



September 1, 2016

Dear Members of the Department of Defense Military Family Readiness Council (MFRC):

The TRICARE for Kids Coalition is a stakeholder group of children's health care advocacy and professional organizations, disability advocacy groups, military and veterans' service organizations and military families committed to ensuring that the Department of Defense meets the unique needs of children of military families.

The Coalition greatly appreciates the MFRC's interest in the healthcare and supports provided to the 2.4 million pediatric beneficiaries in the Military Health System. That interest was obvious in the Council's request that the Defense Health Agency (DHA) brief the MFRC on "*TRICARE for Kids (TFK) Report to Congress: Update from the Office of the Assistant Secretary of Defense for Health Affairs*"¹ at its June 2016 meeting.

"TRICARE for Kids" is the popular name for legislation passed as Sec 735 of the 2013 National Defense Authorization Act (NDAA), which ordered the Secretary of Defense to study the health care and related services for children of members of the Armed Forces, and is used as a colloquialism for the efforts surrounding that legislation and implementation. Then-Undersecretary for Personnel and Readiness, the Honorable Jessica L. Wright, submitted the Section 735 pediatric (Tricare for Kids) report to the Congressional Defense Committees in July of 2014.

The DoD report included 31 significant findings related to the nine Congressionally-directed elements in Section 735. The TRICARE for Kids Coalition responded to this report in September of 2014². While agreeing with the 31 findings, the coalition was also troubled by numerous discrepancies and omissions in the report. Two examples include its failure "to set forth a plan to improve and continually monitor pediatric care" and to make "recommendations for legislation that the Secretary considers necessary to maintain the highest quality of health care for dependent children," both requirements of Sec 735 of the 2013 NDAA.

Addressing these findings and responding fully to Congressional direction are absolutely necessary to ensuring that the Department is meeting the needs of military children and their families.

Unfortunately, the June 2016 MFRC briefing provided by DHA officials failed to address DoD's 31 findings or stakeholders' previously submitted questions to DHA regarding status of those findings in June 2015 (both attached). The MFRC brief by DHA provided little more than a general update. While some of the information was interesting, the brief wasn't specific to the DoD report and left MFRC members with more questions than answers, and advocates with significant concerns.

Besides the failure to address the 31 specific DoD findings, we had significant concerns because of factually incorrect statements with respect to interaction with the Military Compensation and Retirement

¹ Federal Registry Notice: <https://www.gpo.gov/fdsys/pkg/FR-2016-05-18/pdf/2016-11736.pdf>

² TRICARE For Kids Stakeholders Coalition Summary and Analysis: <https://www.childrenshospitals.org/issues-and-advocacy/tricare/tricare-for-kids-stakeholders-coalition-summary-and-analysis>

Modernization Commission (MCRMC) findings regarding the Extended Care Health Option (ECHO) program, the purpose of ECHO, and a key element of the ECHO program, in the DHA briefing.

Because they were stated as fact versus opinion, and because the misstatements will lead to further delay and potentially inappropriate implementation of the Tricare for Kids findings, we would hope that the Council will continue its engagement and leadership on Tricare for Kids, look to DoD to correct the record, and consider receiving relevant testimony from stakeholders and experts. We would specifically recommend the professional staff from the MCRMC, charged with the Commission's research, analysis and recommendations regarding the critical needs of families with exceptional members (EFMPs) who rely on ECHO services.

Similarly, egregious enough to warrant comment and concern by stakeholders was the point made in the briefing about DHA management of the respite care benefit, referencing concerns that it would be used as a babysitting service, a statement which suggests both an unacceptable level of ignorance of families' needs and undue suspicion of motives directed at our most vulnerable military families. These kinds of comments and misconceptions are the type that advocates work tirelessly to correct among the general public, but it is especially concerning when such remarks are provided by the agency charged with reforming these programs and serving these families.

Our concerns with lack of progress addressing the specific findings and the delays in improving pediatric care are mirrored in both the House and Senate Armed Services Committees (HASC and SASC) since the Report was filed in 2014. Last year, regarding DoD's report to Congress, the SASC stated,

"The report deeply concerns the committee because data gaps and deficiencies in this area fail to substantiate the conclusion that the military health system meets the health care needs of children, especially those children with special needs."

Additional statutory language can be found throughout this year's NDAA indicating continuing dissatisfaction with DoD's follow-up regarding this topic³.

Every day that DoD is not moving forward on correcting and improving the issues highlighted in DoD's report, as well as our TRICARE for Kids Coalition response to that report, is a day that military families are not accessing needed supports and services.

The MFRC's continued engagement and leadership in requesting updates and monitoring progress is crucial to ensuring accountability with Congressional directives and DHA's own stated goals of meeting the unique needs of children. To that end, **the TRICARE for Kids Coalition requests the Military Family Readiness Council include as one of its 2016 recommendations to Secretary of Defense Carter a statement that acknowledges the importance of pediatric care for military children and the necessity of updating the Council and stakeholders on actions taken to date and planned to specifically address the 31 findings of the TFK/ Section 735 report and related questions.**

The TFK Coalition appreciates and applauds the diligence of the MFRC regarding TRICARE for Kids matters as DoD works toward filling the gaps, addressing areas for improvement, and improving health care supports and services for military children and their families, especially those with special needs.

