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PERSONNEL AND
READINESS

The Honorable Mike D. Rogers
Chairman
Committee on Armed Services
U.S. House of Representatives
Washington, DC 20515

AUG 13 2025

Dear Mr. Chairman:

The Department's response to House Report 118-125, pages 188-189, accompanying H.R. 2670, the National Defense Authorization Act for Fiscal Year 2024, "Access to Military and Dependent Mental Health Care," is enclosed.

This report provides responses to questions from Congress regarding the average timeline to credential TRICARE mental health providers; the average timeline to process provider payments; whether or not TRICARE has utilized authorities contained in 32 CFR § 199.14 to increase reimbursement rates in certain geographic locations; corrective measures taken since the 2013 Government Accountability Office findings with regard to finding civilian mental health care providers and reimbursement rates; the status of implementing the recommendations found in Department of Defense Inspector General Report No. DODIG-2020-112; and what, if any, additional authorities and resources may be needed by the Department to effectively address the issue of timely access to mental health care for active duty Service members and their families.

Thank you for your continued strong support for our Service members and their families.

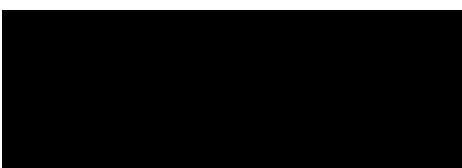
Sincerely,



Merynn Carson, MD
Performing the Duties of the Deputy Under
Secretary of Defense for Personnel and
Readiness

Enclosure:
As stated

cc:
The Honorable Adam Smith
Ranking Member



Report to the Committee on Armed Services of the House of Representatives



Access to Military and Dependent Mental Health Care

August 2025

The estimated cost of this report or study for the Department of Defense is approximately \$1,700 in Fiscal Years 2023 - 2024. This includes \$100 in expenses and \$1,600 in DoD labor.
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INTRODUCTION

This report is in response to the request set forth in House Report 118–125, pages 188-189, accompanying H.R. 2670, the National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2024, which requested a report on access to military and dependent mental health care, including:

(1) an analysis of the average timeline to credential potential TRICARE mental health service providers in comparison to the credentialing timeline of other major insurance networks, including Medicare. The analysis should include TRICARE data identifying application returns, method of notification to applicants and frequency of notifications to potential providers the network application process has been returned, and method of feedback TRICARE provides to potential providers and resolution processes;

(2) an analysis of the average timeline to process provider payments with respect to claims;

(3) an assessment of whether TRICARE has utilized authorities outlined in Manual Part 199.14 to increase reimbursement rates in certain geographic locations; and what corrective measures have been taken since the 2013 Government Accountability Office findings specifically with regard to finding civilian mental health care providers and reimbursement rates;

(4) the status of implementing the recommendations found in Department of Defense Inspector General Report 2020–112 and the estimated implementation date for any recommendations that have not yet been implemented; and

(5) an assessment of what, if any, additional authorities, and resources may be needed by the Department to effectively address the issue of timely access to mental health care for Active Duty service members and their families.

BACKGROUND

TRICARE covers a spectrum of mental health care services. Outpatient treatment is available at multiple military hospitals and clinics, and from TRICARE-authorized private sector providers. Mental health services may be delivered in-person or via telemedicine. Covered outpatient treatment includes psychotherapy, psychological testing and assessment, intensive outpatient programs, medication assisted treatment for substance use disorder (SUD), and partial hospitalization programs. Inpatient mental health services may be obtained at certain large military hospitals, or from TRICARE-authorized private sector providers. Covered inpatient benefits include inpatient hospital services, residential treatment for SUD, and psychiatric residential treatment centers (for children and adolescents).

All providers offering mental health services to TRICARE beneficiaries must be authorized in accordance with 32 CFR § 199.6. TRICARE network providers must be credentialed consistent with TRICARE regulations and in accordance with nationally accepted credentialing standards adopted by a national accrediting body.

