July 1, 2022

The Honorable Lloyd J. Austin III
Secretary
United States Department of Defense
1000 Defense Pentagon
Washington, DC 20301-1000

Dear Secretary Austin:

On behalf of the undersigned organizations representing healthcare clinicians and educational institutions that comprise the backbone of the Military Health System (MHS), we write to thank you and President Biden for delaying all future medical military end strength divestitures by one year. This announcement in the FY23 Defense Budget Request Overview aligns with the FY 2022 National Defense Authorization Act (NDAA) that paused any medical billet reductions for a year from the bill's enactment and required a study from the Comptroller General's office on the data used to justify the individual services' proposed reductions to uniformed physicians, nurses, and allied health professionals. While this "pause" in reductions is welcome, the undersigned organizations are concerned that the service branches, particularly the Navy and Air Force, are still planning to move forward with a substantial reduction in military medical end strength over the next several years which we feel does not align with the current state of our country's health care system and does not fully consider the second- and third-order consequences for the military health system and service members and their families who rely on it for care. In fact, military medicine is already feeling the effects of reduced training numbers and years of slow billet cuts. In addition, previous proposals to eliminate 12,000 to 18,000 uniformed medical billets also do not consider the ways in which the MHS and the country's overall health care system are intertwined and benefit from each other.

Existing Stress on Military Medicine

While there is a current pause on military medical billet reductions, there have already been reductions to overall medical end strength through open billets not being filled and smaller billet divestitures over the years. Many MTFs are currently understaffed and more remote locations are having staffing challenges. In addition, the news of previous proposed reductions is already having a dampening effect in recruiting medical students for military residencies, especially in pediatrics. The number of medical students interested in these residencies has been declining across the services because the proposed cuts to military training billets gives the perception that there is no longer a viable long term career path in military medicine. This same phenomenon is even beginning to negatively affect retention of current uniformed clinicians. In short, constant proposals to reduce medical billets and training programs is hampering the future supply of uniformed clinicians. While we welcome a pause in future medical divestitures, we are already dealing with the deleterious effects of reducing medical billets. Continuing to propose large-scale reductions in medical billets will only worsen the situation.

COVID-19

When proposals to transform the military health system began in 2017, the nation and the world were in a much different place. As we have seen over the past two and a half years, the COVID-19 pandemic has impacted all aspects of life for individuals across the country, including service members and their families. Members of the Armed Forces and their families have experienced numerous disruptions to health care services, childcare, education, permanent change of station orders, finances, and employment, among others. The country has weathered several large COVID-19 surges, with the Delta and Omicron variants causing huge spikes in cases, hospitalizations, and deaths. While these waves have disrupted the lives of military families,

they have also dramatically affected health care systems and health care clinicians across the country, including facilities and physicians staffing the MHS. Many uniformed clinicians have been utilized to provide surge capacity to help run civilian hospitals and COVID-19 vaccination clinics around the country, proving once again the value of the uniformed clinician to respond to public health emergencies. But the toll of the COVID-19 pandemic—long work hours, sporadic lack of protective gear, caring for people dying from the virus, dealing with misinformation and disinformation about COVID-19 and vaccines, and even having to deal with threats of bodily harm from fellow Americans upset with public health recommendations to mitigate the spread of the virus—has weighed heavily on the nation's medical community.

Because of the stress caused by the pandemic, many health care professionals have retired early or have left the medical field for another profession. A recent article in JAMA highlighted an ongoing survey of COVID-19's effects on primary care practices that demonstrated that many clinicians are increasingly burned out, traumatized, anxious and depressed.[1] In a February 2022 survey, the Larry A. Green Center in Virginia also found that 62 percent of 847 clinicians surveyed had personal knowledge of other primary care clinicians who retired early or quit during the pandemic and 29 percent knew of practices that had closed.[2] According to the National Institute for Occupational Safety and Health (NIOSH), worsening staffing issues are now the biggest stressor for clinicians. Health care worker shortages, especially in rural and otherwise underserved areas of the country, have reached critical and unsustainable levels. Data like this underscores our organizations' concern about the ability of the private sector to absorb a large influx of Tricare beneficiaries in the contracted sector, as previous divesture proposals have urged. This is particularly true for pediatric subspecialties and mental health services for all ages.

