



**NATIONAL  
MILITARY FAMILY  
ASSOCIATION**

Together we're stronger

Statement

by the

**NATIONAL MILITARY FAMILY ASSOCIATION**

for

**Subcommittee on  
Personnel**

of the

**UNITED STATES SENATE  
ARMED SERVICES COMMITTEE**

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The Committee

The National Military Family Association (NMFA) is the leading nonprofit dedicated to serving the families who stand behind the uniform. Since 1969, NMFA has worked to strengthen and protect millions of families through its advocacy and programs. We provide spouse scholarships, camps for military kids, and retreats for families reconnecting after deployment and for the families of the wounded, ill, or injured. NMFA serves the families of the currently serving, retired, wounded or fallen members of the Army, Navy, Marine Corps, Air Force, Coast Guard, and Commissioned Corps of the USPHS and NOAA.

Association Volunteers in military communities worldwide provide a direct link between military families and the Association staff in the Nation's capital. These volunteers are our "eyes and ears," bringing shared local concerns to national attention.

The Association does not have or receive federal grants or contracts.

Our website is: [www.MilitaryFamily.org](http://www.MilitaryFamily.org).

**Joyce Wessel Raezer, Executive Director**

Joyce became the Executive Director of the National Military Family Association in 2007. In that position, she leads the Association's programs and initiatives to meet the needs of the families of the seven Uniformed Services and promote improvements in their quality of life. She is frequently called on by government officials, other organizations, and the press to share her expertise on the issues facing military families. She began her work with the Association in 1995 as a Volunteer in the Government Relations Department and subsequently served in various staff positions, including Government Relations Director.

Joyce has represented military families on several committees and task forces for offices and agencies of the Department of Defense (DoD) and military Services. Joyce has served on several committees of The Military Coalition, an organization of 36 military-related associations. She was co-chair of the Coalition's Personnel, Compensation, and Commissaries Committee from 2000 to 2007. In 1999 and 2000, she served on a Congressionally-mandated Federal Advisory Panel on DoD Health Care Quality Initiatives. From June 1999 to June 2001, Joyce served on the first national Board of Directors for the Military Child Education Coalition. In 2004, she authored a chapter on "Transforming Support to Military Families and Communities" in a book published by the MIT Press, *Filling the Ranks: Transforming the U.S. Military Personnel System*. She has served on the Strategic Board of the Department of Defense Millennium Cohort Study Program since 2015.

In 2006, Joyce received the Gettysburg College Distinguished Alumni Award. She was the 1997 recipient of NMFA's Margaret Vinson Hallgren Award for her advocacy on behalf of military families. She also received the "Champion for Children" award from the Military Impacted Schools Association in 1998. In 2007, Military Spouse Magazine listed her on its Who's Who of Military Spouses. On May 29, 2012, she was honored as a Daily Point of Light by the Points of Light Foundation. In 2014, she received the Community Hero Award from the PenFed Foundation.

A Maryland native, Joyce earned a B.A. in History from Gettysburg College, and a M.A. in History from the University of Virginia. The spouse of an Army retiree, she is the mother of two adult children. She is a former teacher and served on the Fort Knox Community Schools Board of Education from 1993 to 1995.

## **EXECUTIVE SUMMARY**

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The United States military is the most capable fighting force in the world. For more than a decade of war, service members and their families never failed to answer the call, steadfastly sacrificing in order to protect our Nation. They made these sacrifices trusting that our government would provide them with resources to keep them ready. Continued national fiscal challenges have left military families confused and concerned about whether the programs, resources, and benefits contributing to their strength, resilience, and readiness will remain available to support them and be flexible enough to address emerging needs. The Department of Defense (DoD) must provide the level of programs and resources to meet this standard. Sequestration weakens its ability to do so. Service members and their families have kept trust with America through 16 years of war with multiple deployments and separations. Unfortunately, that trust continues to be tested.

### **We ask Congress:**

As you evaluate proposals submitted by DoD, consider the cumulative impact on military families' purchasing power and financial well-being, as well as the effects on the morale and readiness of the all-volunteer force now and in the future.

Please:

- Reject budget proposals that threaten military family financial well-being as a way to save money for the government.
- Keep military pay commensurate with service and aligned with private sector wages.
- Preserve the savings military families receive by shopping at the commissary and oppose any reform measures that would reduce the value of the benefit.

We especially ask Congress to end sequestration, which places a disproportionate burden on our Nation's military to reduce the deficit.

We also ask Congress to make improving and sustaining the programs and resources necessary to keep military families ready a national priority.

We ask Congress to:

- Provide oversight to ensure DoD and the individual Services are supporting families of all components by meeting the standards for deployment support, reintegration, financial readiness, and family health. Fund appropriately at all levels.
- Ensure adequate funding for military child care programs, including child care fee assistance programs. Improve access to installation-based child care and increase availability of part-time and hourly care.
- Facilitate easier paths to both licensure and employment for military spouses and veterans who are in the mental health field when they work with our service members and their families. Include military spouses who enter the mental health profession in federal loan-forgiveness programs.
- Expand service member and family access to Military OneSource counseling and other assistance to one year post-separation.
- Ensure appropriate and timely funding of Impact Aid through the Department of Education (DoEd).

- Continue to authorize DoD Impact Aid for schools educating large numbers of military children and restore full funding to Department of Defense Education Activity (DoDEA) schools and the DoDEA Grant Program.
- Bring the Extended Care Health Option (ECHO) benefits on par with State Medicaid waiver programs and extend ECHO eligibility for one year following separation.
- Correct inequities in Survivor benefits by eliminating the Dependency and Indemnity Compensation (DIC) offset to the Survivor Benefit Plan (SBP). Make the Special Survivor Indemnity Allowance (SSIA) permanent.
- Ease the financial burden and coverage confusion faced by Medicare-eligible, medically-retired wounded, ill, and injured service members.

After 16 years of war, we continue to see the impact of repeated deployments and separations on our service members and their families. We appreciate Congress' recognition of the service and sacrifice of these families. Your response through legislation to the ever-changing need for support has resulted in programs and policies that have helped sustain our families through these difficult times.

On January 23, 2017, the National Military Family Association posted this letter to our incoming Secretary of Defense, James Mattis, on behalf of the military families we serve:

**DEAR SECRETARY MATTIS...**

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The National Military Family Association would like to congratulate you on becoming our Nation's 26<sup>th</sup> Secretary of Defense (SECDEF). We realize you have your work cut out for you, so we extend our commitment to helping you keep up with the pulse of our military families.

As you know, military life is something unknown to many Americans. Your new role gives you an opportunity to elevate the strengths and the challenges of today's service members and their families. You will have numerous opportunities to help narrow the military-civilian divide that widens as the wars in Iraq and Afghanistan continue to fade from public view. Your inspiration will show Americans that their support and understanding is critical to the well-being and success of the ones who stand on, and behind, our front lines.

While the nature of military deployments has changed, the frequency of those deployments hasn't. Military families still need continuous support, no matter what type of deployment they face. **Because for military families, gone is gone, and they're still "one man down" on the home front.**

A strong family is essential to an individual service member's mission readiness. Military families need your commitment to provide the necessary support to promote family readiness. We recognize the burden of sequestration is heavy—we've seen military families carry the weight of unfair and unbalanced budget cuts since sequestration began. They'll look to you to ease this hardship. As the voice of military families for more than four decades, we are eager to share their real-life experiences with you. **Military family support and services should not be casualties of budget battles on Capitol Hill**, and we are ready to arm you with the information to justify their necessity and end sequestration.

With the launch of a new military retirement system and upcoming Congressionally-mandated changes to military health care, it is urgent that you fill vacant senior leadership positions within the Department of Defense with the best quality people as quickly as possible. The programs and services that fall under those positions — such as the Under Secretary of Defense for Personnel and Readiness, Assistant Secretary for Health Affairs, and Deputy Assistant Secretary for Military Community and Family Policy— address the specific '*day-to-day*' challenges of our military families. Without the required oversight and support these key positions provide, readiness will be compromised, and families will be at risk.

Secretary Mattis, military families are the war-weary backbone of our military, and our Association is committed to working with you to preserve their resilience. As our military moves towards an enhanced state of readiness with ever-changing demands and missions, we pledge to stand by you as the trusted voice of our nation's families. We look forward to being your ally, because **together we're stronger**.

***Members of Congress, we ask the same of you.***

## **PAY AND COMPENSATION**

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We appreciate Congress making the pay raise at Employment Cost Index (ECI) a priority in the Fiscal Year 2107 National Defense Authorization Act (FY17 NDAA). Congress chose the Employment Cost Index (ECI) as the standard for active duty pay raises in order to recruit and retain the quality of service members needed to sustain the all-volunteer force and we thank you for meeting that standard this year.

We believe that Basic Allowance for Housing (BAH) is an essential component of military compensation. We oppose any changes that threaten to reduce military families' pay.

***We ask Congress to keep military pay commensurate with service and aligned with private sector wage increases.***

## **MILITARY HEALTH SYSTEM REFORM**

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Our Association thanks the Senate Armed Services Committee (SASC) Personnel Subcommittee Members and professional staff for their extraordinary efforts and dedication to addressing military family concerns during the Military Health System (MHS) Reform process. The FY17 NDAA health care provisions represent a massive restructuring of the direct care system as well as significant changes to purchased care contracting, and many provisions clearly reflect concern for the beneficiary experience. Our Association is hopeful MHS Reform will eventually enable more military families to consistently access the right care at the right time and in the right place as well as improve the patient experience within military hospitals and clinics.

NMFA has three objectives to communicate through this statement. We seek to:

- Provide an overview of the current state of the MHS focused on problems that must be resolved to provide military families with an appropriate health care benefit
- Outline our reactions to the FY17 NDAA health care reform provisions, particularly as they relate to the problems outlined above
- Identify gaps or MHS problem areas not addressed by the FY17 NDAA or the upcoming implementation of the T17 contracts, and suggest possible solutions for future policy changes or legislative action

The quality and value of the military health care benefit should reflect the extraordinary demands of military service. MHS care should be on par with services provided by top performing civilian health systems. Military Treatment Facility (MTF) policies, procedures and customer service should have a beneficiary focus designed to facilitate access to care. TRICARE networks and reimbursement policies should be on par with high quality commercial plans. In short, military health care should be an unmitigated benefit to families – not another sacrifice to add to the many that military families already make in support of their service members. We truly appreciate your efforts on MHS Reform that will get us closer to that goal.

## **MHS REFORM VISION: ARE WE ALL ON THE SAME PAGE?**

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The MHS is unique with its dual readiness and benefit provision missions. Its readiness mission must achieve both a medically ready fighting force that is healthy and capable of deploying as needed and a ready medical provider force capable of delivering health and

combat-casualty care for service members in operational environments. The MHS benefit provision mission delivers the earned health care benefit to family members, retirees, and survivors. The two missions intersect when military medical personnel provide care to family members and retirees in MTFs, honing their medical skills in the process.

