



AFAP ISSUE UPDATE BOOK

Active Issues

July 2010

**Active Army Family Action Plan (AFAP) Issues
Sorted by Subject Area**

#	Issue title	Status	Subject area	Entered
566	Childcare Fee Category	Active	Child Care	11/04
524	Military Spouse Unemployment Compensation	Active	Employment	11/02
545	Federal Retiree Pre-Tax Health Insurance Premiums	Active	Employment	11/03
615	Donation of Leave for Department of Defense (DoD) Civilian Employees	Active	Employment	12/07
631	Career Coordinators for Army Wounded Warrior Soldiers, Family Members & Caregivers	Active	Employment	01/09
634	Death Gratuity for Beneficiaries of Department of the Army (DA) Civilians	Active	Employment	01/09
649	Compensatory Time for Department of the Army Civilians	Active	Employment	01/10
656	Reserve Component Government Employees' and their Family Members' Access to TRICARE Reserve Select	Active	Employment	01/10
553	Survivor Benefit Plan and Dependency & Indemnity Compensation Offset	Active	Entitlements	11/03
600	Family Care Plan Travel and Transportation Allowances	Active	Entitlements	11/06
621	Minimum Disability Retirement Pay for Medically Retired Wounded Warriors	Active	Entitlements	12/07
626	Traumatic Servicemembers' Group Life Insurance (TSGLI) for Post Traumatic Stress Disorder (PTSD), Traumatic Brain Injury (TBI) and Uniplegia	Active	Entitlements	12/07
633	Cost of Living Allowance (COLA) Dependents Cap	Active	Entitlements	01/09
643	Service Members Group Life Insurance (SGLI) Cap	Active	Entitlements	01/09
654	Monthly Stipend to Ill/Injured Soldiers for Non-Medical Caregivers	Active	Entitlements	01/10
655	Reduced Eligibility Age for Retirement of Reserve Component Soldiers Mobilized in Support of Overseas Contingency Operations	Active	Entitlements	01/10
657	Reserve Component Inactive Duty for Training Travel and Transportation Allowances	Active	Entitlements	01/10
515	Application Process for Citizenship/Residency for Soldiers and Families	Active	Family Support	11/02
574	Funding for Reserve Component Reunion and Marriage Enrichment Classes	Active	Family Support	11/04
596	Convicted Sex Offender Registry OCONUS	Active	Family Support	11/06
630	Availability of Standardized Respite Care for Wounded Warrior Caregivers	Active	Family Support	01/09
632	Community Support of Severely Wounded, Injured and Ill Soldiers and Their Families	Active	Family Support	01/09
652	Family Readiness Group External Fundraising Restrictions	Active	Family Support	01/10
483	Incentives for Reserve Component Military Technicians	Active	Force Support	11/00
529	Retirement Services Officer Positions at Regional Support Commands	Active	Force Support	11/02
612	Army Career and Alumni Funding	Active	Force Support	11/06
617	Federal Hiring Process for Wounded Warriors	Active	Force Support	12/07
653	Funding Service Dogs for Wounded Warriors	Active	Force Support	01/10
488	TRICARE Prime Remote for Fam Members Not Residing with Military Sponsor	Active	Medical	03/02
558	TRICARE Prime Travel Cost Reimbursement for Specialty Referrals	Active	Medical	11/03
572	Family Member Eyeglass Coverage	Active	Medical	11/04
583	Advanced Life Support Services on CONUS Army Installations	Active	Medical	01/06
597	Co-Pay for Replacement Parts of Durable Medical Equipment and Prosthetics	Active	Medical	11/06
610	Traumatic Brain Injury Rehabilitation at Military Medical Centers of Excellence	Active	Medical	11/06
618	Health and Wellness Centers (HAWC)	Active	Medical	12/07
619	Medical Care Access for Non-Dependent Caregivers of Severely Wounded Soldiers	Active	Medical	12/07
629	24/7 Out of Area TRICARE Prime Urgent Care Authorization & Referrals	Active	Medical	01/09
638	Medical Nutrition Therapy (MNT) Benefits for All TRICARE Beneficiaries	Active	Medical	01/09
641	Over Medication Prevention and Alternative Treatment for Military Healthcare System Beneficiaries	Active	Medical	01/09
644	Shortages of Medical Providers in Military Treatment Facilities (MTF)	Active	Medical	01/09
646	Active Duty Family Members Prescription Cost Share Inequitability	Active	Medical	01/10
651	Extended Transitional Survivor Spouses' TRICARE Medical Coverage	Active	Medical	01/10
661	TRICARE Allowable Charge Reimbursement of Upgraded/Deluxe Durable Medical Equipment	Active	Medical	01/10
614	Comprehensive Behavioral Health Program for Children	Active	Medical/Command	12/07
625	Transitional Compensation (TC) Benefits for Pre-existing Pregnancies of Abused Family	Active	Medical/Command	12/07
639	Deferment of Advanced Individual Training (AIT) Soldiers with Exceptional Family Members	Active	Medical/Command	01/09
648	Behavioral Health Services Shortages	Active	Medical/Command	01/10

#	Issue title	Status	Subject area	Entered
650	Exceptional Family Member Program Enrollment Eligibility for RC Soldiers	Active	Medical/Command	01/10
457	Modification of Weight Allowance Table	Active	Relocation	11/99
458	Newly Acquired Dependent Travel Entitlement	Active	Relocation	11/99
609	Total Army Sponsorship Program	Active	Relocation	11/06
592	Post Secondary Visitation for OCONUS Students	Active	Youth	01/06
620	Medical Entitlements for College Age Family Members	Active	Youth	12/07

Issue 457: Modification of Weight Allowance Table

a. Status. Active

b. Entered. AFAP XVI; Nov 99

c. Final action. No (Updated: 28 May 10)

d. Subject area. Relocation

e. Scope. The current Joint Federal Travel Regulation (JFTR) Permanent Change of Station (PCS) weight allowance table does not support the changing Army demographics. More service members are entering with established Families, Families are larger, and Retention Control Points have been extended, creating increased career longevity. Using the current PCS weight allowance table, service members frequently pay excess costs, unload valuable property prior to moving, do not ship essential belongings, and must replace or store items.

f. AFAP recommendation. Amend enlisted portion of the PCS weight allowance table in the JFTR to more closely match the officers' portion, making:

(1) Weight allowance of an E1-E4 equal to the weight allowance of a O1

(2) Weight allowance of an E5 equal to O2

(3) Weight allowance of an E6 equal to O3

(4) Weight allowance of an E7 equal to O4

(5) Weight allowance of an E8 equal to O5

(6) Weight allowance of an E9 equal to O6-O10

g. Progress.

(1) The weight allowances are established by law. A change to the law requires a concurrence by all of the Services. A Deputy Under Secretary of Defense (DUSD), Military Personnel Policy (MPP) working group, comprised of representatives from all Services, was formulated in August 2000 to review the current weight allowances and determine if a weight increase was warranted. The working group considered the basic allowance for housing standards, excess weight cost data, years of service, regular military compensation, rank, family size, and dependency status (with or without dependents).

(2) The Services concurred with a change to the JFTR to increase the PCS administrative weight allowance from 20 percent to 25 percent of the authorized weight allowance or 2,500 pounds, whichever is greater, effective 1 October 2002. An administrative PCS weight allowance is authorized on a PCS to or from a permanent duty station (PDS) outside the continental United States at which Government-owned furnishings are provided.

(3) The Services nonconcurred with the two DUSD (MPP) legislative proposals for an across the board weight allowance increase. As a Quality of Life (QOL) initiative based on an increase in the number of service members entering the Services with Families, the Services supported an increase to the PCS weight allowances for pay grades E1 through E4. The National Defense Authorization Act (NDAA), dated 12 December 2001, increased the PCS weight allowances for pay grades E1 through E4, effective 1 January 2003.

(4) The FY 06 NDAA authorized increased PCS weight allowances for senior noncommissioned officers, grades E7 through E9, effective for orders issued on or after 1 January 2006. The Sergeant Major of the Army and equivalent in each Service is authorized a PCS weight allowance of 17,000 pounds with dependents and

14,000 pounds without dependents for the remainder of his/her military career.

(5) The Services concurred with a change to the JFTR for a higher weight allowance (not to exceed 18,000 pounds) of a member below the pay grade of O-6 on a case-by-case basis due to hardship in April 2006.

(6) In June 2006, the Assistant Secretary of the Army, Financial Management, Research Analysis and Business Practices, agreed to develop a business case for increased weight allowances.

(7) Effective 1 February 2009, the administration weight allowance for accompanied tours to Korea increased from 25 percent to 50 percent of the PCS weight allowance.

(8) In July 2009, U.S. Army G-4 proposed a change to the JFTR to allow the Service concerned to establish the administrative weight allowances by location not to exceed 50 percent. Status: Under review by the Services.

(9) In September 2009, the House of Representatives' version of the NDAA FY 10 proposed an increase in the weight allowances for grades E5 through E9 of 500 pounds for each grade. The proposal was not included in the approved NDAA FY 10. The approved NDAA FY 10 requires the Secretary of Defense to submit a report containing a review of the allowances, recommended changes and an estimated cost for the recommended changes not later than 1 July 2010.

(10) In May 2010, the Services concurred with the Chairman, Joint Chiefs of Staff's report to Congress advising that the weight allowances are currently adequate and suitable for members of the Armed Forces.

(11) GOSC review.

(a) May 00. Members questioned why there is a variance weight allowance between officers and enlisted. Army will work this issue in two stages. The first will seek an increase in the OCONUS administrative weight allowance for junior enlisted, and the second will explore the weight allowance disparity between the ranks.

(b) Nov 00. ODCSLOG will meet with the SMA to work on a strategy to get support from the other Services.

(c) Mar 02. Issue remains active to pursue weight allowance increase for E5-E9s.

(d) Nov 04. The VCSA did not accept the unattainable recommendation and kept the issue active, noting that the square footage of housing is changing under RCI and recognizing that the Army is changing in the future (size of housing, fewer PCS moves).

(e) Jan 06. The VCSA asked for a business case analysis for increased HHG weight allowance using the long term effect of force stabilization and unit stabilization. A request to develop the business case analysis was sent to the Office of the Deputy Chief of Staff, G-4, Center for Logistics Innovation.

(f) Nov 06. The GOSC requested to keep the issue active.

(g) Jun 10. Issue remains active to explore a way ahead. The VCSA said to make one more attempt to elicit the support of the other services, considering that they have RCI housing as well. The VCSA said he also wanted G-4 to address the SMA's question about why there is a different standard for enlisted and officers.

h. Lead agency. DALO-FPT

Issue 458: Newly Acquired Dependent Travel and Transportation Entitlements

a. Status: Active

b. Entered. AFAP XVI; Nov 99

c. Final action. No (Updated: 8 Apr 10)

d. Subject area. Relocation

e. Scope. Service members who acquire new dependents after the effective date of permanent change of station orders (as cited in Joint Federal Travel Regulations (JFTR) appendix A) are not entitled to travel and transportation allowances for those dependents. This results in the service member paying out-of-pocket travel and transportation expenses to move newly acquired dependents.

f. AFAP recommendation: Amend the JFTR to establish date of marriage, adoption, or other legal action as the authorization date to establish dependent status for travel and transportation entitlements.

g. Progress.

(1) Current transportation entitlements only allow shipment of household goods (HHG) and travel of dependents acquired before the effective date of the orders. The effective date of the orders, for simplicity sake, is the date the individual signs into his/her new duty station. Service members receive Basic Allowance for Housing (BAH) or Overseas Housing Allowance (OHA) at the "with dependent" rate on the effective date of the marriage or adoption. The same dates are used for starting dependent medical, dental, PX, and commissary privileges. However, the effective date of the permanent change of station (PCS) orders is the date used to establish dependent travel and transportation allowances in conjunction with a PCS move. DoDI 1315.18 (Jan 05) paragraph E4.4.5 contains this guidance. As such, there is no authority to move at Government expense a dependent (or to move the dependent's HHG) acquired after the effective date of the PCS orders to the member's current permanent duty station (PDS).

(2) From FYs 02-03, Army proposed this initiative to the other Services who had mixed support. The proposal establishes date of marriage, adoption, or other legal action as the effective date for dependent status for travel & transportation allowances. On 13 Mar 03, DAPE-PRC discussed current PCS authorizations with Assistant Secretary of Army for Manpower and Reserve Affairs to determine if a change to the JFTR was possible to allow SM to use remaining HHG authorizations to move newly acquired dependents HHG. In Aug 03, the Per Diem Committee indicated that the current legislation does not allow transportation authorized for items acquired after the effective date of the orders. Their response is based on Comptroller General and OSD General Counsel Decisions.

(3) On 11 Jul 05, the Asst DCS, G-1 Mr. Lewis, attempted to garner support for this initiative from the other Services at the quarterly ADCSPER breakfast. The other Services were again mixed in their support.

(4) The ULB process is a mechanism to obtain authority in law to permit this allowance. In August 2006, Army submitted a ULB for FY 09. Army, Air Force, Joint Staff, and special operations low intensity conflict (SOLIC)

voted to support this ULB. Navy and Coast Guard voted to defer it to FY 10. OSD program and evaluation (PA&E) voted not to support this ULB. The final decision was to defer to FY 10.

(5) In August 2007, Army re-submitted this ULB for consideration for FY 10 while simultaneously attempting to garner support for this ULB from the other Services. Army, J1, SOLIC, and RA supported the proposal. Air Force voted to defer the proposal FY 11. Air Force advised that there was insufficient information/analysis to convince Air Force Corporate Boards. Air Force was also concerned that changes in tour length are not specifically required. Navy, OSD Comp, OSD PA&E, and Coast Guard did not support the proposal. Navy advised new authority was not needed, and that Title 37 USC 406 does not prohibit payment of allowance after PCS date, and to consider simply revising the Joint Federal Travel Regulations. OSD PA&E advised that the DOD should compensate members and not their dependents. Coast Guard advised that this issue should be vetted at military advisory panel (MAP) level. Because of the limited support, USD P&R did not support the proposal.

(6) In January 2009, DAPE-PRC recommended to VCSA to categorize this AFAP item as unattainable and to close this item. VCSA non-concurred with DAPE-PRC recommendation and decided to keep the proposal active.

(7) In September 2009, DAPE-PRC informed the JFTR MAP of the Army's intent to convene a Principals meeting (senior round table) to gain consensus.

(8) DAPE-PRC requested and awaits data from Defense Manpower Data Center (DMDC) of Army Active and Reserve Component Soldiers who reported acquiring dependents (i.e., spouse, adopted child, parents, and step parents) during the previous five (5) fiscal years (FY 03-08). We will use this data to revise cost analysis and submit an updated FY 12 ULB. This data will be made available before convening the Principal's meeting.

(9) During the 2nd quarter of FY 10, DAPE-PRC requested USAREUR G-1's position and an updated business case in order to strengthen business case, garner Sister Service support.

(10) DAPE-PRC revised the overall cost analysis based on the increased end strength from 540K (FY 08) to 549K (FY 09) or 1.67% and cost per move planning factor that increased from \$4K to \$5K. DAPE-PRC requested additional data from DMDC of Soldiers stationed OCONUS who acquired dependents by marriage, birth, or adoption. We will prepare a revised FY 13 ULB for submission during the 4th quarter of FY 2010 (FY 13A ULB Cycle).

(11) Due to changes in the Army Principal leadership, we did not convene a Principal's meeting as originally planned for the 2nd quarter of FY 10. DAPE-PRC will update business case and cost analysis prior to convening a Principal's meeting on 3rd quarter FY 10. The intent behind the Principal's meeting is to determine the feasibility of this AFAP issue (i.e., Active or Unattainable). Should this remain active, Army will refocus strategy based on Sister Service recommendation and explore Service discretion (e.g., Pilot/phase-in travel and transportation al-

lowances based on OCONUS locations with established tour normalization).

(12) GOSC review.

(a) Nov 03. ASA (M&RA) indicated that they would forward this issue to the legislative process.

(b) Nov 04. The GOSC did not support an unattainable recommendation. G-1 will analyze this issue from the perspective that Soldiers will be stabilized for longer periods of time at duty stations.

(c) Jan 06. Issue will remain an active AFAP issue. This issue has had no support from the other Services or the Per Diem Committee. However, it was noted that with Soldiers remaining on station longer and with the Army bringing large numbers of Soldiers CONUS there needs to be an administrative fix so Soldiers' new dependents would qualify for travel to the Soldier's next duty station.

(d) Dec 07. The issue remains active.

h. Lead agency. DAPE-PRC

Issue 483: Incentives for Reserve Component Military Technicians

a. Status. Active

b. Entered. AFAP XVII, Nov 00

c. Final action. No (Updated: 25 Mar 10)

d. Subject area. Force Support

e. Scope. All Reserve Component (RC) Soldiers, regardless of civilian employment status, should be entitled to the Selective Reserve Incentive Program (SRIP), to include non-prior service and prior service enlistment, reenlistment, affiliation bonuses, educational loan repayments, and the Montgomery GI Bill Kicker. Military technicians (MT) perform in both a military and civilian capacity; yet, they are not eligible for incentives afforded to other members of the RC. Currently, incentives received as a Soldier prior to becoming a MT are terminated when they accept a MT position. The policy denies a benefit afforded to other categories of Reserve Component Soldiers and, in many cases, places a huge financial burden on a reservist who takes a civilian position to enhance the readiness of the force.

f. AFAP recommendation. Authorize Army Reserve MTs to receive and retain incentives contained in the Selected Reserve Incentive Program.

g. Progress.

(1) Memorandum dated 4 Apr 04 sent to DA G-1 to transfer incentive program management for Army Reserve Soldiers to the Chief, Army Reserve (CAR). Overall management authority not delegated and no further delegation of authority is expected.

(2) The NDAA FY 2005 repealed the eligibility prohibition for MTs to obtain or retain the affiliation bonus.

(3) In Apr 05, DA G-1 formally non-concurred with the pending revision to the Department of Defense Instruction 1205.21 because MTs were still precluded from SRIP eligibility. The FY06 Defense response permitted MTs to receive bonuses for reenlistments effected in theater.

(4) Defense granted authority to cancel recoupment actions for Soldiers who had received a bonus and are going into the Military Technician Program. Effective May 2008, Selected Reserve Soldiers who accept a MT position will have their enlistment/reenlistment/affiliation bo-

nus terminated without recoupment regardless of the length of service in the losing SELRES status. The 6 month SELRES membership rule is eliminated for these Soldiers.

(5) Three initiatives highlight the impact of SRIP prohibition upon the Military Technician (MT) Program. RAND, funded by DA G-8, conducted an out brief in September 2009, on the factors impacting Full Time Support staffing requirements and experiences as they relate to readiness. The Center for Army Analysis conducted a cost benefit analysis of the MT Program as it relates to policies, incentives, career progression and conditions of employment. The Army Reserve conducted a survey of former MTs to identify trends and issues impacting employment decisions. Studies and survey statistically support rescinding Defense policy.

(6) Memorandum signed by CAR dated 14 December 2009 sent to DA G-1 requesting changes to DoDI 1205.21, AR 601-210, and AR 135-7 to allow MTs eligibility for SRIP benefits. At the Multi-Component Enlisted Incentives Review Board on 16 Mar 10, the DA G-1 (DMPM) requested an opinion from the board members and further justification from the Army Reserve. The CAR's memorandum contained statistics but additional details were provided. DA G-1 response expected by EOM April 2010.

(7) GOSC review.

(a) May 01. GOSC was informed of the legislative proposal being submitted to address this issue.

(b) Nov 04. Issue remains active pending legislation.

h. Lead agency. USARC

i. Support agency. DAPE-MP

Issue 488: TRICARE Prime Remote for Active Duty Family Members Not Residing With Military Sponsors

a. Status. Active

b. Entered. AFAP XVIII, Mar 02

c. Final action. No (Updated: 29 Mar 10)

d. Subject area. Medical

e. Scope. The FY01 National Defense Authorization Act (NDAA), Section 722, authorized TRICARE Prime Remote (TPR) for Active Duty Family members (ADFMs) who reside with members of the Uniformed Services eligible for TPR within the 50 United States. Military Service members are eligible for TPR if they live and have a duty assignment more than 50 miles (or 1 hour's drive time) from a military medical treatment facility (MTF). ADFMs who do not reside with their TPR eligible sponsors, regardless of the reason for the geographical separation, are currently not eligible for the TPR benefit.

f. AFAP recommendation. Provide TPR access for all ADFMs who reside in TPR zip code areas.

g. Progress.

(1) Per the FY01 NDAA, TPRADFM was implemented on 1 Sep 02 for ADFMs who "reside with" their TPR eligible sponsors. While eager to expand the benefit to provide coverage for ADFMs living in remote areas due to government orders, Congress has been unwilling to expand coverage to Families who live in remote areas by choice. This is consistent with a congressional unwillingness to extend the TPR benefit to retirees or AD Families who live in remote areas by choice.

(2) ADFMs who are eligible for TRICARE and who live in a TRICARE Prime Service Area (PSA) may enroll in TRICARE Prime whether or not they reside with their sponsor and even if their sponsor is enrolled in TPR. In addition to the areas surrounding most military installations with military treatment facilities, PSAs include Base Realignment and Closure (BRAC) sites and other locations designated in current contracts.

(3) This Issue has been actively pursued for several years. Some improved access has been acquired for ADFMs in remote areas, particularly for Reserve Component (RC) Families. MEDCOM/OTSG made several unsuccessful attempts between 2001 and 2005 to obtain TMA/HA approval on legislation to provide the TPRADFM benefit to all ADFMs in TPR zip code areas regardless of a sponsor's location.

(4) The FY03 NDAA provided some relief from the TPR "resides with" requirement. It allows family members already enrolled in TPRADFM to remain in TPRADFM in the same zip code area while their AD sponsor serves an unaccompanied tour subsequent to the TPR assignment. It also gives family members of activated RC members on orders of over 30 days eligibility for TPRADFM if they reside in a TPR zip code area with the activated member/sponsor at the time of activation. A 10 Mar 03 ASD(HA) memorandum implementing the FY03 NDAA provision also permits RC members and their Families to enroll in TRICARE Prime when the member is on orders for over 30 days (previous policy was 179 days or more).

(5) The FY06 NDAA, Section 714, provides for exceptional eligibility for TRICARE Prime Remote. In accordance with this new law, DoD may (not required) provide for coverage of a remotely located dependent or spouse who does not reside with a military sponsor if the Secretary determines that exceptional circumstances warrant such coverage. We had thought this provision would increase the opportunity for those SMs who must support split households, per their family care plans, to receive the TPRADFM benefit. MEDCOM/OTSG anticipated that OSD would propose a rule to implement the change.

(6) MEDCOM/OTSG monitored the status of the ASD(HA)/TMA decision to implement the NDAA FY06 provision. The ASD(HA) disapproved a proposed option/Decision Paper for implementing the TPRADFM waiver authority on 17 Jan 07. The Services received this notice on 18 Jul 07.

(7) The Acting TSG forwarded to ASD(HA) a 13 Aug 07 Memorandum formally requesting that the new ASD(HA) review the 17 Jan 07 disapproval. MEDCOM/OTSG knew that situations of Soldiers having to send their immediate Families to live in areas other than their home stations during deployment or recuperation will only continue to increase. Providing TPRADFM to additional ADFMs would give them access to the best TRICARE program with the least personal cost for these Families. It would also lessen the healthcare worry/concern for parents/Service members while deployed.

(8) TMA officially requested MEDCOM/OTSG 'example' criteria to help support our 13 Aug 07 Memorandum for a re-look of the disapproved TPRADFM waiver authority.

(a) The formal Deputy SG reply to TMA's tasker, which provides criteria identified by MEDCOM/OTSG, was drafted by the MEDCOM/OTSG TRICARE Division and OTSG/MEDCOM Staff Judge Advocate office.

(b) The 2 criteria for TPRADFM approval are as follows: (1) Activation of an official Family Care Plan that results in movement of the family, whole or part, to an area not classified as a Military Health System PSA. (2) Official government authorized movement of a family under the Joint Federal Travel Regulation, Volume 1, Section U5222 (VARIOUS UNIQUE PCS ORDERS) in which the family is sent to a "designated place" that is not classified as a PSA.

(9) TMA acknowledged receipt of the MEDCOM/OTSG supporting criteria as outlined in item #8b above. This occurred in the 2nd QTR FY08. This was followed by a 1 Apr 08 official TMA tasker to the Navy and USAF for their input to the MEDCOM/OTSG criteria. Both Navy and Air Force concurred with us and our Family Care Plan criteria.

(10) On 10 Jul 08, TMA requested additional information from all the Services. The request was for the number of Service members that would be required to maintain an official Family Care Plan per Department of Defense Instruction, 1342.19, SUBJECT: Family Care Plans. MEDCOM/OTSG utilized the latest (FY06) official Army G1 demographics on their website; <http://www.armyg1.army.mil/hr/demographics.asp>.

MEDCOM/OTSG provided numbers for both AC and RC populations as follows: Dual Military = 45,779; Single w/ Children = 38,478; Grand Total = 84,257.

(11) 21 Jan 09, TMA informed the Services that based on the criteria identified in section 8.b of this paper; a request for legislative change was submitted to the USD (P&R) office for signature. TMA added another sub-population to the legislative change request; College Bound children, and we support this addition. Unfortunately, TMA informed the Services that the document has been in the USD (P&R) office since Nov 08, and the document requesting legislative change currently remains at USD (P&R).

(12) On 7 Apr 09, the HQDA AFAP IPR acknowledged our request for HQDA involvement in seeking USD(P&R) review and approval. TMA informed MEDCOM/OTSG on 6 Aug 09, that the legislative proposal is still stalled in the USD(P&R) office. The document has been in the USD (PR) office since Nov 08.

(13) 23 Mar 10, attempts to ascertain the status of the ASD(HA)/TMA proposed legislative proposal have been unsuccessful. Inquires to both ASA(M&RA) and ASD(HA) will continue. Resubmission of the Nov 08 document by ASD(HA) may need to be requested.

