Fiscal Year 2024 National Defense Authorization Act

Everyday military families face challenges obtaining care for their kids at the right time, in the right setting, from the right provider. While all children have unique needs as compared to adults, military children face additional challenges due to the nature of their parents' service.

The practical difficulties that accompany deployments and frequent relocations must be taken into consideration in fashioning the medical, educational, and social policy necessary to support these military children and their families. These considerations take on an even higher significance when a child has a complex or chronic medical condition or disability.

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.

Tricare for Kids, 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 2.4 million children covered by Tricare, asks Congress to:

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

The Defense Health Board concluded in 2017 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 and recommended DHA adopt such a standard, yet DHA has 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.

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*

2. Protect Safe Access to Medication and Pharmacy Care for Children

The recent Tricare pharmacy contract (TPharm5) made major cuts in its pharmacy network targeting independent and community pharmacies as well as specialized pharmacies which are often needed to craft medication that will meet unique needs of children. After an immediate outcry from families and providers, DoD and Express Scripts (ESI) re-opened the network briefly in December but made no substantive or reimbursement changes.

Furthermore, through the retail pharmacy contract, Tricare is implementing policies that require children and youth with well controlled regimens to drop their current medications and try other options until they fail, instead of allowing continuity of care on the medication prescribed by the child's provider. The policies embedded in ESI authorization forms include requirements that children "fail first" on "preferred" medication before they can obtain or even refill the medication prescribed by their provider and do not appear to make exceptions for children who are stable on their current medication.

Children, especially those with chronic or complex medical conditions, often need customized medication for their size, weight, age and complexities, and customized pharmaceuticals are not generally available from commercial pharmacies. It has been estimated that in a children's hospital as much as 70 percent of the medications dispensed require some type of pharmacy customization. For example, medications commercially manufactured for adults are often packaged in doses too large or too strong to be given to children and must be divided down into smaller doses or diluted, must typically be preservative-free, and often must be converted from solid to liquid for infants who cannot yet eat. Parents cannot just take a bottle of large pills and "break them into small pieces" for an infant. Typical chain pharmacies usually do not provide the kind of explicitly detailed modifications unique to that child. Families generally rely on a hospital's in-house pharmacy or an independent community-based pharmacy to provide these exacting requirements. These very pharmacies were cut from Tricare's network.

Another wrinkle making flexibility necessary for meeting children's unique medication needs is that children at times must rely on "off-label" use of medications, i.e., drugs that have not been tested specifically for children. Although pediatric providers are adamant advocates for more pediatric specific research, and improvements have been made, many medications were not tested specifically on children for a range of reasons, and children's access to this off-label medication in many instances must be protected with flexibility in coverage policies. This type of limited – or fail first-formulary structure does not adequately account for pediatric considerations, as very specific, tailored and sometimes off-label medications are frequently prescribed to children, particularly for unique child populations, such as children with chronic or rare diseases. Many new gene therapies must be administered when first symptoms are identified, to be most effective. Any delay in providing these drugs due to a requirement to "fail first" or to seek an exception to policy could lead to worsening of the condition and/or result in higher costs.

Similarly, children grow and develop quickly and cannot afford the disruption of care and harm that can occur while "failing first" on the "preferred" formulary medication, or either being forced to use off-label medication or being refused off-label usage. This is particularly concerning for children being treated for seizure conditions or a mental health diagnosis. These children and their families spend months working with their doctor searching for a drug that works for their condition, with their body chemistry. Under a closed/limited formulary structure the child's current prescription may not be covered causing a potentially problematic interruption to the child's care plan.

Families are also reporting that because of these barriers, they are resorting to filling necessary and successful medications on their own, out of their own pockets. This is not sustainable, and not a way to sustain the Force of the Future. Military families deserve better, and it is sure to be reflected in recruitment and retention trends if access to care continues to be impeded. Furthermore, military families have little to no work around measures, as they are not eligible for drug manufacturer programs such as co-pay assistance because they have a federal health insurance plan.

