STATEMENT OF THE

THE MILITARY OFFICERS ASSOCIATION OF AMERICA (MOAA)

before the

House Armed Services Committee
Subcommittee on Military Personnel

On

Exceptional Family Member Program

February 5, 2020

MOAA is the nation's largest and most influential association of military officers. It is an independent, nonprofit, politically nonpartisan organization. With more than 350,000 members across all Uniformed Services – including active duty, National Guard, Reserve, retired, former officers, and their families – the association plays an active role in military personnel matters, and especially proposed legislation affecting the career force, the retired community, and veterans of the Uniformed Services.

MOAA does not receive any grants or contracts from the federal government

Karen Ruedisueli – Director, Health Affairs, MOAA

Karen Ruedisueli is MOAA's director of government relations for health affairs. In this capacity, she also serves as co-chair of The Military Coalition's (TMC) Health Care Committee. Karen joined MOAA from the National Military Family Association where she spent six years advocating for families of the Uniformed Services with a focus on health care and military caregivers. Karen has testified before Congress and built relationships with DoD leaders to advance solutions to Military Health System problems and ensure transparency and accountability in policy implementation. She recently co-authored a *Health Affairs* article, "Families with TRICARE Report Lower Health Care Quality and Access Compared to Other Insured and Uninsured Families," with the Children's Hospital of Philadelphia PolicyLab.

A graduate of the University of Michigan, Karen worked as a marketing professional and management consultant before becoming a military spouse. She has extensive experience in market research, brand strategy, and new product/service development. She has also been a guest lecturer at Northwestern University's Kellogg Graduate School of Management on the topic of brand-based innovation.

As an Army spouse, Karen was an active Family Readiness Group (FRG) member and served as a battery-level FRG leader during the unit's train-up and deployment to Afghanistan. She also volunteered as the co-director of research for Blue Star Families and led the development and analysis of their first Military Family Lifestyle Survey. Karen and her husband, MAJ Kurt Ruedisueli (Ret), currently reside in the Washington, D.C., metro area with their two children.

CHAIRWOMAN SPEIER AND RANKING MEMBER KELLY. On behalf of the Military Officers Association of America (MOAA), thank you for hosting this hearing on the Exceptional Family Member Program (EFMP). We appreciate this opportunity to express our views particularly as they relate to EFMP families' ability to access high-quality medical care.

We are truly grateful for your unwavering commitment to not just the men and women who defend our nation, but to their families as well.

Executive Summary

The Exceptional Family Member Program is an important tool for ensuring military families are not sent to locations that lack necessary medical and educational services for their special needs family members. Many EFMP families express frustration and report ineffective EFMP medical screening leading to gaps in care. Special needs families also report challenges with the Military Health System (MHS) that are exacerbated due to their increased need for medical care.

We believe this topic is particularly important given recent study findings by the Children's Hospital of Philadelphia PolicyLab indicating a heightened prevalence of behavioral health and special health care needs among military children. PolicyLab's research also found that TRICARE families were less likely to report accessible or responsive care compared to civilian peers. Military families whose children had complex health or behavioral health care needs also reported worse health care access and lower quality care than similar non-military families. These gaps in access and quality of care must be addressed.

While improvements to the EFMP medical screening process are much needed, those alone will not address the concerns of special needs families.

MOAA recommends the following steps to improve both the EFMP and MHS to more effectively take care of military families:

EFMP Recommendations

- EFMP medical screening must not only identify providers at the gaining location, but also more effectively assess actual appointment availability before approving families to accompany their service members.

- TRICARE referral policy must allow EFMP families to obtain specialty care referrals for providers at the gaining location in advance of PCS moves to streamline medical transitions and minimize disruptions in care.
- DoD and the Services must develop and publish metrics to evaluate medical screening and assignment coordination effectiveness and identify areas where improvement is needed.
- The Office of Special Needs must implement a continuous quality improvement system to ensure the EFMP is optimized to address not only the critical and evolving needs of EFMP families but also the ever-changing medical and educational systems that serve them.
- DoD must bring TRICARE's Extended Care Health Option (ECHO) respite care in line with State Medicaid Waiver programs by increasing the total number of ECHO respite hours from 192 annually to the Medicaid Waiver program average of 695 respite hours per year. Although ECHO is not part of EFMP, it plays an important role for many EFMP family members.

MHS Reform Recommendations

Transfer of MTFs to DHA

- The Defense Health Agency must develop metrics to measure military treatment facility (MTF) compliance with TRICARE Prime access standards, including appropriate referrals to civilian care when needed. Military families must be assured access to care even when MTFs experience appointment shortages.
- DHA must designate, and publicize, an online tool allowing families to report MTF problems. There is not currently a well understood and effective system for patients to report complaints, get resolution and have their issues tracked and reported to DHA to identify systemic or long-term problems.

Transformation of Direct Care System

- We ask Congress to protect the Uniformed Services University of the Health Sciences and graduate medical education programs to ensure a robust pipeline of military medical professionals in the future.
- For care transitioned from MTFs to civilian providers, DHA must ensure warm hand-offs for medically complex patients. We also ask Congress to monitor the impact of uniformed pediatric billet cuts to ensure military kids are transitioned to appropriate pediatric care and not simply moved to adult providers.

- Anticipating MTF realignment and rightsizing, together with direct care system specialty care consolidation, we ask DHA and Congress to protect patient choice regarding travel and referrals for specialty care.