As we interpret the FY17 NDAA MHS Reforms we see Congressional intent to “right size” the direct care component, retaining only beneficiary care that directly contributes to the readiness mission and outsourcing the rest to civilian providers via the TRICARE program. We also see a variety of related provisions intended to beef up the purchased care component. These changes should help ensure access for beneficiaries who must transition their healthcare to the private sector as a result of right sizing. They should also allow families to access care with high performing civilian providers and health care systems. Other provisions are intended to improve integration between the purchased and direct care components. Still others focus on purchased care cost savings to DoD.

Our Association supports this vision for MHS Reform. Over the past 15 years when MTF capacity contracted due to medical provider deployments, many families were moved to civilian providers in the community. Our families were generally very satisfied with quality and access to care with their community providers. In fact, we only heard complaints about this policy when families were forced to move back into the MTFs. With the emphasis on improved access to high quality purchased care running throughout the reform provisions, we enthusiastically support this vision of MHS Reform.

Under our interpretation of the Congressional intent for MHS Reform, we have four main concerns regarding the reform process:

- In meetings with DHA, the managed care support contractors and other Military and Veteran Service Organizations (MSO/VSOs), we have noted that MHS Reform is not being discussed in terms of a vision or overarching strategy. Out of necessity, Congress presented the reform in a series of complex NDAA provisions that direct specific changes with no opportunity to explain linkages or outline the strategic vision for the MHS. Extraneous provisions (e.g., hearing aids, medical foods) that are valued and appreciated but not directly related to MHS Reform also detract from the big picture. We believe the lack of shared strategic vision presents an obstacle to effective implementation of MHS Reform.
- As beneficiaries are moved from direct to purchased care, problems with TRICARE’s reimbursement policies will become more prevalent as they impact more families. We fear this will be a particular problem for families with young children, given TRICARE’s historic pediatric reimbursement issues, caused by an inappropriate alignment with Medicare reimbursements. Reform measures did not address the challenges faced by patients needing care involving emerging treatments and technologies. If the intent is to move a significant portion of military family care into the purchased component, Congress must soon focus on fixing TRICARE reimbursement issues so they don’t impede beneficiary access to appropriate care.
- We fear DoD will determine only minimal right-sizing is necessary and retain most military family care in the MTFs. If this happens, we believe future MHS reforms will be necessary to make additional tangible improvements to access, quality of care, and the patient experience within MTFs.

- Massive change in a health system where the primary focus – the reason for being – is medical readiness and combat casualty care, will lead to reduced focus on some beneficiary issues. What will happen, for instance, to progress on pediatric care problems while MTF management responsibilities are being shifted to the DHA and managed care support contracts are being restructured and a Joint Trauma Center is being developed? We believe that even advances on access to care may be at risk as the MHS turns its attention to implementing FY17 NDAA health care reforms versus improving day-to-day operations.

Our concerns about day-to-day operations and non-reform related improvements are exacerbated by the timing of the new TRICARE managed care support contracts (T17 contracts). With T17 contracts slated to go live in October 2017, DHA will be simultaneously implementing several significant organizational changes as well as managing T17 implementation that includes a Managed Care Support Contractor (MCSC) change for approximately two-thirds of CONUS beneficiaries. Additionally, MHS Reform will necessitate modifications of the T17 contracts even before they are implemented. From a military family perspective, the current timing means TRICARE beneficiaries will experience a MCSC change in October 2017 and then almost immediately face the TRICARE program restructure in January 2018. We believe it would be beneficial to delay T17 implementation until January 2018 to align with the introduction of TRICARE Select. Delaying T17 implementation will create one major communication event regarding TRICARE changes versus staggering multiple messages across several months.

In an MSO/VSO meeting with a senior DoD official late last year, we recommended a formal process for MSOs and VSOs to provide feedback on T17 implementation and the MHS Reform process. DHA has embraced this suggestion and developed a construct for regularly gathering Association input. We hope this approach will be institutionalized so it continues even as leadership in the DHA and the office of the Assistant Secretary of Defense for Health Affairs turns over. While we believe this partnership will ensure beneficiary perspectives are included in MHS Reform implementation, we remain concerned about beneficiary problems with the MHS that are not addressed by T17 or the FY17 NDAA. What happens to issues such as concurrent hospice for terminally ill military kids, diagnostic genetic testing coverage denials, and Extended Care Health Option improvements to bring the program in line with state Medicaid waiver services? These issues cannot be put on the back burner for the next few years as focus is shifted to MHS Reform.

### **TRICARE SELECT AND OTHER TRICARE REFORM**

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Before we move into an overview of MHS deficiencies and how the FY17 NDAA health care provisions address them, we'd like to provide our perspectives on the TRICARE reform plan outlined in Section 701 since this TRICARE program restructure is not directly linked to identified beneficiary problems.

As we review Sec. 701, it is our understanding TRICARE Reform outlined in that section does the following:

- Eliminates the current TRICARE self-managed options – TRICARE Standard (non-network) and TRICARE Extra (network) – and replaces them with a self-managed



- preferred provider option called TRICARE Select that, like TRICARE Standard, includes the option of using non-network providers for slightly higher copays/cost shares
- Establishes an enrollment requirement for TRICARE Select
  - Creates two tiers of beneficiaries for the purpose of out-of-pocket costs under TRICARE Select:
    - NEW Active Duty Family Members (ADFMs) and future NEW Retirees = those who enter service on or after 1/1/18
    - GRANDFATHERED ADFMs and Retirees = those who entered service before 1/1/18
  - Maintains current out-of-pocket costs for GRANDFATHERED beneficiaries except for a new TRICARE Select enrollment fee and catastrophic cap increase for GRANDFATHERED retirees that will go into effect in 2020 contingent on TRICARE Select performance improvements relative to TRICARE Standard/Extra
  - Changes and/or increases out-of-pocket costs for NEW beneficiaries in a variety of ways:
    - Increases the catastrophic cap for NEW retirees
    - Converts many health care encounter fees from cost shares to fixed dollar copays for all NEW beneficiaries
    - Applies an annual index to all fixed dollar fees based on the military retiree cost of living adjustment (COLA) for all NEW beneficiaries
    - Increases the TRICARE Prime enrollment fee for NEW future retirees
    - Establishes a new TRICARE Select enrollment fee for NEW future retirees
  - Eliminates the preauthorization requirement for TRICARE Prime specialty care referrals

We are disappointed in the choice to create a two tier system based on when someone enters military service because it injects a new level of complexity into an already complex system. However, we are especially grateful Prime is maintained as a zero out-of-pocket cost option for ADFMs and that costs for NEW ADFMs remain largely unchanged for TRICARE Select (the only increase is an index applied to fixed dollar fees including the deductible and catastrophic cap). We appreciate that Congress chose to link moderate GRANDFATHERED retiree cost increases to improved TRICARE Select performance/value.

Our Association believes that NEW retiree out-of-pocket cost adjustments are reasonable and future increases will be predictable and linked to retiree COLA. Relatively low out-of-pocket costs reflect the value of service while catastrophic caps protect families from potential financial hardship related to medical expenses. Given the extraordinary risks assumed during the course of military service, we believe it is appropriate to protect service members, retirees, their families, and survivors from financial risk wherever possible.

We welcome the attempt to streamline access to specialty care by eliminating the specialty care preauthorization requirement. It will be important to educate families that without preauthorization there is no guarantee TRICARE will pay for specialty care even if referred/recommended by their Primary Care Manager (PCM.)

The FY17 NDAA mandates 85 percent network coverage of TRICARE beneficiaries. However, we and others have raised concerns about how robust TRICARE Select's PPO network will be across the country and how much beneficiary choice it will provide. The promise of a PPO network with better access and cost will create an expectation among beneficiaries who must

now pay an enrollment fee to access their basic TRICARE benefit. What happens if DoD and its TRICARE contractors cannot deliver on the promise? What costs will TRICARE beneficiaries not residing in a location with a PPO network incur for the enrollment fee they now must pay? How will the new TRICARE Select option work for beneficiaries who currently use TRICARE Standard as second-payer to their employer-sponsored plans?

Why are these questions important? Military families must be able to understand TRICARE Select and what the change means in how they access and pay for health care. Given the recent cuts to the Basic Allowance for Housing (BAH), reductions in family support programs, and continued threats to the commissary benefit, military families are poised to perceive TRICARE Select as a diminished benefit relative to TRICARE Standard/Extra. It is critical that DHA, the managed care support contractors, and military associations can clearly communicate about TRICARE Select.

We thank Congress for including a TRICARE Select enrollment grace period to ensure beneficiaries maintain coverage during the transition period. The unprecedented Select enrollment requirement demands an effective communications plan and we appreciate Congressional oversight via the DoD Enrollment Plan report requirement.

Oversight and accountability are crucial during reform of this magnitude so we thank Congress for including the DoD and GAO report requirements to monitor access to purchased care.

While we are generally supportive of TRICARE Select and the other TRICARE Reform measures, that support is dependent on the assumption that access to care is enhanced and the adjusted fees and COLA-based index will put an end to the sporadic and unpredictable health care fee increases that we have experienced over the past several years. A well-defined and predictable health care benefit is critical in keeping the faith with the all-volunteer force.

#### **MHS BENEFICIARY CARE PROBLEMS AND MHS REFORM PLANS: HOW WELL DO THEY MATCH UP?**

In the past, our testimony has outlined problems military families encounter with the direct and purchased care systems. In this document, we seek to recap those issues and identify which will be addressed with FY17 NDAA health care provisions, where gaps still exist, and potential solutions for unresolved issues.

First, we would like to thank Congress for Sec. 704, which removes the referral and preauthorization requirements for TRICARE Prime beneficiaries seeking urgent care. This is an enormous improvement in acute care access and allows military families to access care in an appropriate setting, not the ER. Removing the referral requirement simplifies the policy so it is easily understood and implemented by families, providers and managed care support contractors. This provision will have such a positive impact on military families seeking care for sick or injured family members when their PCM is unavailable or when they are traveling or PCSing.

#### **PROBLEM: MTF Acute Appointment Shortages**

For years, military families have asked for better access to MTF acute care appointments for medical problems such as ear infections and strep throat – conditions that aren't emergencies,

but must be treated promptly. The inability to make sick appointments at the MTF continues to be one of the main complaints we hear:

- Multiple data sources validate the anecdotal information we receive from our volunteers and military families. From October 2016 through January 2017, our Association fielded a survey of 9,566 military spouses. Thirty percent of respondents who use an MTF for primary care indicated they *rarely* or *never* get an acute appointment within the 24 hour access standard.
- This problem is further substantiated using DHA transparency data. From April through August 2016, the number of MTFs that failed to meet the 24 hour access standard for acute care appointments ranged from 48 percent to 68 percent. While we recognize this timeframe covers PCS season – when both the beneficiary population and uniformed MTF staff may be in flux leading to scheduling challenges – the number of noncompliant MTFs still seems unacceptably high.

