

Statement

by the

NATIONAL MILITARY FAMILY ASSOCIATION

for

**Subcommittee on
Personnel**

of the

**UNITED STATES SENATE
ARMED SERVICES COMMITTEE**

February 23, 2016

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. They 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.

The FY17 Administration Budget Health Care Proposal: Where's the Reform?

We appreciate Congress has listened to beneficiary concerns regarding the Military Health System (MHS) and are gratified you want to make the MHS work better for all beneficiaries via military health care reform. We hope the changes Congress enacts will truly make a difference in military families' ability to access the right care, at the right time, and in the right place. Our families deserve no less.

Given Congress' clearly stated objectives for MHS Reform, our Association had hoped the Department of Defense (DoD) budget proposal would outline plans to improve beneficiary access, quality, safety, and the patient experience in addition to addressing fiscal sustainability. Instead, DoD has once again rebranded the same old system, incorporated numerous fee increases, and deemed it new and improved.

While we appreciate DoD's budget proposal has finally acknowledged several areas of deficiency within the MHS including access challenges, lack of first call resolution, a cumbersome referral process, administrative burdens and care delays during Permanent Change of Station (PCS) moves, and pediatric issues, simply cataloging the problems does not constitute institutional reform.

We continue to analyze and will present a detailed response to DoD's budget proposal for the Personnel Posture Hearing on March 8, 2016. In the meantime, this document outlines our expectations for MHS Reform together with a detailed assessment of problem areas that must be addressed to deliver meaningful improvements in military family health care.

The State of the Military Family

For military families, although combat operations in Iraq and Afghanistan have officially ceased, it certainly doesn't feel like the wars are over. Thousands of service members continue to deploy across the globe facing hazardous conditions and lengthy family separations. Looming worldwide threats lead military families to anxiously consider how their service members might be deployed in response. On top of this, our families are also grappling with job insecurity due to military downsizing and financial stress as a result of compensation and benefit cuts. Perhaps most worrisome for today's military families is there seems to be no end in sight to either global military conflicts or threats to their financial security.

Importance of Health Care for Military Families

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. The military health care benefit must address the unique conditions of service and the extraordinary sacrifices demanded of service members and their families.

Service members and their families consistently rate health care as one of the most valued aspects of the military compensation and benefits package, even as they also share stories of delayed access and confusing procedures. As such, the impact of health benefit changes on recruiting and retention must also be considered as part of MHS Reform.

Why MHS Reform Now?

Our Association believes now is the time to tackle MHS Reform. We agree with the Military Compensation and Retirement Modernization Commission (MCRMC) report that the TRICARE status quo is unsustainable. TRICARE—both the benefit and the system in place to deliver the benefit—faces pressure on multiple fronts and beneficiaries will continue to feel pressure as they access care and in the cost of that care. Specifically, TRICARE’s beneficiary satisfaction and fiscal sustainability have both declined. As the FY17 budget proposal makes clear, further dilution of the current TRICARE benefit is inevitable as DoD nibbles around the edges, making incremental changes while increasing beneficiaries’ out-of-pocket costs. **We appreciate Congress has made MHS Reform a priority and trust reform efforts will focus on ensuring both the benefit and the system charged with delivering the benefit work better for military families.**

Acknowledgement of Dual Readiness and Benefit Missions

The MHS is unique in that it has dual readiness and benefit provision missions. The MHS 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 is to provide 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 Military Treatment Facilities (MTFs) honing their medical skills in the process.

With our Association’s mission and expertise in advocating for military families, we have clear perspectives on how MHS Reform must address beneficiary issues. However, we acknowledge benefit reform efforts must not preclude the MHS from achieving its military medical readiness goals.

