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STATEMENT FOR THE RECORD

OF

THE MILITARY COALITION (TMC)

Submitted to the

HOUSE AND SENATE ARMED SERVICES COMMITTEES
SUBCOMMITTEES ON PERSONNEL

concerning

Views on Military Health Care

June 23, 2017

CHAIRMAN_____, RANKING MEMBER_____, AND DISTINGUISHED MEMBERS OF THE SUBCOMMITTEE, The Military Coalition (TMC), a consortium of nationally prominent uniformed services and veterans' organizations, is grateful to the committee for this opportunity to express our views concerning personnel and compensation issues affecting the uniformed services community. This statement provides the collective views of the following military and veterans' organizations, which represent approximately 5.5 million current and former members of the seven uniformed services, plus their families and survivors.

Air Force Association
Air Force Sergeants Association
Air Force Women Officers Associated
Army Aviation Association of America
Association of Military Surgeons of the United States
Association of the United States Army
Association of the United States Navy
Chief Warrant and Warrant Officer Association, U.S. Coast Guard
Commissioned Officers Association of the U.S. Public Health Service, Inc.
Enlisted Association of the National Guard of the US
Fleet Reserve Association
Gold Star Wives of America, Inc.
Iraq and Afghanistan Veterans of America
Jewish War Veterans of the United States of America
Marine Corps Reserve Association
Military Chaplains Association of the United States of America
Military Officers Association of America
Military Order of the Purple Heart
National Guard Association of the United States
National Military Family Association
Naval Enlisted Reserve Association
Non Commissioned Officers Association
Reserve Officers Association
Service Women's Action Network
The Retired Enlisted Association
Tragedy Assistance Program for Survivors, Inc.
United States Army Warrant Officers Association
United States Coast Guard Chief Petty Officers Association
Veterans of Foreign Wars

The Military Coalition, Inc. does not receive any grants or contracts from the federal government.

Executive Summary

TRICARE Fee Issues

The Coalition believes the budget-proposed reversal of the TRICARE fee grandfathering provisions in the FY2017 NDAA is inappropriate for many reasons.

DoD health costs are declining, not rising. The Pentagon's own data from its annual reports to Congress show DoD health costs continue to decline from past levels. Both TRICARE for Life and purchased care costs have been dropping for some time.

The Coalition takes issue with DoD's assertions regarding the share of DoD health costs that historically have been or should be borne by beneficiaries, which fail to adequately exclude the cost of readiness, inefficiency and other DoD-driven decisions that drive system costs.

The Coalition believes beneficiaries should not be expected to absorb any share of readiness costs. In this regard, both DoD and Congress acknowledge the primary purpose of military treatment facilities and their associated training, staffing, maintenance and support is to meet readiness needs.

Military beneficiaries should not be expected to bear any share of increased costs over which they have no control, such as additional costs caused by DoD inefficiencies, productivity shortfalls, or management decisions that inhibit care in military facilities or drive more beneficiaries into civilian care.

The Coalition believes TRICARE beneficiaries' fees should not grow faster than their military income does. The Coalition supports the COLA adjustment process established in current law, and does not support tying fees to a national health care cost index that would consume an ever-greater share of their income over time.

The Coalition believes it would be inappropriate to make any further arbitrary increases in pharmacy copays, and the current COLA adjustment process should be allowed to work as provided for in current law.

The Coalition strongly opposes the DoD budget proposal to eliminate grandfathering of current TRICARE fees for beneficiaries who entered service before January 1, 2018. To the extent any such significant reduction is applied to fundamental programs used to induce generations of people to serve a career in uniform, it should only be applied prospectively, as Congress did with retirement reform in the FY2016 NDAA and TRICARE reform in the FY2017 NDAA.

Advancing Readiness and Beneficiaries' Experience of Care

The Coalition applauds the broad range of FY2017 NDAA provisions requiring improvements in appointment systems, hours of service, elimination of certain pre-authorization and referral requirements, value-based care initiatives, clinical productivity standards, ABA therapy

reimbursement rates, telehealth services, disease management programs and joint trauma initiatives.

Areas of Potential Concern Under TRICARE Reform

The Coalition recommends expansion of the TRICARE Select provider network beyond the network associated with Prime, to include providers who have been willing to accept normal Medicare/TRICARE-allowed charges. A robust network of TRICARE Select providers will be required to ensure current Standard beneficiaries who elect to utilize TRICARE Select or who don't have access to Prime do not incur unnecessary out-of-network charges.

In recognition that lack of access to the Select network is often due to decisions beyond the control of the beneficiary, the Coalition recommends non-network deductibles and charges should be limited to beneficiaries who have access to, but choose not to use, network providers.

The Coalition appreciates the Subcommittee's effort to address the first-year TRICARE transition concerns regarding enrollment, and appreciates the Defense Health Agency's change to mitigate those concerns by automatically enrolling TRICARE Standard or Extra beneficiaries into TRICARE Select.

