

Military Health System Reform: What is it and What Does it Mean for Military Families?

OVERVIEW

The Military Health System (MHS) is in a period of significant transformation. MHS reform, mandated by the Fiscal Year 2017 (FY17) National Defense Authorization Act (NDAA), is leading to broad changes to the administration and composition of the MHS. This reform will have long-term implications for how and where service members, retirees, and military families access their health care.

While it's common to think of MHS reform as a single effort, it actually consists of three separate but interrelated changes, two mandated by the FY17 NDAA and one undertaken independently by the Services. The FY17 NDAA shifted the administration of Military Treatment Facilities (MTFs) from the individual Services to the Defense Health Agency (DHA). It also directed DHA to conduct a review of all MTFs to determine which needed to be "right-sized."

The first two elements of MHS reform are law and unless Congress changes the law, the Department of Defense must enact these changes and report progress to Congress. Separately, in its FY2020 budget, the Department of Defense proposed cutting 18,000 medical billets and replacing them with combat support and warfighting positions, in order to boost readiness.

This paper reviews the background of the MHS reform process, analyzes the possible impact on military families, and offers NMFA's position on each element of the proposed reforms.

NMFA'S CORE PRINCIPLES ON MILITARY FAMILY HEALTH CARE

At NMFA, we stand firmly on these core principles regarding health care for military families:

- » Health care is an earned benefit. The value and quality of the health care benefit must be commensurate with the value of military service. Degrading the value of the benefit by decreasing quality or unduly increasing costs is unacceptable.
- » The health care benefit must continue to include a no-cost option for active duty families.
- » Military families have the right to expect high quality, easily accessible primary and specialty care wherever they happen to be stationed. If high quality care is not available in the civilian network, families must have access to an MTF.

MHS Reform Element 1: DHA Management of MTFs

The FY17 NDAA included a provision transferring administrative and management responsibilities of all MTFs from the individual military services to DHA. This has been a gradual process, taking place in stages.

In October 2018, DHA assumed responsibility for 31 hospitals and clinics. The following year, on October 1, 2019, DHA formally took administrative responsibility of all MTFs. However, DHA did not have sufficient personnel to fully manage all MTFs, nor had they put in place the necessary processes and systems. For that reason, the services continued to provide day-to-day administrative support to MTFs while DHA worked to increase its capacity and establish its administrative structures. That support was scheduled to end on September 30, 2020.

By February 2020, DHA had established four of 21 planned “market offices” to manage MTFs: The National Capital Region; Central North Carolina; Coastal Mississippi; and Jacksonville, Florida. However, the national emergency caused by the COVID-19 pandemic led to a diversion of DHA and military medical resources, making it impossible for DHA to continue the transition process. In response, DHA announced on April 2 a 90-day pause in MTF transition activities, with the plan to reassess after 45 days. As of August 26, DHA has not announced a resumption of the transition process.

NMFA'S POSITION: This element of MHS reform should be least visible to beneficiaries. Most beneficiaries will not know, or care, if their MTF is managed by DHA or by one of the service branches. Part of the rationale behind transitioning control of MTFs to DHA was to provide service members and families a standardized, predictable health care system — particularly in the area of patient-facing administrative processes. It should allow for a common approach to collecting data and evaluating measures of quality, as well as make it easier for best practices to be shared across the MHS. Centralizing administration and management under DHA should eliminate many of the inconsistencies in health care that have frustrated military families.

We believe success of this transition will be determined by:

- » Standardized/common patient-facing administrative processes across MTFs
- » Greater coordination of care when families transition from one duty station to another
- » Increased fidelity in quality measures
- » Increased transparency of quality measures to beneficiaries

To date DHA has not met its mandate to standardize clinical and business practices across the MHS. We urge DHA to provide an update on their progress in developing and implementing consistent policies, procedures, and standard clinical and business processes, as well as metrics to ensure performance-based accountability.

MHS REFORM ELEMENT 2: MTF “RIGHT-SIZING”

Section 703 of the FY17 NDAA directed the Department of Defense (DoD) to submit an “implementation plan to restructure or realign the military medical treatment facilities,” in order to sharpen the MHS’ focus on operational and medical readiness. This plan was required to identify MTFs that should be restructured and a justification for doing so, including an analysis of the capacity of the civilian network to absorb patients.