(14) GOSC review.

(a) Nov 02. The GOSC reviewed the provisions of the FY03 NDAA as they relate to this issue.

(b) May 05. GOSC did not support closing this issue. The changing Army footprint will impact the medical system.

h. Lead agency. MCHO-CL-M

i. Support agency. TMA

Issue 515: Application Process for Citizenship/Residency for Soldiers and Families

a. Status. Active

b. Entered. AFAP XIX, Nov 02

c. Final action. No (Updated: 3 May 10)

d. Subject area. Family Support

e. Scope. Soldiers and Family members encounter problems with the citizenship and residency application process. Under most circumstances, the Immigration and Naturalization Service (INS) will not accept Department of Defense (DOD) physical exams and fingerprinting. The Family member application process is further complicated by language barriers and inaccessibility to INS services and facilities. Lack of effective assistance to Soldiers and their Families causes emotional hardship, additional costs, distraction from mission, and possible deportation of Family members.

f. AFAP recommendations.

(1) Designate and train a liaison at the installation level to assist Family members with the INS process, including review of documentation for accuracy and completeness.

(2) Coordinate with INS for approval of DOD administered fingerprinting and physical examinations.

g. Progress.

(1) Liaison to assist Family members with USCIS process.

(a) In 3rd Qtr FY03, FMWRC Family Programs (FP) met with USAHRC to develop plan to accomplish recommendation. USAHRC establishes guidance for citizenship issues within the Army.

(b) In 4th Qtr FY06, FMWRC FP submitted an update to AR 608-1 requiring the addition of USCIS liaison function within the ACS Relocation Readiness Program. The revision was published on 6 Dec 06.

(c) ACS Relocation Readiness staff are the primary liaisons to USCIS at installations and are trained annually at the DoD Joint Services/Agency Relocation Training Conference. Area USCIS employees serve as guest speakers at these training events.

(2) Fingerprinting and physical examinations.

(a) A physical examination and electronic fingerprinting at a USCIS approved site is required to obtain an adjustment of status for permanent residency, allowing individuals to receive a USCIS permanent resident card (aka green card).

(b) In Apr 06, the Under Secretary of Defense (Personnel and Readiness) sent a letter to the Director, USCIS, requesting acceptance of physical examinations and electronic fingerprints from military installations. In May 06, the Director, USCIS, approved and outlined the process for acceptance of physical examinations and fingerprints for military personnel, but did not agree to all biometric data collection by the military. The USCIS did not approve this request for Family members.

(3) As a result of the 12 Jun 06 AFAP GOSC meeting, the Army G-6 was tasked to coordinate the military services' biometric capabilities with USCIS requirements. The Army G-6 Biometrics Task Force (BTF) reported an established process with USCIS, DoD, and the Federal Bureau of Investigation (FBI) whereby the Soldier/applicant applying for citizenship provides a signed Privacy Act statement to USCIS to allow for use of pre-

viously obtained fingerprints. This process does not exist for Family members of the Soldier.

(4) In Jun 06, USAHRC communication with OUSD(P&R) indicated USCIS was willing to implement the OUSD(P&R) request for acceptance of military examinations, provided that USCIS is provided with the names of military physicians who will perform the physical examinations and the specific locations where the examination will be performed.

(5) In Jun 08, the Department of Homeland Security, USCIS Chief, Field Operations, issued an executive memorandum instructing FODs to initiate contact with military installations in their jurisdictions to assess the immigration needs, including biometric collection, of Soldiers and their Family members and provide services on a regular basis at military installations.

(6) In May 09, FMWRC FP coordinated with the FMWRC PAO to publish the USCIS plan, advising installations to work collaboratively with the USCIS Field Offices, who will provide USCIS services on the installations, including biometric collection, for Soldiers and Families.

(7) In Mar 10, OACSIM-ISS coordinated with OTSG to complete an updated cost analysis for Army physicians to conduct physical examinations required for Family members. OTSG will determine AMEDD policy regarding the distribution of MTFs and providers that will perform physical examinations for Family members.

(8) In Mar 10, OACSIM-ISS communicated with USCIS officials to obtain clarification regarding USCIS biometric collection procedures. OACSIM-ISS will continue to engage with USCIS to pursue USCIS recognition of military biometric collection procedures.

(9) GOSC review.

(a) Jun 06. GOSC declared the issue active. The VCSA stated the Army is leading OSD efforts on biometrics and that CIS does not realize the service's capability. G-6 was tasked to inform CIS of our capability so they will accept DOD administered fingerprints.

(b) Jan 10. Issue remains active to further pursue USCIS recognition of military fingerprinting and physical exams. The VCSA questioned why the military, despite processing countless security clearances a year, is not considered capable to fingerprint for CIS applications and why doctors, who take care of wounded Soldiers on the battlefield, are not capable of doing physical examinations without CIS certification. The Surgeon General responded that the pilot at Fort Bragg demonstrated that certification is possible and said that with some energy this can be done.

h. Lead agency. DAIM-ISS

i. Support agency. USAHRC, OTSG and OUSD(P&R)

Issue 524: Military Spouse Unemployment Compensation

a. Status. Active

b. Entered. AFAP XIX, Nov 02

c. Final action. No (Updated: 3 Jun 10)

d. Subject area. Employment

e. Scope. Military spouses are not entitled to receive unemployment compensation in all states when accompanying service members on a permanent change of station (PCS) move. Many states consider leaving a

job due to military sponsor relocation as a voluntary departure, not involuntary; therefore, spouses do not qualify for unemployment compensation. The loss of income creates a financial hardship on the Family until the spouse is re-employed.

f. AFAP recommendation. Enact legislation directing all 50 states, the District of Columbia and the US Territories to establish relocation during PCS moves as an involuntary separation, thereby granting unemployment compensation to all qualified recipients.

g. Progress.

(1) The web links above have been added to the Army website at <http://cpol.army.mil/library/permis/> (listed under Unemployment Compensation for Federal Employees (UCFE)).

(2) During 2002, the Policy and Program Development Division of the AG-1 for Civilian Personnel submitted this issue to the Civilian Personnel Management Service (CPMS) Benefits Legislative Work Group. In 2003, CPMS indicated that the issue had previously been submitted by Air Force in November 1997, but was disapproved citing a 1992 Supreme Court Decision. CPMS further indicated that they would not support further attempts to initiate this type of legislation.

(3) During the 2005 AFAP GOSC, it was recommended that Dr. Chu speak to the Governors' association. On February 27, 2006, the Secretary of Defense addressed the governors at a "Governors-only" session of the National Governors Association's winter conference.

(4) As an additional effort, it was decided during the March 2007 AFAP GOSC that support from the CASAs should be initiated. This initiative asked the CASAs to contact their state labor and employment offices to help reduce the financial hardships that our military Families experience and to ensure military spouses and BRAC affected spouses are granted UC when relocating with their sponsors. Letters were mailed to the CASAs in May 2009.

(5) To cover spouses affected by BRAC, letters to CASAs were changed to add BRAC affected spouses. This required sending letters to CASA representatives of 21 states to address only BRAC affected spouses: AL, AK, AZ, AR, FL, GA, HI, IL KY, LA, MD, MA, MI, MO, NJ, NC, OK, OR, PA, SC, and WA.

(6) In response to the CASA support letters mailed May 2009, Hawaii and DC CASA representatives contacted AG-1 CP with willingness to help with this initiative. Continue to monitor via email for progress. Since May 2009, Hawaii provides UC eligibility.

(7) As of March 2010, IA provides UC eligibility. OH and TN are seeking state legislation to provide UC eligibility. TN has two bills that have not passed.

(8) In response to the January 2010 GOSC, coordination with the Office of Secretary of Defense, Personnel & Readiness (OSD P&R) has been established, and current state discussion on UC eligibility information is being updated on a constant basis.

(9) At the onset of this issue, there were only 8 states providing UC eligibility to military spouses and now as of 26 May 2010, the majority of the states have established UC to military spouses to include BRAC-affected spouses. Therefore, AG-1 CP has completed the initial goal of

this issue and will continue to monitor the progress of the remaining states not currently providing UC eligibility to military and BRAC-affected spouses.

(10) GOSC review.

(a) Jun 06. The issue remains active.

(b) Jan 10. Issue remains active to continue to liaise with the 12 states that deny UC to military spouses who relocate because of military orders. The Deputy Undersecretary of Defense for Military Communities and Family Policy explained that his office has a full time staff member who is working this issue.

(c) Jun 10. Issue remains active for another focused effort on the remaining ten states. The ACSIM said he would convene a task force and said he would need Army Materiel Command's assistance to work through this.

i. Lead agency. DAPE-CPZ

k. Support agency. DUSD (MCFP) & OSD (P&R)

Issue 529: Retirement Service Officer (RSO)

Positions at Regional Support Commands

a. Status. Active

b. Entered. AFAP XIX, Nov 02

c. Final action. No (Updated: 3 Jun 10)

d. Subject area. Entitlements

e. Scope. The United States Army Reserve does not have regional Retirement Service Officers to assist individual Soldiers and Families. Two Army Reserve Personnel Command (AR PERSCOM) representatives provide retirement counseling services as an additional duty. Soldiers may not receive crucial retirement counseling which adversely affects their ability to make timely and accurate decisions regarding their entitlements and benefits.

f. AFAP recommendation. Authorize and fund a Retirement Service Officer at each Regional Support Command.

g. Progress.

(1) During FY04, HRC-STL developed a plan to create a RSO branch at HRC-St. Louis to provide support to each RSC. The plan included one RSO position supporting each RSC, AR-MEDCOM, and other Army Reserve agencies not aligned under a RSC. This plan was briefed to Chief, Army Reserve on 18 Mar 04. He strongly supported this initiative.

(2) The Director, HRPD, in a memorandum dated 25 Mar 08, requested Chief, Army Reserve, to staff and appropriately fund four personnel (RSC positions) as an initial phase to support AFAP Issue 529.

(3) LTG Stultz, Chief, Army Reserve, acknowledged on 4 Aug 08 the need for retirement support services but recommended a "holistic approach" to support this broad mission.

(4) In Oct 08, a review was completed on the staffing levels of Active Component RSOs. The Ft. Hood staffing model was used as a basis for determining staffing requirements and is used as the basis for the Army Reserve Retirement Service Offices COA 2. Due to the complexity of the Reserve Retirement process as well as the geographical dispersion of Soldiers, the RC RSOs will have more non-traditional contact with the Army Reserve Soldier.

(5) Reserve retirement is a two-step process. In step one, receipt of the *Notification of Eligibility for Retired Pay Age 60 (Twenty Year Letter)*, the Reserve Soldier must decide to: remain in an active status; become a "gray area" retiree, subject to recall; be discharged or separated from the military; and make an RC-SBP election. The AR Soldier has 90 days to make these decisions and return the forms to HRC. Step two is receiving and completing the Retirement Application Packet around the age of 58. The retirement application is mailed to the Reserve Soldier and returned to HRC. HRC-STL has Career Advisors and Retired Pay analysts available to assist AR Soldiers in answering questions or specific inquiries

(6) The analysis reviewed: TPU strength of each RSC; number of Retiring Reserve Soldiers; the number of Gray Area Reservists; Reserve Retiree population; and the Reserve retirement process. Troop strength ranges from 33.8K to 50.6K for each RSC for a total strength of 208K; the Army Reserve averaged 6700 retirees over the last 3 years; Gray Area Reservists number 103K; Retiree strength ranges from 55.2K to 93.3K per RSC for a total Army Reserve retiree population of 296.8K. These numbers do not include Family members.

(7) An additional factor considered was the large geographical area of the RSCs. Each RSC covers 7 to 19 states.

(8) LTG Stultz, Chief Army Reserve, on 1 Sep 08, authorized a field grade officer position in the Army Retirement Services Office to assist in development of a "holistic" plan for an Army wide Retirement Services Program to include development of RSC Retirement Services Officer billets.

(9) Coordination is ongoing with COL John Donovan, the OCAR G-1, to include developing the funding for 16 RSO positions in the OCAR FY 13-16 POM.

h. Lead agency. DAPE-HRP-RSO

i. Support Agency. USARC and HRC

Issue 545: Federal Retiree Pre-Tax Health Insurance Premiums

a. Status. Active

b. Entered. AFAP XX, Nov 03

c. Final action. No (Updated: 6 May 10)

d. Subject area. Employment

e. Scope. By law, federal retirees are not allowed to pay their health insurance premium with pre-tax dollars as federal employees are authorized. Federal employees pay their health insurance premiums with pre-tax dollars through a program call Health Benefit Premium Conversion. To not allow Federal civilian and military retirees to pay health insurance premiums on a pre-tax basis inflicts a financial burden on retirees' income.

f. AFAP recommendation. Authorize federal retirees to pay health insurance premiums on a pre-tax basis.

g. Progress.

(1) Legislation introduced in 111th Congress:

(a) H.R.1203 was reintroduced during the 111th Congress by Representative Chris Van Hollen of Maryland on 25 February 2009. This was referred to several house committees and there are 212 cosponsors as of 23 April 2010; an increase of 8 co-sponsors since 14 December 2009.

(b) S.491 was reintroduced into Congress by Senator Jim Webb of Virginia. It was referred to the Committee on Finance. There are currently 47 cosponsors as of 12 April 2010; an increase of 1 co-sponsor since 14 December 2009.

(2) Information paper was included in the Army Posture Statement in May 2009.

(3) Bills were on hold pending healthcare reform. Now that the Healthcare Reform Bill has passed on 23 March 2010, momentum on these bills should continue. AG-1 CP will continue to monitor legislation for progress..

(4) GOSC review.

(a) Nov 06. The issue remains active.

(b) Jan 10. Issue remains active to monitor legislation in the 111th Congress.

h. Lead agency. G-1, DAPE-CPZ

Issue 553: Survivor Benefit Plan (SBP) and Dependency Indemnity Compensation (DIC) Offset

a. Status. Active

b. Entered. AFAP XX, Nov 03

c. Final action. No (Updated: 6 May 10)

d. Subject area. Entitlements

e. Scope. Spouses or children of active duty Soldiers are provided Survivor Benefit Plan (SBP) annuity (55% of retired pay entitlement) upon a service-connected death. Dependency and Indemnity Compensation (DIC) (current rate of \$948/month) is payable in all service-connected deaths. SBP to the surviving spouse is offset dollar for dollar by receipt of DIC. Survivors of a deceased Soldier deserve full survivor benefits from the military service and the VA.

f. AFAP recommendation. Eliminate the SBP/DIC offset and award full SBP and DIC for service-connected deaths.

g. Progress.

(1) A provision of the NDAA 2008 granted partial relief by establishing a Special Survivor Indemnity Allowance (SSIA) for spouses affected by the DIC offset of the SBP annuity. The SSIA will be \$50 per month for FY2009; increases in \$10 increments to \$100 per month in FY 2014; and SSIA will end 2016.

(2) A provision of Public Law 111-31, 22 Jun 09, changed SSIA as follows: for months during fiscal year 2014, \$150; for months during fiscal year 2015, \$200; for months during fiscal year 2016, \$275; for fiscal year 2017, \$310; and will end 1 October 2017.

(3) The United States Court of Appeals for the Federal District upheld *Sharp v. United States* allowing three military surviving spouses to receive both SBP and DIC payments with no offset, based upon remarriages after age 57 and being eligible for SBP and DIC. This ruling affected approximately 280 Army surviving spouses.

(4) Two legislative proposals that would eliminate the SBP/DIC offset (H.R. 775 and S. 535) were introduced in the 111th Congress. H.R. 775, introduced 28 January 2009, was referred to the Subcommittee on Military Personnel. On 15 March 2010, a motion to discharge committee was filed by Representative Walter P. Jones, Petition No: 111-10. S. 535, introduced 5 March 2009 was referred to the Committee on Armed Services. If

enacted, either of these legislative proposals would eliminate the SBP/DIC offset.

(5) On 24 Jul 09, the CSA signed the memorandum to the CJCS asking for support to convene an interagency working group to look at working toward a single payment that would eliminate the confusion and perception of inequality caused by the offset. Assistant Director Military Compensation, Office of the Deputy Undersecretary of Defense for Military Personnel Policy (USD(P&R)), sent a reply for the Secretary of Defense's approval to send to the CJCS, stating that USD(P&R) would convene the interagency working group. As of 3 May 2010, USD(P&R) was awaiting approval of the letter, after which they will ask the Services and JCS for members to participate in the working group.

(6) On 30 Apr 10, Mr. Gary McGee, Assistant Director Military Compensation, Office of the Deputy Undersecretary of Defense for Military Personnel Policy, confirmed DoD continues to oppose eliminating the SBP/DIC offset.

(7) GOSC review. The May 07 GOSC concurred that this issue remain active to monitor legislative proposals.

h. Lead agency. DAPE-HRP-RSO

Issue 558: TRICARE Prime Travel Cost Reimbursement for Specialty Referrals

a. Status. Active

b. Entered. AFAP XX, Nov 03

c. Final action. No (Updated: 29 Mar 10)

d. Subject area. Medical

e. Scope. The TRICARE Prime travel reimbursement benefit is distance based and not cost based. Reimbursement is available for non-Active Duty TRICARE Prime enrollees and TRICARE Prime Remote beneficiaries when they are referred for specialty care more than 100 miles from the primary care manager location. The current benefit does not take into account the impact of multiple trips of shorter distance. Beneficiary travel costs for care provided by specialty providers' results in significant costs to beneficiaries. This is especially true when care requires multiple trips to the provider.

f. AFAP recommendation. Reimburse TRICARE Prime and TRICARE Prime Remote enrollees actual cumulative travel costs for specialty provider care.

g. Progress.

(1) OTSG, in conjunction with TMA, has explored several options for meeting this recommendation, per the Required Actions/Milestone section. These options were rejected due to significant increases to the Defense Health Program and increased administrative burden on the TRICARE Regional Offices (TROs) and the MTFs. The following are a few key points related to the previously developed recommendations.

(a) OTSG proposed a legislative change (Title 10, United States Code, 1074i) to the benefit allowing travel cost reimbursement for cumulative distances of more than 100 miles.

(b) TMA formed a temporary workgroup to analyze and discuss the OTSG proposal. The workgroup recommended non-concurrence for a 100-mile cumulative change due to significant costs and increased administrative overhead, but did recommend changing the current

benefit to 60 miles. This second proposal would allow for reimbursement of travel expenses when a beneficiary travels more than 60 miles (one-way) for specialty care.

(c) The Principal Deputy, Assistant Secretary of Defense (Health Affairs) (PD ASD(HA)) was opposed to both a 100 cumulative mile change and the workgroup recommended 60-mile proposal. TMA estimated a 100 cumulative mile benefit would cost an additional \$23.1M/year over the \$8M/year for the current benefit. In addition to the increased cost, a 100-mile cumulative benefit would create an increased administrative burden on the TROs and MTFs responsible for executing the current benefit.

(d) Since TMA opposed both recommendations, OTSG has re-examined the benefit proposal in order to develop an alternative approach to meeting the AFAP recommendation.

(2) OTSG's then proposed an alternative proposal (based on 100 miles or less) that would have minimized the overall cost of a cumulative travel benefit by focusing on two areas.

(a) First, the proposal would eliminate the need for the patient to file a claim. Patients will receive automatic reimbursement based on analysis and calculation of data found on TRICARE claims. This would eliminate the current processing fee of \$32.50 per claim.

(b) Second, the new proposal would only reimburse for mileage expenses. Since the covered trips will be 100 miles or less, there is a reduced need to cover all reimbursable expenses. Most patients making trips 100 miles or less are incurring only mileage expenses. There will be no reimbursement for other expenses such as per diem, tolls, and hotels.

(3) A detailed cost estimate on this new alternative proposal had revealed significantly higher than expected costs. A sample of beneficiaries shows that approximately 5% of family members will qualify for this new travel benefit. This is within the 5-10% range of the original estimate. However, family members are traveling more cumulative miles than originally expected. Family members are traveling an average of 239 one-way miles per quarter. Original estimates were 150 miles. The JFTR would reimburse family members for round trip miles. Under this new estimate, the JFTR would reimburse for an average 478 miles per eligible family member per quarter. If 5% of all active duty family members are reimbursed for this benefit, it would cost \$25M/quarter or \$100M/year.

(4) This proposal will still require legislative (Title 10, United States Code, 1074i) and regulatory (Joint Federal Travel Regulations) changes.

(5) This proposal did not change any aspect of the current travel benefit. Prime enrollees traveling more than 100 miles for specialty care will experience no change in benefits.

(6) Cost methodology was then re-validated to determine accuracy. The Methodology is sound and the proposal costs were deemed valid, based on historical data from the MHS Management and Analyst Reporting Tool (M2) data warehouse.

(7) TSG briefed topic at General Officer Steering Committee (GOSC) on 27 Jan 2009. This potential bene-

fit was seen as an important part of caring for our Soldiers and their Families.

(8) In August 2009 we received memorandums from the Surgeons General of the US Navy and US Air Force offering guarded, support for the proposal, while opining that added DHP cost may be a factor. In a 25 September 2009 email communication from the USAF, they indicated a neutral position based on the counter-intuitive logic that many USAF beneficiaries would be eligible for this benefit and the associated cost for the government.

(9) In early September we received TMA's formal response to our proposal. In the memo, TMA's Deputy Director, expressed concerns about the cost of the proposal and indicating the current travel benefit was adequate. The memo cited Section 713 language that NDAA 2010 that would have reduced the mileage limitation to 50 miles. This language for Section 713 does not appear in post-committee versions of NDAA 2010. In December 2009 a memo was then sent to the Deputy Director, TMA requesting an update on the TMA position.

(10) In January 2010 we received an email from TMA indicating that NDAA 2010 provides the latitude for reimbursement under exceptional circumstances. The TMA action officer has indicated that TMA is proposing a rule under which exceptional circumstances would be defined as travel under 100 miles but with over an hour drive time. We have been advised that TMA does not support any additional enhancement beyond this proposed rule. We are awaiting TMA guidance on this NDAA language.

(11) GOSC review. The Nov 06 GOSC requested the issue remain active.

h. Lead agency. DASG-HSZ

i. Support agency. TMA

Issue 566: Childcare Fee Categories

a. Status. Active

b. Entered. AFAP XXI, Nov 04

c. Final action. No (Updated: 10 May 10)

d. Subject area. Child Care

e. Scope. There are 6 total Family income categories and 6 fee ranges. Families with significant income differences are paying the same fee within each category. The limited number of categories results in a \$6,000 to \$15,000 variance within categories of the fee schedule. This variance is inequitable and causes a financial burden.

f. AFAP recommendations.

(1) Increase the number of categories to reduce the financial variance.

(2) Increase the number of fee ranges with new fee categories while maintaining the existing fee range parameters.

g. Progress. Proposed DoD Child Care Fee Policy for SY 2010-2011 (August 2010 - July 2011) is currently under review by DUSD, P&R (Dr. Stanley). The policy will increase the number of income categories and expand the fee ranges as requested in this AFAP issue. ACSIM-1S is preparing an Army child care fee policy plan that will move all CYSS installations to operate under a single, standard child care fee within the next three years and meet the intent of the prescribed DoD fee policy. Navy

and IMCOM-Europe have already moved to a single standard fee schedule with great success.

h. Lead agency. DAIM-ISS

i. Support agency. IMWR-CY, OSD-P&R

Issue 572: Family Member Eyeglass Coverage

a. Status. Active

b. Entered. AFAP XXI, Nov 04

c. Final action. No (Updated: 16 Apr 08)

d. Subject area. Medical

e. Scope. There is currently no eyeglass coverage under TRICARE for Family members of active duty service members and military retirees. The Frame of Choice Program is not available to Family members. One pair of eyeglasses costs approximately \$100-\$400. There are Families with several members who require eyeglasses, thus multiplying the expense. Eyeglasses are a necessity and this expense adversely impacts the Family budget.

f. AFAP recommendations.

(1) Fund a portion of the cost of eyeglasses under TRICARE.

(2) Outsource eyeglass fabrication through contracted vendors at a reduced price.

(3) Provide Frame of Choice Program at cost from the Military Lab.

g. Progress.

(1) Retirees may receive prescription military eyeglasses at no-cost, by placing an optical order at any military eye care clinic. Retirees need only provide a valid eyeglass prescription from a military or private sector appointment. Another available option for some retirees exists through the Department of Veterans Administration (DVA). Retirees that are assessed as having a 10% disability may seek eye examinations through the DVA and gain a pair of civilian-style glasses at no cost.

(2) AAFES has a very affordable selection of eyeglasses. Considering the many advantages offered by AAFES worldwide operations, it would not be prudent to pursue an independent system for outsourcing prescriptive eyewear for military beneficiaries. Outsourcing optical fabrication was extensively studied by the DoD Optical Fabrication Enterprise with an independent DoD contractor, Grant-Thornton, in 2003-2004. It was determined that additional outsourcing of optical fabrication is not cost effective.

(3) All things considered, AAFES provides the best source for eyewear for family members considering AAFES reasonable costs, enforced standards, and the worldwide availability of 133 Optical Shops that are now complemented by online optical services.

(4) AAFES currently has a very affordable selection of eyeglasses. The average price paid for glasses at AAFES is \$116, which is 33% less than the US reported average. A pair of single vision glasses can be obtained for \$40, and frugal shoppers can purchase single vision glasses for as low as \$30 during promotions. Bifocals are available for \$75 or less during sales at all AAFES optical shops.

(5) Savings may be particularly remarkable for children. Unlike private sector stores, AAFES Optical Shops provide safety lenses at no additional charge to all child-

ren under age 18. Promotionals usually feature low cost glasses for children.

(6) The alternative of establishing a separate military outsourced program would result in costs similar to AAFES' most affordable packages. However, such a program would burden our clinics, reduce access to care, provide little choice, and undermine AAFES and the morale & welfare funds it generates.

