Submitted by Jeremy Hilton to the June 16, 2016 meeting of the Military Family Readiness Council

White Paper for DoD Military Family Readiness Council Meeting
On TRICARE for Kids and the Extended Care Health Option (ECHO)

The purpose of this white paper is to provide an understanding of the ECHO benefit as it relates to the TRICARE for Kids Discussion at the 16th of June MFRC meeting, a recent history of relevant discussion, and recommend the Military Compensation and Retirement Modernization Commission's recommendation regarding the ECHO benefit be implemented.

The Extended Care Health Option, otherwise known as the ECHO benefit, is, according to 32 CFR § 199.5, (codified in Section 1079 of Title 10, United States Code),

> "a supplemental program to the TRICARE Basic Program… [whose purpose] … is to provide an additional financial resource for an integrated set of services and supplies designed to assist in the reduction of the disabling effects of the ECHO-eligible dependent's qualifying condition." [1]

The Department of Defense's position regarding this program is as follows,

> "Congress thus gave DoD much more discretion in its coverage of ECHO benefits than it has concerning medical benefits provided under the Basic Program. ECHO enables DoD to provide additional support services for Active Duty Family Members who are subject to frequent relocations to geographic locations that lack sufficient state resources for individuals with special needs…ECHO non-medical services such as respite care and behavior modification need only be determined by the Director, TMA, to assist in the reduction of the disabling effects of the ECHO-eligible dependent's qualifying condition."[2]

The 2013 Senate Armed Services Committee Report (SR 112-173), directed DoD,

> "to assess participation in the ECHO program by eligible dependents with special needs, and to explore options to provide more flexible benefits under that program without increasing costs to the Department."

The 2013 NDAA, as part of Sec 735, commonly referred to as TRICARE for Kids, directed the DoD to conduct,

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

Neither the response to the Senate Committee report, completed in May of 2013[3], nor the resulting DoD TRICARE for Kids report[4], published in July 2014, was adequate. It is my opinion that the ECHO program is in need of significant reform.

Consistent with that opinion, the Military Compensation and Retirement Modernization Commission (MCRMC), stated the ECHO program is not being administered as intended, stating,

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[1] CFR Title32 Volume 2, Sec 199-5
[2] DoD Supplementary to 26 July 2013 Filing
[3] DoD ECHO Report May 2013
[4] DoD TRICARE for Kids Report July 2014

> "the Congress intended ECHO as an alternative to unavailable waiver benefits. Yet ECHO benefits, as currently implemented, are not robust enough to replace state waiver programs when those programs are inaccessible to Service members and their EFMs."

The MCRMC recommended significantly enhancing the benefits delivered through the ECHO program. [5]

In April 2015, Secretary of Defense Carter, in response to the MCRMC ECHO recommendation, stated,

> "While the Department supports the objective of expanding services available to family members with special needs, we cannot fully assess the Commission's recommendations within their timelines for implementation. Furthermore, the Commission acknowledges that more work will be needed before determined which of the many state Medicaid waiver programs would be the most helpful and beneficial to our military families with special needs.
>
> It will take the Department time to evaluate these programs, including any associated costs. In addition, ECHO currently does not have a process for implementing consumer directed care and that will take time to both evaluate and establish. The Department can more readily evaluate two specific services identified by the Commission: 1.) respite care and 2.) incontinence supplies. Other areas, such as custodial care, will need some additional study. The Defense Health Agency will lead the Department's review and determine the way forward in July." (of 2015)."

The MCRMC took it upon itself to conduct the additional study Secretary Carter requested and published a follow-up to their January 2015 recommendation in December of 2015.[6] The results of that final recommendation as well as the Excel spreadsheet[7], created to support their recommendation, are available in footnotes 6 &7 as well as attached to this white paper (via email).

We must ensure appropriate resources for these vulnerable military families, not only as the right thing to do, but also as a military readiness concern. Helping families to "assist in the reduction of the disabling effects" for a military child allows the service member to succeed with their unique mission. State Medicaid resources in civilian communities have long been available to individuals with disabilities, while a military family living in the same community is unable to access those resources because of state-specific rules. Military children should not be penalized for the service their mother or father renders to the nation.

I strongly encourage the Military Family Readiness Council endorse the MCRMC ECHO recommendations to the Secretary of Defense for implementation.