In February 2020, DoD released the report required under Section 703. The report identified 50 MTFs for “right-sizing.” The majority of the MTFs identified will transition to caring for active duty service members only. Family members and retirees will be shifted to the civilian network. In some locations, active duty family members may be assigned a primary care manager in an MTF in order to support military medical professional readiness. No timeline was given for this transition and DHA stated it would be “conditions based,” depending on the quality and availability of care in the civilian network.

In May 2020, the Government Accountability Office (GAO) released a report analyzing DHA’s plans for MTF restructuring. The report raised questions about the accuracy of DHA’s assessment of the quantity and quality of health care available in the civilian networks at locations selected for MTF restructuring. GAO also found that once the restructuring process is underway, DHA has no procedures in place to assess whether it’s working, or to reverse the process and bring beneficiaries back to the MTF.

NMFA'S POSITION: DHA has admitted that shifting beneficiaries to the civilian network might create challenges in some locations, implicitly acknowledging that the civilian network may have difficulty absorbing the increased demand for health care. The GAO report indicates DHA does not have an accurate picture of the quality and capacity of the civilian health care network, making those challenges even more likely.

It’s also essential to consider the impact of the COVID-19 pandemic, which has presented many civilian health care practices with enormous financial challenges, as patients delayed or deferred non-urgent care for fear of contracting the virus. The Medical Group Management Association reported in late April that 97 percent of medical practices have experienced a negative financial impact directly or indirectly related to COVID-19, forcing many practices to lay off staff. Smaller practices that operate on thin margins under normal

circumstances may not be able to weather the sustained loss of revenue. Increased use of telemedicine has provided some practices with a financial lifeline. However, it is difficult to assess the long-term impact of the pandemic on the civilian health care system.

This is relevant to the issue of MTF restructuring because DoD is depending on a robust network of health care providers to absorb the greater demand for care. One of DoD's underlying assumptions is that new providers will enter the local civilian networks as beneficiary demand grows; however, circumstances have changed dramatically, and we can no longer assume that will be the case.

Continuing with MTF right-sizing without an accurate and recent view of the quality and capacity of civilian health care networks puts the health of military families at risk. NMFA supports pausing all MTF right-sizing until the end of the national emergency; at that time, the capacity and quality of the civilian networks at the identified locations must be reassessed before the transition proceeds. For right-sizing to proceed, NMFA expects:

- » Greater transparency on local conditions (quality and capacity)
- » Increased/improved communications to affected beneficiaries
- » Improved/more reliable provider directories with measures of provider quality

MHS REFORM ELEMENT 3: BILLET REDUCTIONS

In its FY20 budget request, DoD indicated its intention to eliminate 18,000 medical billets across the Army, Navy, and Air Force. The Department provided no information about which locations or medical specialties would be impacted. In response, Congress included a provision in the FY20 NDAA halting billet reductions until DoD and the Services demonstrate they have addressed all readiness and beneficiary care impacts via reviews, analyses, mitigation plans, and beneficiary outreach. That report was due in June 2020, but due to the impact of the COVID-19 pandemic, DoD requested an extension.

NMFA'S POSITION: The lack of information about the billets set to be cut makes it difficult to assess the impact on beneficiaries' access to care, as well as how the quality of care may be impacted with a shift to network providers. Given the Services' emphasis on force readiness, we are concerned the cuts will disproportionately affect specialties such as pediatrics, obstetrics, and family practice that primarily provide care to family members.

We understand ensuring a medically ready force and a ready medical force are DHA's priorities. However, DoD has a responsibility to ensure families have the services and support they need wherever they happen to be stationed, which includes access to high-quality health care — an earned benefit. The scope of the proposed cuts combined with questions about the viability of the civilian network give us concern that DoD will not be able to meet this responsibility.

To ensure families are able to receive high-quality medical care, NMFA expects:

- » Full transparency surrounding medical billet cuts, including affected locations and specialties
- » Reliable information about network capacity in affected locations, including quality metrics
- » A reassessment of the role of military medicine in light of lessons learned from the COVID-19 emergency

Who We Are

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, Space Force, Coast Guard, and Commissioned Corps of the USPHS and NOAA.