OFFICE OF THE UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, DC 20301-4000

PERSONNEL AND READINESS

MAY - 8 2019

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

Dear Mr. Chairman:

The enclosed report is in response to the Senate Report 114–255, page 205, accompanying S. 2943, the National Defense Authorization Act for Fiscal Year (FY) 2017, which requests the Department to provide a quarterly report on the effectiveness of the Autism Care Demonstration (ACD). Enclosed is the fourth-quarter report for FY 2018 that covers data from July 2018 to September 2018.

This is the third submission of ACD data under the new T2017 TRICARE contracts. Transition to the new contracts led to some data reporting inconsistencies; however, the data is becoming more consistent and accurate. Participation in the ACD by beneficiaries and providers is robust and continues to grow. The Department adopted the new Category I Current Procedural Terminology Codes for Applied Behavior Analysis (ABA) services, and continues to make improvements to the ACD.

In summary, the Department is committed to ensuring military dependents diagnosed with Autism Spectrum Disorder have timely access to medically necessary and appropriate ABA services. 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

The Honorable Adam Smith
Chairman
Committee on Armed Services
U.S. House of Representatives
Washington, DC 20515

MAY - 8 2019

Dear Mr. Chairman:

The enclosed report is in response to the Senate Report 114–255, page 205, accompanying S. 2943, the National Defense Authorization Act for Fiscal Year (FY) 2017, which requests the Department to provide a quarterly report on the effectiveness of the Autism Care Demonstration (ACD). Enclosed is the fourth-quarter report for FY 2018 that covers data from July 2018 to September 2018.

This is the third submission of ACD data under the new T2017 TRICARE contracts. Transition to the new contracts led to some data reporting inconsistencies; however, the data is becoming more consistent and accurate. Participation in the ACD by beneficiaries and providers is robust and continues to grow. The Department adopted the new Category I Current Procedural Terminology Codes for Applied Behavior Analysis (ABA) services, and continues to make improvements to the ACD.

In summary, the Department is committed to ensuring that military dependents diagnosed with Autism Spectrum Disorder have timely access to medically necessary and appropriate ABA services. 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 Senate 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 William M. "Mac" Thornberry
Ranking Member

Report to Congress

The Department of Defense Comprehensive Autism Care Demonstration

Quarterly Report to Congress

Fourth Quarter, Fiscal Year 2018

In Response to: Senate Report 114–255, Page 205, Accompanying S. 2943, the National Defense Authorization Act for Fiscal Year 2017

The estimated cost of this report or study for the Department of Defense (DoD) is approximately $12,000 for the 2019 Fiscal Year. This includes $0 in expenses and $12,000 in DoD labor.

EFFECTIVENESS OF THE DEPARTMENT OF DEFENSE COMPREHENSIVE AUTISM CARE DEMONSTRATION

EXECUTIVE SUMMARY

This quarterly report is in response to Senate Report 114–255, page 205, accompanying S. 2943, the National Defense Authorization Act for Fiscal Year (FY) 2017, which requests the DoD provide a quarterly report on the effectiveness of the Comprehensive Autism Care Demonstration (ACD). Specifically, the committee requests the Secretary to report, at a minimum, the following information by state: "(1) the number of new referrals for services under the program; (2) the number of total beneficiaries enrolled in the program; (3) the average wait-time from time of referral to the first appointment for services under the program; (4) the number of providers accepting new patients under the program; (5) the number of providers who no longer accept new patients for services under the program; (6) the average number of treatment sessions required by beneficiaries; and (7) the health-related outcomes for beneficiaries under the program." The data presented below was reported by the Managed Care Support Contractors (with oversight from the government), hereinafter referred to as the Contractors, and represents the timeframe from July 1, 2018, through September 30, 2018. This is the third submission of ACD data under the new T2017 TRICARE contracts. The Defense Health Agency (DHA) continues to work with both Contractors to obtain uniform data across regions. The data may be underreported due to the delays in receipt of claims.

