OFFICE OF THE UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, D.C. 20301-4000

PERSONNEL AND READINESS

DEC 26 2018

The Honorable James M. Inhofe
Chairman
Committee on Armed Services
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

This report responds to section 733 of the National Defense Authorization Act for Fiscal Year 2018 (Public Law 115-91), which requires the Secretary of Defense to submit to the Committees on Armed Services a report on Military Health System (MHS) plans to improve pediatric care and related services for children of members of the Armed Forces.

The MHS' dual mission is to provide high quality health care in support of the full range of military operations, and to sustain the health of all those entrusted to our care, including more than 2.4 million pediatric beneficiaries. The enclosed report outlines the MHS' plans to improve pediatric care through the alignment of preventive pediatric health benefits, development of measures to evaluate the quality of pediatric primary and specialty care, and coordination of care for children with medically complex needs. The report also addresses the MHS' plans to enhance collection and reporting of pediatric data in order to improve health outcomes.

Major transformational reorganization, including changes to the TRICARE program, administration and oversight of military treatment facilities under the Defense Health Agency, and early implementation of MHS GENESIS, the new electronic health record, have all influenced various elements within the report. These changes are creating new opportunities for the MHS to better evaluate, quantify, and validate the quality of care provided for not only pediatric beneficiaries, but all members of the Armed Forces and their families.

Thank you for your interest in the health and well-being of our Service members, veterans, and their families. A similar letter is being sent to the Chairman of the House Armed Services Committee.

Sincerely,

James N. Stewart
Assistant Secretary of Defense for Manpower and Reserve Affairs, Performing the Duties of the Under Secretary of Defense for Personnel and Readiness

Enclosure:
As stated

cc:
The Honorable Jack Reed
Ranking Member

OFFICE OF THE UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, D.C. 20301-4000

PERSONNEL AND READINESS

DEC 26 2018

The Honorable William M. "Mac" Thornberry
Chairman
Committee on Armed Services
U.S. House of Representatives
Washington, DC 20515

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Sincerely,

James N. Stewart
Assistant Secretary of Defense for Manpower and Reserve Affairs, Performing the Duties of the Under Secretary of Defense for Personnel and Readiness

Enclosure:
As stated

cc:
The Honorable Adam Smith
Ranking Member

Report to Armed Services Committees

THE PLAN TO IMPROVE PEDIATRIC CARE AND RELATED SERVICES FOR CHILDREN OF MEMBERS OF THE ARMED FORCES

Required by: Section 733 of the National Defense Authorization Act for Fiscal Year 2018 (Public Law 115–91)

The estimated cost of this report or study for the Department of Defense is approximately $14,000 in Fiscal Years 2018 - 2019. This includes $5,500 in expenses and $8,090 in DoD labor.
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EXECUTIVE SUMMARY

This report responds to section 733 of the National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2018 (Public Law 115-91), which requires the Secretary of Defense to submit a report to the Committees on Armed Services on Military Health System (MHS) plans to improve pediatric care and related services for children of members of the Armed Forces. This final report builds upon an interim report submitted in June 2018, providing a plan for each of the elements identified below, and includes data where available.

Section 733 of the NDAA for FY 2018 requires the Secretary of Defense to provide:

1. A plan to align preventive pediatric care with standards for such care under the Patient Protection and Affordable Care Act (PPACA) and guidelines established for such care under Medicaid and with recommendations by organizations that specialize in pediatrics;
2. A plan to develop a uniform definition of "pediatric medical necessity";
3. A plan to develop measures to evaluate and improve access to pediatric care, coordination of pediatric care, and health outcomes;
4. A plan to assess access to pediatric specialty care in the annual TRICARE evaluation report to Congress;
5. A plan to improve the quality of and access to behavioral health care, including intensive outpatient and partial hospitalization services;
6. A plan to mitigate the impact of permanent change of station (PCS) and other service-related relocations on continuity of care for children who have special medical or behavioral health needs; and
7. A plan to mitigate deficiencies in data collection/utilization/analysis to improve pediatric care and related services.

Key findings from the seven elements noted above reveal:

1. **MHS plans to align preventive pediatric care with the standards of such care under PPACA, guidelines established under Medicaid, and with recommendations by organizations that specialize in pediatrics.** MHS actively develops and updates benefits for the TRICARE program by conducting consistent and vigilant reviews of research, practice, and outcomes for the pediatric population. The plan to ensure current preventive pediatric care under the TRICARE Basic Program (the medical benefit) is consistent with PPACA involves completion of a comprehensive gap analysis. This gap analysis is currently in progress with an expected completion in 2019. The gap analysis is expansive, and includes all age groups of beneficiaries with a focus on traditional clinical practice, and international models of preventive care with the inclusion of social determinants of health. MHS will continue to align preventive care for adult and pediatric care within the bounds of statutory authority through regular monitoring and ongoing evaluation of parity with standards and guidelines to ensure children of members of the Armed Force receive consistently high quality health care. The preventive care comprehensive gap analysis will be complete by December 31, 2019, and a review of findings from the gap analysis and final recommendations will occur no later than December 31, 2020.

2. **MHS plans to develop a uniform definition of "pediatric medical necessity."** MHS does not plan to develop a uniform definition of "pediatric medical necessity." Rather, MHS plans to continue to utilize the uniform definition of "medical necessity" to apply to all beneficiaries to ensure safe and effective care, as the existing definition of "medical necessity" is outlined in statutory and regulatory language. Statutorily under the TRICARE program, a service or supply is medically or psychologically necessary if it is to prevent, diagnose, or treat a mental or physical illness, injury, or bodily malfunction; this applies to both adult and pediatric beneficiaries. To determine which services or supplies are medically necessary, TRICARE uses a hierarchy of reliable evidence to determine safety and efficacy. Although research and published controlled studies in the pediatric fields are often not as robust as in the adult population, the hierarchy of evidence includes utilization of published reports from national professional medical associations, national medical policy organization positions, and national expert opinion organizations (e.g., the American Academy of Pediatrics (AAP)) when more robust research is not available. Additionally, TRICARE's rare disease policy, off-label use policy for drugs and devices, and provisional coverage authority (developed in response to section 704 of the NDAA for FY 2015 (Public Law 113-291)), provides coverage outside the reliable evidence criteria. A secondary level of medical necessity for children would imply that there are two standards for safe and effective care, when in fact all TRICARE beneficiaries are entitled to the same level of scrutiny and protection offered by the multiple levels of evidence in the hierarchy. Title 32 Code of Federal Regulations (C.F.R.) § 199.4 (g)(15).

3. Appendix A: Summary of MHS Plans for Section 733 of NDAA for FY 2018

	Element	Plan	Timeline
1	A plan to align preventive pediatric care with standards for such care under the PPACA and guidelines established for such care under Medicaid and with recommendations by organizations that specialize in pediatrics.	To ensure current preventive pediatric care under the TRICARE Basic Program (the medical benefit) is consistent with PPACA, a comprehensive gap analysis is in progress, with expected completion set for no later than December 31, 2019. Review of findings from the gap analysis and final recommendations will be made no later than December 31, 2020.	Gap analysis conducted **December 31, 2019**; Recommendations published **December 31, 2020**
2	A plan to develop a uniform definition of "pediatric medical necessity."	MHS feels confident a single hierarchy of evidence to support medical necessity is the standard of care for all beneficiaries. The hierarchy allows for different levels of evidence that can be applied to the pediatric population as needed.	N/A; Reevaluation expected **every 18 to 24 months**
3	A plan to develop measures to evaluate and improve access to pediatric care, coordination of pediatric care and health outcomes.	The current pediatric data display will be expanded to include approved measures once methodology and maturity is validated. Approved measures will added to the current display with the plan to have a display by December 31, 2019 able to evaluate pediatric care and health outcomes.	All approved measures will be added to the pediatric data display, with iterative updates thereafter, by **December 31, 2019**

Element		Plan	Timeline
4	A plan to assess access to pediatric specialty care in the annual TRICARE evaluation report to Congress.	Pediatric access metrics for third next appointments, specialty appointments, and specialty referrals are undergoing analysis for inclusion in the *FY 2020 Evaluation of the TRICARE Program, Access, Cost and Quality* (with access, cost, and quality data through FY 2019).	Access measures will be added to the *2020 TRICARE Evaluation* **March 1, 2020**
5	A plan to improve the quality of and access to behavioral health care including intensive outpatient and partial hospitalization services.	The MHS plan is to have an annual report to monitor quality of and access to behavioral health care. The report will include pediatrics measures including, but not limited to, intensive outpatient and partial hospitalization services. The next report and analysis will be due in October 31, 2019.	Next annual report to be completed by **October 31, 2019**
6	A plan to mitigate the impact of PCS and other service-related relocations on continuity of care for children who have special medical or behavioral health needs.	MHS plans to monitor the impact of PCS and other service-related relocations on continuity of care for children through three mechanisms: (1) measurements from the CY 2018 TRICARE contract regarding transfers of care between regions; (2) collection of data on assignments from the Services' Exceptional Family Member Program (EFMP); and (3) implementation of standardized Family Member Travel Screening (FMTS) processes.	Stand-up of collaborative working group **September 30, 2019**; Comprehensive roll out of standardized FMTS forms **December 31, 2019**
7	A plan to mitigate deficiencies in data collection/utilization/analysis to improve pediatric care and related services.	Establishment of a pediatric data display, including pediatric metrics for access, reinforce the commitment to pediatric specific data. MHS will continue to provide consistent metrics (purchased and direct care) with mitigation of deficiencies in data standardization/ collection/utilization/analysis.	Ongoing; all approved measures will be added to the pediatric data display **December 31, 2019**

4. Appendix B: TRICARE Medical Necessity Clause - Statutory and Regulatory Guidance) provides detailed guidance on acceptable sources of scientific data and relative weights to inform TRICARE coverage decisions. At this time, MHS has no plans to change the existing uniform definition of medical necessity, as it is already providing safe and effective care for all ages of beneficiaries. Consistent reevaluation, approximately every 18 to 24 months, ensures that TRICARE benefits are informed by new data, research, and/or clinical literature.

