic viability for critical medical resources and PPE. Based on HHS's requirements, the DoD leveraged innovative acquisition strategies to expand domestic production of critical medical supplies such as ventilators, N95 respirators and filter media, surgical masks, screening and diagnostics equipment, medical gloves and gowns, pharmaceuticals and other therapeutics, and vaccine injection devices.

Recognizing the critical role the Defense Acquisition Workforce has played in the response and recovery, DoD realized the structure and processes developed in operationalizing the JATF needed to be formally codified and sustained in preparation for future national emergencies. Accordingly, on October 13, 2020, DoD formally established the Defense

Assisted Acquisition (DA2) Cell, nested within the Joint Rapid Acquisition Cell (JRAC) to provide an enduring resource for future interagency assisted acquisition requirements.

In support of HHS, the U.S. Government's single agency leading the COVID-19 public health response efforts, DoD continues to support industrial base expansion efforts. Facilitated by DA2 (and previously JATF) the DoD has awarded 34 contracts to date, valued at $1.8 billion, to expand the domestic health and medical resources industrial base. The Defense Acquisition Workforce continues to actively respond to HHS requirements to expand domestic production for Testing and Diagnostics, PPE, and to mitigate constraints in the medical supply chain.

On behalf of HHS, DoD has also coordinated the shipment of over 878 thousand pounds of COVID Test Kits and the delivery of over 55 million needles and syringes to the U.S. from China through US Transportation Command.

Support to the Defense Industrial Base

Defense Production Act

The DPA provides broad authorities to meet U.S. defense, essential civilian, and homeland security requirements. There are three distinct DPA authorities: Title I, Title III, and Title VII. DPA Title I authorities may be utilized to prioritize federal contracts over all other orders; control distribution of scarce materials within the civilian economy; allocate scarce materials against federal or private contracts; and prevent hoarding of scarce materials. DPA Title III provides incentives to industry to develop, maintain, modernize, and expand production capacity or critical technologies. These incentives include loans/loan guarantees, purchases/purchase commitments, and grants and subsidies. DPA Title VII authorities contain mandatory survey authority for any U.S. registered business entity; antitrust immunity for industry to develop and implement national emergency preparedness plans; the Committee on Foreign Investment in the United States (CFIUS); and Civilian Executive Reserve, called into federal service during a national emergency.

DPA Title I, III, and VII authorities were heavily leveraged during the national response to the COVID-19 pandemic. Through DPA Title I, FEMA, HHS, and other federal partners placed priority rated orders for health and medical resources to respond to COVID-19, including PPE and ventilators. The DPA Title III Program was appropriated $1 billion to the

DPA Purchases account via the CARES Act in order to "prevent, prepare for, and respond to the coronavirus." Of the $1 billion appropriated to the DPA Title III Program, $213 million was allocated to increasing production capacity for critical health resources, including N95 respirators and testing consumables; $687 million was allocated to mitigating financial impacts to companies within the DIB and ensuring the survival of critical capabilities; and $100 million was allocated to establishing a Federal Credit Line Program with U.S. International Development Finance Corporation (DFC). The expenditures have protected U.S. workers and ensured that essential elements of the industrial base survived COVID.

Through DPA Title VII, DoD, the U.S Treasury Department and other interagency partners have maintained a watchful eye on opportunistic foreign investment in critical infrastructure sectors, and FEMA established a voluntary agreement for enhanced coordination and cooperation with private sector manufacturers, distributors, and industry representatives to provide critical healthcare resources to respond to the pandemic.

DPA Title III Loans through the U.S. International Development Finance Corporation

E.O. 13922, issued on May 19, 2020, delegated authority under section 302 of the DPA to the U.S. International Development Finance Corporation (DFC) in order to establish a Federal Credit Line Program. To enable execution of E.O.13922, DoD allocated to the DFC $100 million of the $1 billion provided under the CARES Act for domestic production of strategic resources needed to respond to the COVID-19 outbreak, and to strengthen any relevant domestic supply chains. The DFC has over fifty years of experience operating federal lending programs in emerging markets, with specific expertise in manufacturing lending. Responsibility for the management and execution of the loan program is shared by DFC and DoD. To note, the DFC has setup a specific COVID-19 lending team to focus on this program in order to not interfere with its Congressional mandates for international development finance. Applications are screened by an interagency panel consisting of representatives from DFC, DoD, HHS, the U.S. Department of State, the U.S. Department of Commerce, and the Executive Office of the President. DFC loans will help create, maintain, protect, expand, and restore domestic industrial base capabilities supporting the national response and recovery to the COVID-19 outbreak, as well as improve the resiliency of domestic supply chains. DFC is actively evaluating 19 key pandemic response projects for a total of $2.9 billion dollars. To

date, DFC has approved three loans worth $1.4 billion that increase manufacturing capacity for COVID-19 vaccine vials, development, and testing.