1. AVERAGE TIMELINE TO CREDENTIAL TRICARE MENTAL HEALTH SERVICE PROVIDERS

Credentialing determinations must be made within 180 days from the date a provider credentialing package is submitted for consideration. TRICARE Managed Care Support Contractors (MCSCs) maintain accreditation with URAC (formerly known as the Utilization Review Accreditation Commission). The 180-day timeline is part of URAC’s accreditation requirements. Detail on credentialing deadlines beyond this standard — that is, granular detail on how long it takes to credential providers, is unavailable as it is proprietary and confidential to the MCSCs. TRICARE is in alignment with industry; 1,325 health plans’ credentialing activities are accredited by either URAC or the National Committee for Quality Assurance (NCQA) (which maintains the same credentialing timeline requirement as URAC) indicating that they all must meet this 180-day standard. These accredited commercial and Federal health plans and systems include well known organizations such as Blue Cross & Blue Shield, Aetna, Cigna, Optum, Geisinger, Centene, United Health Care, and Kaiser. A full listing of accredited agencies may be found on the URAC and NCQA websites. Throughout the lifetime of the T-2017 contracts, the MCSCs continue to outperform URAC’s credentialing standard of 180 days for credentialing mental health providers.

URAC mandates written notification of credentialing decisions. Both MCSCs have established provider notification processes that include written notice of approvals and denials within 30 days of the decision. The MCSCs closely monitor applications and contact providers to obtain missing information required to continue the credentialing process. Providers may contact the MCSCs to discuss their application status and discuss any credentialing deficiencies preventing approval. Providers may also review their application status on the MCSCs’ respective websites.

2. AVERAGE TIMELINE TO PROCESS PROVIDER PAYMENTS

The average number of days it takes for the MCSCs to issue payment to a provider is 2.02 days from the date that claims processing is complete. The TRICARE T-2017 contracts include multiple standards and metrics for Claims Processing timeliness. Both MCSCs are meeting all Claims Processing standards and metrics. During the 9-month period spanning August 1, 2022 – April 30, 2023, TRICARE MCSCs processed over 3.6 million claims for mental health services.

MCSC	Number of Claims
HNFS	1,433,267
HGB	2,233,044
TOTAL	3,666,311

3. UTILIZATION OF AUTHORITIES TO INCREASE REIMBURSEMENT RATES IN CERTAIN GEOGRAPHIC LOCATIONS

When necessary, the Department uses existing TRICARE authorities to increase reimbursement rates in certain geographic areas for certain provider types. The Department has utilized one waiver for child psychiatry in Florida.

- (1) Network rate waivers allow a higher individual provider payment rate than would otherwise be allowable when Department of Defense (DoD) determines that an adequate number and mix of qualified health care providers is unavailable in a specific locality and determines higher rates are necessary to maintain an adequate network. Network waivers have a cap of 15 percent above the current Civilian Health and Medical Program of the United States Maximum Allowable Charge and are approved by the Director, Defense Health Agency (DHA).
- (2) Locality-based rate waivers (LBWs) are used when DoD determines that access to specific health care services is severely impaired. Through LBWs, higher payment rates can be applied to all similar services performed in a locality, or a new locality could be defined for application of the higher payment rates. LBWs are currently utilized under the T-2017 contract and as of December 2024, there are 22 active waivers, 14 in Alaska and eight in other States. The specialties covered in Alaska include non-routine gynecology (GYN), internal medicine hospitalists, perinatology, plastic surgery, pain management, pulmonary, orthopedic, and physical medicine rehab services, neurosurgery, orthopedic services, otolaryngology, rheumatology, primary care, urology, and fetal echo cardiogram. The eight LBWs outside of Alaska provide enhanced TRICARE rates in severely impaired localities in the States of Florida, Hawaii, Idaho, Missouri, South Dakota, and Wyoming. The specialties covered under the eight LBWs for these States include newborn care services, obstetrics/GYN professional services, orthopedic and spine services, inpatient neonatology and perinatology, internal medicine services, prosthetic eye services, and child psychiatry.

