STATEMENT FOR THE RECORD

THE TRICARE FOR KIDS COALITION

before the

Senate Armed Services Committee
Subcommittee on Personnel

On

Military Personnel Policies and Military Family Readiness

February 27, 2019

CHAIRMAN TILLIS AND RANKING MEMBER GILLIBRAND. 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 children of military families receive the unique care, supports and services they need.

We appreciate the opportunity to submit testimony regarding issues impacting the health and wellbeing of children in military families as it is a major element of family readiness. Areas of emphasis in this statement are 1) the Coalition's response and reaction to the Defense Health Agency's (DHA) most recent report to the Committee on pediatrics, 2) Exceptional Family Member Program, and 3) Health and safety hazards in military base housing.

1. **Response and reaction to the most recent Defense Health Agency Report submission to the Committee in December 2018.**

Tricare is based generally on Medicare, which is formulated and maintained for older adults; and regularly results in "square peg, round hole" situations for children and their families.

Our Coalition was created around passage of legislation known as "Tricare for Kids", passed in the 2013 NDAA requiring the Secretary of Defense to complete a comprehensive review of all pediatric policies and practices, and report on plans and progress to address those gaps and barriers to care. In the wake of less than fulsome reporting, subsequent NDAAs have required additional information.

The Coalition is pleased with the continued interest and commitment by the Committee to continue to oversee pediatric health care services and support developments. The Coalition is concerned about the timeliness of DHA progress, including implementing improvements, addressing gaps and barriers, as well some of the direction of decisions, for example, the decision not to instill a pediatric medical necessity standard.

The Coalition respectfully requests the Committee consider providing more specific direction to DHA regarding pediatric care, aligning with the details discussed below. The agency took a great step forward by tasking the independent advisory council, the Defense Health Board (DHB), with a report on Pediatric Health Care Services, completed in 2017. The Defense Health Agency has stated its agreement with the DHB recommendations and conclusions, yet we continue to see disconnects, included some pointed out below. **Specific direction from the Committee to DHA to align with the DHB conclusions in a timely manner may now be warranted.**

(Full DHB report available: https://health.mil/About-MHS/OASDHA/Defense-Health-Agency/Defense-Health-Board/Reports)

The following analyses of excerpts from the most recent report by DHA to Congressional oversight committees as required in the 2018 NDAA, along with Tricare for Kids responses, demonstrate the need for specific direction to DHA concerning pediatric care.

(Full report available: https://www.health.mil/About-MHS/OASDHA/Defense-Health-Agency/Congressional-Relations/Reports-to-Congress/Signed-in-2018)

1. With respect to " **MHS plans to align preventive pediatric care with the standards of such care under PPACA, guidelines established under Medicaid, and with recommendations by organizations that specialize in pediatrics"** the DHA reported that a gap analysis is currently in progress with an expected completion in 2019. The gap analysis is expansive, and includes all age groups of beneficiaries with a focus on traditional clinical practice, and international models of preventive care with the inclusion of social determinants of health. … The preventive care comprehensive gap analysis will be complete by December 31, 2019, and a review of findings from the gap analysis and final recommendations will occur no later than December 31, 2020.

- TFK: DHA announced alignment with AAP Bright Futures guidelines for a segment of children in 2016 but it is unclear exactly how and whether this has been implemented. Timeliness and the seeming need to "reinvent the wheel" are common elements throughout DHA's response to the original Tricare for Kids legislation, and preventive care provides a good example. A ten year old child will have reached adulthood from the time the original legislation passed and DHA is still studying preventive care. Preventive care guidelines and Bright Futures protocols are widely accepted norms and have been for some time; and are updated regularly to address issues such as social determinants of health. It would be more effective and efficient it seems, to align with best practices and widely accepted norms rather than use agency resources to research and create its own practices. This is especially true as the volume of pediatric beneficiaries in Tricare isn't large enough to make parochial protocols make sense (other than for issues unique to military children, such as specifics to address exposure to base housing hazards); furthermore, children move on and off Tricare regularly with various transitions among commercial or public health insurance options, at times such as separation from service, activation or deployment status, non-military parent's employment status, need for Medicaid or CHIP, and so forth. Having Tricare pave its own way with standards that are unlike others is not efficient nor does it serve the needs of Tricare covered children well.