Mitigating Impacts on the Defense Industrial Base

Since the onset of COVID-19 the Office of Industrial Policy has hosted calls with key DoD stakeholders and the leaders of more than fifteen Associations representing over three million businesses. The goal of these industry calls has been to establish a high level channel of communication to address the numerous issues created within the defense industrial base due to the pandemic. These calls have created a vital link to partner businesses and lead to unique ways of solving problems jointly.

The Office of Small Business Programs launched the Defense Small Business Webinar series in April 2020 to help small businesses in the defense industrial base remain strong and resilient throughout COVID. In 2020, DoD OSBP held 7 webinars, reaching over 4,000 participants.

The Department has diligently implemented acquisition-specific language of the CARES Act. In addition, my office has issued necessary guidance and direction to the DoD contracting workforce to acquire COVID-related supplies and services in the most expeditious way. The Department also ensured our guidance was informed by frequent and meaningful engagement with industry, both through recurring meetings and open engagements to seek industry input to key policy initiatives. The goal of our guidance was to ensure a healthy DIB in the face of the COVID 19 crisis. Our implementation approach and related policies outlined in some forty-six policy documents have focused on three areas: 1) Allowing companies to continue to work (while maintaining workplace safety); 2) Providing liquidity to the DIB; and 3) Implementing legislation in a way that provides complete spending transparency.

Allowing Companies to Continue to Work

From the onset of the pandemic, the Department worked to ensure the DIB, within the parameters of public health guidance established by the Centers for Disease Control, could continue to perform safely in an effort to limit both the impact on national security and

resulting cost and schedule impacts to our readiness and modernization efforts. On March 19, 2020, the Department of Homeland Security (DHS) published a memo designating the DIB as critical national infrastructure. Following this designation, the Under Secretary of Defense for Acquisition and Sustainment and the Office of Defense Pricing and Contracting (DPC) immediately published guidance leveraging the DHS designation to ensure the DIB could continue to work. DPC issued guidance highlighting telework for both government and contractor staff to enable continued performance despite facility closures or other COVID-19-related impacts.

Providing Liquidity to the Industrial Base

On March 20, 2020, DPC issued a Class Deviation to increase the progress payment rates in the Defense Federal Acquisition Regulation Supplement (DFARS) to 90 percent for large business concerns and 95 percent for small business concerns. This action addressed the number one issue the DIB identified—liquidity or cash flow from prime contractors down through their supply chains to small businesses. This move was critical in enabling the DIB to continue working throughout the national emergency. In addition to DoD direct payments to vendors, many primes have passed these payments down to 2nd and 3rd tier suppliers, providing liquidity at all levels. As of January 31, 2021, this action has infused an estimated $4 billion in cash to all levels of the DIB. Primes have assisted suppliers by accelerating payments, restructuring performance based payment schedules, and employing other favorable payment terms.

Support to the Organic Industrial Base

Like their counterparts in the Defense Industrial Base, the Organic Industrial Base experienced similar financial and production challenges that would have negative long-term impacts to readiness if both Congress and the Department had not intervened. During the height of the pandemic, individual depot, arsenals, and shipyards experienced a range of employee non-availability extending to full closures of production plant operations. But, across the Organic Industrial Base, the Services took aggressive actions to protect and support their workforces. In addition to providing the appropriate PPE, depots, arsenals, and shipyards conducted routine health screening, applied staggered shift-changes and flexible production scheduling, and

instituted disciplined workspace cleaning and social distancing standards. In coordination with their customer commands, this combination of actions has restored production operations to normal levels as the organic industrial base continues to manage and stabilize depot-level production. To mitigate the financial losses incurred during the pandemic caused by reduced demand, delayed materiel inductions, and lower productivity, the Defense Committees generously granted $1.45B of Defense appropriations for transfer into the Defense Working Capital Fund Components. This cash infusion was critical to stabilizing out-year labor rates of the organic depots and to preserving the Military Services' buying power for organic sustainment. This was also essential to ensuring that commercial vendor deliveries and payments were met and contracts were awarded with sufficient lead-time to meet demands and to avoid draining cash balances below acceptable levels.