5. **MHS plans to develop measures to evaluate and improve access to pediatric care, coordination of pediatric care, and health outcomes.** Select pediatric measures have been posted publically for MHS since 2018 on health.mil, with additional data available on Hospital Compare[1] (provided by the Centers for Medicare and Medicaid Services (CMS)), giving individuals the ability to evaluate and compare the quality of care for adult and pediatric populations. Additionally, the National Committee for Quality Assurance's Healthcare Effectiveness Data Information Set (HEDIS®) measures broadly address effectiveness, access and availability, and utilization; within MHS, three HEDIS®

[1] https://www.medicare.gov/hospitalcompare

measures focused on the pediatric population (appropriate pharyngitis testing, appropriate upper respiratory infection testing, and well child visits) are currently measured and reported. In 2015, in an effort to expand pediatric metrics, a collaboration of Federal partners identified more than thirty additional measures in the domains of preventive care, better care, and lower cost, for further examination and potential inclusion in the first iteration of the MHS pediatric data display. After feasibility testing throughout 2016 and 2017, three initial measures were posted in 2018. MHS plans to add additional measures iteratively throughout 2019 as fidelity of the data for both purchased care (PC) and direct care (DC) can be established. Additional measures are expected be identified, evaluated, and added over time.

Analysis and standardization of data sources to establish externally comparable reporting of measures between PC and DC are ongoing, and include exploration of Leapfrog Group pediatric measures. Future standardization of practice, alignment of data systems, and the new electronic health record (EHR), MHS GENESIS (planned deployment through quarter three (Q3) FY 2024), provides a standardized platform for inpatient and outpatient documentation that is expected to allow for improved data collection and validity. MHS also continues to stratify measures to evaluate pediatric access to, coordination of, and outcomes of care. Additionally, as part of the transformation to a high reliability organization, MHS has also adopted a clinical community organizational model to promote continuous process improvement. General pediatric care is aligned within the Primary Care Clinical Community (PCCC), which seeks to achieve decreased unnecessary variance in health care practices to promote evidence-based health care.

Pediatric data on access to primary care, specialty care, and specialty referrals are currently in progress, with a validated data methodology expected by August 31, 2019 for anticipated inclusion in the *FY 2020 Evaluation of the TRICARE Program, Access, Cost and Quality* (with access, cost, and quality data through FY 2019). MHS plans to add all approved measures (as feasibility is determined) to the pediatric data display by December 31, 2019.

6. **MHS plans to assess access to pediatric specialty care in the annual TRICARE evaluation report to Congress.** Pediatric-specific metrics continue to expand in the annual Evaluation of the TRICARE Program, Access, Cost, and Quality. Metrics to assess access to pediatric specialty care have been developed, and MHS is continuing to determine feasibility and validity. At the time of this report, these metrics are undergoing analysis for inclusion in the annual TRICARE Evaluation reports, beginning with the *FY 2020 Evaluation of the TRICARE Program, Access, Cost and Quality* report (with access, cost, and quality data through FY 2019), due March 1, 2020.

7. **MHS' improvements of the quality of and access to behavioral health care, including intensive outpatient and partial hospitalization services,** were largely implemented through statutory changes in the TRICARE benefit in FY 2016. The subsequent publication of TRICARE Policy Manual revisions in FY 2017 established parity for behavioral health with that of medical and surgical treatment and benefits. These statutory changes, which included new benefit coverage of intensive outpatient

programs (IOPs) for mental health (MH) and substance use disorder (SUD) treatment, opioid treatment programs (OTPs), office-based outpatient treatment for medication-assisted treatment of opioid use disorder, and outpatient treatment of substance abuse, have already shown improvement in quality and access to behavioral health care services. The number of TRICARE authorized inpatient and outpatient facilities serving adult and pediatric needs continues to grow; especially noteworthy is a 66 percent increase in the number of TRICARE authorized child and adolescent psychiatric residential treatment facilities. An annual report is now providing metrics to evaluate the access to and quality of behavioral health care, in all settings. In October 2018, the initial report on access to behavioral health care, including intensive outpatient and partial hospitalization services, was completed (results are summarized Element 5). MHS plans to report findings as a component of the *FY 2019 Evaluation of the TRICARE Program, Access, Cost and Quality* report (or a future equivalent report, as appropriate), due March 1, 2019. The next annual report focused on behavioral health care is expected on October 31, 2019.

8. **MHS' mitigation of the impact of PCS and other service-related relocations on continuity of care for children who have special medical or behavioral health needs is an ongoing, collaborative process.** Mitigation of the impact of PCS includes increased access to resources and services, and MHS' many diverse programs are positively assisting families with relocation. The expansion of telehealth services, as outlined in section 718 of the NDAA for FY 2017 (Public Law 114-328), is further helping to decrease the impact of relocation, by allowing connections between providers and beneficiaries not geographically co-located. Telehealth programs in place within the MHS also facilitate provider-to-provider and provider-to-patient teleconsultation platforms, facilitate access to subspecialists, and reduce both patient and provider travel. The Family Support Center (FSC) EFMP decreases the impact of relocation through the giving and receiving of "warm hand-offs" to facilitate families with non-medical information and referral resources for their effective engagement with the new community.

   In order to centralize and provide metrics on the impact of these programs, MHS plans to begin formal coordination and collaboration with all components and programs to monitor the impact of PCS and other service-related relocations on continuity of care for children. This collaboration, expected to begin in 2019, allows three monumental process in place to establish equilibrium and begin to generate data for review and evaluation. The three processes include: (1) Defense Health Agency (DHA) administrative oversight of military medical treatment facilities (MTFs), which started October 1, 2018; (2) implementation of the TRICARE contract with two contractors after region realignment started January 1, 2018; and (3) full implementation of the FMTS, anticipated for December 31, 2019. The collaborative group led by DHA will include key stakeholders such as representatives from both Managed Care Support Contractors (MCSCs), all Service EFMP programs, the Office of Special Needs (OSN) representing the FSCs, and other groups as indicated. The group will define the data necessary to measure the impact of PCS and relocation. Data will be collected from three primary sources: (1) MCSC data regarding transfers of care between regions; (2) Services' EFMP collections of data on assignments and returns from PCS due to medical/behavioral

complexity; and (3) data from OSN on implementation and outcomes after standardized FMTS processes. The comprehensive roll out of standardized FMTS forms is on track for full implementation by December 31, 2019, through the new governance process of a Defense Health Agency Procedural Instruction (DHA-PI). The formal collaborating working group will be complete by the end of FY 2019.

9. **MHS' mitigation of deficiencies in data collection/utilization/analysis to improve pediatric care and related services is a top priority.** The identification and description of specific pediatric care measures, available in both DC and PC, are currently available on public web sites. Improvements in the collection, utilization, and analysis to provide a basis for evaluation, improvement, and future priorities continue to evolve. Consolidation of the TRICARE regions from three to two also provides an opportunity to decrease the diversity of data, and greater opportunity to compare data between regions and with direct care. Consistent and standardize data fields within the newly implemented EHR, MHS GENESIS, will improve knowledge of the quality, access, efficiency, and compliance of pediatric care in MHS. The anticipated full operational capabilities of MHS GENESIS, with current deployment planned through Q3 FY 2024, provides a single medical record worldwide. Continued efforts with the MHS during the MHS GENESIS implementation cycle, leverages a spectrum of measures in current use, access, referrals, experience of care, by stratifying data to outcomes for children, as a subpopulation to the TRICARE general population. Continued expansion and integration of data collection/utilization/analysis has provided an increasing number of metrics for demonstration of quality and access to pediatric care in the external and internal pediatric data display. The PCCC will monitor the data, outcomes, and impact of these changes in order to create a more extensive infrastructure and framework to identify, monitor, and assess the quality of care provided to children and all beneficiaries within MHS. Pediatric data continues to increase and MHS plans to report pediatric data annually in the TRICARE Evaluation report, beginning in the *FY 2019 Evaluation of the TRICARE Program, Access, Cost and Quality* report and beyond (or future equivalent report, as appropriate), due March 1, 2019.

Summary

MHS continues its evolution to an optimally structured, prepared, and increasingly data-supported organization, able to adapt to the rapid evolution of health care innovation and research. DHA, as the eventual single entity for oversight and administration of MTFs, aims to leverage this role to decrease unnecessary variances in care, cost, and quality, and design, define, and align care worldwide in order to facilitate the readiness of Service members. Transformational change in the abilities and capabilities of MHS to exploit opportunities for technology, data transparency, and family collaboration will reinforce the MHS commitment to "families' first, mission always."

Appendix A summaries MHS plans for each element of section 733 of NDAA for FY 2018.

INTRODUCTION

MHS' dual mission is to provide high quality health care in support of the full range of military operations, and to sustain the health of all those entrusted to MHS care. The commitment to pediatric beneficiaries is entrenched in the belief that the health of children is part of MHS' sacred trust. The health of children and families receiving consistent high quality health care and support services is an essential way to support war fighter readiness. In Department of Defense Instruction (DoDI) 1342.22, *Military Family Readiness*, the Department of Defense (DoD) defines the term "family readiness" as a family's preparedness to effectively navigate the challenges of daily living experienced in the unique context of military service. MHS recognizes the significance of family readiness and its impact on military readiness, performance, retention, and recruitment (DMDC, 2010).

MHS provides a wide range of programs and services to support the health care of approximately 9.4 million beneficiaries, 2.4 million of which are pediatric beneficiaries (newborn to 21 years of age). Service members and their families receive health care through two components for care delivery, the DC component where care is delivered in MTFs, and the PC component, where care is delivered in the community. TRICARE contracts with MCSCs and civilian providers to expand and augment the scope of care available to beneficiaries. It is the combination and collaboration of DC and PC that provides the comprehensive network of health care resources necessary for MHS to meet the health care needs of military members and their beneficiaries.

MHS continues to monitor, evaluate, and implement benefits and policies based on the rapid evolution of health care innovation and research, both internal and external to DoD. Advancement within MHS is most commonly realized through policy, oversight, and technology changes. Several concurrent and ongoing efforts, listed below, are leading the way in which MHS matures into a more agile and transformational organization:

1. **TRICARE Region Changes:** Section 701 of the NDAA for FY 2017 (Public Law 114-328), ordered extensive changes to the TRICARE health care benefit used by Service members, retirees, and their families to be implemented by January 1, 2018, including establishment of TRICARE Select, new cost sharing requirements, and changes to referral and preauthorization processes. Effective January 1, 2018, the TRICARE PC contracts were also restructured from three regions to two (and from three MCSCs to two) to support consistency and accountability across the PC component. This change is reducing complexity, and creating an improved, seamless application of health benefits. The streamlining of services provides much needed support to medically complex family members when transferring across/between regions.