There have been several TRICARE reimbursement changes since the publication of the Government Accountability Office findings in 2013. A final rule entitled “TRICARE; Mental Health and Substance Use Disorder Treatment,” 81 FR 61068, published in the Federal Register on September 2, 2016, modified the TRICARE regulation to reduce administrative barriers to access to mental health benefit coverage and improved access to SUD treatment for TRICARE beneficiaries, consistent with earlier DoD and Institute of Medicine recommendations, as well as current standards of practice in mental health and addiction medicine, and governing laws. This rule eliminated unnecessary quantitative and nonquantitative treatment limitations on SUD and mental health benefit coverage and aligned beneficiary cost-sharing for mental health and SUD benefits with those applicable to medical/surgical benefits. It also expanded covered mental health and SUD treatment under TRICARE, including coverage of intensive outpatient program (IOP) services and opioid treatment programs (OTPs) and streamlined the requirements for mental health and SUD institutional providers to become TRICARE-authorized providers. Finally, it established allowable all-inclusive per diem payment rates for psychiatric and SUD partial hospitalization programs (PHPs), IOPs and OTPs.

4. STATUS OF IMPLEMENTING THE RECOMMENDATIONS IN DODIG REPORT 2020–112¹

In response to the Department of Defense Inspector General (DoDIG) recommendations, as of March 31, 2025, the following updates and estimated implementation dates are provided:

Recommendation 1

We recommend that the Assistant Secretary of Defense for Health Affairs (ASD[HA]) update the ASD(HA) Memorandum, “TRICARE Policy for Access to Care,” February 23, 2011, to remove the eight-visit limitation for outpatient mental health care.

DoD Update: There is no limitation on outpatient mental health care, and the above referenced policy provision has been superseded. Consistent with the principles of mental health parity, DoD engaged in formal Agency rulemaking and policy revisions to reduce administrative barriers to treatment and increase access to medically or psychologically necessary mental health care, consistent with TRICARE statutory authority and program design. Change 183 to the TRICARE Policy Manual (TPM), dated June 17, 2017, removed all remaining quantitative treatment limitations on mental health. There is no limitation, and the above referenced policy has been superseded by Change 183. Closure was recommended with supporting documentation.

Recommendation 2

We recommend that the Defense Health Agency (DHA) Director:

2.a. Develop a single Military Health System-wide staffing approach for the Behavioral Health System of Care that estimates the number of appointments and personnel required to meet the enrolled population’s demand for mental health services.

DoD Update: DHA has standardized the staffing and manpower Behavioral Health Model that utilizes workload factors to estimate provider and support staff requirements to meet specific military medical treatment facility (MTF) demand for services. Additionally, Deputy Secretary of Defense Memorandum, “Stabilizing and Improving the Military Health System,” December 6, 2023, specifically discussed manpower requirements.

The MHS Staffing model was finalized in 2024, and the staffing model will be included in a manpower policy.

- a. Current status – Behavioral Health Model is complete. The model covers the requirements for provider, support, and administrative staff and is part of the DHA Manpower Models (DM2) portfolio. The J-1 Manpower and Organization Division is addressing the official acceptance and sign-off on the DM2 portfolio as well as a separate document that specifically identifies the behavioral health requirements analysis used to develop Behavioral Health Model.

¹ https://media.defense.gov/2020/Aug/12/2002475605/-1/-1/1/DODIG-2020-112_REDACTED.PDF.

- b. Challenges our agency faced in trying to close this recommendation – There are no challenges at this time
- c. How can these challenges be addressed to expedite closure? – Not applicable
- d. Anticipated closure date – August 29, 2025

2.b. Establish policy that identifies which population of beneficiaries by MTF will receive outpatient specialty mental health services through the direct care system.

DoD Update: DHA Administrative Instruction 6490.01, “Behavioral Health System of Care,” February 22, 2023, defines the population of beneficiaries at each MTF that should expect to receive outpatient mental health care in the direct care system. This action was closed.

2.c. Update and clarify DoD and Defense Health Agency policy, including TRICARE policy to:

2.c.1. Update the access to care standard for a non-urgent initial behavioral health assessment in DHA and TRICARE policy to be consistent with the 7-day standard established by ASD(HA) Memorandum, TRICARE Policy for Access to Care, February 23, 2011.

DoD Update: Please note that the Department only partially concurred with this recommendation. DoD intends to clarify Direct Care system guidance on the access to care standard of 7 days for non-urgent behavioral health assessment. The non-urgent behavioral health assessment/referral has been defined and is included in the draft DHA Procedural Manual, “Standard Process and Procedures for Optimizing Healthcare within the Military Health System (MHS).” This policy has completed formal coordination with a projected final publication in December 2025. Anticipated closure date is December 31, 2025.