We appreciate that **Sec. 704: Access to Urgent and Primary Care Under TRICARE Program** directs DoD to determine MTF primary care clinic hours based on the MTF's requirement to meet TRICARE Prime access standards and primary care utilization patterns and authorizes DoD to expand clinic hours if necessary. However, we would have liked to see DoD and/or GAO reporting requirements to ensure transparency and accountability in the implementation of this provision, which may require shifting or adding staff.

Given that MTF acute appointment access remains the most prevalent complaint regarding direct care, and is substantiated by both survey and DHA transparency data, we believe more must be done to ensure improvements. Most importantly, DoD must monitor acute appointment access using meaningful metrics that identify underperforming MTFs. This information should be used to understand obstacles to meeting access standards and develop solutions focused on addressing those obstacles. If acute access problems persist, we ask that you consider future legislation mandating enhanced reporting and data-driven process improvements on the acute care access issue.

We appreciate DHA has included representatives from the Services' Surgeons General offices in MSO/VSO Working Group and Executive sessions to brief on access to care initiatives. As the MTF management structure evolves, we would like to see a point person(s) responsible for MTF beneficiary access continue to participate in those meetings and be held accountable for MTF performance against published access standards.

#### **PROBLEM: MTF Routine Care Scheduling Challenges**

Families report **delays in scheduling** preventative, routine, and follow up care.

- In NMFA's military spouse survey, 30 percent of MTF users said they rarely or never get a routine appointment within the 7 day access standard.
- DHA's transparency data indicates that 26-42 percent of MTFs failed to meet the 7 day access standard for routine appointments during the April-August 2016 timeframe.
- Please note MTF access problems are not exclusive to family members. We regularly hear about service members who are unable to get timely appointments. Failure to provide timely care to service members is a readiness issue.

Not only are some families unable to schedule routine appointments within a reasonable time frame, but the **process for scheduling is cumbersome**. Families are frequently required to

call the appointment line multiple times in the hopes of finding an opening within the currently available appointment book and are often confronted with an entirely different set of rules from one installation to the next.

We appreciate **Sec. 709: Standardized System for Scheduling Medical Appointments at MTFs**. A standardized appointment scheduling system, together with the first call resolution mandate, should alleviate many challenges families currently face when making MTF appointments. Assuming the online option is user-friendly, it should appeal to military families accustomed to conducting much of their family business online and via mobile apps.

Thank you for requiring a **Sec. 709 Implementation Plan** from DoD. As you review the plan, please consider the following:

- The online appointment system should be easy to access. Unless there are major improvements to TRICARE Online, it should not be part of the new system.
- The online system should include the ability to not only schedule an appointment, but to change or cancel an appointment as well.
- The system should include an ability to track first call resolution rates.
- Both the online and manual systems should allow families the option to schedule acute appointments with providers other than their PCM, or even outside of their Patient Centered Medical Home (PCMH,) if there is no availability in the PCMH.

**PROBLEM: Direct Care System Variable Quality and Safety**

We remain concerned about the mixed results found during DoD's 2014 MHS Review, which identified considerable variation across the system for both specific clinical quality measures and for individual MTFs. Issues identified in the review are consistent with feedback we continue to hear from military families. Some are very pleased with their MTF care, while others relay stories that clearly demonstrate quality and safety issues.

*"I had a visible lump on my knee that developed over several years following a trauma. It was causing pain to the point I needed crutches at times and my PCM sent me for ultrasound and an ortho referral. Ortho ordered an MRI which they claimed to show nothing abnormal. After seeing the head of ortho at the military hospital and being accused of being a drug seeker, despite the visible lump about the size of an egg on my knee, I finally got a referral to a civilian specialist who took one look at the MRI and said, there's a ball of scar tissue sitting on your nerve, we can book you for surgery in 2 weeks." – Military Spouse*

*"Over a year ago, I went to see my doctor at the MTF to discuss some symptoms I'd been having. He dismissed my concerns and I subsequently went back at least 5 times for the same issue. They never took it seriously, even when I told them I was having trouble swallowing solid food. I finally decided to switch to TRICARE Standard so I could see a civilian specialist. He listened to my symptoms and immediately scheduled further testing...for the next day. During that test, the civilian specialist discovered a problem that needed surgery very quickly. This diagnosis explains the symptoms I had been complaining about to the doctors at the MTF and military emergency rooms for the past year. I believe I could have (and should have) had this surgery a year ago, if one of the PCMs I saw at the MTF (because I never did see the same PCM twice) had given me the referral I asked for*

*again and again. Unfortunately, because my condition had gotten so much worse, they were unable to correct it with laparoscopic surgery and had to do a much more invasive surgery. As a result, my recovery has been much lengthier and more difficult.” –Air Force Spouse*

Another finding of particular concern involved follow up on sentinel events. The MHS Review found the execution and content of root cause analysis (RCA) to understand the possible causes of adverse health events related to care (sentinel events) remains highly variable across the Services and MTFs. In addition, there has been a failure to routinely follow up on reported RCAs to ensure systemic issues identified were corrected.<sup>1</sup>

**Sec. 702: Reform of the Administration of the DHA and MTFs** requires a DHA professional staff, including a Deputy Assistant Director for Medical Affairs with responsibility for clinical quality, patient safety and the patient experience. We trust this position will be held accountable for improved quality of beneficiary care. It is also critical that DHA’s High Reliability Organization initiative, established in response to findings of variable quality across MTFs in the 2014 MHS Review, be continued.

We appreciate that **Sec. 726: Program to Eliminate Variability in Health Outcomes & Improve Quality of Health Care Services Delivered in MTFs** establishes a program of clinical practice guidelines for certain diseases and conditions and hope this enhances quality of care for beneficiaries with chronic health conditions.

We also thank you for **Sec. 727: Adoption of Core Quality Performance Metrics**. However, we feel this is only a partial solution since it assumes there is an existing culture of data-driven process improvements within the direct care component. Simply requiring performance metrics does not ensure they will be appropriately applied to enhance quality of care.

We appreciate that **Sec. 751: Comptroller General Reports on Health Care Delivery and Waste in the MHS** requires a GAO report to assess the delivery of health care within the MHS (including processes for reporting and resolving adverse medical events). If this report indicates the MHS has not fixed the highly variable RCA sentinel event reporting and follow up uncovered in the 2014 MHS Review, it will be imperative for Congress to mandate corrective action.

Our Association is concerned FY17 NDAA health care reform provisions don’t go far enough to address the primary care quality problems reported by our military families. While we don’t believe Congress should prescribe medical treatment protocol, we do believe **it is important for Congress to require and monitor the implementation of data-driven process improvements** that are the cornerstone of modern high performing health systems.

Once the FY17 NDAA quality metrics are adopted, it will be critical to ensure they are used to identify beneficiary care problem areas and develop plans for corrective action as necessary. We would like **greater transparency not only with performance data, but how it is being leveraged to improve military family care**. For instance, our analysis of DHA transparency data shows the direct care system is underperforming on a HEDIS pediatric primary care

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<sup>1</sup> Military Health System Review Final Report to the Secretary of Defense – August, 2014

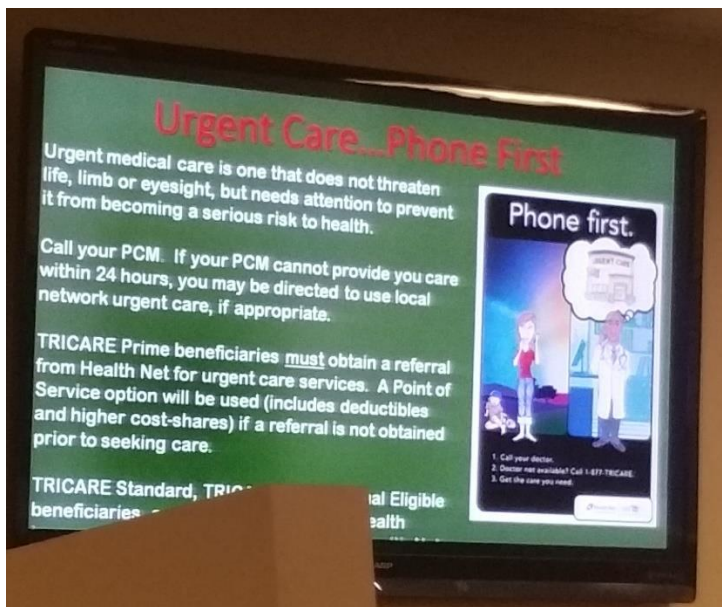
measure: Pharyngitis Pain/Pediatric Strep Testing Rates. According to HEDIS Outpatient Quality Measures, pharyngitis (inflammation of the throat) is the only condition among upper respiratory infections where antibiotic use may be appropriate. U.S. medical leaders recommend only children diagnosed with strep be treated with antibiotics. The HEDIS measure indicates what percentage of children prescribed an antibiotic received a strep test. The average for health plans nationwide is 85 percent. Approximately 3/4 of MTFs fall below the national average in terms of strep testing to verify appropriate antibiotic use. More than 1/3 of MTFs are at least 10 points below the national average. Data is only beneficial to military families if used to direct improvements at MTFs such as Bayne-Jones Army Community Hospital at Fort Polk or the 1<sup>st</sup> Special Operations Medical Group at Hurlburt Field where only 60 percent of military kids prescribed antibiotics are tested for strep.

**We also suggest DHA develop a process to conduct “exit interviews” for active duty families who switch from TRICARE Prime to TRICARE Select.** Given the new TRICARE Select enrollment requirement, it should be feasible for DHA to identify and contact families who make the switch. We believe there is great opportunity for identifying direct care problem areas by talking to families who elect to leave TRICARE Prime’s zero out-of-pocket cost option for TRICARE Select’s deductible and copays. Identifying problems and taking corrective action will help not only military families, but it will contribute to DHA’s goal of retaining family member care within the direct component.

**PROBLEM: Policies and Patient Experience Vary Across MTFs**

**Inconsistent Policy Implementation at the MTF Level:** MTF Commanders currently have a great deal of authority when it comes to setting policies at their facilities. While this is understandable given the complexity of the MHS and the unique conditions of each location, the existence of policies and procedures that vary from one MTF to another can make it even harder for mobile military families to effectively navigate the system.

**Poor/Inconsistent Communication:** Related to inconsistent policy implementation is the varying quality and extent of communication at MTFs. For example, DoD announced the Urgent Care Pilot in January 2016 and started it on May 23, 2016. In January 2017, a family member



visited the Dumfries Health Center (a clinic of the Fort Belvoir Community Hospital system) and saw this message on the electronic board stating that Prime beneficiaries must obtain a referral for urgent care services or face Point of Service charges.

