March 27, 2014

Jonathon Woodson, MD
Assistant Secretary of Defense for Health Affairs
Director of the Defense Health Agency
1400 Defense Pentagon
Washington, DC 20301-1400

Re: Section 735 of the FY2013 National Defense Authorization Act

Dear Dr. Woodson:

The American Academy of Pediatrics (AAP), a non-profit professional organization of more than 62,000 primary care pediatricians, pediatric medical subspecialists, and pediatric surgical specialists dedicated to the health, safety, and well-being of all infants, children, adolescents, and young adults, is sending you the attached letter to share our thoughts and recommendations on improving TRICARE coverage for dependent children of our nation’s military families.

Section 735 of the FY 2013 National Defense Authorization Act, often referred to as the “TRICARE for Kids” provision, directs the Secretary of Defense to conduct a comprehensive review of TRICARE policies with respect to pediatric care. Our letter makes recommendations regarding each of the nine areas that the Department of Defense (DoD) will address in its study, as well as recommendations for DoD to consider including in its report to Congress. While we have many suggestions for DoD in the letter, we particularly encourage DoD to consider:

- Aligning TRICARE with Medicaid’s Early and Periodic Screening, Diagnosis and Treatment (EPSDT) standards, as well as Bright Futures guidelines for pediatric preventive care;
- Adopting AAP’s definition of medical necessity for all dependent children in military families that are covered by TRICARE; and,
- Reviewing the payment rates for pediatric care and eliminating or modifying the ability of regional contractors to require providers to provide a “discount” from the CHAMPUS National Pricing System (CMAC).

We appreciate the opportunity to share our thoughts and recommendations on study authorized by Section 735 of the FY13 NDAA. We stand ready to work with DHA on this issue and would welcome an opportunity to discuss this matter in more detail with DHA leadership.

Sincerely,

James M. Perrin, MD, FAAP
President
The American Academy of Pediatrics (AAP) appreciates this opportunity to share thoughts and recommendations on improving TRICARE coverage for dependent children of our nation’s military families.

Section 735 of the FY 2013 National Defense Authorization Act, often referred to as the “TRICARE for Kids” provision, directs the Secretary of Defense to conduct a comprehensive review of TRICARE policies with respect to pediatric care. The provision also requires that the Department of Defense (DoD) provide a report to Congressional defense committees that includes the findings of the study, a plan to improve and continuously monitor the access of dependent children to quality health care, and any recommendations for legislation that the Secretary considers necessary to maintain the highest quality of care for dependent children in military families.

Specifically, Section 735 directs the Secretary to conduct a study that includes the following:

1. A comprehensive review of the policies of the Secretary and the TRICARE program with respect to providing pediatric care.
2. An assessment of access to pediatric health care by dependent children in appropriate settings.
3. An assessment of access to specialty care by dependent children, including care for children with special health care needs.
4. A comprehensive review and analysis of reimbursement under the TRICARE program for pediatric care.
5. An assessment of the adequacy of the ECHO Program in meeting the needs of dependent children with extraordinary health care needs.
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.
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.
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.

The health care of children in military families is of paramount importance. AAP has issued clinical reports such as “Health and Mental Health Needs of Children in US Military Families,” to advise the civilian pediatrician in serving children from military families. The AAP also published a supplemental volume of *Pediatrics* in February 2012 devoted to the role of the pediatrician in military medicine.

Recently, the Section on Uniformed Services recently created the Military Youth Deployment Support Video Program, which was adopted and used widely by the U.S. Army Medical Command. More than 300,000 copies have been distributed world-wide to military families, various military youth-serving professional agencies, and primary care offices.
While the AAP is proud of the leadership that the Section on Uniformed Services provides, it is also important to note that more than 50 percent of military children receive their health and mental health care from nonmilitary providers. This care is often provided outside the gates of military installations, and especially to children of active service members in the National Guard and Reserve. This fact heightens the importance of a comprehensive benefit package for these children, as well as adequate incentives and payment for civilian providers to participate in TRICARE.

Academy members are acutely aware of how challenging the conflicts in Iraq and Afghanistan have been for military personnel and their families. Up to 2 million U.S. children have been exposed to a wartime deployment of a loved one in the past 10 years. This background is especially relevant as children who have had parents deployed as part of the Iraq and Afghanistan theaters may have unique needs that children in non-military families often do not face.

With these facts in mind, the AAP is very appreciative of Congress’ willingness to authorize the study outlined in Section 735 of the FY13 NDAA. We urge the DoD to use the results of the study to make recommendations to improve TRICARE policy with respect to pediatric care. As DoD undertakes this important study, the AAP makes the following recommendations regarding each of the nine areas that DoD will address in its study, as well as recommendations for DoD to consider including in its report to Congress.