TRICARE Reform

- Dramatic TRICARE copay increases present barriers to accessing maintenance medications and recurring treatments such as mental health visits and physical, speech, and occupational therapies.
  - We request Congress halt pharmacy copay increases scheduled to occur through 2027 and ensure no future disproportionate pharmacy copay increases.
  - We also ask Congress to return to TRICARE percent cost shares for mental health visits and physical, speech, and occupational therapies — 15% for active duty family members and 20% for retirees.
- We urge DHA to add "dissatisfaction with MTF access or quality of care" to the list of Qualifying Life Events (QLEs) to prevent military families from being trapped in MTFs that do not meet their needs.
- DHA must fix TRICARE coverage gaps for emerging technologies and evolving treatment protocols and implement the Defense Health Board recommendation to broaden TRICARE's definition of pediatric medical necessity. A pediatric-specific definition of medical necessity is needed to avoid pediatric gaps in care due to TRICARE's alignment with Medicare's reimbursement policies that are designed for seniors. As MHS reform moves more care into the TRICARE network, these coverage gaps will present problems for a greater number of beneficiaries.

Military Special Needs Families

PolicyLab Study: Special Needs Prevalence Among Military Families

We appreciate the Subcommittee's attention to the needs of military special needs families. It is particularly important to get medical care right for special needs families given their heightened prevalence within the military community. A recent study by the Children's Hospital of Philadelphia (CHOP) PolicyLab,[1] published in the August 2019 edition of *Health Affairs*, indicates a higher prevalence of special health care needs among children covered by TRICARE compared to their civilian peers:

Children's Hospital of Philadelphia PolicyLab Study:

> There was also a significant difference in the prevalence of complex health care needs, as measured by both the CSHCN Screener and behavioral health diagnoses, across insurance groups. The overall reported prevalence of children with at least one special health care need was 20.2 percent, with that prevalence being highest among children with TRICARE (28.5 percent) and lowest among uninsured children (12.6 percent). The overall prevalence of a behavioral health diagnosis was 11.6 percent. Children ages 0–17 covered by TRICARE had the highest prevalence of behavioral health diagnoses (15.7 percent), a rate nearly twice as high as that among uninsured children (7.9 percent), and the prevalence was 10.7 percent among children with commercial insurance and 13.6 percent among those with public insurance.

Military kids are 40% more likely than civilian kids to have at least one special health care need. They are 35% more likely than civilian kids to have a behavioral health diagnosis. While the PolicyLab study did not address why military kids are more likely to have complex medical needs, we know from talking with special needs families that the military health care benefit is a powerful retention tool for them. Gaining a better understanding of the reasons behind military kids' increased prevalence of special needs would be a worthwhile topic for future research.

Special Needs Military Families Face Unique Challenges

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. Frequent geographic relocations are a fact of life for

[1] "Families with TRICARE Report Lower Health Care Quality and Access Compared to Other Insured and Uninsured Families" – *Health Affairs*, Aug 2019
https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2019.00274

military families and they inevitably disrupt the continuity of care that is so important in managing complex medical conditions. After every move, special needs military families must begin a lengthy cycle of referrals, authorizations and waitlists at each new duty station, resulting in repeated gaps in care. A nationwide shortage in medical specialists means even when families have successfully navigated the authorization and referral process at their new location, they may face a delay of weeks or even months before treatment can restart. Military families fear these repeated treatment delays have a cumulative and permanent negative effect on their special needs family members. Some of this disruption is unavoidable and families understand that. However, we believe the Exceptional Family Member Program (EFMP) medical screening and assignment process is not always entirely effective and certain Military Health System (MHS) policies and processes in both the direct and purchased care systems further impede access to care for special needs families.

Exceptional Family Member Program Medical Screening

The EFMP helps families in two ways: by making sure special needs are considered during assignments and by offering families information and referrals to non-medical support within DoD, the Services and the local community[2]. In the assignment process, personnel are assigned to new duty locations based on military requirements and then the EFMP medically screens family members for eligibility to accompany them based on availability of medical and educational services at the gaining installation. This is important because access to appropriate medical and educational services may be limited in overseas and remote locations.

As of October 2018, approximately 8% (137,000) of military family members received support from EFMP[3].

Military Family Feedback on Medical Screening

Unfortunately, we hear from some family members that the screening process does not always work as intended and families are sometimes sent to areas that lack needed medical care. This can happen when a medical specialist retires or PCS's away from the gaining location in between the screening process and the family's arrival at the new location. More frequently, families perceive that medical screening may identify providers at the gaining location but does not assess actual appointment availability. Some families arrive at their new duty station to find providers no longer accept

[2] https://www.militaryonesource.mil/family-relationships/special-needs/exceptional-family-member/the-exceptional-family-member-program-for-families-with-special-needs

[3] https://fas.org/sgp/crs/natsec/IF11049.pdf

TRICARE or aren't taking new TRICARE patients. Other providers may have long wait lists for new patient appointments that lead to gaps in care for special needs family members.

> *I know that services are reviewed before families arrive at the gaining base, but those services are not always offered as stated. We are currently at a base where half of the services we need are two hours away. This is either because the services offered in our area have a long wait list or those specialties do not treat the age needed. Had someone picked up the phone to call the services before we came, it would have been discovered that this was not the best place for us to be for medical care.*
>
> *—Air Force Special Needs Parent*

Joint Base Lewis-McChord (JBLM) and the Colorado Springs area offer robust services for military special needs families, particularly those who have a family member on the autism spectrum. The JBLM Center for Autism Resources, Education and Services (CARES) is an innovative center providing patient-centered care for military children with autism and their families. JBLM CARES offers occupational, physical and speech therapy, Applied Behavior Analysis, EFMP Systems Navigation and respite care among other services. We appreciate this innovative approach to providing care to military families impacted by autism. Both the JBLM and Colorado Springs areas have an extensive network of TRICARE providers as well. As the number of special needs families assigned to JBLM and Colorado Springs-area installations has increased, demand for some services has outstripped supply, resulting in long wait lists. Educational organizations have also told us that local schools are having trouble meeting demand for special education services due to the high number of special needs military families assigned to these areas. We commend the services for identifying JBLM and Colorado Springs as areas with significant benefits for special needs families, but the **EFMP must do a better job assessing actual appointment availability before approving families to accompany their service members**.

