Tricare for Kids Calls on Congress to Address the Needs of Military Children
Fiscal Year 2023 National Defense Authorization Act - March 2022

Tricare for Kids is a stakeholder group of children's health care advocacy and professional organizations, disability advocacy groups, military and veteran service organizations and military family advocates committed to ensuring that the military health system meets the unique health needs of the more than two million children covered by Tricare.

Everyday military families face challenges obtaining care for their kids at the right time, in the right setting, from the right provider. Families are often forced to navigate a complex health care system that is based on the needs of adults. While all children have unique needs as compared to adults, military children–particularly those with complex or chronic needs–face additional challenges due to the nature of their parents' service.

The health and wellness of military families play an important role in ensuring military readiness. Military kids deserve health care that is tailored for their unique health needs, which entails appropriate coverage, access to services, and a system that is accountable to its stakeholders.

To that end, TFK urges Congress to include in the FY23 NDAA the following provisions:

1. Establish a Pediatric Medical Necessity Standard and Align with Pediatric Best Practices

The Defense Health Board concluded that children covered by Tricare are disadvantaged from receiving necessary services because Tricare does not utilize a pediatric specific medical necessity standard and hierarchy of evidence that takes pediatric medical necessity into account. The DHB's December 2017 Pediatric Health Services report recommended DHA adopt such a standard, yet DHA has repeatedly refused to do so.

The pediatric specific definition of medical necessity recommended by the American Academy of Pediatrics (AAP) would 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, 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."

Furthermore, military children currently do not enjoy the same standard of care as their civilian counterparts covered by Medicaid, because Tricare has not adopted Medicaid's Early and Periodic Screening, Diagnostic and Treatment (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, 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.

Ostensibly, DHA adopted the AAP recommendations for preventive care, a schedule of childhood well care best practices called Bright Futures in 2018 after the Defense Health Board recommended it. However, there have been no announcements, education to providers, policy manual updates, or increase to reimbursement to reflect the coverage change. It is difficult, therefore, to know whether or how the new policy has been implemented.

These failures to account for the unique needs of kids is especially harmful in the context of the mental health crisis facing our nation's children and youth because these specific pediatric coverages are crucial to the prevention, screening and early intervention that can help reduce need for higher acuity and crisis care down the road. Historically, research has demonstrated that every dollar spent on prevention has a thirty percent return in the long run. With high percentages of children of military families covered by Tricare for many years as dependents, and high percentages becoming servicemembers themselves, it is less expensive for Tricare to invest in childhood services than deny them.

Congress must step in to:

- Require DHA to adopt the AAP recommended pediatric medical necessity definition
- Align standard of care with Medicaid by requiring Tricare to adopt the EPSDT standard
- Require DoD to take appropriate steps to ensure Tricare alignment with Bright Futures guidelines implemented appropriately to ensure children are receiving the recommended periodic screenings.
- Direct DHA to 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.

2. Strengthen Coverage and Access to Mental, Emotional and Behavioral (MEB) Health Care Services and Supports

Children in military and veteran families face all the typical stressors impacting their civilian counterparts, as well as unique factors such as a parent regularly in harm's way, or a parent's service-related injuries. Yet families continue to face barriers to care for their children's MEB needs. From prevention to early intervention, community supports, crisis care, to better understanding and navigation of higher acuity care, we must improve coverage and incentivize easy access for children and youth in military and veteran families.

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 TFK'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." While some challenges such as provider shortages are universal, there are certainly barriers to mental health care access that Congress can fix.

Instead, Tricare continues to be plagued by self-imposed barriers to access. For example, Tricare mental health copays have more than doubled since 2017 for active duty family members on TRICARE Select and all military retirees and their families.

Furthermore, In March 2021, DHA announced policy changes to the TRICARE Autism Care Demonstration (ACD). While appreciative of DHA's intended focus on family-centered care, TFK expressed concern about disruption in care and unreasonable program requirements, and supported the independent review ultimately directed by the FY22 NDAA. Further review, including input from providers and families has confirmed that the changes have curtailed access to care, such as discontinuing school and community settings and Activities of Daily Living such as toileting, and contain disruptive and unreasonable requirements such as a parent assessment.

