February 2016

Make TRICARE Work for Kids

Tricare for Kids Coalition
Proposals for Tricare Reform

The following major issues of interest and concern for the Tricare for Kids (TFK) Coalition should be addressed in "Tricare Reform" as DoD and Congress contemplate improvements, work to fill gaps, and correct deficiencies in pediatric healthcare, incorporating key points of the Military Compensation and Retirement Modernization Commission (MCRMC) and TFK reports:

Coverage

1. Meet the unique needs of children across the spectrum of health, well-being, developmental needs, prevention, primary, routine and acute care.

    - Align the TRICARE benefit with the American Academy of Pediatrics' (AAP) "Bright Futures" standards, and Medicaid's Early Periodic Screening Diagnostic and Treatment (EPSDT) standard aligning Tricare with Medicaid, CHIP, and the Affordable Care Act exchange plans.

    - Adopt the American Academy of Pediatrics (AAP) definition of medical necessity and commensurate hierarchy of reliable evidence used to determine whether a procedure or treatment is appropriate, as described in its July 2013 Policy Statement "Essential Contract Language for Medical Necessity in Children."

2. Families of children with special, chronic and complex medical needs.

    - Ensure that ECHO best meets their needs with targeted services and resources, by implementing the legislative language proposed by the MCRMC in December 2015, to align with MCRMC Recommendation #7.

    - Closely monitor the EFMP proposed regulation and implementation just released per NDAA 2010, for adherence to intent and meeting the current needs of families.

- The Autism Care Demonstration, while a great step forward, is currently a cause for concern. It should be closely monitored for adherence to intent and ensuring that families actually have access to the care that is now covered.

3. Refine the TRICARE benefit to allow for Intensive Outpatient Treatment (IOP) that more closely aligns with child, youth and family needs; ensure recent proposed regulations appropriately address the gap, and are meaningfully implemented.

Access

4. Ensure pediatric network adequacy, including access to pediatric specialists – so that children receive the right care at the right time in the right setting.

5. Facilitate patient (child and family) centered care and medical home models tailored to the child's health needs.

6. Provide military families access to care coordination and management networks anchored by children's hospitals specifically to meet the needs of children with medical complexity and their families.

7. Ensure a pediatric specific mental and behavioral health system of care which is child and family centered, provides wrap around and community based care tailored to the child's needs from least restrictive to most intense options, including intensive outpatient treatment.

8. Align Residential Treatment Center certification requirements with those found in the civilian sector; ensure recent proposed regulations appropriately address the gap, and are meaningfully implemented.

9. Align payment policies to the needs of pregnant women, infants, and children.

10. TRICARE should afford more flexibility in reimbursement for care designed for and tailored to children. Reimbursement should follow appropriate care, not form the basis for care decisions.

Accountability

11. Require a DoD Stakeholder Engagement Team that includes families, providers and advocates. Families, providers and advocates must be integrated into the DoD processes for reviewing and ensuring children's health benefits, coverage, access and quality, and for vetting and assisting with messaging of changes, reforms, and opportunities.

12. Adopt DoD system-wide definition of child with special health care needs, consistent with other appropriate federal agencies (HRSA)

13. Ensure full implementation of 2010 NDAA, which created DoD Office of Community Support for Military Families with Special Needs and follow-up on GAO Report 12-680 "Better Oversight Needed to Improve Services for Children with Special Needs" (see above, regulations just released).

14. Ensure that DoD policy aligns with best practices in the communities of expertise and that it is based upon sound evidence and data analysis.

    - Mitigate deficiencies in data collection, data utilization, and data analysis, in collaboration or contract with organizations specializing in data analysis and utilization specific to pediatrics, per standards in the pediatric community.
    - Subject matter experts that are global and national thought leaders in the field can help DoD avoid the trap of creating its own system of quality and outcome measures and data collection points., which would not be meaningful or credible due to the small numbers of children covered and lack of consistency with national standards.

15. Too often TRICARE reimbursement policy is the result of Medicare policy, which does not make sense for children. Ensure that policy is
    - Based upon sound principles,
    - Demonstrated need,
    - Will create desired outcomes, and
    - Tailored to the unique needs of the children and families served.
    - E.g.s, Melody Heart valve, compound medication for childhood needs, inpatient or outpatient decisions made by physicians based on child's needs and pediatric community standards of care, not Medicare, etc.).

16. TRICARE should not ask pediatric providers to absorb the cost of medically appropriate care for children or to choose outdated care options when the standard of practice calls for something different. (e.g., Melody heart valve; specialty nutritional consultation and provision, sedation for procedures such as MRI or wound care, etc.).

17. Legislation must include timelines, guidelines, benchmarks and specific oversight for implementation compliance, which can be set forth by a Congressionally appointed Commission with expertise in relevant fields such as data, healthcare systems, pediatric networks, pediatric providers and other children's health advocates, and family representation.

18. Hearing

    Ensure military children's healthcare, particularly related to those with disabilities and chronic medical conditions, is an integral part of any conversation related to updating the Military Healthcare System. We recommend a **specific Personnel Subcommittee hearing or hearings on pediatrics** to address these issues.

Discussion: DoD Must Demonstrate Commitment to Reform

Throughout military children's health there is a huge disconnect between policy and practice, and reports, resources, surveys, and family feedback. These disconnects are harmful to the children and families being underserved, and result in a loss of credibility for the military health system, which has so much to be proud of.

There is much discussion around ideas of enlarging service areas and capabilities with the direct care system and increasing Tricare's responsibilities to meeting the needs of children of military families, yet, there has been little action to date in the last 15 years that demonstrates DoD/DHA's capability to move forward with pediatric specific improvements despite ample opportunity and in fact, direction from Congress and DoD leadership.

Congress should require DoD/DHA to demonstrate its capability and commitment to meaningful implementation of previous requirements before entrusting it with much more.

DoD's TFK Report assured Congress that it was meeting the needs of children in its care, but The Senate Armed Services Committee rightly noted:

> *Although the report concluded that the military health system meets the health care needs of children, including children with special health care needs, it acknowledged significant gaps and deficiencies in data collection, data utilization, and analysis. 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.*

- For instance, the TFK report describes complex care management as an area with gaps and need for improvement. Yet DHA officials state that there is no need to work with stakeholders to explore complex care models.
- At the most recent Autism Care Demonstration roundtable, much of the discussion centered around the medical appropriateness of ABA – that is not a point for discussion at this time, it has already been settled by the creation of the demonstration project, yet the reticence of the team managing the demonstration to accept the premise of the Demonstration Project is obvious, and could continue to cause barriers to access to the care that is to be provided by the ACD. Similarly, it is not clear that the Department is collecting and analyzing ACD information for furthering understanding of challenges and opportunities going forward.
- Furthermore, one of the reasons given that there is no need (despite the July 2014 report which states there are gaps and opportunities to improve in that area) is that exceptional family members whom would require complex care are already enrolled in patient centered medical homes. Yet, a recent DoD Office of Special Needs report just released reveals that only 6% of exceptional families state that they are enrolled in a patient centered medical home.