(7) To serve Soldiers and military beneficiaries worldwide, AAFES in 2008 provided a new and novel means to gain low cost glasses. AAFES has "FramesDirect for the US Military", a virtual optical shop on its online Exchange Mall. FramesDirect extends AAFES capacity to serve all remotely located beneficiaries. The contracted online optical company offers an exceptional selection of frames. Complete single vision prescription eyeglasses (including shipping) starts at \$39. If the purchaser is not satisfied with the glasses, AAFES ensures purchases made via their Online Mall are backed by a 100% money back guarantee.

(8) The DoD Optical Fabrication Enterprise (OFE) produces 1.4 million pairs of eyeglasses per year for both AD and retired military members. Requiring military labs to serve family members would more than double the current workload. The OFE is more cost effective than outsourcing, but our military optical laboratories are currently at full production to meet the readiness and optical needs of a military at war. An added mission to serve all family members and retirees would undermine the laboratories' critical mission.

(9) Based on comments of the former Sergeant Major of the Army at the GOSC in January 2009, this fourth recommendation was added to consider whether the military's FOC program may be extended to include retirees, or to significantly improve the cosmetic appearance of the current standard brown frame.

(10) To better serve our active service members, the tri-service Optical Fabrication Advisory Board (OFAB) that oversees the expansive OFE reviewed the potential for updating the military's standard brown frame. As a result, the OFAB requested the OFE to challenge America's frame companies to submit for trial, frames that are as durable and cost effective as the current standard military frame (S9), yet in step with today's professional styles. The submission process has been completed, and four candidate frames are now in field testing.

(11) GOSC review.

(a) May 05. GOSC was briefed on various strategies being explored to resolve this issue.

(b) Nov 06. GOSC requested issue remain active to increase AAFES publicity of low-cost glasses and to explore options for Families that do not live near an AAFES facility.

h. Lead agency. DASG-HS-O

i. Support agency. TRICARE Management Agency, Optical Fabrication Enterprise, AAFES

Issue 574: Funding for Reserve Component (RC) Reunion and Marriage Enrichment Classes

a. Status. Active

b. Entered. AFAP XXI, Nov 04

c. Final action. No (Updated: 29 Mar 10)

d. Subject area. Family Support

e. Scope. Funding is not available to provide the Prevention and Relationship Enhancement Program (PREP) training required by the Deployment Cycle Support Plan (DCSP) for RC Soldiers and their Families in contrast to the Active Component. Soldier's pay and allowances, spouse travel, child care, supplies, materials, and facilities are not funded to support PREP training. Funding this program, will enhance relationships, reduce the risk for abuse and divorce, increase readiness and retention and bring the RC into full compliance with this phase of the DCSP.

f. AFAP recommendation. Fund PREP for the Army National Guard and the US Army Reserve.

g. Progress.

(1) USAR actions.

(a) The CAR in the Warrior Citizen Message, dated 13 January 2005, authorized and directed the implementation of DCS Task 3.4.7(One day Marriage Workshop Training). Army Reserve submitted an Unresourced Requirement (URR) for \$12 million; however, it was not approved in the FY05 supplemental.

(b) The program is referred to as "Strong Bonds" is the Army Chaplain program providing training to couples, singles and Families. This program evolved from the Building Strong and Ready Families program.

(c) USARC Command Chaplain's office allocates the funding for each command per their request.

(d) Marriage workshops are being planned in areas that have the highest concentration of Family members within the region of the RSC to make it as easy as possible for Soldiers and spouses to attend. Since 2004, the Army Reserve has conducted almost 1,000 events.

(e) VCSA direction GOSC 4 May 2005: The VCSA said that that in the near term we cannot forget that we've got a far-term issue in terms of the health of the force. He asked the Director of the Army Budget to find out why this initiative (Funding of Marriage Retreats) fell off the \$57B supplemental spreadsheet. He concluded by saying, "We'll get this resolved."

(f) On 9 August 2005, contacted OCAR Human Resources to get assistance obtaining information from Director of the Army Budget Office reference VCSA comments at the 4 May 05 GOSC. In December 2005, OSD validated the \$7.6 million OMAR that was submitted in 2nd quarter FY05 for FY06.

(2) ARNG actions.

(a) The ARNG Chaplain office has requested additional funding through this year to meet shortfalls in excess of \$6.1M. Tax on the program of \$1.8M (internal to the Army National Guard) and an additional documented shortfall of \$4.3M are essential for continuation of the program. Additionally the need for Pay and Allowances will allow for easier execution and obligation control.

(b) Ninety more trained instructors. A total of 833 Strong Bonds trained instructors have been trained since 2005.

(c) One hundred twenty nine (planned 559) – Strong Bonds Events have been planned and funds obligated for their completion. There have been 47 cancelled events in FY10 due to the Continuing Resolution Act and subse-

quent funding issues – specifically NGPA. 89 After Action Reports have been received to date. AAR's are at 72% return rate compared to 73% in FY09.

(d) A Marriage Enrichment Class is designed to train 60-80 people (30-40 couples). There are cost constraints per event that the ARNG should not exceed. Each event has been cost analyzed to not exceed \$29,500 dollars for lodging and for materials for each weekend. Service member pay and allowance is the responsibility of the state. The SFPD and State Chaplains, received guidance on all necessary requirements to conduct Marriage Enrichment Seminars with funding limitations from ARNG-OC in conjunction with NGB-SFSS. This was done on 29 May 2009, the date that the Chief of Chaplain's office released their Operating Guidance. FY2010 MOI is expected by end of March 2010.

(e) The State Family Program Director (SFPD) continues to be responsible for logistics support in the conduct of these seminars. These responsibilities include hotel procurement, meeting room negotiations, informational materials, Invitational Travel Orders for spouses, and budget management in conjunction with NGB-SFS.

(f) The Active Duty, USAR and ARNG Chaplains Components have all partnered with the ARNG Family Program to maintain the strongbonds.org website for registration and collection of metrics. Service members and families provide this when they access the website for information on Marriage Enrichment seminars and other events. This website was launched on May 15, 2006.

(g) Joint Force Headquarters (JFHQ) SFPD has coordinated directly with their JFHQ Chief of Chaplains to schedule Marriage Enrichment Seminars. The Family Program Office and the Office of the Chaplain has ensured that the event is within the states allocation of events and that the Chaplain training is supportable by a trained instructor. This is for quality control and tracking.

(h) The Chaplain instructor administers a survey assessment tool before and after the seminar to measure the effectiveness of the seminar on improving communication, stress management, and the expectation of reunion. Data collection is ongoing for historical purpose.

(i) After Action Reports (AARs) are received from each State and Territory following each training event to account for attendance and total funds expended.

(3) GOSC review.

(a) May 05. The VCSA said that this is an important issue addressing the health of the force and asked for feedback on the funding of marriage enrichment for the Reserve Components.

(b) May 07. The issue remains active.

(c) Jan 10. Issue remains active to pursue funding to train instructors and attendance at Strong Bonds retreats for Reserve Component Soldiers and Families. Army Materiel Command requested expansion of Strong Bonds to DA Civilians. The VCSA referenced a five-year longitudinal study that shows divorce rates are five times less for those who participate in Strong Bonds. The Chief of Chaplains clarified that the study also showed a correlation to higher marriage and Family satisfaction. The Deputy Director for Army Budget said they are

addressing the funding of Strong Bonds across all components for FY10.

h. Lead agency. ARZ-CH; ARRC-CH

i. Support agency. NGB-SFSS

Issue 583: Advanced Life Support Services on CONUS Army Installations

a. Status. Active

b. Entered. AFAP XXII, Jan 06

c. Final action. No (Updated: 10 Jun 10)

d. Subject area. Medical

e. Scope. The Department of the Army does not require Advanced Life Support (ALS) services on CONUS Army installations. The Army provides Basic Life Support (BLS) services; however, timely ALS services are not provided on all CONUS Army installations. In accordance with the applicable National Fire Protection Association (NFPA) guideline for ALS services, an 8-minute response time to 90% of the incidents is the accepted standard. Lack of ALS services increases response time which jeopardizes the health and safety of the CONUS Army Family.

f. AFAP recommendation. Mandate that all CONUS Army installations to include Alaska and Hawaii provide Advanced Life Support services on or near the installation in accordance with the National Fire Protection Association standard.

g. Progress.

(1) Emergency Medical Services (EMS) are available at all Army installations in the United States, but are provided in a variety of ways. EMS may be provided through the MTF, through the garrison fire department, and/or through an off-post provider. There is no single Army entity or office having overall responsibility for regulating or resourcing EMS operations. There is no Army-wide standard for ALS response time. The NFPA "8 minute" standard represents the opinion of many subject matter experts, and is accepted on a wide basis. The difference between the recently published standard in the DoDI 6055.6's Table E3.T1 and the NFPA standard revolves around definitions of response times and how it is measured. The DoDI uses an aggregate time of 12 minutes for ALS or 10 minutes for Basic Life Support (BLS) as the time from "when the call is received to an EMS team's arrival on the scene". The NFPA definition of 8 minutes measures the response time between "the EMS team leaving the station and arriving on scene".

(2) While most Army installations currently meet the proposed "8-minute response" standard, this standard may not be feasible on some installations because of their size, mission, and geographical location. This variation in response times also exists within civilian EMS systems.

(3) On 6 Oct 05, MEDCOM published standards for EMS programs operated by Army MTF's but did not include response time mandates due to differences in EMS requirements, missions, and geographical locations. The standards require that the programs, at a minimum, meet the state and local standards of the surrounding community. Commanders may request exceptions or variances due to local circumstances or conditions.

(4) On 9 Mar 06, IMCOM and MEDCOM first met in a work group to discuss standards for all Army EMS operations and to determine a way ahead. A data call of garrisons and MTF's was initiated to determine the current baseline for EMS operations and the resources that would be needed to meet an Army-wide standard. IMCOM agreed to analyze the data call responses to determine cost estimates to conduct ALS at the installations that currently did not provide that service IAW the 8 Min/90% standard.

(5) On 22 Aug 06, the IMCOM and MEDCOM met in a Work Group (WG) to discuss the analysis of costs associated with providing ALS care to installations within the 8 minute NFPA standard. IMCOM's analysis of the available data indicates it would cost about \$25.1M more to provide ALS at the installations that lack this service. The analysis also estimated that it could cost up to \$88 million to conduct ALS at the 83 installations pertinent to AFAP Issue 583. However, only \$35.7M was reported in the data call responses.

(6) MEDCOM recommended that IMCOM and MEDCOM Resources Management (RM) Directorate conduct a mutual, open book analysis of EMS costs at Army installations to obtain a more accurate estimate of required costs to conduct ALS. MEDCOM EMS data was revalidated by MEDCOM's RM Directorate. Following this process, MEDCOM RM continued to recommend further study with input from each installation's RM to obtain a more accurate estimate of costs. In a Memorandum dated 1 Feb 07 to TSG from Commander, IMCOM, it was stated that they saw no need for a comprehensive open book analysis of MEDCOM pre-hospital EMS costs.

(7) On 1 Dec 06, TSG recommended by memo to CG, IMCOM that MEDCOM and IMCOM mutually adopt the EMS response standards found in DoDI 6055.6, DoD Fire and Emergency Services. CG, IMCOM subsequently indicated full agreement by memo dated 1 Feb 07. DoDI 6055.6, later published on 21 Dec 06, establishes response time standards in various functional areas.

(8) On 13 Jul 07, the MEDCOM/IMCOM WG conducted a WG meeting chaired by the MEDCOM CoS and the IMCOM Chief of Operations. The Commands agreed to the EMS response standards as outlined in DODI 6055.06, DoD Fire and Emergency Services Program, dated 21 Dec 06, and to determine the resources needed to ensure all installations meet the standard.

(9) MEDCOM/IMCOM met in San Antonio from 17-21 Sep 07 to draft the plan for implementing the recommendation and develop a memorandum of agreement (MOA) between the two Commands which will document pre-hospital EMS responsibilities addressing BLS and ALS on each IMCOM/MEDCOM installation.

(10) On 11 Oct 07, the draft MOA was briefed to the IMCOM SEL. The document was then slightly modified and re-staffed to the IMCOM regions for feedback by 17 Dec 07.

(11) On 6 Feb 08, the MEDCOM/ IMCOM WG met in San Antonio to evaluate the regional feedback and discuss unresolved funding issues prior to developing an OPORD instructing Installations and medical tenets to develop local MOAs and transition plans prior to moving the Command level MOA forward for approval.

(12) On 16 May 2008, a joint tasking from both MEDCOM and IMCOM was sent to their respective subordinate commands instructing them to develop local MOAs (based on the draft Command MOA) and transition plans to identify required resources and costs associated with the provision of EMS within each installation as provided by the draft MOA.

(13) IAW the above joint tasking, local draft MOAs and transition plans were developed as required.

(14) This topic was briefed to the DP91/.59 CoC on 28 August 2009 due to TRADOC concerns regarding EMS range support and impact of MOA on current range support arrangements. TRADOC concurred with MOA after it was agreed to add sentence in the MOA stating. "This MOA does not affect any existing EMS range support agreements in place".

(15) The MOA was signed by the TSG on 22 Sept 2009 and forwarded to IMCOM. MOA was signed by IMCOM on 6 March 2010. MEDCOM and IMCOM jointly prepared implementing instructions for completion of local MOAs.

(16) As of 10 June 10, HQDA had validated IMCOM's EMS UFR requirements for the POM, but they were not approved as "critical," and therefore remain unfunded. Instructions will now advise installations to maintain status quo until UFR funding is secured.

(17) GOSC review.

(a) Jun 06. The issue remain active.

(b) Jan 10. Issue remains active pending approval of the MOA between MEDCOM and the IMCOM and subsequent resourcing.

(c) Jun 10. The Surgeon General requested the issue remain active pending funding (\$12M) in the 13-17 POM.

h. Lead agency. MEDCOM

i. Support agency. IMCOM

Issue 592: Post Secondary Visitation for OCONUS Students

a. Status. Active

b. Entered. AFAP XXII, Jan 06

c. Final action. No (Updated: 8 Apr 10)

d. Subject area. Education

e. Scope. OCONUS high school students incur greater travel expenses to visit post secondary schools than CONUS based students. Although many informational resources are available, on-site visits afford students the opportunity to make the most informed decision. Upon arrival at the CONUS point of entry, OCONUS Families will assume comparable travel expenses to those of CONUS Families. Minimizing the disparity in travel expenses will decrease the financial burden to OCONUS Families.

f. AFAP recommendation. Authorize a one-time round trip airfare to a CONUS point of entry for OCONUS students, who have been accepted to a post secondary school, and one guardian.

g. Progress.

(1) Army proposed a change to the JFTR and US Code to the military advisory panel (MAP) members of the Per Diem, Travel and Transportation Allowance Committee

(PDTATAC). The other Services have no strong position for or against this issue.

(2) This initiative requires a change in law after gaining the support from the other Services, OSD and Congress.

(3) During the fourth QTR of FY 08, the Army ULB COC did not support the FY 11 ULB and advised pursuing a policy change for increasing the Space A travel priority for High School Seniors. We discussed the COC decision with USAREUR, and they advised DAPE-PRC to pursue a post secondary education travel program that mirrors the current dependent student travel program. The current dependent student travel program allows round trip dependent transportation at Government expense from the permanent duty station (PDS) to the school and return. Changing the Space A travel rules for High School students falls short of achieving what USAREUR proposed in this AFAP submission. As such, DAPE-PRC will re-submit a ULB for FY 12 while simultaneously eliciting support from EUCOM thru USAREUR for the ULB to allow round trip transportation at Government expense from the PDS to the prospective school and return.

(4) On September 2009, Army submitted a revised ULB for FY 12 along with updated cost estimates based on the number of high school seniors enrolled in OCONUS DoDDS schools for each Service, and estimates from the National Center for Higher Education Management Systems of High School graduates going directly to college.

(5) On September 2009, Army informed the JFTR Military Advisory Panel (MAP) of the Army's intent to convene a Principal's meeting (senior roundtable) and gain consensus on this issue. During the Principal's meeting, DAPE-PRC will also propose a revised and less ambiguous AFAP recommendation for approval that reads, "Authorize one annual round-trip for one parent to accompany their dependent senior student at any time within a fiscal year (1 Oct - 30 Sep) between the member's OCONUS PDS and the dependent student's school in the U.S. The service member senior student must demonstrate guaranteed acceptance at a post secondary institution. The purpose is to allow similar transportation allowances that are currently authorized for dependent student transportation in the Joint Federal Travel Regulations (U5260 Dependent Student Transportation) for one accompanying parent."

(6) On December 2009 OSD convened a ULB Summit. DAPE-PRC briefed this AFAP issue during this ULB Summit in preparation for the FY 12A ULB final vote.

(7) On January 2010 OSD released the results of the FY 12A ULB final vote. The voting members deferred this AFAP issue for the FY 13 ULB cycle. DAPE-PRC requested from USAREUR G-1 an updated business case and their current position on this AFAP issue. We will evaluate the comments received on February 2010 from the voting members of the FY 12A ULB Summit, integrate USAREUR input, and prepare a revised ULB for submission during the FY 13A ULB cycle.

(8) Since the Army presented this AFAP issue ULB during the December 2009 OSD FY 12A ULB Summit, we did not convene a Principal's meeting as originally planned for the 2nd quarter of FY 10. DAPE-PRC will

convene as needed a Principal's meeting and address the concerns of the Air Force (ULB Summit "No" vote) and Navy's recommendation to defer.

h. Lead agency. DAPE-PRC

Issue 596: Convicted Sex Offender Registry

a. Status. Active

b. Entered. AFAP XXIII, Nov 06

c. Final action. No (Updated 14 Apr 10)

d. Subject area. Family Support

e. Scope. The OCONUS population is not afforded the same information about convicted sex offenders as personnel stationed in CONUS. No OCONUS registry of convicted sex offenders with a Department of Defense Identification/Installation Access Card exists, thereby denying overseas community members the ability to identify a potential risk of harm to the community. Overseas personnel are more vulnerable to potential assaults by convicted sex offenders.

f. AFAP Recommendations.

(1) Establish a searchable convicted sex offender registry comparable to CONUS registries and make it available to the military community.

(2) Require all convicted sex offenders who reside OCONUS and are authorized a Department of Defense Identification/Installation Access Card to register with the installation Provost Marshal Office and be entered into a registry system

g. Progress.

(1) G-1 provided the Under Secretary of the Army an EXSUM regarding this issue (outlining DoD impact), which was then forwarded to the Under Secretary of Defense for Personnel and Readiness (USD (P&R)).

(2) Army G-1 convened an OCONUS Sexual Assault Offender Registry Working Group (WG) comprised of DoD, Air Force and Army Staff proponents to address the timeliness, legal, regulatory, personnel, assignment, cost, enforceability, and community safety impacts associated with this issue.

(3) Army G-1 conducted research to establish that this issue has merit. The Army WG reviewed the AFAP conference recommendations, outlined an action plan, and addressed the most cost effective means to address this issue.

(4) There remains a gap in tracking registered sex offenders in the military. There is no national database of "registered" offenders; by law each state/locality maintains such a list. The requirement is put on the individual convicted offender to "register" in a new jurisdiction upon moving. For Soldiers, policy requires them to notify the local DES/PM after they register locally. There is no current requirement for civilian dependents to notify the local DES/PM. Non-Family members who are known registrants on a central registry for child molestation and intend occupancy of, or overnight visitation to, family housing are required to sign in at the Provost Marshal's Office.

(5) Army must implement policy to identify, track, and manage sex offenders across the Army. The G-1 led a review of Army policies and procedures regarding military, civilian, and family member sex offenders within the Army, in response to guidance from the Secretary of the Army. The review identified gaps in policy and proce-

dures. On 13 Apr 09, HRPD briefed the Secretary of the Army on Army policy regarding sex offenders Army-wide. The Director of the Army Staff directed a full review of all policies and procedures relating to sex offenders who are associated with the Army. The G-1 convened a Director of the Army Staff-approved Rapid Process Review Working Group (WG) to conduct a 60 day full review of policy and procedures. The working group held its first meeting 29 Apr 09. The WG identified policy/ procedure gaps and prepared an action plan to address identified issues. The WG included representatives from the Assistant Secretary of the Army (Manpower & Reserve Affairs) (ASA (M&RA)), Office of the DCS, G-1 (HRPD; DMPM; HRC), the Office of The Judge Advocate General, the Provost Marshal General, the Assistant Chief of Staff for Installation Management, the Office of the Chief, Public Affairs, the Office of the Chief, Legislative Liaison, and US Army Accessions Command. The action plan (29 Jun 09) includes 30 actions to address accessing, registration, and management of sex offenders, including military, civilian, family member, and contractor sex offenders. The WG reviewed policy from sister Services as well.

(6) Army G-1 is a member of the Department of Justice's International Working Group (IWG) which is developing an international tracking system for registered sex offenders when they leave the United States. Army G-1 will continue to participate in the IWG to determine if Army sex offender data can be tracked in this new international tracking system. Based on the results of that initiative, and the number of sex offenders identified, the Army will then determine the cost effectiveness of establishing its own system, posting a roster to current IMCOM web sites, or utilizing the DOJ international tracking system.

(7) Issue has DA regulatory impact. Working group identified thirteen regulations for proponents to revise to close the identified gaps.

(8) GOSC review.

(a) May 07. The issue was declared active.

(b) Jan 10. Issue remains active and is refocused to address sex offender registry across the Army, not just OCONUS.

h. Lead agency. DAPE-HRH

i. Support agency. OSD (P&R), SAMR-HR, DAPM-OPS, DAJA-AL, IMWR-FP, AHRC, DAPE-MPO-D, DAPE-MPE, WSO-JTFSAPR, CCE, DAPE-CP, DAPE-MPE-PD, Departments of Justice and State, INTERPOL, U.S. Marshals Service

Issue 597: Co-Pay for Replacement Parts of Durable Medical Equipment (DME) and Prosthetics

a. Status. Active

b. Entered. AFAP XXIII, Nov 06

c. Final action. No (Updated: 29 Mar 10)

d. Subject area. Medical

e. Scope. TRICARE beneficiaries pay up to 25 percent co-pay for replacement parts for DME and prosthetics. DME is necessary equipment (e.g., hospital bed, respirator, and wheel chair), purchased or rented for use in the treatment of an injury or illness. Examples of replacement parts would include custom-made equipment such as a wheel chair seating system or a socket for a prosthetic limb. These items can run in the

thousands of dollars and the required co-pay is creating a financial hardship for TRICARE beneficiaries.

f. AFAP Recommendation. Eliminate Co-Pay for replacement parts of DME and prosthetics.

g. Progress.

(1) DME is purchased or rented medical equipment used for the treatment of an injury or illness which is also medically necessary. DME may include wheelchairs, hospital beds/attachments, oxygen equipment, respirators, and other non-expendable items. Prosthetics are replacement devices necessary due to significant conditions resulting from trauma, congenital anomalies, or diseases. Prosthetics may include substitute devices for limbs, digits, hearing aids, etc.

(2) Per the TMA, about 533,229 military beneficiaries used TRICARE to obtain DME in 2005. Most were retirees/family members/survivors, who totaled about 426,456 users. Of this number, about 114,489 were non-TRICARE for Life (TFL) retiree/dependent users. Non-TFL Active Duty family member (ADFM) users totaled about 58,041 persons. TMA states TRICARE data on DME replacement parts is not readily identifiable within TRICARE claims data. In any case, many re-deployed young Service Members processed through the Army Medical Evaluation Board/Physical Evaluation Board (MEB/PEB) process are subsequently placed on the Temporary Disability Retirement or the Permanent Disability Retirement Lists. These young retirees, most of whom are eligible for Department of Veterans Affairs (DVA) services, also have the option to obtain DME, prosthetics, and replacement parts under TRICARE, with the associated retiree co-payment requirements.

(3) ADFMs enrolled in TRICARE Prime and TFL users do not have co-payments under TRICARE. In 2005, 315,302 ADFMs and retirees/dependents used DME as TFL users (3,335 and 311,967 respectively) at a government cost of about \$66M. Under TFL, Medicare is first payer (for DME, 80%) and TRICARE, as second payer, reimburses the 20% Medicare DME co-payment. Retiree DME and prostheses co-payments are: Prime and Extra, 20% of negotiated fees and Standard, 25% of the allowable charge. ADFM DME/prostheses co-payments are: TRICARE Extra, 15% of negotiated fees and Standard, 20% of the allowable charge. Beneficiaries needing DME are given authorizations for specialty referrals, except for DME costing less than \$500, which does not require an authorization. There is no co-pay for MTF issued DME, which, if available, is issued on loan with a hand receipt.

(4) According to a DVA representative, most veterans are eligible to receive DME, prosthetics and replacement parts through DVA without incurring a co-payment. Such users may receive the required product at either a DVA hospital or outpatient facility. A provider/supplier can also submit a bill/claim for the DME, prosthetic or associated replacement parts directly to DVA for payment. Beneficiaries would only be liable for co-payments associated with the visit. This benefit, implemented through vendors and suppliers under contract with DVA, is not available to family members.

(5) In response to Army, Acting TSG's request, TMA has agreed to enhance the TRICARE Web site content to

reflect additional benefit information on DME and prosthetics. TMA has also agreed to:

(a) Develop a DME/prosthetics Fact Sheet for use of Beneficiary Counseling and Assistance Coordinators (BCACs), providers and beneficiaries, including information on replacement parts.

(b) Create a news release for distribution to the general public and the military media on DME and prosthetics.

(c) Update all marketing and education products with enhanced TRICARE information on prosthetics and DME, including replacement parts.

(6) In March 08, TMA responded with a summary of how their website was updated which includes the following: FACT SHEETS: The DME Fact sheet on the tri-care.mil Web site was updated to reflect current policy; NEWS RELEASE: Newsletter Issue 5 (May 2007) - Orthotics: "What's Covered by TRICARE?" & West Region Provider Bulletin Issue 3 (March 2007); MARKETING AND EDUCATION PRODUCTS: Provider Handbooks, v.4 (Section 5, Medical Coverage), May 2007; Provider Quick Reference Charts, v.2 (TRICARE Coverage Benefits and Services chart), June 2007; TRICARE Summary of Beneficiary Cost Brochure (updated October 2007); Provider "Certificate of Medical Necessity Required for some "DME" - North Region TRICARE Reserve Select Handbook, v.4 (Section 2, Covered Services, Limitations & Exclusions), October 2007. All of our program handbooks (Prime, Extra, Standard and TRS) contain DME information in the "Covered Services, Limitations & Exclusions" section.