<u>National Provider Shortages Demand TRICARE Referral Policy Change</u>

While improved medical screening for appointment availability is needed, that alone won't address problems families face in transitioning care. Some medical specialties have nationwide provider shortages. Developmental pediatrics is one example. There is probably not a single developmental pediatrician in the U.S. without a waitlist for new

patients. To address this reality, **TRICARE referral policy must allow EFMP families to obtain specialty care referrals for the gaining location in advance of PCS moves**.

Current TRICARE Prime policy requires families to PCS before they can transfer their TRICARE enrollment, schedule an appointment with the new Primary Care Manager (PCM), get specialty care referrals from the PCM, and then wait for the referrals to be processed. Only then can families contact specialty providers at their new location to make appointments or get on waitlists. Between the relocation process, the wait for a PCM new patient appointment, and the referral processing time, some EFMP families report a 1-2 month gap in care before they even get on specialists' wait lists.

My daughter has an extremely rare syndrome that has several rare diseases that fall under it. PCSing is always a troubling time in our family, even if we move to an area with every specialist she needs, because we are put into a situation where we can't have her medical specialists set up at our incoming location for IMMEDIATE care. We wait to be enrolled in our new region, we wait for an appointment to see our new PCM, and then we wait for her PCM to refer us to, more often than not, outside civilian specialists. Most of the time there's at least a 3- to 6-month wait for the specialists to see new patients, and that's on top of the weeks that have already passed waiting to get in to see the new PCM and waiting for your referrals. Two of our last three PCSs, we ended up in the emergency room with life threatening complications/illness and no specialists who were familiar with her history and her diseases.
—Active Duty Service Member

This process could be streamlined, and disruptions in care minimized, by allowing families to get specialty care referrals for the gaining location before they PCS.

<u>GAO Report: Performance Metrics Needed</u>

Effectively addressing the medical screening issue starts with a better understanding of its scope. **We ask Congress to require DoD to develop and publish metrics to evaluate medical screening and assignment coordination effectiveness**. A May 2018 Government Accountability Office (GAO) report, *DoD Should Improve Its Oversight of the Exceptional*

Family Member Program[4], indicates each Service uses various mechanisms to *monitor* how service members are assigned to installations, but the report contains no details on how the individual Services are assessing assignment coordination *effectiveness*. This issue has also been raised on multiple occasions with the Military Family Readiness Council. We agree with GAO's recommendation that the Office of Special Needs (OSN) develop common performance metrics for assignment coordination across the Services. Specifically, EFMP assignment coordination performance metrics should:

- Include measures of military family satisfaction with the assignment coordination process focused on the ability to obtain necessary medical care at the gaining installation.
- Track compassionate reassignments and off-schedule PCS moves due to inadequate medical resources at the gaining installation. Compassionate reassignments of this nature indicate system failure and should be analyzed to identify and address process breakdowns.
- Be reported at the installation level to provide actionable information.

Army EFMP Evolving

At the Family Readiness Initiatives Forum[5] held at AUSA on Feb. 5, 2019, Army leadership announced a new approach to give Soldiers and families a greater voice in the EFMP assignment process. Under the new policy, Soldiers will be given pre-screened PCS location choices to research and choose from. We view the Army's announcement as a positive development and applaud any effort to provide families with more transparency and input to the assignment process. We look forward to hearing about progress and lessons learned on this new initiative from Army EFMP personnel.

National Academies Report Findings

Findings from the 2019 National Academies of Sciences, Engineering, and Medicine report *Strengthening the Military Family Readiness System for a Changing American Society*,[6] a report prepared at the request of the Military Community and Family Policy (MC&FP) office, should also be considered as we examine the EFMP.

The National Academies Committee on the Well-Being of Military Families was formed to study the challenges and opportunities facing military families and what is known about effective strategies for supporting and protecting military children and families.

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[4] https://www.gao.gov/products/GAO-18-348

[5] https://www.ausa.org/events/family-readiness-initiatives-forum

[6] https://sites.nationalacademies.org/dbasse/bcyf/military-families-well-being/index.htm

The Committee also developed recommendations for DoD regarding what is needed to strengthen the support system for military families.

The National Academies report recommends a Dynamic Sustainability Framework for military family support programs including:

> A continuous quality monitoring system that utilizes solid measurements is needed to ensure a complex adaptive system that continues to progress in its effectiveness and relevance. The premise of on-going monitoring is not to find fault or blame, but to promote a culture of learning in the system through data-driven feedback loops that support continuous quality improvement.

As EFMP improvements are considered and policy changes such as the Army's attempt to provide more transparency to the assignment process are implemented, **a continuous quality improvement system will help ensure the EFMP is optimized** to address not only the critical and evolving needs of EFMP families but also the ever-changing medical and educational systems that serve them.

TRICARE Extended Care Health Option (ECHO)

Although not part of EFMP, another important program for military special needs families is the TRICARE Extended Care Health Option (ECHO). Congress established ECHO as a substitute for state Medicaid Waiver services that are often unavailable to mobile military families.

Medicaid Waiver programs provide long-term care services in home- and community-based settings to those who would otherwise require care in an institutional setting. Many states have lengthy waitlists for their Medicaid Waiver programs leaving military families unable to access services when they PCS from one state to another moving from waitlist to waitlist.