The Dumfries and Fairfax clinic websites, accessible through the Fort Belvoir Community Hospital site, have a link to the TRICARE website about the Urgent Care Pilot in small print at the bottom of their websites. While small, this

link is more accessible than anything to be found on the main Fort Belvoir Community Hospital page.<sup>2</sup>

Contrast the information provided by Fort Belvoir and its satellite facilities with that provided by the Guthrie Clinic at Fort Drum, NY. On the Guthrie Clinic home page, the Urgent Care Pilot is highlighted under Announcements. Guthrie has also been promoting the Urgent Care Pilot rules on its Facebook feed.<sup>3</sup> MTF leaders must ensure benefit, policy, or procedural changes are communicated effectively and in a timely manner. They should not add to the misinformation already conveyed by some non-DoD sources.

Families often state they cannot count on getting accurate information from their MTFs. They also complain of difficulties in obtaining lab results, errors in medical records, and providers' failure to return phone calls.

**Lagging Customer Service Innovations:** DoD has been slow to adopt customer service innovations common in civilian health plans, such as the Nurse Advice Line (NAL) and Secure Messaging. New program rollouts often lack patient focus. While DoD has analyzed the NAL's business impact, it has not to our knowledge surveyed users to ensure the service meets beneficiary needs. Although Secure Messaging aligns with young military families' preferred communication methods, adoption rates at MTFs have lagged. We suspect this is linked to implementation issues such as the wide variety of names for the system (Relay Health, MiConnect, Medical Homeport Online, Army Medicine Secure Messaging and simply Secure Messaging) and inconsistent MTF, clinic, and provider adoption.

We appreciate that **Sec. 702: Reform of the Administration of the DHA and MTFs** requires DHA to assume responsibility for administration of all MTFs. Currently, DHA sets policy but MTFs have no accountability to the Agency for implementation of that policy. Consolidating MTF administration under DHA should allow the Agency to enforce policy and ensure consistent communication. In theory. However, the Fort Belvoir Community Hospital and its clinics – including the Dumfries clinic that displayed inaccurate information about the Urgent Care Pilot seven months after it launched – are part of the Defense Health Agency's National Capital Region Medical Directorate. While we are concerned about Dumfries patients getting inaccurate information regarding the Urgent Care Pilot, we are even more concerned that this incident indicates a lack of expertise or motivation at all levels of the chain of command to ensure families get the right information. To us, it suggests that we will have to go beyond simply consolidating all MTFs under DHA to ensure accurate and consistent policy and information dissemination.

We thank you for including **Sec. 718: Enhancement of Use of Telehealth Services in MHS** directing DHA to incorporate telehealth into both the direct and purchased care components. By developing telehealth services to improve access to care and monitor individual health outcomes, DoD can provide health care industry leadership in telehealth. We look forward to seeing the benefits telehealth can provide to mobile families experiencing frequent geographic separations.

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<sup>2</sup> Fort Belvoir Community Hospital: <http://www.fbch.capmed.mil/SitePages/Home.aspx>; Fairfax Health Center: <http://www.fbch.capmed.mil/About/fairfax.aspx>; Dumfries Health Center: <http://www.fbch.capmed.mil/about/dumfries.aspx> (accessed 2/11/17)

<sup>3</sup> Fort Drum MEDDAC, <http://www.drum.amedd.army.mil/SitePages/Home.aspx> (accessed 2/11/17)

We're willing to give the new DHA/MTF management structure a chance. However, if policy variations and inconsistent communications persist after a reasonable start up period, we recommend that Congress require a management implementation plan focused on beneficiary facing issues and follow on monitoring similar to that required for Sec. 703: Military Medical Treatment Facilities.

**PROBLEM: Cumbersome Referral and Authorization Process:**

The referrals and authorizations needed to obtain network specialty care can result in delays and disruptions to care. These issues become more pronounced during PCS moves. Military families recognize continuity of medical care is one of the sacrifices they must make as a result of the highly mobile military lifestyle. Unfortunately, many TRICARE and MTF policies hinder rather than facilitate the smooth transition of care during PCS moves. For instance, specialty care requires a new referral and authorization in the new location while patients are often required to reconfirm an existing diagnosis before seeking treatment.

*"With my second, I had to establish care with a new PCM after a move at 35 weeks pregnant to get a referral to an OB. The provider (off-post) laughed her head off at my hugely round self when I explained I needed a referral. She sent it through marked urgent and Tricare denied the referral because she didn't have a documented pregnancy test in the billing codes. Another visit for in-office lab work and I got my referral, finally!" –Military Spouse*

**Sec. 701: TRICARE Select and Other TRICARE Reform** eliminates the specialty care preauthorization requirement for outpatient care. We welcome this attempt to streamline access to specialty care, but it is only a partial solution. As the preauthorization requirement is lifted, it will be important to educate families on the new policy so they understand that without preauthorization they face some risk that TRICARE may deny coverage for certain care and services. Since some of TRICARE's coverage policies are outside the civilian plan norm (e.g. denying coverage for many diagnostic genetic tests covered by commercial insurance and other government payers, "inpatient only" rules at odds with pediatric standards of care), families cannot count on their provider offices to know when a particular service is at risk of being denied.

The TRICARE T17 contracts include an electronic referral processing system. It is our understanding this system will make it feasible to transfer specialty referrals electronically from one geographic location to the next, even across TRICARE managed care support contractor regions. However, DHA seems reluctant to commit to utilizing this capability to streamline the transition of specialty care. Removing the requirement to get a new specialty care referral following a PCS, and allowing the existing referral to transfer electronically to the new duty station, would greatly help military families transition care in a timely fashion.

**PROBLEM: Areas with TRICARE Network Inadequacy**

In some locations, families complain of a shortage of network providers in the network and that many of those listed in TRICARE contractors' network lists are no longer accepting new TRICARE patients. We fear this problem will become worse as TRICARE reimbursement rates become less competitive relative to other payers.



We thank Congress for the multiple provisions that attempt to address this problem. The provisions focused on growing and improving the TRICARE network will also allow beneficiary care to shift from the direct to the purchased care component as DoD implements **Sec. 725: Adjustment of Medical Services, Personnel Authorized Strengths, and Infrastructure in MHS to Maintain Readiness and Core Competencies of Health Care Providers**. This provision directs DoD to “right-size” the MHS limiting MTF care, medical personnel end strengths and MHS infrastructure to only that required for critical wartime medical readiness skills and service member medical readiness. It also requires that beneficiaries affected by these measures have the ability to receive care through the purchased care networks.

- **Sec. 705: Value-Based Purchasing and Acquisition of Managed Care Support Contracts for the TRICARE Program** requires DHA to transfer contracting responsibility for MCSCs to the Office of the Under Secretary of Defense Acquisition, Technology & Logistics. We hope this provision will enable DoD to improve TRICARE contract accountability to enhance access and quality of care as well as the health care experience.
- Sec. 705 also requires DoD to develop value-based incentive programs. We appreciate this provision says DoD must maintain assurance that beneficiaries will have timely access to care and not incur any additional costs.
- We appreciate that **Sec. 706: Establishment of High Performance Military-Civilian Integrated Health Delivery Systems** seeks to improve access to high quality care via partnerships with civilian providers. We believe aspects of this model have been successfully employed at Fort Drum, NY, and look for implementation of this provision to take military-civilian medical partnerships to the next level for both beneficiary care and medical provider readiness training opportunities.

**PROBLEM: TRICARE Slow to Cover Emerging Technologies and Treatment Protocols**

Health care is in a period of rapid change and innovation. Since TRICARE coverage policies are governed by statute, they are difficult to update to cover new technologies. As a result, TRICARE beneficiary care lags that of civilians. Military families who receive care at MTFs have better access to health care innovations, since the rules governing MTFs are less stringent than TRICARE’s regulations for purchased care. Unfortunately, we don’t see any provisions in the FY17 NDAA that address this issue.

We appreciate Congress gave DoD the authority to cover emerging technologies in the FY15 NDAA. However, DoD seems reluctant to exert that authority. In the case of Lab Developed Tests (LDTs,) TRICARE’s demonstration project still covers only a fraction of tests covered under commercial plans, Medicare, and Medicaid. We have heard that dozens of military families have faced coverage denials for diagnostic genetic tests that are routinely reimbursed by other payers. As one physician familiar with TRICARE coverage said:

*“If DoD wants to insert themselves in the clinical decision making process, they must do it in a clinically relevant timeframe.”*

In other words, taking years to review and evaluate diagnostic genetic tests that have widespread acceptance, use, and reimbursement in the medical community and commercial insurance plans is unacceptable.

If Congress succeeds in the goal of right-sizing the direct care component and shifting significant beneficiary care to the TRICARE program, the prevalence of these reimbursement issues will grow dramatically. The next iteration of MHS Reform must address current TRICARE coverage gaps and create a process for the timely resolution of future coverage discrepancies.

**PROBLEM: TRICARE Customer Service Issues**

The contracting process leads to regular MCSC turnover. These changes rarely go smoothly and the result is customer service disruptions for military families. In some cases, where referral/authorization processing was disrupted, it has even affected access to care. TRICARE's T17 contracts move to two TRICARE Regions will result in a contractor change for approximately two-thirds of TRICARE beneficiaries. As mentioned before, we have significant concerns about a change of this magnitude being undertaken in conjunction with numerous MHS Reform initiatives.

Additionally, the process for resolving TRICARE problems is disjointed, ineffective, and unclear to military families. We hear from many resourceful military families facing legitimate TRICARE coverage and reimbursement problems – they simply do not know where to turn when the standard MCSC customer service resources fail to resolve their problem. DHA's answer is typically to refer us to the TRICARE Regional Office (TRO). This is not a resource that is readily available to beneficiaries – most have never even heard of a TRO – and it should not be the only resource for resolving complex TRICARE issues. Military families should not face experiences such as the following relayed to us by a military mom and former Navy nurse after her son's life altering injury:

*"I do think that the cumbersome beyond belief system that we are putting our service members and their families through at the worst time of their lives is within your scope of concern. As individuals, I believe that most of the people involved are kind hearted and sincerely doing their best. As a group, and there are at least two dozen people actively involved on my son's "team", it is a broken system. No one in charge or accountable, poor communication, control issues, lack of trust among the constituents, policies that defy common sense...we are completely beaten down. A Naval Academy grad, a retired admiral and a Navy nurse, and we are completely beaten down. Especially the fact that everyone involved says, "I'm sorry but this is the system." I love Navy medicine, but to have to fight every step of the way for what should be readily provided without red tape, delays, and difficulty has been the most disappointing experience of my life." – Military Mom and former Navy Nurse*

No FY17 NDAA provisions address issues with TRICARE customer service. In fact, the implementation of **Sec. 702** and the assumption by DHA of administrative responsibilities in the MTFs could confuse patients receiving MTF care about what entity has the responsibility to resolve their concerns.

