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SUMMARY AND ANALYSIS BY THE TRICARE FOR KIDS STAKEHOLDERS COALITION

Initial Response:

“Study on Health Care and Related Support for Children of Members of the Armed Forces”

September 2014

BACKGROUND

On July 15, the Under Secretary of Defense for Personnel and Readiness, the Honorable Jessica L. Wright, submitted a Report analyzing pediatric health care coverage under TRICARE to the House and Senate Armed Services Committees. The Report, commonly referred to as the “TRICARE for Kids (TFK) Report,” was a requirement of Section 735 of the Fiscal Year 2013 National Defense Authorization Act (NDAA), directing the Secretary of Defense to conduct a comprehensive review and analysis of health care provided to dependent children of members of the Armed Forces.

The TRICARE for Kids Stakeholders Coalition, consisting of pediatric provider organizations, military and veterans’ service organizations, disability groups and military families, has been working since January 2013 for the purposes of providing input to the Department of Defense (DoD) on its provision of healthcare to our military children and coordinating next steps. The Coalition appreciates that its feedback and recommendations were included for consideration in the TFK Report and has asked Secretary of Defense, the Honorable Chuck Hagel, to also incorporate the feedback into the recently directed 90 day review of the military health system.

While each organization has its own perspective and priority issue areas, in order to provide an easy-to-reference summary and response to the TFK Report, *the Coalition has compiled the following from analyses, concerns and reactions collected from partner organizations and military families.*

EXECUTIVE SUMMARY

The TFK Report concluded that the Military Health System (MHS) is meeting the needs of children in its care—including those with special health care needs—as specifically addressed under each of the nine elements listed in Section 735. This overall finding is not surprising, as this Report was an internal review conducted by the Defense Health Agency (DHA), which administers the TRICARE program.

Although the Report concluded that TRICARE was meeting the needs of children, it also acknowledges in every element of the study that there are significant “gaps,” “areas for clarification” and considerable deficiencies in data collection, utilization and analysis. These findings might be better described as “areas in need of improvement.” These gaps and findings align with many of the areas identified and recommendations made by Coalition partners to the DoD for consideration in preparing the Report. Those areas are ripe for and in need of immediate attention. TFK stakeholders are pleased that the Report acknowledges areas of concern and urges action in a timely and collaborative manner.

An overarching theme woven throughout the Report is the lack of data and meaningful utilization of data, or inability to collect data, which then limits the analysis in many of the elements examined. Many areas, such as specialty care, the Extended Care Health Option (ECHO) program, care management and the Exceptional Family Member Program (EFMP), lack sufficient data to support the DoD’s conclusion that it is providing adequate care and support, particularly to military families with special needs. This lack of data and appropriate analysis is consistent with a recent *New York Times* article [“In Military Care, a Pattern of Errors but Not Scrutiny.”](#) published on June 28, 2014. The Coalition aligns itself with the comments of Dr. Jonathan Woodson, the Assistant Secretary of Defense for Health Affairs, in a [follow-up](#) to the *New York Times* investigation:

“The people we serve expect us to improve. The American public expects us to improve. We expect ourselves to improve.” Woodson called for greater attention to patient safety and more openness about problems in treatment. “In moments like these, it can be easy to close down,” he said. “We need to do the opposite. We need to become even more transparent.”

In each of the nine areas of the Report, the TFK Coalition identifies substantial opportunities for the DHA and the DoD to work with the Congress and stakeholders to collect better data, increase transparency, enhance safety and institute changes to improve TRICARE for one of our most valuable resources, our military children.

OPPORTUNITIES IN THE REPORT TO IMPROVE CARE AND CARE EXPERIENCES FOR MILITARY CHILDREN

Short-term Goals

There are many steps that can be taken to address specific shortfalls, gaps and need for more clarification and collaboration acknowledged in the Report, including:

- Align with preventive benefits available through the Patient Protection and Affordable Care Act (ACA), Bright Futures and Medicaid’s Early and Period Screening, Diagnostic and Treatment (EPSDT).

- Align medical necessity definition for purchased care sector with AAP recommendation and broader definition allowed in the direct care system to ensure a consistent benefit and care.
- Create a pediatric physician advisory group with internal and external practitioners that meets on a regular basis to provide pediatric specific perspective on policy and practices.
- Establish an Advisory Panel on Community Support for Military Families with Special Needs as [required by law](#).
- Amend the inpatient only list TRICARE adopted from Medicare for pediatrics.
- Several reimbursement areas cited in the Report could be addressed right away as an indication of good faith and a pathway toward streamlined processes. These could be implemented in conjunction with a pediatric payment advisory group.
- Adjust definitions and provider categories as necessary to cover medical nutrition for children with complex nutritional needs.
- Implement internal ECHO reforms and increase flexibility of ECHO benefit to ensure that it aligns with the Centers for Medicare & Medicaid Services (CMS) standards for community based supports and provides improved access and continuity of care to families.
- Pediatric appropriate regulation of compounded medication coverage.
- Convene data stakeholders advisory group to assist with metrics, appropriate comparisons, etc. for pediatrics including complex care and care coordination and management.
- Immediately adopt mental and behavioral health standards more commonplace in pediatric care systems such as wrap around care, intensive outpatient programs, family centered care, community based care and uniform access to specialty care.
- Remove artificial barriers to residential treatment center certifications.
- Particularly with regards to EFMP families, compile recommendations from the many recent reports and studies and create a checklist of action items and issue areas to address. Tackle in collaboration with internal and external stakeholders.

Long-term Goals

While there are many more long-term goals that need to be addressed, it is imperative for integrity of the system that work begins on the following:

- The lack of data, inefficiency of collection and analysis and inability to meaningfully utilize data must be addressed for the long-term.
- Ensure qualified EFMP beneficiaries have access to Medicaid waiver services through Medicaid reform.
- Streamline process for pediatric-specific coverage and reimbursement issues that are child/patient centered.
- Implement coding changes that more accurately reflect pediatric care such as APR-DRGs.
- Allow TRICARE to formulate policies and coverage with best practices identified and recommended by other federal agencies with substantive oversight; for example, instead of conducting its own analyses regarding substance abuse treatment and mental and behavioral health on which to design policies, utilize SAMSHA studies and reports.