> *Military families function with one parent gone for long periods. Add to that we do not live by family due to moving constantly. Also add to that we never have deep roots with friends because of the moving. There is no population of special needs parents that need respite more! Our family finally has respite care via Medicaid after an 8-year wait on the waitlist.*
>
> *—Military Special Needs Parent*

ECHO serves a relatively small population of the most severely impacted special needs families including those with intellectual disabilities, serious physical disabilities, multiple disabilities that affect separate body systems, and autism spectrum disorder. In FY17 there were approximately 19,000 beneficiaries registered in ECHO.[7] Because ECHO is intended to fill a gap for families unable to obtain Medicaid Waiver services, Medicaid Waivers should serve as the benchmark for ECHO covered services. However, ECHO currently falls short relative to Medicaid waiver services, particularly in terms of respite care.

The Military Compensation and Retirement Modernization Commission (MCRMC) validated this issue in their 2015 report[8] and recommended ECHO covered services be increased to more closely align with state Medicaid Waiver programs. The MCRMC's state-by-state Medicaid Waiver analysis showed the average state Medicaid Waiver provides 695 respite hours per year while ECHO provides only 192 respite hours annually.

The current ECHO respite level of 16 hours per month disadvantages military families relative to state Medicaid Waiver recipients. The low number of ECHO-authorized respite hours also presents a barrier to receiving any respite care, since many families report difficulties finding a respite provider willing to work with them given the low number of hours involved. Managed care support contractors verify that many home health agencies don't want to engage in intermittent, low hour care.

> *"As the parent of a special needs child whose medical needs can change drastically depending on her current health status, I can say it is impossible to navigate the supposed respite care she qualifies for. Our daughter was/is still nonverbal, "severely" autistic, and requires tube feedings. She also has a serious lung disorder and heart defects that will require multiple open-heart surgeries in the future. I was told by her ECHO case manager… that she qualified for 16 hours a month respite care through that program. We called about that but were unable to get a nursing company to return our call, even with a referral. Nobody is willing to sign on for this. We have been here over a year and still have no respite care or any hope for it."*
>
> —*Military Special Needs Parent*

DoD has taken important steps to improve ECHO including expanding coverage to incontinence supplies and issuing a proposed rule to eliminate the concurrent ECHO benefit requirement for respite coverage (i.e., allowing families to access respite services

[7] https://fas.org/sgp/crs/natsec/IF11002.pdf
[8] https://docs.house.gov/meetings/AS/AS00/20150204/102859/HHRG-114-AS00-20150204-SD001.pdf

even if they don't use another ECHO benefit). **It is critical DoD address the respite deficiency by increasing the total number of ECHO respite hours from 192 annually to the Medicaid Waiver program average of 695 respite hours per year.**

EFMP families face many challenges in navigating military life while also caring for their special needs family members. We appreciate that Congress and DoD have developed the EFMP and ECHO to ensure families can access needed medical care and special education resources, but they are falling short of serving special needs families as intended. We appreciate the Subcommittee's attention to these issues and stand by to assist as you consider ways to optimize these important programs.

Military Health System Reform & Special Needs Families

With the FY17 NDAA, Congress set into motion massive MHS reform measures intended to improve focus on medical readiness, find efficiencies, and address problems patients encounter with access to care, quality of care, and the patient experience. MHS Reform is focused on three main lines of effort:

- **Transition of MTF administration and management from the Services to DHA**. Goals include patient facing standardization across the direct care system; improved health outcomes, access to care and patient experience; lower total management cost. Limits role of Services' Surgeons General in the direct care delivery system but maintains their oversight of the operational medical force readiness.
- **Transformation of the direct care system** with a greater focus on readiness and maintaining medical provider currency including MTF right-sizing and realignment; conversion of some uniformed medical billets to civilian positions; change in the mix of care provided at MTFs; consolidation of specialty care and establishment of centers of excellence; increase in civilian training agreements for combat casualty care skills; expanded eligibility for MTF care for veterans and civilians to support uniformed provider currency.
- **TRICARE Reform** including rebranding of TRICARE Standard/Extra to TRICARE Select; establishment of an annual open enrollment period with qualifying life events; conversion of Standard/Extra percent cost shares to fixed dollar copays; establishment of beneficiary Groups A (grandfathered) and B (new) based on sponsor date of entry into military service;

reconfiguration of TRICARE contracts to provide greater beneficiary choice and value-based care.

PolicyLab Study: Military Family Satisfaction with Access and Quality of Care

We appreciate MHS reform is intended to address problems beneficiaries encounter with the system. For years, we have heard complaints from families who face a variety of barriers to accessing care including challenges getting appointments, high levels of inconvenience in using the system, and TRICARE coverage gaps among other issues. We recognize any large health care system will have some dissatisfied patients and, until recently, it was difficult to know if military families were facing more problems with access and quality of care than their civilian counterparts.

The recent CHOP PolicyLab study[9], in addition to showing higher prevalence of special health care needs among military children, also found that TRICARE families were less likely to report accessible or responsive care compared to their civilian peers. Military families whose children had complex health or behavioral health care needs reported worse health care access and quality than similar non-military families.

Children's Hospital of Philadelphia PolicyLab Study:

> The accessibility of care for children on TRICARE was comparable to that for children on public insurance or those who were uninsured. Children in TRICARE-insured families experienced significantly worse responsiveness in care, compared to the other three groups (commercially insured, publicly insured, uninsured.)
>
> TRICARE-insured families, particularly those whose children have complex health care needs, face greater barriers to health care access and receipt of high-quality care than their peers do, which may be indicative of challenges due to mobility between installations and subsequently in getting high-quality, continuous care once a need is recognized.