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

Children and adolescents must have a comprehensive, age-appropriate benefit package. As AAP notes in its Policy Statement, “Principles of Health Care Financing”:

The health insurance package should cover all pediatric services including preventive and wellness services, acute, inpatient and chronic services, including developmental, pregnancy-related and other reproductive health, newborn care, mental and behavioral health, substance abuse disorders, emergency services, facilitative, habilitative, and rehabilitative services and devices, palliative, home health and hospice care services, prescription drugs, vision care services, and oral health services reflecting the scope of benefits recommended by the American Academy of Pediatrics and the National Business Group on Health.¹

TRICARE is a strong health care program, and generally offers comprehensive coverage for its members, but, since it largely mirrors the federal Medicare program, which is primarily focused on adults, it is worth examining whether there are any areas where the benefit package does not finance care to address all of a child’s health and developmental needs. AAP believes that an age-appropriate health insurance benefit package for children should be based on the comprehensive, fully inclusive set of services provided by the Early and Periodic Screening,

¹ American Academy of Pediatrics, Committee on Child Health Financing. “Principles of Health Care Financing.” Pediatrics, 2010; 126; 1018
Diagnosis and Treatment (EPSDT) regimen embodied in Medicaid as well as the preventive care recommendations in Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents, as stipulated in Section 2713 of the Affordable Care Act for private insurance.

The guiding principle for child health care under Medicaid is EPSDT, which has been shaped to fit the standards of pediatric care and to meet the special physical, emotional, and developmental needs of children. Federal law requires that Medicaid cover a comprehensive set of benefits and services for children. Unlike insurance benefits targeted at adults, EPSDT provides age-appropriate benefits so that young children receive medically necessary health, mental health, and developmental services.

According to Medicaid regulations, screening services “to detect physical and mental conditions must be covered at established, periodic intervals (periodic screens) and whenever a problem is suspected (inter-periodic screens).” Federal law also states that treatment must include any “necessary health care, diagnostic services, treatment, and other measures,” that fall within the federal definition of medical assistance that are needed to “correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services.” As such, all medically necessary diagnostic and treatment services must be covered, regardless of whether or not such services are otherwise covered under State Medicaid plans for those older than 21.

The AAP urges DoD to review the benefits offered under its TRICARE program to see how it aligns with the EPSDT standard. If the study determines that it is not as robust as EPSDT, AAP encourages DoD to adopt a standard of care equivalent to EPSDT to ensure that all dependent children in military families have access to all needed health care services to treat any health care conditions that are found in screenings in the most appropriate settings possible. While many dependent children in military families with special health care needs are able to and do receive EPSDT services by qualifying for Medicaid services, all children in military families would enjoy age-appropriate benefits if TRICARE mirrored EPSDT.

Closely linked with EPSDT, Bright Futures is a national health promotion and disease prevention initiative developed by the Health Resources and Services Administration in conjunction with AAP that addresses children's health needs in the context of family and community. Evidence-informed content for well-baby and well child visits are available through the Bright Futures Periodicity Schedule and supporting information contained in the Bright Futures monograph. In addition to use in pediatric practice, many States implement Bright Futures principles, guidelines and tools to strengthen the connections between state and local programs, pediatric primary care, families, and local communities. If TRICARE policy is not already in alignment with Bright Futures, AAP urges DoD to ensure that the preventive care recommendations are adopted, implemented and covered by each regional contractor in TRICARE.

While Bright Futures is the age-appropriate guideline for preventive pediatric health care, it is important to note that each child and family is unique, and that the recommendations for preventive pediatric health care are mostly designed for the care of children who have no manifestations of serious health problems, and are growing and developing along common trajectories. Unfortunately, all children do not always enjoy these realities, and, as such, additional well or check-up visits may become necessary depending on the needs of the child and

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2 http://brightfutures.aap.org/clinical_practice.html
his or her family. Developmental, psychosocial and chronic disease issues for children and adolescents often require frequent counseling and treatment visits separate from preventive care visits. When any of these challenges occur, TRICARE should ensure that dependent children in military families receive the health care services they need.

In addition to examining the breadth of services covered under TRICARE, AAP recommends that DoD also review TRICARE’s definition and utilization of medical necessity to determine what services to finance. Many times insurers—both private and public—determine that a particular service does not meet their definition of medical necessity and will therefore deny coverage for that service and refuse to pay providers for the service. Unfortunately, as noted in “Essential Contractual Language for Medical Necessity in Children” published in July, 2013, the term “medical necessity” is generally ill-defined.

