



**NATIONAL  
MILITARY FAMILY  
ASSOCIATION**

Together we're stronger

Statement of

**Kathleen B. Moakler  
Government Relations Director**

**NATIONAL MILITARY FAMILY ASSOCIATION**

Before the

**Subcommittee on  
Military Personnel**

of the

**UNITED STATES HOUSE OF REPRESENTATIVES  
ARMED SERVICES COMMITTEE**

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Military families serve our country with pride, honor, and quiet dedication. The National Military Family Association is the leading nonprofit organization committed to strengthening and protecting the families of the men and women currently serving, retired, wounded or fallen. We provide families of the Army, Navy, Marine Corps, Air Force, Coast Guard, and Commissioned Corps of the USPHS and NOAA with information, work to get them the benefits they deserve, and offer programs that improve their lives. Our over 40 years of service and accomplishments have made us a trusted resource for military families and the Nation's leaders.

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

The Association does not have or receive federal grants or contracts.  
Our website is: [www.MilitaryFamily.org](http://www.MilitaryFamily.org).

#### **Kathleen B. Moakler, Government Relations Director**

Mrs. Moakler has been associated with the National Military Family Association since 1995 as a member of the headquarters staff. She was permanently appointed to Government Relations Director in October 2007. In that position, she monitors the range of issues relevant to the quality of life of the families of the seven uniformed services and coordinates a staff of 4 deputy directors. Mrs. Moakler represents the interests of military families on a variety of advisory panels and working groups, including the DoD/VA Survivors Forum, and the State Department Interagency Roundtable. Mrs. Moakler is co-chair of the Survivor Programs Committee for the Military Coalition (TMC), a consortium of 34 military and veteran organizations and serves on the Retiree Committee. She is often called to comment on issues pertaining to military families for such media outlets as the NY Times, CNN, NBC News, NPR and the Military Times. She writes regularly for military focused publications.

An Army spouse of over 28 years, Mrs. Moakler has served in various volunteer leadership positions in civilian and military community organizations in that time. She has worked with many military community programs including hospital consumer boards, commanders' advisory boards, family readiness groups, church councils, youth programs, and the Army Family Action Plan at all levels. She believes that communication is paramount in the efficient delivery of services and the fostering of a rich community life for military families. She holds a Bachelor of Science degree in Business Administration from the State University of New York at Albany. Mrs. Moakler has been awarded the Army Commanders Award for Public Service and the President's Volunteer Service Award.

Mrs. Moakler is also a military mom. Her daughter, Megan is an Army nurse who has served two tours in Iraq and is presently stationed at Ft. Sill, Oklahoma, and son, Matthew is an Army major stationed at Ft. Belvoir, Virginia. Her oldest son, Marty, works for Hulu.com and is an aspiring writer/actor in Los Angeles, California. Mrs. Moakler and her husband, Colonel Martin W. Moakler, Jr. USA (retired), reside in Alexandria, Virginia.

Chairman Wilson and Distinguished Members of the Subcommittee, the National Military Family Association thanks you for the opportunity to present testimony on the quality of life of military families – the Nation’s families. The military health care benefit is an important component of that quality of life for our active duty, reserve component, and retired service members, their families, and survivors. Your recognition of the sacrifices of these families and your response through legislation to the increased challenges facing them has been greatly appreciated.

We endorse the recommendations contained in the statement submitted by the Military Coalition. In this statement, our Association will expand on several issues of importance to military families as they relate to Family Health. We will expand on other aspects of the quality of life of military families in our statement for the record for the Subcommittee’s hearing on Military Personnel issues scheduled for March 17, 2011.

## **Family Health**

Family readiness calls for access to quality health care and mental health services. Families need to be assured the various elements of their military health system are coordinated and working as a synergistic system. The direct care system of Military Treatment Facilities (MTFs) and the purchased care segment of civilian providers under the TRICARE contracts must work in tandem to meet military readiness requirements and ensure they meet access standards for all military beneficiaries.