2.c.2. Develop a standard definition and required elements for an initial non-urgent mental health assessment and develop a way to track whether the assessment is completed within the 7-day standard, in either a primary care or a specialty mental health clinic.

DoD Update: DHA Procedural Manual, “Standard Process and Procedures for Optimizing Healthcare within the Military Health System (MHS),” has completed formal coordination with a projected final publication in December 2025. This policy will consolidate other policies, which is expected to improve the efficiency of future updates. Anticipated closure date is December 31, 2025.

2.c.3. Describe standard procedures for implementing centralized appointing for behavioral health services.

DoD Update: DHA Procedural Manual, “Standard Process and Procedures for Optimizing Healthcare within the Military Health System (MHS),” has completed formal coordination with a projected final publication in December 2025. This policy will consolidate other policies, which is expected to improve the efficiency of future updates. Anticipated closure date is December 31, 2025.

2.c.4. Standardize the outpatient mental health care process of providing behavioral health services from first patient contact through follow-up care for a patient needing non-urgent outpatient mental health care.

DoD Update: DHA Procedural Manual, “Standard Process and Procedures for Optimizing Healthcare within the Military Health System (MHS),” has completed formal coordination with a projected final publication in December 2025. This policy will consolidate other policies, which is expected to improve the efficiency of future updates. Anticipated closure date is December 31, 2025.

2.c.5. Align the Defense Health Agency and TRICARE requirements for outcomes monitoring using standardized measurement tools and assessment intervals intervals. Specifically, update the TRICARE Policy Manual (Psychotherapy) to be consistent with the DHA Procedural Instruction 6490.02.

DoD Update: The Department concurs with the principle that all Behavioral Health patients (in both direct care and private network care) should be administered clinical outcome tools and monitored throughout the episode of care. To help achieve this, DHA awarded its TRICARE T-5 contracts that included language on behavioral health outcomes monitoring and standardizing the tools that will be used to assess and monitor clinical symptoms related to Post-traumatic Stress Disorder, Anxiety, and Depression. The TRICARE Operations Manual (TOM) discusses audits of behavioral health measures in Chapter 7, Section 6, paragraph 8.0, and also outlines the medical documentation requirements in TPM Chapter 1, Section 5.1, Paragraph 3.8. Health care delivery under the T-5 contracts is expected to commence on January 1, 2025.

However, the Department does not concur with aligning the frequency of assessments and treatment tools between TRICARE private sector care and direct care because this would ignore readiness mission requirements for active duty Service members, which are largely inapplicable for most other TRICARE-covered beneficiaries. This action was closed.

2.d. We recommend that the Defense Health Agency Director develop a method for the Military Health System to book patient appointments in the purchased care system to confirm that patients are able to obtain care, except when a patient chooses to book directly with a purchased care provider.

DoD Update: The TRICARE T-5 contracts include this language for new patient visits. The T-5 contract states the contractor shall provide an option through its call center for beneficiaries enrolled to the network to schedule first-time appointments in the network. A first-time appointment is a new patient visit with a provider. Health care delivery under the T-5 commenced on January 1, 2025.

Additionally, the DoDIG report indicates implementing the recommendation in 2.d will enable the MHS to monitor and track those patients who are unable to obtain an outpatient mental health appointment due to the lack of TRICARE civilian provider availability. There are additional requirements in T-5 related to access and compliance with outpatient behavioral health visits following an inpatient discharge. Those requirements include the MCSC following up with a

beneficiary within two business days of a mental health inpatient discharge to ensure the beneficiary has a follow up appointment secured within 7 calendar days of discharge. Also, providing an additional follow-up within two business days of the appointment to ensure the beneficiary was seen, and if not, assist the beneficiary with securing another appointment.

The TRICARE Health Plan monitors the Network Appointment Availability Report (R260), which provides data on average availability of appointments for all provider categories. This action is closed.

2.e. We recommend the Defense Health Agency Director include TRICARE provider appointment availability for TRICARE beneficiaries within the network adequacy report.

