MILITARY COMPENSATION AND RETIREMENT
MODERNIZATION COMMISSION

WASHINGTON, D.C.

July 10, 2015

The Honorable Joseph Heck
Chairman, Personnel Subcommittee, House Armed Services Committee
2216 Rayburn House Office Building
Washington, DC 20515

Dear Mr. Chairman,

My fellow commissioners and I greatly appreciate the House Armed Services Committee hearing with Department of Defense (DoD) officials on June 11, 2015, regarding the Commission's health care recommendations. As stated in our final report, wartime medical requirements are not jointly developed, the case mix in military hospitals is not well aligned with sustaining medical readiness, DoD has few tools to attract a better case mix into military hospitals, and the current flow of funding does not incentivize a focus on medical readiness. We were very pleased when DoD officials acknowledged these challenges during the hearing. Given the importance of medical readiness for the welfare of Service members during contingency operations and the challenges to maintaining medical readiness, we commend your focus on this critical issue.

In response to hearing testimony, we would like to provide clarifying information regarding the Essential Medical Capabilities (EMCs) framework in our final report. As shown in Figure 1 of the attachment, the Commission recommended EMCs to be expansive and flexible to protect the full range of medical capabilities associated with contingency operations, not just trauma care. Our accompanying legislative proposals defined EMCs as "… a limited number of critical medical capabilities that … include clinical and logistics capabilities necessary to accomplish operational requirements…" This definition would enable DoD to align EMCs with any current and planned contingency operations, including combat operations, humanitarian operations, or care of infectious diseases. It would also preclude substitution of essential medical and logistics capabilities by beneficiary health care.

The Commission concluded that the EMC framework is needed to bring a new case mix into military hospitals. The current design of the military health program often incentivizes the delivery of beneficiary health care in peacetime rather than growing the provider skills required in combat. As shown in Figure 2 of the attachment, the majority of cases in military hospitals are childbirth and newborn care rather than procedures similar to those of contingency operations. For example, DoD officials stated during the hearing that rheumatologists are substituted for battlefield surgeons. This is symptomatic of the mismatch between the case mix in military treatment facilities and those necessary for contingency operations.

As stated in our final report, "[r]esearch reveals a long history of the military medical community needing to refocus its capabilities at the start of wars, after concentrating during peacetime on beneficiary health care." The Commission therefore continues to recommend comprehensive and systematic solutions to address readiness risk within the military medical program. We greatly

appreciate your continued attention on this critical issue and are available to provide additional information to you or your staff. My point of contact is Bob Daigle, who can be reached at 703-692-1999 or robert.daigle@mcrmc.gov.

Sincerely,

Alphonso Maldon, Jr.
Chairman

Attach: a/s

Attachment

Figure 1. Components of Essential Medical Capabilities

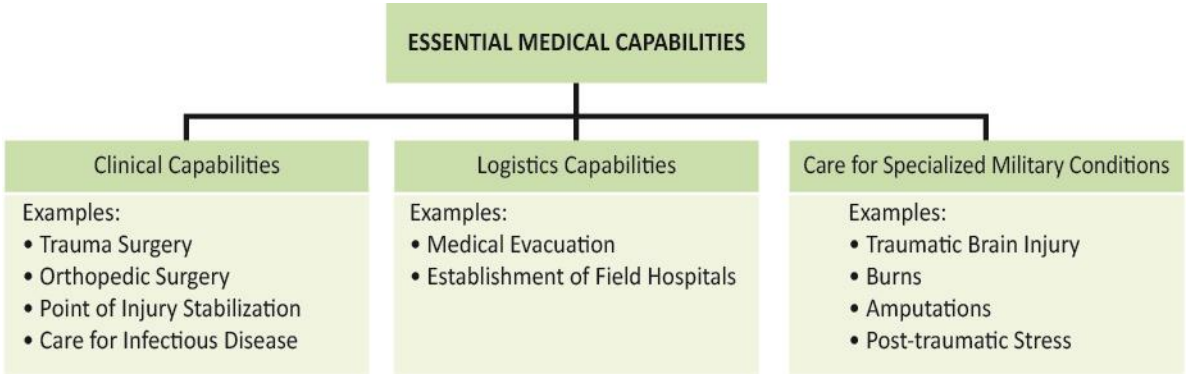

Figure 2. Top 10 Inpatient Procedures in Military Treatment Facilities, FY 2013