(7) The TMA response to TSG's request for pursuit of a legislative change to eliminate co-payments for DME and prosthetic replacement parts referred to a pending report from the Task Force on the Future of Military Healthcare. The Task Force issued their report in December 07 and did not recommend eliminating DME co-payments. TMA, in their evaluation of the final Task Force report, did not propose any elimination of DME co-pays.

(8) Research within OTSG information systems demonstrated there is no current Army system for tracking utilization of DME repair parts. In addition, coordination with TMA confirmed that the co-pay is a statutory requirement and cannot be eliminated by a TMA policy change. TMA recommended OTSG request in writing that TMA consider proposing the co-payment elimination. In response, on 12 Sep 08 OTSG submitted a letter to TMA requesting assistance in proposing a legislative change to eliminate co-pays. In addition, we asked for assistance in isolating utilization data that can be used in the preparation of a Unified Legislative Benefit (ULB) proposal. In Nov 08, we received a response from TMA. They offered to work with us to define replacement parts and complete our data request in order to build a reliable cost estimate as part of a ULB.

(9) During the 2Q FY 09, TMA investigated to see if they could isolate utilization and cost data. TMA can report DME and prosthetic procedure codes by fiscal year, however, their ability to determine whether or not specific equipment and supplies were replacement parts is still problematic. Currently, the use of specific codes for re-

placement DME or prosthetic items is inconsistent. TMA does not require that replacement modifier codes be used for replacement DME and Prosthetic items. For example, a recent query indicated that only \$500,000 was paid by TRICARE beneficiaries in FY07 for DME or Prosthetic replacement parts. This estimate is considered to be considerably lower than earlier estimates. TMA believes they can require the contractors to identify replacements on claims based on any new benefit structure that is enacted but we cannot accurately determine which DME or prosthetic claims in the past were procured as replacement parts.

(10) TMA reviewed their internal procedures to determine how their contractors are currently coding replacement modifiers on DME and prosthetics. Since the use of replacement modifier coding is standard practice with Medicare, they suspect that the solution would be to determine what direction Medicare has given to their providers on claim coding for replacement DME and prosthetic devices and provide the same direction in their TMA manuals.

(11) During 2QFY10, the TMA manual change language was drafted and sent for inclusion in a consolidate policy change package to be staffed for comment in April 2010. Internal and external reviewers will then have 30 days to comment. When the package is sent for comments, an Independent Government Cost Estimate is also requested. Once all comments are received, we will review them and respond to them. Any necessary revisions to the policy may be made at that time. This usually takes about 30 - 45 days from the close of the comment period. The final package is sent for internal agency coordination and this could take 4 weeks, or so. If all goes well and on track, this change will be published around July 2010.

(12) Once TMA's managed care support contractors start reporting DME and Prosthetic replacement cost and utilization in their M2 database system, we will assess data quality for the purpose of seeing if this information can be used to build a ULB. Factors to consider are time it takes for the contractor to make changes in their internal requirements, provider education, and number of actual claims which are processed for replacement.

(13) GOSC review. At the May 07 GOSC, the issue was declared active. OTSG will monitor the status of TMA's response/completion of the actions requested herein.

h. Lead agency. DASG-HSZ

i. Support agency. TRICARE Management Activity

Issue 600: Family Care Plan (FCP) Travel and Transportation Allowances

a. Status. Active

b. Entered. AFAP XXIII, Nov 06

c. Final action. No (Updated: 8 Apr 10)

d. Subject area. Entitlements

e. Scope. Soldiers requiring activation of Family Care Plans (FCP) are not compensated for the travel of dependents and shipment of the dependent's household goods. Selected household goods; such as infant equipment, computers and personal comfort items, are necessary for the emotional and physical well being of the

DEERS dependent(s) in their new environment during an already stressful time. Implementation of Soldier's FCP should not create additional financial hardship and emotional stress on the Soldier and Family.

f. AFAP Recommendations.

(1) Authorize funded travel for DEERS dependent(s) to FCP designated location for deployments greater than 179 days.

(2) Authorize funded shipment of household goods limited to 350 pounds weight allowance per DEERS dependent to FCP location for deployments greater than 179 days.

g. Progress.

(1) In February 2007, Army MAP member of the Army G-1 proposed a change to the JFTR to establish this authorization. The MAP members of the other Services were not supportive of this proposal. Additionally, Per Diem Committee Director advised Army MAP member that there currently is no legislative basis to add this authorization to the JFTR.

(2) A legislative change is required to establish the basis for this authorization in the JFTR and our mechanism for transacting such a change is the Unified Legislative Budget (ULB) process. Army G-1 submitted this item as a ULB for FY 10. With all the other competing priorities in the ULB process and the relatively high cost of this proposal, Army did not support sending it to the Department of Defense (DOD) for consideration.

(3) DAPE-PRC submitted this item again as a ULB for consideration in FY 11. USD P&R deferred it to FY 12. The support for the proposal was mixed in FY 11. Army, J1, SOLIC, RA, and HA supported the ULB. Air Force, US Coast Guard (USCG), and OSD PA&E voted to defer the proposal to FY 12. Air Force advised voting organizations to consider a 120 day TDY or greater and consider targeting the proposal by grade. USCG advised the proposal needs further analysis. PA&E advised voting organizations to consider targeting the proposal by grade. Navy and COMPT did not support the proposal. Navy advised this is a policy issue not statutory, and statutory authority already exists under 37 USC 406(e), therefore a ULB is unnecessary. COMPT advised if the member decides to move their dependents back and forth between the designated location and their duty station, they have basic pay and FSA to pay for doing so, and it is the individual's responsibility to take care of his/her Family. COMPT also indicated the proposal needs further analysis.

(4) The JFTR outlines a variety of options that authorize travel and transportation allowances for members to relocate dependents with secretarial waiver to CONUS or OCONUS designated location. These options are incident to a member receiving indeterminate TCS order or a PCS move to/from an OCONUS unaccompanied tour. There is no authorization for travel and transportation allowances when a servicemember deploys greater than 179 days with a unit on TCS orders.

(5) On September 2009, Army informed the JFTR Military Advisory Panel (MAP) of its intent to convene a Principal's meeting (senior roundtable) and gain consensus on this issue.

(6) On January 2010, DAPE-PRC briefed the Deputy G-1 and the VCSA during the AFAP General Officer Steering Committee (GOSC). The VCSA concurred with the Deputy G-1's recommendation to refocus Army Strategy since the preponderance of the affected population is Army (approximately 67%) to include Sunset clause provision with Army as the "Pilot Program" or Service discretion (for deployments greater than 179 days).

(7) On January 2010, DAPE-PRC resubmitted an updated ULB with revised cost estimates after carefully evaluating data from 2003-2009 on Army losses due to parenthood, which averaged 2003 uniformed members. The ULB was deferred to the FY 13A ULB Cycle.

(8) During the 2nd quarter of FY 2010, DAPE-PRC participated in a ULB peer review with Army and Sister Service. DAPE-PRC will include ULB peer review recommendations from Sister Service to strengthen Army's business case.

(9) During the 2nd quarter of FY 2010, DAPE-PRC elicited from USAREUR G-1 updated data and information to reinforce Army ULB and business case prior to FY 13A ULB Cycle submission. DAPE-PRC will prepare a ULB for submission during the FY 13A ULB Cycle and incorporate ULB peer review recommendations and USAREUR input.

(10) GOSC review. The Jan 10 GOSC declared the issue remain active to explore alternative strategies to resolve this issue.

h. Lead agency. DAPE-PRC

Issue 609: Total Army Sponsorship Program

a. Status. Active

b. Entered. AFAP XXIII, Nov 06

c. Final action. No (Updated: 10 May 10)

d. Subject area. Relocation

e. Scope. The current sponsorship program is not effectively implemented, utilized, monitored, and inspected Army wide. Soldiers arriving at some gaining installations/units do not benefit from having an assigned sponsor. If assigned, the sponsor may not be adequately trained. A Soldier's critical first impression may be negatively impacted due to inadequate sponsorship.

f. AFAP Recommendations.

(1) Standardize and enforce Total Army Sponsorship Program (TASP) throughout the Army through the Command Inspection Program (CIP).

(2) Add the TASP to the CIP using AR 600-8-8 Appendix B checklist.

g. Progress.

(1) In Feb 06, the Vice Chief of Staff, Army (VCSA) approved the initial concept to develop the Virtual Installation Movement System (VIM). United States Army Family and Morale, Welfare and Recreation Command (FMWRC) determined implementation of the VIM and adding Army Regulation (AR) 600-8-8, The Total Army Sponsorship Program, Appendix B checklist in the Command Inspection Program would standardize and enforce the TASP Army wide. However, at the Jan 10 AFAP General Officer Steering Committee, FMWRC reported that VIM was not funded, therefore is no longer an option to standardize TASP. FMWRC recommended that TASP

be viewed from a holistic perspective that takes into consideration the current Army OPTEMPO.

(2) During the Jan 10, AFAP GOSC, the VCSA stated that fixing TASP will make a huge impact in the lives of Soldiers and directed that AFAP Issue # 609 be placed on fast track and presented again at the Jun 10 GOSC.

(3) In Mar and Apr 10, OACSIM-ISS contacted the Chief, IMHR-M, who relayed that he and Human Resources (Fort Hood) are working an alternative to VIM and exploring possibilities of modifying existing automation systems to improve in/out processing. The system will include features to track sponsorship processes from the beginning to end state.

(4) In Apr 10, OACSIM-ISS forwarded copies of the AFAP 609 Issue Paper, an excerpt from the AFAP GOSC transcript that addresses TASP, and a copy of DA Form 7274 (Sponsorship Survey) and the Sponsorship Questionnaire (appendix B) to Inspector General (IG) Office (FORSCOM) to use while inspecting TASP at select commands throughout FORSCOM. FORSCOM IG agreed to provide pertinent information regarding their findings through appropriate channels to ACSIM to consider when revising AR 600-8-8.

(5) In Apr 10, OACSIM-ISS facilitated a teleconference with Fort Hood (G-1) to discuss AFAP Issue 609 and identified organizations to target for the TASP working group. OACSIM-ISS established a working group, which discussed the purpose of the group, and highlighted the need to identify gaps in the policy; explore barriers to implementation of the policy; and identify best practices to consider when writing the Rapid Action Revision.

(6) In Apr 10, OACSIM-ISS added TASP to the Soldier-Family Action Plan, under Family Programs and Services, 2.1 for routine monitoring.

(7) In Apr 10, OACSIM-ISS participated in an IMCOM/ACSIM Strategic Communications Planning meeting to initiate a StratComm Plan for TASP. In May 10, OASIM-ISS completed the IMCOM Community Strategic Communication Planning Overview and IMCOM Strategic Communication Messages templates and submitted it to IMCOM/ACSIM StratComm office.

(8) In May 10, Command Sergeant Major (CSM), ACSIM-IMCOM convened a working group to identify ways to improve TASP. Participants in the meeting included CSMs from FMWRC and Korea; Sergeant Major, DA G1; Chief, IMHR-M; the Chief, OACSIM Soldier Family Readiness Division; the ACSIM/IMCOM Surgeon, and action officers from OACSIM-ISS, FMWRC and IMCOM. The group decided that the regulatory guidance for TASP is clear, but needs visibility and enforcement Army wide. An action plan was developed that outlines the following tasks: ACSIM to prepare an EXORD for the VCSA's signature that includes language that enforces mandatory sponsorship for Soldiers in the rank of E-1 through O-6 (including Soldiers in Initial Entry Training) and states the EXORD supersedes AR 600-8-8, TASP; IMCOM to use AR 600-8-8, TASP as a baseline to prepare an OPORD for the Commanding General's, IMCOM signature; ACSIM-StratComm to develop a StratComm plan that targets commands, Soldiers, Families, and Civilians and appoints someone to serve as a member on the working group; and FMWRC to field

the Boss Program for recommendations on renaming the program so that the name correlates the program to readiness.

(9) GOSC review. The Jan 10 GOSC declared the issue active to fast track an approach to sponsorship that can function in the current operational environment. TRADOC stated the Army holds off giving Soldiers in the training base their final assignment to try to get it right in terms of ARFORGEN. Even if a unit is trying to implement sponsorship, it has less time to do that effectively. FORSCOM noted the VIM module would have tracked Soldiers between installations and ensured they are deployable, getting their medical checks and appropriate out-processing. ACSIM stated that IMCOM has to do a better job with the warm handoff for Soldiers and their Families as they move from point A to B and said that sponsorship is one of the many second and third order effects of not doing this correctly. The VCSA noted that the most dangerous period for suicide is transition: transition to go home for leave, from AIT to first unit, between units, and units to school.

h. Lead agency. DAIM-IS

j. Support agency. IMHR-M

Issue 610: Traumatic Brain Injury (TBI) Rehabilitation Program at Military Medical Centers of Excellence

a. Status. Active

b. Entered. AFAP XXIII, Nov 06

c. Final action. No (Updated: 29 Apr 10)

d. Subject area. Medical

e. Scope. While there is a range of rehabilitative services available at military Medical Centers of Excellence, there is not a comprehensive, integrated system of TBI-focused rehabilitative services. The military healthcare system is referring the service member to Department of Veterans' Affairs and civilian TBI rehabilitation centers. This disallows simultaneous treatment for service members with multiple injuries which jeopardizes the window of opportunity to regain lost capacity. Additionally, studies show recovery from a life altering event requires a holistic approach to medicine to include consistent support networks, comrades, and a team of health care providers.

f. AFAP Recommendation. Establish a comprehensive integrated rehabilitative program for TBI patients at military Medical Centers of Excellence.

g. Progress.

(1) To date, various DoD agencies have taken steps to address TBI and have made recommendations to the Assistant Secretary of Defense for Health Affairs. The Army recognizes TBI as a significant health and operational concern, is taking the lead in addressing these recommendations, and is committed to ensuring all Soldiers receive the evaluation, treatment, management, and rehabilitation services they need. DoD opened the Defense Centers of Excellence (DCoE) in November 2007 and that organization continues to expand. The role of the DCoE is to coordinate and assess prevention, best practices, quality care, and research across the DoD for TBI and psychological health. In January 2009, DCoE established a 24/7 call center to answer questions related to TBI and psychological health. The Defense and Veteran

Brain Injury Center (DVBIC) was established in 1992 as collaboration between DoD and Veterans Affairs to serve as a focal point for TBI, specifically clinical care and standards, research, and education. OTSG collaborates regularly with the DCoE and DVBIC on TBI matters.

(2) In July 2007, the Army TBI Task Force Report was finalized and submitted to the Acting TSG for approval of follow-on actions. The TBI Task Force made 47 recommendations. These recommendations translated into an Action Plan and one action was added regarding funding for the TBI program. The development of TBI programs was a component of the Action Plan that relates to this AFAP issue.

(3) The Acting TSG established the Proponency Office for Rehabilitation and Reintegration (PR&R) in May 2007. The purpose is to serve as the single Army source for all rehabilitation and reintegration healthcare issues, specifically the oversight, coordination, and synchronization of rehabilitation and reintegration care and related activities for Soldiers with TBI, amputations, polytrauma, vision and hearing impairments, burns, and chronic and acute musculoskeletal injuries. Specific to TBI, the PR&R is responsible for executing the TBI Action Plan.

(4) MEDCOM is working to ensure that comprehensive integrated TBI screening, identification, treatment, and rehabilitation are in place at each Army Military Treatment Facility (MTF) proportionate to the TBI patient population and MTF mission. The Army TBI program established a standardized, comprehensive program that provides a continuum of integrated care and services for Soldiers and patients with TBI from point-of-injury to return to duty or transition from active duty and/or return to highest functional level. The TBI program supports the most severely injured patients who require the most intense inpatient rehabilitation programs by providing initial acute treatment and then transferring care to a Department of Veterans Administration (DVA) Polytrauma Rehabilitation Center (PRC). The program also supports mild TBI detection, evaluation, and treatment efforts for all Soldiers. The program also includes a full range of specialty and subspecialty care at a limited number of Army high patient density sites. Planning for Family support systems at each facility is ongoing.

(a) AMEDD continues to utilize the DVA Polytrauma Rehabilitation centers and Soldiers are evaluation and treatment at DVA polytrauma network sites (PNS) to enhance access, ensure lifelong care coordination, provide specialized clinical care/case management, and serve as resources to other facilities continues to increase.

(b) The Army Medical Department (AMEDD) utilizes comprehensive TBI services provided through the DVBIC. The DVBIC provides strong evidence of a working tri-service, comprehensive, interagency systems model for TBI. Currently, the Army has one center at WRAMC, one at Brooke Army Medical Center (combined with Wilford Hall Medical Center), and one satellite clinic at Fort Bragg. Additionally, DVBIC personnel are now working at Carl R. Darnall Army Medical Center, Landstuhl Regional Medical Center, and Evans Army Community Hospital.

(c) The Army has adopted the DVBIC model and amended it to meet Army needs. The PR&R is validating

TBI programs throughout the AMEDD. Twelve facilities have achieved full validation: Bayne-Jones Army Community Hospital (ACH), Blanchfield ACH, Eisenhower Army Medical Center (AMC), Fox Army Health Center (AHC), Lawrence Joel AHC, Lyster AHC, MEDDAC-J, Patterson AHC, Tripler AMC, Schofield Barracks Health Clinic, Winn ACH, and Womack AMC. Twenty facilities have achieved initial validation and remaining facilities are on track for validation in FY10.

(d) Each Army MTF has an identified TBI Program Manager.

(e) The MEDCOM published a TBI Operation Order on 9 April 2008 and FRAGO 1 on 25 November 2009. Seven standardized patient education tools have been developed and distributed. Development of the first seven computer based educational tools and training products is complete with intent to post them to MHS Learn in the spring of 2010. These education tools, along with over 300 Army personnel attending the DVBIC TBI training conference each year, and routine communication between OTSG and the RMCs/MTFs facilitate information sharing and dissemination of best practices.

(5) A DoD level Directive Type Memorandum (DTM) in development establishes policy, assigns responsibilities, and provides procedures on the revised management of mild traumatic brain injury/concussion for all deployed personnel. This directive will apply to all leaders within the DoD, Service members, and medical personnel engaged in ongoing DoD missions, and it will standardize terminology, procedures, leadership actions, and medical management to provide maximum protection of Service members. The DTM contains events that mandate medical evaluation, directs leader assessment after specified events, establishes minimum required data fields for monthly reports, establishes revised clinical algorithms for management of concussion in the deployed setting, and provides guidance on the management of recurrent concussions. The Services, in collaboration with the Defense Center of Excellence drafted the DTM; pending final signature. Although this is not yet policy, some organizations are aware of the pending directive and are operationalizing it ahead of its release. Army has drafted a Campaign Plan for Warrior Mild Traumatic Brain Injury Management to operationalizing the DTM and an "Educate, Train, Treat and Track" campaign plan to facilitate line leader and medical effort collaboration to improve acute concussion identification and management. The goal is a cultural change in fighter management after concussive events to include identification and treatment close to point of injury, documentation of the incident, and expectation of recovery with early treatment.

(6) At the January 2010 AFAP General Officer Steering Committee, the Vice Chief of Staff, Army directed that this issue remain open until the initially validated programs receive full validation. He also directed that we 'take care of' the Reserve components. Based on this guidance, efforts to fully validate at least 30 Army TBI programs, to include programs at four Reserve component projection platforms, are ongoing and the required actions for this task were amended.

(7) GOSC review. The Jan 10 GOSC declared the issue active to track the certification of 21 TBI centers

and to clarify TBI support provided by the VA.

h. Lead agency. DASG-HS-CN

i. Support agency. US Army Medical Research & Material Command (Defense and Veterans Brain Injury Center) and VA

Issue 612: Army Career and Alumni Program (ACAP) Funding

a. Status. Active

b. Entered. AFAP XXIII, Nov 06

c. Final action. No (Updated: 25 Mar 10)

d. Subject area. Force Support

e. Scope. Current and future budget cuts seriously threaten the effectiveness of ACAP. The program assists Service Members (SMs) and their Families to be successful in their transition from federal service to civilian life. Approximately 11,000 SMs were retained on active duty in 2005 from briefings provided by ACAP. Loss of ACAP's employment assistance and support for job searches will result in higher unemployment rates, increased unemployment compensation and reimbursement costs paid by the Department of Army.

f. AFAP Recommendations.

(1) Eliminate future ACAP budget reduction.

(2) Expand the ACAP operating budget to maintain a viable program to serve SMs and their Families.

(3) Maintain professional staff to provide personalized services currently available.

g. Issue History. This was an OCONUS direct submit issue to the Nov 06 GOSC.

h. Progress.

(1) In Jun 07, the Lean Six Sigma study conducted by ASA(M&RA) recommended improving ACAP by expanding accessibility for Soldiers to ACAP utilizing WEB services. Implemented as ACAP Express, it allows Soldiers to access the menu of available ACAP services and schedule appointments for themselves from any location via the internet 24/7 and was launched 28 Feb 08. Eligible Soldiers utilize tools such as resume writer from the world-wide web in the same manner they would at an ACAP Center. If they begin ACAP early on in the transition process, Soldiers and Family members are more able to utilize individual transition counseling and employment assistance offered by ACAP, and subsequently more prepared for their transition.

(2) ACAP Express was evaluated in Feb 09 and found to be successful. In the first year, over 12,000 Soldiers registered and utilized ACAP Express. Soldier feedback critiques are supportive of ACAP Express, and request additional tools be placed on-line. Although ACAP Express eases the burden on the ACAP staff by allowing some self-service, the mission continues to increase with support to the WTUs and AW2 populations, and supporting the G-1's Continuum of Service concept with additional emphasis on transition to National Guard and Army Reserve, as well as Army Civilian Employment. For example, the Department of Army Civilian Human Resource Agency, AW2 Operations Division and ACAP have developed a process to bypass the resumix system for all AW2 Soldiers. These focused efforts will continue and expand.

(3) For FY 09, the Army acknowledged funding requirements of \$5.3M and provided \$4.14M. A request for

supplemental Overseas Contingency Operation (OCO) funding was submitted and the Army provided \$1.3M. The POM FY 10-15 submission identified a revised critical level of \$6.387M. The funded level for FY 10 is \$4.7M, further reduced by congressional and MACOM adjustments to \$4.1M. A request for \$1.329M Army OCO Funding for FY 10 was withdrawn when OSD provided \$1.3M to make-up the FY 10 shortfall.

(4) Issue was considered by the AFAP GOSC 1 Jul 09. Several attendees emphasized the value of ACAP services, in particular to OCONUS Soldiers, demobilizing National Guard and Reserve Soldiers and Wounded Warriors. Other discussion addressed a secondary issue of updating ACAP service delivery and consideration of strategies utilized by online civilian employment services. The VCSA said that ACAP is a viable program that the Army needs to fund and said he would take this issue into budget discussions, and the issue remains active.

(5) A meeting with the Assistant Chief of Staff for Installation Management, Resource Directorate (ACSIM-RD) on 28 Jul 09 between the Director ACAP and Deputy Chief, Resource Integration Division subsequently supported AFAP 612 and a commitment was made to restore an additional \$1M if II PEG Total Obligation Authority (TOA) level permits. To date, Army has provided an additional \$800K in FY 11 in support of AFAP 612. An update will be provided to the VCSA during the next AFAP GOSC. This issue went before the II PEG for POM FY 12-17 in an effort to restore an appropriate level of funding, and was favorably received.

(6) GOSC Review. The Dec 07 GOSC requested the issue remain active.

i. Lead agency. AHRC-PDP-T

Issue 614: Comprehensive Behavioral Health Program for Children

a. Status. Active

b. Entered. AFAP XXIV, Dec 07

c. Final action. No (Updated: 7 May 10)

d. Subject area. Medical/Command

e. Scope. Multiple barriers exist in providing timely, convenient and appropriate Behavioral Health Care Services for children of Active Duty Soldiers, Wounded Warriors and Veterans. There is a critical shortage of Behavioral Health Care Child and Adolescent Providers to meet the current demand. Many Behavioral Health providers are unable to dedicate their entire practice to children's therapy due to occupying administrative positions and performing adult behavioral health care. For example, 504 child psychiatric providers were contacted and only 13% stated they were providing full time child psychiatric services. The difficulty in recruiting and training direct care providers and a lack of a national educational plan to raise awareness in schools and identify treatment needs, further exacerbate the problem. Comprehensive services are not readily available, nor aligned with other ranges of services for military children, thus creating unneeded barriers to quality Behavioral Health Care.

f. AFAP Recommendations.

(1) Create and implement a unified, comprehensive source of Children's Behavioral Health Services

(Psychiatrists, Psychologists and Social Workers) with dedicated providers and timely access to care, working in concert, for children of all Soldiers.

(2) Increase, integrate and streamline existing Behavioral Health Support Services with other counseling services (Military Family Life Consultant, Morale Welfare and Recreation, Chaplain, Child Youth Services, Military Child Education Coalition) to provide a comprehensive range of Behavioral Health Services for children of all Soldiers.

g. Progress.

(1) The Child, Adolescent and Family Behavioral Health Proponency (CAF-BHP) was established in FY10 and is located at Fort Lewis WA. The CAF-BHP replaced the Child and Family Center of Excellence, expanding the mission to support and sustain a comprehensive, integrated, behavioral health system of care for Military Children and their Families at installations throughout the Army.

(2) In FY10, the CAF-BHP completed a formal on-site Child and Family Population Behavioral Health Assessments at Fort Lewis, Fort Carson, and Fort Wainwright. The CAF-BHP completed preliminary Population Behavioral Health Assessments, utilizing available data and consultation, at Fort Bragg, Fort Drum, Fort Campbell and Fort Hood.