Our Association strongly asserts MHS Reform efforts must make a distinction between readiness costs and benefit costs. The MHS budget associated with service member medical readiness, medical provider readiness, wartime operations, and the care of wounded, ill, and injured service members **should not** be included in the cost structure of providing a health care benefit to the children, spouses, and surviving family members of service members and retirees. Our Association believes DoD has not effectively differentiated health care readiness costs from the costs of providing the employer-sponsored benefit. **This failure, we believe, puts both the readiness function and access to care for family members, retirees, and survivors at risk.**

Requirements for Providing the Earned Health Care Benefit to Military Families

The MHS should provide health care on par with that available via high quality commercial plans, tailored to address military families' unique needs, but at a significantly lower cost to acknowledge the value of service. We will consider MHS Reform a success if it achieves the following:

Access to High Quality Care

MHS Reform should ensure military families have ready access to primary care including urgent, routine, and preventative care. Primary care should also include care coordination services as needed. Another requirement is easier access to specialty care. We realize there are medical specialist shortages in many civilian and military communities, particularly among pediatric and behavioral health providers. We don't expect the TRICARE program to work miracles where specialties are scarce, but we do expect robust networks that provide access and choice to the extent possible. MHS Reform must consider service members are ordered to all parts of the U.S. and the world with varying degrees of access to Military Treatment Facilities (MTFs) and civilian medical assets. The MHS must provide military families with access to care regardless of where they live.

The Department of Defense (DoD) has already published Access Standards for Care¹ including urgent care (24 hours), routine care (7 days), and specialty care (4 weeks.) While we believe the Access Standards provide a good benchmark for acceptable access to care, we also note awareness of the standards is low among the beneficiary population and compliance is variable at the MTF level.

Access to care also includes coverage that is appropriate for all beneficiary populations and aligns with the most current medical best practices. MHS Reform must allow coverage policies to evolve with innovations in technologies and treatment protocols and ensure it meets the needs of all beneficiary segments.

We thank Congress for the FY16 NDAA provisions such as the Urgent Care Pilot, provisions to improve access to care and TRICARE portability, and the enhanced MHS reporting requirements that will address some of the current TRICARE problems until systemic reforms occur.

Reliable, safe, high quality care across both the Direct and Purchased Care systems is non-negotiable. Quality and safety must be measured and monitored to ensure military families are receiving the best possible medical care.

Policies Designed to Address the Unique Challenges of Military Service

The MHS must be designed to facilitate the transition of care for a mobile population. MHS Reform must identify and fix areas where the current system exacerbates disruptions in care necessitated by Permanent Change of Station (PCS) moves. With MHS Reform, families should be

¹ TRICARE Policy for Access to Care/HA Policy: 11-005

able to seamlessly transfer prescriptions and existing specialty care, including OB services, to new pharmacies and providers without delay.

MHS Reform must also consider issues associated with deployments and family separations.

The benefit must work for families who are geographically separated. It must also provide enhanced coverage for mental health and other conditions caused or exacerbated by the extraordinary stress families experience during deployment.

Costs that Acknowledge the Value of Service

We reject the notion that health care is “free” for military families. While military families may not pay monthly premiums, deductibles, or co-pays under TRICARE Prime, service members earn the benefit by way of the extraordinary demands, risks, and sacrifices associated with military service. Comparisons with civilians’ out-of-pocket costs, while helpful in assessing the military health benefit’s value, are largely irrelevant when determining fair out-of-pocket costs for military families.

We appreciate that past DoD proposals have not included increased TRICARE costs for active duty and their family members. We also appreciate DoD’s assurance that any proposed TRICARE enrollment fee changes will not apply to medically retired service members and survivors. MHS Reform must continue to adhere to these principles.

Our Association has always been open to introducing a mechanism for modest cost increases for retirees and is willing to engage in conversations about appropriate fee levels and additional MHS efficiencies. However, we believe out-of-pocket expenses for retirees must be contained to avoid diminishing the value of the earned retirement benefit.

Areas to Consider with MHS Reform – What’s Working?

MHS Reform should maintain or expand upon areas that are currently working for beneficiaries, including:

- **Access to Care in Certain Areas:** Health care is local, so access problems vary by location. There are some MTFs and TRICARE network areas where families are satisfied with their access to care.
- **Pockets of Excellence Within the Direct Care System:** Beneficiaries in some areas tell us they receive exceptional care at their MTFs. MHS leaders must ensure best practices within the system are identified and widely disseminated.
- **Mental Health and Applied Behavior Analysis (ABA) Coverage:** TRICARE has tailored coverage in these areas in recognition of military families’ unique needs. Mental health care is available without referral and at zero out-of-pocket cost. As some military families struggle to cope after 14 years of war, it is vital these policies continue. DoD has also enhanced ABA coverage to meet the needs of family members with autism. Current ABA coverage is the result of years of deliberation, research investigation, and pilot program

evaluation. The resulting coverage levels DoD has deemed appropriate for military families must remain linked to high-quality, evidenced-based practices in the future.

