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Introduction

The Office of the Deputy Assistant Secretary of War for Military Community and Family Policy Office of Special Needs (OSN) submits its sixteenth annual report to the congressional defense committees, as required by 10 U.S.C. § 1781c.

Nearly one in ten Service members across the Total Force has a dependent enrolled in the Exceptional Family Member Program (EFMP). The Department's commitment to these families is a critical component of mission readiness and family well-being. This report outlines the OSN's progress during Fiscal Year (FY) 2025, which runs from October 1, 2024 through September 30, 2025. Central to OSN's FY25 efforts was a proactive campaign to fundamentally improve program oversight and monitoring, refine EFMP policy to clarify expectations, implement a standard information technology (IT) system to drive standardization, enhance our framework for early intervention and special education services, and strengthen strategic communications. The report includes the following:

- A description of any gaps in services available through the Department of War (DoW) for military families with special medical or educational needs.
- A description of actions being taken, or planned, to address the identified gaps in services available through the DoW for military families with special medical or educational needs.
- Extended Care Health Option (ECHO) program data.

Oversight and Monitoring: EFMP Accountability and Insight

FY 2025 marks the EFMP Outcomes and Accountability Model's (OAM) inaugural year of full implementation. The OAM incorporates enhanced oversight mechanisms, including key performance indicators (KPIs) and an in-depth reliability process. This data-driven framework addresses the need for enhanced oversight, a finding corroborated by the Department of Defense Inspector General (DODIG) audit DODIG-2023-102 dated August 1, 2023. The OAM delivers insight into EFMP performance with added granularity, establishing a reliable baseline to measure progress, identify gaps, and drive continuous improvement. The enhanced data empowers the Department to report on the EFMP with greater precision, ensuring accountability to both Congress and the military families we serve.

The EFMP is critical to ensuring that the families of Service members have access to necessary medical and educational services during relocations. Therefore, an integral component to the Department's enhanced oversight and monitoring capabilities is the collection and reporting of data on the assignment coordination process. In FY 2025, the Department managed the complex relocation process for approximately 23,501 EFMP families, including 17,061 continental United States (CONUS) and 6,440 overseas assignments.[1] This volume of coordinated moves highlights the significant operational scale of the EFMP assignment process

[1] The Department of the Army began reporting the KPI for CONUS assignments the third quarter (Q) of FY 2025. Therefore, the total number of complex reassignments did not include CONUS assignment data from the Army for Q1 and Q2.

to force readiness. This new, standardized data provides the Department with a clear baseline to assess workload, analyze process cycle times, and gauge proper resourcing.

The OAM directly measures effectiveness of the screening process by identifying and tracking assignments that become problematic after relocation. A problematic assignment occurs when a Service member or their family must return early or relocate because necessary medical services or other support are not available. These situations result from undisclosed or newly identified medical conditions, changes in condition before or after arrival, loss of services at the assigned installation, or educational issues affecting the family. As depicted in Table 1 below, the reported average rate of problematic assignments across the Services went from 6.4 percent in the fourth quarter of FY 2024 to 1.2 percent in the fourth quarter of FY 2025. The available data shows a reduction, however it is important to note that not all Services reported data for every quarter. Regardless, this positive trend demonstrates a decrease of problematic assignments across the Department. Overall, the Department remains committed to reducing the stress and instability that can arise from a problematic relocation.

Table 1. Percent of Total Executed Assignment Orders that Resulted in a Problematic Assignment

	Army	Navy	Marines	Air Force	DoW Average
Q4, FY25	0.1%	0.9%	1.6%	4.7%	**1.2%**
Q3, FY25	0.3%	1.7%	2.3%	3.9%	**2.1%**
Q2, FY25	1.4%	2.6%	1.4%	5.0%	**3.3%**
Q1, FY25	11.7%	7.4%	1.9%	3.3%	**4.0%**
Q4, FY24	10.4%	N/R	1.8%	5.6%	**6.4%**
Q3, FY24	N/R	3.4%	1.5%	5.8%	**4.0%**
Q2, FY24	N/R	3.8%	0.3%	N/R	**2.8%**
Q1, FY24	N/R[2]	7.3%	1.5%	N/R	**4.9%**

Based on the reported data, "New Condition After Arrival" was the leading cause for CONUS problematic assignments for the FY, comprising 56.9 percent of instances as shown in Figure 1. "Worsening Condition After Arrival" followed at 16.2 percent. The data highlighted "Screening Failure" (15.2 percent) as an area for needed improvement.

[2] N/R designates data not reported for the quarter.