“Medical necessity” is used by public insurers like Medicaid and Medicare and in private insurance contracts to refer to medical services that are generally recognized as appropriate for the diagnosis, prevention, or treatment of disease and injury. Health insurance coverage is moderated by a host of federal regulations and statutes, State mandates and other rules. Although provider agreements with insurers are usually written with these rules and regulations in mind, it is often the case that they are not written with the pediatric population as a focus.

The Academy urges all insurers, as well as DoD through the TRICARE benefit, to adopt a definition of medical necessity that is more functional or operational and specific to meet the needs of children. In addition, although evidence of effectiveness is a cornerstone of most definitions of medical necessity, it is important to acknowledge that such data may not be readily available for all services offered for children.

Ideally, a definition for medical necessity for children would be governed by traditional evidence grading, and if that is not available, then a hierarchy or algorithm of standards would be applied. Since traditional evidence is not always available for all services provided for the pediatric population, AAP has published two policy statements to aid decision makers, including DoD, in classifying clinical recommendations and ensuring transparency in issuing clinical guidelines.

If, as is often the case, scientific evidence is insufficient for a particular therapy or treatment, then professional standards of care for children should be considered.

Because of some of the uncertainty surrounding scientific evidence and clinical guidelines for providing health care for children, AAP recommends that the pediatric definition of medical necessity should be as follows:

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

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4 Ibid.

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.\(^6\)

According to the TRICARE Appeals Fact Sheet, “medical necessity determinations are based solely on medical necessity—whether, from a medical point of view, the care is appropriate, reasonable, and adequate for the condition.”

The AAP strongly encourages the Department of Defense to adopt the Academy’s definition of medical necessity for all dependent children in military families that are covered by TRICARE. DoD should also examine how willing TRICARE has been to work with providers and military families to pay for a treatment that may be new or does not have the usual amount of peer-reviewed evidence to demonstrate its effectiveness.

In addition to better defining what services are covered and the definition of medical necessity used to determine what will be excluded, AAP encourages DoD to conduct a comprehensive review of the application of its current policies for children across all branches of the Department of Defense (Army, Air Force, Marines, Navy, National Guard, Coast Guard). The Academy recognizes that DoD has moved to a unified command with the implementation of the Defense Health Agency (DHA) in October 2013, and we are hopeful that this will help alleviate any problems with variability between the services. In the meantime, as DHA grows and develops under its new mission, there are still likely to be significant discrepancies between the services in priorities and approaches to child health challenges. We urge DoD to determine whether policies are implemented differently between different branches. We would also respectfully urge DoD to determine whether these department’s health care policies and procedures with regards to children are communicated effectively to service personnel and their families and whether one branch is most effective at this.

Also, a comprehensive review of pediatric care provided by TRICARE should examine the quality of service delivery across the regional carriers with whom TRICARE contracts to provide care, including those inside the Continental United States (CONUS) and those outside the Continental United States (OCONUS). AAP believes that there may be differences in interpretation or application of policies for pediatric care amongst regional contractors. It would be especially helpful to know if there are significant differences between regional contractors regarding the provision of primary, specialty and mental health care in a timely manner, the quality and safety of health care delivered, and the outcomes of such care. In addition, DoD could also determine if there are wide variations between regional contractors and their policies toward providers, including enrolling criteria and procedures, payment levels and timeliness of paying claims, and levels and types of communications to and from providers.

In tandem with this study, the AAP recommends that annual benchmarks for contractor performance in the delivery of pediatric care be reviewed and assessed for qualitative validity. It should be readily apparent by performance measures if a regional contractor is performing at an adequate level with an adequate supply of participating pediatricians. The Evaluation of the TRICARE Program: Access, Cost, and Quality, Fiscal Year 2013 Report to Congress highlights

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many benchmarks to demonstrate how the military health system compares to its civilian counterparts, but there are few pediatric measures mentioned or highlighted in the report. It would be beneficial for future reports to include more benchmark data related to pediatric care.

DoD should also develop a TRICARE Physician Advisory Committee to advise the department on practice standards, quality and safety issues, formulary and durable medical equipment, access to care, eligibility and enrollment issues, and patient satisfaction. This committee should include pediatricians to ensure that policies toward children and providers of care for children are included for consideration by the committee. The structure of this committee could parallel the Physicians Professional Advisory Committee of the United States Public Health Service or modeled after physician advisory committees commonly implemented by major insurance carriers.

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

Children are not just “little adults.” Children have different health care needs and require services from different types of providers and different types of facilities. In the study authorized by Section 735, the Academy feels it would be beneficial for DoD to examine which providers are delivering care to dependent children in military families, as well as where families are going to receive such services. This type of information can help DoD determine if dependent children are receiving care from the most appropriate and qualified providers. For example, DoD should determine the percentage of children who:

- Receive pediatric care from pediatricians or family physicians.
- Receive care from other providers like advanced registered nurse practitioners, physician assistants and/or other providers.
- Have access to a patient-centered medical home.
- Receive care by TRICARE Network Providers.
- Have civilian care close to the duty station they live nearby.