- **Current Beneficiary Costs:** Current low out-of-pocket costs reflect the value of service while catastrophic caps protect military families from potential financial hardship related to medical expenses. Given the extraordinary risks service members assume during the course of military service, we believe it is appropriate to protect them from financial risk wherever possible.
- **U.S. Family Health Plan (USFHP):** USFHP beneficiaries express high satisfaction with the program. They appreciate assistance from Care Managers so they do not have to navigate the system on their own. They have access to robust provider networks. Military families using USFHP benefit from wellness, prevention, and disease management programs as well as provider outreach to enhance communication. All of these programs result in better health care outcomes. Compared to TRICARE Prime enrollees, USFHP participants have 33% fewer inpatient days and 28% fewer emergency room visits.²

What's not working? Access to Care Issues

Access to care is the broadest area of concern and takes many forms, including:

Direct Care Acute Appointment Shortages

For years, our Association has advocated for better access to urgent care. When military families call the MTF to make an appointment for a sick or injured family member, too many are told there are no appointments available. Too many are told they cannot get a referral to an urgent care in the community. Too many are left with the Emergency Room as their only option for treatment of acute medical problems such as ear infections and strep throat – conditions that aren't emergencies, but must be treated promptly.

In late 2015, our Association fielded a survey of 4,010 military spouses. Nearly 30% 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 is consistent with findings from a health care survey fielded by the Military Officer Association of America (MOAA) in December 2015 in which 29% of active duty spouses reported they rarely or never get an acute care appointment within access standards.

Military families lead complicated lives rife with uncertainty. Obtaining health care for sick or injured family members should not be complicated or uncertain.

In April 2015, NMFA conducted an Acute Care Campaign via social media. Our goal was to demonstrate the breadth of acute care barriers as well as illustrate how access challenges impact military families. Over the course of the campaign, we engaged thousands of beneficiaries in a dialog and collected 131 stories about acute care access problems. With a worldwide network of Volunteers, frequent engagement with the military community, and our own experiences as

² Final Report of the Military Compensation and Retirement Modernization Commission – January, 2015

military family members, we are able to differentiate common themes versus unique situations. Stories collected during our outreach campaign highlight how difficult it is for many families to access the right care, at the right time, in the most appropriate setting. Specific findings include:

- **Military families recognize their Primary Care Manager (PCM) is the best source for care when they are sick or injured.** As a recent DoD Health.mil article (*Pediatricians Serve as Important Resources for Parents*) points out, pediatricians have specialized training and skills versus general practitioners and parents understand this. Continuity of care is also important to military families.

“Military families would vastly prefer not to be sent to the ER or urgent care. Not only is it more expensive for the military when this happens, but it interrupts patient care and continuity and does not provide the best care for our families.” (Military Spouse)

- However, **military families face a variety of challenges in obtaining timely acute appointments with their direct care PCMs/pediatricians.** When families call for acute appointments, they are often told:
 - The next appointment is days or weeks away, so no appointment is made and families are left to determine appropriate next steps
 - To call back the next day
 - To go to the ER
- When a PCM/pediatrician appointment is unavailable, **military families often face confusing, inconsistent policies for obtaining network urgent care referrals.**
- **Most military families would prefer to avoid the ER, but often find it is their only option for care.** They are frustrated by the inconvenience and delay in care resulting from ER use.
- **Military families experience delays in follow up specialty care when they can't be seen by their PCM/pediatrician.** TRICARE doesn't accept referrals from ER or Urgent Care providers necessitating an additional visit with a PCM just to get the recommended referral.

Other MTF Appointment Issues

- **Routine Care Scheduling Challenges:** Families report delays in scheduling preventative, routine, and follow up care.
 - In NMFA's military spouse survey, 31% of MTF users said they rarely or never get a routine appointment within the 7 day access standard.
 - 42% of active duty spouses in MOAA's health care survey said they rarely or never get routine appointments within access standards.
- Not only are some families unable to schedule routine appointments within a reasonable time frame, but the **process for scheduling is cumbersome.** Families are often required to call the

appointment line multiple times in the hopes of finding an opening within the currently available appointment book. We appreciate DoD has started to take steps to remedy this problem, but we believe routine appointment availability should still be examined during MHS Reform discussions.