### **Improving Access to Care**

Our Association continues to monitor the experience of military families with accessing care within both the direct care and purchased care segments of the Military Health System (MHS). We are concerned our MTFs are stressed from ten years of provider deployments, which directly affects the quality, access, and cost of health care. We have consistently heard from families that their greatest health care challenge has been getting timely care in both the direct and the purchased care systems. Their main challenges with the direct care system are:

- access to their Primary Care Managers (PCM)
- availability of after-hours care
- having appointments available in MTFs for 60, 90, or 120-day follow-ups recommended by their providers

Their main challenges with purchased care system, according to TRICARE’s *Health Care Survey of DoD Beneficiaries 2009 Annual Report* are difficulty in accessing personal doctors and specialty care.

Our Association hears frequent complaints by families regarding the referral process. Families who are unfamiliar with the process at their facility and in their TRICARE region report not being able to obtain an appointment within access standards. Often, they find that a provider on the TRICARE Managed Care Support Contractor’s (MCSC) list is no longer taking TRICARE or taking new patients. The difficulties sometimes cause the beneficiary to give up on the referral process and never obtain the specialty appointment their PCM believes they need. Our Association is concerned with the impact these delays or the lack of even getting the referral is having on the quality of care and beneficiary outcome. We cannot stress enough how continuity of care is important to maintain our families’ quality of care. We recommend Congress require the Department of Defense (DoD) report on the management of the referral process—both within the direct care system and between the direct care and purchased care sectors—and the impact on beneficiaries’ access to care.

We see even more issues ahead that could affect beneficiary access. The TRICARE Management Activity (TMA) will roll out the new TRICARE Third Generation (T3) contract in the TRICARE North Region beginning April 2011. At that time, the remaining two TRICARE Regions will still be operating under the existing TRICARE Next Generation (T-Nex) contract. Because of the recent announcement of a T3 award change in the South Region and subsequent protest filed, full T3 implementation will remain in a holding pattern, preventing contractors' renegotiation with approximately 66 percent of our civilian TRICARE providers. With the demands and uncertainties to providers in regards to health care reform's added requirements and expenses along with looming Medicare reimbursement rate changes, we are concerned about providers' long-term willingness to remain in the TRICARE network and about the contractors' ability to recruit new providers. Thus, the combination of factors may result in a decreased access to care for military families.

### **National Guard and Reserve Member Family Access to Care**

We remain especially concerned about access to care for our National Guard and Reserve families. These families also need increased education about the multiple types of TRICARE health care benefits in which they are eligible to participate. We recommend Congress request a report to assess the coordination and continuity of health care services for our National Guard and Reserve families as they frequently move from activated TRICARE Prime coverage to non-activated status and TRICARE Reserve Select (TRS) or their employer civilian health care insurance plans. We also believe that paying a stipend to a mobilized National Guard or Reserve member for their family's coverage under their employer-sponsored insurance plan while the service member is deployed may work out better for many families in areas where the TRICARE network may not be robust.

### **TRICARE Reimbursement**

Our Association is concerned that continuing pressure to lower Medicare reimbursement rates will create a hollow benefit for TRICARE beneficiaries. We are appreciative Congress passed the *Medicare and Medicaid Extenders Act of 2010* (P.L.111-309), which provided a one-year extension of current Medicare physician payment rates until December 31, 2011. As the 112<sup>th</sup> Congress takes up Medicare legislation this year, we ask you to consider how this legislation will impact military health care, especially our most vulnerable populations, our families living in rural communities, and those needing access to mental health services.

While we have been impressed with the strides TMA and the TRICARE contractors are making in adding providers, especially mental health providers to the networks, we believe more must be done to persuade health care and mental health care providers to participate and remain in the TRICARE system, even if that means DoD must raise reimbursement rates. We frequently hear from providers who will not participate in TRICARE because of what they believe are time-consuming requirements and low reimbursement rates. National provider shortages in the mental health field, especially in child and adolescent psychology, are exacerbated in many cases by low TRICARE reimbursement rates, TRICARE rules, or military-unique geographic challenges, such as large military beneficiary populations in rural or traditionally-underserved areas. Many mental health providers are willing to see military beneficiaries on a voluntary status. We need to do more to attract mental health providers to join the TRICARE network. Increasing reimbursement rates is just one way of enticing them.