Collaboration is Critical

There are many situations in which collaboration with the civilian sector could help the DoD and DHA, for example, with respect to data, to determine which data to collect, how to meaningfully analyze for pediatrics, preferred metrics and assistance with civilian sector comparisons. Some of these areas include alignment of services available under Medicaid's EPSDT program, the ACA and Bright Futures, assessing access to specialty care and building of a complex care management and coordination system.

It is imperative that the DoD refrains from reinventing the wheel in order to address each of these areas in the Report. While some of the issues are unique to the DoD, such as the interaction of EFMP, ECHO and other support programs run by the military branches, and TRICARE and other programs run by DHA, many of the issue areas are those in which civilian organizations have expertise, interest and a commitment to serving military families. Public-private partnerships are critical to addressing the issues and findings in this Report, and TFK Coalition partners stand ready to assist, consistent with the [Joint Chiefs of Staff White Paper on Expanding Public Private Partnerships](#).

NEXT STEPS

Over the past few years, there have been numerous studies, hearings, surveys and GAO reports detailing the significant barriers facing special needs military families in accessing healthcare and support services. There have been countless recommendations but little action. The TFK Report is unique but consistent with findings of other recent reports and studies. When compiling feedback from stakeholders to formulate this response to the TFK Report, families' frustration was evident, as demonstrated by this comment:

“It took veterans dying before action was taken to address VA problems; similarly the 90 day review of the military health system was ordered by Secretary Hagel after several high profile tragedies. We request our DoD leadership, both civilian and military, to act much more quickly and decisively to address health care for children, particularly our most vulnerable children with special health care needs. All indications in this Report, as well as previous studies, are of systemic issues which need to be addressed expeditiously, not after collecting five or ten years of data. We need our leaders to step up to ensure that what happened at the VA isn't repeated with our military kids.”

Indeed, although requested by Congress, the Report did not set forth a plan to “improve and continually monitor” pediatric care. Therefore, an ongoing dialogue between the DoD and stakeholders, along with close monitoring by Congress, is in order to ensure next steps are taken and that pediatric care is continually monitored and improved.

The TFK Coalition plans to meet with the DoD, the DHA and the House and Senate Armed Services Committees (HASC and SASC) to discuss next steps to implement solutions that address gaps and clarify and improve areas of concern, including possible legislative fixes to the deficiencies noted in the Report. The group is preparing for a Congressional briefing and is requesting HASC and SASC hearings to discuss these important findings and next steps as part of the 2016 NDAA process.

Although the Report itself does not technically make any recommendations for legislation as requested by Congress, it states “recommendations concerning the issues discussed in this Report will be evaluated for possible submission as part of DoD's annual Unified Legislation and Budgeting (ULB) Process.” The Coalition also plans to meet with DHA to review the ULB process and changes DHA might propose in this process that would not require additional legislation.

The TFK Coalition appreciates the opportunity to work with Congressional and DoD leadership to implement improvements identified by stakeholders and acknowledged in the TFK Report, and ***urges Congress and the DoD to act quickly and decisively to address gaps and findings presented.***

DETAILED ANALYSIS

Below are summaries and analyses of each of the nine elements that DHA examined in the Report.

1. A comprehensive review of the policies of the Secretary and the TRICARE program with respect to providing pediatric care.

Medical Necessity

The TFK Coalition appreciates that the Report acknowledges children have unique health needs, and that TRICARE definitions of medical necessity and the hierarchal evidence for approval of treatments are not always aligned with pediatric practice standards.

The Report explains that DHA has differing statutory criteria for determinations of medical necessity in its purchased care sector as compared to the direct care system. This results in an inconsistent benefit for military families. Citing a commitment to “evidence-based medicine,” TRICARE states it is authorized to approve purchased care only when it is “medically or psychologically necessary and appropriate care based on reliable evidence, and rendered by a TRICARE-authorized provider in accordance with other TRICARE program requirements.” DHA hierarchy of reliable evidence includes only “published research based on well controlled clinical studies, formal technology assessments, and/or published national medical organization policies/positions/Reports.”

There is no doubt that evidence of effectiveness is a cornerstone of medical necessity, yet such tightly prescribed data for children is not always readily available. Due to their very nature of constant growth and development, and the societal responsibility to protect children, they are not always the subject of such controlled and prescribed studies. Pediatric providers are adamant advocates of robust research for children’s health needs, but the reality is that strict adherence to this adult based standard of reliable evidence will result in children not receiving the care and treatment they need that is widely and more quickly accepted and practiced elsewhere in the healthcare system.

The Report then acknowledges that definitions of medical necessity differ between the broader healthcare system and TRICARE. As such, the Report identifies a gap in the TRICARE medical necessity standard. The Report cites stakeholders being “confused or unaware” of TRICARE coverage and limitations related to the requirements for medical necessity in the “purchased care” component. The TFK stakeholders suggest that the gap is less about stakeholder confusion and more about the result that children in the military are denied care and treatment options that are commonly recognized as medically necessary by other health plans and payers.

The Report advises examination of two areas for clarification to address the shortcomings of TRICARE’s medical necessity standard:

- Review processes for evaluating emerging technology in use in the general community but not supported by the hierarchy of evidence required for the TRICARE purchased care program.

- Review regulatory provisions for TRICARE program cost-sharing of care that appears to have gained acceptance in the larger medical community but does not meet the TRICARE-specific definition applicable to the purchased care component.

As proposed by many of the stakeholders, this examination provides the opportunity for TRICARE to adopt the American Academy of Pediatrics (AAP) definition of medical necessity as described in its July 2013 Policy Statement "[Essential Contract Language for Medical Necessity in Children:](#)"

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.

An appropriate pediatric specific definition of medical necessity creates the framework for appropriate coverage, access quality and reimbursement for pediatric care, making bureaucratic appeal and exception policies and practices less necessary, and lessening the burden of overcoming such barriers on families and providers. Formulating such policy is integral to improving health care for children of military families.