- **Impact of Recapture Efforts on Appointment Scheduling:** While we support DoD's efforts to recapture care back into the direct system to better utilize existing capacity and fixed assets, we fear some MTFs may be overreaching leading to access problems. We have also seen questionable referral decisions that seem to be driven by specialty care recapture. For instance, families stationed at MCB Quantico have been told they must receive physical therapy at Walter Reed National Military Medical Center. Travel time from Quantico to Walter Reed only meets the one hour drive time access standard under the most optimal conditions. Restricting appointments to Walter Reed effectively creates a barrier to accessing necessary physical therapy for Quantico families.

Please note MTF access problems are not exclusive to family members. We regularly hear about service members who are unable to get timely appointments. We recently talked to a service member with a foot injury. When he called to schedule an appointment, the next available opening was five weeks away. **Failure to provide timely care to service members is a readiness issue.**

Cumbersome Referral and Authorization Process:

The referral and authorization needed to obtain network specialty care can result in delays and disruptions to care. Many families report problems with referral processing. 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.

"I can't tell you how many times that when we did get referrals they were for the wrong sort of service because that's just who came up first in the system with no regard to sub-specialty." (Military spouse)

"PCMs should be able to transfer referrals across TRICARE regions. My example: My daughter was diagnosed with moderate scoliosis in May 2013. We PCS'd in June and had to start the process all over once we settled into our new location. By the time we had all the required referrals and seen all the appropriate specialists, we had wasted almost four months waiting for treatment. She finally got her back brace on October 1, and her curve had progressed significantly." (Military spouse)

Difficulty Accessing Coverage While Traveling

It is imperative families have access to urgent care while traveling. It is unacceptable the Emergency Room is the only option for care for military families who are traveling or en route

during a PCS. We appreciate the Urgent Care Pilot included in the FY16 NDAA and hope DoD's implementation allows urgent care visits while military families are away from home.

“Traveling through states during a PCS move when your child needs to see a doctor is a nightmare. My daughter had an eye infection when we were traveling and stopped in the Midwest from NC to CA. The only option was the ER since we were not in our Tricare region. I spent hours on the phone with Tricare and my PCM from my previous state to get a referral so my daughter could be seen in a clinic. It was like pulling teeth from everyone right down to getting a prescription. Plus the time changes with offices made it difficult. It took 2 days and countless time on the phone between Tricare and the doctor's office. I felt helpless and angry having to fight for care for my 1 year old.” (Military spouse)

Purchased Care Access Issues

- **Areas with TRICARE Network Inadequacy:** In some areas, families complain there is a shortage of providers in the network and those listed often are no longer accepting new TRICARE patients. We fear this problem will become worse as the Affordable Care Act and Medicaid expansion increase the demand for medical providers.
- **Behavioral Health Provider Shortage:** One of the consequences of 14 years of war is increased demand for mental health services which continues to outstrip supply. MHS Reform must explore innovative solutions, including greater coordination between the military and civilian provider base, to address this problem.
 - Data from NMFA's spouse survey and MOAA's health care survey indicate alarming rates of behavioral health usage among military families. These studies show that between 40-50% of military spouses have sought behavioral health care for someone in their family.
 - TRICARE utilization data also indicates high levels of behavioral health care use. TRICARE Prime beneficiary behavioral health utilization was 54% higher than the corresponding rate for civilian HMOs in FY14. The TRICARE report hypothesizes this disparity reflects the more stressful environment many active duty service members and their families endure³.
 - We recognize there is a national shortage of mental health providers. While TRICARE contractors have expanded their behavioral health provider networks to help meet demand, military families in some areas continue to report provider shortages, especially for psychiatric care for children and teens.

³ Evaluation of the TRICARE Program FY2015

<http://www.health.mil/Military-Health-Topics/Access-Cost-Quality-and-Safety/Health-Care-Program-Evaluation/Annual-Evaluation-of-the-TRICARE-Program>

What's Not Working? Quality and Coverage Issues

Direct Care System

- **Variable Quality and Safety:**

- We are concerned DoD's 2014 MHS Review of quality measures showed mixed results with considerable variation across the system for both specific clinical measures and for individual MTFs. This is consistent with feedback we hear from military families. Some are very pleased with their MTF care while others relay stories that clearly demonstrate quality and safety issues. We appreciate DoD has launched a High Reliability Organization initiative.