*We recommend Congress require a DoD report on the impact on beneficiaries of the MHS referral process. We ask Congress also to require a report assessing the coordination and continuity of health care services for National Guard and Reserve families as they transition from one TRICARE status to another. Lastly, we ask for a legislative change to allow reserve component families to be given the choice of a stipend to continue their employer-provided care during the deployment of the service member.*

## Pharmacy

For several years now, our Association has cautioned about DoD generalizing findings of certain civilian beneficiary pharmacy behaviors and automatically applying them to the military population. As part of the President's FY 2011 Budget proposal, DoD recently announced it would adjust certain pharmacy co-payments. DoD's intent is to drive beneficiaries away from Retail pharmacies and toward TRICARE Mail Order Pharmacy (TMOP) utilization, which should lower government costs and increase DoD savings. Our Association has long championed a zero co-payment for generic Tier 1 medications in TMOP and we applaud DoD's proposal to implement this as one of their cost-saving measures. While we believe the rationale behind the proposed changes is sound, we request that Congress require DoD to report on how these changes impact beneficiary behavior and health care quality outcomes.

We do have some concerns with the proposed increase in co-pays for retail formulary and non-formulary medications and the impact this increase will have on beneficiaries who have no choice but to rely on the retail pharmacy for urgent non-maintenance medications. For example, the young families of deployed National Guard or Reserve members or recruiters usually do not live close to an MTF pharmacy. When their child needs an antibiotic for an urgent medical condition, such as pneumonia or an ear infection, they have no other option than the retail pharmacy. Currently, they would pay \$3 for a course of a generic antibiotic treatment; under DoD's proposal, they would now pay \$5. Beneficiaries who need certain medications not suited for TMOP because they are a narcotic or their chemical compound is not suitable for home delivery would also pay more under DoD's proposal.

We are also concerned about the effect of the proposed co-pay changes on our wounded, ill, and injured service members and those already medically retired. This population may be adversely affected because of the frequent alteration to their medication protocols by their health care providers in order to achieve optimum medical benefits for their often-changing medical conditions. Their medications may appear to be a maintenance drug, but are actually intended to be used only for short-term relief. Sending them to the mail order for a 90-day supply just because the co-payment is less may in fact cost the beneficiary and the government more because of frequent changes in doses. Many of the prescriptions needed by the wounded are for newly FDA-approved medications, which will most likely place them in non-Formulary Tier 3 status. This may place an unfair financial burden on this population because they tend to utilize a higher number of medications.

Beneficiaries who have no choice in where they must obtain their medications should not be subjected to co-payment increases aimed at changing the behavior of those who do have choices. DoD must consider the possible effects of its co-payment changes as it plans for implementation and may need to devise alternative co-payment adjustments to protect beneficiaries during these situations. We look forward to discussing potential options with Members of Congress and DoD.

In addition to the elimination of the TMOP co-payment for generic drugs as an enticement for beneficiaries to switch maintenance medications from retail to TMOP, we believe there are additional ways DoD could experience increased pharmacy savings. These include:

- Make all medications available through TRICARE Retail pharmacy also available through TRICARE Mail Order Pharmacy (TMOP)
- Provide medications treating chronic conditions, such as asthma, diabetes, and hypertension at the lowest level of co-payment regardless of brand or generic status

- Implement *The Task Force on the Future of Military Health Care* recommendation to include over-the-counter (OTC) drugs as a covered pharmacy benefit, thus eliminating the need for more costly pharmaceuticals that have the same efficacy as over-the-counter options.