Many challenges EFMP families encounter with the Military Health System (MHS) are not unique to special needs beneficiaries but have a more pronounced impact on them due to their heavy use of the system. MOAA is hopeful MHS Reform will address these issues, but we are concerned that we have not yet seen many improvements in access, quality of care and the patient experience. While we support MHS reform goals, we also have numerous concerns about how the speed and magnitude of proposed changes — including overhauls to direct care system administration and management, MTF

[9] "Families with TRICARE Report Lower Health Care Quality and Access Compared to Other Insured and Uninsured Families" – *Health Affairs*, Aug 2019
https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2019.00274

rightsizing and realignment, and a new market-based TRICARE construct — may be putting beneficiaries, and particularly special needs military families, at risk.

Transition of MTFs to DHA

MOAA supports MHS reform goals of seeking efficiencies and standardizing policies and processes within the direct care system. However, as the transition of MTFs to DHA administration/management proceeds, we have the following concerns and recommendations for ensuring beneficiary needs are considered during the process:

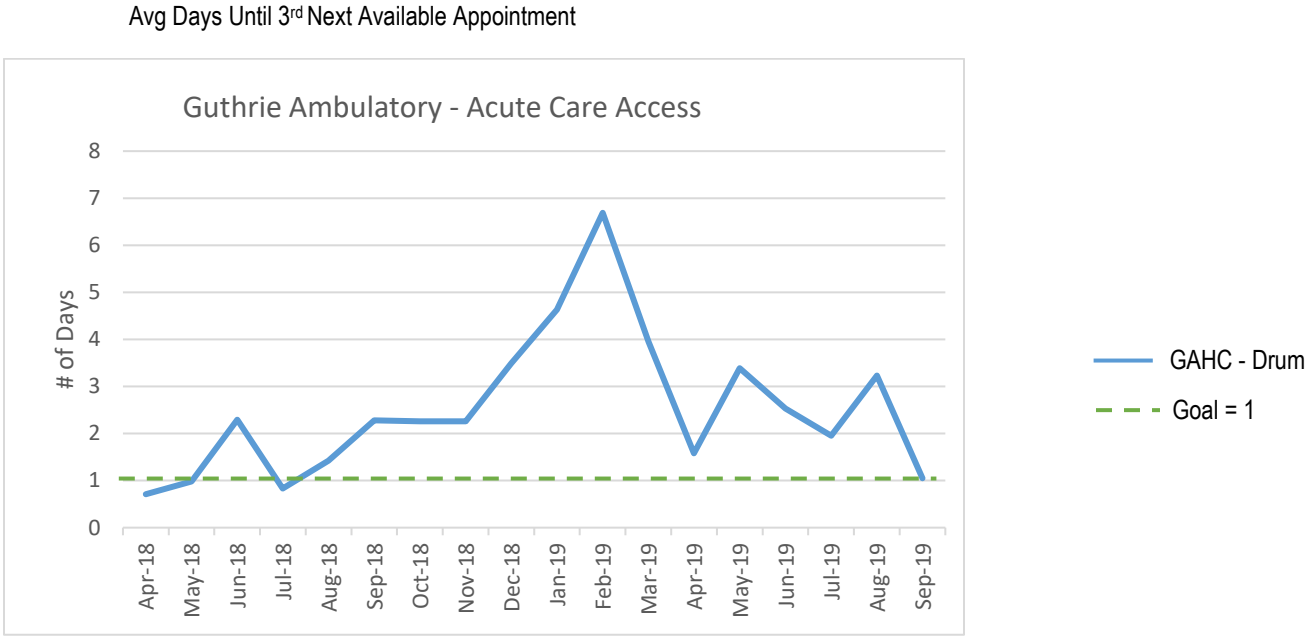
- MTF policy standardization must include **performance metrics that measure compliance to TRICARE Prime access standards** and don't penalize leakage to TRICARE network.

  Military families must have access to care even when their MTFs have appointment shortages. We understand the importance of maximizing caseloads for military providers and optimizing use of the direct care system infrastructure. We appreciate the challenge of managing appointment availability when both providers and patients regularly PCS in and out of the area and realize appointment shortages will sometimes happen. According to TRICARE Prime Access to Care Standards[10], patients should be referred to the TRICARE network when they can't get a timely appointment but that policy is not consistently followed.

> **Fort Drum/Guthrie Ambulatory Health Care (GAHC) – July 2019**:
>
> ***Army Spouse***: *I've been to urgent care more than my provider and it's very sad. You should be able to see your provider and be able to follow up with whatever you got going on in a month or so. And you can't do any of that. It's ridiculous.*
>
> ***GAHC Employee***: *I work at Guthrie and the real reason everyone is struggling is that all our providers have had to PCS and it is also affecting the soldier clinics and they are aware of this issue. I myself have to wait for care but once fully staffed again it will be better. No one is allowed to change insurance randomly anymore, we now have enrollment periods which should be October, then you can change if need be?*

[10] https://health.mil/Reference-Center/Policies/2011/04/26/TRICARE-Policy-for-Access-to-Care

According to MHS Transparency Data[11], GAHC – Fort Drum has failed to meet the TRICARE Prime acute care access standard for much of the past year.



While we appreciate families can now use urgent care without a referral, urgent care should not become a substitute for a beneficiary's PCM. Also, as noted by the Guthrie employee, families who can't get appointments at the MTF can no longer switch to TRICARE Select as needed to get care in the civilian network —they must wait for the annual open enrollment period or a qualifying life event. Families must rely on MTFs to adhere to access standards or they may not be able to access appropriate care.