2. **DHA Oversight and Administration of MTFs:** Section 702 of the NDAA FY 2017 (Public Law 114-328), directs a major transformation of MHS, including the transfer of certain authorities and control from the Military Departments to DHA. Substantial challenges are inherent in implementing major reform such as those required under section 702 of this legislation, not the least of which is maintaining "a ready medical force and a medically ready force." While progress is well underway to implement the statutory requirements included in section 702, MHS continues to work on how best to

harmonize roles and responsibilities of the DHA and the Military Departments. As articulated previously, DHA has submitted plans to "transition to the end state of a fully integrated system of readiness and health, underpinned by a new health care delivery and management model that meets the intention of 10 U.S.C. § 1073c. MHS efforts focus not only on the goal of reducing redundant and unnecessary headquarters overhead, but on building a structure that drives improved outcomes for readiness, health, and cost." Phase one of MTF administration under DHA commences October 1, 2018. Full implementation is planned to occur in scheduled phases over the next several years. At the time of this report, eight MTFs have aligned under DHA during the first phase;[2] this restructuring promotes standardization, identifies efficiencies, and improves reporting of outcomes to validate quality improvement through improved beneficiary outcomes across the system.

3. **MHS GENESIS:** Implementation of MHS GENESIS, the commercial off-the-shelf product by Cerner, is also underway as the single enterprise EHR. MHS GENESIS is expected to improve interoperability with private sector systems, which is a vital aspect of health care quality. The standard platform of MHS GENESIS will include common clinical applications, interfaces, and a shared infrastructure that "when configured, results in a much greater commonality in practical workflows, roles, order sets, plans and reports, as well as the training materials to support them" (Sullivan, 2018). MHS GENESIS will integrate inpatient and outpatient records, connect medical and dental information across the continuum of care, standardize data collection, and facilitate information sharing with providers, patients, and their families. MHS GENESIS is currently live in select West Coast MTFs, with roll out scheduled to continue worldwide through Q3 FY 2024.

The changes and challenges within the infrastructure of MHS allow for innovation and opportunity to evaluate, quantify, and validate the quality of care provided for all members of the Armed Forces and their families.

Overview of DoD's Military Health System

MHS' unique blend of DoD health care resources across the DC and PC components provides access to high quality health care services while maintaining the capability to support military operations. The 9.4 million TRICARE beneficiaries include Service members, National Guard and Reserve members, retirees and their families, survivors, certain former spouses, and other eligible individuals worldwide. This total includes an estimated 2.4 million beneficiaries aging from birth to 21 years. TRICARE is a set of health care benefits defined by statute, and MHS meets the medical needs of enrolled beneficiaries through a comprehensive worldwide health care system that combines the best of military medicine and community medical resources. (Statutory authority for the TRICARE benefits are available in Appendix C: TRICARE Overview.)

[2] The eight phase one sites include: (1) Walter Reed National Military Medical Center; (2) Fort Belvoir Community Hospital; (3) Jacksonville Naval Hospital; (4) 81st Medical Group (MDG) at Keesler Air Force Base; (5) Womack Army Medical Center; (6) 4th MDG at Seymour Johnson Air Force Base; (7) 628th MDG at Joint Base Charleston; and (8) 43rd Medical Group at Pope Field.

MTFs in the DC system provide health care delivered by uniformed service personnel, DoD civilians, and/or contracted civilian health care professionals. Within MTFs, eligible beneficiaries enrolled in TRICARE Prime (the Health Maintenance Organization (HMO)-like option), are enrolled in a Patient-Centered Medical Home (PCMH) and assigned a Primary Care Manager (PCM), who is responsible for delivery and coordination of care. PCMs provide referral to specialty care as medically necessary.

Supplementing the DC component is the PC component. PC is delivered by TRICARE authorized civilian health care providers in the community. PC providers include TRICARE authorized civilian health care professionals, institutions, pharmacies, and suppliers who have entered into a network participation agreement with a TRICARE regional contractor. Network providers include civilian network PCMs assigned to beneficiaries enrolled in TRICARE Prime and civilian network specialty care providers who provide care to Prime beneficiaries through referral and authorization. Network primary and specialty care providers also function as TRICARE Select providers (the Preferred Provider Option). Additionally, TRICARE authorized non-network PC providers provide care to beneficiaries through choosing to "participate" on a claim-by-claim, case-by-case basis. This system of collaboration between the resourcing and care of DC and PC provides adults and children with a wide range of medical primary, specialty, preventive, and behavioral health care provider services and setting options.

As noted above, section 701 of the NDAA for FY 2017 (Public Law 114-328), required substantive changes to the TRICARE program. These changes to the TRICARE benefit used by Service members, retirees, and their families were implemented on January 1, 2018, and included establishment of TRICARE Select as a self-managed, preferred provider network option to replace TRICARE Standard and Extra. Changes further established annual enrollment fees and fixed dollar copayments for Active Duty family members (ADFMs) and retirees who join the Armed Services on or after January 1, 2018, and enroll in TRICARE Select or in TRICARE Prime. It also authorized DoD to establish an annual enrollment fee for TRICARE Select for beneficiaries who were in the Active Duty or retired categories prior to January 1, 2018.

In addition to these legislative changes, TRICARE awarded two new MCSCs, which decreased the number of regions administering the health care benefit from three to two. The reduction to two regions supports consistency in benefit administration by reducing the potential for administrative variation across regions, reducing administrative cost, and enhancing seamless transition support for a mobile TRICARE beneficiary population. TRICARE North and South Regions were combined to form TRICARE East, while TRICARE West remained mostly unchanged. The new East Region contract was awarded to Humana Government Business, Inc., and the West Region contract to Health Net Federal Services, LLC. The PC component of TRICARE now includes:

- The TRICARE East Region: Alabama, Arkansas, Connecticut, Delaware, the District of Columbia, Florida, Georgia, Illinois, Indiana, Iowa (Rock Island Arsenal area only), Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Mississippi, Missouri (St. Louis area only), New Hampshire, New Jersey, New York, North Carolina, Ohio,

Oklahoma, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas (excluding the El Paso area), Vermont, Virginia, West Virginia and Wisconsin.

- The TRICARE West Region: Alaska, Arizona, California, Colorado, Hawaii, Idaho, Iowa (except the Rock Island Arsenal area), Kansas, Minnesota, Missouri (except the St. Louis area), Montana, Nebraska, Nevada, New Mexico, North Dakota, Oregon, South Dakota, Texas (areas of Western Texas only), Utah, Washington, and Wyoming.

In addition to TRICARE benefits, some military families and children qualify for state and other federal programs (e.g., Medicaid, Medicare) to meet specific needs. These programs, their resources, and eligibility requirements are unique to specific regions within the state of residence. Beneficiaries who are eligible to utilize the federal and/or state benefits may qualify for services that are not part of the TRICARE Basic Program or the Extended Care Health Option (ECHO) Program. Military Department and Personnel programs (Family Support Services) augment civilian community programs by providing additional unique resources to military families with programs such as childcare and recreation programs.

Elements of the Plan

This report outlines current initiatives, plans for improvement, and programs to enhance and enrich pediatric care. As required by section 733 of the NDAA for FY 2018 (Public Law 115-91), these are outlined in seven elements:

1. A plan to align preventive pediatric care with standards for such care under the PPACA and guidelines for such care under Medicaid and with recommendations by organizations that specialize in pediatrics;
2. A plan to develop a uniform definition of "pediatric medical necessity";
3. A plan to develop measures to evaluate and improve access to pediatric care, coordination of pediatric care and health outcomes;
4. A plan to assess access to pediatric specialty care in the annual TRICARE evaluation report to Congress;
5. A plan to improve the quality of and access to behavioral health care including intensive outpatient and partial hospitalization services;
6. A plan to mitigate the impact of PCS and other service-related relocations on continuity of care for children who have special medical or behavioral health needs; and
7. A plan to mitigate deficiencies in data collection/utilization/analysis to improve pediatric care and related services.

ELEMENT 1
A plan to align preventive pediatric care with standards for such care under the PPACA and guidelines for such care under Medicaid and with recommendations by organizations that specialize in pediatrics

MHS actively develops and updates benefits for the TRICARE program by conducting consistent and vigilant reviews of research, practice, and outcomes for the pediatric population. TRICARE medical and preventive pediatric benefits are part of the TRICARE Basic Program,

which outlines the medically necessary preventive, primary, specialty, and behavioral health care benefits available to adult and pediatric beneficiaries. The plan to ensure current preventive pediatric care under the TRICARE Basic Program (the medical benefit) is consistent with PPACA involves a comprehensive gap analysis (already in progress), with an expected completion set for 2019. The gap analysis is expansive, and includes all age groups of beneficiaries with a focus on traditional clinical practice, and international models of preventive care with the inclusion of social determinants of health.

As currently written, the TRICARE Basic Program largely aligns with standards for such care under the PPACA, guidelines for such care under Medicaid, and with recommendations by organizations that specialize in pediatrics. TRICARE preventive benefits are based on guidelines from the U.S. Department of Health and Human Services, which include recommendations from the United States Preventive Services Task Force (USPSTF), Health Resources and Services Administration, and Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices for helping to inform revisions and modifications to TRICARE program benefits. In addition, Health Promotion and Disease Prevention, annual examinations for beneficiaries ages six through 21 include those services recommended by the AAP and Bright Futures.

MHS will continue to align preventive care for adult and pediatric care within the bounds of statutory authority through regular monitoring and ongoing evaluation of parity with standards and guidelines to ensure children of members of the Armed Force receive consistently high quality health care. On an ongoing basis, MHS will review preventive benefits to ensure parity with standards and guidelines where statutorily possible, and engage with organizations that specialize in pediatrics to discuss guidelines and research in pediatric care to ensure alignment within the bounds of statutory authority. MHS plans to complete a comprehensive gap analysis by December 31, 2019. A review of findings from the gap analysis and final recommendations will be made by December 31, 2020.

