Tricare for Kids: Agency Actions to Address the Needs of Military Children

1. Adopt EPSDT and Establish a Pediatric Medical Necessity Standard

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

Then, to properly implement EPSDT, DHA should adopt the pediatric specific definition of medical necessity and hierarchy of evidence recommended by the American Academy of Pediatrics (AAP) to cover: "health care interventions that are evidence based, evidence informed, or based on consensus advisory opinion and that are recommended by recognized health care professionals, 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…" so that children are not harmed by the current Tricare definition and hierarchy of evidence as concluded by the Defense Health Board report on Pediatric Health Care.

Much as Tricare adopted the AAP guidelines "Bright Futures" in 2018, the Military Health System could make these changes administratively, in fact, in 2017, the Defense Health Board recommended: "Modify the administrative interpretation of the regulatory language in 32 Code of Federal Regulations 199.2 to broaden the use of the "hierarchy of reliable evidence" for the benefit of pediatric beneficiaries.

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

The Coalition urges continued focus on closing gaps and strengthening DoD's commitment to the mental, emotional and behavioral health for children of military families and recommends the following administrative actions:

- **Create a Mental/Behavioral Health Patient Navigator Program:** Establish a pilot program on MHS mental/behavioral health appointment schedulers for direct and purchased care incorporating congressional oversight and reporting requirements. Recommended by IG report.

- **Institute Requirements to Improve Appointment Availability and Provider Directories:** Institute T-5 requirement for appointment availability as part of network adequacy, as well as enhanced provider directory accuracy requirements specific to behavioral health care to eliminate duplicates, providers no longer practicing, wrong provider types and contact information. Recommended by IG report.

- **Improve Provider Directories to Include Specialties:** Require a nationwide list of institutional and highly specialized providers and provide accurate specificity in directories with respect to specialty focus and ages served. Inaccurate or difficult to navigate provider directories are affecting access to care.

- **Remove Age Restrictions for Military Families to Receive Psychiatric Residential Treatment:** Remove age restrictions for Residential Psychiatric Treatment, including eating disorders Residential Treatment. TRICARE

policies prevent military families, including retiree beneficiaries, over the age of 20 years old from receiving residential psychiatric treatment. However, if the same families experience substance use disorder, they are permitted to receive this care regardless of their age. Artificial barriers to access such as age restrictions must be removed. 50% of mental illness onsets by the age of 14 years old, and the other 50% by the age of 24 years old. For example, binge eating disorder, the most prevalent eating disorder, onsets between the age of 22-24 years old. In turn, many military children and spouses will begin their onset after the age of 20 when coverage is not available. The consequence of not providing this coverage has led to military families either including debt to pay for care, sending their families to inappropriate levels of care, or not receiving care. For example, TRICARE East permitted one 21-year-old military child with an eating disorder to go to a lower level of care called Partial Hospitalization (day program) and pay out of pocket for the nighttime portion to make it residential care. This family incurred significant debt and also drew down the TRICARE day limit for partial hospitalization care, which later creates a challenge when she was clinically ready to step down to PHP and didn't have any available days for care. Military families shouldn't have to be told to game the system in order to access medically necessary care.

- **Expand Tricare Select Navigator Pilot for Mental Health and complex care:** Expand or build upon the Tricare Select Navigator pilot in addition to implementing the mental/behavioral health services scheduler pilot to further address the documented difficulties (Journal of Health Affair Sept 2019, et al) with respect to obtaining appointments, approvals, and authorization for behavioral health and other complex conditions.

- **Make Telehealth Flexibilities Permanent:** Insofar as can be done administratively, make permanent the telehealth flexibilities implemented during the COVID national emergency, including permitting providers to serve Tricare patients across state lines to ensure access to critical MEB services.

- **Open Up Purchased Care Provider Contracting to Improve Network Adequacy:** Ensure contractors continually credential mental health providers regardless of overall network adequacy status, and work with contractors to improve the authorization process for institutional providers.

- **Ensure Bright Futures Implementation:** Take appropriate steps to ensure that Tricare alignment with Bright Futures (AAP guidelines for preventive care) is being implemented appropriately to ensure children are receiving the recommended periodic screenings and consider further alignment with behavioral health specific screening recommendations.

3. Recognize Dependency of Incapacitated Adult Children

Adult incapacitated children of servicemembers and retirees are dependents, which ensures Uniformed Services IDs, Tricare eligibility and any other rights and privileges afforded to military families. The financial dependency procedure that has been adopted by policy, not by statute, to determine whether parent/s are responsible for the support for their adult incapacitated children is being used to the detriment of military families, per the GAO.

Administrative steps can be taken to protect these vulnerable families, namely DoD recognizing dependency adjudicated under existing federal law defining and governing the treatment of adult incapacitation status and dependency, as meeting the requirements in Title 10 of US Code rather than utilizing a bureaucratic and difficult to navigate process by DFAS that is redundant, inconsistent, dependent on location and cost of living, and likely in violation of families' civil rights (eg, calculations valuing an adult incapacitated child as ½ other adults in the household). Many of the issues with this process are discussed in a June 2020 GAO Report. There is no need for DoD to require families to go to the expense and machinations of a separate dependency process when one already exists outside of DoD purview that is recognized for all other purposes. A financial test may be appropriate for some dependency circumstances, but not all as is currently the practice, and the process must be clear, streamlined, non discriminatory, consistent and provide due process. Again, the 2020 GAO Report concludes that this administratively defined process is harming our most vulnerable military families.

Also of great concern is the inability or inconsistency of MHS systems for designating a patient as an incapacitated adult. Often, parents are told they cannot be given laboratory results or ask about consults, even with documented dependency and guardianship. As an administration highly invested in meeting the needs of persons with disabilities and their families, anything that can be done to convey to DHA the importance of addressing this issue and requesting that DHA examine and implement ways to better document and serve these patients and their families would be critical.

4. Halt the Reduction of Military Medical End Strength

Medical billet cuts and restructuring could harm families' access to care and potentially have negative unintended and long-term consequences, including disruptions to the medical education pipelines that are integral to training pediatricians for military connected children and all children. Major structural changes such as billet cuts can have far reaching unintended second- and third-order consequences. For example, there are shortages of most pediatric specialists throughout the country already; what will decreasing numbers of uniformed physicians trained mean for access to care for both military and civilian communities? We strongly support the precautions in previous NDAAs entreating DoD to fully understand and address the short and long-term implications for families' access to care that would be caused by reductions in billets.

5. Provide a Mechanism for Communicating Beneficiary and Provider Problems

Stand up a DHA mechanism for beneficiaries/families and purchased and direct care providers to report complaints and concerns about Tricare coverage, denials, incorrect provider directories, network adequacy, access to specialized care within a reasonable distance from their homes, overdue or consistently inaccurate payments, and other related issues. With no mechanism to report issues, there is no way to track, measure and respond. Often by the time problems reach the ears of those tasked with solving them, they have grown and festered, and in some cases caused irreversible harm to the families experiencing them.

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

Other federal agencies have implemented similar mechanisms such as the Center for Medicare and Medicaid Service's (CMS) HIPAA complaint portal, and CMS' Consumer Information and Insurance Oversight (CCIIO) portal for Mental Health Parity and Addiction Equity Act (Parity Act) violations. Once again, we suggest no need to reinvent a wheel, instead DHA should model one or more of these examples.