Jeremy Hilton
ktp1995@gmail.com

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[5] MCRMC Recommendation Number 7
[6] MCRMC ECHO Recommendation December 2015
[7] MCRMC ECHO Excel Spreadsheet

MILITARY COMPENSATION AND RETIREMENT
MODERNIZATION COMMISSION

WASHINGTON, D.C.

Extended Health Care Option (ECHO) and
Medicaid Home and Community Based Services (HCBS) Waivers

Findings:

- The Commission's Final Report describes a problem faced by military families with exceptional family members. The Medicaid Home and Community Based Support (HCBS) waiver services offered at the state level for those with disabilities are often unavailable to military families. If these families are moved from state to state on a frequent basis, they may never reach the top of a state's waiting list for Medicaid services. On average, military families move every 3 years, while the average waiting time for state services is over four years (50 months).
- The TRICARE Extended Care Health Option (ECHO) program offers an alternative to some, but not all common Medicaid waiver services. In some cases, ECHO offers similar services to Medicaid, but cost and service caps and restrictions on delivery and eligibility often makes this alternative inferior.

Recommendation:

- The Commission's Final Report recommended that services covered through ECHO should be increased to more closely mirror state Medicaid waiver programs, to include allowing for consumer-directed care. Expanded services would still be subject to the ECHO benefit cap of $36,000 per fiscal year, per dependent.
- Note that one portion of the ECHO recommendation was implemented by the Defense Health Agency (DHA) on 1 October 2015 following the release of the Commission's final report. The new policy reimburses military families for the cost of adult diapers when necessary and appropriate for exceptional family members.

Recommended Legislative Language:

SEC. ___. EXTENDED CARE HEALTH OPTION (ECHO).

Section 1079 of title 10, United States Code, is amended by adding at the end the following:

"(q) In carrying out the Extended Care Health Option (ECHO) the Secretary of Defense, after consultation with the other administering Secretaries, shall ensure that the services provided under such option are an alternative to, and are comparable to, the services provided under the applicable (as determined by the Secretary of Defense) State plans for medical assistance under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).".

Additional Analysis:

- The Commission used historical data on state Medicaid services to estimate the cost of expanding DOD benefits. This effort was complicated by the fact that states are inconsistent in the way they name, categorize and describe services. They are also inconsistent in the method used to estimate and track costs. Using a standard taxonomy of services published by the Centers for Medicare and Medicaid Services (CMS), the Commission coordinated with State Directors of Developmental Disabilities Services to compare and rationalize all services and costs across the 50 states and the District of Columbia. The input to this analysis was state HCBS waiver applications that primarily serve the intellectually and/or developmentally disabled (I/DD) community.
- This effort enabled the Commission to:
  - compare services and costs between states, and
  - produce a coherent representation of services across all states for comparison with ECHO services.

Commission Analysis Findings:

- The analysis of services produced:
  - A comprehensive summary of state services based on a common taxonomy with an indication of the frequency with which each service is offered and provided. A summary is provided below:

HCBS Waiver Services [1] Not / Partially Provided by ECHO	Percent of States Providing
02 Round-the-Clock Services [2] (e.g., group living)	78%
03 Supported Employment	94%
04 Day Services [3]	94%
06 Home Delivered Meals	14%
07 Rent and Food Expenses for Live-in Caregiver	16%
08 Home-based Services [4]	90%
09 Caregiver Support [5] (e.g., respite, attendant care)	98%
12 Services Supporting Self-Direction	50%
14 Equipment, Technology, and Modifications [6]	98%
15 Non-Medical Transportation [7]	74%
16 Community Transition Services	50%
17 Other Services [8]	62%