Bright Futures/Medicaid EPSDT/ACA Requirements

The Report states emphatically that the military health system “fully supports the basic tenants of AAP’s Bright Futures program, including its screening tool for screening autism and developmental screening at each visit through five years of age.” The MHS provides well child care that covers services provided to children from birth through age five years, which includes “routine newborn care, health supervision examination, routine immunizations, and periodic health screening and developmental assessments in accordance with AAP guidelines.” However, the Report also notes that at six years of age, the well child benefit ends and children are then covered under the clinical preventive services as outlined in the *TRICARE Policy Manual*, and that the TRICARE preventive care program as it relates to pediatric beneficiaries does not conform to the AAP periodicity guidelines under Bright Futures.

Because of this finding, the Report lists as a gap that the preventive care benefit “is not consistent with ... AAP’s Bright Futures program.” It encourages an analysis of the utilization of health care benefits by children ages 6 to 21 years to assess if developmental- and age-appropriate care is being delivered as compared to not only AAP Bright Futures guidelines, but also the Patient Protection and Affordable Care Act (ACA) and Medicaid’s Early and Periodic Screening Diagnostic and Treatment (EPSDT) services. Better alignment with these guidelines will not only result in better care for active duty families, but also ensure a smoother transition to the civilian healthcare markets for the hundreds of thousands of veteran families expected in the next decade and beyond.

This review and resulting further alignment with the ACA, EPSDT, and Bright Futures is appropriate and encouraged.

Habilitative Care

The Report notes that rehabilitation is a covered TRICARE benefit when medically necessary, but habilitation services are available only for Active Duty Family Members (ADFM) through the ECHO program and are subject to an annual dollar limit of \$36,000 per year. The Report claims there is a current statutory exclusion of habilitative care from the TRICARE Basic program. This varies from the ACA which

recognizes habilitative services and devices as an essential health benefit without lifetime or annual dollar caps on care.

Identifying this lack of habilitative care as a possible gap in coverage, the Report notes that DHA should determine if the current benefit of habilitative care authorized under ECHO only for ADFMs promotes age-appropriate and developmental support for children along with skill attainment and sustainment that is distinct from rehabilitative care, and whether to specifically cover habilitative care under the Basic program.

Habilitative services, provided in order for a person to attain, maintain, or prevent deterioration of a skill or function never learned, are uniquely necessary for children, due to their stages of growth and development. Habilitative services should be covered as a basic health benefit as medically necessary, just as rehabilitation services are covered.

Compounded Medications

The Report acknowledges that pediatric patients often use compounded medications based on their medical needs and developmental abilities and to increase the palatability of medications. This is well documented. 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. However, in November 2013, TRICARE sent beneficiaries notifications that their prescriptions of compounded medications would no longer be covered. TRICARE then suspended implementation of this policy, in response to confusion generated and outcry from the beneficiaries and providers, pending publication and review of a qualifying list of medications by the Food and Drug Administration.

The Report contains a finding that the announced but deferred halt of coverage for compound medications in 2013 “may have negatively affected pediatric beneficiaries.” To address this, the Report suggests a review of the usage of compounded medications for pediatric beneficiaries and a review of the impact of the DHA decision on coverage for compounded medications.

This review is warranted and should take into account children’s need for specialized pharmaceuticals. There are many instances in which compounded medications are the only safe and effective medications for children. This can be the case for children with chronic disabilities, for those with allergies to commercial additives, or infants and children who cannot tolerate an adult dose, for lifesaving medications that must be specially formulated, and in cases of drug shortages in which medication is not otherwise available. 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. It is vital that TRICARE tailor its regulations to protect all pediatric pharmaceutical usages.

Nutritional Therapy

The Report identifies a potential gap in the way TRICARE defines and therefore covers nutritional therapy. Medical nutrition is too narrowly defined and counseling and management are only covered as part of diabetic care. The finding is consistent with the broader concern that TRICARE is not keeping pace with current best practices nationally for specialized pediatric care. The TFK Coalition applauds the Report’s acknowledgement that TRICARE lacks proper information of numbers and conditions for which medical nutrition management and therapy are necessary. The Report’s recommendation that TRICARE determine the extent of use of special metabolic formulas by children with complex metabolic or digestive disease to

maintain essential nutrition and medical food, and assess the benefit of nutritional counseling and management when provided by nutritionists and/or registered dietitians as authorized providers for children with complex medical and metabolic medical conditions, is valid and should be done in consultation with experts in the relevant specialized pediatric care.

ABA Therapy

The TFK Report did not specifically analyze the MHS coverage of applied behavioral analysis (ABA) as a treatment option for children with developmental disabilities. However, the specific coverage of ABA and related therapies has been an evolving front, through the use of demonstration projects and more, moving from an ECHO benefit toward a medical benefit for beneficiaries with autism, as described in the Report. This is in keeping with accepted practices in the broader healthcare system, and an example of a treatment option for which private sector and other government payers are moving more quickly than TRICARE to recognize the medical necessity of behavioral therapies. For example, CMS recently issued an informational bulletin regarding coverage of medically necessary treatment services for children and youth with autism. The bulletin clarifies that medically necessary services, including “behavioral and communication approaches,” should be covered under states’ EPSDT Medicaid plans. This guidance was intended to clarify existing law and ensure that children with autism receive the “healthcare they need, when they need it.” While TRICARE’s coverage of behavior intervention services, like ABA, for beneficiaries with autism is evolving, efforts are still needed to provide affordable coverage under the TRICARE Basic program along with all other medical care for all beneficiaries with developmental disabilities, including autism.

2. An assessment of access to pediatric health care by dependent children in appropriate settings.

The Report concludes that the MHS provides adequate access to care in appropriate settings. However, given the limited and largely irrelevant data presented, a more accurate conclusion is the MHS has inadequate data to assess access to pediatric care by dependent children in appropriate settings.

The Report defines adequate access as the ability of the direct and network components to provide sufficient numbers and types of providers to assure that medical services delivered to a covered child will be accessible without unreasonable delay.