  Our Coalition would like to see DHA directed to adopt (and adapt with) fully developed best practices without having to reinvent the wheel each time, using DHA time and resources to develop something specific only when the unique needs of its population warrant it – for example, creating a response to the base housing health and safety crisis.

2. Regarding **MHS plans to develop a uniform definition of "pediatric medical necessity."** The DHA reported that it does not plan to develop a uniform definition of "pediatric medical necessity." Rather, MHS plans to continue to utilize the uniform definition of "medical necessity". … MHS has no plans to change the existing uniform definition of medical necessity….

- TFK: It is troubling to learn of the DHA intent to "continue" to use the "existing definition" when Congress, the DHB and the TFK Coalition have all expressed grave

concerns about current practices and limitations negatively affecting children's access to medically necessary care. Furthermore, DHA arrived at its conclusion although it regularly reports that it agrees with all the recent Defense Health Board recommendations regarding pediatric care, and pediatric medical necessity concerns were a major element of the DHB publication.

Our Coalition would like to see the Committee direct DHA to implement an existing pediatric medical necessity standard (which are discussed thoroughly in the DHB report) particularly we recommend the American Academy of Pediatrics model language.

3. DHA stated that **MHS' improvements of the quality of and access to behavioral health care, including intensive outpatient and partial hospitalization services** a) were largely implemented through statutory changes in the TRICARE benefit in FY 2016.

- TFK: The September 2016 final rule expanding behavioral health services and streamlining authorization of institutional providers offered a tremendous opportunity to increase access to needed services. Actual implementation has been slow, with TRICARE policy manual updates not completed until more than a year after the final rule's effective date, just as regional consolidation, new managed care support contracts and benefit plan changes were being implemented. The most significant barrier to accessing behavioral health services is a lack of clear, accurate information, for both providers and families.

  In order to optimize the utilization and impact of statutory and policy improvements, our Coalition sees a need for:

- **A checklist on Humana's and HealthNet's TRICARE websites identifying the process, timeline, responsible entity for each step, and online location of forms and other information for institutional behavioral health providers that want to serve military families**. This is where the intended streamlining of provider certification and participation stalls, with each provider organization separately navigating a murky process with multiple players.

- **A regularly updated list on https://health.mil of TRICARE-certified institutional behavioral health care providers, by type.** Behavioral health treatment is often quite specialized, e.g., targeting a particular age group or condition, and the most clinically appropriate treatment setting is not always in the family's community, state or TRICARE region. Both families and referring providers need this information**.**

- **Regularly updated provider directories on Humana's and HealthNet's websites, with useful search functions.** The specialty nature of behavioral health care and the geographic spread of providers don't lend themselves to searches limited to zip codes, states, or proximity to MTFs. It also appears that the directories include only in-network providers, which may be acceptable under the managed care support contracts, but reinforces the need for a national list of all certified providers on https://health.mil.

b) and regarding Substance Use Disorder "SUD is rare in the pediatric population, and treatment for SUD mostly appears in the age 18-21 population. Across the whole population, 98 percent of SUD

stays and 99 percent of SUD encounters are for patients aged 18 and older (including dependent children)."

- TFK: Once again, while the DHA purports to support and agree with the DHB recommendations, contrast the above DHA statement with this excerpt from the DHB report: "While the Board did not examine the issue of substance use in pediatric populations, it acknowledges that these disorders can significantly affect children and youth, in both civilian and military populations. In FY 2014 through FY 2016, among females ages 13-17, **the top** Medicare Severity Diagnosis-Related Group for inpatient admissions was 'poisoning & toxic effects of drugs age 0-17.' The Board feels substance use disorders are an important area that warrants further research and assessment." [emphasis added]

  Our Coalition would like to see a consistent understanding by DHA and resulting priority for this category.

4. The DHA reports that **MHS' mitigation of the impact of PCS and other service-related relocations on continuity of care for children who have special medical or behavioral health needs is an ongoing, collaborative process.** Mitigation of the impact of PCS includes increased access to resources and services, and MHS' many diverse programs are positively assisting families with relocation.