From a pediatric perspective, the United States' supply of pediatric subspecialists is inadequate to meet children's health needs. Many children must wait more than 3 months for an appointment with a pediatric subspecialist. Approximately 1 in 3 children must travel 40 miles or more to receive care from a pediatrician certified in adolescent medicine, developmental behavioral pediatrics, neurodevelopment disabilities, pulmonology, emergency medicine, nephrology, rheumatology, and sports medicine. This problem is compounded by the fact that in some subspecialties, fewer medical residents are choosing careers in pediatric subspecialties, and the existing subspecialist workforce continues to age. There is also a significant disparity in the geographic distribution of pediatric subspecialists across the country, resulting in many underserved rural and urban areas.

Along with excessive distances and lack of capacity to accept new patients, many practices have been severely affected by workforce shortages because of the pandemic and are not accepting new patients. On top of the stressors caused by the pandemic, there are many private sector clinics and hospitals in the United States that cannot participate in Tricare because of the low payment rates. In addition, a report by the GAO in May of 2020 found that DoD methodology to determine MTF's restructuring relied on civilian health care assessments that did not consistently account for provider quality or account for access to an accurate and adequate number of providers near MTFs.[3]

Mental Health Crisis

In addition to stress on the medical community caused by COVID-19, the pandemic has accelerated the mental health crisis in our country. The COVID-19 pandemic has created profound challenges for communities,

---

[1] Abbasi, J. "Pushed to Their Limits, 1 in 5 Physicians Intends to Leave Practice," JAMA, April 19, 2022, Vol. 327. No. 15. oi:10.1001/jama.2022.5074

[2] Ibid.

[3] Government Accountability Office, *Defense Health Care: Additional Information and Monitoring Needed to Better Position DOD for Restructuring Medical Treatment Facilities*, GAO-20-371, Washington, DC. May 2020.

families, and individuals, leading to a range of emotional and behavioral responses due to the uncertainty, duration, need for quarantine, and loss of family members or loved ones during the pandemic. For the pediatric population, we have witnessed soaring rates of mental health challenges among children, adolescents, and their families, exacerbating the situation that existed prior to the pandemic. For example, rates of childhood mental health concerns and suicide rose steadily between 2010 and 2020 and by 2018 suicide was the second leading cause of death for youth ages 10-24. The pandemic has intensified this crisis, as across the country we have witnessed dramatic increases in the past two years in Emergency Department visits for all mental health emergencies including suspected suicide attempts. According to the CDC, between April and October 2020, hospital emergency departments saw a rise in the share of total visits that were from children for mental health needs. This situation is why the American Academy of Pediatrics, the Children's Hospital Association and the American Academy of Child and Adolescent Psychiatry declared a national emergency in children's mental health last fall and recently released the Blueprint for Youth Suicide Prevention.

On top of this, we know that children in military and veteran families face all the typical stressors impacting their civilian counterparts, as well as unique factors such as a parent regularly in harm's way, deployments and prolonged separations, frequent moves, and possibly having to care for a parent with a service-related injury. Yet military families continue to face barriers to receive needed services for mental, emotional, and behavioral health needs, for both active-duty members and their beneficiaries. From prevention to early intervention, community supports, crisis care, and better understanding and navigation of higher acuity care, we must improve coverage and incentivize easy access for service members as well as children and youth in military and veteran families.

Unfortunately, proposals to reduce the number of uniformed mental health professionals in the MHS will only worsen the situation for military families. The civilian sector does not have enough mental health providers to keep up with demand as it stands now. With a lack of mental health professionals, it often falls upon primary care family physicians and pediatricians to screen for and provide integrated mental health services to their patients. But military families will also lose access to many of these clinicians as well if past divestiture proposals were to move forward with no changes. Removing options for military families to access mental, emotional, and behavioral health services at MTFs and military hospitals belies the current reality and will only make it harder to military families to access needed care. These services not only need to be maintained in the military health system, but they also need to be expanded, as fewer options within the Tricare network and the civilian sector squeeze out military families.