It would also be helpful to determine how far families have to travel from their duty stations to receive health care services, both for general pediatric services and specialty pediatric care, and how long wait-lists for such services are near each duty station. DoD could also determine whether a change in duty station affects the delivery of health care for service personnel and their families.

AAP believes that children in military families, like children in civilian households, should be able to access health care services by appropriate, credentialed providers in the most appropriate setting possible. Sometimes this may be by a provider at an on-base military treatment facility. At other times, the service should be provided by a civilian pediatrician in their office off-base. As such, AAP urges DoD to examine whether different policies exist for health care services delivered at military treatment facilities or off-base facilities.

Because so many civilian pediatricians treat children from military families, the DoD might also consider formalizing a cultural competency program for providers who agree to accept
TRICARE patients. Several high-quality program models already help civilian pediatricians and other youth-serving professionals better understand the stresses involved in military families and the challenges and opportunities military service creates for a family’s children. MilitaryKidsConnect.org, the Military Child Initiative, and the AAP’s own Military Deployment and Medical Home webpage provide models that would help those who are new to providing care to children in military families understand their unique needs and culture.

Finally, when discussing access to care, we urge DoD to examine impediments that may preclude providers from participating in an insurance program. Two of the main obstacles for participating in any insurance program are payment levels and the amount of paperwork required to participate in the program. Pediatricians need to know that payment for their services will actually cover the costs of providing such services or they may choose not to participate. Pediatricians and other providers also need to be able to provide their services without having to complete burdensome paperwork. The Academy provides recommendations on payment levels in section 4 of this letter, but also urges DoD to review the paperwork burden confronting participating providers.

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

In addition to general pediatric needs, many children require access to specialty services, whether on a short-term basis to treat a specific episode or injury, or on a long-term basis because of life-long conditions or complex diagnoses. There are many pediatric subspecialists providing a wide range of services at major military teaching facilities in the United States. However, pediatric subspecialists are few in number even in non-military treatment facilities, and in the military tend to practice at major military centers. These locales are generally in the Washington, DC, and Tidewater, VA, areas, in Texas and on the West Coast. We urge the DoD to use the opportunity provided by Section 735 of the FY13 NDAA to determine how far families travel to obtain specialty pediatric care.

AAP also believes that DoD should review the demand for pediatric subspecialty services and examine any wait lists for such services to determine the most commonly requested subspecialty services and whether there are enough providers at military treatment facilities or civilian pediatric subspecialists enrolled with TRICARE to meet the needs of the children who require subspecialty care. This is especially true for pediatric mental health care services, particularly with the large numbers of children in military families who have experienced one or both parents being deployed to Iraq and/or Afghanistan over the past 10 years. There are recent and emerging studies specifically describing the effects on children of parental wartime deployments. For example, one AAP Clinical Report notes:

*Most commonly, children experience separation as loss. Concomitant fear and chronic anxiety have been shown to disrupt the developing architecture of the brain. Children, and even adolescents, watch closely for parental cues to gauge their own degree of distress in a given situation. Maladaptive parental coping or distress may be the single most important predictor of child biopsychosocial symptoms during stressful situations, such as wartime deployment. Some military families may be at higher risk of distress, especially if they are young.*
experiencing a first separation, have recently relocated, include a foreign-born spouse, have young children, are junior enlisted (entry pay level), are single parents, or have children with special needs. Service members and families who have not anticipated an extended wartime deployment, such as activated National Guard and Reserve personnel, may be especially challenged.7

As the clinical report notes, there is a definite need to have mental health services available to help children deal with wartime deployment of a parent or guardian.

This examination of access to specialty services should also include a review of whether or not DoD’s Access to Care Standards are being met for accessing specialty services. DoD should determine whether there are military installations or regional contractors under TRICARE that routinely fail to provide specialty services within 28 days as suggested by the Access to Care Standards. If so, DoD should determine the main reasons for the delay in providing such care. DoD could focus on whether there are particular specialties that have extremely long waiting lists for services. The consequences for not meeting access standards in TRICARE should also be examined.

In regards to TRICARE regional contractors, how the “out-of-network” policy is interpreted and applied between regions would also be valuable to discern. DoD could establish a way to track how much families are paying out of pocket for their medical benefit due to limited access to primary and specialty services. Out-of-network policy by regional contractors becomes especially onerous for children with certain rare conditions where there may be a short list of facilities able to provide optimal specialized care. Examples of this include rare neurodegenerative diseases, as well as certain cardiac conditions. It would be helpful to identify the incidence of these rare and severe diseases and identify centers of excellence that would be exempted from out-of-network limitations/restrictions.