TRICARE, the MTFs, and the managed care support contractors must develop a better process allowing beneficiaries to escalate issues if they cannot be resolved with the typical customer service resources. If the TRO is intended to serve this purpose, all beneficiaries and those who support them (e.g., case managers, patient advocates) should be well-versed in the TRO's function and how to contact the appropriate person at the TRO. If significant patient volume is

shifted from the direct to the purchased care component, customer service issues will become more prevalent making it even more important to institute a process for resolving problems and ensure adequate customer service resources from both the managed care support contractors and the TROs.

## **SPECIAL POPULATIONS TO ADDRESS WITH MHS REFORM**

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### **Reserve Component Families**

National Guard and Reserve families are poorly served with their current TRICARE options. When activated, their families become eligible for TRICARE, but coverage and network providers may not align with their civilian plans. This leads to confusion and disruptions in care as families switch to providers in the TRICARE network.

We thank you for **Sec. 748: Assessment of Transition to TRICARE Program by Families of Members of Reserve Components Called to Active Duty and Elimination of Certain Charges for Such Families** to study Reserve Component (RC) family member difficulties in transitioning health care to the TRICARE program during active duty orders.

We have long advocated for more flexibility in allowing RC families to retain their service member's employer sponsored plan when activated, perhaps by paying them a stipend to help cover premiums. We believe MHS Reform does not have to be a "one size fits all" solution. TRICARE coverage should be tailored to meet the unique needs of Reserve Component families.

### **Special Needs Military Families**

Caring for a special needs family member can be difficult and draining for any family. However, the impact for military families is magnified by the unique challenges associated with military service and TRICARE policy. We had hoped MHS Reform would ensure military special needs families are appropriately supported as they navigate multiple systems of care for their family members.

- **PCS:** A PCS will, by definition, disrupt the continuity of care that is so important in managing complex medical conditions. After every move, special needs families must begin a lengthy cycle of referrals, authorizations and waitlists resulting in repeated gaps in care.
- **ECHO:** State Medicaid programs provide assistance not covered by TRICARE: respite care, custodial care, and more flexible medical coverage. TRICARE's Extended Health Care Option (ECHO) was designed to provide coverage for non-medical services often covered by Medicaid, but not allowed under TRICARE. However, the Military Compensation and Retirement Modernization Commission (MCRMC) found ECHO benefits, as currently implemented, are not robust enough to replace state waiver programs.<sup>4</sup> DoD has assured us they are working on ECHO improvements. However, other than a policy update to cover incontinence supplies, there has been no tangible progress on this issue.
- **Case Management:** Families often run into roadblocks when establishing or re-establishing care for special needs family members. When this happens, they need effective case management services to help them navigate obstacles to obtain the needed care and

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<sup>4</sup> Final Report of the Military Compensation and Retirement Modernization Commission – January, 2015

services. Families who contact our Association have no idea where to turn when their existing case managers fail to resolve their problems.

Sec. 701's elimination of the preauthorization requirement for specialty care will streamline the process of transferring care during a PCS somewhat, but it is only a partial solution. T17 is supposed to include enhanced case management services. We look forward to learning more about those to see if they address military family concerns regarding case management.

Removing the requirement to get a new specialty care referral following a PCS, and allowing the existing referral to transfer electronically to the new duty station, would greatly help special needs military families transition care in a timely fashion.

We are encouraged by DHA's stated commitment to addressing ECHO shortfalls. However, if there is no change in respite care policy – a well-documented gap relative to state Medicaid waiver programs – within the next year, we believe the next round of MHS Reform must include a legislative fix to bring ECHO in line with the program's legislative intent.

### **Pediatric Population**

The MHS provides care for 2.4 million military kids, but because TRICARE reimbursement is based on Medicare, a program for senior adults, its policies are not always optimal for pediatric care.

**Concurrent Hospice Care:** Last summer, the TRICARE for Kids (TFK) Coalition, of which NMFA is a member, was contacted about two terminally ill military kids who could not access hospice because it would mean foregoing curative care per TRICARE hospice reimbursement policy. This is an outdated policy, based on Medicare requirements for senior adults. Acknowledging that the path of a child's illness is unpredictable and parents refuse to give up hope and therefore curative care, Medicaid and commercial plans will now cover hospice in addition to curative care for pediatric patients.

When Rep. Walter Jones (R-NC/3<sup>rd</sup>) contacted DHA about the issue, DHA responded it is a statutory issue and implied that military kids are not lacking palliative care due to other TRICARE services and supports in place. The TFK Coalition subsequently met with members of a children's hospital palliative care team who explained in detail how military kids are not getting the same level of care as children on Medicaid and commercial health insurance who have access to hospice services:

- The goal of palliative care, of which hospice is a part, is to improve the quality of life of patients with serious/terminal illnesses. What kids want more than anything is to be at home.
- While TRICARE does cover in home nursing care, it is provided by an LPN. This is not the same level of care that hospice provides - typically RN care.
- Without RN level care, the child is at higher risk for future ER visits and hospital readmissions. Example: A child is sent home from the hospital. After several days, the child is in intractable pain. If that child has hospice, the family can ask the hospice nurse to evaluate the child. The hospice nurse can communicate with the child's medical provider and adjustments can be made to the pain control plan. Without hospice, the family only has

LPN care. An LPN does not have this same level of authority so the family's only option for their child in intractable pain is an ER visit and likely readmission.

- According to the children's hospital representatives, they no longer even bring up the option of hospice care to military families (even though this is what they would normally recommend) because they know TRICARE will not cover it – this is probably why we aren't hearing directly from more families.
- The palliative care team also mentioned the hardships military families face when their terminally ill child is hospitalized. This team noted that our families typically don't have extended family or an established support system nearby to help out with other children and may be dealing with the service member's absence. Thus, military families are even more in need of hospice services to allow their child to remain at home than are typical families with a terminally ill child.

We have discussed the Concurrent Hospice issue with DHA leadership. Their response 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), as well as establishing a demonstration project to allow TRICARE to cover concurrent hospice for pediatric patients. Unfortunately, it will take about a year to get a demonstration up and running. We don't believe this is an adequate response. Military families with terminally ill children deserve access to the current standards of pediatric care, including concurrent hospice services.

**Medical Necessity:** TRICARE's adult-based definition of medical necessity prevents some kids from getting 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.”<sup>5</sup> 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.”<sup>6</sup> 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.

**Habilitative Care:** Habilitation services are available only for active duty family members through the ECHO program and are subject to an annual dollar limit of \$36,000. This differs from the ACA which recognizes habilitative services and devices as an essential health benefit without lifetime or annual dollar caps on care. Habilitative services, provided for a person to attain or maintain a skill for daily living, are uniquely necessary for children due to their stages of growth and development. Habilitative services should be covered as a basic health benefit as medically necessary just as rehabilitation services are covered.

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<sup>5</sup> DoD Report to Congressional Defense Committees: Study on Health Care and Related Support for Children of Members of the Armed Forces - July, 2014

<sup>6</sup> DoD Report to Congressional Defense Committees: Study on Health Care and Related Support for Children of Members of the Armed Forces - July, 2014

**Medical Nutrition:** TRICARE's current definition of medical nutrition is too narrow and counseling and management are only covered as part of diabetic care. TRICARE is not keeping pace with current best practices nationally for specialized pediatric care.

We are grateful for **Sec. 713: Coverage of Medically Necessary Food and Vitamins for Certain Conditions Under the TRICARE Program** that addresses the Medical Nutrition problem outlined above by authorizing TRICARE to cover medically necessary food, vitamins and related supplies.

Although not part of Congress' MHS Reform, we would also like to express our appreciation for a recent DHA policy update that brings TRICARE's well child care in line with the American Academy of Pediatrics Bright Futures guidelines.

### **TRICARE Behavioral Health Changes Need Faster Implementation**

Sixteen years of war have left families with behavioral health problems and reintegration challenges that may last for many years. It is a moral imperative to provide service members and their families with the help they need after years of enduring repeated combat deployments. While we appreciate the comprehensive revisions to TRICARE mental health coverage outlined in the final rule issued on September 2, 2016, the lack of timely policy implementation speaks to our concerns about DoD's capacity to parallel process multiple major changes as part of T17 and MHS Reform. Although the TRICARE final rule on revised mental health regulations was "effective" October 3, 2016:

- The new regulations require between 90 and 100 changes to TRICARE policy and reimbursement manuals, which the Defense Health Agency projected would be completed by the end of 2016.
- The only TRICARE manual changes that DHA has released to date are related to eliminating the quantitative treatment limitations (day and dollar limits, copayments).
- The current managed care support contractors do not have any policy guidance to implement the new treatment services or to streamline the authorization of current institutional providers.
- Currently participating providers are operating under the outdated standards.
- New providers who would like to participate cannot, until DHA issues new policy guidance and the managed care support contractors put their implementation processes in place.

The managed care support contractors are ramping up for the consolidation to two regions and transition to T17 contracts; incorporating the new behavioral health elements does not appear to be in their work plans at the moment.

### **PERSPECTIVES ON HEALTH CARE AND READINESS**

Affordable and timely access to health care is important to all families, but it is vital for military families. Repeated deployments; caring for the wounded, ill, and injured; the stress and uncertainty of military life; and the need to maintain family readiness demand quality and readily available health care. Families need a robust and reliable health care benefit in order to focus on managing the many challenges associated with military life versus worrying about how they are going to access and pay for essential health care. We appreciate your dedication

to improving health care for our military families and stand by to help with future reform efforts.

## **COMMISSARY**

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Military families consistently tell us the commissary is one of their most valued benefits. We view the commissary as an important element of military compensation and thank Congress for fully funding it in the FY17 NDAA. However, we are concerned about changes to commissary operations that the Defense Commissary Agency (DeCA) is implementing pursuant to provisions included in last year's Defense authorization. Specifically, DeCA is abandoning the previous "cost plus five percent" pricing model and replacing it with variable pricing, in which prices would fluctuate based on local competitors' prices. DeCA has also announced plans to introduce private label products.

Taken together, these changes represent a significant departure from DeCA's traditional business model. We are not convinced that DeCA officials have the expertise to manage these new systems. In addition, while we acknowledge that private label products might be popular with customers, we wonder how including them in the product mix will generate enough revenue to reduce the need for appropriated funds, as DeCA claims. If the changes do not generate the needed revenue – or if customers respond by shopping elsewhere – how will DeCA make up the shortfall?

It is worth noting that DeCA has embarked on this transformation with little to no input from the military families it serves. We have suggested that DeCA reinstitute the Patron Advisory Council, which would ensure greater transparency and accountability to commissary customers. Military families rightly expect the commissary to offer high quality products and shopping experience in addition to good value. That focus on the customer must not be lost as DeCA undergoes changes in its operations.

It is also important to remember that the Exchange retail stores are highly dependent on foot traffic from nearby commissaries. Any threat to the health of the commissary is a risk to the military resale system as a whole. This is particularly concerning as Services reduce funds for installation Morale, Welfare, and Recreation (MWR) programs. These programs are increasingly dependent on the Exchanges for funding. If Exchange sales revenues decrease, funding for MWR programs will go down as well.

