



Statement

by the

NATIONAL MILITARY FAMILY ASSOCIATION

for

**Subcommittee on
Military Personnel**

of the

**UNITED STATES HOUSE
ARMED SERVICES COMMITTEE**

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

Kelly B. Hruska, Government Relations Director

Kelly is the Government Relations Director of the National Military Family Association and took on this role in 2015. In this role, she leads the Association's advocacy for the families of the eight Uniformed Services and monitors the range of issues relevant to their quality of life. She began her work with the Association in 2007 as a Government Relations Deputy Director and served as Outreach Coordinator in 2014.

Kelly has represented military families on several committees and task forces for offices and agencies of the Department of Defense (DoD) and military services. She is co-chair of The Military Coalition (TMC), an organization of 34 military-related associations. She is also co-chair of TMC's Survivor Committee. In 2008-2011, she represented NMFA on the first DoD Military Family Readiness Council.

Prior to joining NMFA, Kelly worked to develop the next generation of entrepreneurs as the chief of staff of CONNECT and the chief of staff of the San Diego Regional Economic Development Corporation.

A Navy spouse for 26 years, Ms. Hruska has served in various volunteer leadership positions in civilian and military community organizations including COMPASS mentor, Navy-Marine Corps Relief Society, The Girl Scouts, and Navy Spouses Clubs. She was also appointed to the City Commission on Children and Youth by the Corpus Christi City Council.

Kelly is a recipient of the Navy's Meritorious Civilian Service Medal in recognition of her work on behalf of service members and their families at Navy Region Center Singapore.

A Pennsylvania native, Kelly earned her B.A. in Political Science from La Salle University and a Master of Public Administration from Shippensburg University. Ms. Hruska and her husband, Captain Jim Hruska, USN (Ret) reside in Annandale, Virginia with their daughter, Emily.

Thank you for the opportunity to present testimony concerning the Exceptional Family Member Program. After an unprecedented 18 years of continuous war, we continue to see the impact of repeated deployments and separations on our service members and their families. We appreciate your recognition of the service and sacrifice of these families, as well as the unique challenges facing families who have a child or other family member with special needs. Your response through legislation to the ever-changing need for support has resulted in programs and policies that have helped sustain these families through difficult times.

The Exceptional Family Member Program (EFMP) has evolved since its inception in 1979. Its original purpose was to make sure families had adequate medical services as they moved from installation to installation throughout the United States and overseas. Started by the Army, the other Services soon created their own programs that reflected the unique circumstances their families experienced. Over 40 years, the EFMP has expanded its scope and services to include three components – identification and enrollment, assignment coordination, and family support.

Military families tell our Association the issues they face in caring for a family member with special needs are complex. Most often, meeting these needs requires the coordination of many distinct military and community entities, with the responsibility for that coordination too often falling to the family. Military families caring for a special needs family member not only need medical and/or educational support, they also may require assistance from state and local agencies, relocation help, respite, and family support, especially if they are also faced with the deployment of their service members.

The accommodations and services provided through the EFMP are an incentive to remain on active duty for some military families. According to a 2019 study, *Strengthening the Military Family Readiness System for a Changing American Society*, by the National Academies of Sciences, Engineering and Medicine:

For some families, the benefits and accommodations the military makes to support families with special needs are an incentive to remain on active duty. The advantages include medical benefits afforded to the EFMP family members and assistance coordinating with schools and other programs and services. They also include the service member having the ability to take time off work to manage the special needs (although some supervisors might be more stringent) without worrying about getting fired or losing money the way one might in a civilian job if required to “clock out.”¹

In the Fiscal Year 2010 (FY10) National Defense Authorization Act, Congress created the Department of Defense (DoD) Office of Community Support for Military Families with Special Needs – now Office of Special Needs (OSN). OSN was created to enhance and improve DoD support around the world for military families with special needs, whether medical, educational, relocation, or family support. Over the years, OSN has worked to standardize the military services’ assignment coordination procedures and family support, as well as to provide more information to families about the resources available to them.

¹ National Academies Press, *Strengthening the Military Family Readiness System for a Changing American Society* (2019), Chapter 4, p.164.