(3) Child and Family population data at all Army Installations has been collected and an applied algorithm has been used to determine a required number of behavioral health providers for each population.

(4) The CAF-BHP focuses on 5 key tasks designed to increase access for Military Children and Families to behavioral health services by:

(a) Promoting coordination and integration of Child and Family programs at the Army and installation level.

(b) Developing and providing behavioral health models for schools and civilian communities that promote prevention, early detection and delivery of care.

(c) Providing coaching and training programs for primary care clinicians in the evaluation and management of common behavioral health disorders.

(d) Serving as a repository of knowledge and a clearing house for overarching guidelines of state-of-the-art behavioral health care for Army Children and Families.

(e) Centralizing and standardizing data collection for needs identification, outcome measurement and performance improvement.

(5) The CAF-BHP currently has recruited a multi-disciplinary team of 20 personnel to support the mission in the following divisions: outreach, training, evaluation, and Strategic Communication.

(6) The CAF-BHP interface with organizations, universities, and subject matter experts throughout the nation has allowed for increased marketing opportunities to recruit Child/Adolescent behavioral health providers. The CAF-BHP Strategic Communications Division has been created to play a key role in designing marketing strategies for, decreasing the stigma associated with behavioral health, collaborating with military and civilian agencies in developing systems of care, and promoting a healthy and resilient Army Community.

(7) The task of the Outreach Division of the CAF-BHP is to assist and support the development of an Integrated Comprehensive Behavioral Healthcare Delivery System promoting optimal military readiness, wellness, and resilience in Children and Families.

(8) The Outreach Division is responsible for assisting in establishing the Child and Family Assistance Centers (CAFAC) and School Behavioral Health Programs (SBH). It is divided into two multidisciplinary teams. The teams include SME in systems of care, School BH, psychiatry, psychology, social work, administration, and program evaluation. The teams will work on-site and remotely to be available for ongoing support to installations, including guidance and consultation on clinical issues.

(9) Proposals to pilot a Child and Family Assistance Center (CAFAC) at Fort Lewis and Fort Carson have been submitted for MEDCOM PTBI funding. The CAFAC Program Model supports the delivery of a comprehensive, integrated, behavioral health system of care, designed to provide easy access through a single entry portal.

(10) Schofield Barracks currently has an established CAFAC, originally named SAFAC (Soldier and Family Assistance Center), which has successfully provided integrated comprehensive behavioral health services since 2006.

(11) Following the CAFAC pilots at Fort Lewis and Fort Campbell, prioritized sites for early proliferation of Child and Family Assistance Centers (CAFAC) include: Fort Hood, Fort Bragg, Fort Bliss, Fort Campbell, Fort Sill, and Fort Drum.

(12) The task of the Training Division of the CAF-BHP is to develop and implement behavioral health curricula and training modules for primary care providers and support staff. Evidence-based modules are being developed to promote prevention, early identification, evaluation, and treatment of common behavioral health concerns presenting in a primary care setting. It is expected that these modules will become standard Army-wide in screening and treating Children and Adolescents in primary care.

(13) The CAF-BHP is collaborating with national SMEs and organizations (American Academy of Pediatrics, American Academy Child and Adolescent Psychiatry and American Psychological Association) in developing these curricula to ensure utilization of best practices.

(14) Primary care providers and support personnel will be trained by CAF-BHP staff in screening common behavioral health concerns, identification of problematic functioning, effective intervention strategies in primary care, and referral guidelines to specialty behavioral health care. The CAF-BHP will serve as an ongoing consultation resource for primary care providers.

(15) Army School Behavioral Health Programs (SBH) currently include: Tripler/Schofield Barracks, Fort Meade, Fort Campbell, Landstuhl/Baumholder, and Bavaria/Vilseck, Netzaberg and Grafenwoehr. Fort Lewis SBH Program proposal, submitted in FY10, has been approved and funded. MOAs are being established and hiring is underway. Behavioral health care services in schools have been initiated. Fort Carson SBH Program proposal has been finalized and is awaiting Command

approval. Tripler has submitted a growth proposal to expand services and is awaiting Command approval. Fort Campbell has expanded behavioral health services and behavioral health staff to all 8 on-post schools. An Academy for School Behavioral Health was established in FY10 and has currently trained staff from all existing School Behavioral Health Programs.

(16) GOSC review.

(a) Jun 08. The issue remains active. A representative from the National Military Family Association (NMFA) stated that a research study was presented at the Madigan conference that showed an increase in counseling visits at midpoint of deployment and three months after redeployment. Other attendees noted increase in adolescent incidents on installations. The NMFA has partnered with the Rand Corporation to do a study on deployment and related issues with children. The Surgeon General asked that the study look at the Reserve Component as well as the Active. The VCSA stressed the importance of getting programs and services out to children who need support. He referenced Military One Source and the increased programs and funding in Youth Services.

(b) Jan 10. Issue remains active to further develop behavioral health programs in schools and the community. Attendees identified the need to reach children within the RC and Accessions Command and suggested an approach that is not just garrison based. The VCSA commented about the value of online counseling, especially for geographically separated populations.

h. Lead agency. DASG-HSZ

Issue 615: Donation of Leave for Department of Defense (DoD) Civilian Employees

a. Status. Active

b. Entered. AFAP XXIV, Dec 07

c. Final action. No (Updated: 10 Mar 10)

d. Subject area. Employment

e. Scope. Voluntary Leave Transfer Program (VLTP)-eligible DoD Civilian employees on leave without pay face avoidable financial hardships. VLTP does not have a common leave bank to which all DoD employees can donate. Additionally, lost annual leave at the end of the year (use or lose) is not automatically deposited into a leave bank. The resultant loss of income only increases the stress and burden already experienced by employees and their Families.

f. AFAP Recommendation. Create a DoD-wide leave donation bank within VLTP for DoD Civilian employees funded through both donation and automatic collection of unused use or lose annual leave.

g. Progress.

(1) When DoD informed Army in FY09 of the decision not to create a DoD-wide Leave Bank, the option was raised to create an Army-wide Leave Bank. In 2009, HQDA polled the Army commands, which declined to participate in an Army Leave Bank Pilot. It does not appear to be in Army's best interest to establish an Army-wide Leave Bank, based on feedback from commands and the additional resources required to manage and process memberships, applications, donations, etc. Upon sug-

gestion in the 2009 September AFAP IPR, additional inquiries were made to a broader audience, and found interest in establishing local Leave Banks rather than an Army-wide Bank. HQDA is in the process of establishing an Army Leave Donation Policy which will include guidance on Leave Banks and the voluntary donation of use or lose annual leave.

(2) HQDA has worked with the Civilian Human Resources Agency (CHRA), DFAS, and other Federal Agencies on details of local leave banks, to include administration, payroll issues, the creation of an automated database, and levels of control. After looking into their current functionality, DFAS determined, in March, 2010 that there is no systematic way for employees to have all their use or lose leave moved into a leave bank. Army requested information on the capability to make changes to the payroll system in March, 2010. Anticipated costs, if any, will be relayed upon receipt of the DFAS information.

(3) Army briefs the topic of leave donations during the annual Defense Employee and Labor Relations Symposium, during training courses for HR Specialists, and continues to provide guidance on improving the existing leave donation methods. At a minimum, reminders are distributed yearly to encourage donations, especially toward the end of the leave year when annual leave might otherwise be subject to forfeiture.

h. Lead agency. DAPE-CPZ

i. Support Agency: DFAS, CHRA

Issue 617: Federal Hiring Process for Wounded Warriors

a. Status. Active

b. Entered. AFAP XXIV, Dec 07

c. Final action. No (Updated: 26 May 10)

d. Subject area. Force Support

e. Scope. The Federal hiring process fails to connect Federal hiring officials with qualified Wounded Warrior applicants. Information flow and the complexity of hiring systems limit access to noncompetitive government career opportunities. Federal hiring officials are often unaware of noncompetitive direct hire authority for Wounded Warriors in addition to Veterans preference for competitive hiring actions. Wounded Warriors often become frustrated or overwhelmed and abandon their search for government positions, resulting in the loss of already-trained and fully-qualified personnel assets.

f. AFAP Recommendations.

(1) Create a category within the Priority Placement Program to provide a searchable applicant pool of qualified Wounded Warriors for consideration by Federal hiring officials.

(2) Develop an automated, comprehensive, integrated system compatible with the Federal hiring systems where Wounded Warriors and governmental hiring officials can go to query job and applicant availability.

(3) Establish an education and training program for Federal hiring officials and Wounded Warriors on noncompetitive governmental employment opportunities.

g. Progress.

(1) CHRA proposed using the Automated Stopper and Referral System (ASARS), the Priority Placement Program (PPP) tool, to give all Wounded Warrior resumes

maximum exposure across DOD. While the Deputy Under Secretary of Defense (DUSD) and DOD's CARE Division supported the proposal, other components did not reach a consensus to approve it.

(2) As a result of the non-decision to implement the proposal, CHRA proposed alternative solutions, to include Army piloting the proposed program or creating an Army-only program similar to the Army Family Member Placement Program. CARE and the DOD components did not reach a consensus to approve the alternative proposals.

(3) CHRA and the Assistant G-1 for Civilian Personnel (AG1 CP) reevaluated the PPP proposals submitted and determined that they no longer support them. Army needs to fill Base Realignment and Closure (BRAC), Insourcing and Mission-Critical positions quickly. The PPP proposals, if implemented, could potentially increase the amount of time it takes to fill these and other vacancies.

(4) As an alternative to the PPP proposal, CHRA has been partnering with the Department of Veteran Affairs to integrate the use of their Veteran Resume Inventory (VetSuccess.gov) into Army recruitment business processes. Veterans may upload their resume to the website which is searched by hiring managers in the public and private sector. In November 2009, CHRA recommended the addition of functionality to the website that would allow federal agencies to search by the duty location preferences and job interests of the registered Veterans, sort resumes by Veterans' Preference, and track Veteran Race and National Origin data. The tentative launch date of the redesigned website is sometime in July 2010. After the redesign, Army HR Specialists can market the website to Veterans while supporting ACAP transition assistance briefings and to hiring managers during strategic recruitment discussions.

(5) CHRA will propose and draft an "Individuals with Disabilities" support memorandum for VCSA signature and distribution, instead of a Wounded Warrior support memorandum. The memo will directly link hiring efforts to the Department of Defense's established goal to have 2 percent of the DOD workforce consist of people with targeted disabilities. Hiring managers will be instructed to provide a justification in cases where they choose to not select a "qualified" Wounded Warrior because Army will be missing an opportunity to get closer to DOD's 2% goal. According to the Equal Employment Opportunity and Civil Rights (EEOCR) office, only 1.05% of the Army's workforce consists of individuals with targeted disabilities.

(6) CHRA has included a drop down box, on the Civilian Personnel On-line Employment page directing Wounded Warriors to the Army Wounded Warrior (AW2) Program and the Army Career and Alumni Program (ACAP).

(7) In July 2008, CHRA created a networking and non-competitive placement process that starts with Army Wounded Warriors contacting their AW2 advocate if they are interested in DA civilian employment. AW2 advocates, Army Career Alumni Program (ACAP) and Department of Labor representatives assist Army Wounded Warriors in determining their employment preferences (e.g. job interests, location preferences, tour of duty preferences, etc) and in creating a resume for distribution to CHRA HQ. CHRA HQ posts the resume on an online

resume inventory and sends it to all Civilian Personnel Advisory Center (CPAC) representatives and Equal Employment Opportunity representatives. CPAC and EEO representatives share the resumes with the hiring managers they service, and try to find placement opportunities. The networking process gets the resumes to hiring managers in the specific locations AW2s indicate they want to work, as well as leverages the current non-competitive hiring authorities for veterans. While there are 5893 service members and veterans registered with the Army Wounded Warrior program, CHRA has received only 224 AW2 resumes from the AW2 Program Office. The AW2 Program office has stated that there are a variety of reasons why only 5669 AW2s have not been entered into the process. Some reasons for not entering the career referral process include that the AW2 is still in rehabilitation, has returned to duty, or is pursuing a degree. Of the 239 AW2 resumes received since July 2008, CHRA has coordinated the placement of 42. Overall, Army has hired 212 AW2s.

(8) CHRA has implemented a searchable AW2 resume inventory for AW2 at <http://www.chra.army.mil>. The URL for the inventory is sent to command HR directors, EEO, and the AW2 Program office.

(9) CHRA has added the Wounded Warrior consideration option to the automated work order forms that are filled out when requests to recruit fill are submitted (i.e. the Recruitment Information Package (RIP) and Gatekeeper Checklist.)

(10) The Mandatory New Supervisor's Training now includes a briefing on non-competitive hiring practices. This briefing will educate new supervisors on how they may hire wounded warriors directly instead of using the competitive hiring process.

(11) CHRA will create a web-based Veteran employment education tool that explains the federal hiring process, Veterans' Preference, Veterans' Hiring Authorities and avenues to federal employment for different Veteran categories, e.g. Disabled Veterans, hospitalized Veterans, Veterans seeking degrees, Veterans seeking marketable job skills, etc. The tool will be reviewed by ACAP before implemented.

(12) CHRA will designate HR Specialists as Veteran Employment Coordinators (VECs) who will attract, recruit, and advise Veterans regarding continuing service with Army as a civilian; educate Veterans on how to pursue Army civilian career opportunities; ensure Department of Army managers and supervisors are thoroughly familiar with Veteran hiring authorities and Veterans' preference; implement a Veterans' recruitment support plan with special emphasis on disabled Veterans; and report statistics to leadership on Veteran recruitment support, use of Veteran hiring authorities and number of Disabled Veterans hired. The program will be created using existing resources. The VECs duties are collateral duties, i.e. make up less than 25% of the HR Specialist's major duties.

(13) GOSC review. At the Jun 08 GOSC, the G-1 briefer said that he has directed Army Civilian Personnel to liaison with the Army Wounded Warrior Program (AW2) to see if there is a way to work one-on-one with AW2 Soldiers to assist with the Federal employment

process. The Surgeon General stressed that liaison with the Warrior in Transition Units will ensure that all wounded Soldiers receive assistance with Federal employment, not just those in AW2. The AMC CSM emphasized need for an integrated, streamlined process that allows employers to hire wounded Soldiers. As a result of the Dole-Shalala legislation and the Army Medical Action Plan, the Army will develop a comprehensive transition plan for every wounded Soldier. The VCSA noted that Welcome Back Heroes is teaming with Fortune 5000 companies to assist with job placement for spouses and parents of wounded Soldiers.

i. Lead agency. DAPE-CHP

Issue 618: Army Wellness Centers (AWC)

a. Status. Active

b. Entered. AFAP XXIV, Dec 07

c. Final action. No (Updated 7 May 10)

d. Subject area. Medical

e. Scope. Installations Army wide do not have standardized/consolidated wellness centers that promote preventable health conditions and improve the mental and physical well being of Army Families. According to Army Training Requirements & Resources System from 2003 to 2005, the US Army discharged 2,323 Soldiers due to overweight issues at a direct recruitment and training cost to the US Army of \$61 million which could have been preventable. Due to positive lifestyle changes, Family members utilizing the health and wellness centers have been taken off hypertensive medications. Modeling centers after the United States Army Center for Health Promotion and Preventive Medicine Europe would positively impact the health and welfare of Soldiers and Families throughout the Army.

f. AFAP Recommendation. Create an integrated center at each installation (separate from the hospital) modeled after the Europe HAWC.

g. Progress.

(1) USACHPPM Europe has completed the setup of 5 Army Wellness Centers. These are located at: Heidelberg - personnel and equipment funded by CHPPM Europe; Stuttgart - personnel and equipment funded by CHPPM Europe; Vicenza - personnel funded by OASD (HA) equipment funded by Garrison; Landstuhl - personnel and equipment funded by CHPPM Europe; Grafenwoehr- funded by CHPPM Main's HPPI program – newest.

(2) USACHPPM conducted a survey locating Army Wellness Centers that are currently active. The survey identified staffing and services offered and identified the targeted populations. This provides a starting point for assessing what is currently available and what will be needed to implement the program throughout the Army.

(3) In the 2012-2017 POM Army Public Health Command (APHC) (P) will brief the Army Wellness Centers as an emerging requirement with an estimated cost of \$44M providing high visibility to the initiative. See above costs.

(4) On 7 January 2010 The Surgeon General was briefed on the APHC(P) plans to deliver integrated health promotion thru facilitation of Health Promotion Councils with Health Promotion Coordinators and standardizing Army Wellness Centers throughout Army communities.

TSG gave approval of current plans. On 12 January 2010 TSG provided an update to the AFAP GOSC and got further endorsement of the plan from VCSA and CG, IMCOM.

(5) An overarching Memorandum of Agreement between US Army Medical Command, US Army Forces Command, US Army Installation Management Command, US Army Materiel Command, and US Army Training and Doctrine Command regarding the implementation of the US Army Public Health Command (Provisional) Health Promotion Initiatives on Army Installations which includes each organizations' responsibilities implementing AWCs on military installations is being forwarded to MEDCOM for staffing after being approved by the CG of APHC(P).

(6) On 3 March 2010 CG and members of the APHC(P) briefed the following individuals from the organizations as listed at the Pentagon on the APHC(P) Health Promotion initiatives that includes AFAP 618, Establishment of Army Wellness Centers. Those in attendance were: Army Suicide Prevention Task Force, MEDCOM Chief of Staff, Deputy of the Well-Being Division, G1, IMCOM Division Surgeon, Comprehensive Soldier Fitness Program and the Office of the Chaplains. The meeting was to inform the other organizations of APHC(P) plans and alert them that an MOA regarding the initiative would be coming to them.

(7) APHC(P) has begun plans on a Lean Six Sigma Rapid Improvement Event (RIE) to establish current best practices used in AWCs and then will initiate an evaluation of the program using the Public Health Assessment Program in the Directorate of Health Promotion and Wellness.

(8) USACHPPM has a representative who regularly participates on the Comprehensive Soldier Fitness (CSF) Program workgroup. USACHPPM continues to use that forum to keep the CSF Program informed of progress in establishing the Army Wellness Centers in CONUS. CSF has also been in contact with Heidelberg's Wellness Director in order to get information on the metrics they are using to measure physical fitness for the CSF's Global Assessment Tool (GAT). It incorporates the same metrics developed by CHPPM Europe Heidelberg Wellness Center to measure physical fitness in her Comprehensive Soldier Wellness Program.

(9) USACHPPM also has a staff officer working with the Suicide Prevention Task Force (soon to become the Health Promotion and Risk Reduction Task Force) at the Pentagon to provide information to the task force on initiatives that may be relevant to health promotion/suicide reduction initiatives.

(10) APHC(P) will continue to work to get cooperation from other organizations outside of MEDCOM needed to implement the AWC concept. Funding requirements are updated and going into the 2012 – 2017 POM.

(11) GOSC review.

a. Jun 08. The issue remains active.

b. Jan 10. Issue remains active to proliferate the AWC model across the Army. OTSG and ACSIM addressed the inclusion of Wellness Centers into the Services and Infrastructure Core Enterprise (SICE). Expansion of Wellness Centers is currently focused on active installations, but MEDCOM is willing to partner with

the Reserve Components.

h. Lead agency. MHCB-HP

i. Support agency. MCHB-TS-H

Issue 620: Medical Entitlements for College Age Family Members

a. Status. Active

b. Entered. AFAP XXIV, Dec 07

c. Final action. No (Updated: 26 Mar 10)

d. Subject area. Youth

e. Scope. Military Families must make a decision to purchase private insurance for their dependent children who are full time students beyond the age of 23, or leave them uninsured. Military Family members enrolled full time in an accredited institution of higher learning lose their dependent entitlements on their 23rd birthday. Frequent mobilization and relocation challenges of the military Family often require the dependent student to interrupt their education, thus extending the time it takes to achieve their academic goal. Some employer-sponsored health insurance plans provide for full medical coverage for dependents up to their 25th birthday. Adjustment of the Department of Defense policy to include full-time students up to the age of 25 will provide relief from the out of pocket medical expenses or the purchase of private health insurance coverage.

f. AFAP Recommendation. Increase dependent entitlement eligibility for full time students to age 25 years.

g. Progress.

(1) Approval of this action is not within the Department's authority and will require change to legislation (Title 10). Of note, this proposal would affect members of all Military Services and all Services' medical facilities.

(2) In 2008, the Defense Enrollment Eligibility Reporting System (DEERS) reported a DoD total of 6,447 dependent children of active duty sponsors and 39,768 dependent children of non-active duty sponsors ages 21 and 22 enrolled as full time students.

(3) The OTSG is hesitant to support the proposal without additional funding because:

(a) Implementation would add significant costs to both direct and private sector areas without commensurate funding. In FY10 alone, the cost is estimated at \$43.8 M for the Army, with a total of cost of \$258.3 M through FY14 as calculated by TMA for the Army alone.

(b) As stated in the Business Case the estimates are based on "observed age-related trends in the currently eligible population of college-age children with Uniformed Services sponsors," and not actual data on children who would become eligible if this is enacted. The disparities between the two could result in significant funding shortfalls thus making agreement risky.

(c) This expansion of benefits runs contrary to other departmental and OSD efforts to control costs such as the current Quadrennial Defense Review (QDR) effort.

(4) TRICARE Management Agency (TMA) and Service coordination is pending with a target for completion by end of the 3d Qtr, FY 10.

(5) The recently signed National Health Care Reform bill does not apply to military families enrolled in TRICARE. However, lawmakers have introduced HR 4923 which would alter TRICARE so that it covers

children up to age 26 who do not have their own coverage. The proposal as written has a 1 October 2010 effective date. When enacted this would direct Department of Defense to provide entitlements to those eligible.

h. Lead agency. AHRC-PDP-P

i. Support agency. OTSG, DASG-RM

Issue 621: Minimum Disability Retirement Pay for Medically Retired Wounded Warriors

a. Status. Active

b. Entered. AFAP XXIV, Dec 07

c. Final action. No (Updated: 10 Jun 10)

d. Subject area. Entitlements

e. Scope. Wounded Warriors involuntarily separated from the military often encounter financial hardships due to the current disability retirement pay rates. Wounded Warriors with a disability rating of 30% or higher receive a disability retirement. The amount is based on years of service, rank, and the rating percentage (10 USC, Sec.1401), which may be below the national poverty level. Insufficient financial support causes undue additional strain on both Servicemembers and Families already coping with their medical conditions.

f. AFAP Recommendation. Award medical retirement pay for all Servicemembers with a 30% or higher disability rating to at least the minimum equivalent retirement pay of an E-6 with 10 years service or current entitlements, whichever is higher.

g. Progress.

(1) Dec 19, 2008, OSD augmented the Departments capability to sustain enhanced oversight and management of Wounded Warrior matters by establishing the Wounded Warrior Care and Transition Policy Office (WWCTP). The SOC, Co-chaired by the DepSecDef and the DepSecVA provides comprehensive management and systematic coordination to ensure seamless and transparent transition of Services members between the DoD and DVA. The Secretary of the Army and the Vice Chief of Staff, Army are the Army's representation to the SOC.

(2) On July 2, 2008, Chief of Staff, Army asked General (retired) Franks Jr. to lead an effort to review the medical evaluation board (MEB) and physical evaluation board (PEB) processes, recommend process adjustments and develop short and long range recommendations for specific action and resource. With the support of the DCS, G-1 and OTSG, GEN (Ret) Franks assembled a number of experts from across the Army to include Wounded Warriors who have been through the Physical Disability Evaluation System (PDES) process. This included surveys of Soldiers and Families in order to be as inclusive as possible, listening to new ideas and initiatives while retaining the core mission focus. Based on the Task Force's work, three strategic recommendations were made:

(a) In 2007, the WWCTP initiated the DES Pilot to eliminate the dual adjudication of disability ratings now done independently by the Service Departments and US Department of VA. The Department of Veterans Affairs is the responsible agency for administering disability ratings.

(b) Begin a National Dialogue regarding the duty to our volunteer force that become wounded, ill or injured as a result of doing their duty in the era of persistent conflict.

(c) Transformation of the current PDES.

(3) In December 2009, the SOC, having previously discussed the issue of 30% disability, shifted its focus from the equity and parity of the 30% disability rating to ensuring the quality of the criteria for ratings, and for ratings to be more consistent. There is currently no support in the SOC to pursue this issue as well as no apparent congressional support.

(4) GOSC review.

(a) Jun 08 GOSC. The FORSCOM representative said that they think this is a great initiative and suggested that the Army look at industry disability standards. He also expressed concern about the perception of an E6 with ten years service who sees a PFC who had been on tour with him, receive a comparable retirement pay. The Surgeon General addressed the discrepancies between military and Veterans Affairs (VA) disability ratings. The VCSA said that he wanted all Wounded Warrior legislation that was not successfully codified to be "refreshed" and "sent back up one more time". The VCSA said he thought the 30 percent rating was too low, but he anticipated help on this.

(b) Jun 10. Issue remains active. The VCSA voiced his support for this issue. He told G-1 to take this back to the Senior Oversight Committee (SOC), but noted that a lot of work needs to be done prior to that. He also said we should take this back to General Franks and stated that he would personally "take this one on". The Surgeon General asked that if there is a relook of medical retirement pay, that it be part of a comprehensive revision of the disability evaluation system, particularly the 30 percent disability threshold.

h. Lead agency. DAPE-PRC

Issue 625: Transitional Compensation (TC) Benefits for Pre-existing Pregnancies of Abused Family Members

a. Status. Active

b. Entered. AFAP XXIV, Dec 07

c. Final action. No (Updated: 3 May 10)

d. Subject area. Medical/Command

e. Scope. Transitional Compensation (TC) does not account for pre-existing pregnancies when determining TC benefits. The benefit is intended to reduce victim disincentives to reporting abuse by providing transitional compensation to abused Family Members of military personnel who were separated and discharged due to the abuse. Extending TC benefits to unborn children upon birth will increase financial support for abused Families and may encourage reporting of abuse.

f. AFAP Recommendation. Extend TC benefits to the unborn children of pre-existing pregnancies upon birth.

g. Progress.

