Tricare for Kids calls on Congress to Address the Needs of Military Children FY2022 National Defense Authorization Act

1. Adopt EPSDT and Establish a Pediatric Medical Necessity Standard

Ensure military children have the same standard of care as their civilian counterparts covered by Medicaid, by adopting the "Early and Periodic Screening, Diagnostic and Treatment" or EPSDT standard. EPSDT covers "necessary health care, diagnostic services, treatment, and other measures...to correct or ameliorate defects along with physical and mental illnesses and conditions discovered by the screening services…" and is designed to "assure that individual children get the health care they need when they need it – the right care to the right child at the right time in the right setting."

In fact, the origins of Medicaid's EPSDT can be traced to a 1964 government study entitled *One Third of a Nation: A Report on Young Men Found Unqualified for Military Service*. The study examined the reasons that approximately 50 percent of the young men drafted into the military in 1962 were rejected for compulsory military service. The report documented the majority of these young men failed as a result of physical, mental and developmental conditions which could have been diagnosed and successfully treated in childhood and adolescence. These findings helped lead President Johnson to submit recommendations for child health coverage under Medicaid in 1967 that became the EPSDT standard we know today. This history illustrates why it is essential that Tricare adopt EPSDT to ensure children in military families receive the care they need, commensurate with children covered by Medicaid.

In addition, Congress should direct Tricare to adopt the pediatric specific definition of medical necessity recommended by the American Academy of Pediatrics (AAP) to cover: "health care interventions that are evidence based, evidence informed, or based on consensus advisory opinion and that are recommended by recognized health care professionals, such as the AAP, to promote optimal growth and development in a child and to prevent, detect, diagnose, treat, ameliorate, or palliate the effects of physical, genetic, congenital, developmental, behavioral, or mental conditions, injuries, or disabilities…" In detail: http://pediatrics.aappublications.org/content/132/2/398.

In support of this recommendation, it is imperative to note that the Defense Health Board's *Pediatric Health Care Services Report*, released December 18, 2017 came to a similar

conclusion. The report documented that TRICARE is out of step with both commercial plans and Medicaid and concluded TRICARE's current definition of medical necessity disadvantages children from receiving needed services. The report prompted Congress to inquire in the next NDAA about its intent to implement pediatric medical necessity. DHA reported to Congress that it *agreed with all DHB conclusions, yet specifically stated it would not adopt a pediatric definition*.

DHA cannot have it both ways.

The DHB includes a thorough discussion of the problems with the current definition and the hierarchy of evidence used to determine medical necessity.

Key issues identified by DHB include:

> Pediatric patients who receive care in the purchased care component may not receive the same services as those patients who receive care in the direct care component due to the MHS's definition of medical necessity and the hierarchy of reliable evidence, which only apply to purchased care
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> The nature of pediatric clinical research precludes some pediatric services and treatments from ever meeting the hierarchy of reliable evidence threshold outlined [by Tricare]
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> The current definition of medical necessity disadvantages children from receiving some needed services
>
> The complexity of medical necessity determinations increases when discussing the needs of children with a pervasive developmental disorder that affects many areas of functioning (i.e., children with complex needs…)
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> DHB Pediatric Services Report, December 2017

Tricare for Kids has been advocating for the adoption of these standards since the Coalition's inception and the original Tricare for Kids legislation. In its December 2018 response to Congress, DHA stated it would not implement pediatric medical necessity, despite repeated urging by the Committees, advocates and the independent review of the Defense Health Board (DHB).

Military families cannot afford another several years that children are denied necessary services. The TFK Coalition believes it is time for Congress to direct DHA to align with EPSDT and adopt the AAP definition of pediatric medical necessity to ensure children in military families receive medically necessary care.

2. Halt the Reduction of Military Medical End Strength

For the last several years there have been various proposals to dramatically reduce the number of military medical billets, including one in 2020 to reduce these billets by approximately 18,000 slots. While reductions of those numbers have not been fully realized, largely due to Congressional action requiring greater review and data analysis before any such reductions take place, the Coalition is extremely concerned that medical billet cuts may still be moving forward, which could harm families' access to care and potentially have negative unintended and long-term consequences. This includes disruptions to the medical education pipelines through the Uniformed Services University of the Health Sciences (USUHS) and other Graduate Medical Education (GME) programs that are integral to training pediatricians for military connected children and all children.