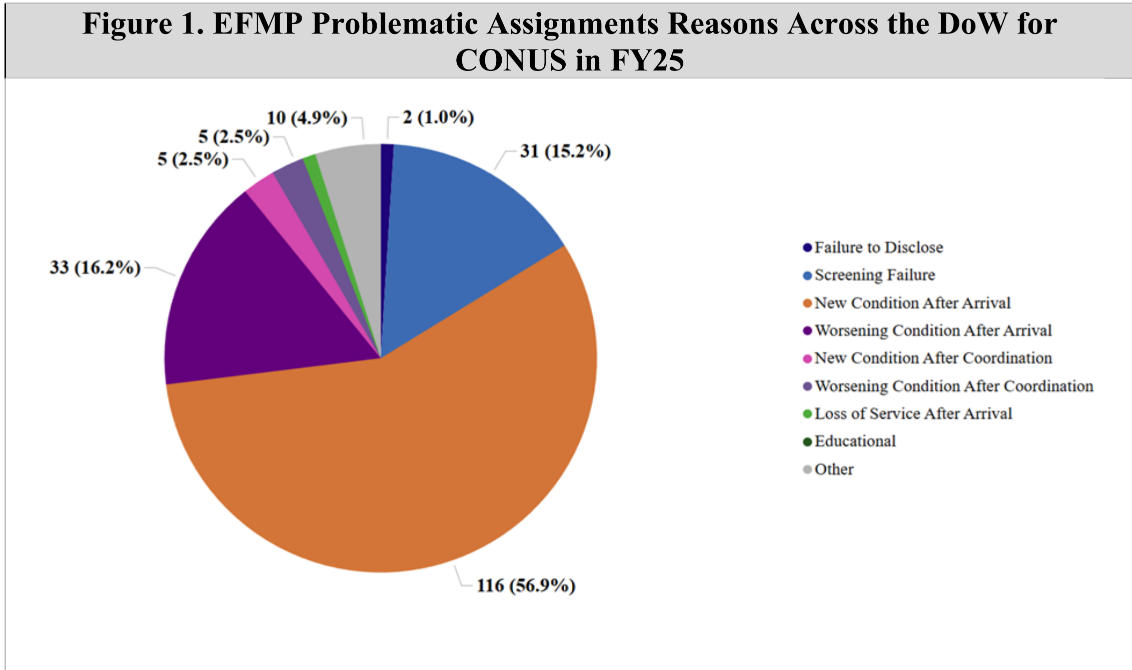


Figure 1. EFMP Problematic Assignments Reasons Across the DoW for CONUS in FY25

Figure 2 identifies "Loss of Service After Arrival" (41.4 percent) as the primary cause for problematic overseas assignments, highlighting the unique challenges of maintaining specialized care in overseas and remote settings. This critical insight allows the Department to develop targeted plans to improve service availability assessments. "New Condition after arrival" (34 percent) was the second highest factor for problematic assignments overseas, indicating this occurs in both CONUS and overseas assignment coordination. Notably, the Army reported difficulty collecting this metric and did not provide data on the reasons for problematic assignments for FY 2025; the Navy did not provide the measure for the third and fourth quarters of FY 2025. Therefore, Figures 1 and 2 do not include this data. The Army and the Navy are performing the necessary actions to ensure this performance metric is reported in all future data submissions.

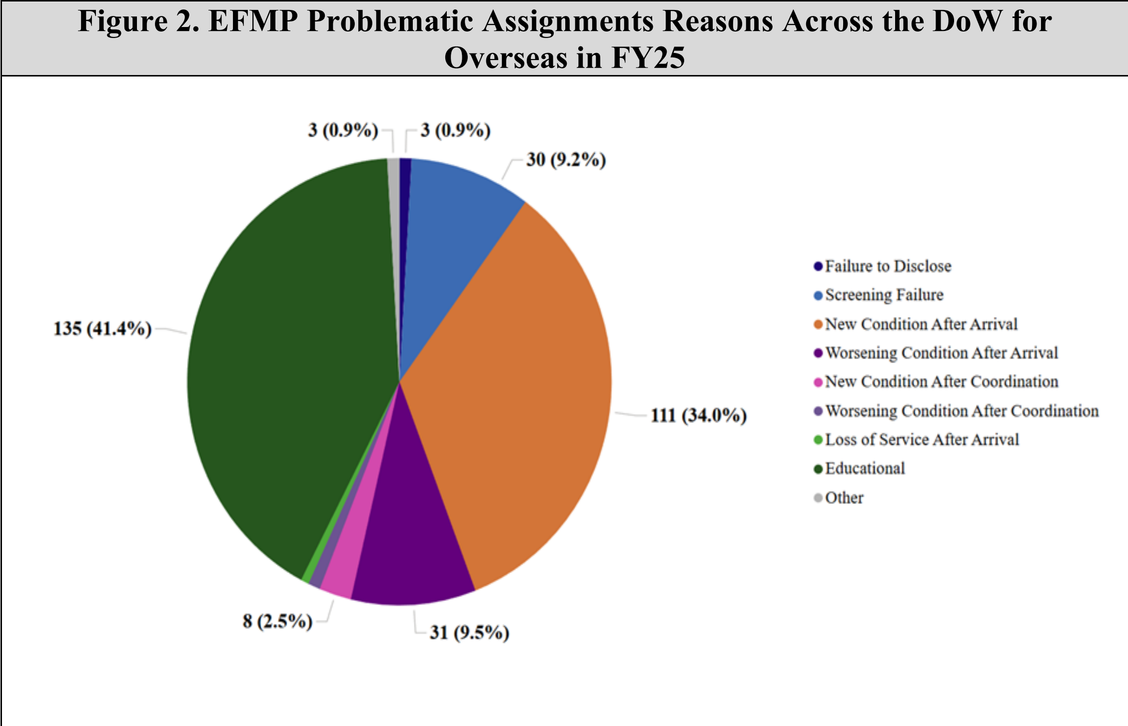


Figure 2. EFMP Problematic Assignments Reasons Across the DoW for Overseas in FY25

Another key assignment coordination metric is the reasons why family member travel is not recommended. This data is used to enhance strategy around policy and staffing decisions. Figure 3 shows "Wait time" (33.7 percent) and "Distance to Care" (31.2 percent) as the two most cited reasons for non-recommended family travel decisions. Also, the top three specialty types resulting in a non-recommended family travel decisions were "Applied Behavior Analysis" (32.9 percent), "Behavioral Therapy/Counseling" (17.8 percent), and "Developmental Pediatrician" (17.4 percent). As OSN continues implementation of the OAM, analysis includes emphasis on identifying installations and service areas experiencing availability concerns, including gaps in access to certain specialists.