MHS Reform must ensure continuous improvement efforts are consistently integrated across the entire Direct Care system.

- 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. **Failure to follow up on sentinel events is unacceptable.**⁴ We have asked how this is being addressed and have not received any information.

- **Beneficiary Quality Perceptions:** Military family members feel care is compromised by provider turnover/lack of continuity of care, inadequate appointment length, and direct care providers who don't listen or review patient medical history.

"We left the Prime system and switched to standard because there was high doctor turnover in our military clinic leading to poor patient care." (Military spouse)

"I went to see my doctor for back pain and he asked me if I wanted to discuss the upper back or lower back. We couldn't talk about both. I had to make a second appointment." (Military spouse)

- **Inconsistent Policy Implementation at the MTF Level:** MTF Commanding Officers 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 that vary from one MTF to another can make it even harder for military families to effectively navigate the system. Inconsistent policies for referring patients to TRICARE network urgent care is one of the most common examples. Another recent example we've heard relates to TRICARE's new Lactation Supplies and Support Policy. To its credit, DoD introduced the policy with an integrated communications plan including a Facebook Town Hall to answer beneficiary questions. The policy very clearly stated there were no restrictions on when an expectant or new mom could purchase a TRICARE covered breast pump. We've subsequently learned Landstuhl Regional Medical Center implemented the policy with a

⁴ Military Health System Review Final Report to the Secretary of Defense – August, 2014

restriction. LRMC OBGYN will only provide the necessary breast pump prescription/order at 38 weeks. It is discouraging DoD's strategic communications plan to educate military families about the new policy is undermined by inconsistent implementation at the MTF level.

- **Poor Communication:** Families complain about difficulties in obtaining lab results, errors in medical records, and providers' failure to return phone calls. Similar to access, communication quality varies across MTFs. For instance, when the Direct Care recapture rolled out, affected families from Madigan Army Medical Center at Joint Base Lewis-McChord received a letter welcoming them back to the MTF together with a pamphlet highlighting the advantages of being seen at Madigan. Madigan also had a Patient Advocate specifically designated to field beneficiary questions about the recapture. Contrast this with the way the recapture was handled at Womack Army Medical Center at Fort Bragg. Affected patients received a post card alerting them to a Primary Care Manager (PCM) change with no further explanation. When we called Womack, the Patient Advocate could not answer our questions about the recapture waiver process, but made it clear we should not send families to her.
- **Lagging Customer Service Innovations:** DoD is slow to adopt Customer Service innovations, 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 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.

Purchased Care

- **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. 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 still covers only a fraction of tests available via commercial plans, Medicare, and Medicaid.

Earlier this year, the family of an Active Guard Reserve (AGR) soldier in Indiana contacted us for help in obtaining a diagnostic genetic test (an LDT) for their son. His doctors believe he may suffer from a rare genetic syndrome and recommended the test to inform their treatment decisions and better understand the child's prognosis. TRICARE denied coverage. After many months, we were eventually able to help the Indiana family obtain the test at Walter Reed. The family traveled from Indiana to Maryland for a blood draw. The baby's blood sample was then sent to a commercial laboratory in Wisconsin for testing. Since the testing was done as a "courtesy," the family doesn't have access to the genetic counseling and possible future genetic

testing necessary to determine next steps. MHS Reform must address this issue to ensure military family medical treatment evolves to include new technologies and treatment protocols.

- **Customer Service Issues:** The contracting process leads to regular Managed Care Support Contractor (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 will move to two TRICARE Regions resulting in an inevitable MCSC transition for many TRICARE beneficiaries.