The new T3 contract will provide TRICARE MCSC and Express-Scripts, Inc., the ability to link pharmacy data with disease management. This will allow for better case management, increase adherence/compliance, and decrease cost, especially for beneficiaries suffering from chronic illness and multiple conditions. However, this valuable tool will only be available this year in the TRICARE North Region because the T3 contract still remains under protest in the remaining two Regions.

*We applaud the proposed changes to co-pays for TMOP participants as a way to drive more beneficiaries to TMOP to increase DoD efficiencies. We support the rationale behind proposed changes to the co-payments for the Retail pharmacy, but caution that beneficiaries should not be penalized for the purchase of urgent, non-maintenance drugs or those drugs not available via mail order.*

### **National Health Care Proposal**

Our Association is cautious about all the changes proposed in the *Patient Protection and Affordable Care Act* (P.L. 111-148) and their potential impact on TRICARE and CHAMPVA. We thank Congress for including a provision in the NDAA FY11 to allow TRICARE to provide coverage for TRICARE eligible young adult beneficiaries up to the age of 26. Our families have been asking for this added benefit. We await its implementation and are appreciative that DoD is working hard to ensure TRICARE Young Adult (TYA) Standard/Extra coverage is made available before our beneficiaries' college age students graduate this May. We appreciate the inclusion of a TRICARE Young Adult Prime option by Congress and look forward to its implementation this fall, as well. We understand DoD is addressing the issue of access to MTFs for those eligible TYA Prime non-ID card holders. However, we still need Congressional action to allow CHAMPVA to allow young adults up to the age of 26 to participate.

*Congress needs to act to provide health care coverage to young adults, up to the age of 26, who are eligible for CHAMPVA.*

### **Cost Saving Strategies in the 2012 Budget**

We appreciate DoD's continued focus on cost savings strategies in the 2012 budget. DoD's proposed TRICARE changes include a change in enrollment fees for TRICARE Prime for under age 65 retirees and a change in pharmacy co-pays. DoD should also incur savings through better management of health care costs. Our Association has always supported a mechanism to provide for modest increases to TRICARE Prime enrollment fee for retirees under 65. TRICARE Prime, the managed care option for military beneficiaries, provides guaranteed access, low out of pocket costs, additional coverage, and more continuity of care than the basic military health benefit of TRICARE Standard. The annual enrollment fee of \$230 per year for an individual retiree or \$460 for a family has not been increased since the start of TRICARE Prime in 1995.

We agree that DoD's proposed increase of \$5 per month per family and \$2.50 per month per individual plan is indeed modest. We applaud DoD for deciding not to make any changes to the TRICARE benefit for active duty, active duty family members, medically retired service members, and survivors of service members and for not making any changes to the TRICARE Standard and TRICARE for Life (TFL) benefit.

We have some concerns regarding DoD's selection of a civilian-based index in determining TRICARE Prime retiree enrollment fee increases after 2012. Our Association has always supported the use of Cost of Living Allowance (COLA) as a yearly index tied to TRICARE Prime retiree enrollment fee increases.

We believe if DoD thought the rate of \$230 for individual and \$460 for family was appropriate in 1995, then yearly increases tied to COLA would maintain that same principle. Our concern over the utilization of a civilian index is based on our concern that civilian health care experts cannot agree on an accurate index to base civilian health care yearly cost increases. The *Task Force on the Future of Military Health Care* “strongly recommended that DoD and that Congress accept a method for indexing that is annual and automatic.” However, the Task Force recommended “using a civilian-only rather than total cost (including civilian and MTF costs for Prime beneficiaries) because the Task Force and DoD have greater confidence in the accuracy of the civilian care data and its auditability.” We ask Congress to adopt the Task Force’s DoD accountability recommendation and require DoD to become more accurate and establish a common cost accounting system across the MHS. Until it can do so, however, we believe increases tied to COLA are the most fair to beneficiaries and predictable for DoD.