It follows that implementation of policy changes under review should be placed on hold pending the outcome of the independent review, and an assessment of that review by the committees of jurisdiction. Otherwise, families, providers, and access to services for military children are disrupted by on-again off-again policies and requirements that may not survive the scrutiny of the review by the National Academies of Science, Engineering and Medicine (NASEM), and assessment by the committees.

Reports from families to date raise concerns that other changes implemented that would ostensibly assist families seeking care are not yet up to speed at the levels needed to support families, and until they are fully ready to be stood up, can be more of a barrier to access than an assistance. Furthermore, halting the changes pending review would

provide families more time to fill the void that has been left in their children's treatment by cuts in ACD services in schools and communities if those cuts survive review.

We appreciate the FY22 NDAA provisions that establish a pilot program on MEB appointment schedulers and require a feasibility assessment of extending COVID-related telehealth licensure flexibilities.

The Coalition urges continued focus on strengthening commitment to the MEB health for children of military families and recommends the following:

- Institute T-5 requirement for appointment availability as part of network adequacy, as well as enhanced provider directory information and functionality, as detailed in number 3, below. (Recommended by 2020 IG report).
- Specify that Tricare require a nationwide list of institutional and highly specialized providers and provide accurate specificity in directories with respect to specialty focus and ages served.
- Ensure contractors continually accept all categories of MEB health providers into the network regardless of overall network adequacy status, and direct DHA work with contractors to improve transparency and clarity around the authorization process for institutional providers.
- Reduce TRICARE mental health copays to address the financial barrier to access military families face (H.R. 4824 the Stop Copay Overpay Act).
- Place a moratorium on the 2021 changes to Autism Care Demo pending outcome of independent review ordered by FY22 NDAA.
- Make permanent the viable reimbursement and telehealth flexibilities implemented during the COVID national emergency, including taking steps to permit providers to serve Tricare patients across state lines (details tbd awaiting results of feasibility study required by FY22 NDAA).
- Ensure Tricare alignment with Bright Futures so that children receive recommended periodic screenings
- Continue to monitor reports required by, and analyze steps taken in, recent NDAAs to make additional changes and improvements as the opportunities are identified. This is critical to trying to get up to speed and then stay ahead of future needs.

3. Improve TRICARE Provider Directory Information and Functionality

Ensure military families can easily access current and accurate directory information for TRICARE-authorized providers. Because the DHA does not specify how directory information must be organized or presented, searching the managed care support websites for necessary care is time consuming and confusing, and too often yields no usable results. The issues go well beyond identifying a provider that is not currently accepting TRICARE patients, not identifying a provider that is recently authorized, or not identifying providers that are TRICARE-authorized but not participating in-network. The underlying categorizing of provider types and fixed search parameters are larger problems.

Provider directory points are included above, in section 2, because they are critical to improving access to mental, emotional, and behavioral care, but it is also important to understand the breadth and depth of the issue not only for MEB care, but also for many kinds of specialty pediatric care. For example, professional providers such as physicians, dentists, and other allied health professionals are searchable by practice specialty and zip code, with significant limitations. There is not a master list of provider types or specialties, so enrollees must guess at what words to enter in the search, results do not identify whether the provider serves special populations such as pediatrics or geriatrics, and the distance from the searched zip code cannot be changed by the user. Often, the categories are not specific enough to contemplate the universe of pediatric specialties, subspecialties and age ranges that are necessary information when seeking care for children with complex and chronic conditions.

Directory information for institutional providers has the same problems, made worse by the lack of an authorized institutional provider type within the fixed search radius of a zip code, as well as inconsistency with TRICARE policy identifying provider types. For example, for beneficiaries under age 21, TRICARE covers residential treatment centers providing mental health treatment, and the regulatory description excludes "facilities providing care for patients with a primary diagnosis of mental retardation or developmental disability." When searching the East region website for "residential treatment," five choices appear as drop-down selections. Logically, a user would assume that these are five distinct treatment settings, and they are all covered by TRICARE. In fact, none of these clearly and accurately describes the covered setting.