MTF appointment shortages pose a particular risk for special needs families since they must obtain all referrals for specialty care from their PCMs:

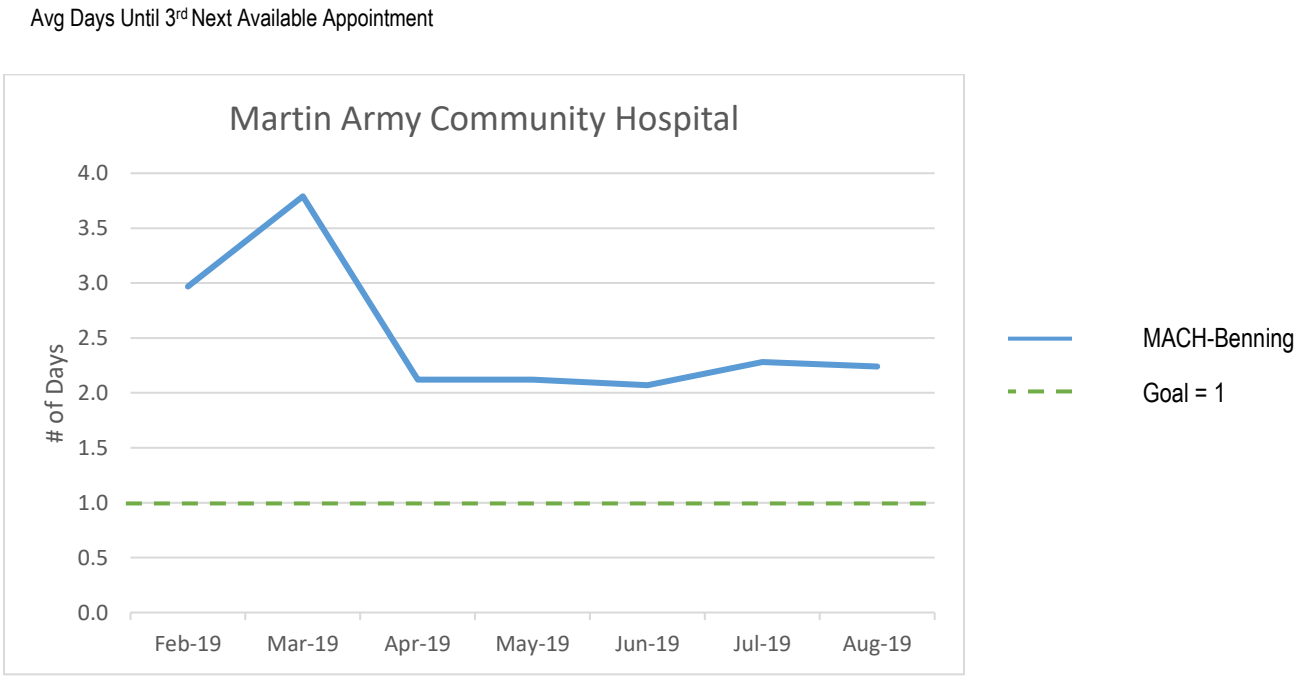
Fort Benning/Martin Army Community Hospital (MACH) – August 2019
So far this year, the clinics on post have not been able to provide acute services for my family 4 times this year: Feb. 1, May 31, June 5, Aug. 22. Yesterday morning I called to make a same-day appointment. I was informed that the first available appointment was on September 13 —22

[11] https://www.health.mil/Military-Health-Topics/Access-Cost-Quality-and-Safety/Patient-Portal-for-MHS-Quality-Patient-Safety-and-Access-Information/See-How-Were-Doing/MTF-Comparer?DmisIds=0330#pagecolumns_0$content_1$rpComparisonListCategories$ctl00$lvAccordionMeasures$ctrl0$hlAnchor

days away. Tricare access standards state that we be afforded an appointment within 24 hours. I called Tricare East customer service to attempt to change providers to an off-post facility and was informed that I was restricted due to my address being on post. I then called to attempt to speak to a patient advocate and no return call was made to me by close of business. I ended up taking my daughter to urgent care, and while I am thankful for that service, that should not be the answer to acute care issues. My daughter has reactive airways and needed to be seen for a related issue. Urgent care has no way to refer us to a provider that can follow her for this issue or provide follow-up care. It is clear to me that BMACH is unable to provide the necessary services and follow-up care to my family.

—Army Spouse/Special Needs Parent

According to MHS Transparency Data[12], Fort Benning's MACH consistently failed to meet the TRICARE Prime access standard for acute care during the timeframe cited by the Army spouse above:



[12] https://www.health.mil/Military-Health-Topics/Access-Cost-Quality-and-Safety/Patient-Portal-for-MHS-Quality-Patient-Safety-and-Access-Information/See-How-Were-Doing/MTF-Comparer?DmisIds=0048#pagecolumns_0$content_1$rpComparisonListCategories$ctl01$lvAccordionMeasures$ctrl0$hlAnchor

We understand appointment shortages will happen. But when a family experiences problems making appointments over a six month period, the MTF must adhere to access standards and refer them out to a civilian PCM. It is critical that DHA monitor MTF compliance to access standards to ensure military families have access to care.

- **DHA must designate, and publicize, an online tool allowing families to report MTF problems.**

No large medical system will be without patient complaints. We appreciate MHS reform is intended to address issues with access, quality and the patient experience, but we are concerned that MHS reform's massive system-wide changes will lead to increased patient problems in the short term. We also fear DHA does not currently have visibility to many of the challenges families face in the direct care system, including appointment shortages but also encompassing many other barriers to accessing care.

I'm so done! We've been waiting for 2 months for this appointment to get my daughter's MRI. At Walter Reed right now and they don't have her on the schedule. They offered me Sunday from 1-6am.

—Military Spouse

Our case manager has been at Ft Campbell for over 18 months and doesn't have a working voicemail. She proceeded to tell me to just keep calling back until she answered.