The Coalition, while supportive of DoD's efforts to provide the best value in health care delivery for all stakeholders, has some concerns how these efforts will mesh with the new set of TRICARE contracts (T-2017), which have already been awarded and are slated to start in the fall of 2017. For example, the requirement for annual contract re-award consideration poses potential challenges for beneficiaries with regard to continuity of coverage and providers.

Wounded, Ill, and Injured Service Member Care

The Coalition recommends Congress:

- Continue to monitor closely the full implementation of a joint DoD and VA interoperable electronic health record.

- Implement and sustain an integrated, multidisciplinary, comprehensive behavioral health system to address the rising rates of service members and veterans suffering from traumatic injuries such as post-traumatic stress disorder (PTSD), traumatic brain injury (TBI), and sexual assault-military sexual trauma.

- Direct the Defense Department to participate in and support development of novel drug therapies for the treatment of military PTSD, in particular those drug candidates with the potential of reaching the clinic in the near term.

- Designate funding to gather the multitude of health lessons learned on women in combat during Operations Enduring Freedom and Iraqi Freedom and require the services to incorporate them into medical and operational doctrine and practice and uniform and equipment design. Additionally, DoD and VA should embark on research projects to

better understand how best to treat PTSD, TBI, muscular-skeletal injuries, amputations and injuries to reproductive organs in both men and women--which may or may not require different approaches.

- Support research on the impact of service members' exposure to environmental toxins or hazardous substances, and/or deployment illnesses resulting from their military service (e.g., burn pit exposure in Iraq and Afghanistan and Camp Lejeune contaminated water).

- Standardize terminology, definitions, eligibility criteria, and roles and responsibilities around wounded warrior policies, programs, services, and administration of medical and non-medical support (e.g., recovering warrior categories, all categories of case managers, caregiver support and benefits, powers of attorney, and comprehensive recovery plans).

- Standardize the coordination of DoD and VA care, treatment and all Departments' case management, and medical and non-medical programs and services.

- Support and encourage establishment of clinical billets within VHA for USPHS physicians, nurses (including APRNs), dentists, therapists, and other health professionals.

Guard and Reserve Health Care

The Coalition believes it should be a priority to bring more consistency and rationality to Guard and Reserve beneficiaries' health coverage through various stages of active and inactive duty service and gray area retirement.

The Coalition recommends Congress:

- Amend title 10, United States Code, to authorize the Secretaries of the military departments to provide annual medical exams, behavioral health and annual dental exams to members of the reserve components periodically needed to meet readiness and fitness standards pre- and post-deployment.
- Permit federal employees who are reservists eligible for the Federal Employee Health Benefit Plan (FEHBP) the option of enrolling in TRICARE Reserve Select (TRS).
- Permit members of the IRR to enroll in TRS as an incentive for their continued service.
- Authorize a subsidy for coverage during the period of gray-area retirement.
- Seek improvements to the pre- and post-activation health assessment and corrective programs.

The Health of Military Children

Military families with terminally ill children deserve access to the current standards of pediatric care, including hospice services concurrently with curative treatments.

The Coalition believes the next round of MHS reform should include the American Academy of Pediatrics (AAP) definition of medical necessity as the determinant for pediatric TRICARE patients.

The Coalition believes if there is no change in respite care policy – a well-documented gap relative to state Medicaid waiver programs – within the next year, the next round of MHS Reform must include a legislative fix to bring ECHO in line with the program's legislative intent by January 1, 2018.

End of Executive Summary

Reforming the Military Health System

Introduction - The Coalition sincerely appreciates the hard work, detailed analysis, and the compromise that went into the development of last year's FY2017 NDAA. The members and the professional staff should be commended for their exhaustive efforts, the results of which provide our military with a comprehensive and modernized health benefit plan that supports both medical readiness and beneficiary care. The changes scheduled to be implemented in the very near future, and in the out-years, represent a large scale systemic transformation. In many respects, these changes were much needed, and many have been long sought by the Coalition.

The Coalition has noted the work of previous Commissions and of the numerous studies regarding the TRICARE program, and commends the Subcommittee for rightly recognizing the time had come for significant action to improve both medical readiness and beneficiary care delivery.

FY2018 Defense Budget Submission

Unfortunately, the recent FY2018 defense budget submission did not contain any actual health care reforms, but primarily recommended additional TRICARE fee increases TMC believes are inappropriate.

Congressional intent in last year's NDAA legislation was to pave the way for sweeping changes to the Military Health System and the TRICARE program. The reforms focused on improving the beneficiary experience, ranging from access to care to streamlining TRICARE benefit options. The Coalition has long advocated for many of these improvements. Part of accepting this package of improvements meant acceptance of some fee increases.