It is important to remember that uniformed pediatricians are critical in both general medical capacity (warfighting) and to honor the commitment to care for the family members of those who serve. While uniformed pediatricians have a long history of excellence as first-line physicians near combat, they are also distinguished in providing specialty and subspecialty care and saving children's lives who are critically ill. Without an adequate number of uniformed pediatricians, and training programs which instruct to the needs of the military, the medical care of military children, especially those living in isolated duty locations, will most certainly suffer.

Because major structural changes such as billet cuts can have far reaching unintended second- and third-order consequences, they should only be undertaken after conducting research, including work force analyses and communication with communities and stakeholders. Therefore, we strongly support the precautions in the FY2020 and 2021 NDAAs, emphasize the need to fully understand and address the short and long-term implications for families' access to care that would be caused by reductions in billets, and urge continued Congressional oversight.

3. Strengthen Coverage and Access to Mental, Emotional and Behavioral Healthcare Services and Supports

The Coalition urges continued focus on strengthening commitment to the mental, emotional and behavioral health for children of military families. From prevention, to early intervention, community supports, crisis care and better understanding and navigation of higher acuity care, we must make coverage and access easy and incentivized.

An August 2020 DoD Inspector General (IG) report confirmed DoD is not meeting outpatient mental health access to care standards for active duty service members and their families. Similarly, the findings of an August 2020 GAO report on eating disorders in the military confirm the Coalition's concerns, particularly screening and access to care for all Tricare covered

beneficiaries, including children. Furthermore, an article in the September 2019 issue of the *Journal of Health Affairs* also concluded that "[m]ilitary families whose children had complex health or behavioral health care needs reported worse health care access and quality than similar nonmilitary families. Addressing these gaps may require military leaders to examine barriers to achieving acceptable health care access… particularly for children with complex health or behavioral health needs."

These are just three of the latest compelling examinations of the inadequacies and barriers to care in all aspects of mental, emotional and behavioral health for Tricare covered children.

The Coalition recommends the House and Senate Armed Services Committees:

- Require DHA to implement DoD IG recommendations, including:
    - Establish a pilot program on MHS mental and behavioral health appointment schedulers for both direct and purchased care incorporating congressional oversight and reporting requirements
    - Institute a T-5 requirement for appointment availability as part of network adequacy reports as well as enhanced provider directory accuracy requirements specific to behavioral health care to eliminate duplicates, providers no longer practicing, wrong provider types and contact information.
- Specifically, in relation to the above IG recommendations, Congress should:
    - Specify that Tricare shall require a nationwide list of institutional and highly specialized providers accepting Tricare patients and provide accurate specificity in directories with respect to specialty focus, and ages served. This is necessary because those families needing higher acuity care for their children cannot just look "in their zipcode" – this is the kind of care that is highly specialized and not available in many locales.
    - Expand or build upon the Tricare Select Navigator pilot in implementing the mental health services scheduler pilot, referenced in the IG report and above, to further address the documented difficulties with respect to obtaining appointments, approvals, and authorization for behavioral health as well as complex conditions. The Coalition is pleased with initial reports that the Tricare Select Navigator pilot has been well received and effective for the families selected. Selected beneficiaries with two or more chronic or complex medical conditions, or who have claims totaling $100,000 per year receive assistance in navigating the system in various ways, like finding a provider, helping with scheduling appointments, etc. We would like to see more transparency and communication about the availability of the pilot in order to make sure it is being accessed by all eligible interested families, and we

also believe it could be a vehicle for providing assistance in these additional areas of demonstrated need as well.

- Make permanent the telehealth flexibilities implemented during the COVID national emergency, including permitting waivers for providers to serve Tricare patients across state lines to ensure access to critical mental, emotional and behavioral health care services.

- Ensure contractors continually credential mental health providers regardless of overall network adequacy status, and direct DHA to work with contractors to examine and improve the authorization process for institutional providers.

- Take appropriate steps to ensure that Tricare alignment with Bright Futures (AAP guidelines for preventive care) is being implemented appropriately to ensure children are receiving the recommended periodic screenings. Furthermore, look beyond Bright Futures to determine whether additional best practices, such as AAP screening guidelines specific to mental, emotional and behavioral health need to be implemented. Although Tricare announced it was adopting Bright Futures in 2018, anecdotally, it is unclear whether and how that is being implemented. Preventive screenings and early identification are more critical than ever given the mental and behavioral health challenges our children are facing as a result of the pandemic.