What's Not Working? Lack of Metrics, Benchmarks, Accountability, and Oversight

- DoD and GAO reports consistently highlight the lack of high quality metrics leading to an inability to evaluate military health system performance. Without proper metrics, it will be impossible to monitor progress against MHS Reform goals.
 - The 2014 MHS Review identified a major gap in the ability of the MHS to analyze system-wide health care information. It also observed there is no mechanism to recognize patient input making it difficult to act on feedback from patients regarding their needs. We noted MHS metrics utilized in the report are sometimes incomplete or misleading. For instance, DoD's access measure indicates the average wait time for an acute appointment is 0.97 days, outperforming access standards. However, that metric only measures the timing of actual appointments scheduled. It does not capture suppressed demand or those patients told to call back or go to the Emergency Room because no appointments were available.
 - DoD's *Study on Health Care and Related Support for Children of Members of the Armed Forces* acknowledges a lack of common data evaluation systems or metrics within DoD or the Military Departments to evaluate the programs that support the physical and behavioral health care needs of children. Throughout the report, conclusions are drawn on limited and largely irrelevant data. Although the report "concludes the MHS is meeting the needs of the children in its care, including those with special needs," we believe a more accurate conclusion is MHS has inadequate data to evaluate access to pediatric care in appropriate settings.
 - Most recently, the GAO released a report on the TRICARE Pharmacy Pilot. GAO concluded DoD has not fully monitored the pilot's performance and thus does not know whether it is working as intended. We agree with the GAO that this information would be beneficial given the expansion of the pilot requirements to all beneficiaries.
- Our Association finds it discouraging that even legislative fixes are not guarantees of MHS improvement. DoD frequently cites Section 704 from the FY15 NDAA granting them authority for provisional TRICARE coverage for emerging health care services and supplies. Yet they have failed to exert that authority to make coverage improvements. Section 735 of the FY13 NDAA required not only a study on pediatric care for military-connected children, but also a plan to improve and continuously monitor military kids' access to care. Since the study's release in July

2014, DoD has released minimal information regarding next steps. DoD's seeming inability to move forward in a timely manner and engage in transparent communication lowers stakeholder and beneficiary confidence that improvements are possible.

Special Populations to Address with MHS Reform

- **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 have long advocated for more flexibility in allowing Reserve Component families to retain their 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.
- **Maternity/OB:** The military has a large population of young families, so it is not surprising that inpatient procedures at military hospitals are predominantly related to pregnancy, childbirth, and newborn care.⁵ MHS Reform must not only ensure safe, high quality care for our expectant moms, it must also address the unique challenges associated with the military lifestyle.
 - **Quality:** The MHS Review noted inconsistent performance on maternal and neonatal birth outcome measures with higher rates of maternal hemorrhage and undefined neonatal trauma than the national average.
 - **Provider Consistency:** Our informal military maternity care survey revealed moms are largely satisfied with the care they receive. The most frequently cited complaint about military maternity care is the lack of provider consistency. Respondents were uncomfortable with seeing a new provider at each appointment. They feared the lack of continuity compromised the quality of their care. These concerns were even more prevalent among moms who had a previous birth experience in a civilian facility with greater provider consistency.

“I would say of the three birth experiences I had, the two in civilian hospitals were my best. Not that the military facility was bad but it really does make a huge difference when you get to see the same doctor throughout the entire pregnancy. With my first at Tripler Army Medical I think I saw 9 different doctors and had never seen the one who delivered me. Just felt very impersonal and a bit frustrating having to retell situations or issues since they were not with me from the beginning.” (Military spouse)

⁵ Final Report of the Military Compensation and Retirement Modernization Commission – January, 2015

- **PCS:** The MHS must facilitate the transition of maternity care following a PCS to allow the expectant mom to follow the recommended prenatal care schedule.
 - Unfortunately, Direct Care policies and appointment shortages can slow the process. Our Association spoke with a young mother who PCS'd during the 28th week of her pregnancy. She had been identified as high risk by the OB at the losing duty station. Before being assigned to an OB at the new duty station, she had to see her new PCM and take a pregnancy test, despite the fact she had carried her records to verify not only the pregnancy, but also her high risk status. Even after verifying the pregnancy, she could not get an appointment until she was 36 weeks.
 - Transitioning prenatal care to a TRICARE Network provider can present another set of problems. Many civilian OBs are reluctant to accept a new patient after a certain point in the pregnancy. One mom told us she PCS'd toward the end of her pregnancy. She called every OB in the TRICARE directory and nobody would take her as a patient. Finally, one office told her to just show up at the hospital when she went into labor and they would have to deliver her. This is not an acceptable level of care for military families. Expectant moms should have a resource to help them navigate obstacles in re-establishing network prenatal care.
- **Deployment:** The extraordinary stress associated with deployment must also be considered when shaping MHS maternity care.
 - A Fort Bragg doctor recently published a study showing women with a spouse deployed during their pregnancy are at increased risk for preterm birth and postpartum depression.⁶ MHS Reform should consider the option of group prenatal care as it seems to have a positive effect on adverse perinatal outcomes among women with deployed spouses.
 - New moms we surveyed noted the importance of a wireless connection during labor and delivery when their partner is deployed. Most said their MTF lacked wireless. This technology allows the service member to experience the child's birth and support mom even though he or she is not physically present.
- **Special Needs:** 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. MHS Reform must ensure military special needs families are appropriately supported as they navigate multiple systems of care for their family members.