Institutional behavioral health treatment warrants particular attention in the provider directories for two reasons: the relative scarcity of authorized providers and the high acuity of symptoms and behaviors that require this level of care. For these reasons, both the managed care support contractors and DHA (e.g., through Military One Source) should make information about these providers highly visible and accurate, including target populations and conditions, and clearly identify both in-network and out-of-network authorized providers. When military families need to place a child or other dependent in an out-of-home treatment setting, it is critical that they be able to quickly review all the appropriate providers across the country. There will not be adequate, if any, providers in most zip codes or communities. The families should be able to see the geographic locations relative to family members, friends, or other trusted resources if the treatment placement is not close to home.

Furthermore, because basing decisions for Exceptional Family Member Program (EFMP) participants rely in part on provider directories, the fact they are often inaccurate, incomplete, or not specific enough, results in denials of duty stations unnecessarily, or placements in duty stations where children's needs cannot be met. When care can be found using directories, extensive wait times are not taken into account, thus flooding the market with additional care needs resulting in longer wait times for both military and civilian patients.

Thus, Congress should:

- Institute T-5 enhanced provider directory accuracy requirements specific to behavioral health care to eliminate duplicates, providers no longer practicing, wrong provider types and contact information. (Recommended by IG report. Same as 2. above)
- Specify that Tricare require a nationwide list of institutional and highly specialized providers (Same as 2. above)
- Require provider directory specificity with respect to specialty focus and ages served
- Upon assignment to a duty station, require EFMP assignment coordinators to provide families with the results of their provider queries confirming availability of services within the relevant access standards, that were used to determine the basing decision.

4. Halt the Reduction of Military Medical End Strength

TFK continues to be concerned about proposals to dramatically reduce the number of military medical billets in each of the services. The proposed billet cuts and restructuring could harm families' access to care and potentially have negative unintended and long-term consequences, including 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.

Concerns are especially relevant with the American Academy of Pediatrics (AAP), the American Academy of Child and Adolescent Psychiatry (AACAP) and the Children's Hospital Association (CHA) recently declaring a mental health emergency for children and adolescents. There is already a mental and behavioral health provider shortage in the Military Health System (MHS) documented in a January 2022 DoD report on behavioral health requirements, and further reductions in pediatricians and mental health clinicians would jeopardize availability of care. 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.

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. This was recently demonstrated in uniformed pediatricians' role in caring for families leaving Afghanistan. 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 lives of critically ill children.

In addition, major structural changes such as billet cuts can have far-reaching, unintended, second- and third-order consequences. In fact, one study has demonstrated a loss of surgical skills for military surgeons due to moving care out of MTFs and shifting care to civilian facilities. Another study showed that limiting access to military hospitals and treatment facilities could worsen quality and safety of care for military families. Any proposed medical billet cuts should only be undertaken after conducting research, including workforce analyses and communication with communities and stakeholders. We strongly support the precautions and pauses in previous NDAAs, including Sec. 721 of the FY 2022 NDAA that requires a report by the Comptroller General's office within one year of enactment on the analyses used to support any reduction or realignment of military medical manning, and continued Congressional oversight to fully understand and address the short- and long-term implications for families' access to care that would be caused by reductions in billets.

- Maintain the current status for review of medical billet cuts pending comprehensive analyses of impact.

5. Improve ECHO to Fulfill Purpose of Providing Medicaid Waiver Services to Mobile Military Families

The Extended Care Health Option (ECHO) program, created by Congress to guarantee that military families impacted by complex and chronic conditions or disabilities would be able to utilize the same type of home and community-based services that are offered through the states but are generally too difficult for mobile military families to access, must be updated to ensure those services are comparable to home and community-based services that are offered through the states. The 2021 NDAA made TFK-championed improvements to ECHO, including increased respite hours, but left important elements for future consideration. The FY22 NDAA directed a study of continuity of care provided by the ECHO program, due in March 2022. As of March 18, the report is not available. Pending its outcome, additional solution sets may be identified. Meanwhile, important issues are still unresolved.

Habilitation is intended to help "attain, keep or improve" skills or functions (compared to "re-learning or re-gaining" as with rehabilitation) and is critical for developing children, but not covered by ECHO, nor are residence and vehicle adaptations, especially egregious given the shortage of ADA accessible military housing. ECHO may cover service and modification of durable equipment and assistive technology devices, as well as training in usage, but this has not been codified, which would ensure its application. The coverages should specifically include both equipment and modifications, as children grow and develop more rapidly than is acknowledged by existing policies and practices that are often based on adult needs.