Figure 3. Family Travel Non-Recommendations Due to Service Availability for FY25

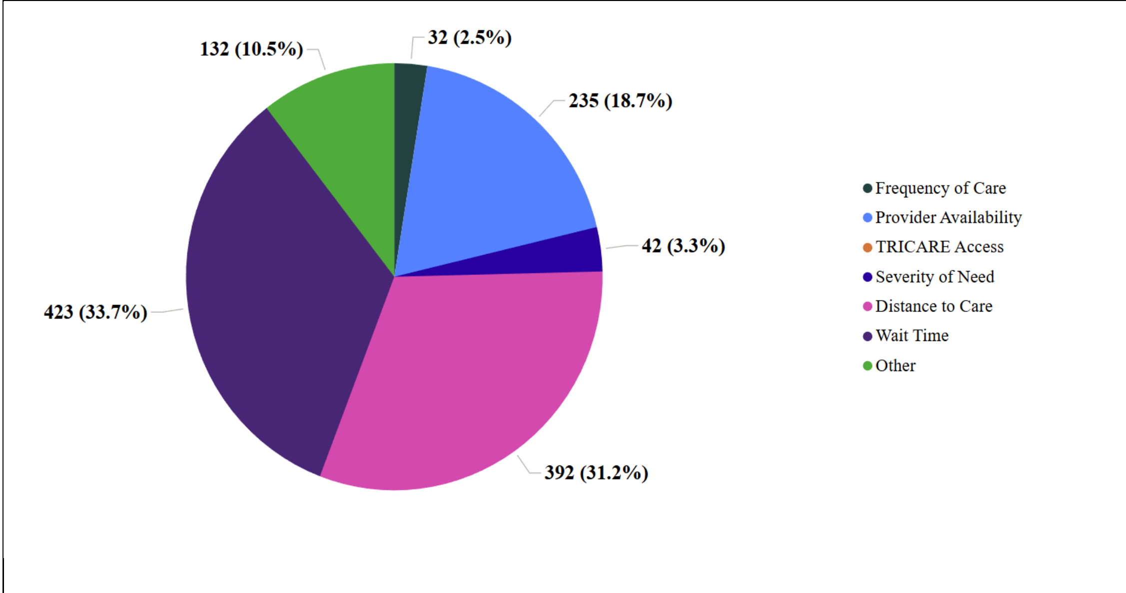
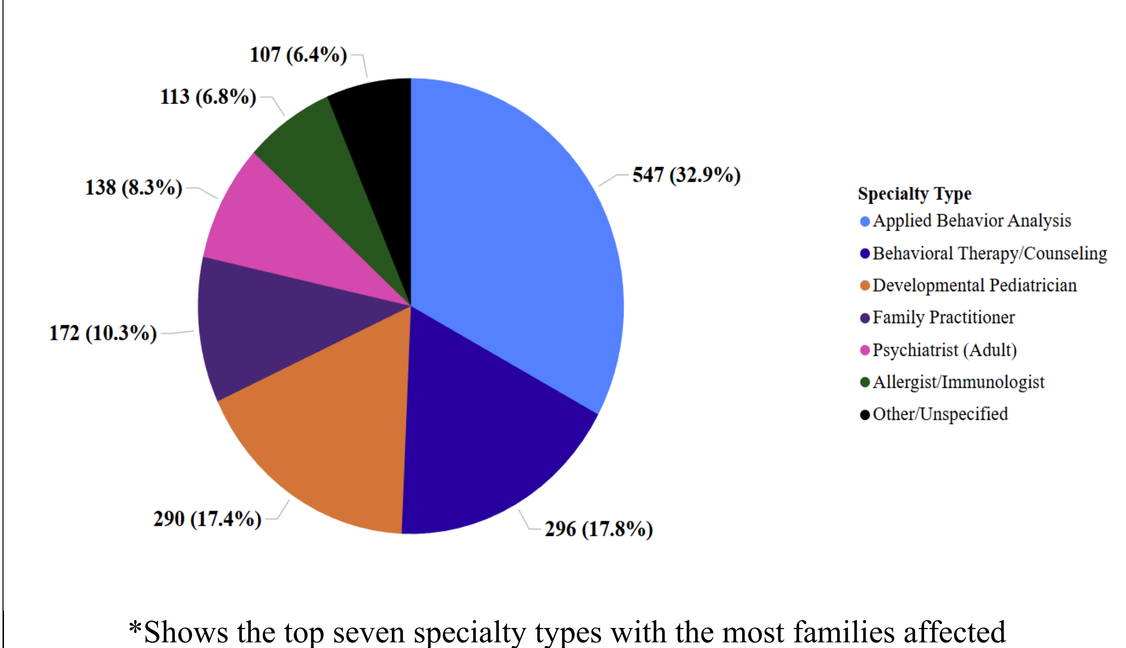