—Military Spouse/Mom of Special Needs Twins

When families encounter problems at their MTFs, they often do not know where to turn. Many are unclear on whether their problem should be addressed by the MTF or the TRICARE contractor. Patient advocates vary in their responsiveness and effectiveness. Expecting families to go directly to the MTF commander is not realistic —most will not perceive this as an option.

DHA must provide families with a highly publicized, easy-to-use online tool to report access to care and patient experience problems. These problems must be addressed, tracked and reported up to DHA to identify systemic or long-term issues. The Interactive Customer Evaluation (ICE) system may be the right platform, but it

currently has low awareness among families, and it is unclear if problems submitted via ICE are reported up to DHA.

Transformation of Direct Care System

We are looking forward to the FY17 NDAA Sec. 703 report release to better understand plans for direct care system realignment and rightsizing. In general, MOAA doesn't oppose changing how the military health care benefit is delivered, but we do oppose any reductions to the value of the benefit and/or beneficiary access to high quality care.

Last year's proposed medical billet cuts were a shock given the Sec. 703 report on Direct Care System realignment has not yet been released. We remain concerned that without proper research and mitigation plans, proposed billet cuts may negatively impact readiness and beneficiary access to care.

We are not convinced DHA and the Services have properly assessed TRICARE network adequacy given the potential influx of patients displaced from MTFs. Multiple factors have the potential to significantly increase demand for civilian network care including the proposed billet reductions, potential MTF rightsizing pending release of the Sec. 703 report, and the possible inclusion of MTFs in the Department of Veterans Affairs Community Care Networks.

MOAA appreciates the inclusion of Sec. 719 in the FY20 NDAA with reporting requirements intended to verify DHA and the Services are conducting necessary research, analysis and mitigation plan development before cutting uniformed medical billets or otherwise reducing care delivery in MTFs.

Other concerns and recommendations related to Direct Care System transformation include:

- What are plans for military medical education programs? **We ask Congress to protect the Uniformed Services University of the Health Sciences and graduate medical education programs to ensure a robust pipeline of military medical professionals** in the future.
- In MTFs that are downsized or closed, how will patient care be transitioned to civilian providers? **We ask DoD to ensure warm hand-offs for medically complex patients. We also ask Congress to monitor military kids' care impacted by cuts to uniformed**

pediatric billets to ensure military kids are transitioned to appropriate pediatric care and not simply moved to adult providers.

- What will Direct Care System specialty care consolidation look like in practice? Will family preferences be considered in referral decisions? How will travel to MTF Centers of Excellence be handled? **We ask DoD and Congress to protect patient choice regarding travel and referrals for specialty care** related to the establishment of military medical centers of excellence.

TRICARE Reform

TRICARE Copay Increases Present a Barrier to Accessing Care

MOAA is disappointed that, to date, TRICARE reform seems to be primarily focused on DoD savings by shifting more out-of-pocket costs to beneficiaries. We urge Congress and DoD to reconsider out-of-pocket cost increases and focus on fixing TRICARE policies that impede access to care, particularly for special needs families.

- **We ask Congress to return to TRICARE percent cost shares for mental health visits and physical, speech, and occupational therapy visits —15% for active duty family members and 20% for retirees.**
  - TRICARE's current fixed dollar copays have more than doubled beneficiary out-of-pocket costs for these visits. Because therapies (including mental health) are now considered specialty care, families are paying a significant portion of relatively low-cost treatments. Beneficiary cost shares now range from 30-45% of these lower cost appointments.

> *It is the physical therapy copays which make this medical care unaffordable for many. Personally, I am trying to figure out how a copay for PT is equivalent to a copay for a brain surgeon. I fail to understand why and who defined PT as specialty care for this high of copay.*
>
> —*Military Retiree*

  - Because therapies typically require recurring appointments, these excessive copays have a significant cumulative effect on families over a short treatment period. Some families report they have had to skip or cut short treatment plans due to copay increases.

> *We have had to cut back our speech therapy sessions in half because copays have more than doubled and our budget is still the same. What this means is that our child is not receiving the therapies she needs because we cannot afford the high weekly copays!*
>
> — *Military Spouse*

- DoD's September 2019 Report to Congress, *Consolidation of Cost Sharing Requirements under TRICARE Prime and Select*[13], validates these concerns.

> Approximately one-quarter of beneficiaries with household incomes below $50,000 reported postponing primary care sometimes, often, or usually. Rates of postponing specialty care or therapy requiring multiple visits were higher (about 30 percent) and, by beneficiary group, ADFMs were more likely to postpone care due to costs for therapy requiring multiple visits or picking up medications (25 percent) or specialty care (30 percent).

- **We request Congress halt pharmacy copay increases scheduled to occur through 2027** and ensure future pharmacy copay increases are not disproportionate (i.e., do not exceed the military retired pay cost of living adjustment or COLA.)
  - EFMP families without MTF access are hit hard by pharmacy copay increases since their family members often require multiple maintenance medications.
  - The TRICARE pharmacy copay table passed in the FY18 NDAA included annual increases that far exceed typical retiree COLA.
  - Congress passed TRICARE pharmacy copay increases to pay for the Special Survivor Indemnity Allowance (SSIA), a partial fix for the Widow's Tax (or Survivor Benefit Plan-Dependency and Indemnity Compensation (SBP-DIC) offset.[14]) MOAA opposed this because it is the government's responsibility – not military beneficiaries' – to fund the needed compensation for survivors whose sponsors died as a result of military service. Additionally, pharmacy copay increases negatively impacted many of the military survivors intended to benefit from SSIA.

[13] https://health.mil/Reference-Center/Congressional-Testimonies/2019/03/27/Consolidation-of-Cost-Sharing-Requirements-Under-TRICARE-Select-and-TRICARE-Prime

[14] https://www.dfas.mil/retiredmilitary/survivors/Understanding-SBP-DIC-SSIA.html

Now that the FY20 NDAA has eliminated the Widow's Tax, and SSIA will be sunset, Congress must halt pharmacy copay increases.