To date much of the discussion around the TPharm5 cuts has been around problems with rural access, an important consideration, but TFK is concerned that neither Congress nor Tricare has the full picture of the ramifications of the recent TPharm5 cuts to critical pharmacy providers and the dangerous fail-first policies that will harm our most vulnerable children of military and veteran retiree families covered by Tricare.

Tricare access standards, focused only on drive time to the nearest network pharmacy, do not adequately capture the barriers faced by families of medically complex children after losing access to pharmacies that offer specialized services, limited distribution drugs, or niche locations (e.g., hospital lobbies or other medical provider settings). Tricare should allow flexibility in contracting to include hospitals' specialty pharmacies, community-based and independent pharmacies that are necessary to meet children's unique needs and covering in a timely manner the drugs that are considered appropriate by the prescribing provider.

TFK therefore requests a comprehensive study by GAO to:

- *determine the scope of the pharmacy cuts and how they impact access to medication for children, especially those with rare, complex or chronic conditions, and likewise,*
- *analyze the scope and impact of the policies that were embedded in the contract such as fail-first and off-label requirements, and whether these policies are valid in that context, or must be promulgated as federal regulation;*
- *examine whether military families are disadvantaged from receiving drug manufacturer cost share assistance because Tricare is considered a federal health insurance plan, and what steps should be taken to provide parity with the civilian sector*.

3. Coverage of Pediatric Fluoride Varnish

Tricare ostensibly adopted *Bright Futures*, the American Academy of Pediatrics periodicity guidelines for preventive care, in 2018. However, in practice and because of lack of policy communication, it has been difficult to ascertain whether this has actually occurred.

For example, to date Tricare does not cover the fluoride varnish offered to children in both primary pediatric physician visits as well as dental offices. This is covered preventive service without cost share by Medicaid and all plans subject to the Patient Protection and Affordable Care Act. The USPSTF recommended in 2014 that primary care clinicians apply fluoride varnish to primary teeth of all infants and children starting at the age of primary tooth eruption. In 2021, the USPSTF recommended that all children younger than 5 years should receive fluoride varnish. As such, all children age 5 and younger including those in military families, deserve to have application of fluoride varnish fully covered, as per USPSTF recommendations and as a separately paid service (ie, not considered incidental to the office visit). At this point in time, Tricare is the only payer that does not cover fluoride varnish and other fluoride preparations, although it states to Congress and publicly that it has adopted Bright Futures guidelines.

Dental caries (tooth decay) is the most common chronic disease of childhood, a "silent epidemic" that disproportionately affects poor, young, minority populations and children living below 100% of the poverty level. Children with special health care needs, including those with developmental delay, complex neurodevelopmental disabilities, or congenital heart disease are also affected disproportionately. This difference may be attributable to challenges with home care routines such as toothbrushing and use of medications with high sugar content, among other factors. In a retrospective longitudinal study of children with autism spectrum disorder, Down syndrome, congenital heart disease, and cerebral palsy, the study determined that the caries risk among the group of children with special health care needs was higher than among the control group, but the risk differed significantly by diagnosis. The caries burden was greatest in children with congenital heart disease, followed by those with autism spectrum disorders.

Fluoride varnish is a concentrated topical fluoride applied to the teeth that sets on contact with saliva and prevents dental caries. Advantages of this modality are that it is well tolerated by infants and young children, has a prolonged therapeutic effect, and can be applied by both dental and nondental health professionals in a variety of settings.

Congress must specifically require Tricare to cover fluoride varnish for best health outcomes and to provide equity with those covered by commercial insurance and Medicaid.

Congress should:

- *Require DoD to include fluoride varnish as a covered benefit, and take appropriate steps to ensure Tricare alignment with USPSTF and Bright Futures guidelines are implemented appropriately to ensure children are receiving the recommended preventive care.*

4. Improve Tricare Provider Directory Functionality for Pediatric Behavioral and Specialty Care

Ensure military families can easily access current and accurate directory information for Tricare authorized providers. for higher acuity behavioral and mental health care for children and other pediatric specialties.