Figure 4. Family Travel Non-Recommendations Due to Specialist Availability for FY25



*Shows the top seven specialty types with the most families affected

Family Support Service Delivery and Utilization

Family Support (FS) is another EFMP component, providing crucial non-clinical case management and resources. In FY 2025, FS providers demonstrated the program's impact through more than 333,000 direct client sessions and nearly 400,000 information and referral activities. To ensure continuity of care during relocations, FS providers also facilitated over 13,000 warm hand-offs, connecting families with new support teams before their arrival. This robust engagement highlights the central role FS providers play in building family resilience and readiness.

In accordance with the William M. (Mac) Thornberry National Defense Authorization Act (NDAA) of FY 2021, the Department standardized EFMP respite care. Ongoing monitoring of standardization and quality control data calls determined a total of 3,236 military families are utilizing EFMP Family Support Respite Care as of FY 2025 Q4. The standard allotment hours for EFMP respite care are 20 for Level of Need (LoN) 2 and 32 hours for LoN 3 per family. On average, families with LoN 4 used 27.0 hours of respite care per month, while those with LoN 3 used 19.7 hours.[3]

The implementation of the OAM in FY25 ushered in a new era of accountability for the EFMP, equipping the Department with a validated, enterprise-wide baseline to measure performance. However, this model also brought remaining data integrity issues into sharp focus. Although the Services achieved partial compliance with the new reporting requirements, an in-depth reliability review revealed significant gaps in data reporting and reliability. To address the challenges, the Department mandated each Service experiencing data issues submit a formal Corrective Action Plan (CAP) starting FY 2025 Q4. Through rigorous monitoring of these CAPs and continued reliability reviews, OSN expects to achieve full data fidelity in FY 2026 and deliver on its commitment to provide reliable, effective support for Service members and their families.

Establishing a Standard Information Technology System

OSN continues efforts to develop and implement a new unified EFMP platform across the Department to further enhance EFMP standardization, which in turn will streamline data collection and reporting. The Department announced a strategic pivot from the previous plan to adapt a Service-specific application in December 2025. The Department will now deliver a centrally owned and operated system, ensuring full control over security, functionality, and long-term sustainability.

This new platform is the cornerstone of our standardization effort. It will provide each family with a single, portable record to create a consistent and transparent EFMP experience across all Services, reducing the administrative burden during relocations. For the Department, it will generate reliable, real-time data crucial for effective oversight, gap analysis, and ultimately, improving support for military families. OSN will perform the necessary actions to ensure the

[3] The Navy did not provide data for this metric and is performing the necessary actions to report this measure in all future data submissions.

system is designed and implemented to seamlessly meet the needs of families and fulfill the purpose of the program.

Improving Oversight and Monitoring of DoW's Early Intervention and Special Education Services

In FY 2025, OSN advanced efforts to strengthen oversight of early intervention services (EIS) and special education services for eligible DoW dependents. The Department sought to shift from a framework centered solely on policy compliance to a framework that monitored policy compliance and outcomes. To do so, OSN revised the current framework for monitoring EIS and special education services by establishing performance targets for performance indicators, developing an Outcomes-Driven Accountability (ODA) matrix, and requiring CAPS to ensure areas of non-compliance are addressed within the given timeframe.

Establishing targets was an essential component to revising the current compliance framework and addressing the Department's responsibility to have quantifiable indicators as outlined in Department of Defense Manual (DoDM) 1342.12, "Implementation of Early Intervention and Special Education Services to Eligible DoD Dependents," June 17, 2015. Targets provide a structured pathway for evaluating performance, prioritizing improvement actions, and sustaining consistent implementation across programs. To establish targets, OSN reviewed existing DoW policy, applicable Federal requirements, and DoW baseline data collected over a span of 5 years to identify realistic and attainable success measures.

The development of the ODA matrix addressed the need for a process to make determinations (i.e., findings) from the data received, while ensuring the incorporation of outcome and compliance data. OSN leveraged the Department of Education's process for making determinations to inform the Department's process. The model enables OSN to integrate regulatory requirements with indicators of student success and to use performance information to prioritize support and improvement actions. Through the ODA, an annual determination will be assigned to DoDEA and the Military Services that determines if the entity meets requirements, needs assistance, needs intervention, or needs substantial intervention. OSN structured the matrix to emphasize student/child outcomes, ensure compliance with DoDM 1342.12 requirements, and support accountability.

Notably, the Department incorporated the requirement of CAPs in the revised process to serve as the core mechanism for addressing identified areas of noncompliance and strengthening program performance through defined actions within a designated timeframe. The goal of the CAPs is to resolve deficiencies and reduce the likelihood of recurrence. This action ensures the Department is monitoring the timely correction of non-compliance.

Collectively, these enhancements represent a significant advancement in the Department's ability to monitor performance, identify emerging risks, and support timely corrective action and targeted technical assistance, indicator alignment, and target setting, OSN anticipates full implementation of the enhanced model by Fall 2026 aligning with data reporting for the 2025-2026 school year.