Although OSN has made some progress, an integrated approach to supporting these families remains the goal and not the reality for many. Families need a seamless transition and a warm hand-off between installation family support, TRICARE regions, the mix of military and civilian medical providers, and a universal case management process across the Military Health System (MHS). MHS leaders and their TRICARE contractor partners must be more engaged with their family support counterparts both through the OSN and at the local levels to develop a coordinated case management system that includes military and community resources, as well as health care.

ASSIGNMENT COORDINATION

Military families complain EFMP assignment coordination is not thorough. Some say they are sent to areas with insufficient medical or educational assets to meet their needs. In other cases, providers exist, but long waitlists preclude access. This seems to be a problem for families with children on the autism spectrum at Joint Base Lewis-McChord (JBLM.) Many families being sent to JBLM report long wait lists for therapies even with the opening of the Center for Autism Resources, Education and Services (JBLM CARES.) ***We ask Congress to require DoD to develop and publish performance metrics to evaluate assignment coordination effectiveness to include evaluation of capacity of the available medical services and therapies and not just a yes/no availability.***

Our Association believes there needs to be more transparency in the assignment coordination process. Assignment coordinators need to provide more explanation to service members when they are not screened for an assignment. It is not uncommon to hear from families that they did not screen for an overseas assignment, but they know someone else with a similar diagnosis in their desired location. There are many reasons why families could be denied – possibly that health care specialty is at capacity or a provider has recently transferred from the duty station. Without a proper explanation, the family makes assumptions and then present the assumptions as fact.

Service members also need to be more transparent in the assignment coordination process. In a recent report on the well-being of military families, the National Academies of Sciences referenced the Department of Defense Exceptional Family Member Benchmark Study (Bronfenbrenner Center for Translational Research, 2013) indicating that, “military families enrolled in the EFMP expressed concerns regarding stigma surrounding special needs family members and military career advancement.”² Families have told us they’ve reduced school services for their child so they can go to their choice location. Some service members have moved their families overseas without command sponsorship because they were told there wasn’t adequate medical or educational services in their gaining location. Some service members don’t enroll their family members in the EFMP, even though enrollment is mandatory for active duty service members with a family member with special needs, because they are concerned it will hurt their career progression. While service members may not be able to have it all, open communication may allow them to have a long and satisfying military career while their family has access to the proper educational and medical supports and resources along the way.

A May 2018 Government Accountability Office (GAO) report *DoD Should Improve Its Oversight of the Exceptional Family Member Program*³, indicates each service uses various mechanisms to monitor

² National Academies Press, *Strengthening the Military Family Readiness System for a Changing American Society* (2019), Chapter 4, p. 161.

³ <https://www.gao.gov/products/GAO-18-348>

how service members are assigned to installations, but the report contains no details on how the individual services are monitoring assignment coordination effectiveness. We agree with GAO's recommendation that the OSN develop performance metrics for assignment coordination, specifically:

- OSN should develop common assignment coordination performance metrics across the Services. 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.
- Metrics should track compassionate reassignments/off schedule PCS moves due to inadequate medical resources at the gaining installation for EFMP families that were approved for that location. Compassionate reassignments of this nature indicate system failure and should be monitored to identify and address process breakdowns.
- Metrics should be reported at the installation level to provide actionable information.

MILITARY CHILDREN'S EDUCATION

Like most families, military families care deeply about the quality of their children's education. Military parents also worry about the effect that the military lifestyle has on their children's education – specifically, frequent military-ordered moves. Typically, military families move every two to three years, so a military-connected child can expect to attend six or more schools by the time they complete high school.

The Interstate Compact on Educational Opportunity for Military Children, which has been adopted by all 50 states and the District of Columbia, as well as the Department of Defense Education Activity (DoDEA), addresses many of the most common transition-related challenges faced by military-connected children moving to new schools. The widespread adoption of Common Core or similar standards means that military children are more likely to find familiar curricula and academic standards in their new schools. Together, the Interstate Compact and Common Core, help provide today's military children with smoother transitions and a more consistent academic experience than previous generations. Still, public schools are locally controlled – and financed – so policies, resources, and requirements vary from state-to-state and even district-to-district. Understandably, this is a source of stress for military families, who want their children to have the best possible education.