Unfortunately, although the Report provides numerous data points, only one measure actually evaluates access: percentage of pediatric encounters with non-network providers. The Report concludes that adequate access is proven since only 7 percent of encounters occur with non-network providers.

While this statistic provides some insight on the ability of the direct care system and TRICARE network to provide adequate access to care, it has limitations. Looking solely at percentage of pediatric encounters with non-network providers assumes that all families who encounter barriers to obtaining care in the direct system and/or network are offered the option of a non-network provider or know that they have the option of insisting on a non-network referral. Feedback from families indicates that it is seldom the case that they are offered non-network referrals. By relying only on this measure, the Report also completely fails to evaluate the timeliness of care or medical care that families forego due to access barriers.

What other data does the Report contain that is unrelated to evaluating access to care?

The Report includes an outline of TRICARE program regulations regarding access standards as well as the TRICARE Policy for Access to Care providing specific guidance to MTFs on adherence to access standards. However, the Report provides no evaluation of TRICARE's performance against these access standards or to what extent MTFs are complying with the TRICARE Policy for Access to Care. Anecdotal evidence, such as the number of families directed to the emergency room when same day appointments are not available at the MTF, suggests that in many instances access standards are not being met and MTFs are not following the TRICARE Policy for Access to Care.

The Report provides data on pediatric encounters in the following settings: outpatient office visits, emergency room visits, inpatient hospitalizations, and same day surgeries. For each of these settings, the Report provides number of visits, and utilization rates by age group. Examining these data points without relevant civilian benchmarks provides no insight into adequacy of pediatric access to care.

What are information gaps in evaluating pediatric access to care?

The Report identifies the following information gaps:

- Appointment availability
- Wait times for appointments
- Drive times
- Delays due to the referral and authorization process
- Percentage of TRICARE network providers that are functionally available (i.e., not unreachable, duplicate listings, no longer accepting TRICARE or not accepting new patients)

The TFK Coalition concurs; additionally any assessment of adequate access to pediatric care in appropriate settings must include:

- MHS/TRICARE performance against access standards
- MTF compliance rates for TRICARE Policy for Access to Care
- Beneficiary feedback on barriers to access

3. An assessment of access to specialty care by dependent children, including care for children with special health care needs.

The Report states that out of the total of the pediatric population receiving care within the MHS, 19 percent of that care is attributed to pediatric specialty appointments or visits. Out of that proportion, 80 percent of those visits are directly coded (or linked) to specialty pediatric providers (both direct care and purchased care). This information was obtained directly from the MHS data repository. However, there are no means of assessing whether access to care, satisfaction with care, or quality of care issues exist for pediatric specialty care. Annual TRICARE evaluations measure those elements for the general population, but do not break out pediatric care experiences. Pediatric specialty care is an important aspect of military healthcare and should be separately reviewed on an annual basis.

MHS ability to collect and analyze appropriate data with respect to the pediatric population has proven difficult, and at times non-existent. Data deficiencies and difficulties appear to have led to confusion and at

times misinterpretation. The Report states, for example, “DoD data show that OB/GYN was the most commonly utilized specialty for beneficiaries age 18 to 21 years.” They relate these to female preventative diagnoses and pregnancy. It is further stated that OB-GYN and behavioral health were the two highest proportion specialties in the MHS, and again the 18-21 year olds had the highest rate. Thus, these statements leave the reader to wonder if the demographic data includes all females in that age group, including spouses and active duty females. It is highly unlikely that dependent pediatric beneficiaries are the highest users of OB/GYN services.

Behavioral Health

The TFK Report’s evaluation of behavioral and mental health consisted of briefly outlining benefits available and making comparisons that were limited in their usefulness. The Report failed to analyze outdated regulations that comprise artificial barriers, and the lack of up to date best practices such as wrap around care, child and family centered care, and access to specialty behavioral and mental health services, and did not delve into the barriers to access caused by payment rates, internally or externally.

The Report states the second highest specialty utilization rate was for “behavioral health within the ranges of 13 to 17 years, with 0.3 visits per beneficiary, and ages 5 to 12 years and 18 to 21 years, each with 0.2 visits per beneficiary.” It goes on to state:

The MHS behavioral health utilization data are consistent with the Centers for Disease Control and Prevention’s National Health and Nutrition Examination Survey (NHANES), which reports that approximately 13 percent of children ages 8 to 15 years had a diagnosable mental disorder. The most common disorder is attention-deficit/hyperactivity disorder (ADHD) which affects up to 9 percent of this population.

This statement leads the reader to believe that ADHD is the top reason pediatric beneficiaries seek mental health treatment, which may be incongruent with an earlier statement that notes that mental health (depressive) concerns is the one of the top two reasons for emergency room visits.

For behavioral health, the Report cites the Centers for Disease Control (CDC) and NHANES prevalence data that “13 percent of children ages 8 to 15 years” have a diagnosable mental disorder. By contrast, the Surgeon General estimates that up to 21 percent of children and adolescents have a diagnosable mental or addictive disorder, 11 percent with significant functional impairment and 5 percent with extreme functional impairment. The Report finds it “not surprising” that the utilization of behavioral health care is less than one visit per beneficiary (ages 5 – 21) per year but, again, there is no comparison with non-TRICARE enrolled children and youth. And it seems intentionally confusing to state prevalence data in one form (percentage of population) and utilization in another (as a rate vs. the percentage of youth who accessed services).

Separate from this Report, through a request made by Senator Harkin, the DoD provided the following information:

Data from FY 2012 indicate that 32,954 of our 1,525,570 Active Duty Family Members (ADFM)s under the age of 21 who are eligible beneficiaries (2.16 percent) received mental health services in our direct care or MTF system, and 93,532 ADFM beneficiaries under 21 years of age (6.13 percent) received mental health services in our purchased care system. Data from FY 2012 also indicate that 7,025 of our 893,914 retiree family members (RFMs) under the age of 21 who are eligible beneficiaries (.79 percent) received mental health services in our direct care system, and 57,003 RFM beneficiaries under 21 (6.38 percent) received mental health services in our purchased care system.