However, central to this package of sweeping TRICARE reforms was that all who had entered service prior to Jan. 1, 2018, would be grandfathered into the existing fee structures. New entrants into the services after Jan 1, 2018, would be subject to higher fees in the future.

The FY2018 defense budget submission seeks to eliminate grandfathering and impose significantly higher fees on currently protected beneficiary categories, except for active duty members and family members not enrolled in TRICARE Select, medically retired members and their families, and survivors of those who died on active duty. The latter would be treated the same as active duty family members, with no participation fee and lower cost shares.

To ensure equity for active duty family members who might not live near a military treatment facility, the budget envisions a no-cost care option will be available to them regardless of their assignment location.

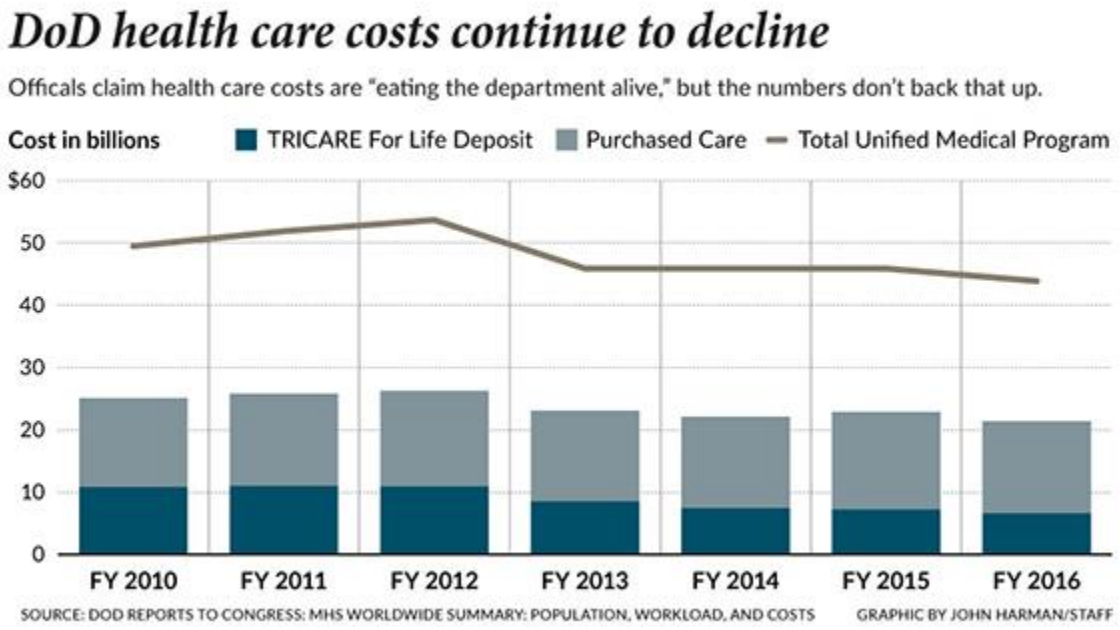
Finally, the FY2018 DoD budget submission proposes adjusting fees annually by a National Health Expense (NHE) cost index, rather than by the annual cost-of-living index established by Congress in current law. The net effect of this would be to significantly increase the magnitude of annual fee increases.

TRICARE Fee Issues

As in the past, DoD has asserted increases are needed based on concerns about potential health cost growth and a desire to shift a greater share of DoD health costs to beneficiaries.

The Coalition believes the FY2018 budget-proposed reversal of the TRICARE fee grandfathering provisions in the FY2017 NDAA is inappropriate for many reasons.

DoD Health Costs Are Declining, Not Rising -- The Pentagon's own data from its annual reports to Congress show health costs areas of the DoD budget continue to decline from past levels. Both TRICARE for Life accrual payments and purchased care costs have been dropping for some time.



Readiness vs. Benefit Costs -- The chief objective of the military's health system, unlike all civilian health systems, is to enhance and sustain military readiness and force health protection. This is an important distinction, as this aspect requires the dedication of substantial human capital and a significant commitment of DoD resources.

It entails a significant cadre of regular and reserve health care professionals and a significant network of military treatment facilities to meet both peacetime and wartime medical readiness requirements.

In the Coalition's view, the cost of maintaining these personnel and facilities must first and foremost be considered a cost of readiness rather than a benefit expense.
As addressed clearly in the FY2017 NDAA, both DoD and Congress acknowledge the primary purpose of DoD medical facilities and the associated personnel is to meet readiness needs, and

DoD and the Services are expected to base their size, structure, and organization on those readiness needs. Beneficiary needs are distinctly secondary.

The Coalition agrees strongly these, and the associated costs such as training, administration, and operations and maintenance, are readiness costs—not benefit costs. Accordingly, beneficiaries should not be expected to absorb any share of costs relative to readiness.