For families located or relocating to other areas where major military treatment facilities are not located, AAP encourages TRICARE to identify resources for specialty services in general and particularly for children with special needs. This would include developing a list of facilities and specialties located reasonably near duty stations where members are likely to be assigned. DoD should develop a list of specialty resources and assist families in identifying and connecting with specialty resources prior to moving the service member and his or her family to their new assignment.

For families who have one parent deployed overseas, many times the remaining spouse will return “home” to live with extended family – often times far from the duty station. DoD and TRICARE need to ensure that children in a military family, especially those with special health care needs, can access local health care providers without barriers. For those enrolled in TRICARE Prime, a managed care option where a beneficiary enrolls with a Primary Care Manager (PCM), the family should be able to see a local pediatrician without first having to obtain permission from the Prime Provider on the day of service.

In addition, AAP encourages DoD to ensure that the Exceptional Family Member Program (EFMP) is adequately staffed and up-to-date to continue to provide community support, housing, medical, educational, and personnel services to military families that have a child with special health care needs, also known as an Exceptional Family Member (EFM). EFMPs should also assist regional military outpatient facilities to provide services for families and healthcare for children in meeting those with special needs that are within the usual scope of care for primary care health facilities. Civilian network providers should also have training and resource development in EFMP and ECHO services for pediatric patients. For families that are transferring duty stations, EMFP staff should have the proper training, guidance and assistance to ensure that a service plan is in place prior to the arrival of the service member and their family.

AAP recommends that the Department of Defense use the study authorized by Section 735 to determine what percentage of dependent children in military families with special health care needs are actually identified as EFMs and properly enrolled in EFMP. Differences in enrollment and function between branches of the military, regional contractors under TRICARE, and between CONUC and OCONUS should also be examined.

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

The Medicare Resource-Based Relative Value Scale (RBRVS) physician fee schedule, which reformed physician payments for Medicare recipients—and with which TRICARE is closely aligned—was enacted by Congress and signed into law as part of the Omnibus Budget Reconciliation Act of 1989 (OBRA). Traditionally, payment rates for pediatricians lag behind rates for adult care. AAP encourages DoD to review the payment rates for pediatric care, and, at a minimum, require regional contractors to reimburse pediatricians at 100 percent of Medicare RBRVS payment levels.

OBRA created a uniform RBRVS physician payment system based on an objective measures of physician workload (work relative value units [wRVUs]), accurate assessments of practice expense (PE) in providing services, and an additional payment factor representing the professional liability cost inherent in providing each service. Together, these three components make up the total relative value units (RVUs) for the services. The RBRVS system helped eliminate some of the dramatic disparities when payments were specialty- and primary care-specific and based on the customary, prevailing, and reasonable (CPR) or usual, customary, and reasonable (UCR) fees for the service provided. Congress also established a budget-neutral conversion factor (CF) that would not increase Medicare payments above that seen under the CPR system.

It is important to note, however, that the work estimates driving the RBRVS Medicare physician fee schedule were developed primarily to reflect the services rendered to the typical Medicare patient and, as such, may not accurately reflect the breadth and scope of work expended to provide care to neonates, infants, children, and adolescents. As AAP notes in its Policy Statement “Application of the Resource-Based Relative Value Scale System to Pediatrics,” children are often less cooperative and more anxious, which means that “many services and procedures for children, even when the more frequent need for procedural sedation is accounted
for, require more face-to-face time compared with similar services provided to the typical adult.”

Children also require constant adaptations to the physical examination, in response to their constantly changing behavior and level of cooperation.

As for the practice-expense component, pediatric practices are also more readily affected by factors such as prevalence of low-intensity office visits, larger volume of telephone calls, and increased case management requirements. In addition, the PE component of the RBRVS is reported differently based on whether the service is provided in an office setting (non-facility), a hospital or another facility. The facility PE component is much lower for office settings, which many pediatricians utilize, than non-office facility settings because of Medicare’s separate payments for hospital services under Part A and physician services under Part B. As such, total RVUs to physicians for the same service provided in the office setting exceed the RVUs for a similar service provided in the hospital or other facility setting.

These examples show how a pediatrician’s actual payment might be under-valued, even in the Medicare RBRVS system. However, the RBRVS system has payment levels higher than what most pediatricians are anecdotally paid in TRICARE. As such, AAP encourages DoD to examine how to best match the payment levels for pediatric services with those given to providers of adult care in TRICARE.