Approximately 16,277 children currently receive Applied Behavior Analysis (ABA) services through the ACD as of September 30, 2018. Total ACD program expenditures were $268.3 million for FY 2017 and $313.7 million for FY 2018. The transition to the T2017 TRICARE contracts found that providers were being counted in multiple locations, representing an overestimate of available providers. The problem has since been corrected and the number of ABA providers accounted for as of September 30, 2018, is 30,067. The total average wait time from the date of referral to the first appointment for ABA services is within the 28-day access standard for specialty care; for this reporting period, the average wait time is approximately 28 days. Several localities, as noted in Table 3 below, exceed the access standard and the Contractors are actively working to recruit new providers as appropriate. The majority of these localities are located in the East region. The government is working with the Contractors, particularly in the east region, to identify reasons for the increase in localities exceeding the 28-day standard. To address the areas exceeding the 28-day limit, the Contractors are inviting providers and large provider groups to become new TRICARE providers or determining if they can add providers in those regions. To do so, the Contractors are working with individual patients and families, some of whom may have been placed on a "wait list" by one provider even though other providers are available, and ensuring other appropriate services are available, as needed. The number of ABA providers continues to grow. The average number of ABA sessions rendered are outlined below in Table 6 by state. These sessions were reported as the paid average number of hours per week per beneficiary, as the number of sessions does not necessarily represent the intensity or frequency of services. Further, conclusions about ABA services utilization variances by locality or other demographic information cannot be confirmed due to the unique needs of each beneficiary. Finally, the first opportunity to report health-related outcome measures data is available. While the findings are of concern, as 86 percent of

beneficiaries saw little to no change in symptom presentation after six months of ABA services, these findings should be interpreted with caution as this is just one data point in a comprehensive review and further exploration and analysis is required, and the DoD will provide an update in subsequent reports and a comprehensive analysis after the conlusion of the demonstration, which is currently set for December 2023.

BACKGROUND

ABA services are one of many TRICARE covered services available to mitigate the symptoms of Autism Spectrum Disorder (ASD). Other services include, but are not limited to: speech and language therapy (SLP), occupational therapy (OT), physical therapy (PT), medication management, psychological testing, and psychotherapy. In June 2014, TRICARE received approval from the Office of Management and Budget to publish the ACD Notice in the Federal Register. In July 2014, three previous programs were consolidated to create the ACD. The program is based on limited demonstration authority with the goal of striking a balance that maximizes access while ensuring the highest level of quality services for beneficiaries. The consolidated demonstration ensures consistent ABA service coverage for all TRICARE eligible beneficiaries, including active duty family members (ADFMs) and non-ADFMs diagnosed with ASD. ABA services are not limited by the beneficiary's age, dollar amount spent, number of years of services, or number of sessions provided. All care is driven by medical necessity. Generally, all ABA services continue to be provided through purchased care. Additionally, several innovative programs are ongoing at military treatment facilities (MTFs) to support beneficiaries with ASD and their families. The ACD began July 25, 2014, and was originally set to expire on December 31, 2018; however, an extension for the demonstration until December 31, 2023, was approved via a Federal Register Notice published on December 11, 2017. The notice stated that additional analysis and experience is required in order to determine the appropriate characterization of ABA services as a medical treatment, or other modality, under the TRICARE program coverage requirements. By extending the demonstration, the government will gain additional information about what services TRICARE beneficiaries are receiving under the ACD, how to most effectively target services where they will have the most benefit, collect more comprehensive outcomes data, and gain greater insight and understanding of the diagnosis of ASD in the TRICARE population.

RESULTS

1. The Number of New Referrals with Authorization for ABA Services Under the Program

The number of new referrals with an authorization for ABA services under the ACD during the period of July 1, 2018 through September 30, 2018 was 2,062. This was a decrease from the previous quarter (5,163). This does not reflect an actual decrease in the number of new patients; rather, the previous number was elevated because of the conversion to the T2017 contracts. This data point has now leveled out since the start of the new T2017 contracts and is in line with the previous (T3) contract for numbers of quarterly referrals. A breakdown by state is included in Table 1.