The importance of this distinction is noteworthy, as it has been DoD's practice in recent years to associate funding challenges with the costs of supporting beneficiaries rather than the strategic imperative of maintaining a ready force. The cost of readiness should not be borne by the beneficiary via a variety of fee increases.

Inefficiency Costs -- Additionally, the findings of the recent Military Compensation and Retirement Modernization Commission and the contents of the FY2017 NDAA acknowledged a wide array of inefficiencies in the military health care system, from the duplication of functions among the various services to appointment and referral problems and the dramatically lower productivity of military health professionals compared to their civilian counterparts. The latter issues drive up DoD costs by forcing more beneficiaries into private sector care.

Military beneficiaries should not be expected to bear any share of increased costs over which they have no control, such as additional costs caused by DoD inefficiencies or management decisions that inhibit care in military facilities or drive more beneficiaries into civilian care.

The Coalition* is grateful to the Subcommittee for your efforts to address these readiness and efficiency issues directly in the FY2017 NDAA. But these concerns are far from being resolved, and relatively modest implementation actions to date provide no justification to overturn Congress previous decisions to grandfather TRICARE fees for current beneficiaries.
(*While the Association of the United States Army supports this testimony generally, they do not support aligning MTFs under the Defense Health Agency.)

Historical Comparison of Beneficiary Costs -- For years, DoD leaders have argued current beneficiaries should pay a specific share of DoD costs, and that should be based on the share of DoD costs represented by the initial TRICARE fees established in 1996.

The Coalition takes issue with DoD's historical cost-sharing assertions, which fail to adequately exclude the cost of readiness, inefficiency and other DoD-driven decisions that drive system costs.

Further, Coalition representatives were engaged by DoD in negotiating the initial TRICARE fees two decades ago, and there was never any discussion about beneficiaries accepting any set share of DoD costs, which would have been as inappropriate in1996 as it is today.

TRICARE Fee Standards -- The Coalition believes there should be standards by which fees are set and adjusted. Where flat fees have been established, the Coalition and Congress have accepted the principle that beneficiary fees should not rise faster than their compensation does.

Accordingly, Congress established the annual retired pay COLA process as an appropriate adjustment mechanism.

The Coalition agrees with Congress' past legislative action tying TRICARE fee increases to the same inflation index used to adjust military retired pay. The Coalition does not support adjusting fees by the DoD-proposed National Health Expense cost index.

The budget assumes the proposed NHE index would raise fees by an average of 5.8 percent per year, which the Coalition believes violates the principle Congress has established and would ensure health fees would consume an ever-greater share of beneficiaries' compensation over time. The Coalition believes this is particularly inappropriate when the NHE cost index growth has nothing in common with actual DoD health benefit costs.

In this vein, the Coalition is concerned that making exceptions to established standards (the statutory COLA adjustment index) already has led to disproportional increases in TRICARE pharmacy copays.

In the latest exception, the FY2016 NDAA raised these copays to levels designed to generate enough mandatory spending offsets to fund lump sum retirement requirements for future entrants under the military retirement reform provisions.

As a result, the current $10 retail generic copay for military beneficiaries is more than twice as much as civilians without health insurance pay at Wal-Mart for a wide array of generic drugs.

The Coalition believes it would be inappropriate to make any further arbitrary increases in pharmacy copays or to otherwise alter the statutory COLA adjustment process as it now applies to these and other TRICARE fees.

The Coalition thanks the Subcommittee for reflecting through its reform efforts in the FY2017 NDAA the recognition that decades of arduous service and sacrifice in uniform constitute a very large, pre-paid, in-kind premium that warrants a top-tier health benefit – a benefit which should be significantly better in cost and value than any civilian health plan.

The Coalition strongly opposes the DoD budget proposal to eliminate grandfathering of current TRICARE fees for beneficiaries who entered service before January 1, 2018.* To the extent any such significant reduction is applied to fundamental programs that already induced generations of people to a career in uniform, it should only be applied prospectively, as Congress did with retirement reform in the FY2016 NDAA and TRICARE reform in the FY2017 NDAA. (*The National Military Family Association would prefer a single payment schedule for current and future beneficiaries that adjusts fees based on the annual COLA percentage rather than the excessive fee increases imposed for future service entrants in the FY2017 NDAA.)

Advancing Readiness and Beneficiaries' Experience of Care

The Coalition enthusiastically supports most of the new health care provisions contained in the FY2017 NDAA. Collectively, they should go a long way toward achieving many of the

Coalition's goals and objectives. They address many of the systemic and problematic issues that have been chronically associated with access, quality of care, and the safety and consistency of beneficiary care. The legislation modernizes the benefit and addresses acquisition reform of TRICARE's purchased care contracting.