In February 2018, the Secretaries of the Army, Navy and Air Force sent a letter to the National Governor's Association affirming the importance of education to military families and calling on governors to ensure military-connected children in their state receive the best possible education. We commend the Secretaries for highlighting the importance of education and agree states and districts should set policies and allocate resources to support military children and provide them with a high-quality education. We also believe the federal government has a role to play.

Districts serving large numbers of military children rely on Impact Aid funding from the Department of Education and the DoD to help offset the additional expenses they incur, as well as compensate for lost property tax revenue when a district includes federal property such as a military installation. It is incumbent on DoD and the federal government to ensure school districts charged with serving military-connected children have the support they need to provide the best possible education. We are grateful to Congress for authorizing \$50 million for DoD Impact Aid and

\$20 million in Impact Aid for schools serving military children with special needs in the FY20 Appropriations. ***We ask Congress to protect this funding to offset the costs incurred by districts educating large numbers of military children.***

We continue to be concerned about the financial burden posed on school districts educating large numbers of military children with special needs. We wholeheartedly support sending military families with special needs family members to locations where their medical and educational needs can be met. However, in practice, this has led to concentrations of special needs military families in locations such as JBLM, where a large military treatment facility (MTF) and other specialized services are available. While the ready availability of services through the military and local civilian community benefits military families enrolled in the EFMP, we are concerned about the unintended burden on the school districts serving these installations, which must provide special education services. Serving unusually large numbers of children with severe special needs places great strain on the budgets of these school districts. We fear that in the long term this financial pressure will affect the quality of the education services these districts are able to provide. ***We ask Congress to require DoD to study where military families with severe special needs are concentrated and whether DoD Impact Aid for schools serving military children with special needs is appropriately allocated.***

Over the past year, families have reached out to our Association to express concerns about the lack of, or overtaxed educational resources, available to children with special needs in their local schools. In many cases civilian students, as well as military-connected students are affected. Some military families have demanded Impact Aid dollars be withheld from the local schools to force them to correct the problems. We would argue that withholding Impact Aid is not the solution. Our Association believes a dialogue regarding what an “appropriate” education consists of, within the constructs of the Individuals with Disabilities Education Act (IDEA), is in order. Although IDEA is not in the purview of this Committee, we urge you to reach out to your colleagues on the Education and Labor Committee to begin the dialogue.

MILITARY HEALTH SYSTEM (MHS)

What have families experienced during two years of Military Health System (MHS) Reform? Military families are grateful for referral free civilian urgent care as they now have access to care when their MTFs are full or closed. However, families have seen few other improvements across the system. In fact, TRICARE contractor transition problems plagued families throughout the entire first year of reform implementation with customer service challenges and rampant claims processing problems. Within the direct care system, there were few noticeable improvements to administrative hurdles or the patient experience. Although we recognize the primary objective of MHS reform was cost savings and a re-focus on readiness, we had hoped the higher out-of-pocket costs would be used for improvements across the system to improve the patient experience. Instead, families are paying considerably more for the same broken system.

Our Association is also concerned about the potential for unknown consequences on special needs family members as the MHS reforms refocus the system on readiness and as it reduces the number of military medical professionals. Will these changes limit access to specialized care for special needs family members in MTFs? Could families be sent to a location based on current specialty capacity only to see that specialty capacity reduced due to deployments and/or personnel transfers, forcing those military families to seek care in the community. We already know many special needs

families choose TRICARE Select to allow for greater flexibility or because the specialties their families need are not available at the MTF or in the network. As changes occur in the structure of the MHS over the next few years, the TRICARE Select option could become an important option for this group of families who might find availability of the care their special needs family member requires disappearing from their MTF.