Sincerely,

Kara Tollett Oakley

Kara Tollett Oakley

Chair

³ Sec 580, GAO Report on EFMP (page 233) and Sec 762, Report on Plan to Improve Pediatric Services (page 452) at <https://www.gpo.gov/fdsys/pkg/BILLS-114s2943pcs/pdf/BILLS-114s2943pcs.pdf>

Significant Findings in Report to Congressional

Defense Committees:

Study on Health Care and Related Support for Children of Members of the Armed Forces

Office of the Secretary of Defense July 2014

Element 1: A comprehensive review of the policies of the Secretary and the TRICARE program with respect to providing pediatric care.

1. Review processes for evaluating emerging technology in use in the general community but not supported by the hierarchy of evidence required for the TRICARE purchased care program.
2. Review regulatory provisions for TRICARE program cost-sharing of care that appears to have gained acceptance in the larger medical community but does not meet the TRICARE-specific definition applicable to the purchased care component.
3. Analyze use of health care benefits by children ages 6 to 21 years to assess if developmental- and age-appropriate care is being delivered as compared to AAP-recommended periodicity schedules and guidelines, the 2010 Patient Protection and Affordable Care Act, or Medicaid's Early and Periodic Screening, Diagnosis and Treatment benefit.
4. Determine the extent of use of special metabolic formulas by children with complex metabolic or digestive disease to maintain essential nutrition and medical food.
5. Assess the benefit of nutritional counseling and management when provided by nutritionists and/or registered dietitians as authorized providers for children with complex medical and metabolic medical conditions.
6. Determine if the current benefit of habilitative care authorized under ECHO only for ADFMs promotes age-appropriate and developmental support for children along with skill attainment and sustainment that is distinct from rehabilitative care, and whether legislative changes to remove the current statutory exclusion of habilitative care from the Basic program would be appropriate.
7. Usage of compounded medication for pediatric beneficiaries and review the impact of the DHA decision on coverage for compounded medications in compliance with Public Law 113-54, Drug Quality and Security Act, once the FDA provides direction on implementation of the new law.
8. Reimbursement policies and their flexibility for safe and effective care of the pediatric beneficiary as pediatric health delivery models change.

Element 2: An assessment of access to pediatric health care by dependent children in appropriate settings.

9. Future assessments should focus on more finely tuned access metrics, including wait times and referrals, reasons for higher rates of non-network ER use, and availability of providers. Evaluate currently available metrics and data sources to assess if they effectively address adequacy of access for pediatric beneficiaries.
10. Specific analyses of the pediatric population in the annual Evaluation of TRICARE Programs: Access, Cost and Quality would provide a comprehensive review of adult and pediatric ER utilization rates in the MHS.
11. Strategies are needed to accurately differentiate between utilization of freestanding versus hospital-based ER utilization and cost differences, which could inform assessment of access of services.
12. Potential recapture of pediatric ER visits through review of diagnoses and acuity of visits would inform access of services.
13. Study of regional contractor required reports to evaluate the need for contract modifications to have data available for finely tuned access metrics, including wait times and referrals, reasons for higher rates of non-network ER use, and availability of providers.

14. Evaluate the need for contract modifications to develop NARs that would reflect availability of providers on a monthly basis.

Element 3: An assessment of access to specialty care by dependent children, including care for children with special health care needs.

15. Potential methods for coding that will more easily identify pediatric specialty or subspecialty providers, or allow for dual (adult and pediatric) coding.
16. Further define diagnosis for high-utilization specialty providers and access standards between referrals and appointments.
17. Collecting data on pediatric access and provider specialty in the annual MHS TRICARE survey could be a useful tool for tracking pediatric access and satisfaction, including use of specific questions on CAHPS to assess family satisfaction specific to pediatric care.
18. Determine the components of a consistent NAR for direct and purchased care component that identifies for referrals and consultations the participating pediatric subspecialty providers.
19. Regional contract requirements for NARs to include network adequacy as measured by utilization of pediatric subspecialty providers.
20. Consider the inclusion of the pediatric population in the annual Evaluation of TRICARE Programs: Access, Cost and Quality report to provide a comprehensive review of adult and pediatric care in the MHS.

Element 4: A comprehensive review and analysis of reimbursement under the TRICARE program for pediatric care.

21. Periodically review reimbursement policies in order to collaborate on innovative processes needed to continue to meet the unique health care needs of children as health care delivery models change.

Element 5: An assessment of the adequacy of the ECHO Program in meeting the needs of dependent children with extraordinary health care needs.

22. Review data regarding EFMP family members eligible for ECHO enrollment, current ECHO-enrolled beneficiaries who continue to be eligible for services, and current ECHO-enrolled beneficiaries who due to changes in condition are no longer eligible for ECHO services. Collaborate with the MHS Beneficiary Education and Support Division, the Military Departments, TROs, the Office of Special Needs, and contractor partners to provide information to all eligible families and track ECHO enrollment and utilization.
23. Develop satisfaction or outcome measurements for all ECHO programs with regard to impact on beneficiaries and family readiness.