The Coalition notes the provisions affecting the Defense Health Agency (DHA) and the Services are nothing short of sweeping. The DHA is on an aggressive timetable for many of the provisions, and already is in the process of submitting initial implementation plans.

The Coalition has suggested – and is grateful the DHA has agreed to – formation of a joint working group between DHA officials and Coalition association representatives to pool institutional and beneficiary perspectives in the process of implementing the broad array of fundamental changes in the delivery of DoD health care. A similar joint working group helped ensure smooth implementation of the TRICARE for Life program, and we are hopeful for a similarly productive outcome on the new package of reforms.

The Coalition supports any and all improvements which directly enhance beneficiaries' experience with their health care. Additionally, the Coalition appreciates the opportunity to work closely with DHA officials on the implementation, communication and evaluation of the wide range of new programs and initiatives.

In particular, the Coalition supports FY2017 NDAA provisions requiring:

- A standardized patient appointment system.
- Appointment resolution on the first call.
- Elimination of pre-authorization requirements for urgent care and most TRICARE Prime specialty referrals.
- Extended hours for both urgent and primary care at MTFs.
- Value-based incentives based on quality of care outcomes.
- Clinical productivity standards for MTF providers
- Provision of hearing aids for dependents of retirees at government cost.
- Beneficiary participation in the Federal Employees Dental and Vision insurance programs.
- Improved provider reimbursement rates for Applied Behavior Analysis (ABA) therapy.
- Enhanced telehealth services.
- New programs to incentivize all categories of beneficiaries to participate in comprehensive disease management programs.
- Creation of a Joint Trauma organization and joint trauma level 1 and 2 platforms at certain MTF's.

Potential Areas of Concern

As much as the Coalition enthusiastically endorses the bulk of the health care reform provisions of the FY2017 NDAA, there are some aspects we believe may merit additional consideration in the time ahead.

The Coalition supports the establishment of a more streamlined benefit plan from the current three options into two. The new option, TRICARE Select, will be a preferred provider option (PPO) and will replace TRICARE Standard with an Extra-like network of TRICARE providers who will have agreed to accept a pre-negotiated rate of payment.

Definition of TRICARE Select "Network Provider" -- Under the current TRICARE Standard program, the normal Standard copay is 25% of TRICARE-allowed charges. Beneficiaries who use providers in the Prime network realize modestly lower copayments (20%). That is, there is a benefit for using a network provider, but no penalty for not using one.

Currently, there are three categories of providers, in terms of their willingness to see TRICARE patients:

- Those who agree to accept a discounted payment rate (below the Medicare rate) and participate in the Prime network;
- Those who don't want to be in the Prime network and the associated discounted payments, but who are willing to see Standard patients and be reimbursed at the Medicare-allowed rate; and
- Those who refuse to accept any TRICARE patients and demand higher-than-Medicare rates.

The Coalition recommends expansion of the TRICARE Select provider network beyond the network associated with Prime, to include providers who have been willing to accept normal Medicare/TRICARE-allowed charges. A robust network of TRICARE Select providers will be required to ensure current Standard beneficiaries who elect to utilize TRICARE Select or who don't have access to Prime do not incur unnecessary out of network charges.

Network Coverage and Purpose of Non-Network Charges -- The Department of Defense has advised the new Select network will cover 85% of beneficiaries -- roughly the same as current TRICARE beneficiary coverage. Legislative language states that DoD is to ensure at least 85% of the beneficiary population under TRICARE Select is covered by the network by January 1, 2018. That leaves 15% of beneficiaries at risk for access and cost issues.

The new Select plan establishes significantly higher deductibles and other costs for post-1 Jan 2018-entrant beneficiaries who use out-of-network providers.

Normally, such higher out-of-network charges are meant to incentivize beneficiaries to choose to use network providers. The problem with the retired military community is many could live in rural areas where Select networks may not exist. So their use of out-of-network providers is by necessity, not by choice.

In recognition that lack of access to the Select network is often due to decisions beyond the control of the beneficiary, the Coalition recommends non-network deductibles and charges should be limited to beneficiaries who have access to, but choose not to use, network providers.

The Coalition appreciates the Subcommittee's effort to address the first-year TRICARE transition concerns regarding enrollment, and appreciates the Defense Health Agency's

change to mitigate those concerns by automatically enrolling TRICARE Standard or Extra beneficiaries into TRICARE Select and continuation of TRICARE Prime which is not affected.

Value-Based Purchasing and Establishment of Military-Civilian Integrated Health Delivery Systems -- The Coalition supports DoD's and Congress' efforts to encourage innovation and competition in health care delivery and contracting, with the goal of obtaining the best value for beneficiaries and the government. The inclusion of value-based payment methodologies, which includes outcomes-based criteria with capitated payments for a variety of potential provider arrangements, is an example of this effort.