We are gratified that both Congress and DoD have recognized the importance of commissary savings to military families and have expressed their commitment to preserving the value of the benefit. However, we are concerned about what will happen if the changes do not generate the expected revenue.

Given the importance of the commissary benefit, ***we ask for close Congressional monitoring as DeCA embarks on this transformation.***

## **MILITARY RETIREMENT SYSTEM**

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Service members with fewer than 12 years of military service are faced this year with an important decision – whether to opt in to the "blended" retirement system created in the FY16

NDAA or remain in the current system. This choice has significant long-term financial ramifications for service members and their families. It is vital to ensure these young service members – and their spouses – are given the tools and resources they need to make the decision that is in their financial best interest.

We are pleased DoD has recognized this responsibility and is taking steps to ensure that service members are informed about the new retirement system. They have recently launched an online course that will educate service members about the new plan and their options. We are especially glad the Department recognizes that the choice of retirement plan must be a family decision and is making the online course available to spouses as well.

However, while these initial steps are encouraging, more needs to be done to ensure service members and spouses are fully educated about their retirement choices and the benefits and drawbacks of each choice. First, the Department must do more to raise awareness of the new retirement system, especially among military spouses. While we are pleased the online training will be available to spouses, it is currently housed on a site few spouses have cause to visit. We would like to see better utilization of Military OneSource to raise awareness of the new retirement system and the training available to families. In addition, in our view, online training is not sufficient. Better family access is needed to the financial education provided by Military Family Life Counselors and unit Personal Financial Managers. Service members and families should receive in-person training and guidance to answer their questions and ensure they make the best choice for their long-term financial well-being.

We appreciate the new military retirement system will allow more service members to accumulate retirement savings while preserving the defined benefit for those who serve a full career. However, we ask Congress to consider amending the plan to increase its value for service members. Specifically, we ask Congress to increase the maximum level of matched contributions to service members' Thrift Savings Plan (TSP) accounts to 5 percent—the level recommended by the Military Compensation and Retirement Modernization Commission (MCRMC). Because the match is based on service members' basic pay, rather than total compensation, service members should have the option of a higher match in order to maximize their retirement savings. We also ask Congress to extend the government match for the full career of the service member, rather than ending it at 26 years of service.

Finally, we note that the adoption of the new retirement plan is likely to affect the Survivor Benefit Plan (SBP). Will future retirees elect to pay into SBP if they have TSP accounts to leave their survivors? What would a lower participation rate mean for the overall health of the SBP? These are important questions that need to be studied. We ask Congress to direct DoD to study the potential impact the blended retirement system will have on the Survivor Benefit Plan.

***We ask Congress to increase the maximum level of matched contributions to service members' TSP accounts to 5 percent—the level recommended by the Military Compensation and Retirement Modernization Commission (MCRMC).***

***We ask Congress to extend the government match for the full career of the service member, rather than ending it at 26 years of service.***



***We ask Congress to direct DoD to study the prospective impact the blended retirement system will have on the Survivor Benefit Plan.***

#### **CUMULATIVE EFFECTS OF CUTS THREATEN MILITARY FAMILIES' FINANCIAL READINESS**

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Recent years have seen military pay raises below the ECI and caps to service member housing allowances. Looking ahead, service members face increased health care costs and the need to contribute to their retirement savings. Taken together, these changes represent reduced purchasing power for service members and their families. We ask you to consider the cumulative effects of these policies on military families' financial well-being and reject any proposals that ask families to shoulder a greater financial burden.

***We ask Congress to reject budget proposals that threaten military family financial well-being as a way to achieve savings for DoD.***

#### **SEQUESTRATION: AN ONGOING THREAT TO FAMILY READINESS**

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The effects of sequestration have already resulted in cuts to benefits and programs military families utilize to maintain their readiness. Much of the funding for these programs is embedded in the Service Operations and Maintenance Accounts, which have been the hardest-hit by sequestration. Understanding what is affected by sequestration has been confusing for families.

The total effect of sequestration on military families is unclear. What is clear is that military families do not deserve having to deal with such uncertainty – uncertainty of the availability of programs they rely on, uncertainty of whether their service member will receive the training they need to do their job safely, the uncertainty of not knowing what new cost they will be asked to absorb from their own pockets.

While the Bipartisan Budget Act of 2015 provided some relief for FY16 and FY17, we know with future cuts required down the road, military families will continue to see threats to the programs and resources they require for readiness.

***We ask Congress to end sequestration and end the threat to the resources military families depend on for their readiness.***

#### **WHAT DO TODAY'S MILITARY FAMILIES NEED TO ENSURE READINESS?**

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It has often been said while the military recruits a service member, it must retain a family. Our Association has long argued in order to build and maintain the quality force our Nation demands, the military must support service members as they balance the competing demands of military service and family life. We were gratified to see significant family-focused proposals in recent years. We urge Congress to continue to strengthen the programs and services available to support all troops and families in diminishing uncertainty and meeting the daily challenges of military life.

One of the greatest challenges facing military families is instability caused by frequent military-ordered moves. The effect of these frequent relocations is most clearly visible when considering the issue of military spouse employment. Like their civilian counterparts, military families typically rely on two incomes to help make ends meet. However, despite the fact that most military spouses both need to and want to work outside the home, the unemployment rate these spouses is nearly 23 percent<sup>7</sup> - more than triple the national average. Much of this is due to constant relocations, which force military spouses to leave their jobs and start over in their new locations.

Military children are also affected by military-ordered moves. While most Permanent Change of Station (PCS) moves occur during the summer months, not all do. It is not uncommon for children to be pulled out of school midway through the year and dropped into a new environment.

Military families tell us they need more flexibility in order to minimize the upheaval associated with moving. Yet, budget issues may reduce flexibility for families facing a military-ordered move. On February 8, the Navy announced Sailors and families should expect a compressed household goods move schedule due to the constraints caused by the ongoing Continuing Resolution.<sup>8</sup> The military must evolve to meet the needs of today's military families, but it needs a predictable budget and appropriation to do so.

***We ask Congress to provide military families with greater flexibility in timing their relocation either before or after a service member's permanent change of station (PCS) report date.***

## **CHILD CARE**

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Military families frequently cite the lack of high quality, affordable child care as among the most significant challenges they face. In part, this reflects a national shortage of affordable child care options. However, the need for child care is especially pressing for the military community, which is disproportionately composed of young families. According to the *2015 Demographics Profile of the Military Community*, more than 40 percent of military personnel have children. Of the nearly 1.8 million military-connected children, the largest cohort – 37.5 percent – is under age five.<sup>9</sup>

Like all working parents, service members with young children need access to affordable child care in order to do their jobs. However, the military lifestyle comes with unique challenges and complications for families. Service members rarely live near extended family who might be able to assist with child care. Their jobs frequently demand long hours, including duty overnight. They are often stationed in communities where child care is expensive or

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<sup>7</sup> 2015 Demographics Report Profile of the Military Community,

<http://download.militaryonesource.mil/12038/MOS/Reports/2015-Demographics-Report.pdf>

<sup>8</sup> "Household Goods Move Timelines Compressed Due to FYCR", February 9, 2017,

[http://www.navy.mil/submit/display.asp?story\\_id=98793](http://www.navy.mil/submit/display.asp?story_id=98793).

<sup>9</sup> 2015 Demographics Profile of the Military Community,

<http://download.militaryonesource.mil/12038/MOS/Reports/2015-Demographics-Report.pdf>

unavailable. Service members frequently deploy or travel for training or other assignments, putting strain on at-home parents.

We are gratified DoD has recognized the need for child care among military families and has made it a priority, to include exempting child care staffing from the recently-announced federal hiring freeze. They are to be commended for the high quality of many of their facilities and the standards they set for professional development and training of their staff. We were also pleased to see child care provisions such as expanded hours for installation child development centers (CDCs) included by DoD in last year's Force of the Future initiatives. However, while expanded CDC hours will address the needs of some military families, we urge Congress and the Department to consider additional steps in order to meet the needs of military families with young children.

***Ensure installation CDCs are adequately staffed:*** For families living on or near a military installation, on-base CDCs are often the preferred choice for child care, offering a convenient location and high quality care at an affordable price. However, in some locations demand for spots at installation CDCs far outstrips supply. In many places the waiting list is so long the CDC is effectively not an option for military families. In some locations, the issue is lack of physical capacity. However, in many locations the reason for the insufficient supply of on-base care is not a lack of space; it is a lack of staff. The process of hiring CDC personnel is lengthy and arduous. It can be difficult for CDC directors to find, hire, and put into place qualified staff. This limits the number of children a facility can serve. DoD should analyze whether and how the hiring process can be streamlined while still ensuring that necessary background checks and training take place to ensure children's safety. We also urge Congress to ensure child care workers remain exempt from hiring freezes. Budget cuts should not prevent CDC directors from staffing their facilities appropriately.

***Increase availability of part-time and hourly care:*** We hear from many military families frustrated by the lack of hourly or drop-in care at installation CDCs. Many military families – especially those overseas or in remote locations – do not have easy access to reliable caregivers. For those families, access to drop-in care at an installation child care facility can greatly enhance their quality of life, enabling parents to go to medical appointments, run errands, and volunteer in their communities. This service can be especially vital when a service member is deployed, providing the at-home parent with a much needed break. Increasing the number of hourly slots would also help address a common conundrum faced by military spouses after a PCS move: they can't look for work without child care, but thanks to DoD priority guidelines, they aren't eligible for child care if they're not working. DoD should evaluate the programs at installation CDCs to ensure the mix of care offered – full time, part-time and hourly – meets the needs of the families they serve.

***Increase participation in the child care fee assistance program:*** The fee assistance program operated by the services is an innovative, effective approach to the problem of insufficient child care availability on base. The program helps offset the cost of child care in the civilian community, ensuring participating families can access high quality care at an affordable cost. Unfortunately, relatively few families take advantage of this benefit. Expanding participation in the child care fee assistance program would address many families' child care needs. We recommend the following steps:

- **Increase the number of eligible providers:** DoD has stringent requirements for child care providers participating in the fee assistance program, to include national certification, regular inspections, and background checks. However, many states have less stringent requirements for providers. In those locations, families often have difficulty locating a provider who meets DoD's eligibility requirements. The Office of Military Community and Family Policy and the Defense State Liaison Office (DSLO) have worked together to encourage states to increase their standards to meet DoD's and have had a great deal of success in this regard. We encourage them to continue with this effort.
- **Standardize Service requirements:** Because the fee assistance programs are operated by the individual Services, there are variations in eligibility requirements for providers and families. Some Services require families live a certain distance from an installation in order to participate in the program; others have no geographic restrictions. The Marine Corps requires providers to have a specific national certification that is not required by the other Services. These differences lead to confusion and frustration among families. We ask you to direct DoD to review Services' fee assistance programs with the goal of standardizing eligibility requirements.
- **Raise awareness of the program among military families:** We consistently encounter families who have no idea the fee assistance program exists. From our experience, it would seem most families learn about the program through word of mouth from other military families. If families are not aware of the fee assistance program and cannot obtain care on base, they may be forced to seek out less than optimal caregivers who provide care at a lower cost. DoD must ensure the Services are providing information about the fee assistance program to eligible families to ensure military children are receiving quality care.