Particularly without knowing the types or number of mental health services received, it appears that utilization of mental health services is below what would be expected based on national prevalence estimates.

While the Report concedes that TRICARE standards are not consistent with current best practice nationally, i.e., definition of medical necessity, coverage of preventive services, timely adoption of “emerging technology,” it does not acknowledge just how antiquated mental health services, in particular, are. Intensive outpatient services are not covered at all, and it is not clear whether in-home services are covered under the outpatient benefit. The regulations for psychiatric residential treatment centers (RTCs) were last updated in 1995, and we believe the certification standards date to 1989 – even at that time far exceeding requirements of state licensing agencies and the three national accrediting organizations (Joint Commission, Commission on Accreditation (COA), and Commission on Accreditation of Rehabilitation Facilities (CARF)). TRICARE requires RTCs to be accredited by the Joint Commission (vs. Medicaid which allows accreditation by any of the three entities), and also requires separate certification by a national contractor to ensure compliance with TRICARE’s standards. The TRICARE standards do not result in higher quality or safer care, but do result in keeping licensed, accredited, willing providers out of the network by their imposition of overly burdensome standards, an institutional treatment environment, a lengthy and expensive application process, and the requirement that all children and adolescents in the same residential unit as a TRICARE beneficiary receive the same level of care, regardless of who is paying for their care or what their treatment standards may be.

The review undertaken for the TFK Report apparently did not include review and findings of previous DOD beneficiary surveys and reports. The [2007 An Achievable Vision: Report of the Department of Defense Task Force on Mental Health](#) includes many observations about inadequate access to children’s behavioral health services, which are informative and relevant to this analysis such as:

- The stressors inherent in military life make basic mental health services as important and time-sensitive as basic health care. Currently, TRICARE access standards consider basic mental health care in the same category as medical specialty referrals. Under this standard, initial mental health appointments can be significantly delayed. Basic mental health care should be considered comparable to primary health care. Non-emergent mental health symptoms and disorders must be seen as quickly as non-emergent medical problems.
- Intensive outpatient treatment programs have been adopted as a standard practice in the private sector and the Veterans’ Health Administration. TRICARE, however, does not reimburse for this care, requiring instead that patients be referred to more expensive residential or inpatient care, which is often situated farther from where they live.
- Children have particularly constrained access to treatment services, especially adolescents with substance abuse problems, who are often best treated through intensive outpatient or partial hospitalization services. Outpatient and partial hospitalization treatment for substance abuse are virtually non-existent in many geographic regions, requiring families to send their children two to four states away for inpatient treatment, which is more expensive and not clinically indicated.
- Specialized mental health care for children and adolescents appears to be in particularly short supply. It is not unusual for a parent to report waiting six to nine months for an initial child psychiatry

outpatient appointment or for providers to report that children had to be sent to another state for inpatient treatment.

- TRICARE officials acknowledged much of what the Task Force repeatedly heard: Accessing residential treatment services for children and adolescents is especially problematic. Relatively few residential treatment centers are willing to become TRICARE providers because TRICARE regulations require an additional certification by a national contractor above the community norm of accreditation by Joint Commission, COA or CARF. TRICARE should accept accreditation of residential treatment facilities for children by any nationally-recognized accrediting body, as is the norm in the civilian sector.
- Service members and family members who rely on the TRICARE network have less access to care than TRICARE network provider lists suggest because the lists of mental health professionals are routinely populated by providers who are not accepting TRICARE patients. It is not unusual for a family member to be given a list of names and phone numbers for 30 to 100 community therapists, only to find that those providers are not currently accepting TRICARE patients, or that the first available appointment is too far in the future. In one instance, a mental health professional at the MTF called over 100 listed mental health providers and found only three who would accept new TRICARE referrals. Commonly, family members report that they give up after the tenth or eleventh call.
- In the recent survey of TRICARE civilian providers, low reimbursement was the most-cited reason for not taking TRICARE patients. TRICARE has the option of adjusting rates for specific provider categories and services to correct for serious access problems. The option has not been used for any mental health services.
- Clinical social workers and clinical psychologists hired to work in military treatment facilities are not classified in the “Medical Career Group” for pay purposes. Other health professionals such as optometrists, pharmacists and speech pathologists are in the Medical Career Group, where the maximum pay is about \$15,000/year higher than for clinical social workers and clinical psychologists.
- Although some MTFs provide psychological health care to all beneficiaries, most offer treatment only to active duty service members. This gap is especially problematic because many family members prefer to be served by uniformed providers who understand military life, or need to be served by the MTF because the installation is located in a rural area where there are few alternatives in the community.
- There is an inadequate number of providers. A thorough review of available staffing data and findings from site visits by the Task Force to 38 military installations around the world clearly established that current mental health staff are unable to provide services to active members and their families in a timely manner, and do not have sufficient resources to provide newer evidence-based interventions in the manner prescribed.
- The current allocation system is problematic. For example, suppressed demand is not tracked. The system is built on a model of narrowly-defined, billable mental health services.

The “Achievable Vision” report concluded that the TRICARE mental health system was inadequate and effectively limits care through a system that is inconvenient and cumbersome, similar to much of the feedback provided to the DoD for the TFK Report, yet most of the issues raised in either forum remain unaddressed.

Data provided by the DHA in other forums, but not cited in the report demonstrates that “mood disorders” is by far the top pediatric diagnosis (other than live births) in the MHS, in terms of both volume and cost. In light of this sobering statistic, it is difficult to discern why the Report did not actually analyze current provision of behavioral health services, concerns raised by stakeholders for consideration in the review such as the need to modernize mental health service provision to embrace best practices including wrap around care, child and family centered care, IOPs, consistent access to specialty care, care in the least restrictive setting appropriate, and collaborative and innovative ways to access that care.

For example, telepsychiatry and similar specialty services could be contracted with pediatric specialists and thereby provide more consistent access to quality specialty behavioral health programming and clinics such as those based in children’s hospitals.

The TFK Coalition urges additional and timely action in furtherance of improving behavioral health coverage, access and quality of care for military children appropriate to their needs.