Improving the EFMP through Policy Enhancements

The OSN continually seeks to refine and strengthen support structures for EFMP implementation. Recognizing that effective policy is a living instrument that must evolve, this section details efforts and proposed enhancements to Department of Defense Instruction (DoDI) 1315.19, "Exceptional Family Member Program," June 23, 2023. These efforts are driven by the principle of continuous improvement and are directly shaped by stakeholder feedback, most critically from families the EFMP is designed to serve. The primary goal of these enhancements is to increase the clarity and consistency of DoDI 1315.19, thereby ensuring that all military families enrolled in the program receive the timely, comprehensive, and compassionate support they rightfully expect.

Family Support

OSN enhanced EFMP-FS services by increasing specificity of roles and responsibilities to improve service delivery for military families. In addition, OSN identified, opportunities for improvements opportunities in annual personal contacts and respite care. Ultimately, OSN's improvements to EFMP-FS services represent a targeted effort to deliver more specific, responsive, and collaborative support to Service members and their families.

Identification and Enrollment Criteria

OSN identified gaps in the application and interpretation of current enrollment criteria for family members with special medical and educational needs. Specifically, disaggregating asthma and attention deficit hyperactivity disorder into two distinct enrollment criteria from other physical and mental conditions remains a source of ambiguity and inconsistency for health care providers, posing the risk of disparate enrollments across the Military Departments.

FAdditionally, current application of chronic conditions as defined across a myriad of conditions such as malignancies, mental health disorders, and conditions requiring special medical equipment have been a source of ambiguity for health care providers in making enrollment determinations. In response to these challenges, OSN initiated the issuance process to revise section 3 of DoDI 1315.19, "Exceptional Family Member Program." Revisions will focus on prioritizing the family member's health, safety, and well-being based on the utilization of care and resources beyond the level of a healthy individual. Notably, OSN will incorporate feedback from EFMP enrollment personnel at each Military Service and from Military Health System subject matter experts.

Assignment Coordination

OSN recognizes the need for continuous improvements to the assignment coordination process for Service members and their families. Gaps in communication, transparency, and access to care during a permanent change of station (PCS) remain the pacing challenge to relocation readiness, which impacts both family and mission readiness. OSN is enhancing the process to holistically include the inputs of the family with active engagement from EFMP medical and assignment coordination personnel and the gaining command leadership, with the aim of supporting a mission-ready force where Service members with dependents enrolled in the

EFMP can proceed to a new location with confidence that care and resources are available to meet their needs with minimal delay.

Strengthening Family Support through Outreach, Relationships, and Training

OSN dedicated its strategic communication efforts in FY 2025 to translating direct stakeholder feedback into tangible solutions that address the needs of military families. Through a focused strategy of outreach, relationship building, and direct engagement, OSN captured the lived experiences of families and the professionals who support them. These insights directly informed the development of digital tools, training initiatives, and strategic relationships designed to close identified service gaps and enhance the support ecosystem.

The OSN participated in 16 stakeholder engagements, including collaborative events, family forums, and professional training sessions. Stakeholders consistently reported the need to better equip the wide range of professionals who support military families with disability related needs. In response, the OSN swiftly developed and executed an innovative, multi-faceted initiative to address this service gap directly.

A cornerstone of this response was enhancing the OSN's flagship digital tool, "EFMP & Me." On July 10, 2025, OSN launched a "Civilian Providers" user role, later broadening and renaming it to "Community Stakeholders" on September 3, 2025. This evolution equips a family's support network, from medical providers to school professionals, with the same trusted information, enabling more informed and coordinated support.

Complementing this digital solution, OSN expanded its reach through an innovative collaboration with the Kennedy Krieger Institute. By leveraging Kennedy Krieger Institute's expertise and extensive digital platform, OSN embedded EFMP-specific information into its curriculum, efficiently scaling the Department's ability to educate a broad professional audience. To enhance internal capabilities, OSN trained 75 EFMP Family Support staff on standardizing communications and leveraging digital resources to customize family support more effectively. Furthermore, OSN extended its outreach directly into the community, training 60 medical and school-based mental health professionals from both the Military Departments and civilian sectors through engagements with Georgetown University. These sessions informed community professionals on how EFMP interacts with their specific fields and offered strategies to support military families.

The EFMP & Me online tool remained the most visited resource for program information on Military OneSource, guiding 29,819 users through 37,358 sessions and generating 104,735 overall views. The tool's checklists with the highest user engagement are the "About EFMP and Enrollment" (2,143 clicks), "Medical" (1,734 clicks), and "PCS" (1,149 clicks), which correspond with the priority needs of families. Family members (4,646) and Service members (4,021) represented the largest segment of users, showing the OSN reached its key audience. The "Exceptional Family Member Program," "Educational Needs," and "Adult with Special Needs" MilLife Guides offered streamlined, subject-specific resources and received a total of 17,316 views. The Education Directory for Children with Special Needs generated 31,772 views

across 11,481 sessions. Its top-viewed pages, including the School Age and Early Intervention directories, underscore OSN's commitment to providing resources that assist families in navigating their children's educational needs.