Another initiative to complement value-based payment efforts, and to enhance both the beneficiaries experience with care and access to care, will be through DoD establishing care integration with high-performing civilian health delivery systems. The intent is for DoD to establish these partnerships at a local and/or regional basis, and integrate and coordinate care across the continuum. The goal is to leverage and optimize DoD's resources where it makes sense, and to better rationalize resources – especially to enhance readiness.

The Coalition, while supportive of DoD's efforts to provide the best value in health care delivery for all stakeholders, has some concerns how these efforts will mesh with the new set of TRICARE contracts (T-2017), which have already been awarded and are slated to start in the fall of 2017. For example, the requirement for annual contract re-award consideration poses potential challenges for beneficiaries with regard to continuity of coverage and providers.

Wounded, Ill, and Injured Service Member Care

While the Department of Defense (DoD) and the Military Services continue to execute and maintain programs to care for and support our most vulnerable service members, veterans, and their family members and caregivers, TMC has seen deterioration in program execution and some indication of a reduction in resources and funding because of current fiscal constraints.

Though combat and operational tempo have eased on several fronts, the short- and long-term needs of our wounded, ill and injured warriors remain constant. Their care and support will be needed for decades, particularly for younger Post-9/11 service members.

Unconventional warfare creates new and unique challenges for both the warfighters and the medical systems responsible for their care. Because of the advances in medical treatment in the field, we as a nation should continue to expect and prepare for the survivors of catastrophic wounds, illnesses, injuries, and disabilities from battle. Continuity of support and benefits are essential to the transition process allowing our wounded to regain normalcy as soon as possible and as much as possible upon their return.

PTSD Medications -- Until very recently, gains in treatment of military-related PTSD have been modest. Among drug therapies, the two approved by the FDA more than 15 years ago for the treatment of PTSD have shown limited effectiveness in treating the disorder in treating military

PTSD. Recently, several companies have pursued drugs for PTSD, including one non-addictive drug that successfully completed Phase 2 development and has been granted Breakthrough Therapy designation by the FDA. This allows expedited approval of drug candidates that offer the prospect of substantial improvement over existing treatments for serious medical conditions.

Female Combat Medical/Protection Issues -- Over 200,000 women served in the combat zones of Iraq and Afghanistan over the past 15 years, and many were injured, wounded and killed. Now that all ground combat units have been opened to women, DoD and Congress should take advantage of the many still-scattered lessons learned about protecting the health of women serving in war zones and in actual combat.

In many cases, these lessons are still seen as questions deserving answers. For example, are there differences between men and women when it comes to preventing and treating PTSD, TBI, and muscular-skeletal injuries? What did we learn about preventing and treating female UTIs? Are changes in women's uniforms, boots, body armor, rucksacks, etc., needed to provide them the same combat effectiveness and protection as men? Many lessons were learned on a unit level, but have these been gathered and shared up the chain of command so they can be folded into service-wide medical and operational doctrine and training?

DoD-VA Coordination -- The need to strengthen coordination and create a seamless and integrated health and benefits system of care and services between the DoD and the Department of Veterans Affairs (VA) is more important than ever for our wounded, ill and injured, their families and caregivers as they move between these government systems.

TMC is grateful to the Congress for their willingness to engage the veteran and military service organizations and to work together to pursue legislation these last several years.

We also applaud the recent announcement that the VA is pursuing procurement of the same health record system used by DoD, and we encourage joint testing of the systems throughout implementation.

However, the Coalition remains concerned about future efforts and what the impact will be on the health and well-being of our wounded, ill and injured going forward given the uncertainty of relief from sequestration, budget shortfalls, leadership vacancies in the new Administration, and other domestic and international uncertainties facing our nation.

Both agencies have stated repeatedly they can't meet the needs of our recovering warriors without the help of outside organizations. Yet, DoD and VA continue to be seen by outside agencies and organizations as being isolated, closed and stove-piped systems that haven't leveraged their federal and non-federal relationships to establish meaningful, long-term, public-private partnerships they say they want and need. More than ever, our recovering warriors need the Congress, the Administration, DoD, and the VA to be in lock step to remove the barriers that impede collaboration, cooperation and communication.