Element 6: An assessment of the adequacy of care management for dependent children with special health care needs.

24. DoD collaborative review to establish a formal family-focused process to evaluate the adequacy of care and case management in meeting complex individual health needs and promoting quality cost-effective outcomes.
25. Develop a formal collaborative process in and between direct and purchased care to define and review outcomes for appropriate care/case management of pediatric beneficiaries and their families.
26. Develop outcome/efficacy metrics for the impact of case management in direct and purchased care for beneficiaries with significant medical/behavioral health issues.
27. Future longitudinal study on the impact of PCMH on pediatric beneficiaries in the MTF setting.

Element 7: An assessment of the support provided through other Department of Defense or military department programs and policies that support the physical and behavioral health of dependent children, including children with special health care needs.

- 28. Develop a common core of programs/benefits that support families available at all installations with criteria for evaluating effectiveness of programs and outcomes.
- 29. Evaluate a process for a “one-stop-shopping system” to support families in evaluating the multitude of services available in the Military Departments, DoD, and community to meet their needs.

Element 8: Mechanisms for linking dependent children with special health care needs with State and local community resources, including children’s hospitals and providers of pediatric specialty care.

- 30. Future study to develop and test consistent processes of communication and collaboration between nonclinical and clinical support for the family’s network of needs.

Element 9: Strategies to mitigate the impact of frequent relocations related to military service on the continuity of health care services for dependent children, including children with special health and behavioral health care needs.

- 31. Formalized collaboration of EFMP Military Department medical and regional contractors in determination of availability of medical resources in complex medical case prior to relocation.

From: TRICARE For Kids Coalition
To: Defense Health Agency Pediatric Integrated Project Team

Questions for Submission to the PIPT for the June 24, 2015 meeting with stakeholders

A. The Tricare for Kids Coalition identified the following list of opportunities to improve care and care experiences for military connected children pursuant to the DoD Pediatric Report to Congress released in July 2014.

1. For each of the following issues identified in the Section 735 Report and recommendations made by stakeholders:

What is the DoD/DHA position on the topic/recommendation?
What is the status and summary of activity since the Report publication date?
Please describe a plan for implementation?
What if any, additional authority is needed?

- Aligning Tricare with preventive benefits available through the Patient Protection and Affordable Care Act (ACA), Bright Futures and Medicaid's Early and Period Screening, Diagnostic and Treatment (EPSDT).
 - Aligning medical necessity definition for purchased care sector with AAP recommendation and broader definition allowed in the direct care system to ensure a consistent benefit and care.
 - Creating a pediatric physician advisory group with internal and external practitioners that meets on a regular basis to provide pediatric specific perspective on policy and practices.
 - Establishing an Advisory Panel on Community Support for Military Families with Special Needs as [required by law](#).
 - Amending the inpatient only list TRICARE adopted from Medicare for pediatrics.
 - Addressing reimbursement areas cited in the Report and stakeholder comments throughout the process. Would you discuss the need for and work with a pediatric payment advisory group to address?
 - Adjusting definitions and provider categories as necessary to cover medical nutrition for children with complex nutritional needs.
 - Implementing internal ECHO reforms and increase flexibility of ECHO benefit to ensure that it aligns with the Centers for Medicare & Medicaid Services (CMS) standards for community based supports and provides improved access and continuity of care to families.
 - Ensuring that compounded medication coverage and regulation allows pediatric needs to be met.
 - Convening data stakeholders advisory group to assist with metrics, appropriate comparisons, etc. for pediatrics including complex care and care coordination and management.
 - Immediately adopting mental and behavioral health standards more commonplace in pediatric care systems such as wrap around care, intensive outpatient programs, family centered care, community based care and uniform access to specialty care.
 - Removing artificial barriers to residential treatment center certifications.
 - Particularly with regards to EFMP families, compiling recommendations from the many recent reports and studies and creation of a checklist of action items and issue areas to address. Can you assure this stakeholder community that this will be done in collaboration with internal and external stakeholders?
2. For each of the following deep dive issues identified in the Section 735 Report and recommendations made by stakeholders:

What steps has DHA/DoD taken since the Report publication date to begin to address:

- The lack of data, inefficiency of collection and analysis and inability to meaningfully utilize data.

- Ensuring that qualified EFMP beneficiaries have access to Medicaid waiver services.
- Streamlining the process for pediatric-specific coverage and reimbursement issues that are child/patient centered.
- Implementing coding changes that more accurately reflect pediatric care such as APR-DRGs.
- Allowing TRICARE to formulate policies and coverage with best practices identified and recommended by other federal agencies with substantive oversight; for example, instead of conducting its own analyses regarding substance abuse treatment and mental and behavioral health on which to design policies, utilize SAMSHA studies and reports.

B. In the 2015 NDAA DHA was given flexibility to cover emerging technology.

3. How and when does DHA plan to implement this flexibility for pediatric health care?