- TFK: all efforts on this front are appreciated; effectiveness, however, is unclear, as the Coalition has yet to see evidence of any major improvement. The use of the term "collaborative process" while sounding promising, is unclear. While DHA does report some welcome progress coordinating with the Services and Office of Special Needs, advocates are only cautiously optimistic as this progress has been expected for years now. Furthermore, DHA does not appear to be working with families collaboratively.

  This issue is particularly important for EFMP families, who already face a myriad of challenges (see next item). In 2018 and continuing into 2019 to some degree, the managed care contract and plan design transitions have been disastrous for families with any non-typical family health needs as they have dealt with wildly inaccurate provider directories (which play a much larger role than most realize as they are used to determine EFMP assignments, plus incomplete or inaccurate listings wreak havoc with access and network/non-network categorization for all), increased cost shares, and inaccuracies by TRICARE in cost share payments, payments toward caps, coverage denials, and conflicting information at every turn. DHA is aware of problems and appear to be addressing issues, but the steps taken are often opaque to stakeholders and families, leaving us to wonder how targeted, strong and prioritized the DHA action may be toward our identified issues areas of concern.

  Beyond the obvious and immediate need for addressing transition and related barriers, for the long term DHB recommendations provide much fodder for DHA to work with in terms of improving the experiences. Two key items are the recommendation to "[r]equire inclusion of parents in working and policy groups at all levels" and the absolute need for better care coordination especially during PCSs. Again, aligning

with best practices and working with organizations specializing in pediatrics (and not just pediatrics, but even the much smaller category of complex pediatrics) who have made headway in this space of complex care coordination, make much more sense than reinventing the wheel.

Our Coalition would like to see DHA create more opportunities for family inclusion in policy groups, more regular stakeholder advocacy interaction on pediatric issues as the stakeholders bring necessary perspective from families and providers, and to work with stakeholders such as children's hospitals to improve care coordination for EFMP families.

5. Pediatric issues of importance and relevance to those in the DHA report, but not specifically referenced there:

- **Emerging and high cost treatments in pediatrics**.

Children with rare and/or significant medical conditions are most likely to rely on high cost, emerging treatments that are often the target for cost cutting and utilization measures.

TFK is very concerned that Tricare must be nimble in order to ensure that children receive the care they need in a timely manner, which often differs greatly from timeliness for adults. There is a waterfall of emerging and promising treatments for rare and serious childhood conditions, which are almost all very expensive and have specific procedures for use in children, and don't fit neatly in Tricare payment methodologies. This reality which is already challenging, coupled with the new pharmacy tier benefit changes could spell disaster for families of the most vulnerable children. Furthermore, DHA is looking to align care between MTFs and purchased care sectors – while this is appropriate to provide all with robust care, it is likely that this initiative will be used to limit certain genetic and therapeutic testing currently only allowed at MTFs.

Our Coalition has expressed to DHA that we would appreciate an ongoing stakeholder presence in a concerted DHA effort to discuss and prepare for access, coverage, and payment for emerging pharmaceutical, genetic, and advancing technology treatments as they apply to children and pediatric care. **Direction to DHA from the Committee in support of this request would be appreciated.**

- **Extended Health Care Option (ECHO)**

In 2015 the Military Compensation Retirement Modernization Commission (MCRMC), in alignment with our Coalition's concerns, found that access to Medicaid home and community-based services (HCBS) waiver benefits provided at the state level is a ongoing issue for military families with exceptional family members (EFMs); that many Service members encounter HCBS waiting lists that exceed their time assigned to a location, and referenced an FY 2013 DoD-commissioned study found that military families with special needs rely on Medicaid to obtain specific supplementary services that are either not provided or not fully covered by TRICARE

The MCRMC recommended that DHA increase services covered through the ECHO to more closely align with state Medicaid waiver programs, including custodial care and respite care hours that match state offerings, more flexible expanded services subject to existing ECHO benefit caps, and modernizing the program to better serve current demographics of the Force.