Restraints on Deployment and Surge Capacity

As world events have demonstrated over the past several years, the role of the uniformed health professional is more important than ever and a key component of the Armed Forces. During the withdrawal of the United States military operations in Afghanistan, medical manpower was critical to the success of Operation Allies Welcome (OAW). From screening refugees in theater, to providing evacuee medical care on planes—including delivering babies while in flight—uniformed medical personnel, who had received proper training and were deployable at a moment's notice, were able to screen for infectious disease, provide primary and specialty care, and ensure that the withdrawal was able to lift more than 100,000 out of the country in a manner of weeks.

In addition to Afghanistan, the current pandemic has highlighted the risks of cutting surge capacity within the military health system. Uniformed medical personnel have played critical roles throughout the whole of our nation's response to COVID-19, with many deploying in support of Defense Support of Civil Authorities (DSCA) missions, staffing FEMA vaccination sites and integrating with civilian hospitals across the country, proving once again the value of the uniformed clinician to respond to public health emergencies. If we have learned anything from the pandemic it is that we must ensure our military medical system can work in support of

national surge capacity to fulfill the crisis response mission without compromising beneficiary access to essential medical care. Reducing medical billets, especially considering the pandemic and the recent withdrawal from Afghanistan, undermines this military surge capacity.

Medical Education and Training

For decades, the DoD Graduate Medical Education (GME) program has provided the millions of Armed Forces families with a highly trained, well-staffed, and accessible health care provider workforce. Most uniformed clinicians train at a military medical center (MEDCEN), staffed with a combination of uniformed and civilian (often retired military) physicians who have experience with remote duty stations and deployments. In addition, the Uniformed Services University of the Health Sciences (USU) plays a critical role in training and supplying military clinicians that civilian training programs do not. For example, USU is the single largest accession source of military medicine and provides development training, resources, and research support to faculty at military training facilities worldwide. USU specialized programs provide unique education and training opportunities to develop medical force readiness through military field exposure and military-specific treatment competencies that are not available through training in the civilian sector. A November 2019 analysis by the non-profit Institute for Defense Analysis (IDA) found that USU is a far better value for DoD than other means of training military healthcare professionals and called for expanding USU to better meet national military and civilian priorities. Consequently, the USU serves as a force multiplier for military and non-military physicians and other health care providers throughout the military and non-military health systems.

Being able to perform both simple and complex medical procedures in combat environments and post deployment settings is vital for military readiness and overall troop health. Accounting for more than 25 percent of physicians on active duty, medical practitioners trained at USU are more than 70 percent likely to commit to military career service after training. University graduates participate in more operationally relevant training courses and are deployed more than 250 percent longer than other accession sources – an average of 731 days compared to 266 for other military physicians.

In light of physicians, nurses and allied health professionals leaving the medical workforce in large numbers due to the pandemic, medical education and training programs take on a greater importance to help replenish the workforce. Graduate medical education training positions within the military health system play a vital role in producing culturally competent, combat ready, military medical officers. Reducing such positions would undermine a well-functioning military health system. If GME billets were dramatically reduced, these training opportunities would not automatically be picked up in the civilian sector. Even if one were to propose a partnership with civilian GME programs to ensure the military specific training that is required, the capacity may not exist. The current number of residency positions are unable to address growing nationwide physician shortages. The excess need created by the elimination of military GME may not be able to be replaced in the private sector. This problem is compounded by the fact that fewer medical residents are choosing careers in certain subspecialties and the existing subspecialist workforce continues to age. The training programs provided through military GME billets and USU in these much-needed subspecialties are crucial to providing needed medical care for children in military families, as well as the civilian population that benefits from this training. It would be unwise to leverage short-term cost savings by cutting GME programs, which puts at risk access to highly qualified and military trained medical personnel.