Implementing Legislation

Section 3610 of the CARES Act allows agencies to reimburse contractors for payment associated with the preservation of workforces prevented from working due to COVID-19 facility closures or other restrictions. In addition to increasing progress payment rates, the Department moved swiftly to implement this legislation and provided extensive guidance (to include reimbursement checklists) to the DoD contracting community. In issuing this guidance, we took into consideration industry input. Our implementation approach and paid leave reimbursement guidance provide a framework for contracting officers to assess any claimed, allowable paid leave cost, including sick leave, that a contractor or their subcontractors provide to keep their employees in a ready state, where they are unable to perform due to facility closure or other COVID related impacts.

It is important to note that Section 3610 authorized, but did not appropriate, the funds needed to make these reimbursements. As a result, the Department has only reimbursed approximately $50 million to 84 separate companies to date. While the Department may be able to use other appropriated funds to reimburse contractors, the cost for 3610 is beyond the Department's resourced ability to do so without jeopardizing modernization or readiness. The Department estimates the aggregate potential Section 3610 Paid Leave costs to the DIB is $4.25 billion as of December 1, 2020. This estimate is based on Rough Order of Magnitude

estimates (ROMs), which include both incurred and estimated costs for Section 3610 Paid Leave, as provided by our top twenty-one vendors based on total obligations.

In addition to paid leave costs under Section 3610, industry has incurred and will continue to incur other COVID-19-related costs. The Department has issued extensive guidance to enable reimbursement, to include a checklist designed to reimburse these costs. If the Department receives a supplemental appropriation for these costs, we would prefer to negotiate settlements with major defense contractors at a corporate level to avoid opening individual contracts, which may result in higher costs and significant administrative burden. These other COVID-19-related costs include such items as the purchase of medical PPE, increased cleaning and sterilization costs, health screenings, reconfiguration of production facilities and adjustment to work schedules to implement public health guidance on social distancing, and the costs associated with schedule delays emanating from their supply chain. As with Section 3610, the Department does not have the funding to cover these costs. The Department estimates the impact of these other COVID-19-related costs to the DIB are $6.5 billion as of December 1, 2020. As with the paid leave costs, this cost estimate is based on the industry provided ROMs, which include both incurred and estimated costs through fiscal year 2023. This results in a total impact of $10.8 billion to the DIB for both categories of cost. With an appropriation, the Department could reimburse these costs and maintain our readiness levels and planned modernization efforts in support of the National Defense Strategy. Without an appropriation, the Department would need to absorb these COVID-related costs through reductions in planned modernization programs and reduced readiness levels.

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 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 several 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, under the office of the Assistant Secretary for Preparedness and Response. 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 78.2 million vaccine doses, 59.6 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 20, 2021, DoD has received over one million total doses of the Pfizer and Moderna vaccines, each of which received an Emergency Use Authorization from the FDA. DoD is in the expanded distribution phase with vaccine administration occurring at 332 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 20, 2021, DHA has administered approximately 990,000 of those doses. More than 670,000 personnel have been partially vaccinated, and more than 318,000 have been fully vaccinated (i.e., having received 2

doses). As of February 20, 2021, 18.3 percent of military personnel have been vaccinated with the first dose, and 9 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 in order to support State and territory vaccination efforts. DoD, in collaboration with FEMA, has developed plans to support vaccine centers that could administer up to 6,000 vaccines per 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, California, Texas, and New York with over 1,000 personnel at their state-run vaccine centers. FEMA has provided mission assignments for DoD to support additional sites in Florida, Pennsylvania, and the U.S. Virgin Islands, totaling over 800 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 February 15, 2021, DoD had provided more than $209 million in assistance to 143 countries to aid testing, diagnostic support, infection control, PPE procurement, contact tracing, and more. 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 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.[14] 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.[15] 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.[16] 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 (through implementation of DoD Directive 6420.02 "DoD Biosurveillance" published September 17, 2020) 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.

Conclusion

[14] 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.

[15] Garamone, 2020.

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

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 Reed, Ranking Member Inhofe, distinguished members of the Committee, thank you for your support to the Department and the opportunity to testify before the Committee. We appreciate the critical role Congress plays in ensuring that the Department is prepared to face every challenge at home and abroad. We are also grateful for the transparency and open dialogue afforded by professional staff members from the pandemic's onset, especially their engagement at weekly touchpoints that was invaluable to the nations and our efforts. We 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.