The Coalition recommends Congress:

- ***Closely monitor the full implementation of a joint DoD and VA interoperable electronic health record.***
- ***Implement and sustain an integrated, multidisciplinary, comprehensive behavioral health system to address the rising rates of service member and veterans suffering from traumatic injuries such as posttraumatic stress disorder (PTSD), traumatic brain injury (TBI), and sexual assault-military sexual trauma.*** *Specifically:*
    - *Invest in programs and research to identify at-risk populations, expand evidence-based treatment, and improve delivery of care and rehabilitative and preventive services.*
    - *Invest in research to identify evidenced-base treatments and alternative treatment modalities to address PTSD and TBI conditions.*
    - *Expand and monitor coordination and synchronization of behavioral health resources and outreach efforts between the DoD and VA Suicide Prevention Offices, assuring every call to military and veterans crisis lines is promptly answered.*

- ***Direct the Defense Department to participate in and support development of novel drug therapies for the treatment of military PTSD, in particular those drug candidates with the potential of reaching the clinic in the near term.***

- ***Designate funding to gather the multitude of health lessons learned on women in combat during Operations Enduring Freedom and Iraqi Freedom and require the services to incorporate them into medical and operational doctrine and practice and uniform and equipment design. Additionally, DoD and VA should embark on research projects to better understand how best to treat PTSD, TBI, muscular-skeletal injuries, amputations and injuries to reproductive organs in both men and women--which may or may not require different approaches.***

- ***Support research on the impact of service members' exposure to environmental toxins or hazardous substances, and/or deployment illnesses resulting from their military service (e.g., burn pit exposure in Iraq and Afghanistan and Camp Lejeune contaminated water).*** *Specifically:*
    - *Ensure health care and benefits are established to appropriately compensate and support service members and veterans, family members and survivors, particularly those experiencing catastrophic and devastating cancers, diseases, or death.*
    - *Implement GAO's September 2016 Report (GAO-16-781) recommendation for DoD and VA to examine the relationship between direct, individual, burn pit exposure and potential long-term health-related issues as well as the National Academies of Sciences, Engineering, and Medicine's Report of 2011, which suggested the need to evaluate the health status of service members from their time of deployment over many years.*
    - *Expand on the findings of the United Health Foundation's, "America's Health Rankings: Health of Those Who Have Served Report." This establishes a baseline portrait of the health of those who have served, analyzing 24 health*

measures from the Centers for Disease Control as compared to their civilian counterparts. TMC urges Congress to increase investment in research, and additional studies and treatments to address the high rates of cancer, coronary heart disease and heart attacks among those who have served.

- ***Standardize terminology, definitions, eligibility criteria, and roles and responsibilities around wounded warrior policies, programs, services, and administration of medical and non-medical support (e.g., recovering warrior categories, all categories of case managers, caregiver support and benefits, powers of attorney, and comprehensive recovery plans).***

- ***Standardize the coordination of DoD and VA care, treatment and all Departments' case management, and medical and non-medical programs and services.***

- ***Support and encourage establishment of clinical billets within VHA for USPHS physicians, nurses (including APRNs), dentists, therapists, and other health professionals.***
    - *Across the country, VHA hospitals and clinics remain woefully understaffed. This problem is especially acute in rural and underserved communities.*
    - *As veterans themselves under Title 42, USPHS clinicians are eager to serve fellow veterans.*
    - *A recently-signed (April, 2017) MOA between DVA and the USPHS Commissioned Corps establishes the necessary framework to begin filling VHA vacancies with USPHS clinicians who can provide direct care to our veterans.*

Guard and Reserve Health Care

The Coalition is thankful for the inclusion of authority in the FY2017 NDAA to conduct a pilot program to examine the potential of utilizing the Federal Employee Health Benefit Program (FEHBP) as an option for National Guard and Reserve personnel.

Nevertheless, the authority was a discretionary one, and it remains to be seen whether DoD will exercise the authority.

In the meantime, Guard and Reserve families at different stages of their service and lives continue to experience great inconsistencies in their coverage and its cost.

The Coalition believes it should be a priority to bring more consistency and rationality to Guard and Reserve beneficiaries' health coverage through various stages of active and inactive duty service and gray area retirement.

The Coalition recommends Congress:

- ***Amend title 10 United States Code, to authorize the Secretaries of the military departments to provide annual medical exams, behavioral health and annual dental exams to members of the reserve components periodically needed to meet readiness and fitness standards pre- and post-deployment.***

- ***Permit federal employees who are reservists eligible for the Federal Employee Health Benefit Plan (FEHBP) the option of enrolling in TRICARE Reserve Select (TRS).***
- ***Permit members of the IRR to enroll in TRS as an incentive for their continued service.***
- ***Authorize a subsidy for coverage during the period of gray-area retirement.***
- ***Seek improvements to the pre- and post-activation health assessment and corrective programs:***
    - *Authorize government treatment of reserve component members to correct any medical, dental or behavioral health readiness deficiencies during periodic health assessment screenings.*
    - *Expand funded dental care to cover 180 days post-activation.*
    - *Fund care and services for reserve component members, including mental/behavioral health issues such as substance abuse and suicide.*
    - *Subsidize premiums paid by private employer to allow continuation of private employer family coverage during periods of activation as an option.*
    - *Authorize pre and post active duty care in TRICARE for reservists called to duty under 10 USC 12304b, to include eligible family members.*

The Health of Military Children

The MHS provides care for 2.4 million military children, but because TRICARE reimbursement is based on Medicare, a program for senior adults, its policies are not always optimal for the pediatric care of these children. Hospice care is one example.