The Defense Health Board referenced the MCRMC findings as examples of the challenges facing Tricare covered families, and the fact that ECHO is only available to active duty members as an example of military health system lack of standardization and implementation of best practices enterprise-wide.

Other than recent modest changes to the respite care benefit, there has been no further movement on ECHO modernization or improvement. **The Coalition would like to see the Committee support its objectives of alignment with Medicaid based waiver services per the MCRMC recommendations, implementation of a grace period for eligibility upon separation from active status to cover an average Medicaid waiting list timeframe, and a revisiting of program assumptions, as some of the care that is provided only pursuant to ECHO is medically necessary care and therefore should be available to all beneficiaries under the basic TRICARE program.**

2. **Exceptional Family Member Program (EFMP)**

Continuing with EFMP challenges, again full generations of children with special, often complex needs, have been left without the services and supports needed, while their families are dealing with high op tempos, PCSing, a managed care transition that has been nothing short of disastrous in many quarters, and in some cases such as the subcommittee members heard in a recent hearing, the already serious issues have been compounded by hazardous living conditions on base.

On a positive note, regulations to update the EFMP were published this month, three years in the making. However, the situation has deteriorated to the point that families had to band together and request an Inspector General investigation, after years of failure by DoD to implement recommendations made by the Government Accountability Office and the Military Family Readiness Council. Why does a Congressionally mandated council on military family readiness, staffed with our most senior leaders, have problems helping military families? Much like the current housing crisis, these problems have been identified and recommendations made over the years, but with no sense of urgency or accountability by the implementers, have been left to fester. Sadly, it seems to take Senators asking hard questions for DoD to take action and ensure proper accountability.

The Coalition is pleased that in last year's NDAA, the Committees directed DoD to brief Congress on the status of its response to the most recent GAO EFMP report by March 1, 2019.

At the February 27 hearing, it would be timely then, for panelists to be asked what is DoD's response to, and timeline for implementing the recommendations? Furthermore, given the egregious and longstanding problems, the Coalition respectfully requests the Committee to support the families' request to the DoD IG to investigate the Exceptional Family Member Program's compliance with applicable statutes and instructions. Both would put DoD on notice that the Committee is serious about this issue and give these families confidence that the Senate is in their corner.

3. **Health and Safety Hazards in Base Housing**

The Coalition was pleased to submit testimony for the record for the recent hearings on base housing, and with the Committee's commitment to addressing housing issues. While that testimony lays out our concerns in more detail, we would like to take this opportunity to highlight for the Committee that even with its strong reaction since that date toward inspections and remediation, there remains a need for a public health oriented response to this crisis and its impact on our most vulnerable military families and children.

Military families depend on base housing for many reasons, including when housing on local economy is not affordable or in less appropriate neighborhoods. Furthermore, families who have children with special needs have even more limited housing options when moving to a new duty station. Sometimes, the only affordable housing that is ADA compliant is on-post housing. We are concerned health of those with special needs may be further compromised in housing with these hazards.

The conditions of critical concern around base housing range from mold to vermin to lead and toxic waste. There is no easy answer to this; the problem needs leadership and ownership. A major concern is the apparent lack of ownership of the known health problems arising from these conditions, which prevents them from being addressed promptly and appropriately while the big picture of liability or responsibility is being sorted out.

Meanwhile, however, DHA, the MHS, and TRICARE own the prevention, treatment and promotion of health and wellbeing of its beneficiaries many of whom are especially vulnerable children who live on base and have been and are exposed to these safety and health risks regularly, often with dire consequences. DHA must step up and figure out how to address screening, testing and treatment needs, as well as families' concerns, at the very least.

Toward finding solutions, the Coalition respectfully requests that the Committee request DHA (as it is in the process of taking over management and responsibility for all MTFs, and that DHA work with the services regarding MTFs still under their respective umbrellas) to address the questions and concerns submitted earlier to this subcommittee, and to engage in a candid and meaningful dialogue with stakeholders and military families to better understand the issues, and identify ways we can work collectively to improve military housing and barracks.

The Tricare for Kids Coalition appreciates the opportunity to submit testimony for the record toward improving family readiness.