Definition of Children with Special Health Care Needs

Recognizing inconsistencies within all the data and programs throughout the military health system, the Report suggests that the DoD should adopt an enterprise-wide definition of “child with special needs” particularly the National Institute of Child Health and Human Development definition of children and youth with special health care needs (CYSHCN). The Coalition concurs.

4. A comprehensive review and analysis of reimbursement under the TRICARE program for pediatric care.

The Report found that the MHS payment for pediatric care is “adequate to meet the needs of the pediatric population.” According to the Report, “specific TRICARE accommodations and additional payment groupings accurately reflect the cost and payments involved in providing the specialty care and services for children with special health care needs and chronic health conditions.” Yet stakeholders provided specific examples for which this is not the case. The instances identified in recommendations for which coverage is ostensibly provided, but the reimbursement rate does not include the value of the services, were noted in the Report but not detailed. Similarly, the Report did not address the overarching concern that its payment policies and practices adopted from Medicare, a system created for senior adults, does not always work well for pediatric care and care settings.

The Report states:

*Advocacy groups (AAP and Children’s Hospital Association) have provided opinions related to TRICARE reimbursement practices and policies. Children’s Hospital Association recommends that TRICARE adopt flexible payment policies that allow providers to make the best care decisions for the child. AAP recommends that TRICARE review rates for pediatric care and eliminate or modify the ability of regional contractors to require providers to provide a “discount” from the CMAC. **The MHS remains committed to modification***

of and/or exemptions to existing reimbursement systems, both inpatient and outpatient, consistent with statutory requirements, to continue to ensure access to quality pediatric care for military families.”

Yet, again, many of the issues identified have been on the table for some time (for example, amending the Medicare based “inpatient only” list for pediatrics has been in the queue for more than five years; requested inclusion of the value of a heart valve device implanted during surgery in the reimbursement amount for the corresponding surgery has been ongoing three years) and stakeholders have seen no action to corroborate this statement.

The Report’s stated commitment to flexibility and exceptions for pediatrics is useful going forward in advocating to improve payment rates for pediatric services. However, these areas could and should be addressed internally in a swift and timely manner, in keeping with the DHA’s stated goal of more quickly assessing and understanding pediatric use of emerging technology, and focus on child/patient centered care and outcomes. As recommended, a pediatric physician/clinical/payment advisory group/s would be a helpful tool for DHA in this regard.

5. An assessment of the adequacy of the ECHO Program in meeting the needs of dependent children with extraordinary health care needs.

The Report explained the Extended Care Health Option (ECHO) program but failed to answer whether it is adequate. DHA relied on statistics and previous [reports](#) for its determination, which were inappropriate for the congressionally directed question of adequacy. The Report’s newly published numbers of total ECHO-enrolled children (13,635 in 2012) indicate how DoD regulatory schemes and implementation have negatively impacted those who would be expected to participate in the program ([closer to 100k](#)). A recent West Virginia University study on [“Medicaid and Military Families with Children with Special Healthcare Needs: Accessing Medicaid and Waivered Services”](#), confirmed the concern of under participation, stating: “Specifically, there is a concern that the TRICARE ECHO may be falling short in reaching those families that are both eligible for the option and are in most in need of its services.”

Importantly, the study also concluded:

[Medicaid] is structurally incompatible with the needs of active duty military families. There is simply too much variation across state Medicaid systems to ensure that military families moving across state lines will have access to needed services and programs. We also found a lack of capacity within military family support and medical case management to effectively assist families in their efforts to access Medicaid. There are nodes of expertise within the military health and family support systems, but these are neither coordinated nor systematic. True organizational capacity and institutional memory is lacking.

It is for these reasons that ECHO plays such an integral role for military children with special healthcare needs and must be reformed to function appropriately.

ECHO (created in 2005) is a reincarnation of another program, called the Program for Persons with Disabilities (created in 1997), which replaced another, the Program for the Handicapped (created in 1966). These long standing programs have evolved significantly, while the [underlying rationale](#) has remained the same; “to assist in the reduction of the disabling effects” of the dependent’s qualifying condition due to “(1) the high cost of caring for seriously disabled family members and (2) the limited access to care for many

specialized services because of long waiting lists for public services and state and/or local eligibility restrictions (such as residency requirements), which adversely affect military personnel.”

These eligibility restrictions and waiting lists for military families still exist, hence the need to ensure that military children are not inappropriately penalized for the service of their parents in the military. Because of the broad latitude DHA has in the [implementation of the ECHO program](#), it is also responsible for ensuring its adequacy. As part of determining adequacy, DHA officials should work with parents, beneficiaries, and advocacy groups to:

- Examine ECHO regulations versus outcomes, to include metrics to discern whether or not ECHO is meeting its primary goal, assisting “in the reduction of the disabling effects.”
- Compare the benefits provided by a “typical” Medicaid waiver (or other “state resources”...for which the ECHO program is supposed to be a substitute) to the benefits provide by the ECHO program.
- Ensure ECHO policies are person-driven, inclusive, effective and accountable, sustainable and efficient, coordinated and transparent, and culturally competent; consistent with CMS [standards for community based supports](#).

6. An assessment of the adequacy of care management for dependent children with special health care needs.

While the Report states that case management and care management are integral to patient care for children with special health care needs, it also acknowledges that better data is needed on best practices, optimal patient/care manager ratios, and outcomes.

The Report also states that coordination of case management is more complex when the beneficiary receives segments of his or her medical care in the direct care component (MTFs) and other care in the purchased care components (non-MTFs). Thus, one of the gaps identified in care management is that there is “no clear inter-care collaborative process for direct care, purchased care, and related supports to address medical and non-medical complex beneficiary needs.” In addition, TRICARE regional offices also reported that data is not available to review ECHO beneficiaries and case manager ratios and clinical outcomes.