Pediatric Concurrent Hospice Care -- TRICARE's hospice coverage for pediatric patients is not on par with commercial plans and Medicaid. This means military children and their families can't access critical services now considered the standard of care for those with life threatening illnesses. By statute, TRICARE's reimbursement policy mirrors Medicare requirements, which are based on medical needs of senior adults, such as hospice care for the terminally ill.

Acknowledging that the path of a child's life-threatening illness is unpredictable, and that parents refuse to give up hope, it is expected that parents in these situations will need access to both hospice and curative care—in fact, this is common practice outside of the military.

Medicaid and commercial plans recognize this difference and can cover both hospice and curative care for pediatric patients while TRICARE cannot (Medicare hospice rules for the elderly preclude curative care).

DHA's response to this issue included supporting affected families on a case-by-case basis (although it is unclear what can be done if, in fact, TRICARE is prohibited from covering concurrent hospice by statute), and proposes a demonstration project to allow TRICARE to cover concurrent hospice for pediatric patients. Unfortunately, it will take a year to get a demonstration up and running.

Military families with terminally ill children deserve access to the current standards of pediatric care, including hospice services concurrently with curative treatments.

Medical Necessity -- TRICARE's adult-based definition of medical necessity prevents some children from obtaining the care they need – care that is widely accepted and practiced in the civilian health care system and MTFs. TRICARE is authorized to approve purchased care only when it is "medically or psychologically necessary and appropriate care based on reliable evidence." DoD's hierarchy of reliable evidence includes only "published research based on well controlled clinical studies, formal technology assessments, and/or published national medical organization policies/positions/reports."

While beneficiaries certainly want safe and effective treatment, such tightly prescribed data for children is not always available. TRICARE's strict adherence to this adult-based standard of reliable evidence results in coverage denials for widely accepted pediatric treatments. The American Academy of Pediatrics (AAP) definition of medical necessity is as follows:

"Health care interventions that are evidenced based, evidence informed, or based on consensus advisory opinion and that are recommended by recognized health care professionals, such as the AAP, to promote optimal growth and development in a child and to prevent, detect, diagnose, treat, ameliorate, or palliate the effects of physical, genetic, congenital, developmental, behavioral, or mental conditions, injuries or disabilities."
American Academy of Pediatrics Policy Statement "Essential Contract Language for Medical Necessity in Children" – July 2013

An appropriate pediatric specific definition of medical necessity creates the framework for appropriate coverage, access and reimbursement for pediatric care, making bureaucratic appeal and policy exception less necessary. Formulating such policy is integral to improving health care for military children.

The Coalition believes the next round of MHS reform should include the American Academy of Pediatrics (AAP) definition of medical necessity as the determinant for pediatric TRICARE patients.

Extended Care Health Option (ECHO) and Medicaid -- For special needs military families, frequent relocation presents another obstacle: the inability to qualify for services through Medicaid waivers. Caring for children with complex medical needs can be incredibly expensive.

Most civilian families in this situation ultimately receive some form of public assistance, typically through state Medicaid waivers for home and community based care. State Medicaid programs provide assistance not covered by health insurance, for example, respite care, employment support, supplies, and more flexible medical coverage. These services allow special needs family members, who might otherwise require institutional care, to receive care at home.

Because the demand for these services far outstrips the supply, there is a lengthy waiting list to receive assistance in most states.

For that reason, these services are often out of reach for military families who must relocate before reaching the top of the waitlist.

TRICARE's Extended Care Health Option (ECHO) program was designed to address this imbalance, by covering non-medical services not allowed under TRICARE and not accessible to military families via Medicaid.

However, the Military Compensation and Retirement Modernization Commission (MCRMC) found ECHO benefits, as currently implemented, are not robust enough to replace state waiver programs. The gap in respite services is particularly pronounced with ECHO covering 192 hours of respite per year – far fewer than Medicaid's average of 695 respite hours annually. We are encouraged by DHA's stated commitment to addressing ECHO shortfalls. However, it has been three years since the MCRMC identified this coverage gap.

The Coalition believes if there is no change in respite care policy – a well-documented gap relative to state Medicaid waiver programs – within the next year, the next round of MHS Reform must include a legislative fix to bring ECHO in line with the program's legislative intent by January 1, 2018

Conclusion

The Military Coalition thanks the Subcommittee for your tremendous support of the entire uniformed service community. Your comprehensive and thoughtful reform efforts to modernize and sustain the Military Health System and the TRICARE program will pay dividends well into the future. Thank you for taking our concerns and priorities into consideration as you deliberate on the future of the one weapon system that has never let our Nation down – the men and women who wear and have worn the uniform, along with their family members and survivors.