TRICARE PROGRAM

Barriers to Transferring TRICARE Prime Specialty Care During PCS

Military families recognize they must sacrifice continuity of medical care because of the highly mobile military lifestyle. Unfortunately, TRICARE policy hinders rather than facilitates the transition of care during permanent change of station (PCS) moves. Established specialty care requires a new referral at each new duty station – even for chronic conditions (e.g., Type 1 Diabetes) where on-going specialty care is undoubtedly required. To re-establish their specialty care, newly relocated military families must first have an appointment with a new Primary Care Manager and get a new referral processed resulting in delays and disruptions in care. ***We ask Congress for legislation that requires TRICARE to allow valid specialty care referrals to transfer to the new duty station during a PCS.***

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.

In Section 701 of the FY17 NDAA, Congress eliminated the specialty care preauthorization requirement for outpatient care. We welcome this attempt to streamline access to specialty care, but it is only a partial solution. Allowing a valid referral to transfer to the new duty station would greatly help military families with the timely transition of specialty care. It would also eliminate unnecessary appointments to obtain new referrals and reduce the health care disruptions inherent in PCS moves.

Pediatric Definition of 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. Fortunately, most military children are healthy and won't encounter major TRICARE reimbursement issues due to their minimal use of the program. For those families with special needs children, however, 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 and the wide variety of TRICARE policy problems they encounter, we will seldom see a large public outcry from these families to fix

a single issue. We need a mechanism to address the wide variety and evolving nature of the gaps between Medicare policy and pediatric care needs. Every year we hear about new instances where TRICARE failed to meet the needs of military kids. For example:

“I wanted to let you know about a military family I recently met who had a problem with medical care overseas. Their 4-year old daughter contracted a virus and was an inpatient at a civilian hospital in Germany for several weeks before she passed away. While she was hospitalized her mom slept in the hospital room with her, not realizing that German hospitals – unlike U.S. hospitals – charge a “rooming in” fee. I believe the fee was 75 euros per night, so the total expense was quite large. The service member’s unit took up a collection to pay the bill. U.S. hospitals encourage parents to sleep in the hospital room with their child. Shouldn’t TRICARE cover something like this?”
-Jenna, Navy Spouse

International SOS, the TRICARE Overseas contractor, published a reminder on this issue in their provider newsletter with the following recommended action for overseas providers.

Institutional providers should make parents aware, if they wish to stay overnight to accompany their child, TRICARE will **not** cover the charges and the parent will be issued an invoice to pay the hospital for associated lodging costs, before the child is discharged.

-International SOS Provider Newsletter, March 2018

This does not really address the issue for parents and could, in fact, increase distress or present parents with a terrible choice to either leave their child alone at night or face significant charges.

Another example:

“My child recently had a VCUG, a test that is very difficult for the child because it involves a catheter and voiding on the exam table to assess bladder/kidney function. Her physician recommended partial sedation during the test, but TRICARE did not cover it. Why would TRICARE not cover something my daughter’s doctor recommended? She may need to have this test done again in the future, so we didn’t want her to have a traumatic experience during it.”
-Karen, Army Spouse

The voiding cystourethrogram (VCUG) is used to diagnose a number of bladder conditions. It is a procedure performed mainly on infants and young children. An NIH article⁴ reported that most unsedated children experience an unacceptable level of distress (serious or severe distress or panic) during the VCUG that could be avoided with sedation. Just because Medicare does not have a reimbursement policy for sedation during this procedure (and many other pediatric procedures) does not mean sedation is not the right course of action for pediatric patients.

We believe a pediatric definition of medical necessity is the best way to address TRICARE’S wide variety and evolving pediatric coverage gaps. After our Association, together with the TRICARE for

⁴ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2443423/>

Kids Coalition, repeatedly raised this issue at Military Family Readiness Council meetings, senior DoD leadership requested the Defense Health Board (DHB) to examine opportunities to improve the overall provision of health care and related services for children of members of the Armed Forces. The July 2016 report request specifically directed the DHB to:

Address any issues associated with the TRICARE definition of “medical necessity” as it might specifically pertain to children and determine if the requirement for TRICARE to comply with Medicare standards disadvantages children from receiving needed health care.

The DHB *Pediatric Health Care Services Report*⁵ was released December 18, 2017. The report documented TRICARE is out of step with commercial plans and Medicaid and concluded TRICARE’s current definition of medical necessity disadvantages children from 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 pediatric services (a) meeting definitions of medical necessity used broadly in civilian practice or (b) recommended by recognized medical organizations.