ELEMENT 2
A plan to develop a uniform definition of "pediatric medical necessity"

MHS does not plan to develop a uniform definition of "pediatric medical necessity." Rather, MHS plans to continue to utilize the uniform definition of "medical necessity" to apply to all beneficiaries to ensure safe and effective care, as the existing definition of "medical necessity" is outlined in statutory and regulatory language. To determine if a medical service or supply is medically necessary, a hierarchy of evidence is employed to ensure safe and effective care for all pediatric beneficiaries. The prevailing definition of "medically necessary" care ensures that treatments and services for pediatric beneficiaries are the subject of "well-controlled studies of clinically meaningful endpoints, which have determined its maximum tolerated dose, its toxicity, its safety, and its efficacy as compared with standard means of treatment or diagnosis." Title 32 C.F.R. § 199.4 (g)(15) (Appendix A: Summary of MHS Plans for Section 733 of NDAA for FY 2018)

	Element	Plan	Timeline
1	A plan to align preventive pediatric care with standards for such care under the PPACA and guidelines established for such care under Medicaid and with recommendations by organizations that specialize in pediatrics.	To ensure current preventive pediatric care under the TRICARE Basic Program (the medical benefit) is consistent with PPACA, a comprehensive gap analysis is in progress, with expected completion set for no later than December 31, 2019. Review of findings from the gap analysis and final recommendations will be made no later than 31 December 2020.	Gap analysis conducted **December 31, 2019**; Recommendations published **December 31, 2020**
2	A plan to develop a uniform definition of "pediatric medical necessity."	MHS feels confident a single hierarchy of evidence to support medical necessity is the standard of care for all beneficiaries. The hierarchy allows for different levels of evidence that can be applied to the pediatric population as needed.	N/A; Reevaluation expected **every 18 to 24 months**
3	A plan to develop measures to evaluate and improve access to pediatric care, coordination of pediatric care and health outcomes.	The current pediatric data display will be expanded to include approved measures once methodology and maturity is validated. Approved measures will added to the current display with the plan to have a display by December 31, 2019 able to evaluate pediatric care and health outcomes.	All approved measures will be added to the pediatric data display, with iterative updates thereafter, by **December 31, 2019**
4	A plan to assess access to pediatric specialty care in the annual TRICARE evaluation report to Congress.	Pediatric access metrics for third next appointments, specialty appointments, and specialty referrals are undergoing analysis for inclusion in the *FY 2020 Evaluation of the TRICARE Program, Access, Cost and Quality* (with access, cost, and quality data through FY 2019).	Access measures will be added to the *2020 TRICARE Evaluation* **March 1, 2020**
5	A plan to improve the quality of and access to behavioral health care including intensive outpatient and partial hospitalization services.	The MHS plan is to have an annual report to monitor quality of and access to behavioral health care. The report will include pediatrics measures including, but not limited to, intensive outpatient and partial hospitalization services. The next report and analysis will be due in October 31, 2019.	Next annual report to be completed by **October 31, 2019**
6	A plan to mitigate the impact of PCS and other service-related relocations on continuity of care for children who have special medical or behavioral health needs.	MHS plans to monitor the impact of PCS and other service-related relocations on continuity of care for children through three mechanisms: (1) measurements from the CY 2018 TRICARE contract regarding transfers of care between regions; (2) collection of data on assignments from the Services' EFMP; and (3) implementation of standardized FMTS processes.	Stand-up of collaborative working group **September 30, 2019**; Comprehensive roll out of standardized FMTS forms **December 31, 2019**
7	A plan to mitigate deficiencies in data collection/utilization/analysis to improve pediatric care and related services.	Establishment of a pediatric data display, including pediatric metrics for access, reinforce the commitment to pediatric specific data. MHS will continue to provide consistent metrics (purchased and direct care) with mitigation of deficiencies in data standardization/ collection/utilization/analysis.	Ongoing; all approved measures will be added to the pediatric data display **December 31, 2019**

Appendix B: TRICARE Medical Necessity Clause - Statutory and Regulatory Guidance) provides detailed guidance on acceptable sources of scientific data and relative weights to inform TRICARE coverage decisions by using the established hierarchy of reliable evidence.

The current "medical necessity" requirement applies to adults and children, ensuring that all populations receive safe, effective, and equitable care. Although research and published studies in the pediatric fields are often not as robust as in the adult population, there are other authorities and policies that allow coverage for pediatric health care services that may not meet the reliable evidence standard, including:

- **Rare disease policy:** A rare disease is defined by TRICARE as any disease or condition that has a prevalence of less than 200,000 persons in the U.S., including infants and children. Treatment of rare diseases is reviewed on a case-by-case basis. After assessing the clinical literature, coverage can be provided when it is determined that the proposed treatment for the rare disease is medically necessary and is safe and effective.
- **Off-label use for devices and medications:** TRICARE will cover off-label uses of drugs and devices. Approval for off-label use requires review for medical necessity and demonstrations from the medical literature, national organizations, or technology assessment bodies that the off-label use of the drug or device is safe, effective, and in accordance with nationally accepted standards of practice in the medical community.
- **Cancer clinical trials:** TRICARE will cost-share all medical care and testing required to determine eligibility for a National Cancer Institute (NCI) sponsored Phase I, Phase II, or Phase III cancer clinical trial, including the evaluation for eligibility for pediatric beneficiaries. Coverage includes all medical care required as a result of participation, such as purchasing and administering all approved chemotherapy agents (except for NCI-funded investigational drugs), all inpatient and outpatient care, including diagnostic and laboratory services not otherwise reimbursed under the NCI grant program.
- **Provisional coverage authority:** Developed in response to section 704 of the NDAA for FY 2015 (Public Law 113-291), this program allows the Assistant Secretary of Defense for Health Affairs to "provide provisional coverage for the provision of a service or supply if the Secretary determines that such service or supply is widely recognized in the United States as being safe and effective." This program provides coverage for emerging treatments and technologies that DHA believes will have evidence within five years to satisfy the hierarchy of reliable evidence for coverage under the TRICARE Basic benefit. Provisional coverage may be granted for a period of up to five years.

Approximately every 18 to 24 months, or more frequently, DHA officials conduct medical benefit reviews to gather new data, review newly published literature, and provide revised coverage recommendations. In addition, offering further support to the benefits and policies described above, the ECHO Program and Demonstration Authority provide further opportunities for medically safe care.

- **ECHO:** The ECHO Program, which has no age restrictions, provides supplementary health care services and other special education services to qualifying beneficiaries in order to decrease the debilitating effect of their qualifying condition. ECHO benefits,

individualized to the beneficiary needs, can include but are not limited to durable non-medical equipment, supplemental speech therapy, physical therapy, and/or occupational therapy.

- **Demonstration Authority:** Chapter 55 of 10 U.S.C. § 1092 allows the Secretary of Defense to "conduct studies and demonstration projects on health care delivery system of the uniformed services with a view to improving the quality, efficiency, convenience, and cost effectiveness of providing health care services." Under this authority, the DHA Evaluation of Non-U.S. Food and Drug Administration Approved Laboratory Developed Tests Demonstration Project was started in July 2014. Included under this demonstration was coverage for prenatal and preconception cystic fibrosis carrier screening, and genetic testing that can assist a provider and the family to diagnose a child with a genetic syndrome, physical differences, developmental delay, and/or intellectual disabilities. The Autism Care Demonstration was another example, which provided applied behavior analysis services to pediatric (and adult) beneficiaries diagnosed with Autism Spectrum Disorder (ASD) without age limit.

The complexity of medical necessity determinations increases when discussing the needs of children with a pervasive developmental disorder that affects many areas of functioning (i.e., children with complex needs, cerebral palsy, and/or autism). Distinctions between medical necessity versus educational necessity is an important concept in treating pediatric disorders, as are the nuances between habilitative and rehabilitative care. Currently, in many health benefit plans, medically necessary coverage under the health care benefit is limited to rehabilitative services, meaning care to restore a lost function. Habilitative care is care provided to address a function or skill not yet acquired or a milestone not yet achieved, as would be the case for speech therapy for a non-verbal child with autism or physical therapy for a child with hypotonia. Though statutory authority prevents inclusion of habilitative care from TRICARE Basic Program (the medical benefit), the ECHO Program, which provides supplemental services, covers habilitative services to eligible beneficiaries with qualifying conditions, and their families.

Creating a separate definition of medical necessity for the pediatric population would imply creating two standards for safe and effective care (one for pediatrics and one for adults), when in fact all TRICARE beneficiaries are entitled to the same level of scrutiny and protection offered by the multiple levels of evidence required under the hierarchy of reliable evidence. MHS believes the children of members of the Armed Forces are well-served by the existing definition of "medical necessity" and that sufficient ways and means are available to address special cases for children with complex needs through the authorities, policies, and programs described above.

MHS does not plan to develop a uniform definition of "pediatric medical necessity," as the existing uniform definition of medical necessity provides safe and effective care for all ages of beneficiaries. MHS believes the existing definition, coupled with the additional authorities for provision of coverage (e.g., ECHO, Demonstration Authority) for treatments that do not meet these criteria, is meeting the needs of MHS beneficiaries, including the pediatric population. Consistent reevaluation, approximately every 18 to 24 months, ensures that TRICARE benefits are informed by new data, research, and/or clinical literature.

ELEMENT 3
A plan to develop measures to evaluate and improve access to pediatric care, coordination of pediatric care, and health outcomes

Select pediatric measures have been posted publically for MHS since 2018 on health.mil, with additional data available on Hospital Compare (provided by CMS), giving individuals the ability to evaluate and compare the quality of care for adult and pediatric populations. Additionally, National Committee for Quality Assurance's HEDIS® measures broadly address effectiveness, access and availability, and utilization; within MHS, three HEDIS® measures focused on the pediatric population (appropriate pharyngitis testing, appropriate upper respiratory infection testing, and well child visits) are currently measured.[3]

In 2015, in an effort to expand pediatric metrics, a collaboration of Federal partners identified more than thirty additional measures in the domains of preventive care, better care, and lower cost, for further examination and potential inclusion on the first iteration of the MHS pediatric data display (Appendix D: Pediatric Data Display). The measures, first outlined in the Defense Health Board Pediatric Health Care Services report (August, 2017), have been subject to ongoing development and prioritization as MHS works to identify the data sources and determine interoperability across systems to display the measures in a clear, accurate, and meaningful way. After feasibility testing throughout 2016 and 2017, three initial measures were posted in 2018, with more expected to be added iteratively throughout 2019 as fidelity of the data for both PC and DC can be established.

Beginning in 2019, these approved measures will continue to be added iteratively to the pediatric data display, once they can be implemented with fidelity using current data systems. Measures are being identified and explored to provide data to validate for beneficiaries and providers the areas of additional effort and excellence. The expectation is that metrics will be discovered, evaluated, utilized, expanded, or retired based on the priorities of patient quality and outcomes.