⁶ Christopher M. Tarney, et al., "Association of Spouse Deployment on Pregnancy Outcomes in a U.S. Military Population", *Obstetrics & Gynecology*, 2015

- **PCS:** Frequent geographic relocations are a fact of life for military families. 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. Military families fear these repeated treatment delays have a cumulative and permanent negative effect on their special needs family members.
- **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 services. Families who contact our Association have no idea where to turn when their existing case managers fail to resolve their problems. MHS Reform should include an evaluation of current case management services to determine if they are meeting military families' needs.
- **ECHO:** For special needs military families, frequent relocation presents another obstacle: the inability to qualify for services through Medicaid waivers. State Medicaid programs provide assistance not covered by TRICARE: respite care, employment supports, housing, 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 rendering them inaccessible to many military families who PCS before reaching the top of the list. TRICARE's Extended Health Care Option (ECHO) was designed to address this imbalance by allowing families to access non-medical services not covered under TRICARE. However, the MCRMC found ECHO benefits, as currently implemented, are not robust enough to replace state waiver programs.⁷ DoD has assured our Association they are working on ECHO improvements. However, other than a policy update to cover incontinence supplies, we have heard none of the specifics. Given the importance of ECHO to special needs families, MHS Reform must examine how to improve ECHO benefits.
- **Transition:** 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 Medicaid, which leads either to gaps in treatment or financial hardship for a family trying to pay for needed care. As more service members and families transition out of the military, this problem will become more widespread. 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.
- **Pediatric Care:** The MHS provides care for 2.4 million military kids, but because TRICARE policy is based on Medicare, a program for senior adults, its policies are not always optimal for pediatric care.

⁷ Final Report of the Military Compensation and Retirement Modernization Commission – January, 2015

- **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.” DoD’s hierarchy of reliable evidence includes only “published research based on well controlled clinical studies, formal technology assessments, and/or published national medical organization policies/positions/reports.” While beneficiaries certainly want safe and effective treatment, such tightly prescribed data for children is not always available. TRICARE’s strict adherence to this adult-based standard of reliable evidence results in coverage denials for widely accepted pediatric treatments.
- **Well-Child Care:** DoD’s *Study on Health Care and Related Support for Children of Members of the Armed Forces* acknowledges TRICARE’s pediatric preventative program does not conform to American Academy of Pediatrics (AAP) periodicity guidelines. TRICARE’s well-child benefit ends at age 5 (at age 6 beneficiaries are covered under generally authorized clinical preventative services) whereas AAP recommends screening for physical, emotional, and developmental needs to age 21. We believe TRICARE’s well-child benefit should align with AAP and Affordable Care Act guidelines, as well as Medicaid’s Early and Periodic Screening Diagnostic and Treatment (EPSDT) services.
- **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.
- **Medical Nutrition:** TRICARE’s 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.
- **Behavioral Health:** More than 14 years of war have left families with behavioral health problems and reintegration challenges that may last for many years. During a recent visit to Fort Bragg, our Association learned Womack’s Child and Adolescent Behavioral Health Service refers multiple military children to residential treatment each month. It is a moral imperative to provide service members and their families with the help they need after years of enduring repeated combat deployments. We appreciate the comprehensive revisions to TRICARE mental health coverage outlined in the proposed rule released on February 1, 2016. The updated regulations address several issues we have advocated to change for several years, including:
 - **Removal of TRICARE coverage limits on inpatient mental health services.** We thank Congress for including this provision in the FY15 NDAA.