4. Improve ECHO – Habilitation, DME, and Home and Vehicle Adaptations

Congress created ECHO to guarantee that military families impacted by complex and chronic conditions or disabilities would be able to utilize the type of home- and community-based services (HCBS) that are offered through states, but are generally too difficult for mobile military families to access. However, the ECHO program must be updated in order to ensure comparable services are provided. The 2021 NDAA made TFK-championed improvements to ECHO, but left important elements for future consideration.

The Coalition believes that the ECHO program must specifically cover habilitative services, durable medical equipment (DME) and residence and vehicle modifications that are medically necessary for children. Habilitation is intended to help “attain, keep or improve” skills or functions (compared to “re-learning or re-gaining” as with rehabilitation) and critical for developing children. This coverage should include equipment and modifications, as children grow and develop more rapidly than is acknowledged by existing policies and practices often based on adult needs. Current regulations allow DME coverage, but the terms of coverage should be specified and codified. Most state waiver programs cover medically necessary home and vehicle modifications, but ECHO does not. This leaves military families at a disadvantage to similarly situated civilian families, particularly as ADA compliant base housing offerings are few, difficult to obtain, and families PCS often requiring multiple costly modifications during a career.

5. Recognize Dependency of Incapacitated Adult Children

Adult incapacitated children of servicemembers and retirees are dependents, which ensures Uniformed Services IDs, EFMP and Tricare eligibility, and any other rights and privileges afforded to military families. Recently it has come to our attention that the requirement of a financial dependency test to determine whether parents are paying at least half of the support for their adult incapacitated children is being inappropriately used to the detriment of the military family unit.

A June 2020 GAO report confirmed these concerns and set forth additional ones: "the policy provides limited guidance and inconsistent standards, resulting in the military services developing fragmented approaches for processing applications. … resulting in outcomes that vary among the military …[and] result in increased hardships for military families", including the loss of healthcare coverage and military base access. Furthermore, as noted by the GAO, the process in some instances values an adult disabled child at half that of other adults in the household. This on its face is an egregious civil rights violation that must be remedied at once.

Additional research, reported inconsistencies and the GAO findings leave the Coalition with many questions and concerns regarding the services' role in dependency determinations, particularly whether the services should even be engaged in these determinations.

Instead, Congress should step in to protect these vulnerable families by directing DoD to recognize and align with existing federal law defining and governing the treatment of adult incapacitation status and dependency.

Also of great concern is the inability or inconsistency of MHS systems for designating a patient as an incapacitated adult. Often, parents are told they cannot be given laboratory results or ask about consults, even with documented dependency and guardianship. We ask Congress to communicate to DHA the importance of addressing this issue and request that DHA examine and implement ways to better document and serve these patients and their families.

6. Provide a Mechanism for Communicating Beneficiary and Provider Problems

The Coalition urges Congress to improve the longstanding issue of accountability, by directing DHA to stand up a mechanism for beneficiaries/families and purchased and direct care providers to report complaints and concerns about Tricare coverage, denials, incorrect provider directories, network adequacy, access to specialized care within a reasonable distance from their homes, overdue or consistently inaccurate payments, and other related issues.

When bringing problems along these lines to the attention of policymakers and elected officials through the years, many times we hear the Department respond with some version of "we hadn't heard this was a problem" which begs the question, how would they hear of problems absent organizations such as ours collecting anecdotes, reaching out to beneficiaries and

grassroots, and conducting surveys. Often by the time problems reach the ears of those tasked with solving them, they have grown and festered, and in some cases caused irreversible harm to the families experiencing them.

We encourage DHA to implement a simple reporting tool for military families/beneficiaries and providers to report issues, that follows a simple flow chart for levying complaints, and to require accountability for monitoring and addressing them appropriate to their level of acuity or urgency.

Other federal agencies have implemented similar mechanisms such as the Center for Medicare and Medicaid Service's (CMS) HIPAA complaint portal, and CMS' Consumer Information and Insurance Oversight (CCIIO) portal for Mental Health Parity and Addiction Equity Act (Parity Act) violations. Another example of a quality portal is through The Kennedy Forum's Parity Complaint portal, which can be found here: Complaint Form | Parity Registry. Once again, we suggest no need to reinvent a wheel, instead DHA should model one or more of these examples.