Moreover, additional measures are expected be identified, evaluated, and added over time, to include exploration of additional pediatric measures under the Leapfrog Group. The Leapfrog Group is a national nonprofit organization driving a movement in the quality and safety of American health care. The Leapfrog Hospital Survey collects and transparently reports hospital performance, reflecting hospitals with the highest-value care and giving consumers the information they need to make informed decisions. At the time of this report, the Leapfrog Group is currently measuring two pediatric-specific measures of care quality on its annual Leapfrog Hospital Survey: the Consumer Assessment of Healthcare Providers and Systems Child Hospital Survey and Pediatric Computer Tomography Radiation Dose. In addition to the survey, the Leapfrog Group also appoints a Leapfrog Hospital Safety Grade, which assigns letter grades to hospitals based on their record of patient safety, helping consumers protect themselves and their families from errors, injuries, accidents, and infections.

MHS' journey to high reliability has included the development and enabling expertise that promotes the clinical communities, where practicing providers and staff prioritize the implementation of continuous process improvement for their population. The PCCC includes

[3] https://www.ncqa.org/hedis/

both the adult and pediatric populations, and seeks to decrease unnecessary variance in health care practices and to promote improvement in outcomes through evidenced based health care. Standardization of practice, data systems, and an enterprise wide EHR are expected to allow for improved data reporting and evaluation of patient level outcomes. These outcomes can provide the metrics needed to define the quality of evidence based developmentally appropriate care for all ages and stages of the pediatric population.

The Patient Centered Care Operations Board is evaluating the application of metrics to available data to determine consistency of meeting or exceeding MHS access standards for pediatric primary and specialty care (described in Element 4). Moreover, under the clinical community organizational model, the Behavioral Health Clinical Community has begun an annual evaluation of utilization of, and access to, behavioral health care. The most recent study in October 2018 describes the increase in the use of least restrictive clinically appropriate environments, intensive outpatient and partial hospitalization services, for pediatric beneficiaries (described in Element 5). There will be an annual report that will continue to report utilization and access in the coming years, reported in the *Evaluation of the TRICARE Program, Access, Cost and Quality,* or a future equivalent report, as appropriate.

Ongoing efforts to expand MHS standard data and measures reporting for both DC and PC into adult and pediatric population categories continue. The measures available to evaluate and improve access to pediatric care, coordination of pediatric care, and health outcomes, continue to grow as the standardization of data grows. Pediatric data on access to primary and specialty care, coordination of care, and health outcomes are both internally tracked by the PCCC (e.g., pediatric data display), and externally reported in the Evaluation of the TRICARE Program, Access, Cost and Quality annually. MHS plans to add approved measures to the pediatric data display throughout 2019, adding measures iteratively as they can be implemented with fidelity using current data systems. Measures will be identified in the order they are evaluated, with the expectation that additional measures will be added over time (to include exploration of additional pediatric measures under the Leapfrog Group). MHS plans to add all approved measures (as feasibility is determined) to the pediatric data display by December 31, 2019.

ELEMENT 4
A plan to assess access to pediatric specialty care in the annual TRICARE evaluation report to Congress

MHS continues to implement its plan to expand and report access to pediatric metrics in the annual *Evaluation of the TRICARE Program, Access, Cost and Quality* report. Pediatric data was first described as a specific population in the TRICARE Evaluation Report beginning in FY 2016, and has continued to grow in the number of metrics reported. An excerpt of the FY 2018 report (Appendix E: Excerpt of 2018 Evaluation of TRICARE Program) is an example of the growing information and data available in the annual report. The FY 2019 report will include access data for pediatric primary and specialty care; specific data elements are undergoing analysis at this time. MHS continues to assess the proposed pediatric primary and specialty care access measures to determine the ability of the current data systems to collect the data required for each measure with fidelity.

DC pediatric primary care access is using Next Third Available Measures for 24 Hour (24HR) and Future (FTR) appointments to monitor pediatric primary care access performance. The measure will include data from pediatric and family medicine primary care clinics to which pediatric beneficiaries are empaneled; the measures will exclude flight medicine and internal medicine clinics, which do not empanel pediatric beneficiaries. Pediatric primary care 24HR and FTR appointments performance will be monitored for compliance with MHS Access Standards of one and several days, respectively.

DC pediatric specialty care access performance currently reports data on pediatric beneficiaries under the age of 18, only. Measures reported include the Average Number of Days from Referral Order to MTF Specialty Appointment Booked and the Average Number of Days from MTF Specialty Appointment Booked to Actual Appointment. These are the same access to care measures as those reported for adults. Specialty access to care performance will be monitored for compliance with MHS Access to Care Standards.

Evaluation of the TRICARE Program, Access, Cost and Quality also requires annual reporting on TRICARE MH and SUD access, cost, and quality for both the pediatric and adult population (see Element 5). MHS is now validating and stratifying data to provide metrics that assess access to pediatric specialty care. This data is expected to be finalized and available by August 31, 2019. Once data are fully validated, MHS plans to incorporate the measures into MHS pediatric data display by December 31, 2019, and the FY 2020 Evaluation of the *TRICARE Program, Access, Cost and Quality* (with access, cost, and quality data through FY 2019), due March 1, 2020.

ELEMENT 5
A plan to improve the quality of and access to behavioral health care including intensive outpatient and partial hospitalization services

MHS continues to execute its plan to improve the quality of and access to behavioral health care, including intensive outpatient and partial hospitalization through review of data, patient outcomes, and family reports. Improvements in behavioral health care services were largely implemented through statutory changes in the TRICARE benefit in FY 2016 and the subsequent publication of TRICARE Policy Manual revisions in FY 2017. MHS plans to monitor the impact of the 2016 statutory changes and their effect on the quality of and access to behavioral health care, including intensive outpatient and partial hospitalization services annually. In October 2018, the initial report regarding quality of and access to behavioral health care, including intensive outpatient and partial hospitalization services, was completed; results, summarized within the section and in Appendix F, will be a component of the annual *Evaluation of the TRICARE Program, Access, Cost and Quality* report for FY 2018 and beyond (or future equivalent report, as appropriate).

The rule change described above had four main objectives:

1. To eliminate unnecessary quantitative and non-quantitative treatment limitations on SUD and MH benefit coverage and align beneficiary cost-sharing for MH and SUD benefits with those applicable to medical/surgical benefits;

2. To expand and provide coverage of: IOPs for MH and/or SUD treatment, OTPs, office-based outpatient treatment for medication assisted treatment of opioid use disorder, and outpatient treatment of SUD provided by TRICARE authorized individual providers;
3. To streamline the requirements for MH and SUD institutional providers to become TRICARE authorized providers through streamlined accreditation for partial hospitalization programs (PHPs), and child/adolescent residential treatment centers (RTC); and
4. To develop TRICARE reimbursement methodologies for newly recognized MH and SUD IOPs and OTPs.

The Department's most recent analysis of MH care utilization, access, and cost in the MHS revealed:

- The most common principal diagnoses for children ages one through eight were encounters for speech and language disorders or Pervasive Developmental Disorders (including ASD). Older children, ages nine through 17, more commonly had principal diagnoses of attention deficit hyperactivity disorders (ADHD), severe stress, and adjustment disorders. The oldest children, ages 18-21, most commonly had principal diagnoses for anxiety or major depressive disorders.
- As a percentage of all inpatient MH stays, over 50 percent are for children ages 13 through 17, while the number of outpatient MH encounters (excluding autism) were fairly evenly distributed among the age groups of 1 through 4 (21 percent), 5 through 8 (22 percent), 9 through 12 (20 percent), and 13 through 17 (26 percent).
- Children ages one through eight accounted for 62 percent of all autism outpatient encounters, and most of that care was for children ages five through eight.
- SUD is rare in the pediatric population, and treatment for SUD mostly appears in the age 18-21 population. Across the whole population, 98 percent of SUD stays and 99 percent of SUD encounters are for patients aged 18 and older (including dependent children).
- Psychiatric RTC care is a covered benefit for children and adolescents up to age 21. Psychiatric RTC care is a TRICARE benefit for children and adolescents up to age 21; therefore, it is not surprising to find that adolescents ages 13-17 had the highest utilization of this benefit for FY 2017. While other types of care such as IOP, PHP, OTP, and Substance Use Disorder Rehabilitation Facility (SUDRF) are more commonly utilized by adults, especially those ages 25-34, IOP use increased significantly from FY 2016-2017 for all beneficiary groups for both MH and SUD diagnoses (shown in Appendix F). This sharp increase is likely the result of the behavioral health Final Rule (October 2016) which provided coverage of IOP under TRICARE for the first time. There was a significant drop in PHP use for MH (64 percent), especially for non-Active Duty Service members, which reflects a probable shift from PHP to IOP or another type of outpatient care.

In FY 2018, MHS focused on streamlining the TRICARE accreditation process and leveraging new reimbursement methodologies as key drivers to expand the child/adolescent RTC network. At the time of this report, 48 new RTCs have been added to the network in FY 2018, a 66 percent increase over the total number of RTCs in FY 2017, bringing the new total from 72 centers in FY 2017 to 115 centers at the end of FY 2018. In addition, several more facilities are

actively engaged in discussions regarding network participation, and are expected be added in early FY 2019. Using the PCMH practice model in FY 2017, 21 percent of behavioral health (BH) outpatient encounters and 14 percent of costs occurred in primary care clinics. The rest of the BH care, 73 percent of BH outpatient encounters and 79 percent of costs, occurred in BH clinics.

Preliminary data, shown in Appendix F, reveals that since implementation of the Final Rule changes, there has been an overall decrease in PHP for MH (MH), and an increase in IOP. The decrease by 87 percent in PHPs (MH), to an increase by 400 percent for IOPs (MH) utilization, allows families and children to receive care in the least restrictive environment. The data clearly show that IOP utilization for MH and SUD has grown significantly since the recent overhaul of the TRICARE regulation regarding MH treatment.

Lastly, MHS plans are underway to examine specialty access to care (including MH) by pediatric and adult beneficiary categories, and to analyze specialty care access (to include MH access) according to MHS specialty care access standards. The ability to provide granularity on specific BH pediatric access to care data will grow as more data become available.

MHS' improvements of the quality of and access to behavioral health care, including intensive outpatient and partial hospitalization services, are enduring. MHS plans to continue annual monitoring of quality of and access to behavioral health care, including intensive outpatient and partial hospitalization services in October 2019, and annually thereafter. MHS plans to report findings as a component of the *FY 2019 Evaluation of the TRICARE Program, Access, Cost and Quality* repor, and beyond (or future equivalent report, as appropriate), due March 1, 2019. The next annual report on focused on behavioral health care is expected on October 31, 2019.