Certain medical equipment or services for rare or unusual conditions, even when covered, are not available. This is a small volume but a key constituency – the most vulnerable whose needs most often go unmet to the continued detriment to their health and wellbeing, and the mental and emotional health and wellbeing of their families. This issue appears to be almost entirely one of reimbursement. The medical conditions that prompt the need for unique and rare equipment and services are complex but ensuring provision of those services is not. Tricare has failed families by having no set protocol, and no set reimbursement, and a history of abysmal reimbursement for certain of these equipment and services. Therefore, even when covered, a need goes unmet because there are no providers who are willing or able to contract to provide them. Examples include a combination blood pressure and pulse oximeter monitor

that can be worn all night, and a lift to load a wheelchair into a vehicle. These items are ostensibly covered but rarely fulfilled. Thus, we are asking Congress to step in and require action.

Additionally, there is a great deal of confusion and misinformation for Guard and Reserve families who may become eligible for ECHO and EFMP, regarding their eligibility and responsibilities. Because there is not a defined universe of those eligible, it is difficult to disseminate correct information to combat the misunderstandings.

Congress should act now to address these gaps:

- Require ECHO to cover habilitative services, durable medical equipment (DME) and residence and vehicle modifications that are medically necessary for children.
- Address the problem within ECHO that certain medical equipment or services for rare conditions, which are ostensibly covered, are rarely fulfilled, usually because of lack of reimbursement policy or failure to pay.
- Direct a GAO study to determine the universe of Guard and Reserve eligibility for ECHO/EFMP.

6. Recognize Dependency of Incapacitated Adult Children (AIC)

Adult incapacitated children (AIC) of servicemembers and retirees are dependents, which ensures Uniformed Services IDs, Tricare eligibility and any other rights and privileges afforded to military families.

DoD defines and designates dependency for military families. As discussed more fully in a June 2020 GAO report, the processes for determining AIC dependency "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 health care coverage and military base access. Furthermore, as noted by the GAO, the process in some instances assigns a value to 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.

At the very least, the process for determining dependency for adult incapacitated children must be consistent, clear, streamlined, nondiscriminatory, and provide due process. However, we believe determinations of disability are more appropriately made pursuant to established disability law and policy, as it is not a core DoD expertise and recommend allowing DoD to simply recognize and accept determinations made by federal and state authorities with jurisdiction and expertise, rather than requiring military families to navigate two disparate systems for dependency and guardianship.

The committees must require accountability to address systemic problems. An FY22 NDAA directed report, due February 2022, has not yet been made available as of March 18. Without that report it is unclear whether or when families will see relief. Clearly, no action has yet been taken, resulting in continued "increased hardships for military families" per the GAO report that cataloged many of the issues and led to the FY22 NDAA provision.

Also of great concern is the Military Health System (MHS) inconsistency in policy and practice for incapacitated adult patients. 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 the rights and responsibilities surrounding AIC and their families, and request that DHA examine and implement ways to better document and serve these patients and their families.

Congress should protect these vulnerable families by directing DoD to:

- Recognize civilian dependency determinations, and align with existing federal law defining and governing the treatment of adult incapacitation status and dependency.
- Address the MHS policy and practices for appropriately identifying and serving AIC and their families.

7. Provide a Mechanism for Communicating Beneficiary and Provider Problems

Congress should improve 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.

We ask Congress to:

- Direct 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 require accountability for monitoring and addressing them appropriate to their level of acuity or urgency.

8. Tricare Coverage of Young Adults to Age 26

Align Tricare with a benefit that has been available to civilian families since 2010. This alignment would allow every military child under the age of 26 to continue receiving steady coverage under their parent's plan, just as their civilian counterparts may, for a more comprehensive and seamless transition to a healthy adulthood. Military families deserve parity and the peace of mind that their children have health care coverage while pursuing any manner of further education, trades, or early career choice. This coverage into young adulthood is more important now than ever for military connected youth, as the nation emerges from both twenty years of war, the burden of which has been borne squarely on the shoulders of their families and communities, and a pandemic that has upended teens' routines, plans and disrupted their typical trajectories with ramifications that we have yet to fully evaluate or understand.

- Require Tricare to allow children up to age 26 on their parent's plan.