This request is not a typical "out of date information" or "wrong address" complaint (those challenges exist as they do in all provider network directories), rather a description of how the underlying categorizing of provider types and fixed search parameters are larger problems for pediatric specialty care.

For example, professional providers such as physicians, and other 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, 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. Similarly, highly specialized pediatric providers and institutional/residential care are NOT found in every, or even most, zip codes.

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, and importantly their referring providers, be able to quickly review all the appropriate providers across the country. The families and referring providers 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.

Thus, because highly specialized pediatric care – particularly higher acuity behavioral and mental health providers and institutional care options – are not found in every, or even most, zip codes, Congress should:

- *Specify that Tricare require a nationwide list (rather than zip code based) of institutional and highly specialized pediatric providers*
- *Require provider directory specificity with respect to specialty focus and ages served*

5. Protect Military Medical Training, Billets and End Strength

The Coalition continues to be concerned regarding reduction and realignment of medical billets negatively impacting access to care for military families in both the short and long term, and therefore appreciates and strongly supports the Committees' provisions in the FY23 NDAA and urges continued oversight and increased transparency.

The uncertainty of the last few years surrounding proposed billet cuts and restructuring is still posing a threat to families' access to care and causing negative unintended and long-term consequences 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 around recruiting for and filling the training slots and residency vacancies that have been in question because of reductions and restructuring. To ensure that the military health system continues a robust uniformed medical presence, which is critical to access to care in both the direct care system and civilian sector, TFK recommends a study examining all aspects of the challenges and opportunities for recruiting and retaining pediatricians including whether available incentives are competitive with the private sector.

Congress should:

- *Maintain the current status and oversight of medical end strength.*
- *Commission a GAO study examining the challenges for filling training slots, residencies and billets, including comparison with private sector incentives and recommended improvements if necessary.*

6. Fill ECHO Gaps to Provide Parity with Medicaid Waiver Services for 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 they are meaningful and comparable to civilian benefits. The following issues are still unresolved.

Extended Home Health Care (EHHC) Nursing Services

The intent of the EHHC benefit (a subset of ECHO) is to allow a disabled beneficiary to live at home and avoid the costly expenses and negative outcomes associated with long term skilled care facility care. Tricare prohibits the use of the EHHC benefit if the primary caregiver is employed or seeking an education. While this is questionable policy in and of itself, it is contrary to many other policy initiatives such as those attempting to incentivize spousal employment opportunities, and effectively prevents many otherwise eligible families from accessing the benefit. For example, single parent servicemembers and dual military families are automatically disqualified from utilizing nursing service because the parent or parents are employed.

Habilitation, Equipment and Adaptations

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.

Congress should:

- *Require DHA to allow the primary caregiver to be employed or enrolled in school while accessing EHHC services.*
- *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.*

7. Recognize Dependency of Incapacitated Adult Children (AIC) By Virtue of SSI Beneficiary Status

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. At the very least, the process for determining dependency for adult incapacitated children must be consistent, clear, streamlined, nondiscriminatory, and provide due process. However, it is none of the above. This determination authority is not a core DoD expertise. The process is harming vulnerable military families and negatively affecting retention efforts.

TFK strongly recommends 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.

To this end, the committees must require accountability to address systemic problems. The Coalition appreciates greatly the provision in the FY22 NDAA directing a report, due February 2022, but to this date – March 2023 – the report has not yet been made available. 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 2020 GAO report.

With continued delay, this has now become a crisis, and needs immediate action. While TFK remains committed to overhauling the entire process, we request immediate legislative intervention to protect families now by:

- *A legislative declaration that providing documentation that* ***the adult child of a servicemember or retiree is a social security disability beneficiary comprises automatic determination of adult incapacitated child status for all of DoD purposes.***

Congress should furthermore protect these vulnerable families by directing DoD to swiftly comply with the FY2022 directive for a report that was due more than a year ago, and move forward with a plan 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.*

8. Tricare Coverage of Young Adults to Age 26 on Parent's Plan

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 cover children up to age 26 on their parent's plan.*