ELEMENT 6
A plan to mitigate the impact of PCS and other service-related relocations on continuity of care for children who have special medical or behavioral health needs

MHS must deliver quality health care to ensure a military ready force in the context of its global military presence, frequent deployments, and PCS. Beneficiaries, including children, are located in all 50 states, the District of Columbia, U.S. territories, and at military installations around the world. Children of members of the Armed Forces and their families may relocate every two to three years, and, with each PCS, families must reestablish care networks and begin to build relationships with a new set of providers and other support networks. MHS continually seeks opportunities to work with families to identify areas in which they need support and then fill those gaps. Parents who are well supported are better able to care for their children, particularly for those who have special or complex medical, behavioral, or educational needs.

In order to centralize efforts and provide metrics on the impact of existing programs, MHS plans to begin formal coordination and collaboration with all components and programs to monitor the impact of PCS and other service-related relocations on continuity of care for children. This collaboration, expected to begin in 2019, allows three monumental process in place to establish equilibrium and begin to generate data for review and evaluation. The three process include: (1) DHA administrative oversight of MTFs, which started October 1, 2018; (2) implementation of

the TRICARE contract with two contractors after region realignment, which started January 1, 2018; and (3) full implementation of standardized FMTS, anticipated December 31, 2019.

The collaborative group, led by DHA, will include key stakeholders such as representatives from both MCSCs, Service EFMP programs, OSN representing the FSCs, and other groups as indicated. The group will define the data necessary to measure the impact of PCS and relocation. Data will be collected from three primary sources:

(1) MCSC data regarding transfers of care between regions. As noted previously, in 2018, TRICARE awarded two new MCSCs, a reduction from the previous three. As a result, the lengthy process of reestablishing care has been shortened, and facilitated transfer of referrals between regions has been established. MHS' goal is to ensure a smooth transition for families, particularly for those with children with complex needs, by minimizing redundant and non-value added processes experienced by our families. As feasible, MHS plans to begin collecting data on transfers of care between regions by December 31, 2019.

(2) Services' EFMP collections of data on assignments and returns from PCS due to medical/behavioral complexity. Collection of data on assignments from the Services' EFMP will be done through implementation of DoDI 1315.19, *The Exceptional Family Member Program*. Services' EFMP Family Support Programs assist families in identifying and accessing non-medical programs and services. When a family is relocating, EFMP FSC staff at both gaining and losing sites provide "warm hand-offs" to enhance the family's ability to re-establish non-medical services and enhance a family's effective engagement with the new community. Service EFMP Family Support Programs help families identify and access programs and services, and families are empowered by having information on referral services for both military and community services. As feasible, MHS plans to begin collecting data on assignments from the Services' EFMP by December 31, 2019.

(3) Data from OSN on implementation and outcomes after standardized FMTS processes. The military mission is always the driving force behind a Service member's assignment, and the EFMP helps make sure that family members' documented needs are considered during relocations. EFMP form and process standardization for assignment coordination mitigates the effects of relocation for military families with complex medical behavioral and educational needs; standardized data forms and processes also enhance command decision-making for assignment coordination to result in in the optimal match for the mission and the family.

Standardized FMTS forms are designed to decrease the four core screening challenges of families: (1) being turned away at sister-Service locations; (2) non-credentialed medical providers making medical recommendations; (3) inconsistent form processing times and expectations of families; and (4) inconsistent enrollment of eligible families into the EFMP. In 2018, a collaborative group of members from the Military Community and Family Policy, OSN, Services' EFMPs, and the DHA Clinical Support Division

developed and piloted new standardized forms at 17 MTFs. The pilot demonstrated that MTFs were easily able to integrate the forms into their current processes; the standardized forms were instrumental in ensuring coordination with the gaining medical authority on availability of services at the projected duty location, regardless of Service affiliation; and all families had a similar experience, regardless of the MTF conducting the screening.

Formalization and implementation of the standardized FMTS to all sites is supported by the creation of a new governance tool, a DHA-PI, which began coordination in September 2018. In 2019, MHS anticipates approval of the standardized FMTS forms by Office of Management and Budget, so that subsequent expansion of the pilot can be completed across MHS by December 31, 2019.

Beyond these three efforts, mitigation of the impact of PCS and other Service-related relocations on continuity of care is aided by implementation and expansion of telehealth services throughout MHS. MHS was an early adopter of telemedicine technologies in remote and deployed environments, and has been recently further guided by section 718 of the NDAA for FY 2017. Expanded telehealth services improve access to care, communication between patients and families and providers, and abilities to monitor individual health outcomes, without travel, for beneficiaries with chronic disease or conditions. Successful implementation of pediatric telehealth in the military include the Pacific Asynchronous Telehealth system and Health Experts on Line for Providers. These programs consist of provider-to-provider teleconsultation platforms, facilitate access to subspecialists, and reduce both patient and provider travel. Continued exploration and adoption of telemedicine assists both providers and beneficiaries in the global world in which military families live.

MHS plans to bring together the collaborative group of key stakeholders (to include MCSCs, Service EFMP programs, OSN representing the FSCs, and others) to define the data necessary to measure the impact of PCS and relocation. As feasible, MHS plans to collect data from a variety of data sources, described above, in order to be able to begin to monitor and evaluate the impact of PCS and service-related relocations on continuity of care. In tandem with roll out of standardized FMTS forms, on track for full implementation by December 31, 2019, through the new governance process of a DHA-PI, the formal collaborating working group will be complete by the end of FY 2019.

ELEMENT 7
A plan to mitigate deficiencies in data collection/utilization/analysis to improve pediatric care and related services

MHS plans to continue to mitigate deficiencies in data collection/utilization/analysis to improve the assessment and reporting of pediatric care and related services. The identification and description of specific pediatric care measures available in both DC and PC, where possible, are expected to allow improved knowledge of the quality, access, efficiency, and compliance of pediatric care in MHS. The goal of MHS is to continue to explore opportunities to make accessible data that is timely, relevant, and of interest to parents, families, and caregivers.

In the past, non-standardized data collection systems impeded collection of accurate, meaningful data. The development of the pediatric data display (Appendix D: Pediatric Data Display) evolves as work to reconcile disparate systems and missing data fields is being addressed. All approved measures will be added to the pediatric data display by December 31, 2019. The deployment of MHS GENESIS, currently planned through Q3 FY 2024, provides a standard platform of common clinical applications, interfaces, and a shared infrastructure that, when configured, will result in a much greater commonality. Commonalities of clinical workflows, care provider roles, standardized order sets, and care plans are key to obtaining meaningful data to patients, providers, and families for timely, relevant health care decision-making. MHS continues to improve reporting and evaluation of the quality of care and related services for children of members of the Armed Forces.

Another important initiative that will leverage data to improve pediatric care for children is the MHS' transformation to a high reliability organization, and stand up of the clinical community organizational model to promote continuous process improvement, and enable front line clinicians to hold themselves accountable to MHS standards and clinical outcomes. Through these clinical communities, MHS is able define, prioritize, and implement initiatives that decrease variation, improve outcomes, and positively affect health care. As noted previously, general (non-complex) pediatric care is aligned within the PCCC, while complex pediatrics will be addressed through its own clinical community anticipated to be stood up in late FY 2019. Each of these clinical communities will involve a diverse team of clinicians, data analysts, and program managers to identify and implement specific clinical process improvement initiatives. The initiatives will be designed to decrease variation in care, promote use of evidence-based interventions, and leverage clinical outcome data to drive iterative refinement of pediatric clinical care process models.

The adoption of nationally reported data, with transparency in the MHS results to the individual MTF, has expanded greatly in the last two years. Hospital Compare data from CMS and the evaluation of the pediatric measures under the Leapfrog Group continues to provide beneficiaries with the information needed to understand the quality of care provided across MHS worldwide. MHS will continue to prioritize and mitigate the deficiencies in data collection/ utilization/ analysis, and plans to monitor the impact of these changes in order to create a more extensive infrastructure and framework to identify, monitor, and assess the quality of care provided within MHS. Pediatric data continues to increase and MHS plans to report on progress in the *FY 2019 Evaluation of the TRICARE Program, Access, Cost and Quality* report and beyond (or future equivalent report, as appropriate), due March 1, 2019.

SUMMARY

Multiple congressionally directed reorganizational efforts are currently underway across MHS, which, when taken together, are expected to result in improved health care for all beneficiaries, to include the pediatric population. Highlighted in this report are:

- The adoption of the clinical community model to promote continuous process improvement on the journey toward becoming a high reliability organization;

- Continued efforts to standardize oversight, administration, data collection, and reduction in utilization of disparate data systems for the purpose of enabling more complete, coherent tracking of metrics on quality, access, and cost effective, developmental and age appropriate care for pediatric beneficiaries;
- Continued efforts to enhance MHS' ability to transparently report high quality pediatric metrics;
- Continued efforts to review and implement evidence-based improvements in clinical care through the clinical communities; and
- Standardization of the EHR infrastructure with MHS GENESIS.

MHS remains committed to ensuring that pediatric dependents and their families have access to high-quality care with data that is timely, relevant, and impactful to parents, families, caregivers, and the community. Service members who can rest assured that their family members are receiving the high quality health care they need when they need it, are able to focus on their mission. This approach, and the plans described in this report, fulfill MHS' commitment to "family first, mission always."