- **Expanded coverage for intensive outpatient programs:** Intensive outpatient treatment programs have been adopted as a standard practice in the private sector and the Veterans Health Administration. TRICARE, however, has not reimbursed for this care.
- **Streamlined requirements for institutional TRICARE authorized providers:** While TRICARE’s comprehensive certification standards were once considered necessary to ensure quality and safety, these requirements proved to be overly restrictive and, at times, inconsistent with current industry-based institutional provider standards.

Barriers to Improving TRICARE

Our Association is open to discussing a variety of ideas for improving how the health benefit is delivered to military families. We believe now is the time for Congress and DoD to consider a fundamental overhaul of military health care given the barriers to improving the existing TRICARE program, which include:

- **The current budgetary environment**, with an emphasis on cost-cutting and increased beneficiary contributions, is unlikely to yield TRICARE benefit enhancements. Given the pressure to reduce DoD health care spending, we find ourselves repeatedly fighting just to maintain the current benefit. For example, last year we argued against DoD’s Consolidated TRICARE proposal that would have increased beneficiary costs while doing nothing to enhance the benefit for military families. The Administration’s FY17 budget proposal similarly increases beneficiary costs while failing to improve the benefit or suggest meaningful reform. It is unlikely we will realize TRICARE program improvements during a period of fiscal constraint.
- **TRICARE reimbursement policies, governed by statute, are difficult to modernize.** It literally takes an Act of Congress to make substantive changes to TRICARE coverage policy. This means TRICARE is slow to cover new technologies and treatment protocols. As health care continues to evolve, military families will be left with coverage that lags their civilian counterparts.
- **The Military Health System’s dual readiness and benefit provision missions make it difficult to focus on improving the beneficiary health care benefit:** The critical need to achieve readiness (i.e., a medically ready fighting force and a ready medical provider force capable of delivering health and combat-casualty care in operational environments) leads to a lack of focus on the earned health care benefit for family members, retirees, and survivors. When readiness resources are tight, sick kids lose.
- **The Military Health System’s lack of a unified medical command** leads to inconsistent policy compliance by the Services. There is no measure of MTF compliance and no accountability from the MTF to the Service to DoD in regard to policy adherence. Without a

unified medical command, we are skeptical policy improvements would be consistently implemented at the local level.

- **DoD's demonstrated unwillingness to address known TRICARE problems** leads us to believe they will continue to resist program changes in the future. For instance, despite being given the authority to cover emerging technologies, TRICARE still covers only a fraction of Lab Developed Tests. This means military families are denied coverage for procedures such as noninvasive prenatal tests. DoD has also failed to address pediatric care problems identified in their own *Study on Health Care and Related Support for Children of Members of the Armed Forces*. We fear the cumulative impact of years of unresolved issues will continue to degrade the TRICARE benefit value over time.
- **Fee for service contracts prevent adoption of innovative reimbursement models.** As commercial health insurance and other government payers move toward a greater emphasis on preventative services and outcomes, TRICARE contracts are locked in to the fee for service model. DoD's most recent proposals to "simplify" TRICARE would only expand the fee for service model to the MTFs. This would continue to prevent military families from benefitting from innovations in medical care delivery.

Closing Remarks

We recognize many of the issues we have presented, viewed in isolation, may seem insignificant. However, we urge you to review this feedback with two facts in mind. First, when a military family seeks care in the MHS, their stressors only begin with the immediacy of the medical issue and stretch far beyond to the many extraordinary challenges of military life. Military families deserve a health care system that facilitates, rather than impedes, their access to care. Second, the cumulative impact of these obstacles, delays, and inconveniences magnifies the effect of each one and, in some cases, creates an insurmountable barrier to accessing necessary care.

After the past few years of pay raises below the ECI, BAH cuts, and multiple proposals to eliminate the Commissary benefit, military families are skeptical and likely to view MHS Reform as cuts in disguise. DoD's FY17 health care proposal – with its emphasis on fee increases and lack of detail on MHS improvements – magnifies these concerns. We stand ready to work with Congress and DoD, on behalf of military families, to achieve the stated objective of a Military Health System that works better for all beneficiaries.