

July 19, 2019

The Honorable James Inhofe, Chairman  
Senate Armed Services Committee  
228 Russell Senate Office Building  
Washington, DC 20510

The Honorable Jack Reed, Ranking Member  
Senate Armed Services Committee  
228 Russell Senate Office Building  
Washington, DC 20510

The Honorable Adam Smith, Chairman  
House Armed Services Committee  
2216 Rayburn House Office Building  
Washington, DC 20515

The Honorable Mac Thornberry, Ranking Member  
House Armed Services Committee  
2216 Rayburn House Office Building  
Washington, DC 20515

The Honorable Thom Tillis, Chairman  
Senate Armed Services Committee  
Subcommittee on Personnel  
228 Russell Senate Office Building  
Washington, DC 20510

The Honorable Kirsten Gillibrand, Ranking Member  
Senate Armed Services Committee  
Subcommittee on Personnel  
228 Russell Senate Office Building  
Washington, DC 20510

The Honorable Jackie Speier, Chairwoman  
House Armed Services Committee  
Subcommittee on Military Personnel  
2216 Rayburn House Office Building  
Washington, DC 20515

The Honorable Trent Kelly, Ranking Member  
House Armed Services Committee  
Subcommittee on Military Personnel  
2216 Rayburn House Office Building  
Washington, DC 20515

Dear Chairman Inhofe, Ranking Member Reed, Chairman Smith, Ranking Member Thornberry, Chairman Tillis, Ranking Member Gillibrand, Chairwoman Speier and Ranking Member Kelly:

As you consider the Fiscal Year 2020 National Defense Authorization Act (NDAA), the undersigned organizations representing healthcare providers are very concerned about proposals to eliminate military medical billets and graduate medical education (GME) programs throughout the Military Health System (MHS). We believe that these proposals do not help increase military medical readiness and will be detrimental to the more than 9 million TRICARE beneficiaries, including 2 million children, who receive care through the MHS. Proposals to reduce the number of uniformed military health care provider billets threaten access to primary and specialty health care services throughout the MHS for service members and their families. Reductions in GME billets will also reduce the number of military-trained uniformed providers that are needed to deliver essential health services to members of the Armed Forces and their family members. The undersigned organizations representing healthcare providers **oppose these proposals and strongly urge you to include language in the final conference report from Section 716 in the House bill that prohibits the Secretary of Defense and the Secretaries of the military departments from realigning or reducing military medical end strength until**

**analyses are conducted on potential manpower realignments and the availability of health care services in the local area.**

The administration's proposed FY20 DoD budget included a proposal to eliminate approximately 15,000 military health care personnel billets and replace them with civilian positions.<sup>1</sup> The Defense Health Agency (DHA) has explained its plan to reduce overall uniformed medical positions as part of a strategy to modernize the MHS. The DHA has identified alternative models—civilian hires, contract staff, military-civilian partnerships, or use of existing TRICARE networks—to cover the reduction of uniformed medical personnel.

While perhaps well-intentioned, these proposals would severely reduce the number of uniformed pediatricians, obstetrician-gynecologists, family medicine physicians, and other providers from the MHS, yielding devastating consequences for the members of the Armed Forces and their families who rely on these providers for essential healthcare services.

Women are essential members of the military, making up 16 percent of enlisted members and 18 percent of the officer corps. Women and families also make up the majority of dependents and the most common medical codes utilized in the military are childbirth, followed by other pediatric care. Unless Congress decides to institute an all single, no dependent, male Armed Forces, there will always be a strong and steady need for ob-gyns and pediatricians, as well as family physicians and other providers that care for these populations. Family readiness is an essential component of military force readiness, and **these providers are critical to ensuring American troops are healthy and prepared for warfighting.**

The health of the families of our Armed Forces is a national security priority. The proposed reduction and/or elimination of certain medical specialties would deprive Armed Forces families and their children of accessible, effective, and affordable medical treatment. The DHA has failed to address how these reductions would be carried out in a way to ensure services are not disrupted, wait times are not exacerbated, and access to subspecialty care continues, which are just some examples of the potential issues that will arise if these proposals are implemented.

As indicated in a [2018 GAO report](#), there is already an insufficient workforce capacity to handle the basic health needs of our country's Armed Forces and their families. Reports and studies continue to point to long waiting times for many civilian care providers, as well as significant geographic disparities in care. The DoD's 2015 report to the Congressional Defense Committees on the status of military GME programs points to, "projected shortfalls for staffing in specialties such as Psychiatry, Family Medicine, Pathology, Neurology, and Internal Medicine."<sup>2</sup>

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<sup>1</sup> U.S. Department of Defense, *United States Department of Defense Fiscal Year 2020 Budget Request*. (Washington, DC, 2019). [https://comptroller.defense.gov/Portals/45/Documents/defbudget/fy2020/fy2020\\_Budget\\_Request\\_Overview\\_Book.pdf](https://comptroller.defense.gov/Portals/45/Documents/defbudget/fy2020/fy2020_Budget_Request_Overview_Book.pdf)

<sup>2</sup> U.S. Department of Defense, *Department of Defense Improvements to Oversight of Medical Training for Medical Corps Officers*. (Washington, DC, 2015). <http://health.mil/Reference-Center/Reports/2015/04/30/Improvements-in-Oversight-of-Medical-Training-for-Medical-Corps-Officers>

Another recent [study](#) by the GAO concluded that the DoD has not assessed the suitability of federal civilians and contractors to meet operational medical personnel requirements. The report found that military department officials expressed a preference for using military personnel and cited possible difficulties in securing federal civilian and contractor interest in such positions. The report cited several challenges, including lengthy hiring and contracting processes and federal civilian hiring freezes that affect DoD's ability to use federal civilians and contractors. In fact, senior officials at each of the six Military Treatment Facilities (MTFs) that GAO spoke with for the report cited challenges with the federal civilian hiring process, and five of the six MTF officials noted challenges with the contracting process.

If these proposed reductions are implemented, the DoD and MHS will be further burdened with the backlog of provider visits, subspecialty shortages, and an overall decreased quality of care throughout the military. We must continue to provide the highest quality health care and services for the children, families, and members of our Armed Forces. These reductions would inhibit the ability of the MHS to sustain the workforce essential for present and future medical success, efficacy, and innovation.

As such, we urge you to oppose these proposals and work to pass a bill that ensures the continued progress of the military medical workforce in their efforts to serve the members and families of the Armed Forces serving our country. Section 716 from the House version of the FY 2020 NDAA bill does this by prohibiting the Secretary of Defense and the Secretaries of the military departments from realigning or reducing military medical end strength until analyses are conducted on potential manpower realignments and the availability of health care services in the local area. We urge you to include this language in the final conference report.

Sincerely,

American Academy of Family Physicians  
American Academy of Pediatrics  
American Academy of Ophthalmology  
American Association for Pediatric Ophthalmology and Strabismus  
American Association of Child & Adolescent Psychiatry  
American College of Allergy, Asthma and Immunology  
American College of Obstetricians and Gynecologists  
American Group Psychotherapy Association  
American Medical Association  
American Osteopathic Association  
Council of Pediatric Subspecialties  
National Association for Children's Behavioral Health  
National Association of Pediatric Nurse Practitioners  
National Hispanic Medical Association  
North American Society for Pediatric and Adolescent Gynecology  
Pediatric Pulmonology Training Directors Association  
Society of Critical Care Medicine