## **MILITARY CHILDREN'S EDUCATION**

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The vast majority of military-connected students attend local public schools in their civilian communities. Districts serving large numbers of military children rely on funding from the Department of Education and the Department of Defense to help offset the additional expenses they incur. It is incumbent on DoD and the federal government to ensure that schools charged with serving military-connected children have the support they need to provide the best possible education. Military families often have no control over when and where they move. They worry about the effect multiple moves will have on their children's academic achievement. They deserve the assurance that their children will receive a high quality education wherever they happen to be stationed. ***We urge Congress to continue funding programs designed to support the education of military-connected children.***

### **Impact Aid**

We are grateful to Congress for authorizing \$30 million for DoD Impact Aid and \$5 million in Impact Aid for schools serving military children with special needs in the FY17 NDAA. ***We ask Congress to increase this funding to offset the costs incurred by districts educating large numbers of military children.*** These funds help local school districts meet the education needs of military children in an era of declining state budgets. Both DoD and Department of Education Impact Aid funding are critical to ensuring school districts can provide quality education for military children.

### **Department of Defense Education Activity Grant Program**

The *John Warner National Defense Authorization Act* for Fiscal Year 2007 established a grant program, administered by the Department of Defense Education Activity (DoDEA), to support public schools educating large numbers of military children. This innovative program allows DoD to offer tangible support to public schools charged with educating military-connected students. Schools and school districts are able to identify areas of need among the military children they serve and design programs to meet those needs. The grants have been used to bring Advanced Placement (AP) courses to high schools that would otherwise not be able to provide this level of instruction. Other grants have been used to fund special education, foreign language instruction, and programs to enhance students' proficiency in reading, science, and math.

Since 2009 this program has awarded \$433 million in grants. These three-year projects have supported over 530,000 military-connected students in more than 2,300 schools<sup>10</sup>. We thank Congress for extending the grant program for a year in the 2017 NDAA. However, this valuable program will sunset at the end of this fiscal year absent Congressional action. It would be regrettable if military children lose access to the valuable educational programs that have been made possible through the DoDEA grant program. A relatively small investment can make a huge impact at the local level. ***We ask Congress to reauthorize the DoDEA grant program*** and allow DoD to continue supporting military-connected children in public schools.

### **SPOUSE EMPLOYMENT AND EDUCATION SUPPORT**

Spouse employment and education support is a critical component of military family readiness. Much like their civilian counterparts, many military families rely on two incomes in order to help make ends meet. However, military spouses face barriers hindering their educational pursuits and career progression due in large part to challenges associated with the military lifestyle.

We are gratified in recent years Congress, DoD, the White House, and States have all taken steps to lessen the burden of an active duty member's military career on military spouses' educational and career ambitions. We fully support these initiatives, including DoD's portfolio of Spouse Education and Career Opportunities (SECO), which provides educational funding for select military spouses, career counseling, employment support, and the DoD State Liaison Office's (DSLO) state-level initiatives. However, while progress has been made, military spouses continue to face significantly lower earnings and higher levels of unemployment and underemployment than their civilian counterparts, greatly impacting their families' financial stability.<sup>11</sup>

### **Grow Our Own**

One of our top legislative priorities is to ensure adequate access to behavioral health providers who are attuned to the unique stressors of military life for service members and their families who have endured years of repeated deployments, long separations, and possible injuries or

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<sup>10</sup> Source: <http://www.dodea.edu/Partnership/grants.cfm>

<sup>11</sup> Institute for Veterans and Military Families, *Military Spouse Employment Report*, Syracuse University (IVMF) February 2014: [http://vets.syr.edu/wp-content/uploads/2014/02/MilitarySpouseEmploymentReport\\_2013.pdf](http://vets.syr.edu/wp-content/uploads/2014/02/MilitarySpouseEmploymentReport_2013.pdf)

illnesses. We support efforts to educate and employ military spouses as mental health professionals.

As military families struggle to cope with the effects of 16 years of war, we are seeing an increasing demand for mental health services within our families and community. Since 2004, NMFA's military spouse scholarship and professional funds program has had almost 90,000 applicants. Data from this year's approximately 9,000 scholarship applicants, as well as from active duty spouse respondents to the 2015 health care survey done by the Military Officers Association of America (MOAA), indicate increased rates of behavioral health usage among military families. Both surveys show between 40-50 percent of military spouses have sought behavioral health care for someone in their family.

Unfortunately, access to top-notch care is limited. The shortage of mental health professionals nationally is mirrored in the military community; it is even greater at military installations in remote areas. We believe our Nation has an obligation to prevent, diagnose, and treat the mental health needs of service members and their families. Doing so in the face of a nationwide shortage of mental health professionals will require innovative solutions and strategic public-private partnerships including Congress, DoD, the VA, and other organizations. We believe military spouses may also be a source of help for their community.

Each year we've offered military spouse scholarships, the number of spouses pursuing mental health careers has increased. Our 2017 applicant pool had more than 500 spouses planning to pursue careers in mental health fields. Twenty-two percent of these mental health profession applicants are spouses of wounded or fallen service members.

Many of our military spouses pursuing careers in mental health fields intend to serve military families. Helping these spouses overcome obstacles and pursue their careers has the dual benefit of assisting the individual spouse and family while addressing the shortage of mental health providers in the military community. However, these spouses face obstacles due to the unique challenges of the military lifestyle. In a February 2016 Facebook post a Marine Corps spouse shared an experience all too common for military spouse mental health professionals:

*"I'm looking for fellow military spouses who have completed the practicum and internship process for clinical mental health counseling or who have earned their LPC or LPCC by following California, Arizona, or North Carolina state requirements. We are currently stationed at Camp Pendleton, CA and I will start my practicum this June. **I have excelled in my graduate program and now I am facing major challenges finding a facility that doesn't require a year sign-on and who has openings for new interns starting this summer. One specific problem I'm facing is we aren't sure when new orders will come or where they will be (making it additionally hard to convince licensed supervisors to take a new intern on if I will only be there for a couple months).** Is there anyone who can share a professional contact with me?"*

We offer the following recommendations for Congress to consider:

- Include military spouses and others who enter the mental health profession in federal loan-forgiveness programs;

- Facilitate easier paths to both licensure and employment for military spouses and veterans in the mental health field when they work with our service members and families;
- Provide a tax credit for spouses' re-licensing after a military move to offset the out-of-pocket cost of the additional license;
- Pass legislation to allow military spouses full reciprocity when transferring an active unrestricted mental or behavioral health license from one state to another due to PCS;
- Support partnerships between the Military Health System and the VA to ease spouse difficulties in obtaining clinical supervision hours, reduce licensing barriers, and spur employment of military spouses and veterans in the mental health field.

***We ask Congress to increase access to behavioral health providers by supporting employment efforts of military spouses in the mental health profession.***

***We ask Congress to provide a tax credit for spouses' re-licensing after a military move to offset the out-of-pocket cost of the additional license.***

### **EXCEPTIONAL FAMILY MEMBER PROGRAMS**

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Military families with special needs family members are supported through the Services' Exceptional Family Member Programs (EFMP). The primary mission of the EFMP is assignment coordination, to ensure that special needs families are sent to locations that can meet their medical and educational requirements. However, the EFMP also includes a family support component. While we are grateful that DoD recognizes the importance of supporting special needs families, we hear often from families who tell us that EFMP family support programs are falling short. This is especially true when it comes to respite care.

Families with special needs children have unique child care needs. For those families, dropping a child off at a day care center or with a sitter may not be an option. Instead, parents of special needs children need respite care provided by trained caregivers. Access to quality respite care allows families to run errands, spend time with other children, and simply recharge.

Recognizing the importance of respite care, especially for military families far from the support of friends or extended family, the Services have provided respite care for military families with eligible special needs family members as part of the EFMP family support function. However, because the respite care programs are operated and funded by each of the individual Services, eligibility requirements and the number of respite care hours available to families vary. This is a significant source of frustration to families assigned to joint bases or installations managed by other Services. We are also concerned the current fiscal environment may lead the Services to reduce the level of respite care they offer.

### **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. We appreciate the MCRMC recognized this problem faced by our families with special needs. Most civilian families in this situation ultimately receive some form of public assistance, typically through state Medicaid waivers. State Medicaid programs provide assistance not covered by TRICARE: respite care, employment support,

housing, supplies, and more flexible medical coverage. 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 a military family who must relocate every two to three years. A military family who places their special needs child on a Medicaid waiver waiting list must start again at the bottom of the waiting list when they move to a new state. The Defense State Liaison Office (DSLLO) has recognized military families' inability to access care through Medicaid waivers as one of its high priority issues and is working with state legislatures to address this problem. However, little progress has been made in resolving this disparity.

TRICARE's Extended Care Health Option (ECHO) program was designed in part to address this imbalance, by allowing families to access non-medical services not covered under TRICARE. According to TRICARE's website, benefits covered under ECHO include "training, rehabilitation, special education, assistive technology devices, institutional care in private nonprofit, public and State institutions/facilities and, if appropriate, transportation to and from such institutions/facilities, home health care and respite care for the primary caregiver of the ECHO-registered beneficiary." However, in practice military families find it difficult to obtain services through the program.

This reality was reflected in TRICARE's May 30, 2013 report, *The Department of Defense Report to Congress on Participation in the Extended Care Health Option (ECHO)*, detailing military families' usage of the ECHO benefit. They reported, in 2012, 99 percent of funds expended through the ECHO program were spent on Applied Behavioral Analysis (ABA) therapy and ECHO Home Health Care (EHHC). Although these services are important and popular with special needs families, it is impossible to see this statistic and not wonder why families are not accessing the long list of other services ostensibly available to them under ECHO.

The MCRMC also found ECHO benefits, as currently implemented, are not robust enough to replace state waiver programs.<sup>12</sup> DoD has assured our Association they are working on ECHO improvements. However, other than a policy update to cover incontinence supplies, we have heard no specifics. **Given the importance of ECHO to special needs families, DoD must examine how to bring the ECHO benefit on par with state Medicaid waiver benefits.**

As stated previously, one service much in demand by families is respite care. Respite care is ostensibly available through the ECHO program, but TRICARE policies limit its utility. ECHO sets strict requirements for respite care providers, making it difficult for families to identify eligible providers.

Congress has given DoD much more discretion in its coverage of ECHO benefits than it has concerning medical benefits provided under the Basic Program. Thus, TRICARE has the authority to make changes that would enhance the ECHO program's utility to military families. Aligning ECHO coverage with that of state Medicaid programs, as the MCRMC recommends, would do much to enhance special needs military families' readiness and quality of life.