We do not support DoD’s budget proposal to change the U.S. Family Health Plan (USFHP) eligibility, asking newly enrolled beneficiaries to transition from USFHP once they become Medicare/TRICARE for Life eligible. Our Association believes USFHP is already providing TMA’s medical home model of care, maintaining efficiencies, capturing savings, and improving patient outcomes. Every dollar spent in preventative medicine is captured later when the onset of beneficiary co-morbid and chronic diseases are delayed. It is difficult to quantify the long-term savings not only in actual cost to the health care plan—and thus to the government—but to the improvement in the quality of life for the beneficiary. Removing beneficiaries from USFHP at a time when they and the system will benefit the most from their preventative and disease management programs would greatly impact the continuity and quality of care to our beneficiaries and only cost shift the cost of their care from one government agency to another. Almost all USFHP enrollees already purchase Medicare Part B in case they decide to leave the plan or spend long periods of time in warmer parts of the country. There must be another mechanism in which beneficiaries would be allowed to continue in this patient-centered program. USFHP also meets the *Patient Protection and Accountability Care Act’s* definition of an Accountable Care Organization. They certainly have the model of care desired by civilian health care experts and should be used by DoD as a method to test best-practices that can be implemented within the direct care system.

Our Association understands the need for TRICARE to align itself with Medicare reimbursement payments. DoD’s proposal to implement reimbursement payment for Sole Community Hospitals is another example of its search for efficiencies. According to TMA, 20 hospitals that serve military beneficiaries could be affected by this change. We appreciate the four-year phased-in approach. However, our Association recommends Congress encourage TMA to reach out to these hospitals and provide waivers if warranted and provide oversight to ensure beneficiaries aren’t unfairly impacted by this proposal.

### **Other Cost Saving Proposals**

We ask Congress to establish better oversight for DoD’s accountability in becoming more cost-efficient. We recommend:

- Requiring the Comptroller General to audit MTFs on a random basis until all have been examined for their ability to provide quality health care in a cost-effective manner
- Creating a committee, similar in nature to the Medicare Payment Advisory Commission, to provide oversight of the DoD Military Health System (MHS) and make annual recommendations to Congress. *The Task Force on the Future of Military Health Care* often stated it was unable to address certain issues not within their charter or within the timeframe in which they were commissioned to examine the issues. This Commission would have the time to examine every issue in an unbiased manner.

- Establishing a Unified “Joint” Medical Command structure. This was recommended by the Defense Health Board in 2006 and 2009 and included in the U.S. House Armed Service Committee’s NDAA FY11 proposal and passed by the House of Representatives.

We are supportive of TMA’s movement toward a medical home model of patient and family-centered care within the direct and purchase care systems. An integrated health care model, where beneficiaries will be seen by the same health care team focused on well-being and prevention, is a well-known cost saver for health care expenditures. Our concern is with the individual Services’ interpretation of the medical home model and its ability to truly function as designed. Our MTFs are still undergoing frequent provider deployments; therefore, the model must be staffed well enough to absorb unexpected deployments to theater, normal staff rotation, and still maintain continuity of providers within the medical home.

Our Association believes right-sizing to optimize MTF capabilities through innovating staffing methods; adopting coordination of care models, such as medical home; timely replacement of medical facilities utilizing “world class” and “unified construction standards;” and increased funding allocations, would allow more beneficiaries to be cared for in the MTFs. This would be a win-win situation because it increases MTF capabilities, which DoD asserts is the most cost effective. It also allows more families, who state they want to receive care within the MTF, the opportunity to do so. The Task Force made recommendations to make the DoD MHS more cost-efficient, which we support. They conclude the MHS must be appropriately sized, resourced, and stabilized and make changes in its business and health care practices. We encourage Congress to include the recommendations of the *Task Force on the Future of Military Health Care* in this year’s NDAA FY12. These include:

- Restructuring TMA to place greater emphasis on its acquisition role
- Examining and implementing strategies to ensure compliance with the principles of value-driven health care
- Incorporating health information technology systems and implementing transparency of quality measures and pricing information throughout the MHS (This is also a civilian health care requirement in the recently passed *Patient Protection and Affordable Care Act*.)
- Reassessing requirements for purchased care contracts to determine whether more cost effective strategies can be implemented
- Removing systemic obstacles to the use of more efficient and cost-effective contracting strategies.