A robust on-demand communication strategy supported these digital resources. The Exceptional Advocate eNewsletter grew its base to 35,335 subscribers in FY 2025. The "Office of Special Needs EFMP podcast" series had 1,437 listens, and Military OneSource social media channels displayed OSN-specific content to users 21,472 times.[4]

In FY 2025, OSN acted decisively on direct stakeholder feedback, translating the identified needs of military families into a multi-pronged outreach strategy. Through a combination of digital innovation, strategic relationships, and professional training, OSN aimed to build a more knowledgeable and interconnected support network.

Section 704 of the NDAA for FY 2021: Expansion of TRICARE ECHO Program Benefits

Section 704 of the William M. (Mac) Thornberry NDAA for FY 2021 amended 10 U.S.C. § 1781c(g)(2), which directed the OSN to include data with respect to the Extended Care Health Option (ECHO) program in the annual report to the congressional committees on the OSN activities. According to the statute, this information shall include: 1) the utilization rates of services under ECHO by eligible dependents during the prior year; 2) a description of gaps in such services obtained from information provided by families of eligible dependents; 3) an assessment of the factors that prevent knowledge of and access to ECHO, including a discussion of actions the Secretary may take to address these factors; and 4) an assessment of the average wait time for an eligible dependent enrolled in the program to access ECHO coverage, including a discussion of any adverse health outcomes associated with such wait.

ECHO is a supplemental program to the TRICARE Basic program and provides eligible Active-Duty Family Members (ADFMs) with additional financial resources for an integrated set of services and supplies designed to assist in the reduction of the disabling effects of the ECHO-eligible and enrolled dependent's qualifying condition. Qualifying conditions include: serious physical disability; moderate to severe intellectual disability; multiple disabilities (two or more affecting separate body systems); neuromuscular developmental conditions or other conditions affecting infants or toddlers that are expected to precede diagnoses of moderate to severe intellectual or serious physical disability (as criteria for such are established by the Director, Defense Health Agency (DHA)); or, an extraordinary physical/psychological condition rendering the beneficiary homebound. Note that Applied Behavior Analysis (ABA) services for autism spectrum disorder are cost-shared separately under the Comprehensive Autism Care Demonstration (ACD) and are not discussed in this report.

The ECHO Home Health Care (EHHC) benefit provides medically necessary skilled services to eligible homebound beneficiaries. The maximum annual program year Government

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[4] Due to a mandatory upgrade of the Military OneSource data analytics platform, OSN is unable to compare data to previous years in the FY 2025 report.

cost-share per EHHC-eligible beneficiary for EHHC, including EHHC respite care, may not exceed the local wage-adjusted highest Medicare Resource Utilization Group (RUG-III) category cost for care in a TRICARE-authorized skilled nursing facility, while all other non-EHHC ECHO participants have an ECHO expenditure cap of $36,000 per program year (which excludes their TRICARE Basic program expenditures).

Utilization Rates of Service

As shown in Figure 4, 5,130 beneficiaries with ECHO expenditures (referred to as ECHO patients) used approximately $117.7 million worth of ECHO benefits (an average of nearly $23,000 per patient) during Calendar Year (CY) 2024. These costs exclude all TRICARE Basic program expenditures for these patients. Most of these ECHO expenditures were associated with the EHHC benefit. The claims for the 895 EHHC patients were approximately $89.7 million, an average of approximately $100,000 per patient. Sixty-five percent of these EHHC patients (581 of 895) had annual expenditures over $36,000 during CY 2024. Roughly 97 percent of EHHC patients were younger than 18, with 73 percent being aged 8 or younger.

A total of 4,235 ECHO patients did not participate in the EHHC program during CY 2024. These patients had total Government expenditures of roughly $28 million or approximately $6,600 per patient (excluding any TRICARE Basic program expenditures). Table 1 provides information regarding the top principal diagnoses for these patients by annual expenditures during CY 2024. Please note the ECHO paid services below were not for ABA services.

Figure 4: Calendar Year 2024 ECHO Paid Government Amounts, ECHO Patients, and Paid Government Costs Per Patient for ECHO Home Health Care (EHHC) and Other Non-EHHC Patients by Most Prevalent Principal Diagnoses