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APPENDICES

Appendix A: Summary of MHS Plans for Section 733 of NDAA for FY 2018

Element		Plan	Timeline
1	A plan to align preventive pediatric care with standards for such care under the PPACA and guidelines established for such care under Medicaid and with recommendations by organizations that specialize in pediatrics.	To ensure current preventive pediatric care under the TRICARE Basic Program (the medical benefit) is consistent with PPACA, a comprehensive gap analysis is in progress, with expected completion set for no later than December 31, 2019. Review of findings from the gap analysis and final recommendations will be made no later than December 31, 2020.	Gap analysis conducted **December 31, 2019**; Recommendations published **December 31, 2020**
2	A plan to develop a uniform definition of "pediatric medical necessity."	MHS feels confident a single hierarchy of evidence to support medical necessity is the standard of care for all beneficiaries. The hierarchy allows for different levels of evidence that can be applied to the pediatric population as needed.	N/A; Reevaluation expected **every 18 to 24 months**
3	A plan to develop measures to evaluate and improve access to pediatric care, coordination of pediatric care and health outcomes.	The current pediatric data display will be expanded to include approved measures once methodology and maturity is validated. Approved measures will added to the current display with the plan to have a display by December 31, 2019 able to evaluate pediatric care and health outcomes.	All approved measures will be added to the pediatric data display, with iterative updates thereafter, by **December 31, 2019**
4	A plan to assess access to pediatric specialty care in the annual TRICARE evaluation report to Congress.	Pediatric access metrics for third next appointments, specialty appointments, and specialty referrals are undergoing analysis for inclusion in the *FY 2020 Evaluation of the TRICARE Program, Access, Cost and Quality* (with access, cost, and quality data through FY 2019).	Access measures will be added to the *2020 TRICARE Evaluation* **March 1, 2020**
5	A plan to improve the quality of and access to behavioral health care including intensive outpatient and partial hospitalization services.	The MHS plan is to have an annual report to monitor quality of and access to behavioral health care. The report will include pediatrics measures including, but not limited to, intensive outpatient and partial hospitalization services. The next report and analysis will be due in October 31, 2019.	Next annual report to be completed by **October 31, 2019**
6	A plan to mitigate the impact of PCS and other service-related relocations on continuity of care for children who have special medical or behavioral health needs.	MHS plans to monitor the impact of PCS and other service-related relocations on continuity of care for children through three mechanisms: (1) measurements from the CY 2018 TRICARE contract regarding transfers of care between regions; (2) collection of data on assignments from the Services' EFMP; and (3) implementation of standardized FMTS processes.	Stand-up of collaborative working group **September 30, 2019**; Comprehensive roll out of standardized FMTS forms **December 31, 2019**
7	A plan to mitigate deficiencies in data collection/utilization/analysis to improve pediatric care and related services.	Establishment of a pediatric data display, including pediatric metrics for access, reinforce the commitment to pediatric specific data. MHS will continue to provide consistent metrics (purchased and direct care) with mitigation of deficiencies in data standardization/ collection/utilization/analysis.	Ongoing; all approved measures will be added to the pediatric data display **December 31, 2019**

Appendix B: TRICARE Medical Necessity Clause - Statutory and Regulatory Guidance

Statute / Regulation	Statutory / Regulatory Language
10 U.S.C. § 1079(a)(13) **Contracts for medical care for spouses and children**	a) To assure that medical care is available for dependents, as described in subparagraphs (A), (D), and (I) of section 1072(2) of this title, of members of the uniformed services who are on active duty for a period of more than 30 days, the Secretary of Defense, after consulting with the other administering Secretaries, shall contract, under the authority of this section, for medical care for those persons under such insurance, medical service, or health plans as he considers appropriate. The types of health care authorized under this section shall be the same as those provided under section 1076 of this title, except as follows: (13) Any service or supply which is not medically or psychologically necessary to prevent, diagnose, or treat a mental or physical illness, injury, or bodily malfunction as assessed or diagnosed by a physician, dentist, clinical psychologist, certified marriage and family therapist, optometrist, podiatrist, certified nurse-midwife, certified nurse practitioner, or certified clinical social worker, as appropriate, may not be provided, except as authorized in paragraph (4). Pursuant to an agreement with the Secretary of Health and Human Services and under such regulations as the Secretary of Defense may prescribe, the Secretary of Defense may waive the operation of this paragraph in connection with clinical trials sponsored or approved by the National Institutes of Health if the Secretary of Defense determines that such a waiver will promote access by covered beneficiaries to promising new treatments and contribute to the development of such treatments.
32 C.F.R. § 199.4 (g)(15)(i) **TRICARE requirement for safety and effectiveness**	(g) Exclusions and limitations. In addition to any definitions, requirements, conditions, or limitations enumerated and described in other sections of this part, the following specifically are excluded from the Basic Program: (15) Unproven drugs, devices, and medical treatments or procedures. By law, CHAMPUS can only cost-share *medically necessary* supplies and services. Any drug, device, or medical treatment or procedure, the safety and efficacy of which have not been established, as described in this paragraph (g)(15), is unproved and cannot be cost-shared by CHAMPUS except as authorized under paragraph 199.4(e)(26) of this part. (i) A drug, device, or medical treatment or procedure is unproven: (C) Unless reliable evidence shows that any medical treatment or procedure has been the subject of well-controlled studies of clinically meaningful endpoints, which have determined its maximum tolerated dose, its toxicity, its safety, and its efficacy as compared with standard means of treatment or diagnosis (see the definition of reliable evidence in § 199.2 of this part for the procedures used in determining if a medical treatment or procedure is unproven). (D) If reliable evidence shows that the consensus among experts regarding the medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated doses, its toxicity, its safety, or its effectiveness as compared with the standard means of treatment or diagnosis (see the definition of reliable evidence in § 199.2 for the procedures used in determining if a medical treatment or procedure is unproven).

Statute / Regulation	Statutory / Regulatory Language
32 C.F.R. § 199.2, **TRICARE Hierarchy of Reliable Evidence**	Reliable evidence. (1) As used in § 199.4(g)(15), the term reliable evidence means only: i. Well controlled studies of clinically meaningful endpoints, published in refereed medical literature. ii. Published formal technology assessments. iii. The published reports of national professional medical associations. iv. Published national medical policy organization positions, and v. The published reports of national expert opinion organizations. The hierarchy of reliable evidence of proven medical effectiveness, established by (1) through (5) of this paragraph, is the order of the relative weight to be given to any particular source. With respect to clinical studies, only those reports and articles containing scientifically valid data and published in the refereed medical and scientific literature shall be considered as meeting the requirements of reliable evidence. Specifically not included in the meaning of reliable evidence are reports, articles, or statements by providers or groups of providers containing only abstracts, anecdotal evidence or personal professional opinions. Also not included in the meaning of reliable evidence is the fact that a provider or a number of providers have elected to adopt a drug, device, or medical treatment or procedure as their personal treatment or procedure of choice or standard of practice.

Appendix C: TRICARE Overview

The purpose of the TRICARE program as set forth in Chapter 55 of 10 U.S.C., is to provide a uniform program of medical and dental care (10 U.S.C. § 1071) and pharmacy benefits (10 U.S.C. § 1074g) for members and certain former members of the uniformed services, and for their dependents. TRICARE program private sector PC medical benefits are provided under the "Basic Program" (which refers to the medical benefits set forth under 32 C.F.R. § 199.4) and the "Uniform HMO Benefit" (which refers to the medical benefits set forth under 32 C.F.R. § 199.18). The TRICARE program, as implemented by 32 C.F.R. § 199.17, formerly had a "triple option" structure: Standard was the default fee-for service entitlement, Extra was the Preferred Provider option, and Prime was the enhanced Uniform HMO Benefit option.

Beginning in January 2018, TRICARE Standard and TRICARE Extra were replaced with TRICARE Select. TRICARE Select functions like a preferred provider organization. Unlike Standard, Select requires enrollment during an annual "open season." Beneficiaries will not have to reenroll once they enroll, unless they would like to make a change. In addition, beneficiaries who had TRICARE Standard as of January 1, 2018, were automatically enrolled in Select to avoid risk of loss of coverage. The TRICARE program private sector PC component coordinates care with the MTF DC component, subject to the availability of MTF space and staff capabilities. Additional services for active duty dependents with a qualifying condition are authorized under ECHO (10 U.S.C. § 1079(d)-(f)).

TRICARE administers the congressionally mandated health benefit programs designed to allow beneficiaries choices for their health care related to eligibility. The TRICARE Basic program covers visits for diagnosis or treatment of an illness or injury based on medical necessity. TRICARE Regional Offices, which oversee the regional contractors, provide access and

adequacy monitoring of the network systems while DHA monitors the DC system. Beneficiaries make health care choices that include their preference for care delivery location and cost sharing. Beneficiaries can choose from a variety of TRICARE health care plans, including Prime and Select. These enrollment choices define the access to benefits and any cost shares associated with exercise of the benefits.

TRICARE PC is composed of both network and non-network care. Network care is provided by a "network provider" who serves TRICARE beneficiaries through a network participation agreement with the regional contractor as a member of the TRICARE Prime network, or any other preferred provider network, or by any other agreement with the regional contractor. A "non-network provider" who has no agreement with the regional contractor to provide care to TRICARE beneficiaries, and who may choose to participate in TRICARE on a claim-by-claim basis provides non-network care. Non-network providers are not required to file claims for beneficiaries and may require payment by the beneficiary at the time the services are rendered.

TRICARE Program Benefits and Authorities

In all TRICARE Basic Program options (i.e., the medical benefit component of the TRICARE program), TRICARE may cover only services and supplies that are "medically or psychologically necessary" as required by 10 U.S.C. § 1079(a)(13), and as implemented by 32 C.F.R. § 199.4. The term "health care" under TRICARE includes "MH care" (10 U.S.C. § 1072(10)). The terms "behavioral" and/or "psychological" are also used concerning "mental" health. Pediatric health care benefits are provided through the TRICARE Basic program that includes certain well-child care and preventive care benefits. Pediatric health care benefits are specifically addressed in 32 C.F.R. 199.4(c)(3)(xi). In addition to the medical benefits authorized under the TRICARE Basic Program, ADFMs with qualifying conditions are eligible for supplemental services that are not otherwise covered under the TRICARE Basic Program if they enroll in their Military Department's EFMP and ECHO.

TRICARE is a statutorily defined health benefits program. As such, the TRICARE program is only authorized to cost-share private sector PC supplies or services as part of a beneficiary's covered medical/MH benefit when such care is medically or psychologically necessary (10 U.S.C. § 1079(a)(13)), absent specific additional statutory authority.

Preventive care is generally excluded by law from the Basic Program's medical benefits authorized under TRICARE's private sector PC (10 U.S.C. § 1079(a)(13); 32 C.F.R. § 199.4(g)(37)). Only those services specifically listed in 10 U.S.C. § 1077(a) (specifically authorized medical care for dependents in MTFs), 10 U.S.C. § 1079(a)(2) (specifically authorized content of health promotion and disease prevention visits), 10 U.S.C. § 1074d (specifically authorized primary and preventive health care services), and/or 10 U.S.C. § 1074g (pharmacy benefits program) are not otherwise generally excluded. Using the broad authority of 10 U.S.C. § 1097 to provide for the alternative delivery of health care under Chapter 55, the Uniform HMO Benefit (32 C.F.R. § 199.18(b)) authorizes certain preventive care services not covered under the Basic Program medical benefits when provided to TRICARE Prime enrollees by network providers.