(1) In Jan 08, consulted with ASM Research, the contractor that developed the TC database, to determine whether the database tracks pre-existing pregnancies to establish a baseline or scope of the problem. The system does not track this information.

(2) In Feb 08, FMWRC Family Programs (FP) consulted with FMWRC CJA. FMWRC CJA did not recommend supporting the recommendation because it would require a change in the definition of "dependent," which does not include unborn children.

(3) In Feb 08, FMWRC FP consulted with the US Department of Health and Human Services Children's Bureau, who indicated that services are not made available to unborn children.

(4) In Feb 08, FMWRC FP consulted with OUSD(P&R) regarding unborn children and the definition of "dependent." Changing the definition would require legislation and OUSD(P&R) approval.

(5) In Mar 08, FMWRC FP consulted with the Air Force, Navy, and Marine Corps regarding the extension of TC benefits to unborn children. Navy and Marine Corps do not recognize unborn children as dependents; Air Force did not respond.

(6) In Oct 08, FMWRC CJA stated that a legal definition of "dependent" does not exist that is applicable for all situations. The term "dependent" is outlined in the TC statute.

(7) In Sep 08, at the AFAP IPR it was determined that this issue should be closed as unattainable. However, subsequent to this decision, the Veterans' Benefits Improvement Act of 2008 was passed in Oct 08. This act extends coverage to an insured member's stillborn child under the Servicemembers' Group Life Insurance (SGLI).

(8) In Sep 09, a VA official informed FMWRC FP that, although the Veteran's Benefit Improvement Act was signed into law, the regulation that provides for the definition of stillborn had not been finalized.

(9) In Sep 09, FMWRC FP consulted with FMWRC CJA regarding the feasibility of VA definition/legislation being applied for TC. FMWRC CJA opined that the VA's decision to include stillborn as an insurable dependent under FSGLI alone does not set a precedent for TC. However, FMWRC CJA indicated that the military justice system has the ability to charge a Soldier for two separate offenses if a Soldier causes injury to a child in utero – one for injury to the mother and one for injury to the unborn child. As a result, FMWRC CJA considered that this recent trend within military justice and the passage of UCMJ articles to cover unborn children in certain circumstances, combined with the VA's recent decision, may be justification to support the request of legislative action to change the TC definition of "dependent."

(10) In Nov 09, regulations implementing section 402 of the Veteran's Improvement Act of 2008 were published in the Federal Register and immediately went into effect. The regulation defines the term "member's stillborn child" and applies to deaths occurring on or after October 10, 2008, the date of enactment of the Veteran's Benefits Improvement Act of 2008.

(11) In Mar 10, OACSIM-ISS consulted with FMWRC CJA to reconfirm support to request a legislative change to the definition of "dependent" in the TC statute. FMWRC CJA supports this change as it is consistent with the intended purpose of the TC Program.

(12) In Mar 10, OACSIM-ISS began working to change the definition of "dependent" as defined in the TC statute. A legislative proposal will be submitted under the FY13

Unified Legislative and Budgeting process.

h. Lead agency. DAIM-ISS

i. Support agency. IMWR-JA

Issue 626: Traumatic Servicemembers' Group Life Insurance (TSGLI) for Post Traumatic Stress Disorder (PTSD), Traumatic Brain Injury (TBI) and Uniplegia

a. Status. Active

b. Entered. AFAP XXIV, Dec 07

c. Final action. No (Updated: 29 Apr 10)

d. Subject area. Entitlements

e. Scope. Servicemembers and Veterans diagnosed with PTSD, TBI (other than leading to coma) as well as Uniplegia receive no immediate Traumatic Servicemembers' Group Life Insurance (TSGLI) payment under current regulatory and compensatory guidelines. These diagnoses, which may or may not stem from physical loss, can and often do lead to financial hardship for the Servicemembers, Veterans, and Families. Servicemembers and Veterans who are diagnosed with the conditions cited above may receive monetary compensation from the Physical Disability Evaluation System (PDES) in the future, but receive nothing upon initial diagnoses. Traumatic Servicemembers' Group Life Insurance (TSGLI) already covers TBI when TBI injury results in the inability to carry out at least two of the six activities of daily living and/or coma. Uniplegia (the complete and irreversible paralysis of one limb) by other than amputation is currently not considered in the table of scheduled losses. However, it is being considered for addition. PTSD is not under consideration at this time for payment of TSGLI. Servicemembers and Veterans are forced to make life altering decisions based on the provision of their care, maintaining a viable household, and the potential loss of short and/or long term employment.

f. AFAP Recommendation. Add PTSD, TBI, and Uniplegia as a schedule of loss under Traumatic Servicemembers' Group Life Insurance (TSGLI).

g. Progress.

(1) The July 2008, TSGLI One Year Review added Uniplegia to the TSGLI Schedule of Losses. Traumatic injury and coma resulting in the inability to perform at least 2 activities of daily living are also covered in the TSGLI Schedule of Losses, when TSGLI standards are met.

(2) The FY 2010 NDAA requires the SECDEF, in consultation with SECVA, to provide a study for on treatment of PTSD to be conducted by institute of Medicine of National Academy of Sciences or other independent study.

(3) GOSC review. Following the Jun 08 GOSC, the issue remains active.

h. Lead agency. DAPE-PRC

i. Support agency. VA

Issue 629: 24/7 Out of Area TRICARE Prime Urgent Care Authorization and Referrals

a. Status. Active

b. Entered. AFAP XXV, Jan 09

c. Final action. No (Updated: 23 Mar 10)

d. Subject area. Medical

e. Scope. TRICARE Prime beneficiaries are unable to obtain 24/7 out of area authorizations and referral assistance for urgent healthcare services. Beneficiaries are required to obtain authorizations from their enrollment sites in order to receive urgent care when traveling outside of their area. TRICARE beneficiaries do not have a streamline one call/one resolution process when urgent care needs are required. Out of area referral/ authorization process is confusing, untimely, does not help beneficiaries find needed care and imposes an unnecessary demand while traveling.

f. Conference Recommendation. Establish a 24/7 centralized toll free process for TRICARE beneficiaries to request and acquire out of area urgent care authorization and referral assistance.

g. Progress.

(1) The Army Surgeon General made a personal request to the TMA Deputy Director regarding this issue and requesting the highest attention by TMA. A TMA POC was identified and he was provided the AFAP Issue and supporting documentation on its value added to the MHS and how this effort ties into other MHS business design improvements.

(2) The DoD/MHS Innovation Investment Process (IIP) is currently undertaking a study of NAL usage to support TRICARE Prime beneficiaries and the Medical Home model of healthcare delivery. OTSG/MEDCOM has been involved in the initial discovery and telephone conference calls to Army Military Treatment Facilities that utilize NALs. The contractor (Deloitte Consulting) has been assigned to the initial discovery and has been provided data/supporting arguments that includes this AFAP issue. The initial discovery guidance by TMA to the IIP investigating contractor did not include specifics on out-of-area and after-hours need. OTSG/MEDCOM has provided some specifics on the efficacy and need for NAL usage for out-of-area and after-hours urgent care and even emergency care encounter recording. Enterprise use of NAL (NAL like) programs has been recommended by OTSG/MEDCOM for many years. Past enterprise use of NAL (NAL like) processes has not been well received within the MHS due to limitations of 1-call/1-resolution support and the inability of the process to directly tie into the MHS' systems to record civilian urgent/emergency authorizations and/or make MTF appointments for MTF enrolled beneficiaries. Improvements in universal NAL guidelines and triage logic has provided better metrics to determine efficacy of program and 'cost avoidance' when a beneficiary is triaged and educated to assume a lower level of healthcare resolution from their initial intent. Many beneficiaries have an initial intent of needing an emergency room (ER) visit and after calling a NAL their final execution can be lowered to either a civilian urgent care facility (verses ER), waiting till next day with actual appointment to enrollment site, or "self help" to personally resolve the healthcare need. Recent experience in linking NAL programs into MTF appointing systems has provided needed information to allow improvements to support 1-call/1-resolution business design.

(3) On 3 Apr 09, TMA released an official tasker to their three TRICARE Regional Offices (TROs) and all three Services, that requested input into implementation

alternatives to execute this AFAP issue's recommendation to provide for a 24/7 centralized HOTLINE to support out-of-area urgent healthcare requests and facility/provider locator functions. The MEDCOM coordinated with its sister Services to encourage a unified recommendation to TMA. The MEDCOM requested the following program design components (a - e) to support 24/7 centralized HOTLINE support of all Prime enrolled beneficiaries (some official verbiage removed for this paper):

(a) Standardized application of the required Title 32 Code of Federal Regulation (CFR) Health Care Finder (HCF) program from a toll-free centralized access point for global accessibility by any Prime enrollee.

(b) Standardization and compliance with the HCF program design to formally authorize and record civilian encounter request(s) for a Prime beneficiary when they contact the HCF centralized toll-free call system for out-of-area and after-hours (limited by specified locations) urgent/emergent healthcare needs.

(c) Locator support of the nearest MTF or civilian/host nation network provider/facility that could manage the urgent/emergent healthcare need.

(d) Required notification (within 24 - 48 hours) from the HCF to the beneficiary's enrollment site regarding the Prime beneficiary's urgent/emergent healthcare request and encounter when out-of-area or after-hours. Enrollment site could be either a civilian/host nation PCM or MTF anywhere in the world.

(e) Incorporation and full functional application of a Nurse Advice Line (NAL) information and triage process to the HCF centralized HOTLINE to support any DoD beneficiaries' requests (especially Prime enrollees) for medical advice and/or triage for determining self-help, urgent, or emergent healthcare needs.

(4) On 9 Jun 09, an official memo from TMA informed the Services of TMA's decision regarding the 24/7 centralized, toll-free process tasker. TMA did not accept the AMEDD proposed solution or any of its components. TMA endorsed a different process for single out-of-area encounter authorization by the MCSCs. However, as of 18 Aug 09, the Services were informed in two separate Enterprise Working Groups that this TMA memo will be rescinded. Exact reasons for rescinding the memo is unknown; however, the ability of the MCSCs to execute without a current contract modification was cited.

(5) On 12 Dec 09, another official TMA tasking to the Services for comments regarding the same issue identified in their 9 Jun 09 tasker. The AMEDD sent forward a 14 Jan 10 DSG Memo informing TMA that the AMEDD was again requesting the re-establishment of Title 32 Code of Federal Regulations requirements for an active Health Care Finder (HCF) program, managed by the regional TRICARE contractors (a.k.a MCSC); plus the AMEDD informed TMA of the potential dis-connected efforts to reinstate the HCF under the current TRICARE contracts while at the same time working the IIP effort to provide another contract to support a CONUS-wide HCF functions along with the NAL. As part of our official reply the AMEDD also provided our original 15 May 09 reply after the original recommendations were verified as still appropriate.

(6) Feb 10, the IIP Board of Directors approved a call for Service representatives to assist in the review the Request for Information (RFI) from industry, and to begin the work of drafting a Request for Proposal (RFP) to solicit a vendor that would provide a CONUS-wide centralized NAL and referral assistance service. Once procured, this new contracted functionality would meet the needs of the AFAP recommendations, but only in CONUS.

(7) MEDCOM requests that this issue and its recommendation remain active. This issue and the required efforts support OTSG/MEDCOM's ongoing dialogue with TMA to improve and/or 'fine tune' required actions and business processes involved in the overall TRICARE Prime referral and authorization program. This includes better MHS business designs to support the three key stakeholders in referral and authorizations, i.e. Prime enrolled beneficiary, Prime enrollment site (MTF/Civ provider), and the supporting regional TRICARE contractors (a.k.a MCSC) for civilian claims adjudication efforts.

h. Lead agency. MCHO-CL-M

i. Support agency. TMA

Issue 630: Availability of Standardized Respite Care for Wounded Warrior Caregivers

a. Status. Active

b. Entered. AFAP XXV, Jan 09

c. Final action. No (Updated: 29 Apr 10)

d. Subject area. Family Support

e. Scope. Standardized respite care is not available to all Wounded Warrior dependent and non-dependent caregivers. While all Wounded Warrior caregivers are eligible for respite care, the lack of availability still exists due to inconsistencies in areas such as: information, reimbursement, policy, personnel, and location. Caregivers of Wounded Warriors commonly suffer burn-out and compassion fatigue. In many cases, the Soldier's ability to sustain activities of daily living is directly associated with the well being of the caregiver. The lack of availability of standardized respite care for these caregivers can jeopardize the caregiver's stability and negatively affect the recovery of his/her Soldier.

f. Conference Recommendation. Provide uniform availability of standardized respite care to all caregivers of Wounded Warriors.

g. Progress.

(1) Respite Care is now authorized and provided to members of the Uniformed Services on active duty (regular Army, Army Reserve and National Guard) and veterans) per the provisions of The National Defense Authorization Act (NDAA) for FY 2008, Section 1633 (Respite Care and Other Extended Care Benefits for Members of the Uniformed Services Who Incur a Serious Injury or Illness on Active Duty). Respite care benefits were made effective as of 1 January 2008. Service members or their legal representatives/beneficiaries can submit receipts for reimbursement of respite services provided after 1 January 2008 by a TRICARE-authorized Home Health Agency (HHA).

(2) The TRICARE Policy Manual 6010.54-M, 18 September 2008, under the authority of Public Law 110-181 outlines the "Definitions, Terms & Limitations as Applied

to the Respite Benefit.” The provisions of the TRICARE Operations Manual, Chapter 18, Section 3 and the TRICARE Systems Manual, Chapter 2, Sections 2.8 and 6.4 regarding respite care are applicable in locations in and outside the United States, its territories and the District of Columbia through TRICARE-authorized HHAs. Service members can qualify for respite care regardless of their TRICARE enrollment status (Military Treatment Facility, TRICARE Prime, TRICARE Prime Remote, TRICARE Overseas Program, TRICARE Global Remote Overseas contract and the TRICARE Puerto Rico Contract). The service members’ case manager (or other approving authority) can approve respite care as a part of the medical plan of care.

(3) The Department of Veterans Affairs (VA) has expanded its array of respite services to include care in VA Community Living Centers, community nursing homes and non-VA, non-institutional settings such as adult day health care and in-home respite services. This increases the availability of services to Veterans and their Families by eliminating the need to wait for open medical center beds. These expanded services are outlined in the new VHA Handbook 1140.02 dated 10 November 2008.

(4) Advocates, case managers and counselors continue to inform WII Soldiers and their caregivers of respite benefits. The Compensation & Benefits Handbook for Seriously Ill and Injured Members of the Armed Forces, the newly published Department of Veterans Affairs Handbook and the TRICARE Management Agency continue to update Soldier, Veteran and Family/caregiver beneficiary handbooks and web sites to alert and inform beneficiaries of the extensions of new respite care benefits and locations.

(5) Respite care is still limited in some geographical locations, but locale availability is beyond the scope of the US Army as it is based on the economy and immediate need within the community. Respite services are available on a large scale and can be specifically requested through the case manager, medical treatment facility, Military Medical Support Office, TRICARE Area Office or Department of Veterans Affairs.

h. Lead agency. MCWT-OPT-O

i. Support agency. Army Warrior Transition Command (MEDCOM), TRICARE Management Agency, Department of Veterans Affairs

Issue 631: Career Coordinators for Army Wounded Warrior Soldiers, Family Members and Caregivers

a. Status. Active

b. Entered. AFAP XXV, Jan 09

c. Final action. No (Updated: 29 Apr 10)

d. Subject area. Employment

e. Scope. The Army Wounded Warriors (AW2) Program does not have a sufficient number of AW2 Career Coordinators to assist both AW2 Soldiers and their Families/Care Givers with the transition process. The AW2 Career Cell consists of four Career Coordinators that serves 3,814 Soldiers, their Families/Care Givers, and supports 120 Advocates. Last year, the number of AW2 Soldiers increased by 1,315, adding an average of 108 per month. AW2 Career Cell projections indicate a significant increase of AW2 Soldiers in the coming years.

The industry standard for career management is 1:30; the ratio of Career Coordinators to Soldiers is 1:953. The insufficient number of AW2 Career Coordinators does not allow effective career coordination, employer network development or long term management for the complex employment and education issues affecting AW2 Soldiers and their Families/Caregivers.

f. Conference Recommendation. Increase authorizations and funding for AW2 Career Coordinators assigned to AW2 Soldiers and their Families/Caregivers to reach the industry standard for career management of 1:30.

g. Progress.

(1) National employment based programs often do not reach to Hometown USA and localized employment infrastructure. Current AW2 manning and structure does not provide intensive one-on-one "on-site" employment, education, or training services. The synergy of individualized and personable employment case management can be the impetus for many severely injured Army Veterans to not only try to become self sufficient, but remain self sufficient over the course of the transitional move into the 21st century workforce.

(2) There are two employment specialists and one labor Specialist located at AW2 Headquarters. AW2 Careers continues to research options to hire and train seven additional career/education staff in the 2nd Qtr FY 2011. Adding seven career/education positions will enhance career coordination, employer network development, one-on-one intensive employment related services, and long term management affecting AW2 Soldiers and their Families/Caregivers. The regional Career Coordinators will be able to work the complex employment and education issues including helping the Veteran identify and then manage many different barriers to employment. The seven duty locations identified for the career/education staff are Portland, OR, Milwaukee, WI, Pittsburgh, PA, Albuquerque, NM, Boise, ID, Orlando, FL and Birmingham, AL. The seven positions will provide one-on-one career/education counseling, community outreach and employer support in the regions in which the Soldiers reside.

(3) Forty-eight Military Career Counselors are assigned to the WTUs to assist Soldiers with military career counseling.

(4) Once the seven employment/education specialists are hired, trained and in place the function of the AW2 Headquarters Career Cell will be policy, procedures, business development, strategic planning, management oversight, and regional outreach and employer support. The Warrior Transition Command will impact AW2 future staffing.

h. Lead agency. Army Wounded Warrior Program (AW2)

i. Support agency. Warrior Transition Command (WTC)

Issue 632: Community Support of Severely Wounded, Injured and Ill Soldiers and Their Families

a. Status. Active

b. Entered. AFAP XXV, Jan 09

c. Final action. No (Updated: 29 Apr 10)

d. Subject area. Family Support

e. Scope. Many communities are not aware of how they can support Severely Wounded, Injured and Ill Soldiers and their Families. A robust support network between the Severely Wounded, Injured and Ill Soldier and the community aids in a smooth transition into the civilian community. The support network between the community resources, (i.e., veteran service organizations, schools, local governments, non-governmental organizations, etc.) and these Soldiers and their Families is inconsistent, depending upon community awareness of how best to support them. This collaborative network is essential to the long term recovery of Severely Wounded, Injured and Ill Soldiers, and their Families for reintegration for life.

f. Conference Recommendation.

(1) Implement and communicate a collaborative network support program that connects community resources to the Severely Wounded, Injured and Ill Soldiers, and their Families.

(2) Implement an aggressive management plan that will evaluate the effectiveness of the collaborative network support program.

g. Progress.

(1) As of 1 March 2010, over 120 organizations are part of the Community Support Network and all are indexed. The Community Support Network is an AW2 sponsored initiative to connect severely wounded, ill, or injured veterans with local organizations in their hometown. An additional 600 organizations are being solicited.

(3) AW2's new command, the Warrior Transition Command (WTC), is reviewing a recommendation to expand the AW2 Speakers Bureau pilot program nationwide.

(4) WTC, is reviewing recommendations to expand AW2's social media presence through sites such as Facebook, Twitter, YouTube, TroopTube, and Flickr.

(5) AW2 coordinated with the Army Community Covenant on one event in 2009 and is in the process of identifying opportunities for 2010.

(6) AW2 hosted the first quarterly Community Support Network conference call on 22 January 2010, with a focus on post-traumatic stress disorder and traumatic brain injuries. Thirty-two organizations dialed-in, and speakers included the AW2 SGM, WTC Strategic Communications Division Chief, Defense Centers of Excellence Deputy Director for Outreach, and a AW2 Veteran, who suffers from PTSD and TBI. AW2 is currently planning to host the next quarterly call in April.

(7) AW2 distributed three electronic newsletters to community organizations in November 2009, January 2010, and March 2010. The next newsletter will be distributed at the end of May 2010.

(8) AW2 posted 12 blogs about, or written by, AW2 Community Supporters to raise AW2 Soldiers, Veterans, and Families awareness of the wide range of services available.

(9) AW2 distributed one Community Support NAPS release, a feature story. The article focused on a Veteran with PTSD and his service dog, which he received from an AW2 Community Support Network organization. The article generated 132 articles in 14 states with a readership of 5,295,344, and was posted on 8 websites

with a combined total of 58,847,258 unique visitors per month.

h. Lead agency. Army Wounded Warrior Program (AW2)

i. Support agency. Warrior Transition Command (WTC)

Issue 633: Cost of Living Allowance (COLA)

Dependents Cap

a. Status. Active

b. Entered. AFAP XXV, Jan 09

c. Final action. No (Updated: 10 Jun 10)

d. Subject area. Entitlements

e. Scope. Soldiers do not receive COLA entitlements for more than five dependents. The Defense Finance Accounting System (DFAS) caps the maximum dependent COLA calculation at five dependents. The COLA calculation cap negatively impacts Families with more than five dependents.

f. Conference Recommendation. Eliminate the five dependent cap on COLA.

g. Progress.

(1) Applies only to OCONUS COLA. CONUS COLA rate is paid only at a with dependent rate and a without dependent rate, regardless of the number of dependents.

(2) Consulted with the Per Diem Travel Transportation and Allowance Committee (PDTATAC) [<http://www.defensetravel.dod.mil/perdiem/trvlregs.html>] to gain a better understanding of the OCONUS COLA calculation methodology and the impact on a member having five or more dependents.

(3) PDTATAC explained that the spendable income used to calculate OCONUS COLA is based on averages. The PDTATAC uses spendable income tables computed for average family sizes and income levels to determine the amount of OCONUS COLA paid to members. These tables are based on consumer expenditure surveys from the Department of Labor's Bureau of Labor Statistics that show how people typically allocate their income.

(4) Once members reach 5 dependents, there is no additional income to allocate to COLA types of goods and services, and therefore the dollar amount for number of dependents in excess of 5 remains unchanged. As a result of this meeting, PDTATAC developed a more understandable explanation on OCONUS COLA concept and methodology, which was added to the PDTATAC website Frequently Asked Questions (FAQ) link.

[<http://www.defensetravel.dod.mil/perdiem/faq.html>]

(5) GOSC review. The Jun 10 GOSC declared the issue active. The VCSA said that the Army needs to explain the problem to the other services.

h. Lead agency. DAPE-PRC

Issue 634: Death Gratuity for Beneficiaries of Department of the Army (DA) Civilians

a. Status. Active

b. Entered. AFAP XXV, Jan 09

c. Final action. No (Updated: 5 Mar 10)

d. Subject area. Employment

e. Scope. The preferred beneficiary of a Department of the Army (DA) Civilian killed in a military contingency operation is not always allowed to receive 100% of the

Death Gratuity. The law permits those DA Civilians' eligible survivors (spouse, children, parents, siblings) to receive up to 100% of the Death Gratuity. Other survivor beneficiaries (foster child, fiancée, grandparent, uncle, etc), are only authorized up to 50% of the Death Gratuity; the remaining amount is paid to an eligible survivor or remains with the government. Soldiers' beneficiaries are authorized to receive 100% of their Death Gratuity regardless of their relationship to the Soldier. By differentiating between DA Civilian beneficiaries, the government fails to fully recognize the significance of all survivors' loss.

f. Conference Recommendation. Authorize 100% of the Death Gratuity to be paid to any person(s) designated by the DA Civilian regardless of their relationship.

g. Progress.

(1) Researched similar modification of Public Law 110-181 (10 U.S.C. Section 1477) pertaining to Armed Forces Service Members dated 1 July 2008 to designate 100% to any person as the beneficiary of the \$100,000 Death Gratuity benefit.

(2) Change in legislation to modify Public Law 110-181 (5 U.S.C. Section 8102a) to reflect the same law for DA Civilian beneficiaries has been uploaded into the ULB database on 1 March 2010 with submission to OSD and is on track for FY12 ULB Cycle.

h. Lead agency. DAPE-CPZ

Issue 638: Medical Nutrition Therapy (MNT) Benefits for All TRICARE Beneficiaries

a. Status. Active

b. Entered. AFAP XXV, Jan 09

c. Final action. No (Updated: 29 Mar 10)

d. Subject area. Medical

e. Scope. Medical Nutrition Therapy (MNT) is not a TRICARE benefit. MNT is the assessment and appropriate use of Nutrition therapy for a patient. It is provided at Military Treatment Facilities (MTF) that have dietitians on staff, but is not always available due to deployments, duty station, and appointment availability. Research shows MNT plays a vital role in wellness and disease management. A study done by the Lewin Group, Inc. in 1998, found that cost savings generated from a reduction in both inpatient and outpatient utilization of health care services over time as a direct result of MNT. They estimated \$6.2 M in potential TRICARE cost avoidance savings annually once MNT benefits are achieved. Providing this TRICARE benefit will reduce out of pocket expenses for beneficiaries and reduce overall healthcare costs for TRICARE.

f. Conference Recommendation. Establish MNT as a TRICARE Benefit for all TRICARE beneficiaries.

g. Progress.

(1) In Jan 97, Army and Air Force dietitians briefed the Assistant Secretary of Defense (ASD) for Health Affairs (HA), on the issue of including MNT as a uniform and authorized benefit across TRICARE. The ASD (HA) supported the importance of MNT. He felt that MNT was under-utilized within the Military Health System (MHS), and established HA policy (97-055) to establish MNT as an

intrinsic element of clinical practice, through inclusion as part of demand management, disease management (e.g., practice guidelines), and discharge planning.