One of the concerns with payment for pediatric services under TRICARE is that it is common practice for regional contractors to require providers to provide a “discount” from the CHAMPUS National Pricing System (CMAC). These discounts can be as high as 20 percent, but are usually between 10 and 15 percent. The discount then stays with the contractor; no savings is actually afforded the Department of Defense if a provider agrees to a discount off of CMAC. In addition, every charge a provider submits is subjected to the discount. As such, if a pediatrician gives a 10 percent discount off of CMAC to the regional contractor, every service provided is discounted, even preventive health measures such as providing vaccines. Because of this policy, the discount can bring the payment for providing vaccines to below the cost of administering them. The AAP would respectfully urge that the “discount” policy as a whole be examined. AAP would encourage DoD to consider, at a minimum, to not allow discounts for the administration of vaccines to pediatric patients, or, at the very least, only allow non-E&M codes to be subject to a negotiated discount.

In terms of specific services under TRICARE, the Academy also encourages DoD to compare payment levels for mental health assessments and mental health interventions. With the particular needs of children in military families who have to cope with the stress of having one or both parents deployed, in addition to the normal stress of childhood, it is important that there is adequate access to mental health services. We encourage DoD to compare the payment level under TRICARE for mental health services to that in most private insurance plans and also to confirm that pediatricians may provide mental health services in the primary care setting under the rules of the contractor.

DoD should also consider examining access to specialty care services besides mental health care, particularly for children with special health care needs. DoD may also wish to examine whether

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there is adequate allowance given to see specialists outside the TRICARE Network, especially in the more remote and rural areas of the country where there is likely a general shortage of pediatric subspecialists for children enrolled in TRICARE.

If DoD has not already done so, AAP encourages the department to conduct a TRICARE Network Pediatric Provider Survey, in both CONUS and OCONUS regions. This could help determine whether there are differences in payment across geographic regions and different regional contractors. This could also help unearth whether some contractors are timelier than others in processing payment and appeals of claim denials. DoD may wish to examine whether there are wide variations in payment for the same codes and service levels and if satisfaction, or lack of satisfaction, is causing pediatricians in the civilian sector to refuse TRICARE or stop participating in the program.

Additionally, AAP urges DoD to consider including specific contractual language under TRICARE that addresses the rights and responsibilities of the TRICARE regional contractors. The AAP recommends that annual performance metrics should include ease of communication and responsiveness to providers and patient concerns, timeliness of payments, adequacy of regional networks of care—including primary, specialty and mental health care—timeliness of prior authorizations and appeals, adequacy of EMR linkage from military treatment facilities and regional networks and patient outcomes based on current HEDIS indicators. In addition, as with Medicare, DoD should examine whether appointing regional carrier medical directors or ombudsmen who would be readily available to discuss issues including medical necessity, out of network referrals, RAC audits, contracting and payment issues, procurement of DME, formulary issues, and any other concerns would be helpful to TRICARE enrollees.

When transitioning from one carrier to another, efforts should also be made to include more stakeholder input, including physicians and State Medical Society specialists, to avoid problematic transitions as have recently occurred in several TRICARE regions. In addition, AAP encourages TRICARE and DoD to consider more flexible payment mechanisms. In coverage areas where there are substantial numbers of patients and substantial investments by civilian resources, consideration should be given to demonstration pilots, including partial- and full-risk capitation, bundled episodes of care and global risk. All of these would include value based care metrics and would mirror pilots underway in Medicare. Incentives to carriers should strictly be based on the recommended performance metrics listed above; there should be no incentives for regional contractors to contract with small practices and solo providers at levels below those given to larger practices who may have more bargaining power.

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

The AAP recognizes the importance of the Extended Care Health Option, otherwise known as ECHO, for military families who need assistance in caring for a family member with significant disabilities. ECHO, which acts as a supplemental program to the TRICARE Basic Program, is designed to “provide an additional financial resource for an integrated set of services and supplies designed to assist in the reduction of the disabling effects of the ECHO-eligible dependent’s qualifying condition” according to 32 CFR § 199.5 (codified in Section 1079 of Title 10, United States Code). The ECHO program, which is the successor to the previous DoD
assistance options Program for Persons with Disabilities (PFPWD) and the Program for the Handicapped (PTH), was crafted to offer needed flexibility to services, many non-medical in nature, for children and spouses of active duty military members with significant disabilities.

DoD should closely examine the ECHO program to determine whether it is fulfilling its mission by appropriately providing for the needs of children with significant disabilities in a consistent fashion. AAP urges DoD to examine whether ECHO’s regulations are producing the desired outcomes for the families that participate in the program.