Unfortunately, the DoD’s December 2018 Report to Armed Services Committees, *The Plan to Improve Pediatric Care and Related Services for Children of Members of the Armed Forces*⁶, announced DoD is not planning to develop a uniform definition of pediatric medical necessity and presented no alternative plan to address pediatric care coverage gaps. ***We ask Congress to urge DoD to implement the Defense Health Board’s recommendation to broaden TRICARE’s definition of pediatric medical necessity.*** Fixing TRICARE’s reimbursement problems related to pediatric care is an essential part of the TRICARE reform effort.

TRICARE Extended Care Health Option (ECHO)

We appreciate DoD’s August 2018 proposed rule⁷ eliminating the concurrent ECHO benefit requirement. This would allow beneficiaries enrolled in ECHO to receive respite care regardless of whether another ECHO benefit is received in the same month. We are grateful the proposed rule eliminates this barrier to ECHO respite services. While eliminating the concurrent ECHO benefit requirement is a step in the right direction, ***we ask Congress to expand ECHO respite care hours to align more closely with state Medicaid Waiver programs*** to ensure special needs military families receive adequate support.

Medicaid Waiver programs provide long-term care services in home- and community-based settings to those who would otherwise require care in an institutional environment. Many states

⁵ 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>

⁶ <https://health.mil/Reference-Center/Congressional-Testimonies/2018/12/26/Report-on-Plan-to-Improve-Pediatric-Care-and-Related-Services-for-Children-of-Armed-Forces>

⁷ <https://www.federalregister.gov/documents/2018/08/17/2018-17463/tricare-extended-care-health-option-echo-respite-care>

have lengthy waitlists for their Medicaid Waiver programs leaving military families unable to access services when they PCS from one state to another before reaching the top of the waitlist.

"I have two special needs children and have never been able to access Medicaid services till our recent assignment. When we move out of state this summer, we will again lose services. In 9 years, we have received only 9 months of Medicaid waiver services due to frequent military moves. The process takes so long each time we PCS. It is really discouraging."

-Peggy, Navy Spouse

Congress established TRICARE's ECHO program as a substitute for state Medicaid Waiver services that are often unavailable to mobile military families. Medicaid Waiver program services 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 report⁸ and recommended ECHO covered services be increased to align with state Medicaid Waiver programs more closely. 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.

While the proposed rule eliminating the concurrent ECHO benefit requirement is a helpful first step, we believe it is important for DoD to further address ECHO deficiencies by increasing the total number of respite hours available to families. The current 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 play in intermittent, low hours care.

To ensure that military families' higher out-of-pocket costs result in improvements to their health care system, ***we ask Congress and DoD to:***

- ***Reduce copays for mental health visits and physical, speech and occupational therapies***
- ***Allow valid TRICARE Prime specialty care referrals to transfer to the new duty station during a PCS***
- ***Implement the DHB's recommendation to broaden TRICARE's definition of pediatric medical necessity***
- ***Require DoD to develop and publish performance metrics to evaluate EFMP assignment coordination effectiveness***
- ***Align TRICARE ECHO respite coverage with Medicaid waiver programs***

⁸ <https://docs.house.gov/meetings/AS/AS00/20150204/102859/HHRG-114-AS00-20150204-SD001.pdf>

MILITARY FAMILIES –OUR NATION’S FAMILIES

While our Association and military families may be frustrated with the slow pace of process and service improvement, it is important to note that the DoD and the Service Branches offer services and supports to help our special needs families successfully navigate military life. We appreciate the help Congress has provided over the years and look forward to continuing to work together to ensure the system works for everyone.

Evolving world conflicts keep our military service members on call. Our military families continue to answer this call as well, even as they are dealing with the long-term effects of almost two decades at war. The government should ensure military families have the resources to remain ready. Effective support for military families with special needs must involve a broad network of federal, state and local government agencies, community groups, businesses, and concerned citizens. Our Nation must continue to fund what works to support military families, protect the most vulnerable, and, above all, value their service.