THE MILITARY COALITION
PROUDLY SERVING ALL EIGHT UNIFORMED SERVICES

May 17, 2021

Chairwoman Kirsten Gillibrand
Subcommittee on Personnel
Armed Services Committee
United States Senate
Washington, DC 20510

Chairwoman Jackie Speier
Subcommittee on Military Personnel
Armed Services Committee
United States House of Representatives
Washington, DC 20515

Ranking Member Thom Tillis
Subcommittee on Personnel
Armed Services Committee
United States Senate
Washington, DC 20510

Ranking Member Jim Banks
Subcommittee on Military Personnel
Armed Services Committee
United States House of Representatives
Washington, DC 20515

Dear Chairwoman Gillibrand, Ranking Member Tillis, Chairwoman Speier, and Ranking Member Banks:

The Military Coalition (TMC), a consortium of organizations representing 5.5 million service members, veterans, their families, and survivors**,** urges you to consider several factors as you conduct oversight of the next generation of TRICARE contracts, T-5. The breadth and quality of the TRICARE network is particularly important as congressionally-directed military treatment facility restructuring and medical billet cuts proposed by the Services have the potential to move a significant number of beneficiaries to the civilian sector for care.

The FY 2017 NDAA mandates significant changes to the TRICARE program, including the managed care support contractor construct. The Department of Defense (DoD) is required to seek alternative payment models for health care providers, including value-based incentive programs that shift greater risk to providers and contractors. DoD must also ensure local, regional, and national health plans have an opportunity to participate to achieve greater competition among contractors and more choice for beneficiaries.

TMC supports the intent of these legislative changes to improve access to care, health outcomes, the quality of care and the patient experience. Reforms that provide the Defense Health Agency (DHA) with options to swiftly address contractor performance issues are particularly important. However, these changes come with some risks to TRICARE beneficiaries. As Congress conducts its oversight role of the award process for T-5, we urge you to ensure the following objectives are met:

- **Minimize Transition Disruptions**: TRICARE contractor transitions have historically been rife with problems for beneficiaries including delayed referrals, claims processing issues, and customer service backlogs. We urge DHA to consider ways to minimize disruptions as part of the T-5 process. In addition, we understand an intermediary eligibility/enrollment/encounter contract (or triple-E contract) is being considered to reduce barriers to entry, allowing smaller health plans to participate as TRICARE contractors. While we understand the objectives of a third-party contract, we are concerned about the potential for even more beneficiary problems related to transitioning these functions to a triple-E contractor. We urge Congress to ensure any triple-E contract is implemented such that military families encounter minimal disruptions associated with the change.

- **Shield Beneficiaries from Higher TRICARE Costs**: One of the tenets of value-based care is an upfront investment in high quality care, provider incentives, preventive services, and care coordination to achieve

better health outcomes – and therefore lower health care spending – in the long run. We are concerned the new T-5 construct may, in the short term, result in significant programmatic cost increases for TRICARE. Rising costs have historically been used to justify TRICARE fee increases, so we are understandably concerned that beneficiaries may be tapped to offset rising costs in the future. TMC is committed to blocking proposals to shift health care costs to beneficiaries, particularly if the cost increase results from TRICARE contract changes.

- **Maintain Robust Provider Networks**: With each contract transition, military families face the risk of diminished provider networks as contractors develop competitive bids that necessitate deeply discounted provider reimbursements. We appreciate the T-5 draft RFPs have included limits on individual provider discounts. We also understand the move to increased competition is intended to prevent a downward spiral of narrowed provider networks or networks that lack quality providers. However, the breadth and quality of managed care support contractors' networks for the main TRICARE regions will remain essential to beneficiary access to care in most geographic areas. Please ensure the T-5 process results in regional contracts that improve access to care through robust networks of high-quality providers.

- **Improve Access to Mental Health Care**: An August 2020 DoD Inspector General report, *Evaluation of Access to Mental Health in the Department of Defense*, confirmed anecdotal reports our organizations have been hearing for years. Military families face significant barriers to accessing mental health care. Please ensure T-5 incorporates IG recommendations to improve access to mental health care in the TRICARE network by requiring adoption of a single MHS-wide mental health care staffing model. In addition to maintaining robust provider networks, the T-5 contract must also require contractors to ensure their provider directories are accurate and up to date, so beneficiaries can more easily find an appropriate network provider. We also urge Congress to establish and provide oversight of a mental health schedulers pilot that ensures a "warm handoff" when beneficiaries are referred to mental health care.

In response to a request from the Senate Armed Services Committee during the FY 2021 NDAA process, DoD released in August, 2020 the *Report to the Committee on Armed Services of the Senate: TRICARE Managed Care Support Contract Structure*. We support DoD's recommendations to incorporate phased demonstration projects to test and evaluate multiple contract/network offerings as well as other contract innovations. No wholesale changes to the TRICARE construct should be implemented program-wide without first being tested and evaluated.

The T-5 contracts represent significant change to the purchased care component of the Military Health System. At the same time, the organization and governance of the direct care component of military hospitals and clinics is also being dramatically altered. Our focus has always been – and continues to be – on ensuring these changes do not create obstacles or disruptions that hinder the ability of our members to access quality and affordable health care.

We appreciate the dialog DHA has maintained with TMC and thank you in advance for your leadership and oversight of this critical process to ensure service members, retirees, their families and survivors have the access to high quality health care they deserve.

Sincerely,

Jack Du Teil
President
The Military Coalition

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Air Force Sergeants Association (AFSA)

AMSUS, the Society of Federal Health Professionals

Association of the United States Army (AUSA)

Commissioned Officers Association of the US Public Health Service (COA)

U.S. Coast Guard Chief Petty Officers Association and Enlisted Association (CPOA)

Chief Warrant and Warrant Officers Association, United States Coast Guard (CWOA)

Fleet Reserve Association (FRA)

Gold Star Wives of America (GSW)

Jewish War Veterans of the United States of America (JWV)

Marine Corps League (MCL)

Marine Corps Reserve Association (MCRA)

Military Chaplains Association (MCA)

Military Officers Association of America (MOAA)

Naval Enlisted Reserve Association (NERA)

National Military Family Association (NMFA)

Reserve Organization of America (ROA)

Tragedy Assistance Program for Survivors (TAPS)

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