Table 1

State	New Referrals with Authorization
AK	16
AL	21
AR	5
AZ	24
CA	231
CO	79
CT	7
DC	7
DE	5
FL	178
GA	124
HI	82
IA	0
ID	1
IL	22
IN	19
KS	46
KY	26
LA	29
MA	7
MD	47
ME	0
MI	11
MN	2
MO	32
MS	21
MT	0
NC	163
ND	1
NE	12
NH	2
NJ	11
NM	10
NV	17
NY	15
OH	12
OK	21
OR	2
PA	13
RI	10
SC	26
SD	2
TN	26
TX	250
UT	17
VA	257
VT	0
WA	153
WI	9
WV	1
WY	6
Total	**2,062**

2. <u>The Number of Total Beneficiaries Enrolled in the Program</u>

As of September 30, 2018, the total number of beneficiaries participating in the ACD was 16,277, an increase from the last reporting period (15,454). A breakdown by state is included in Table 2 below.

Table 2

State	Total Beneficiaries Participating
AK	184
AL	259
AR	29
AZ	284
CA	1942
CO	920
CT	55
DC	24
DE	37
FL	1405
GA	805
HI	613
IA	17
ID	4
IL	209
IN	110
KS	287
KY	255
LA	126
MA	57
MD	6
ME	427
MI	68
MN	21
MO	204
MS	112
MT	23
NC	1215
ND	4
NE	88
NH	12
NJ	111
NM	90
NV	223
NY	96
OH	118
OK	155
OR	16
PA	89

RI	21
SC	312
SD	14
TN	316
TX	1800

UT	222
VT	0
VA	1832
WA	1184
WI	29

WV	7
WY	24
Total	**16,277**

3. The Average Wait Time from Time of Referral to the First Appointment for Services Under the Program

For 30 states, the average wait time from date of referral to the first appointment for ABA services under the program is within the 28-day access standard for specialty care. The average wait time of all states from time of referral to first appointment is approximately 28 days. However, for this reporting period, 20 states are beyond the access standard. At this time, causative key factors include delays in Extended Care Health Option enrollment (despite a provisional period of enrollment), beneficiaries changing providers after authorized to one provider, beneficiary preference on appointment time, and families choosing a provider with a wait list. Improvement in processes, such as proactive outreach to beneficiaries, is underway, which is expected to assist beneficiaries in accessing services in a timely manner. ABA providers are directed not to accept beneficiaries for whom they cannot implement the recommended treatment plan within the 28-day access standard. Contractors will not knowingly refer beneficiaries to ABA providers who are unable to provide the recommended treatment to beneficiaries within the 28-day access to care standard. The Contractors continue to work diligently to build provider networks, and will continue to monitor states and locations where provider availability is an issue. The government also reviewed the data for the states that far exceed the standard, including Illinois, Ohio, and Pennsylvania, and found there are outliers driving the averages upward. The outliers are being reviewed to identify causes and solutions. Although the field of behavior analysis is growing, locations remain with an insufficient number of ABA providers able to meet the demand for such services. This shortage is consistent with shortages seen with other types of specialty care providers such as developmental pediatricians and child psychologists, and is not limited to TRICARE. A breakdown by state is included in Table 3 below.

Table 3

State *	**Average Wait Time (# days)**
AK	42
AL	48
AR	11
AZ	11
CA	21
CO	21

CT	0
DE	49
DC	28
FL	41
GA	35
HI	28
IA	0
ID	0

IL	76
IN	8
KS	20
KY	35
LA	42
MA	60
MD	44
ME	0
MI	28
MN	31
MO	18
MS	12
MT	0
NC	58
ND	0
NE	0
NH	0
NJ	40
NM	0

NV	20
NY	79
OH	125
OK	45
OR	0
PA	98
RI	9
SC	58
SD	0
TN	44
TX	43
UT	16
VA	49
VT	0
WA	26
WV	0
WI	0
WY	23

4. The Number of Practices Accepting New Patients for Services Under the Program

For this reporting quarter, the number of ABA practices accepting new patients under the ACD is 3,316, an increase from the last reporting period (2,771). A breakdown by state is included in Table 4 below.