DoD Update: This language is included in the T-5 contracts, which commenced on January 1, 2025. The T-5 contracts require contractors to submit reports indicating the availability of appointments for all TRICARE-enrolled beneficiaries for each Prime Service Area, with rollups for Defense Health Network areas and States. This report provides the monthly average availability of appointments based on average wait time for all provider categories. The contractors have also developed and implemented a system for continuously monitoring network appointment availability for all provider and facility types. Note - these reports are separate from the network status report. This action is closed.

2.f. Develop standardized mental health access to care measures for direct and purchased care for both active duty service members and their families, including tracking:

2.f.1. The time from patient request or referral for mental health care to the time of the initial non-urgent mental health assessment.

DoD Update: DHA currently has in place the ability to monitor direct care Average Days to an Initial, Specialty Care appointment made available centrally through the Near Real Time dashboard. Within the dashboard, Defense Health Networks and MTFs can monitor and assess performance for all Specialty Behavioral Health clinics down to the provider level with data updated monthly. Additionally, a centralized report is made available through the TRICARE Operations Center DHA Analytics & Evaluation website where sites have access to information regarding the time from referral to direct care booked, booked to appointment, and total days from referral to appointment. This report is updated monthly.

TRICARE does not require a referral to access behavioral health care in the private sector for all non- active duty beneficiaries. As a result, the data only reflects the referrals that are entered in the system which does not represent all the behavioral health care being delivered. It does not reflect patient choice, provider continuity, and other variables. Closure was recommended for this action with supporting documentation.

2.f.2. Adherence with outcomes monitoring using standardized measurement tools and assessment intervals.

DoD Update: DHA currently has in place the ability to monitor Direct Care clinical outcomes for Depression and Posttraumatic Stress Disorder made available centrally through the VALUE

dashboard. Within the dashboard, Defense Health Networks and MTFs can monitor and assess performance for all Specialty Behavioral Health clinics down to the provider level. The TRICARE T-5 contracts include language on behavioral health outcomes monitoring and standardizing the tools are used to assess and monitor clinical symptoms related to Post-traumatic Stress Disorder, Anxiety and Depression. The TOM discusses behavioral health measures in Chapter 7, Section 6, paragraph 8.0 and Chapter 1, Section 5.1, Paragraph 3.8. Health care delivery under the T-5 contracts commenced on January 1, 2025. This action was closed.

2.f.3. The number and percentage of mental health referrals that are not used.

DoD Update: DHA currently has in place the ability to monitor unused behavioral health referrals within direct care through the MHS&G Discern report and within Private Sector Care through the MCSC portal. This action was closed.

2.f.4. Reasons patients are unable to book an appointment.

DoD Update: DHA has a process if the patient is unable to schedule in direct care to defer to private sector care. The reasons for the inability to schedule are noted as capability or capacity and this information is available through the all-referral report in Discern. Private Sector Care is monitored through the MCSC portal. The DoDIG asked additional questions regarding the actions to support this recommendation. DHA provided additional information and supporting documentation. Closure was recommended for this action.

5. ADDITIONAL AUTHORITIES AND RESOURCES NEEDED BY DOD TO ADDRESS ACCESS TO MENTAL HEALTH CARE FOR ACTIVE DUTY SERVICE MEMBERS AND FAMILY MEMBERS

No additional authorities are needed currently. The Department remains intently focused on supporting the mental health of our Service members and their families and to expanding innovative approaches to increase access to care.

CONCLUSION

TRICARE covers a wide variety of medically necessary services, including inpatient and outpatient mental health; however, like commercial health plans across the country, TRICARE (both the direct and private sector care) is faced with shortages of mental health providers. DHA did not identify issues with processes or timelines for provider credentialing. DHA verified that claims paid to mental health providers were processed within contractually established timeframes. Further, DHA has existing authorities for implementing LBWs to assure beneficiary access to care and higher locality rates for network providers, to ensure adequate networks. Finally, DHA provides an update on the response to DoDIG Report 2020-112 via this report. No additional authorities are needed currently.

The Department remains intently focused on supporting the mental health of our current and former Service members and their families and to expanding innovative approaches to increase access to mental health care services.