Patient's Most Prevalent Diagnosis	Paid Amount	Patients	Paid/Patient
	ECHO Home Health Care (EHHC) Patients		
Cerebral Palsy or Other Brain Damage	$20,497,722	157	$130,559
Spina Bifida or Other Congenital Anomalies	$13,321,854	167	$79,772
Diseases of the Digestive System	$12,925,132	123	$105,082
Pulmonary/Respiratory/Trach Conditions	$12,873,663	80	$160,921
Downs or Other Developmental Disabilities	$7,816,846	69	$113,288
Conditions Associated With the Perinatal Period	$6,624,225	64	$103,504
Delays in Physiological Development	$2,789,030	35	$79,687
Other Metabolic or Immunity Disorders	$2,736,559	23	$118,981
Autism Spectrum Disorder	$2,331,098	95	$24,538
Diseases of the Heart or Circulatory System	$1,427,995	15	$95,200
Neoplasms	$659,332	6	$109,889
Diseases of the Genitourinary System	$613,829	8	$76,729
Diseases of the Musculoskeletal System	$439,790	3	$146,597
Cystic Fibrosis	$238,698	2	$119,349
Diseases of the Ear	$5,756	1	$5,756
All Other Diagnoses	$4,376,232	47	$93,111
Subtotal	$89,677,761	895	$100,199
	Other Non-EHHC Patients		
Spina Bifida or Other Congenital Anomalies	$11,368,080	1,322	$8,599
Autism Spectrum Disorder	$10,873,712	1,757	$6,189
Delays in Physiological Development	$1,551,108	386	$4,018
Cerebral Palsy or Other Brain Damage	$1,509,349	209	$7,222
Downs or Other Developmental Disabillities	$1,314,598	190	$6,919
Diseases of the Genitourinary System	$627,135	246	$2,549
Conditions Associated With the Perinatal Period	$199,608	21	$9,505
Diseases of the Digestive System	$93,710	21	$4,462
Diseases of the Musculoskeletal System	$58,389	8	$7,299
Other Metabolic or Immunity Disorders	$55,637	8	$6,955
Pulmonary/Respiratory/Trach Conditions	$44,781	6	$7,463
Diseases of the Heart or Circulatory System	$33,892	5	$6,778
Neoplasms	$26,244	6	$4,374
Diseases of the Ear	$18,270	4	$4,567
Cystic Fibrosis	$1,026	1	$1,026
All Other Diagnoses	$248,665	45	$5,526
Subtotal	$28,024,203	4,235	$6,617
	Total Patient Types and Diagnoses		
ECHO Home Health Care	$89,677,761	895	$100,199
Other Non-EHHC Patients	$28,024,203	4,235	$6,617
Total	$117,701,964	5,130	$22,944

Note: Paid amounts in the table above only include ECHO program claims (i.e., Basic TRICARE and Autism Care Demonstration costs are not included).

ADFMs using the ECHO program must be registered in the ECHO program. During FY 2024, 26,757 ADFMs were registered in ECHO.[5] The top five States in terms of enrollment were: 1) Virginia (3,377); 2) California (3,192); 3) Texas (2,859): 4) Florida (1,971); and 5) North Carolina (1,938). Roughly 93 percent of these registrants were younger than 18, with 51 percent age 8 or younger. Nearly 70 percent of these ADFM ECHO registrants had sponsors

[5] While there were 26,757 ADFMs registered in ECHO, as noted in Table 1, only 5,130 patients (19 percent) used ECHO services. The majority of ADFMs register in ECHO to use the ACD. During CY 2024, more than 13,000 ADFMs used the ACD.

who had a rank of senior enlisted (E5-E9), 15 percent had senior officer sponsors (O4-O9), 6 percent had junior officer sponsors (O1-O3), 6 percent had junior enlisted sponsors (E1-E4), and 4 percent had warrant officer sponsors (W1-W5). A total of 41 percent of ADFM registrants had Army sponsors, 26 percent had Navy sponsors, 22 percent had Air Force sponsors, 8 percent had Marine sponsors, and 3 percent had Coast Guard sponsors.

Family-Provided Information Regarding Gaps in ECHO Services

OSN conducted a survey of EFMP families in March 2023. To avoid survey fatigue among families enrolled in the EFMP, DHA determined a survey is not the best way to ascertain gaps in ECHO services. Instead, DHA has been working closely with TRICARE contractors, advocacy groups, and ECHO families to determine the biggest gaps in ECHO services. DHA completed a policy clarification on the receipt of EHHC services when the primary caregiver is absent due to deployment, employment, seeking employment, or pursuing education after speaking with advocacy groups and affected ECHO families. The policy on coverage of EHHC services is now consistent with all statutory and regulatory requirements.

To prevent a gap in the provision of ECHO services during the FY 2025 lapse in appropriations, DHA worked quickly to extend the provisional eligibility status timeframe for families who had initiated the EFMP enrollment process during the Shutdown. Working with the Military Departments, DHA determined that any provisional ECHO enrollees approaching the end of their provisional eligibility status who could not complete the EFMP registration process due to furlough-related Service staff shortages were at risk of a lapse in coverage of essential services. This would have required the families to restart the EFMP/ECHO registration process. DHA successfully extended the provisional eligibility timeframe that applied to families who had initiated the EFMP process during the lapse in appropriations to December 13, 2025, which was 30 days beyond successful execution of the Federal budget process. This ensured families would not lose access to the ECHO services they needed.

DHA continues to work with the TRICARE contractors and ECHO families to identify and resolve gaps in ECHO services.

Assessment of the Factors Preventing Knowledge of and Access to ECHO

After surveying TRICARE contractors and speaking with ECHO families, DHA identified no factors that are actively preventing knowledge of and access to the ECHO program at this time. Both DHA and TRICARE contractors continue to focus closely on providing information to TRICARE members on the ECHO program. The contractors attend health fairs and refer beneficiaries to ECHO case managers to address any questions or need for resources the beneficiaries may have. In addition to in-person offerings, they provide focused web-based seminars to increase awareness of the ECHO program within the military community. They also provide important information about the ECHO program on their websites. This content provides information related to program eligibility, program benefits, ways to access the program, enrollment guidance, and cost/coverage limits. Additionally, contractors provide targeted health messaging on the back of their authorization letters that addresses important subjects like respite care and program exclusions.