Appendix D: Pediatric Data Display

Pediatric Data Display
Immunizations for adolescents (Percentage of adolescents 13 years of age who had one dose of meningococcal vaccine and one tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap) or one tetanus, diphtheria toxoids vaccine (Td) by their 13th birthday)
Childhood immunization status: percentage of children 2 years of age who had four diphtheria, tetanus, and acellular pertussis (DTaP); three polio; one measles, mumps, and rubella; three haemophilus influenza type B (HiB); three hepatitis B; one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A; two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday
Weight assessment and counseling for nutrition and physical activity for children/adolescents: percentage of members 3 to 17 years of age who had an outpatient visit with a primary care provider (PCP) or obstetrician/gynecologist (OB/GYN) and who had evidence of counseling for physical activity during the measurement year
Weight assessment and counseling for nutrition and physical activity for children/adolescents: percentage of members 3 to 17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of counseling for nutrition during the measurement year
Weight assessment and counseling for nutrition and physical activity for children/adolescents: percentage of members 3 to 17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of body mass index percentile documentation during the measurement year
Well-child visits in the third, fourth, fifth, and sixth years of life: percentage of members 3 to 6 years of age who had one or more well-child visits with a PCP during the measurement year
Adolescent well-care visits: percentage of enrolled members 12 to 21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year
Dental care: percentage of enrolled children under age 21 who received a comprehensive or periodic oral evaluation as a dental service within the reporting year
Specialty referral- referral to referral to appointment/appointment to visit (specialty care)
Average number of days to 3rd next available 24 hours appointment
Joint Outpatient Experience Survey (JOES) and JOES-C (Consumer Assessment of Health Providers and Systems)
Family Experiences with Care Coordination Measure Set
Neonatal mortality rate- NPIC source
Child and adolescent major depressive disorder: percentage of patient visits for those patients aged 6 through 17 years with a diagnosis of major depressive disorder with an assessment for suicide risk
ADHD follow-up care
Developmental screening in the first three years of life
Health care-Associated Infections: Central Line-associated Bloodstream Infection
Sickle cell disease: percentage of children with a newborn screen positive for sickle cell disease who receive appropriate preventive antibiotics by 3 months of age
Asthma Medication Ratio: a measure to help providers assess the quality of asthma care received by their patients with persistent and/or chronic asthma
Appropriate treatment for children with upper respiratory infection: percentage of children 3 months to 18 years of age who were given a diagnosis of an upper respiratory infection and were not treated with an antibiotic medication
Appropriate testing for children with pharyngitis: percentage of children 2 to 18 years of age who were diagnosed with pharyngitis, dispensed an antibiotic medication, and received a group A streptococcus (strep) test for the episode
Overuse of imaging: percentage of children, ages 6 months through 4 years, diagnosed with simple febrile seizure who are evaluated with imaging of the head (computed tomography or magnetic resonance imaging) without indications for neuroimaging, including lumbar puncture and complex febrile seizure

Pediatric Data Display
Rate of patients using the emergency department for Level I and Level II diagnoses l II diagnoses

Appendix E: Excerpt of 2018 Evaluation of TRICARE Program

QUALITY OF MHS CARE (CONT.)

Focused Quality Initiatives (cont.)

Pediatrics—Health Care and Related Support for Children in TRICARE

The MHS continues to advance programs, discussions, and decision making for the pediatric population in the areas of quality, safety, access, and satisfaction, with data reporting to represent this unique population. The DHA, along with Service leader partners, continues to engage internal and external stakeholders to facilitate collaboration and increase transparency in this journey. For the past two years, the DHA has presented to organizations inside and outside the federal government, engaging specifically with pediatric advocacy groups to discuss updates of pediatric benefits, pilots, demonstrations, innovations, and metrics. DHA pilots that began in 2016 have been evaluated and based on their impact to all beneficiaries, including the pediatric population, to improve access to care in the least restrictive environment. The TRICARE basic programs will be expanded to include UC visits without referrals and availability of virtual phone visits and TMH visits. Additionally, the NAL has provided invaluable support and increased access to care for families, now expanded to worldwide services. The NAL reports that 25 percent of calls are related to care for children between birth and two years of age.

Sweeping revisions published under the Final Rule revise TRICARE's MH and SUD benefit to achieve MH

child health leaders from CMS, AHRQ, CDC, Health Resource Service Agency, Maternal Child Health Branch, Substance Abuse and Mental Health Service Agency, military Services (Army, Navy, Air Force) pediatric leads, Defense Health, and Health Affairs staff. The resulting dashboard is a result of identifying areas within MHS pediatric care that should be addressed by quality measures with comprehensive measurement domains. The metrics are to be based on domains and health system needs. Measures are chosen to accurately reflect how the MHS is monitoring pediatric care and identifying opportunities for improvement in timely, efficient, and equitable patient- and family-centered pediatric care for both direct and purchased care components. The domains included in performance measure selection and prioritization, all of which are factors in delivering relevant, meaningful, and understandable information, are: importance to health; improvement; stakeholders; scientific acceptability for validity and reliability; feasibility of available, retrievable, reliable, and unbiased data; and data collection and usability cost. The pediatric metrics and dashboard will be iterative and continue to evolve based on assessment of value and feasibility of metrics.

BETTER CARE

Appendix F: Data on Access to Behavioral Health Care

Preliminary data, shown in Table 1, reveal that since implementation of the Final Rule changes, there has been an overall decrease in PHP for MH (MH), and an increase in IOP. The decrease by 87 percent in PHPs (MH), to an increase by four hundred percent for IOPs (MH) utilization, allows the families and child to received care in the least restrictive environment. The data clearly show that IOP utilization for MH and SUD has grown significantly since the recent overhaul of the TRICARE regulation regarding MH treatment.

Table 1. Percent Change in MH and SUD Encounters for All Ages, by Place of Service and Beneficiary Category, FY16 and FY17

	PHP - MH			PHP - SUD			RTC - MH			SUDRF - SUD		
BenCat	FY16	FY17	% Change	FY16	FY17	% Change	FY16	FY17	% Change	FY16	FY17	% Change
ADFM	8,263	1,096	-87%	7,111	8,640	22%	1,349	1,092	-19%	176	190	8%
ADSM	16,097	9,211	-43%	8,730	7,828	-10%	<30	<30	-79%	276	289	5%
NADD	7,644	1,071	-86%	17,919	21,714	21%	1,133	1,029	-9%	531	584	10%
Total	**32,004**	**11,378**	**-64%**	**33,760**	**38,182**	**13%**	**2,501**	**2,125**	**-15%**	**983**	**1,063**	**8%**

	IOP - MH			IOP - SUD			OTP - SUD		
BenCat	FY16	FY17	% Change	FY16	FY17	% Change	FY16	FY17	% Change
ADFM	185	926	401%	<30	293	1600%	<30	68	2300%
ADSM	156	1,456	833%	65	293	351%	<30	<30	0%
NADD	183	1,458	697%	217	1,054	386%	279	122	-56%
Total	**524**	**3,840**	**633%**	**299**	**1,640**	**448%**	**283**	**191**	**-33%**

Table 1 Note: IOP = Intensive Outpatient Program. PHP = Partial Hospitalization Program. OTP = Opioid Treatment Program. RTC = Residential Treatment Center. SUDRF = Substance Use Disorder Rehabilitation Facility. MH = Primary dx of MH. SUD = Primary dx of substance abuse.

Table 2 (below) reports FY 2017 outpatient visits for MH and or SUD diagnoses. Approximately 13.5 percent of all pediatric beneficiaries (323,526 out of approximately 2.4 million) had outpatient encounters for the treatment of a MH or SUD diagnosis. The table displays two age groups of beneficiaries: "Pediatric Age Groups" and "Adult Age Groups." The Pediatric Age Groups section (to include the 18-21 age group) reflects only dependent children, which describes the beneficiary's relationship to their sponsor. Adults age 18-21 listed under "Adult Age Groups" section include only non-dependent children or any adults in that age group that are listed as non-dependent children.

Table 2: Outpatient Utilization Rate by Age Group, Excludes Autism Encounters, FY17

Age Group	# Encounters	# Users	Encounters/User
Pediatric Age Groups			
0	6,360	2,616	2.4
1-4	609,214	38,712	15.7
5-8	618,239	56,981	10.8
9-12	566,058	73,311	7.7
13-17	757,662	96,568	7.8
18-21	306,560	55,338	5.5
Total	**2,864,093**	**323,526**	**8.9**
Adult Age Groups			
18-21	386,445	45,296	8.5
22-24	612,938	70,983	8.6
25-34	1,583,358	202,875	7.8
35-44	1,178,630	155,152	7.6
45-64	1,370,771	230,718	5.9
65+	911,066	215,702	4.2
Total	**6,043,208**	**920,726**	**6.6**
Grand Total	**8,911,513**	**1,244,883**	**7.2**

Table 2 Note: This table includes both outpatient DC and PC encounters. The age is taken from the latest claim for each person in a given year. This table excludes patients where an age could not be determined and adult patients where the age on the claim was listed as under 18.

Appendix G: List of Acronyms

24HR	Next Third Available Measures for 24 Hour
AAP	American Academy of Pediatrics
ADFM	Active Duty Family Member
ADHD	Attention Deficit Hyperactivity Disorders
ASD	Autism Spectrum Disorder
BH	Behavioral Health
C.F.R.	Code of Federal Regulations
CMS	Centers for Medicare and Medicaid Services
DC	Direct Care
DHA	Defense Health Agency
DHA-PI	Defense Health Agency Procedural Instruction
DoD	Department of Defense
DoDI	Department of Defense Instruction
ECHO	Extended Care Health Option
EFMP	Exceptional Family Member Program
EHR	Electronic Health Record
FMTS	Family Member Travel Screening
FSC	Family Support Center
FTR	Future

FY	Fiscal Year
HEDIS®	Healthcare Effectiveness Data Information Set
HMO	Health Maintenance Organization
IOP	Intensive Outpatient Program
MCSCs	Managed Care Support Contractors
MH	Mental Health
MHS	Military Health System
MTF	Military Medical Treatment Facility
NCI	National Cancer Institute
NDAA	National Defense Authorization Act
OSN	Office of Special Needs
OTP	Opioid Treatment Program
PC	Purchased Care
PCCC	Primary Care Clinical Community
PCM	Primary Care Manager
PCMH	Patient-Centered Medical Home
PCS	Permanent Change of Station
PHP	Partial Hospitalization Program
PPACA	Patient Protection and Affordable Care Act
RTC	Residential Treatment Center
SUD	Substance Use Disorder
SUDRF	Substance Use Disorder Rehabilitation Facility
USPSTF	United States Preventive Services Task Force