(2) The Lewin Group, Inc. was awarded an OSD (HA) contract in 1998 to study the cost of covering MNT services under TRICARE. As noted earlier, they estimated a cost savings in excess of \$3M annually. The Army DSG submitted a tri-service proposal for outpatient MNT as a TRICARE benefit in Jul 99. On 10 Jan 01, TMA submitted this proposal for internal review as a potential new benefit; it was not approved due to funding limitations.

(3) In Dec 00, Congress passed and President Clinton signed a Medicare Part B, Medical Nutrition Therapy provision as part of Benefits Improvement and Protection Act, P.L. 106-554. This benefit became effective in Jan 02, and was limited to patients diagnosed with diabetes and/or renal disease based upon cost projections by the Congressional Budget Office. The benefit was contingent on a referral from a physician, and services were covered only if performed by a registered licensed dietitian.

(4) In Dec 03, the Medicare Prescription Drug Improvement and Modernization Act (H.R. 1) was passed into law. It contained two major new benefits which increased utilization of the Medicare MNT benefit including the Medicare Health Support Program and the Initial Preventive Physical Exam. The Medicare Medical Nutrition Therapy Act of 2005 (H.R. 1582 and S. 604), a bill that gives the authority to expand the MNT benefits to include any disease, disorder, or condition deemed medically reasonable and necessary, was introduced in Congress, however was not passed. In the Medicare Physician Fee Schedule Final Rule for 2005, CMS expanded the list of Medicare tele-health services to include individual MNT.

(5) Medicare has historically set the pace for other third party payers, and this is especially true for MNT services for disease management. Today, many civilian health care plans through Cigna, Aetna, Blue Cross/Blue Shield, and Humana, among others, cover MNT for various diagnosis including hypertension, hyperlipidemia, obesity, cancer, and eating disorders.

(6) In Jul 08, the Medicare Improvements for Patients and Providers Act was passed which establishes a procedure by which Medicare may expand coverage of preventive services, including MNT. As evident in research, diet plays an essential role in sustaining human health, maintaining, and enhancing mental performance, and improving physical capabilities. Today, this concept is strongly supported and advocated today by the U.S. Army Center for Health Promotion and Preventive Medicine (USACHPPM) and the Comprehensive Soldier Fitness Program, part of the U.S. Army Posture Statement (2009). Both entities promote and link the five domains of health for Soldiers and their Families, ensuring a fit, ready force.

(7) TRICARE authorizes some inpatient and outpatient nutrition therapies and specifically excludes others, like obesity and weight management. Recently, TRICARE completed a Weight Management Demonstration Project, and based on evidence from this study, may change the coverage for this particular diagnosis. In Jan 09, the Army Family Action Plan raised Issue #638, Medical Nutrition Therapy, which recommended nutritional services as

a TRICARE benefit to cover all categories of beneficiaries.

(8) In Sep 2009, the MEDCOM Judge Advocate General provided a preliminary review of the problem and has determined 2 specific issues that need addressing: (a) is MNT a necessary medical treatment as required by 10 USC 1079, and (b) are registered dietitians an authorized TRICARE provider? A statutory change (10 USC 1079 and 32 CFR, 199.6) will likely be required for both issues. The first one depending on how expansive the MNT coverage will be (disease management and/or prevention and wellness e.g., obesity), and the second issue to add registered dietitians to the approved provider list.

(9) The value of MNT as a TRICARE benefit has many advantages: it resolves the current lack of a uniform benefit for this clinical service; it benefits the patient by improving their quality of life and encourages active participation in managing their medical condition; and it supports the 2007 DoD Task Force on the Future of Military Health Care's recommendations to promote wellness thereby optimize readiness and beneficiary health. The current national debate on health care reform has led health care providers and payers to develop new approaches to meet the challenges of cost containment and quality care. Dietetics professionals are key members of the health care team and are uniquely qualified to provide medical nutrition therapy as an essential reimbursable component of comprehensive health care services.

(10) In Mar 10, a formal request to TMA was prepared and staffed within OTSG for final revision. This memo will ask TMA to consider adding MNT as a TRICARE benefit for all TRICARE beneficiaries, and will ascertain TMA's current position on this issue.

h. Lead agency. MCHO-CL-R

i. Support agency. TRICARE Management Activity

Issue 639: Deferment of Advanced Individual Training (AIT) Soldiers with Exceptional Family Members

a. Status. Active

b. Entered. AFAP XXV, Jan 09

c. Final action. No (Updated: 9 Jun 10)

d. Subject area. Medical Command

e. Scope. AIT Soldiers are proceeding on assignment instructions to OCONUS locations prior to overseas command decision regarding availability of EFM care in their respective unit of assignment. If Soldiers proceed to OCONUS locations prior to decision on availability of EFM care, a change of assignment may occur if EFM is disapproved for the Soldier's OCONUS assignment location. This negatively impacts Families, the Soldier's individual readiness, accomplishment of the unit mission and can result in expenditure of additional permanent change of station funds. Decisions regarding EFM care and command sponsorship/Family travel should be accomplished prior to Soldier proceeding on assignment to OCONUS locations.

f. Conference Recommendation. Require deferment of AIT Soldiers with EFMs until notification is received from OCONUS travel approval authority concerning availability of services and command sponsorship/Family travel decision.

g. Progress.

(1) USAREUR submitted issue for consideration at the January 2009 AFAP GOSC. In Nov 08, FMWRC coordinated this issue with Army G-1, Human Resources Command (HRC), and Army G-3/5/7.

(2) HRC initiated a formal request in Dec 08 to change AR 608-75 (paragraph 1-29e) as follows: "Defer Soldiers with EFMs (including AIT Soldiers) until notification is received from OCONUS travel approval authority about availability of EFM services. Soldiers will remain at current installation pending command sponsorship/Family travel decision from overseas command".

(3) FMWRC coordinated change to AR 608-75 Army-wide in 4th Qtr FY09; results were consolidated for inclusion in the regulation. Collaboration with HRC to obtain concurrence continues.

(4) In Mar 10, HRC provided recommendations for minor changes to the Rapid Action Revision to AR 608-75.

(5) At the Apr 10 AFAP issue review with LTG Lynch, a recommendation was made to close the issue since Revision to AR 607-75 will accomplish the intent of this issue.

(6) GOSC review. The Jun 10 GOSC declared the issue active.

h. Lead agency. OACSIM-ISS

i. Support agency. IMWR-FP, Army G-1, and HRC

Issue 641: Over Medication Prevention and Alternative Treatment for Military Healthcare System Beneficiaries

a. Status. Active

b. Entered. AFAP XXV, Jan 09

c. Final action. No (Updated: 29 Apr 10)

d. Subject area. Medical

e. Scope. No comprehensive strategy exists for over medication prevention and alternative treatment options for Military Healthcare System beneficiaries. Those suffering from injuries/illnesses are often over medicated because alternative treatment options are not readily available. Patients, Families and providers are not adequately educated about over medication and alternative treatment options. The lack of alternative treatment options and/or rehabilitative resources for all beneficiaries contributes to over medication and adversely impacts function and quality of life.

f. Conference Recommendation. Authorize and implement a comprehensive strategy to optimize function and manage pain including but not limited to alternative therapy and patient/provider education for all Military Healthcare System beneficiaries.

g. Progress.

(1) In Oct 08 PR&R at OTSG established a Pain Management Work Group to assess current state of pain management in Army medicine and to provide a roadmap to immediate, effective, efficient, multi-modal approaches to pain management across Army Medical Command.

(a) Group membership included military, Veterans Administration and civilian medicine representatives.

(b) Developed and completed task list of "quick wins"

(1) Clearly identify group priorities.

(2) Determine disciplines required for mission success.

(3) Draft "Army version" of AF Opioid policy for chronic pain.

(4) Develop brief to TSG to advocate establishing Pain Consultant.

(5) Expedite review/revision of DoD/VA CPG for Opioid Therapy.

(6) Consensus on 9 overarching principles of a comprehensive pain management strategy.

(c) Developed task list of complex objectives/goals for group:

(1) Creation of MEDCOM Pain Clinic template.

(2) Begin development of Pain Management OPOD.

(d) Developing manpower and other resource requirements necessary to complete evaluation of MEDCOM pain management capabilities and develop comprehensive pain management strategy for the MEDCOM.

(2) Aug 09, OTSG chartered the Pain Management Task Force to focus resources and attention on the issue of pain management in MEDCOM.

(a) The TF chairperson is the Assistant Surgeon General for Force Projection (ASG FP).

(b) The Army Pain Management Task Force will make recommendations for improving clinical, administrative, and research processes involved with the provision of pain management care and services at MEDCOM facilities.

(c) Areas for analysis and recommendation include, but are not limited to:

(1) Existing pain management policies, procedures, and resources.

(2) Best practices for pain management.

(3) Ongoing pain management research efforts with emphasis on optimizing delivery of effective pain management, minimizing complications, and maximizing function.

(4) Resources required for the early identification, assessment, treatment, and rehabilitation for pain.

(5) Safe and effective complimentary alternative approaches to pain management.

(6) Education training plan for patients, providers, family members and leaders to support patients with pain management issues.

(7) Variables unique to Warriors in Transition.

(8) Integration of pain management strategy to Comprehensive Soldier Fitness Program, Army Campaign Plan for Health Promotion, Risk Reduction and Suicide Prevention (ACPHP), Army Family Covenant, Army Family Action Plan and other DoD, Army and MEDCOM initiatives.

(3) 2010 NDAA mandates that not later than 31 Mar 11, the Secretary of Defense shall develop and implement a comprehensive policy on pain management by the military health care system.

(4) GOSC review. The Jan 10 GOSC declared the issue active pending policy development and standardization across the Army.

h. Lead agency. DASG-HSZ

Issue 643: Service Members Group Life Insurance (SGLI) Cap

a. Status. Active

b. Entered. AFAP XXV, Jan 09

c. Final action. No (Updated: 3 May 10)

d. Subject area. Entitlements

e. Scope. The SGLI cap of \$400,000 is insufficient for many Families. The SGLI cap may be inadequate to secure the surviving Families' financial stability when considering the cost of living and accrued debt at time of death. Consequently, many Soldiers purchase supplemental insurance at significantly higher rates in addition to SGLI. Enabling Soldiers to purchase additional benefits through the SGLI ensures their insurability and offers affordable financial security in the event of death.

f. Conference Recommendation. Increase SGLI cap incrementally to \$1,000,000.

g. Progress.

(1) Determine OSD support of the initiative due to extra hazards" costs. Section 1969 of Title 38, United States Code, provides that there will be an annual assessment for the costs of the extra hazards of duty when actual mortality exceeds peacetime mortality. The "extra hazards" payment is defined as the reimbursement the DoD pays to VA to cover the costs of SGLI claims that are in excess of the peacetime mortality level.

(2) Submit a Uniformed Legislative Budgeting proposal for FY13 A cycle to increase to SGLI coverage in \$50,000 increments up to a maximum of \$1,000,000..

h. Lead agency. DAPE-PRC

i. Support agency. OSD

Issue 644: Shortages of Medical Providers in Military Treatment Facilities (MTF)

a. Status. Active

b. Entered. AFAP XXV, Jan 09

c. Final action. No (Updated: 29 Mar 10)

d. Subject area. Medical

e. Scope. Demand for healthcare exceeds provider availability in MTFs. The Army's projected growth will further increase this demand. Statutes limit salaries, incentives and contracts which exacerbate recruiting and retaining adequate numbers of medical providers. The lack of providers affects timeliness of medical services, impacts Soldier medical readiness and the health of Family members and Retirees.

f. Conference Recommendation.

(1) Expediate staffing of military, civilian, and contracted medical providers to support prioritized needs as identified by the MTF Commander.

(2) Implement new strategies for recruiting and retaining medical providers for MTFs.

g. Progress.

(1) Military Human Capital. The US Army Medical Command (MEDCOM) HCDP is a coordinated effort between US Army Human Resources Command (HRC) and MEDCOM to properly distribute military human capital assets across the MEDCOM. All Human Capital resources (Military, Civilian, and Contractor) are taken into account during development of the plan. The HRC managers coordinate and balance the needs of the Army

with the Soldier's needs to distribute personnel according to the HCDP. The Fall HCDP Conference is held to develop the HCDP for the upcoming Fiscal Year. During the Spring HCDP Conference, the HCDP approved during the Fall conference is validated and adjusted as needed to ensure the approved plan provides equitable distribution while meeting the Army, MEDCOM, and MTF Commanders' requirements. The HCDP Flag Officer Strategic Session will again be held in conjunction with the annual Medical Symposium (May 2010). Topics of discussion will be of strategic importance to the Army Medical Department (AMEDD), and the Flag Officers present will provide strategic manning guidance for the upcoming HCDP cycle (FY12). The HCDP process now includes Veterinary Corps officers and selected Enlisted specialties.

(2) Civilian Human Capital. Multiple developmental programs are available to increase the number of providers in shortage specialties at MTFs, such as the Army partnerships and the Masters of Social Work Program. The OSD is supporting legislation to establish a scholarship program for civilians in Behavioral Health occupations.

(3) Contract Human Capital. Despite the best efforts of contractors, contracting offices, and MTFs to provide robust incentives, certain provider positions at remote and other hard-to-fill locations remain unfilled. In order to improve contract administration and reduce the lead time for awarding contracts, the Surgeon General delegated expedited hiring authority on 17 July 2009 to enable MEDCOM to more rapid hiring of contracting professionals. Additionally, the USAMAA recently concluded a manpower analysis of MEDCOM that identified a shortfall in contracting administration and recommend an increase of 117 additional contracting authorizations to improve all phases of contracting.

(4) Other. MEDCOM, in conjunction with the Army staff, is conducting an ongoing Total Army Analysis to identify operating and generating force requirements. Close scrutiny of policies, procedures and staffing levels across the command and ongoing dialogue with the TRICARE Management Agency continues to ensure the availability of purchased care resources from providers in local communities surrounding our installations as part of our efforts to meet Access to Care standards.

h. Lead agency. MCHR-C

Issue 646: Active Duty Family Members Prescription Cost Share Inequitability

a. Status. Active

b. Entered. AFAP XXVI, Jan 10

c. Final action. No (Updated: 29 Mar 10)

d. Subject area. Medical

e. Scope. There is an inequality of prescription cost share benefits for Active Duty (AD) Family Members not enrolled in a Military Treatment Facility (MTF). Prescriptions filled at a MTF are provided at no cost. AD Family Members who are not enrolled at an MTF and utilize retail or mail order pharmacies for their prescriptions are required to make cost share payments. These Family Members incur cost share fees, (\$3 generic, \$9 brand, \$22 non-formulary, per prescription,

per Family member), which will quickly add up for Families with multiple prescription requirements (i.e., AW2, EFMP, Catastrophic events, etc.). These additional expenses are inequitable and create a financial burden above those who acquire their prescriptions from the MTF.

f. Conference Recommendation. Eliminate prescription cost shares for Active Duty Family Members not enrolled at a Military Treatment Facility.

g. Progress:

(1) Congress enhanced the pharmacy benefit to include the use of a mail order pharmacy and retail pharmacies with the first round of BRAC closures; providing military beneficiaries with three options for medications: the MTF pharmacy, mail order or retail. These options are not tied to a certain plan or enrollment but can be used at the discretion of the beneficiary. MTF enrollment is not a requirement for using the MTF pharmacy as all pharmacies accept prescriptions from civilian doctors, whether TRICARE providers or not. MTF pharmacies purchase medications through the FSS or DoD contracts, most at large discounts as compared to civilian pharmacies. To offset the costs of using more expensive options, Congress implemented a cost share program that requires beneficiaries to pay \$3/prescription for generic medications and \$9/ prescription for brand name products. With the activation of the DoD Pharmacy and Therapeutics Committee, a 3-tier system of medications was established with the 3rd tier being non-formulary medications. Medications identified in this tier have a \$22/ prescription cost-share. Active Duty personnel are exempt from this cost-share and pay nothing if using mail order or retail pharmacies. As with the three tiers of cost-share, there are essentially three tiers of preference for obtaining medications: MTF has no cost-share; mail order can be dispensed with up to a 90-day supply for the \$3/\$9/\$22 co-pay; retail can be dispensed with up to a 30-day supply for \$3.\$9/\$22.

(2) Anticipate limited support from TMA with a request to remove co-pays for prescriptions. The Presidential Task Force recommended increasing co-pays with the DoD Senior Executive Council making their own recommendations in a final report to Congress. They are recommending the following cost-share:

(a) Mail order (90 days): \$0/\$15/\$45

(b) Retail (30 days): \$15/\$25/\$45

(3) DEERS establishes TRICARE benefits eligibility. The system currently identifies Active Duty but has no way to identify a spouse or other family members as being eligible for a waiver of pharmacy co-pays. A systems change request is necessary to allow this process. TMA manages DEERS so we do not anticipate support for this systems change request.

(4) OTSG Pharmacy Consultant made initial contact with the DMCD to determine point of contact for DEERS system change requests in March 2010.

(5) The OTSG Pharmacy Consultant made initial contact with the TMA to determine point of contact for initiating a change to the current regulation providing guidance on prescription co-pay and DEERS eligibility in Mar 10.

(6) The OTSG Pharmacy Consultant made initial contact with MEDCOM JAG to identify modifications of the regulation in Mar 10.

h. Lead Agency: DASG-HSZ

i. Support Agency: TRICARE Management Activity

Issue 648: Behavioral Health Services Shortages

a. Status. Active

b. Entered. AFAP XXVI, Jan 10

c. Final action. No (Updated: 7 May 10)

d. Subject area. Medical/Command

e. Scope. Soldiers, retirees, Family Members, and previously deployed DA Civilians are not able to access timely behavioral health services needed for their treatment and recovery because of the shortage of behavioral health providers. A 16 November 2009 Office of The Surgeon General (OTSG) Information Paper states from June thru October of 2009, the Army lost 72 Psychiatrists and 50 Psychologists and reports an unmet requirement of 923 behavioral health providers for the Active Component alone. The shortage of behavioral health services impacts the health of Soldiers, retirees, Family Members, previously deployed DA Civilians and ultimately contributes to the rising suicide rates, drugs, and alcohol abuse.

f. Conference Recommendations.

(1) Increase the number of readily available behavioral health providers and services for Soldiers, retirees, Family Members, and previously deployed DA Civilians.

(2) Increase the use of alternative methods of delivery; such as tele-medicine.

g. Progress.

(1) Military and Civilian Human Capital.

(a) The Army Active BH inventory as of end of March 2010 is captured in table below. It indicates we have an on-board strength of 3,823.35 (89.15%) against a "need" of 4,288.55 BH providers. There is a shortfall of 465.2 providers Army-wide, in spite of the net increase of 109.75 during the last three months. This also represents a significant increase since 2007; the Army has added 1,264.85 civilian, military and contract BH providers to help meet our needs.

(b) Congressional funds designated specifically for enhancing access to BH totals \$169 M in the FY10 budget. This funding is sufficient to cover the funding for the increased number of BH providers above MEDCOM's base and grants it the ability to apply operational budgets to hire above published requirements based on "needs".

(2) Military Human Capital (Active Duty Component Only).

(a) The AMEDD continues to support and promote incentives to maintain and recruit quality BH professionals. In partnership with Fayetteville State University, MEDCOM developed a Masters of Social Work program which graduated 19 in the first class in 2009 (current capacity is 30 candidates). Additionally, the use of the Active Duty Health Professions Loan Repayment Program (HPLRP) was expanded; and we began to offer a \$20K critical skills accessions bonus for Medical and Dental Corps Health Professions Scholarship Program (HPSP) applicants. The Army used a onetime Critical Skills Retention Bonus (CSRB) for company grade social workers

and behavioral health nurses. Clinical Psychologists have been offered a modified CSRB to enhance their retention (10K per year for two years, 15K per year for three years and 20K per year for four years). The number of Health Professions Scholarship allocations dedicated to Clinical Psychology was increased and the number of starts in the Clinical Psychology Internship Program (CPIP) was also increased. Prior to 2004 the Army historically trained 12 CPIP interns per year and has progressively increased that number, admitting 33 interns in 2009. We implemented an officer accessions pilot program that allows older healthcare providers to enter the Army, serve two years, and return to their communities. Additionally, the Uniformed Services University of Health Sciences (USUHS) Department of Medical and Clinical Psychology offers three degree producing programs, to include a PhD in Clinical Psychology. The Army is allotted three spaces per year in this five year DoD/Tri-Service program. Individuals are then fully licensed.

(b) We support the United States Army Recruiting Command (USAREC) Medical Recruiting Brigade (MRB) with military providers to leverage peer-to-peer recruitment. The MRB recruits students, both in medical school and in other non-physician BH training programs, as well as, fully qualified BH providers. As of 22 April 2010, BH recruitment projections are 90% of the Regular Army mission and 70% of the Army Reserve mission for FY2010. Current incentives include; Active Duty HPLRP up to 120K (40K/year) for Clinical Psychologists and Social Workers; Nurses can accept HPLRP, the Nurse Accession Bonus; and Psychiatric Nurse Practitioners' can participate in HPSP. The MRB continues to leverage the HPSP to support individuals in training to become Clinical Psychologists and Psychiatric Nurse Practitioners which offered 1 and 2 year scholarships in FY2010. We also offered civilians an opportunity to match to 9 Army Clinical Psychology Internships to complete their training. Currently, Psychiatrists are eligible to participate in the Critical Wartime Skills Accession Bonus Program (272K paid in four annual installments). The publication of DoD's DTM 09-009 will allow the Army to offer an Accession Bonus to fully qualified Licensed Clinical Social Workers and licensed Clinical Psychologists.

(3) Civilian Human Capital.

(a) Our on-board strength civilian BH providers grew significantly from 819 on 31 March 2006 to 1,680 on 31 March 2010. This doubling of the workforce during a four year period resulted in the following:

(1) Psychologists (an increase from 288 to 533 or a 85% increase)

(2) Social Workers (an increase from 369 to 854 or a 131% increase)

(3) Psychiatrists (an increase from 89 to 131 or a 47% increase)

(4) Psychiatric RNs (an increase from 73 to 162 or a 122% increase).

(b) To achieve the 105% increase in civilian behavioral health providers, the MEDCOM aggressively pursued several actions to increase the staffing levels. For the past three fiscal years, the MEDCOM centrally funded \$1.5M annually for the student loan repayment program for registered nurses, including psychiatric registered

nurses. It also set aside monies for recruitment, relocation, and retention incentives for all health care occupations. A little more than \$11M was granted to civilian employees in the four behavioral health occupations during the last 18 months through the end of March 2010. Our expenditures for these incentives have increased significantly from FY07 through FY10 (\$251.6K to \$4.48M for psychologists and \$67K to \$2.18M for social workers).

(c) MEDCOM developed a proposal to upgrade Army Substance Abuse Program counselors and psychologists and social workers with an independent practice license from GS 11 to GS 12 or equivalent in National Security Personnel System (NSPS) and those individuals with less than independent license would be upgraded from GS 9 to GS 11. These initiatives recognize the scope of duties and complexity of work performed by these counselors. Additionally, with the mandated repeal of the NSPS, representatives from the Services along with VA representatives participated in a Tri-Service workshop hosted by ASD HA, to develop a Title 38-based alternate compensation and personnel system for health-care occupations that includes behavioral health occupations such as nurses, psychologists and social workers. The intent is to develop an alternate personnel and compensation system to retain the personnel management program and compensation flexibilities under NSPS that do not exist under the provisions of Title 5 GS personnel management rules. Meanwhile, the incumbents of these occupations will remain under the provisions of NSPS and shall be converted to the new alternate system not later than 31 December 2011. These efforts are reducing our turnover rate (losses to Army) from the FY07 base year to end of FY09; (reduced from 14% to 10% for psychologists; from 13% to 10% for social workers; from 14% to 13% for psychiatrists and from 13% to 10% for psychiatric RNs). Our FY10 numbers should validate this positive trend. Even with these initiatives and success in reducing our losses, at present MEDCOM has a total 308 open recruitment actions for these four BH occupations. We believe the labor market for these occupations is tightening as DoD and the VA vie for these highly educated candidates.

(4) Contracting. MEDCOM has increased by 4% the BH contract fill rate from six (6) months ago (September 2009 - 80%) and an increase of 7% from a year ago, March 2009 (Mar 09 -77%). This increase was achieved through:

(a) Use of contracting vehicles to speed the award of contracts.

(b) Contractors utilizing more progressive marketing and recruiting tools to identify potential contractor candidates for BH positions

(c) Converting contractor positions to government civilians.

(5) Despite the best efforts some of the behavioral health specialties and positions at remote and other hard-to-fill locations remain unfilled. The contracting community is employing the following action to improve the situation:

(a) Use of relocation and incentive fees

(b) Speeding the credentialing process for candidates

(c) Expanding marketing to all BH communities to access a larger pool of potential candidates

(d) Implementing the ADCMS and BPAs as tools to award both sustained and contingency BH requirements.

(6) MEDCOM created a new Tele-Health division, with an initial focus on BH and mTBI issues. Services include tele-Psychiatry, tele-Psychology, Medical Evaluation Boards, Temporary Disability Retired Lists, Mental Status Evaluations, tele-Neuropsychology, the School-Based Mental Health Program, the AKO Tele-consultations Service, and the Virtual BH Program. These real-time tele-BH services are provided via video-conferencing technology through a network of 53 active sites across five Regional Medical Commands. Store-and-forward tele-BH services are also provided to theater through email exchange in the AKO Tele-Consultations Service. To date, the Army has provided over 7,000 consultations in 41 countries and in 39 specialties, including BH, through this service. Tele-health increases access to specialty care in geographically dispersed areas, enable greater continuity of care, and provide surge capacity. However, these benefits should be weighed against the costs of diverting providers away from pre-existing face-to-face appointments to perform tele-health encounters

(6) GOSC review. The Jun 10 GOSC declared the issue active. The VCSA recognized the progress that has been made on this issue, but said that he thinks there is a perception that there are not enough behavioral health providers. The VCSA said we should report back at the January 2011 HQDA AFAP conference and let them know everything we've tried to do to fix this.

h. Lead Agency: MCHR-C

Issue 649: Compensatory Time for Department of the Army Civilians

a. Status. Active

b. Entered. AFAP XXVI, Jan 10

c. Final action. No (Updated: 9 Jun 10)

d. Subject area. Employment

e. Scope. DA Civilians who work irregular or occasional overtime receive compensatory time at a disproportionate rate than overtime pay. Compensatory time is granted at one hour off for each hour of overtime worked. Overtime pay is usually paid at one and one-half times the hourly rate. Receiving one compensatory hour for each overtime hour neither acknowledges nor compensates the employee for the impact of lost evenings or weekends.

f. Conference Recommendation. Increase compensatory time for DA Civilians to 1.5 hours off for each hour of overtime worked.

g. Progress.