[1] Attachment 1 provides a definition of services associated with Medicaid waiver service categories.
[2] With these services, a provider has round-the-clock responsibility for health and welfare of a participant in a non-institutional setting. DOD does not provide round-the-clock services outside of an institution other than EHHC.
[3] DOD provides limited day services such as day treatment / partial hospitalization.
[4] DOD provides home-based services (e.g., home health aide, personal care, chore, companion, homemaker) to those who are homebound, requiring medically necessary skilled services beyond TRICARE coverage, and/or requiring frequent interventions, and requiring services specified in a physician-certified Plan Of Care (EHHC recipients). State services are typically less restricted.
[5] ECHO respite care is limited to 192 hours and $36,000 per year. The state average limit is 695 hours. ECHO respite care does not cover absences of the primary caregiver(s) due to deployment, training, employment, seeking employment, or pursuing education. EHHC respite care (for homebound individuals) is limited to 2,080 hours per year but is only provided to allow the primary caregiver to sleep and the caregiver must be in the home.
[6] DOD does not provide some services in this category such as nutritional supplements or personal emergency response systems.
[7] DOD only provides non-medical transportation for institutionalized ECHO beneficiaries (and accompanying medical attendant). States offer this service for beneficiaries in non-institutional settings.
[8] DOD does not provide some services in this category such as housing consultation or individually directed goods and services.

- A list of services offered by the states that are either not currently offered by ECHO or are significantly restricted in scope or availability.
- The analysis of costs produced:
  - An average annual cost per beneficiary for each service category in the services taxonomy.
  - An estimated overall annual cost increase for DOD as high as $178M. This estimate assumes:
    - DOD implements all services offered by HCBS waivers, including those that are non-medical in nature (e.g., supported employment, community transition).
    - DOD expands eligibility for day services (e.g., custodial care[9]) and round-the-clock services (e.g., support for shared residential living) to all ECHO recipients with a valid need, not just those who are homebound.
    - DOD increases the maximum hours of respite care available to all ECHO recipients to match the average state limits and eliminates the requirement for concurrent services.[10]
  - A basic cost model, capable of estimating the cost of partial implementation.
- Recommended legislative changes are being submitted to provide a stronger basis for modifications to this program.

[9] Custodial care is non-skilled personal care, e.g., help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving around, and using the bathroom.
[10] The requirement applies to the Extended Home Health Care (EHHC) program.

Submitted by Megan O'Day, EFMP Systems Navigator, Joint Base Lewis-McChord, to the June 16, 2016 meeting of the Military Family Readiness Council

IMLM-MWA

Exceptional Family Member Program, Joint Base Lewis McChord

MEMORANDUM for Office of the Deputy Assistant Secretary of Defense Military Community & Family Policy, Military Family Readiness Council

SUBJECT: Submission for Comments (Suspense 6 JUN 2016) to Military Family Readiness Council proposed in the Federal Register/Vol. 81 No. 96, 2016-11736

PURPOSE: To identify focus items for FY2016 with respect to agenda item: TRICARE for Kids. TRICARE for Kids works to develop and encourage health care practices designed to address the specific health care needs of military children.

Current Problem & Impact: What processes drive high utilization rates (military more than doubles usage compared to civilians with HMOs) vs NDAA's proposal to increase Tricare fees

Considerations:

1. Accountability of contracted healthcare administrators:

Improve audit review on evaluating current contracts for inaccuracies, noncompliance. Monitor processes linked to policy, automated workflows, spend/performance analytics. Effective audit reviews would likely result in 2% cost savings in the operating margin of the annual budget, general figure for civilian healthcare contract administrators. A simple example on how contracts are currently being audited that has a direct impact to utilization is "Find a Provider" TRICARE online tool often presents incorrect contact information and/or population served or the health care provider is not currently taking new patients and/or is longer a provider for TRICARE.

2. Foster provider collaboration/medical home model by developing/monitoring processes:

Increase the time with PCM for developmental screening or specialty care referrals related to medical home model rather than requiring patient to schedule additional appointment(s).

Develop 5 minute mandatory webinars for PCMs re provider referrals, early intervention services, behavioral health, Exceptional Family Member Program (EFMP), installation family services i.e. Army Community Service, etc.

Incentives to providers to use instant messaging among co-workers/providers.

Standardize job descriptions for nurse case managers/care coordinators.

Eliminate requirement for new referral from PCM for specialty care at every duty station/PCS. Rather, maintain referrals as valid for a specific timeframe (6/12 months).

Flag EFMP patients in ALHTA to alert appointment schedulers the possible need for acute or timely access to care.

3. Point of contact is Mary Herrera, Exceptional Family Member Program, 253-967-9704, mary.k.herrera.civ@mail.mil. Alternate point of contact is Megan O'Day, Exceptional Family Member Program, 253-967-9097, megan.r.oday.civ@mail.mil