To address these issues, the Report suggests that DoD consider conducting a collaborative review to establish a formal “family-focused process” to evaluate the adequacy of care and case management in meeting complex individual health needs and promoting quality cost-effective outcomes. It also suggests developing a formal collaborative process in and between direct and purchased care to define and review outcomes for appropriate care/case management of pediatric beneficiaries and their families. To boost data collection, the Report also suggests DHA consider developing outcome/efficacy metrics for the impact of case management in direct and purchased care for beneficiaries with significant medical/behavioral health issues.

Families have expressed frustration asking: “When will these processes be created? Moreover, how will they be adopted and implemented?” With current data and utilization constraints, the assessment of care management for dependent children with special health care needs cannot be fully answered.

The Coalition concurs with the gaps identified, and urges the DoD to refrain from reinventing the wheel in this area and rather, encourages work with providers and groups such as children's hospitals, with expertise and experience in this area and the related element #8 below, as recommended and outlined in various comments provided by stakeholders in preparation for this Report.

7. An assessment of the support provided through other Department of Defense or military department programs and policies that support the physical and behavioral health of dependent children, including children with special health care needs.

The Report concludes that the DoD and the Military Departments (Army, Air Force, Navy and Marines) provide appropriate programs to support the physical and behavioral health of dependent children, including children with special health care needs. This includes programs like DoD's Morale, Welfare and Recreation Service (MWR), Total Force Fitness (TFF), Warfighter and Family Services, the Military Department's Family Advocacy Program (FAP) and the FAP's New Parent Support Program (NPSP). The Report also discussed the Army's Child and Family Assistance Centers (CAFACs) and School Behavioral Health (SBH) Programs, the Navy's Respite program, and the Air Force's Exceptional Family member Program (EFMP)-Family Support.

Despite these efforts, the Report identifies a gap in these programs because there are no formal criteria for outcomes or program-effectiveness measures in many of these DoD or Military Department programs. Thus, the Report suggests that the DoD consider developing a common core of programs/benefits that support families available at all installations with criteria for evaluating effectiveness of programs and outcomes. This finding isn't new, and the lack of transparency continues to negatively impact the understanding of how DoD intends to rectify this issue. In 2012, in a [briefing to the Military Family Readiness Council](#), OSD noted that a review of 179 military family programs was ongoing, part of a five year initiative to ensure that all family programs have program evaluation. In 2012, of the 179, only 25 percent were reported to have outcome based data or recently undergone internal or external outcome evaluations.

The Report also finds that there is no "single point of contact" for families to obtain assistance in evaluating the most appropriate medical, community, and Military Department programs to meet their needs. As such, the Report suggests the consideration of the establishment of a "one-stop-shopping system" to support families in evaluating the multitude of services available to meet their needs.

The Report states that children with special needs have access to a broad range of innovative and strategic programs and services through TRICARE and the DoD. Programs include: MWR, Warfighter and Family Services, FAP, and NPSP. Each service branch also offers programs to support military families, including Child and Family Assistance Centers (operational at only 5 Army installations), School Behavioral Health Programs (operational at only 8 Army installations), Navy Respite Program (for qualified EFM Categories 4-5), Adolescent Substance Abuse Counseling Service Program, Air Force Respite Child Care, EFMP Family Support Coordinators, and Healthy Habits Clinic.

Regarding the special needs population, the need to assess support programs is not new either. The Senate Armed Services Committee, in its Report No. 111-201, page 137, (accompanying the 2011 NDAA) requested that the Secretary of Defense provide a report on the access to appropriate facilities, services, and

support for military families with dependent children with special needs, almost the same exact question asked here two years later. The GAO was also tasked with evaluating this issue in the same Senate report.

The DoD answer to the 2011 Senate NDAA directive was not much more than an [informational booklet](#), while the GAO reports were significantly more robust in their analysis.

According to the 2012 report by the GAO titled [“Better Oversight Needed to Improve Services for Children with Special Needs”](#), there are no Department-wide benchmarks to set standards for the Services’ EFM programs. As a result, the Department is unable to assess the effectiveness of the branches’ EFM programs and ensure that improvements are made when needed. The TFK Report’s findings did not cite, but concur with the GAO conclusions reached two years earlier; leading stakeholders to conclude no improvements have been made.

The January 2013 GAO report titled [“Department of Defense Policies on Accommodating Children with Special Needs in Child Care Programs”](#) related that “DOD does not centrally collect or maintain data on accommodation decisions; instead they are kept at the installation level...Further, the services have different definitions of special needs, although officials told us DOD is working on a standard definition.” Again, the TFK Report made a similar finding, with no progress one and a half years later.

In addition, at the Military Family Readiness Council, May 2013 meeting, the DoD Office of Special Needs (OSN), [informed the committee](#) that standardization processes for EFMP, which would identify potential improvement and standardization across EFMP processes, policies, and IT systems, would take place in summer of 2013. Over a year later, at a June Military Family Readiness Council meeting, OSN briefed that standardization is still a work in progress. Similarly, the 2010 NDAA dictated that the OSN shall “develop and implement a comprehensive policy on support for military families with special needs.” Four years since establishment of the OSN by the Congress, families are still waiting for the most basic policies and processes to be implemented.

Regarding the adequacy of the EFMP program, an important document was finally finished after four years of consideration; the [EFMP Benchmark Study](#) conducted by Cornell and the University of Kansas. According to the report, “This study was designed to provide additional information through a policy review, practice review (literature analysis and interviews), and a current needs assessment as part of the foundation for developing an effective family support policy across OSN and the four Military Services.” Notably, it concludes “[m]any of the findings in this report corroborate the findings of other studies.” Some of the key findings:

- Of the military family support programs that provided feedback, EFMP family support coordinators had caseloads ranging from 225 to over 300 families per case manager. This kind of intensive caseload severely limits family support to only information and resource referral, thus not adhering to the job description of the EFMP Family Support coordinators outlined by the report.
- EFMP family support services personnel confirmed that amount of EFMP families has often strained both their family support resources and the medical and educational resources in their geographic area to the limit.
- EFMP Families (and EFMP family support personnel) report that they are rarely able to access programs such as Child Youth Services (CYS), if their child or teen has any significant medical,

educational or behavioral issues. From insufficient training and child/staff ratios, CYS programs are unable to provide sufficient access to children with special health needs to these programs.