(1) Costs associated with increasing compensatory time off for employees to 1.5 hours for each hour of overtime worked will vary depending upon the total number of hours of compensatory time worked and the employee's salary. Compensatory time earned is paid at the overtime rate after 26 pay periods if not used. The increased hours of compensatory time earned can result in more time off from work, an additional loss of productivity.

(2) For calendar year (CY) 2009, there were 694,434 hours of compensatory time earned by DA Civilians and

538,590 hours of compensatory time used. A total of 155,844 hours of compensatory time could have been paid out to employees.

(3) If the AFAP recommendation were in effect in CY 2009, the total number of hours of compensatory time earned by DA Civilians would have been 1,041,651 hours (an increase of 347,217 hours). Applying the same compensatory time usage rate, the total number of hours of compensatory time used by DA Civilians could have been 807,885, an increase of 269,295 hours. With the current average General Schedule base salary (not including locality pay) for DA Civilians of \$61,523 (\$29.58 regular hourly rate/\$32.90 overtime rate); the costs associated with the proposed change could result in an increase of approximately \$10.5 million a year for comp time expenditure, not including locality pay.

h. Lead agency. G-1, DAPE-CPZ

i. Support agency. AARP-RM and DFAS

Issue 650: Exceptional Family Member Program Enrollment Eligibility for Reserve Component Soldiers

a. Status. Active

b. Entered. AFAP XXVI, Jan 10

c. Final action. No (Updated: 7 May 10)

d. Subject area. Medical/Command

e. Scope. Reserve Component (RC) Soldiers are ineligible for enrollment in the Exceptional Family Member Program (EFMP). Army Regulation 608-75 dated 22 November 2006, paragraph 1-7a. (2) states mobilized and deployed Soldiers are not eligible for enrollment in EFMP. In order to be eligible for all benefits of the EFMP, you must be enrolled. Enrollment allows EFMP to expedite the process of identifying and providing support to eligible RC Soldiers and Families.

f. Conference Recommendation. Authorize RC Soldiers enrollment in the Exceptional Family Member Program (EFMP).

g. Progress.

(1) In Feb 10 this issue was reviewed by the EFMP Policy Working Group at the EFMP Summit and ranked as the second highest priority.

(2) In Mar 10, draft language was forwarded to ARNG and USAR EFMP POCs for coordination and review.

(3) In Apr 10 consulted with OTJAG regarding draft language.

(4) In Apr 10 EFMP Policy Working drafted proposed language for regulation and developed a process flow chart for enrollment/tracking of RC EFMs.

(5) GOSC review. The Jun 10 GOSC declared the issue active to pursue necessary steps to authorize and track RC enrollment in the EFMP.

h. Lead agency. OACSIM-ISS

i. Support agency: IMWR-FP

Issue 651: Extended Transitional Survivor Spouses' TRICARE Medical Coverage

a. Status. Active

b. Entered. AFAP XXVI, Jan 10

c. Final action. No (Updated: 7 May 10)

d. Subject area. Medical

e. Scope. Transitional Survivor Spouses maintain enrollment in the TRICARE Prime medical health plan at the active duty Family Member status for only three years. At the end of three years, the spouse's status is changed in DEERS to survivor status at the retiree payment rate. In FY01, legislation changed the survivor spouse transition period from one to three years. In FY06, Congress extended the eligibility of survivor dependent children coverage to be the greater of three years or until they lose Title 10 eligibility. The transition period after a death is stressful and challenging for surviving Family Members. The extension of Transitional Survivor Spouses' TRICARE Prime medical coverage will provide additional time for rebuilding after the death of the active duty service member.

f. Conference Recommendation. Extend Transitional Survivor Spouses' TRICARE Prime medical coverage at the active duty Family Member status from three to five years.

g. Progress.

(1) Families/spouses of Soldiers who die on Active Duty are entitled to the same medical/TRICARE benefits as they received as an Active Duty Family Member (ADFM). This continued ADFM status is retained for a 3-year period and is classified as "transitional survivor". The FY06 National Defense Authorization Act provided the entitlement change to Title 10 United States Code (U.S.C.) and allows the Soldier's family/spouse to receive uninterrupted TRICARE enrollment and medical care.

(2) After the 3-year transitional period, the spouse's beneficiary status changes from ADFM to retiree family member. Similar to all other new retirees, this retiree status affects both TRICARE payment rates (cost sharing and enrollment fees) and TRICARE Prime enrollment options (MTF or civilian network). The re-enrollment process is one of the factors that allow MTF the ability to maintain capacity for the Active Duty population. If the MTF does not have capacity, new retirees are afforded enrollment in the civilian network. All minor and unmarried dependent children will remain eligible as "transitional survivor" from date of sponsor's death and until the longer of 3 years, they reach the eligibility age limit (age 21 or age 23, if full-time college student), marry, or otherwise become ineligible for Title 10 medical entitlements.

(3) The OTSG recognizes that the transition period after a death is stressful and challenging for surviving family members. MEDCOM has worked with the SOS Advisory Panel which is tasked to expand and standardize the survivor outreach program. Recent efforts included educating beneficiaries about the existing TRICARE survivor benefit program, as well as identify opportunities to strengthen the survivor program through the SOS Advisory Panel.

(4) Extending transitional healthcare beyond three years requires legislative entitlement changes at the DoD level as the change would affect all Services. It is not clear if the TRICARE Management Activity would support this change. A similar effort to extend dental benefits to five years under AFAP Issue 616 is being worked by OTSG and has resulted in some survivor dental benefit enhancements. Dental benefits for surviving children will mirror the medical survivor benefit. Children will be cov-

ered until 21 or 23 if a full-time student. Efforts to extend dental benefits up to five years under AFAP Issue 616 have not been supported by TMA.

(5) TSG) will send a formal request, asking TMA to assess the feasibility of enhancing the TRICARE Survivor Medical Benefit from three to five years. Following TMA's response, OTSG may also propose forming a multi-service workgroup that could analyze and discuss the OTSG proposal. It is also unclear at this point if the other Services will support extending survivor healthcare benefits.

h. Lead agency. DASG-HSZ

Issue 652: Family Readiness Group External Fundraising Restrictions

a. Status. Active

b. Entered. AFAP XXVI, Jan 10

c. Final action. No (Updated: 9 Jun 10)

d. Subject area. Family Support

e. Scope. Family Readiness Group (FRG) informal funds can only be obtained through unsolicited donations and fundraising efforts on a military installation or through the Unit membership. Department of Defense 5500.7-R (Joint Ethics Regulation) (JER), Section 2, 3-210a (6) (Fundraising and Membership Drives) and Army Regulation 608-1 (Army Community Service), Appendix J (FRG Operations) restrict external fundraising. Without external fundraising capabilities, the majority of the funds raised come from within the FRG membership. External fundraising will ease the financial burden placed on Soldiers and Family Members.

f. Conference Recommendation. Authorize Family Readiness Groups (FRGs) to fundraise in public places external to Reserve Centers, National Guard Armories and military installations.

g. Progress.

(1) Mar 10, IMCOM SJA indicated this issue must be worked by OTJAG.

(2) Mar 10, OTJAG concluded that resolving this issue would require change to OPM and/or Federal Ethics Regulation and potentially have legislative impacts. OTJAG suggested FRGs may fundraise on installations; however, Reserve Component FRGs would be limited to AFRCs or Armories. OTJAG indicated that 501-3c (tax-exempt, nonprofit) status and then fundraise externally.

(3) Mar 10, FMWRC Family Programs reiterated similar recommendations.

(4) Mar 10, reviewed issue with FMWRC SJA. FMWRC SJA will coordinate with OTJAG and provide an opinion on issue resolution and suggested language.

(5) Apr 10, consulted with FMWRC SJA to review way ahead. FMWRC SJA will contact OTJAG to review legal opinion and assist with preparing change to regulation and/or legislation. Requested FMWRC SJA to opine as to whether legislative change is attainable.

(6) At the Apr 10 AFAP issue review with LTG Lynch, a recommendation was made to close the issue as Unattainable as this issue will require legislative change. Change to legislation may not be supported by Office of Personnel Management.

(7) GOSC review. The Jun 10 GOSC declared the issue active to pursue a holistic review of funding for FRGs.

h. Lead agency. DAIM-ISS

i. Support agency. IMWR-FP, OTJAG

Issue 653: Funding Service Dogs for Wounded Warriors

a. Status. Active

b. Entered. AFAP XXVI, Jan 10

c. Final action. No (Updated: 29 Apr 10)

d. Subject area. Force Support

e. Scope. The Department of Defense does not offer a formal program that funds service dogs for Wounded Warriors. There is significant anecdotal evidence that animal assistance programs help patients of all types recover and heal from wounds, injuries and illnesses, both physical and psychological. Service dogs may assist Wounded Warriors in attaining a higher level of independence and self-reliance which allows them to function more successfully in their community and jobs.

f. Conference Recommendation. Fund a formal program to provide service dogs for Wounded Warriors.

g. Progress.

(1) From 15-17 Dec 09 the Veterinary Command and Medical Command held an animal assisted therapy summit at Ft. Myer that addressed the use of therapy dogs in Warrior Transition Units, in military treatment facilities, in combat stress control units and other settings. The agenda included current efforts, research, metrics for program evaluation, logistical and legal challenges. The forum had eight NGO organizations there for the first half of the proceedings to discuss their programs. Other important attendees included staff from: the Warrior Care and Transition Office, MTF, PR&R, Walter Reed, and Combat Stress Control staff who had worked with the dogs in theater. CG, U.S. Army Public Health Command (Provisional) provided remarks and guidance on the final day. Products included mission priorities, a research agenda and the corporate way ahead.

(2) On 5 Feb 10 a meeting was held on Animal Assisted Therapy to follow-up on the Summit held at Ft. Myer in Dec 09. Participants included the Office of The Surgeon General/Medical Command, Walter Reed Army Medical Center, European Region Medical Command, the Veterans Administration, America's Veteran Dogs, National Educational Association of Disabled Students and other non governmental organizations, and included a wide range of disciplines. Topics included:

(a) Optimizing the use of canines in the Combat and Operational Stress Control teams in Iraq.

(b) Moving forward on research opportunities at Walter Reed Army Medical Center and European Regional Medical Command.

(c) Potential use of canines in Warrior Transition Units.

(d) Updating a number of policies, including on Human Animal Bond, Walter Reed Army Medical Center facility policy, and Combat Operational Stress Control policy.

(e) The various models of training which may be helpful.

(f) The importance of being clear on the diverse use of dogs (service dogs, animal assisted therapy, animal assisted activities).

(3) In Feb 10 OTSG developed an Animal Assisted Therapy/Animal Assisted Activities policy letter or memorandum for the Regional Medical Commanders.

(4) On 24 Mar 10 OTSG made a site visit to America's Veteran Dogs campus to begin observe training and demonstration of their Combat Stress dogs such as those in Iraq, and their other Physical Therapy dogs, such as those at Walter Reed Army Medical Center and Eisenhower Medical Center.

(5) On 11 Apr 10 OTSG made a site visit to the National Educational Association of Disabled Students to begin an accurate determination of the training and resources necessary to support an Amy Animal Assisted Therapy program.

(6) Walter Reed Army Medical Center is in the process of organizing a demonstration of Animal Assisted programs on their campus for the Office of the Surgeon General, Veterinary Command and Commonwealth University. The site visit took place in early Apr 10.

(7) GOSC review. The Jun 10 GOSC declared the issue active. The issue will be modified to include reference to both service and therapy dogs for wounded, ill and injured Soldiers.

h. Lead agency. DASG-HCZ

i. Support agency. DoD Veterinary Service Activity, Veterinary Command, Walter Reed Army Medical Center, U.S. Army Medical Department Center and School

Issue 654: Monthly Stipend to Ill/Injured Soldiers for Non-Medical Caregivers

a. Status. Active

b. Entered. AFAP XXVI, Jan 10

c. Final action. No (Updated: 29 Apr 10)

d. Subject area. Entitlements

e. Scope. The Army does not offer a monthly stipend to injured/ill Soldiers who do not qualify for Traumatic Servicemembers' Group Life Insurance (TSGLI) and are certified by a medical provider to be in need of a non-medical caregiver's assistance. Although travel and transportation compensation is provided through the NDAA FY10, there may be additional costs incurred by the non-medical caregiver while caring for the Soldier. Expenses can include child care and the loss of ability to generate income. In the absence of the monthly stipend for non-medical caregivers, the Soldiers that do not qualify for TSGLI could require hospitalization, nursing home care or residential institutional care.

f. Conference Recommendation. Provide a monthly stipend to Soldiers that do not qualify for TSGLI and are certified to be in need of assistance from a non-medical caregiver.

g. Progress.

(1) Army ASA(M&RA) continues to work with the Office of Wounded Warrior Care and Transition Policy to develop and obtain approval of a USD(P&R) Directive Type Memorandum to implement Section 603 of PL 111-84 to establish a stipend for catastrophically injured Service Members. The SOC approved a stipend of \$2,983 per month available to all Service Members who are catastrophically injured in the line of duty and require the assistance of a caregiver to avoid placement in an institution. Currently pending is a SOC decision on the eligible

population for receipt of the stipend. The issue is whether all catastrophically injured Service Members would qualify or only those wounded or injured in a theater of war or, alternatively, only those who would qualify for Combat-Related Special Compensation. As of 23 April, no date has been set for the SOC to make this eligibility determination. Until then, the DTM cannot be approved and the Services are not able to finalize and execute implementation guidance so Service Members can begin receiving the stipend. Retroactive receipt of the stipend is not authorized under the statute.

(2) Congress passed S 1963 23 April 2010. Title I of that bill calls for the Department of Veterans Affairs to establish a training, support, care, and stipend program for family member primary caregivers of Veterans who require assistance with Activities of Daily Living. The bill is currently awaiting the President's signature. The provisions of Title I of this bill impact on the assumptions made in developing the Section 603 DTM. Currently being reviewed are alternative adjustments to the DTM language to adjust for these overlapping provisions.

(3) Expansion of stipend availability to additional Service Members will require Congressional legislative action. A ULB proposal is required to be developed. To make the FY12 legislative cycle, this proposal needs to be developed and submitted NLT May 2010. Army, DoD, OMB, White House, and Congressional ratification will also be required.

(4) GOSC review. The Jun 10 GOSC declared the issue active. The description in the AFAP issue will be modified to more clearly articulate that the intent of the issue is to provide support to the nonmedical attendant.

h. Lead Agency: WTC

i. Support Agency: DA G-1, MCWT

Issue 655: Reduced Eligibility Age for Retirement of Reserve Component Soldiers Mobilized in Support of Overseas Contingency Operations

a. Status. Active

b. Entered. AFAP XXVI, Jan 10

c. Final action. No (Updated: 14 Apr 10)

d. Subject area. Entitlements

e. Scope. RC Soldiers with OCO eligible active duty service between 11 September 2001 and 28 January 2008 do not receive credit for active service towards reduced retirement age. RC Soldiers mobilized in support of OCO after 28 January 2008 will have their retirement date reduced by 3 months for each cumulative total of 90 eligible days of active duty, according to the National Defense Authorization Act (NDAA) for 2008, section 647. RC Soldiers who served between 11 September 2001 and 28 January 2008 have their service unfairly excluded by denying them the same benefits as RC Soldiers who served after 28 January 2008. RC Soldiers mobilized in support of OCO incur the same sacrifices, and warrant the same credit of service toward reduced retirement eligibility age regardless of when they served.

f. Conference Recommendation. Credit OCO eligible active duty service prior to 29 January 2008 towards reduced eligibility age for retirement of RC Soldiers.

g. Progress.

(1) Proposals were made in the first session of the 111th Congress and are still active. They are HR 208, S. 644 and S. 831 and have been referred to the respective armed services committees

(2) HR 208: National Guardsmen and Reservists Parity for Patriots Act. This act would amend Title 10, United States Code, to ensure that members of the reserve components of the Armed Forces who have served on active duty or performed active service since September 11, 2001, in support of a contingency operation or in other emergency situations receive credit for such service in determining eligibility for early receipt of non-regular service retired pay.

(3) S.644/S. 831: National Guard and Reserve Retired Pay Equity Act 2009. A bill to amend title 10, United States Code, to include service after September 11, 2001, as service qualifying for the determination of a reduced eligibility age for receipt of non-regular service retired pay.

h. Lead agency. DAPE-HRP-RSO

i. Support agency. HQs USARC, OCAR, and NGB

Issue 656: Reserve Component Government Employees' and their Family Members' Access to TRICARE Reserve Select

a. Status. Active

b. Entered. AFAP XXVI, Jan 10

c. Final action. No (Updated: 29 Mar 10)

d. Subject area. Employment

e. Scope. Individuals eligible for health insurance under the Federal Employees Health Benefits (FEHB) program and their Family members who serve as RC Personnel are excluded from TRS under Public Law 109-364, the 2007 John Warner National Defense Authorization Act. In contrast, a military retiree who becomes a federal employee can choose to enroll in TRICARE in lieu of one of the FEHB programs; however, RC Personnel who become eligible for FEHB by employment or marriage do not have this option. Providing RC Personnel the option of their health care benefit program would positively impact job satisfaction and allow them to take full advantage of their benefits.

f. Conference Recommendation. Provide all Government employees and their Family members who serve in the RC with the option of selecting either FEHB Program or TRS.

g. Progress.

(1) TRS is authorized under Title 10 U.S.C §1076d for qualified RC Soldiers and their Family Members. TRS is the premium-based health plan available for purchase by qualified members of the Selected Reserve. Developed by the Department of Defense to implement a provision in the NDAA for FY 2005, TRS has undergone major revisions in response to subsequent statutory requirements. Since 1 Oct 07, a member may qualify to purchase and maintain coverage if the SM is a member of the Selected Reserve; and the SM not eligible for or enrolled in the FEHBP. The monthly TRS premiums for CY 2010 were \$49.62 for single coverage and \$197.56 for family coverage.

(2) TRS coverage is similar to TRICARE Standard and TRICARE Extra. Covered members and family members under TRS may access care from any TRICARE-authorized provider, hospital or pharmacy, whether in the TRICARE network or not. TRS-covered members may also access care at MTF on a space-available basis. TRS members and their covered family members pay the same TRICARE cost share and deductibles as active duty family members.

(3) Since Oct 07, the RC has experienced a steady increase of 1,000 to 1,500 enrollees per month into TRS. From Oct 07 to present TRS total plans has increased from 11,960 to 55,231. This increase is five times higher than it was in Oct 07 since the last major TRS program revision by Congress went into effect.

(4) This entitlement would require a legislative change at the Department of Defense level to amend the Public Law 109-364, the 2007 John Warner National Defense Authorization Act.

(5) OTSG will send a formal request, asking TMA to conduct a cost estimate to determine the feasibility of RC service members (SM) and their Family members who are eligible for health insurance under the FEHB program to have the option to enroll in the TRS health plan. Pending TMA's response, OTSG may consider forming a multi-service workgroup that could analyze and discuss the OTSG proposal. It is unclear if the other Services will support this option to provide TRS benefits to RC service members and their Family members eligible for health insurance under the FEHB program.

h. Lead Agency: DASG-HSZ

i. Support Agency: TRICARE Management Activity

Issue 657: Reserve Component Inactive Duty for Training Travel and Transportation Allowances

a. Status. Active

b. Entered. AFAP XXVI, Jan 10

c. Final action. No (Updated: 9 Apr 10)

d. Subject area. Entitlements

e. Scope. There is no legal authority for travel and transportation allowances for RC Soldiers conducting Inactive Duty for Training (IDT) when the training duty station, drill site or assigned unit location is over 50 miles from home of record. Soldiers often travel significant distances from home of record to duty locations due to unit relocation, individual assignments and other factors. Traveling these distances imposes safety risks such as accidents caused by sleep deprivation and decreased levels of alertness. Soldiers can incur out-of-pocket expenses that exceed the actual pay received. Providing travel and transportation allowances for RC Soldiers will alleviate financial burdens and mitigate risks associated with traveling to and from the training duty station.

f. Conference Recommendation. Authorize travel and transportation allowances for RC Soldiers traveling over 50 miles for IDT.

g. Progress.

(1) Section 631 of the NDAA for FY08 amended title 37 United States Code to provide authority for reimbursement of travel expenses of up to \$300 per round trip for certain RC Soldiers who are:

(a) Qualified in a skill designated as critical.

(b) Assigned to a unit or in a reserve pay grade with a critical manpower shortage.

(c) Assigned to a unit or position that is disestablished or relocated due to defense base closure or realignment or other force structure reallocation and the member is required to commute outside the local commuting distance.

(2) ALARACT 249/2008 further defined the normal commuting distance to be within 150 miles.

(3) DoD Manual 4165.63-M "DoD Housing Management (Sep 93) authorizes "Reserve Component personnel to occupy transient Unaccompanied Personnel Housing (UPH) during periods of scheduled inactive duty training at an installation.

(4) AR 21-50, Installation Housing Management (1 Sep 97) states that Reserve component members performing BAT/IDT at installations away from home station are authorized to occupy Visiting Officer Quarters (VOQ)/Visiting Enlisted Quarters (VEQ) on a space available basis at the individual's expense. It further stated that scheduled BAT/IDT personnel are authorized to occupy VOQ/VEQ on an equal basis with active TDY personnel.

(5) If transient government housing is unavailable, the individual service may provide "lodging in kind" during the performance of duties.

(6) Public Law 108-121, the Military Family Tax Relief Act of 2003 contains provisions that allow National Guard and Reserve members, to deduct the round trip costs to travel between their principal residence/place of employment and the BAT/IDT duty location, if that location is in excess of 50 miles or the Soldier is required to stay overnight. These tax provisions are applicable provided the Soldier is not provided free Government transportation or Government furnished lodging.

(7) RC are not treated any differently than active duty personnel who are not reimbursed for travel expenses to and from their duty location.

h. Lead agency. DAPE-PRC

Issue 661: TRICARE Allowable Charge Reimbursement of Upgraded/Deluxe Durable Medical Equipment

a. Status. Active

b. Entered. AFAP XXVI, Jan 10

c. Final action. No (Updated: 29 Mar 10)

d. Subject area. Medical

e. Scope. When the TRICARE beneficiary chooses an upgraded/deluxe DME, the beneficiary must pay full cost out-of-pocket with no reimbursement for the TRICARE allowable charge. DME providers are limited to accepting the TRICARE allowable charge as payment in full for the medically necessary standard DME. Purchasing the upgraded/deluxe DME could improve patient compliance, quality of life, comfort, or function. Reimbursement of the TRICARE allowable charge offsets the increased cost of the upgraded/deluxe DME incurred by the TRICARE beneficiary.

f. Conference Recommendation. Authorize reimbursement of the TRICARE allowable charge for the standard DME when a patient chooses an upgraded/deluxe DME.

g. Progress.

(1) DME is purchased or rented medical equipment used for the treatment of an injury or illness which is also medically necessary. DME may include wheelchairs, hospital beds/attachments, oxygen equipment, respirators, and other non-expendable items.

(2) TRICARE covers DME when prescribed by a physician and if the DME:

(a) Improves, restores, or maintains the function of a malformed, diseased, or injured body part, or can otherwise minimize or prevent the deterioration of the patient's function or condition.

(b) Maximizes the patient's function consistent with the patient's physiological or medical needs.

(c) Provides the medically appropriate level of performance and quality for the medical condition present

(d) Is not otherwise excluded by the regulation and policy.

(3) Active Duty Family Members (ADFM) enrolled in TRICARE Prime and TRICARE for Life (TFL) users do not have co-payments under TRICARE. Under TFL, Medicare is first payer (for DME, 80%) and TRICARE, as second payer, reimburses the 20% Medicare DME co-payment. Retiree DME co-payments are: TRICARE Prime and Extra, 20% of negotiated fees and Standard, 25% of the allowable charge. ADFM DME/ co-payments are: TRICARE Extra, 15% of negotiated fees and Standard, 20% of the allowable charge. Beneficiaries needing DME are given authorizations for specialty referrals, except for DME costing less than \$500, which does not require an authorization. There is no co-pay for MTF issued DME, which, if available, is issued on loan with a hand receipt.

(4) TRICARE in general uses the reimbursement rates established by the Centers for Medicare and Medicaid Services (CMS) for certain items of DME, Prosthetics, Orthotics, and Supplies. CMS updates these rates twice a year in January and July. Inclusion or exclusion of a reimbursement rate does not imply TRICARE coverage.

(5) TRICARE cannot pay when a preferred DME item is unproven or deemed experimental. TRICARE also does not cover unauthorized DME which may be excessive in features which increases the cost when compared to a more similar item without the extra features. There is no reimbursement when the beneficiary who chooses a same class enhanced DME that will provide convenience, size, or function.

(6) OTSG will coordinate with TMA to see if beneficiaries can be authorized reimbursement of the TRICARE allowable charge for the standard DME when a patient chooses an upgraded/deluxe DME at their own expense. If this is not possible, another solution may be to only pay the difference between the authorized TRICARE allowable charge and the full DME charge for upgraded/deluxe DME. OTSG will send a formal request, asking TMA to assess the feasibility of these options to meet the intent of this AFAP recommendation. It is also unclear at this point if the other Services will support authorizing alternative DME reimbursement options. Cost estimates will be determined following the OTSG and TMA's assessment of a way ahead.

h. Lead agency. DASG-HSZ

i. Support agency. TRICARE Management Activity