According to the TRICARE Policy Manual, the following services should be available to participants in the ECHO program:

- Assistive services
- Durable medical equipment, including adaption and maintenance equipment
- Expanded in-home medical services through TRICARE ECHO Home Health Care (EHHC) up to 8 hours a day, five days a week
- Rehabilitative services
- Respite care, up to 16 hours of care a month
- Training for special education and assistive technology devices
- Institutional care when a residential environment is required
- Transportation to and from institutions or facilities in certain circumstances
- Applied Behavior Analysis (ABA) reinforcement services under the DoD Enhanced Access to Autism Services Demonstration
- Special education services
- Vocational training
- Parent and sibling training
- Institutional care
- Equipment adaption and maintenance
- “Other” services as deemed necessary by the Director of TMA

AAP strongly urges DoD to study whether military families enrolled in the ECHO program can access the services they require for their disabled family member and the family caregivers in a timely fashion. DoD should determine if all of these services are available to military families regardless of duty station or geographic region.

AAP also urges that the study demonstrate if some services are utilized at a higher rate than others, if there are particular disabilities that comprise the majority of conditions being treated, and if there are long waiting lists for particular services. For example, DoD may wish to establish how often children with intensive caregiver needs are not able to access medically necessary nursing needs (covered under ECHO Home Health Care). For children with intensive caregiver needs (ventilator, tracheostomy, continuous GT feedings, or suctioning), DoD should examine how many hours of nursing needs are covered by TRICARE resources, and how many are covered by other State or insurance resources, as well as how many medically necessary needs are unmet. In particular, for children with apnea monitors, self-injurious behaviors, and other issues that need frequent continuous caregiver intervention, the study should determine if needs for night and respite care are being met.
In addition, AAP encourages DoD to examine the definitions of “durable equipment” and “durable medical equipment” to determine whether they are adequate in meeting the needs of children receiving benefits from the ECHO program. Currently there appears to be significant interpretation and variation regarding what equipment is approved or denied based on the TRICARE regional contractor unrelated to medical necessity.

One other principal concern with the ECHO program is that it is only available to active-duty service personnel. With the large number of National Guard and Reserve families that have been called into action over the past decade, with many going back and forth between active duty and reserve/guard status, DoD should consider making this program available to all members of the Armed Forces, regardless of active or reserve status. DoD may also wish to examine the feasibility of moving some ECHO services into TRICARE BASIC to allow retiree families to benefit from services as well.

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

Children with special health care needs often require multiple services and providers to maintain and improve their function. For decades, AAP has promoted the medical home concept that encompasses the characteristics of pediatric care considered essential for all children. AAP defines the medical home as a model of primary care that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective. In fact, the medical home concept has received widespread national attention as a mechanism for ensuring quality in health care for children with special health care needs. Unfortunately, because children with special health care needs often require the highest levels of services and support and place many demands on the health care system, they are less likely than children without special needs to have care that meets all of the components of the medical home. AAP supports DoD efforts to promote case management and care coordination for children with special health care needs.

Care for medically complex, special needs children is very different than that of the typical child who may come in to see the pediatrician with an occasional flu or broken bone. Thus, when reviewing the adequacy of care management for dependent children with special health care needs, it is important to emphasize that care coordination does not necessarily equate with case management. For children who need constant, 7-day a week care, with numerous providers and specialists, coordination among several case managers who oversee one or two aspects of a multi-disciplined array of pediatric providers and subspecialists may be needed.

The AAP encourages DoD to use the study authorized in Section 735 to assess the adequacy of the existing case management system available to children, especially those with special health care needs under TRICARE. Case management is a TRICARE benefit, but AAP would urge DoD to use this study to determine how many families use this benefit and for what purpose. DoD can also determine how this service is advertised, promoted or otherwise made known to military families. For example, there is ECHO case management for children using the ECHO Applied Behavioral Analysis (ABA) Demonstration program, but it is unclear whether this differs from other case management available in TRICARE.
In addition, AAP urges DoD to examine how care coordination is offered to families with medically complex special needs children. Care coordination has been defined as “the deliberate organization of patient care activities between two or more participants . . . involved in a patient’s care to facilitate appropriate delivery of health care services,” and typically involves activities like integrating a child’s medical care plans with the care plans developed by other providers or organizations, or discussing a family’s potential needs for non-medical services. It would be valuable for DoD to determine how many providers acknowledge coordinating care and communicating effectively with other providers for a child with special health care needs.

(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.

In order for DoD to provide the best possible support for the physical and behavioral health of dependent children, especially those with special health care needs, constant coordination between TRICARE and the family assistance programs within DoD like EFMP, the Office of Special Needs, and the Military Family Readiness Council should occur.