***TRICARE should enhance the ECHO program's utility to military families by ensuring it covers the products and services families need.***

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<sup>12</sup> Final Report of the Military Compensation and Retirement Modernization Commission – January, 2015



The transition out of the military and into civilian life is difficult for many families but especially so for special needs families, who immediately lose access to ECHO benefits. Families may still face long waits before being eligible for care through Medicaid, which leads either to gaps in treatment or financial hardship for a family trying to pay for needed care. To ease the hardship for families in this situation, we recommend ECHO eligibility be extended for one year following separation to provide more time for families to obtain services in their communities or through employer-sponsored insurance.

***We ask Congress to extend eligibility for the Extended Care Health Option (ECHO) for one year following separation to provide more time for families to obtain services in their communities or through employer-sponsored insurance.***

### **MILITARY FAMILIES IN CRISIS**

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Our country is still at war and military families continue to live extraordinarily challenging lives. Reintegration continues to pose challenges for some. Others are anxious about their financial futures. Most military families are resilient and will successfully address whatever challenges come their way. However, some will need help. It is critical military families trust DoD services and programs and feel comfortable turning to them in times of need. These programs and services must be staffed and resourced adequately so when families reach out for help, they can trust it is available. Military families must be assured our Nation will support them in times of family or personal crisis.

#### **Suicide**

In 2014, the Defense Suicide Prevention Office (DSPO) released a report outlining an approach for tracking military family member suicides. The report, *Suicide and Military Families: A Report on the Feasibility of Tracking Deaths by Suicide among Military Family Members*, was requested by the Senate and House Armed Services Committees.

We appreciate Congress including a provision directing DoD to track military family suicides as well as Reserve Component suicides in the FY15 NDAA, but are frustrated by DoD's delays in developing a plan to meet this mandate. If we don't have solid information on the extent of the issue, targeting solutions becomes more difficult.

#### **Preventing Child Abuse and Neglect, and Domestic Violence**

Research commissioned by our Association<sup>13</sup> and others during the past decade documents the toll of multiple deployments on children and families, the difficulties many families face on the service member's return, and the added strain a service member's physical and invisible wounds can place on a family. These stressors put military families at risk for marital/relationship problems and compromised parenting that must be addressed with preventative programs.

Current research validates families will experience the effects of war long after deployments end. A recent study highlighted parenting challenges fathers face following deployment. The study found that while deployment is a time of great stress for families, the need for support

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<sup>13</sup> Anita Chandra, et al., RAND Center for Military Health Policy Research, Views from the Homefront: The Experiences of Youth and Spouses from Military Families, 2011

and a strong community continues during the extended period of reintegration after the service member returns. This need is particularly pronounced when the returning service member is father to a young child, and he faces the core challenge of reconnecting with a child who has undergone significant developmental changes while he was away.<sup>14</sup> A 2013 research brief issued by Child Trends, *Home Front Alert: The Risks Facing Young Children in Military Families*,<sup>15</sup> concluded many children negatively impacted by a parent's repeated combat deployments will continue to have exceptional needs as they grow older.

Those looking for budget cuts may find it tempting to slash family support, family advocacy, and reintegration programs. However, bringing the troops home from war zones does not end our military's mission, family separations, or the necessity to support military families. "Rotations" and "training exercises" of units to Europe and elsewhere must be accompanied by the same high levels of family support as if service members were heading on a combat deployment. To family members, especially young children, "gone is gone".

Recent media coverage indicates the incidence of child abuse and neglect among Army families has increased. We are concerned the extraordinary stress military families face could lead to increased domestic violence as well. Preventative programs focused on effective parenting and rebuilding adult relationships are essential. The government should ensure military families have the tools to remain ready and to support the readiness of their service members.

We are encouraged the Family Advocacy Program, a Congressionally mandated DoD program designed to prevent and respond to child abuse/neglect and domestic abuse in military families, has redoubled its focus on prevention programs. Their efforts to repair relationships and strengthen family function will be essential. Programs like New Parent Support focus on helping young parents build strong parenting skills early on.

***We encourage Congress and the Department of Defense to ensure that Family Advocacy programs are funded and resourced appropriately to help families heal and aid in the prevention of child and domestic abuse.***

## **SUPPORT FOR TRANSITIONING FAMILIES**

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Transitioning out of the military affects the whole family. In addition to the transition assistance program available to service members, resources relevant to family members need to be identified. Issues such as how to find community resources to replace DoD programs and the military spouse's role in the long-term care of the family as a whole aren't addressed in the transition classes.

In May 2014, our Association conducted a survey of military spouses facing transition. Over half the spouses indicated they were extremely or very concerned about relocation and finding employment. Over three quarters of the spouses were extremely/very concerned about being financially prepared and finding employment for their service member. Access to the

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<sup>14</sup> Tova B. Walsh, et al., "Fathering after Military Deployment: Parenting Challenges and Goals of Fathers of Young Children," *Health & Social Work: A Journal of the National Association of Social Workers*, February, 2014

<sup>15</sup> "Home Front Alert: The Risks Facing Young Children in Military Families", Child Trends, July 22, 2013

counseling and other services provided by Military OneSource, beyond the 180 days currently provided, would make available resources and information to ease some of the concerns of our transitioning military families.

***Expand the opportunity for spouses to access transition information including face-to-face training and on-line training.***

***Expand family access to Military OneSource to one year from a service member's separation from the military.***

### **TODAY'S SURVIVING SPOUSES NEED THE DIC OFFSET ELIMINATED**

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Our Association has long believed the benefit change that would provide the most significant long-term advantage to the financial security of all surviving families would be to end the Dependency and Indemnity Compensation (DIC) offset to the Survivor Benefit Plan (SBP). Although we know there is a significant price tag associated with this change, ending this offset would correct an inequity that has existed for many years. Each payment serves a different purpose. The DIC is a special indemnity (compensation or insurance) payment paid by the VA to the survivor when the service member's service causes his or her death. The SBP annuity, paid by the Department of Defense (DoD), reflects the military member's length of service. It is ordinarily calculated at 55 percent of retired pay. Military retirees who elect SBP pay a portion of their retired pay to ensure their family has a guaranteed income should the retiree die. If that retiree dies due to a service-connected disability, their survivor becomes eligible for DIC.

***We ask the DIC offset to SBP be eliminated to recognize the length of commitment and service of the career service member and spouse.***

#### **Special Survivor Indemnity Allowance**

In the FY08 NDAA, the Military Personnel Subcommittee established the Special Survivor Indemnity Allowance (SSIA) as a first step in a longer-term effort to phase out the DIC offset to SBP.

That initial legislation authorized the SSIA for all survivors affected by the SBP-DIC offset in the amount of \$50 per month for FY2009, with the amount increasing by \$10 monthly for each of the next five years, reaching \$100 per month for FY2014-2016, not to exceed the amount of SBP subject to the offset. The authority to pay the SSIA, under this initial provision, was to expire on March 1, 2016.

In 2009, SSIA payments were extended through the end of FY2017, and the monthly SSIA amounts were increased:

FY2014: \$150

FY2015: \$200

FY2016: \$275

FY2017: \$310, with payment authority expiring as of Sept. 30, 2017.

**As of FY2017, phased SSIA increases will have eliminated roughly 25 percent of the SBP-DIC penalty.**

We appreciate the 18-month extension Congress provided in the FY17 NDAA, but SSIA must be made permanent so SBP-DIC widows will not see an interruption or elimination of the then-\$310 payment.

***Make SSIA permanent so the modest progress in eliminating the DIC offset to SBP will not be lost.***

### **CAREGIVER AND WOUNDED SERVICE MEMBER SUPPORT**

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Service members and their families must be assured our nation will provide unwavering support to the wounded, ill, and injured. This support must extend beyond the recovering warrior's medical and vocational rehabilitation. It must also include programs and services that help military caregivers, typically spouses or parents, successfully navigate their new role.

#### **Medicare Eligible Wounded Warriors & TRICARE Coverage**

Medically retired wounded warriors who receive Social Security Disability Insurance (SSDI) benefits become eligible for Medicare Part A after 24 months on SSDI. At that point, the wounded warrior must enroll in Medicare Part B in order to keep TRICARE coverage. After the wounded veteran enrolls in Medicare Part B, their TRICARE coverage converts to TRICARE for Life (TFL). This poses a variety of problems for the severely wounded population:

- In the worst case scenario, the wounded warrior or his/her caregiver does not realize or is not appropriately informed they must enroll in Medicare Part B (and pay Part B premiums) in order to avoid losing their TRICARE coverage.
- In other instances, the wounded warrior or caregiver understands and enrolls in Medicare Part B and retains TFL. Although medical coverage is retained, the severely wounded veteran is now paying more for medical coverage than most other working-age TRICARE retirees.
- Finally, some severely wounded veterans receive SSDI for over 24 months and are forced onto Medicare/TFL. Eventually, the wounded veteran returns to work, but they are required to stay on Medicare Part B for eight years after returning to work. This results in over \$10,000 in Medicare Part B costs to the severely wounded warrior who returns to work.

This is an extremely complex issue facing the most severely wounded service members and their caregivers. These families face emotionally challenging lives and overwhelming responsibilities. Making a mistake about enrollment in Medicare Part B should not result in the life altering consequence of losing health care coverage. Furthermore, our most severely wounded warriors should not be forced to pay more for their health care than others.

This complex problem crosses many jurisdictions including the Centers for Medicare and Medicaid Services, DoD, the Social Security Administration, the Senate Finance Committee, the House Ways and Means Committee, the HASC and the SASC. Given this problem impacts our most severely wounded veterans and their families, we urge the House and Senate Armed Services Committees to take the lead in creating a solution to this complex issue.

### **Supporting an Enduring Wounded Warrior Mission**

The reduction in combat operations and the resulting decline in combat wounded poses a risk that attention and resources for wounded warrior programs and initiatives will shift to competing priorities. Some of this shift is certainly warranted, but it is critical that improvements made over the last 16 years are not lost as we move forward. We support Recovering Warrior Task Force recommendations to formalize and marshal support for the way forward in wounded warrior care and caregiver support for current and future generations of wounded warriors.

### **MILITARY FAMILIES –CONTINUING TO SERVE**

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Recent national fiscal challenges have left military families confused and concerned about whether the programs, resources, and benefits contributing to their strength, resilience, and readiness will remain available to support them and be flexible enough to address emerging needs. The Department of Defense must provide the level of programs and resources to meet these needs. Sequestration weakens its ability to do so.

Service members and their families have kept trust with America, through more than 16 years of war, with multiple deployments and separations. We ask the Nation to keep the trust with military families and not try to balance budget shortfalls from the pockets of those who serve.

Evolving world conflicts keep our military service members on call. Our military families continue on call as well, even as they are dealing with the long-term effects of more than a decade at war. The government should ensure military families have the tools to remain ready and to provide for the readiness of their service members. Effective support for military families must involve a broad network of government agencies, community groups, businesses, and concerned citizens.