- A lengthy and complicated, nonstandardized paperwork process for families must be completed for each DoD or military department program to determine if they can support the child with special health care needs.
- EFMP personnel reported that the respite care waiting lists remain a frustration for them. They agree with families that sometimes there is a second issue besides that of adequate supply: a lack of transparency around eligibility requirements. Guidelines are interpreted and implemented at different locations, and not always consistently applied.
- According to the study, “The goal and intent of the Navy EFMP Respite Care Program is to operate at a status of less than 90-day average for placement.” This program, while extremely beneficial, has current waiting lists that greatly exceed the goal. According to the ASYMCA of San Diego, the contractor for Navy EFMP Respite, the average waiting list for a qualified family is over six months.

Although available, no references to this information or most of the reports or briefings referenced above, were included in the TFK Report.

In conclusion, practices across DoD and military department programs and policies that support the physical and behavioral health of dependent children, including children with special health care needs vary from one military service to the next. There is little standardized training, requirements, or responsibilities, and again, insufficient data to check for effectiveness. EFMP Family Support Personnel are inundated with heavy caseloads, and family support is being outsourced to grassroots organizations such as the Military Special Needs Network, Specialized Training of Military Parents (STOMP), and American Military Families Autism Support.

The TFK Report reaches many of these same conclusions. The Coalition urges timely and transparent action in order to standardize, reform, measure outcomes, and communicate available supports and services consistent with the intent of the programs.

8. Mechanisms for linking dependent children with special health care needs with State and local community resources, including children’s hospitals and providers of pediatric specialty care.

The Report notes that formal and informal networks link dependent children with State and local resources including children’s hospitals and providers of specialty care. However, the Report also notes that “levels of communication and collaboration among the programs and services needs to be assessed.”

The Report identifies as a gap whether there exists a consistent process of communication and collaboration between nonclinical and clinical providers to “plan, facilitate, coordinate, advocate, and evaluate the most supportive networks to meet family needs.” The Report then suggests that a future study may be needed to “develop and test consistent processes of communication and collaboration between nonclinical and clinical support for the family’s network of needs.”

As reported in the EFMP Benchmark Study, above, installation, medical, educational, state and federal resources vary widely from location to location both in terms of availability as well as determination of eligibility and organizational guidelines. Services are described as rarely equivalent or comparable primarily due to differing installation procedures and guidelines; different state and federal rules, eligibility, and waiting lists.

Significant uncertainty about what families can reasonably expect from agencies in terms of resources and services is created when eligibility rules change or are misinterpreted, when eligibility differs from one installation to the next, when there are fluctuations for funding of services, or significant qualitative differences exist among providers.

Unfortunately, there is no “one-stop shopping” to address the needs of military families. Inexperienced families usually have to figure most of this out for themselves. This process is intensive in both time and labor. However, the Department of Health and Human Services funds Family to Family Health Information Centers (F2F-HICs) in every state and the District of Columbia to assist families of children and youth with special health care needs (CYSHCN) and the professionals who serve them. F2F HICs provide support, information, resources, and training around health issues and are uniquely able to help families because they are staffed by family members with first-hand experience navigating the maze of health care services and programs for CYSHCN. Many of the F2F-HICs already work with military families, but DoD should widely disseminate [information about the F2F-HICs](#).

Additionally, civilian sector organizations are highly engaged in activity that would be informative to this endeavor and element #6 above. For example, children’s hospitals are working toward networks of complex care coordination and management across the country that integrate clinical, non-clinical, hospital based and community based, medical and support services to more effectively and efficiently serve families of children with complex health needs. Collaboration, contracting, and/or otherwise establishing demonstration project centers are all options for addressing this gap and achieving the goal of comprehensive, supportive networks to meet family needs.

9. Strategies to mitigate the impact of frequent relocations related to military service on the continuity of health care services for dependent children, including children with special health and behavioral health care needs.

According to the Report, the Military Departments offer comprehensive support programs to consider family member’s medical and educational needs during the assignment coordination process. The Report discusses the programs designed to provide for stabilization or continuation at a specific location for unique family members with special needs. However, it also finds that transfers between regions can result in disruptions of care, especially by extending wait times for appointments with specialty providers for children with special health care needs. The Report also states the following:

There is no comprehensive system for evaluating care coordination and quality resulting from care coordination in the direct and network care settings. In addition, not all eligible family members are enrolled in Military Department EFMP programs, suggesting a need to understand the reasons for lack of enrollment and to improve outreach to eligible families.

Leadership has previously estimated that under-enrollment of EFMP families is an issue, such as [reported by OSN](#), in comments to the Military Family Readiness Council in 2011, that the number of EFMP families should be closer to 350,000 instead of the 128,582 currently enrolled (per the report in 2013).

Two other areas that complicate continuity of care with transfers identified in this Report are that EFMP medical reviews do not consistently include regional contractors in determination of available medical services in relocation decisions and the current TRICARE restriction that does not allow for enrollment in two regional contractors systems at one time.

Because of this, the Report suggests more formalized collaboration between EFMP Military Departments and regional contractors in order to help determine the availability of medical resources in complex medical case prior to relocation. It also suggests evaluating a limited dual enrollment within two regional contractors for a specified time during relocation to allow for appointments to be made for continuity of care in chronic conditions.

Recognizing that not all eligible family members are enrolled in their Military Department's EFMP program the Report recommends better education of military families about the EFMP process, health care coordination benefits and ECHO eligibility with follow-up enrollment review.

Another gap found by the Report is that purchased and direct care are not linked electronically to provide an integrated medical record or secure messaging for beneficiaries who receive care in both settings. As an area for clarification, the Report suggests reviewing the Military Departments and regional contractor coordination process to consider the level of standardization necessary to create an effective harmonization process for EFMP beneficiaries.

Furthermore, stakeholder recommendations for establishing networks of care management and coordination specifically for children with complex health needs in conjunction with children's hospitals and providers of pediatric specialty care, would address relocation and handoff issues for a large number of EFMP families while providing more efficient and effective care and communication.

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