MOAA is not opposed to modest and predictable out-of-pocket cost increases not exceeding the military retirement cost of living adjustment (COLA.) The dramatic TRICARE copay increases implemented as part of MHS Reform not only diminish the military health care benefit, but they clearly present a barrier to accessing care and they must be addressed.

TRICARE Annual Enrollment Policy May Trap Families in MTFs

We remain concerned about the TRICARE annual open enrollment policy's potential to trap TRICARE Prime families in MTFs that don't meet their needs. We realize an annual open enrollment is a feature of civilian plans and generally have no issues with this new requirement. However, TRICARE Prime's reliance on military hospitals and clinics creates a situation unique to the military and demands a policy tailored to military family needs.

- We **urge DoD to add "dissatisfaction with MTF access or quality of care" to the list of Qualifying Life Events (QLEs)** for the following reasons**:**
  - For commercial health plans, the annual enrollment period locks in beneficiaries to coverage levels, not a single medical facility. While an annual enrollment period is not unreasonable, preventing military families from leaving their MTF if they experience problems with appointment access or quality of care is unreasonable.
  - Allowing families to switch enrollment from Prime to Select provides an important aspect of MTF accountability and will afford the MHS an opportunity to understand why families leave. Giving the MTFs competition by allowing patients to leave when they are dissatisfied will allow the MHS to identify problematic MTFs and develop improvement strategies for local access and quality of care problems.

TRICARE Coverage Gaps Present Challenges for Special Needs Families

TRICARE offers comprehensive coverage that works well for most families. However, EFMP families, particularly those dealing with medical complexity, sometimes face barriers to accessing care due to TRICARE reimbursement policies that are either outdated or a poor fit for pediatric care.

- We urge Congress and DoD to **fix TRICARE coverage gaps for emerging technologies and evolving treatment protocols.**

Since TRICARE coverage policies are governed by statute, they are often difficult to update to cover new medical technologies or treatment protocols. Even when legislation is not required, TRICARE policy often lags advancements. For instance, TRICARE's Criteria for Use on Continuous Glucose Monitors (CGMs) was written in 2009 and not updated until 2020. We appreciate DHA's recent policy update expanding Continuous Glucose Monitor coverage[15] to Type 2 diabetics and bringing it in line with Medicare coverage policy. We remain concerned TRICARE's updated policy still fails to cover all conditions that could benefit from CGMs. Diagnostic genetic testing is another rapidly advancing technology and we are concerned TRICARE policy is not evolving to ensure beneficiaries have access to the current standard of care.

- We ask Congress to **require DoD to implement the Defense Health Board recommendation to broaden TRICARE's definition of pediatric medical necessity.**

  TRICARE's reliance on Medicare reimbursement methodologies, a program designed for seniors, means TRICARE policy is sometimes a poor fit for pediatric care. For families with special needs children, TRICARE policy can mean administrative or financial burdens on top of their child's health care needs and the demands of military service. Due to their small numbers, unique needs, and the wide variety of TRICARE policy problems they encounter, we will seldom see a large public outcry to fix a single issue but it is still critically important to fix pediatric coverage gaps for the small number of impacted families. We need a mechanism to address the wide variety and evolving nature of the gaps between Medicare policy and pediatric care needs.

  The Defense Health Board's *Pediatric Health Care Services Report*[16] was released Dec. 18, 2017. The report documented TRICARE's pediatric policies are out of step with commercial plans and Medicaid and concluded TRICARE's current definition of medical necessity puts children at a disadvantage in receiving some needed services. The DHB recommended the MHS:

  > Modify the administrative interpretation of the regulatory language in 32 Code of Federal Regulations 199.2 to broaden the use of the "hierarchy of reliable evidence" for the benefit of pediatric beneficiaries. Exclusions to the hierarchy described under "reliable evidence" in 32 Code of Federal Regulations 199.2 should not preclude

[15] https://manuals.health.mil/pages/DisplayManualFile.aspx?Manual=TP08&Change=234&Type=ChangeOnly&Filename=TP08C-234COComposite.pdf

[16] Defense Health Board *Pediatric Health Care Services Report* – December 18, 2017 https://health.mil/About-MHS/Defense-Health-Agency/Special-Staff/Defense-Health-Board/Reports

pediatric services (a) meeting definitions of medical necessity used broadly in civilian practice or (b) recommended by recognized medical organizations.

Case Management Services Need an Overhaul

Effective case management could help EFMP families better navigate barriers to care across the MHS, coordinate care across the direct and purchased care systems, and more readily transfer care during PCS moves. Unfortunately, special needs families report case management services are fragmented (with separate case managers at the MTF, managed care support contractor, for ECHO coverage and EFMP non-medical case management) and often inadequate to address their needs. We appreciate the FY20 NDAA directed DoD to conduct a study on MHS case management including the effectiveness of case management practices at MTFs and by managed care support contractors. **EFMP families need case managers who are knowledgeable about the entire military system of care, as well as civilian resources, and proactively address EFMP family needs.**

MHS access to care, quality of care, and patient experience problems are not unique to EFMP families. However, it is important to consider the cumulative impact on special needs families who are frequent users of the system. Problems getting appointments, TRICARE coverage gaps for needed care and services, and dramatic copay increases add up over time and create barriers to accessing care. With the PolicyLab study, we now have evidence that military special needs families face greater problems with access and quality of care than their civilian counterparts. These problems must be addressed as part of MHS reform to ensure military health care is an unmitigated benefit —not another sacrifice to add to the many that service members and their families already make in support of our nation.