AAP recommends that DoD examine if, prior to service members with children changing duty stations—especially those with children with special health care needs and more complex medical conditions—adequate information is forwarded to the accepting commands about the particular needs of that family. This should include information about the physical and behavioral health needs of family members that includes a health and medical summary of conditions and services and needs that should be put in place. TRICARE and the EFMP should review those needs and assist the command and military treatment facility if available in identifying services that can be provided within the military health system and identify resources for service and referral that will be needed prior to the family's arrival.

On arrival, EFMP staff, command and military treatment facility personnel, if available, should work with the family to explain resources and assist with referrals. If a military treatment facility is associated with the command, the child or family member should be provided with the opportunity to be examined to identify needs that can be provided within the military health system. There should be discussions of service and support needs that will and will not be covered by the TRICARE program.

The AAP also recommends that DoD utilize—if they have not already done so—consistent performance measures to verify whether or not the support programs like those mentioned above are being implemented properly and consistently across all regions and duty stations. AAP encourages DoD to determine if the different support programs foster communication between themselves, military and civilian providers, patients, and their families. DoD should also examine whether there are enough respite and child-care options to help military parents navigate and organize the maze of providers needed to take care of medically complex children.

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DoD may also wish to determine whether support systems are widely advertised so that military families know they are available.

(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.

Of all the different aspects of the study authorized by Section 735, the provision examining mechanisms for linking dependent children with special health care needs with State and local community resources, may be one of the most important for families of children with special health care needs, especially after the initial diagnosis for their child.

As mentioned previously, children with special health care needs often work with many different care providers and subspecialists in order to receive the care that they need. Oftentimes, they are able to access some of the needed care from State and local resources. However, many military families may not be aware of available State and local resources, especially after they first discover that their child has special health care needs. It is not uncommon for military families to conduct an exhaustive and frustrating search for primary and specialty care for their family members with complex medical conditions or children with special health care needs. It would be extremely beneficial for these families if there were readily available information about the types of services available from State and local resources that could supplement what they were able to utilize from TRICARE and DoD programs.

As such, the Section 725 study should examine whether military treatment facilities and duty stations have established relationships with State and local Medicaid and health departments. DoD could determine if military treatment facilities have information readily available for parents who need referrals for care and service options not offered at the facilities themselves, if they help families determine how far they will have to travel for services and help arrange for travel to get there, and if they help military families connect with parenting groups that can help them deal with the pressures of caring for their child with special needs and help them find the services they need.

In addition, if not already available, DoD, in tandem with State and local health agencies, could develop a central repository of information about resources in each area where military service personnel with children with and without disabilities are to be assigned. This could be accomplished with a central, regional and local database that would facilitate education and training services for families without unnecessary stress or frustration.

(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.

Part of the sacrifice that military personnel undertake is multiple transfers of duty stations that can take people around the world, with transfers every 2-4 years. While this may be a challenge for members of military families, it can be especially taxing and burdensome for military families that have children with special health care needs.
AAP urges that DoD assist families with special needs children who have to transfer duty stations to find and locate needed providers, subspecialists and facilities that can provide the services needed by the child and his or her family. For families located or relocating to other areas where major military treatment facilities are not located, TRICARE should identify resources for specialty services in general and particularly for children with special needs. This would include developing a list of facilities and specialties located reasonably near locations where members are likely to be assigned. The TRICARE central office should develop a list of specialty resources and assist families in identifying and connecting with specialty resources prior to moving service members and families to their new assignment.

TRICARE and the DoD EFMPs should also assist regional military outpatient facilities to provide services for families and healthcare for children in meeting those with special needs that are within the usual scope of care for primary care health facilities. They should also have information available to families prior to their departure from their immediate past duty station and provide guidance and assistance to insure that a service plan is in place prior to their arrival at their new assignment.

In addition, it is important to recognize that obtaining mental and behavioral health services remains one of the more difficult challenges for primary care pediatricians and practices. This is compounded for military and non-military transient families because of the disruption in care and difficulty in finding resources even in areas where resources exist. Access to medically necessary services is often complicated. Payment options and acceptance of insurance coverage is an ongoing problem, especially with federally sponsored programs such as TRICARE. A survey of family experiences may be helpful and may provide helpful information about available regional resources and identify areas where access is unavailable even when resources exist.

On behalf of the American Academy of Pediatrics, thank you for this opportunity to share our thoughts and recommendations on what DoD should examine in the study authorized by Section 735 of the FY13 NDAA. Ensuring that children of members of the Armed Forces receive the proper health care they deserve is one important way that this country can demonstrate our gratitude, respect and honor for our military and their families. We stand ready to work with DHA on this issue and would welcome an opportunity to discuss this issue in more detail with DHA leadership. If we may provide further information or assistance, please contact Patrick Johnson in our Washington, DC office at (202) 347-8600 or pjohnson@aap.org.