Furthermore, DHA and TRICARE contractors provide training to the Services' EFMP offices so they can educate beneficiaries on the ECHO program's benefits. DHA and its contractors will continue to work tirelessly to educate TRICARE families on the ECHO program and all its benefits through constant and consistent training seminars, providing important contact and program information on all TRICARE websites, and providing web-based seminars to any TRICARE beneficiary interested in the ECHO program.

Average Wait Times for Eligible Dependents to Access ECHO Coverage

For ECHO-enrolled patients, the average wait time (defined as the time between enrollment and the production of the first claim) for EHHC services was 4 months. For other ECHO services, the average wait time was 10 months. Importantly, only 20 percent (2,555) of patients enroll in ECHO prior to submitting a claim for EHHC or ECHO services. However, patients requiring EHHC or ECHO services may seek services under a provisional eligibility status, as needed. It is also noted that enrollment-to-utilization wait times are driven by beneficiary need, and ADSMs often register family members in ECHO as a precautionary measure but do not immediately utilize the benefits, particularly for non-EHHC services. The Department does not have a means of calculating "wait times" for those seeking services without enrolling first.

Eligible ADFM patients must be registered in the ECHO program by their TRICARE contractor to obtain ECHO benefits. On receipt of the required documentation from the ECHO-eligible patient's sponsor, the contractor then enrolls the eligible ADFM patient in the Defense Enrollment Eligibility Reporting System (DEERS) with an ECHO-qualifying Health Care Delivery Plan code 400. In the interim, the contractor may grant otherwise ECHO-eligible and enrolled ADFM patients a provisional eligibility status for a period of up to 90 days during which ECHO benefits will be authorized and payable without finalizing enrollment in DEERS.

To evaluate wait times for beneficiaries enrolled in the ECHO program, DHA identified patients who used the ECHO program for the first time during the period CY 2021-CY 2025. There were 19,833 first-time ECHO patients over this period, with 968 (5 percent) having used the EHHC program. Of the first-time ECHO users during CY 2021-CY 2025, only 3,459 (21 percent) had a record of registering in ECHO. In other words, 79 percent of these first-time patients used the ECHO program without going through the formal registration process. DHA found that higher-volume users were more likely to be registered than users with only one or two ECHO claims. Nearly all users of the EHHC program had registered in ECHO (696 of 724 patients) while only 18 percent of other (non-EHHC) users (2,763 of 15,745 patients) had registered in ECHO prior to use of the program.

The median time from ECHO registration to the first ECHO claim was one month for both EHHC and non-EHHC users.[6] However, 16 percent (567 of 3,459 patients) of those

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[6] DHA attempted to determine the amount of time from a patient's initial qualifying diagnosis to registration in ECHO. However, due to technical limitations in the way the data is coded, it is not always possible to determine the exact date of a qualifying diagnosis. DHA also advised there are limitations on using the time it takes between a diagnosis and registration in the ECHO program as a measure of effectiveness because some patients wait for an extended period before deciding to register and use the ECHO program.

registering in ECHO waited greater than one year to obtain ECHO services (only 5 percent of EHHC patients waited for more than a year). While 50 percent of the patients waited a month or less (the median), the average wait time for all patients was 9 months (4 months average for EHHC patients; for other ECHO services, the average wait time was 10 months). The average wait time exceeds the median wait time because 16 percent of the population waits for greater than one year, which substantially increases the average.[7]

DHA does not currently know the precise reasons for the length of time between registration and ECHO service delivery. Without knowing the reasons for these delays, DHA cannot speculate about such outcomes. DHA would like to note ECHO program registration is set up to be flexible to meet the immediate needs of ECHO families through the provisional eligibility status approach described above. These results indicate the contractors granted provisional eligibility to 79 percent of ECHO patients who went on to use the program without formal registration.

Conclusion

Supporting military families is fundamental to a ready and resilient force. The implementation of the OAM, initiation of the revisions to the EFMP policy, the enhanced oversight of special education and EIS, as well as the expansion of outreach and relationships are not isolated initiatives. Rather, they are interconnected components of a deliberate strategy to build a more responsive system of support. The Department remains steadfast in its mission to support families with special medical and educational needs.

[7] For example, assume that 9 patients waited one month, and one patient waited 80 months. The median (or 50th percentile) wait time would be one month and the average wait time would be 9 months. The presence of one outlier (who waited 80 months) skews the average wait time but does not affect the median wait time.

Appendix A: Acronyms

ABA – Applied Behavior Analysis
ACD – Autism Care Demonstration
ADFM – active-duty family member
CAP – Corrective Action Plan
CONUS – Continental United States
CY – Calendar Year
DEERS – Defense Enrollment Eligibility System
DHA – Defense Health Agency
DoDI – Department of Defense Instruction
DoDM – Department of Defense Manual
ECHO – Extended Care Health Option
EFMP – Exceptional Family Member Program
EFMP-FS – EFMP Family Support
EHHC – ECHO Home Health Care
EIS- Early Intervention Services
FY – fiscal year
HCDP – Health Care Delivery Plan
IG – Inspector General
IT - Information Technology
KPI – Key Performance Indicator
LoN- Level of Need
MC&FP – Military Community and Family Policy
MCSC – managed care support contractor
NDAA – National Defense Authorization Act
OAM – Outcome and Accountability Model
ODA – Outcomes-Driven Accountability
OSN – Office of Special Needs
PCS– permanent change of station
Q – quarter
U.S.C. – United States Code