*We approve of DoD’s modest increase to TRICARE Prime enrollment fees for working age retirees. We recommend that future increases to TRICARE Prime enrollment fees for working age retirees be indexed to retired pay cost of living adjustments. We recommend that Medicare-eligible beneficiaries using the USFHP be allowed to remain in the program. Our Association recommends Congress encourage TMA to reach out to Sole Community hospitals serving large numbers of military beneficiaries and provide waivers if warranted.*

### **Behavioral Health Care**

Our Nation must help returning service members and their families cope with the aftermath of war. DoD, the Department of Veterans Affairs (VA), and State agencies must partner in order to address behavioral health issues early in the process and provide transitional mental health programs, especially during Permanent Change of Station (PCS) moves. Partnering will also capture the National Guard and Reserve member population, who often straddle these agencies’ health care systems.

### **Full Spectrum of Care**

As the war continues, the call for families who need a full spectrum of behavioral health services—from preventative care and stress reduction techniques, to counseling and medical mental health services—is

growing louder. The military offers a variety of psychological health services, both preventative and treatment, across many agencies and programs. However, as service members and families experience numerous lengthy and dangerous deployments, we believe the need for confidential, preventative psychological health services will continue to rise. More importantly, this need will remain high even after military operations scale down.

The rise in suicides among our active duty and reserve component service members demonstrates the need for these mental health services are at dangerous levels. Our Association commissioned the RAND Corporation to conduct a study on the impact of the war on caregivers and children, *Children on the Homefront: The Experience of Children from Military Families*. The study found military children reported higher anxiety signs and symptoms than their civilian counterparts. A recent study by Gorman, et. al (2010), *Wartime Military Deployment and Increased Pediatric Mental and Behavioral Health Complaints*, found an 11 percent increase in outpatient mental health and behavioral health visits for children from the ages of 3-8 during 2006-2007. There was an 18 percent increase in pediatric behavioral health and a 19 percent increase in stress disorders when a parent was deployed. They also found an 11 percent decrease in all other health care related visits. Additional research has found an increase in mental health services by non-deployed spouses during deployment. A study of TRICARE claims data from 2003-2006 published last year by the *New England Journal of Medicine* showed an increase in mental health diagnoses among Army spouses, especially for those whose service members had deployed for more than one year.

Our research also found the mental health of the caregiver directly affects the overall well-being of the children. Therefore, we need to treat the family as a unit as well as individuals. Communication is key in maintaining family unit balance, especially during the deployment phase. Our study also found a direct correlation between decreased communication and an increase in child and/or caregiver issues during deployment. Research is beginning to validate the high level of stress and mental strain our military families are experiencing.

### Access to Behavioral Health Care

The body of research focusing on the increased levels of anxiety and utilization of mental health services and medication causes our Association to be even more concerned about the overall shortage of mental health providers in TRICARE's direct and purchased care network. DoD's *Task Force on Mental Health* stated timely access to the proper psychological health provider remains one of the greatest barriers to quality mental health services for service members and their families. The Army Family Action Plan (AFAP) identified mental health issues as their number three issue for 2010.

While TMA reports significant progress by the TRICARE contractors in adding to the numbers of mental health providers in the networks, these numbers do not automatically translate into a corresponding increase in access. A recently published report in the March 2011 issue of *Military Medicine*, "Access to Mental Health Services for active duty and National Guard TRICARE Enrollees in Indiana," found that only 25 percent of mental health providers listed in the TRICARE contractor's provider list were accepting new TRICARE beneficiaries. Researchers stated the number one barrier to active duty and reserve component service members, and their families in obtaining mental health care in Indiana was the accuracy of the TRICARE mental health provider list. Our Association often hears from families about the number of times they contact a network provider using the TRICARE provider list only to find the provider cannot meet access standards, is no longer taking TRICARE, or is not taking new TRICARE patients. This study validated what the *Task Force on Mental Health* heard from families during their investigation. It is important provider lists must be up-to-date in order to handle real time demands by military families.