Quality of Care at MTFs and Military Hospitals

As we have emphasized previously, major structural changes such as billet cuts can have far-reaching, unintended, second- and third-order consequences. While the MHS transformation has resulted in closing and consolidations of MTFs at certain bases, we strongly encourage DoD to re-evaluate what continued large scale reductions in medical billets that are crucial for staffing MTFs and hospitals may have on the readiness level of uniformed surgeons and clinicians. One recent study has already demonstrated a loss of surgical skills for

military surgeons due to moving care out of MTFs and shifting care to civilian facilities.[4] The result from this study is the exact opposite outcome of what the MHS transformation was intended to achieve. Another recent study showed that limiting access to MTFs could worsen quality and safety of care for military families.[5] Both studies are important to consider in any proposals to reduce military medical billets and close MTFs moving forward.

Considering these concerns, we believe it is appropriate to pause any reductions or realignments in military medical billets and to re-evaluate further closings of military treatment facilities. Many of the undersigned organizations have raised concerns about DoD and DHA's proposed cuts in previous years, noting that they would be detrimental to the more than 9.6 million Tricare beneficiaries, including 2 million children, who receive care through the MHS. Moving forward with proposed reductions, while health care services are already being disrupted for beneficiaries and uniformed and civilian physicians are overstressed and overburdened, would simply exacerbate the devastating impacts on service members and their families. Further, any proposals to eliminate GME and training programs, especially at the Uniformed Services University of the Health Services, which help train and supply the MHS with expertly trained uniformed medical clinicians that provide needed care for our military servicemembers and their families, should be reconsidered. We owe it to the members of the Armed Forces and their families to ensure that we have conducted proper oversight and analysis on the optimal alignment of the Military Health System.

If the health of our families is indeed considered a national security priority, then the reduction or elimination of military medical end strength would do little to improve military wartime readiness. Depriving Armed Forces families and their children of accessible, effective, and affordable medical treatment within the MHS will also reduce family readiness. Servicemen and servicewomen who are deployed need the peace of mind to know that their family back home can get access to needed health care clinicians.

We appreciate your commitment to the men and women of our Armed Forces and their families that support them during their service. As the Department pauses any reductions in medical billets, we would encourage you, along with leadership at the Defense Health Agency, to meet with officials of the undersigned organizations for a dialogue on the current state of medicine in our country. We live in a different world than we did just two and a half years ago, let alone since 2017 when the MHS transformation began. We look forward to working with you to ensure that the MHS is in the best position possible to achieve its mission and provide optimal care for our service members and their family members.

Sincerely,

American Academy of Allergy, Asthma & Immunology
American Academy of Family Physicians
American Academy of Ophthalmology
American Academy of Pediatrics
American Association of Clinical Endocrinology
American College of Allergy, Asthma & Immunology
American College of Obstetricians and Gynecologists
American College of Osteopathic Pediatricians
American College of Physicians

---

[4] Dalton MK, Remick KN, Mathias M, et al. Analysis of Surgical Volume in Military Medical Treatment Facilities and Clinical Combat Readiness of US Military Surgeons. *JAMA Surg*. 2022;157(1):43–50. doi:10.1001/jamasurg.2021.5331

[5] Zogg, CK, Lichtman, JH, Dalton, MK, et al. In defense of Direct Care: Limiting access to military hospitals could worsen quality and safety. *Health Serv Res*. 2021; 1- 11. doi:10.1111/1475-6773.13885

American Group Psychotherapy Association
American Pediatric Association
American Pediatric Society
American Psychiatric Association
American Society for Gastrointestinal Endoscopy
Association of American Medical Colleges
Association of Medical School Pediatric Department Chairs
Council of Pediatric Subspecialties
The Gerontological Society of America
National Association for Children's Behavioral Health
National Association of Pediatric Nurse Practitioners
North American Society for Pediatric Gastroenterology, Hepatology and Nutrition
Society of Critical Care Medicine
Society of General Internal Medicine

cc: Gilbert R. Cisneros, Jr, Under Secretary of Defense for Personnel and Readiness
Seileen Mullen, Acting Assistant Secretary of Defense for Health Affairs
Lt. Gen. Ronald J. Place, Director, Defense Health Agency
Lt. Gen. Robert I. Miller, Surgeon General of the Air and Space Force
Lt. Gen. R. Scott Dingle, Surgeon General of the Army
Rear Adm. Bruce L. Gillingham, Surgeon General of the Navy