While families are pleased more military mental health providers are available in theater to assist their service members, they are disappointed with the resulting limited access to providers at home. Families report they are being turned away from obtaining appointments at their MTFs and clinics and told to seek services elsewhere. The military fuels the shortage by deploying its mental health providers, even its child and adolescent psychology providers, to combat zones. Many providers have returned home after completing a combat tour, only to be overwhelmed by treating active duty members. This concerns us because it can lead to provider compassion fatigue and create burnout, which only exacerbates the provider shortage problem. Our Association would like to be assured DoD is allowing these providers adequate dwell time to get fully rested and reintegrate with their families before returning to work. Our service members and their families rely heavily on this specialty care and they cannot afford for these providers to not be at the top of their game when providing beneficiary care. This situation could create a lose-lose situation, which our Nation cannot afford, especially after nearly ten years at war.

Family members are a key component to a service member's psychological well-being. They must be included in mental health counseling and treatment programs for service members. Families want to be able to access care with a mental health provider who understands or is sympathetic to the issues they face. We recommend an extended outreach program to service members, veterans, and their families of available mental health resources through DoD and VA with providers who inherently understand military culture. We appreciate the VA allowing family member access to Vet Centers; however, we encourage them to develop more family-oriented programs. DoD must also look beyond its own resources to increase mental health access by working with other government agencies, such as the Substance Abuse and Mental Health Services Administration (SAMHSA), especially SAMHSA's Military Families Strategic Initiative, and encourage State agencies to provide their already established services and programs to service members, veterans, and family members. DoD must also educate these other agencies about military culture to make the providers more effective in their support.

Frequent and lengthy deployments create a sharp need in mental health services by family members and service members as they get ready to deploy and after their return. Embedding mental health providers in medical home modeled clinics will allow easier access for our families. There is also an increase in demand in the wake of natural disasters, such as hurricanes and fires. DoD must maintain a flexible pool of mental health providers that can increase or decrease rapidly in numbers depending on demand on the MHS side. Currently, Military Family Life Consultants and Military OneSource counseling are providing this type of preventative and entry-level service for military families. The web-based TRICARE Assistance Program (TRIAP) offers another vehicle for non-medical counseling, especially for those who live far from counselors. The military Services, along with military family members, need to be more aware of resources along the continuum of mental health support. Families need the flexibility of support in both the MHS and family support arenas, as well as coordination of support between these two entities.

There are other barriers to access for some in our population. Many already live in rural areas, such as our Guard and Reserve, or they will choose to relocate to rural areas lacking available mental health providers. We need to address the distance issues families face in finding mental health resources and obtaining appropriate care. Isolated service members, National Guard and Reserve, veterans, and their families do not have the benefit of the safety net of services and programs provided by MTFs, military installation based support programs, VA facilities, Community-Based Outpatient Centers, and Vet Centers. We recommend the use of alternative treatment methods, such as telemental health; increasing mental health reimbursement rates for rural areas; modifying licensing requirements in order to remove geographic practice barriers that prevent mental health providers from participating in telemental health services; and educating civilian network mental health providers about our military culture.

The Defense Centers of Excellence is providing a transition benefit for mental health services for active duty service members, called *inTransition*. Our Association recommends this program be expanded to provide the same benefit to active duty spouses and their children. Families often complain about the lack of seamless transition of care when they PCS. This program will not only provide a warm hand-off between mental health providers when moving between and within Regions, but more importantly, enable mental health services to begin during the move, when families are between duty stations and most vulnerable.

Communities and nongovernment organizations are stepping up to provide mental health services, but more needs to be done. Our Association recently developed a Community Toolkit outlining how community members such as health care providers, educators, and child and youth serving organizations can better support military families. We have been working closely with the White House and the First Lady Michelle Obama and Dr. Biden's military family initiative. We look forward to discussing this initiative with you further.

*We recommend an extended outreach program to service members, veterans, and their families of available psychological health resources, such as DoD, VA, and State agencies. We encourage Congress to request DoD to include families in its Psychological Health Support survey and perform a pre and post-deployment mental health screening on family members (similar to the PDHA and PDHRA currently being done for service members). We recommend the use of alternative treatment methods, such as telemental health; increasing mental health reimbursement rates for rural areas; modifying licensing requirements in order to remove geographic practice barriers that prevent mental health providers from participating in telemental health services; and educating civilian network mental health providers about our military culture. Our Association recommends the "inTransition" program be expanded to provide the same benefit to active duty family members.*

### **Wounded Service Members Have Wounded Families**

Our Association asserts that behind every wounded service member and veteran is a wounded family. It is our belief the government, especially the DoD and VA, must take a more inclusive view of military and veterans' families. Those who have the responsibility to care for the wounded, ill, and injured service member must also consider the needs of the spouse, children, parents of single service members and their siblings, and the caregivers. DoD and VA need to think proactively as a team and one system, rather than separately; and addressing problems and implementing initiatives upstream while the service member is still on active duty status.

Reintegration programs become a key ingredient in the family's success. For the past three years, we have piloted our *Operation Purple® Healing Adventures* camp to help wounded, ill, and injured service members and their families learn to play again as a family. We hear from the families who participate in this camp, as well as others dealing with the recovery of their wounded service members, that, even with Congressional intervention and implementation of the Services' programs, many issues still create difficulties for them well into the recovery period. Families find themselves having to redefine their roles following the injury of the service member. They must learn how to parent and become a spouse/lover with an injury. Each member needs to understand the unique aspects the injury brings to the family unit. Parenting from a wheelchair brings a whole new challenge, especially when dealing with teenagers. Parents need opportunities to get together with other parents who are in similar situations and share their experiences and successful coping methods. Our Association believes all must focus on treating the whole family, with DoD and VA programs offering skill based training for coping, intervention, resiliency, and overcoming adversities. Injury interrupts the normal cycle of deployment and the reintegration process.

DoD, the VA, and non-governmental organizations must provide opportunities for the entire family and for the couple to reconnect and bond, especially during the rehabilitation and recovery phases.

DoD and the VA must do more to work together both during the treatment phase and the wounded service member's transition to ease the family's burden. They must break down regulatory barriers to care and expand support through the Vet Centers the VA medical centers, and the community-based outpatient clinics (CBOCs). We recommend DoD partner with the VA to allow military families access to mental health services throughout the VA's entire network of care using the TRICARE benefit. Before expanding support services to families, however, VA facilities must establish a holistic, family-centered approach to care when providing mental health counseling and programs to the wounded, ill, and injured service member or veteran.

We remain concerned about the transition of wounded, injured, and ill service members and their families from active duty status to that of the medically-retired. While we are grateful, DoD has proposed to exempt medically-retired service members, survivors, and their families from the TRICARE Prime enrollment fee increases, we believe wounded service members need even more assistance in their transition. We continue to recommend that a legislative change be made to create a three-year transition period in which medically-retired service members and their families would be treated as active duty family members in terms of TRICARE fees, benefits, and MTF access. This transition period would mirror that currently offered to surviving spouses and would allow the medically-retired time to adjust to their new status without having to adjust to a different level of TRICARE support.

*We ask Congress to allow medically-retired service members and their families to maintain the active duty family TRICARE benefit for a transition period of three years following the date of medical retirement.*

There are many other health care and behavioral care issues facing our service members, our wounded, ill and injured service members and their families. We will expand on other aspects of the quality of life of military families in our statement for the record for the Subcommittee's hearing on Military Personnel issues scheduled for March 17, 2011.