Table 4

State	Practices Accepting New Beneficiaries
AK	12
AL	52
AR	9
AZ	14
CA	188
CO	51
CT	19
DC	4
DE	4
FL	744
GA	102

HI	18
IA	2
ID	5
IL	152
IN	135
KS	15
KY	71
LA	92
MA	18
MD	3
ME	56
MI	131
MN	2

MO	68
MS	10
MT	4
NC	44
ND	4
NE	5
NH	16
NJ	28
NM	15
NV	3
NY	54
OH	48
OK	15
OR	4

PA	61
RI	3
SC	65
SD	1
TN	102
TX	393
UT	16
VA	175
VT	1
WA	36
WV	3
WI	73
WY	2
Total	**3,316**

5. The Number of Practices No Longer Accepting New Patients Under the Program

The number of ABA practices that stopped accepting new TRICARE beneficiaries for ABA services under the program is 179, an increase from the last quarter (39). Data has been and will continue to be monitored, but it is difficult to pinpoint an exact cause for the increase. It is important to note the below numbers occurred before the change to Category Current Procedural Terminology (CPT) codes, so the increase is not related to those changes. Thus far, the government has not received notification of termination of services from ABA providers during this reporting quarter. A breakdown by state is included in Table 5 below.

Table 5

State	Practices No Longer Accepting New Beneficiaries
AK	0
AL	1
AZ	0
AR	1
CA	0
CO	0
CT	0
DE	0
DC	0
FL	9
GA	23
HI	0

ID	0
IL	7
IN	1
IA	0
KS	0
KY	0
LA	0
MA	21
MD	2
ME	0
MI	1
MN	0
MO	1
MS	1
MT	0

NC	6
ND	0
NE	0
NH	0
NJ	1
NM	0
NV	0
NY	1
OH	0
OK	4
OR	0
PA	1
RI	1

SC	1
SD	0
TN	1
TX	87
UT	0
VT	0
VA	7
WA	0
WV	0
WI	1
WY	0
Total	**179**

6. The Average Number of Treatment Sessions Required by Beneficiaries

The average number of ABA sessions required by beneficiaries is difficult to answer in isolation. ABA research has not established a dose–response relationship between severity, treatment needs, and intensity of services. Additionally, ABA services may be one component of a comprehensive treatment plan for a beneficiary diagnosed with ASD. A comprehensive treatment plan may include SLP, OT, PT, psychotherapy, etc., for the best outcomes for any one beneficiary. Therefore, the numbers outlined by state in Table 6 (below), report only the paid average number of hours of 1:1 ABA services per week per beneficiary receiving services as the "number of sessions." This does not represent the intensity of services or correlation to treatment outcomes. The averages in Table 6 did not account for a claims lag delay and, therefore, these averages do not accurately reflect rendered hours. The government is reviewing the contract requirements to account for a claims lag for accurate reporting. In addition, conclusions cannot be made about ABA services utilization variances by locality or other demographic information due to the unique needs of each beneficiary.

Table 6

State	Average Hours/Week per Beneficiary
AK	5
AL	5
AR	4
AZ	5
CA	5
CO	6
CT	4
DC	5
DE	1
FL	5

GA	4
HI	5
IA	7
ID	1
IL	5
IN	13
KS	6
KY	5
LA	6
MA	4
MD	4
ME	4

MI	6
MN	6
MO	4
MS	2
MT	4
NC	4
ND	7
NE	3
NH	2
NJ	3
NM	6
NV	3
NY	5
OH	6
OK	5

OR	13
PA	4
RI	4
SC	6
SD	8
TN	5
TX	6
UT	6
VT	0
VA	4
WA	4
WV	5
WI	6
WY	4

7. Health-Related Outcomes for Beneficiaries Under the Program

The DoD continues to support evaluations on the nature and effectiveness of ABA services. The publication of TRICARE Operations Manual Change 199, dated November 29, 2016, for the ACD included the evaluation of health-related outcomes through the requirement of norm-referenced, valid, and reliable outcome measures; the data collection began on January 1, 2017. Currently, there are three outcome measures required under the ACD: the Vineland Adaptive Behavior Scales, Third Edition (Vineland-3) is a measure of adaptive behavior functioning; the Social Responsiveness Scale, Second Edition (SRS-2) is a measure of social impairment associated with ASD; and the Pervasive Developmental Disabilities Behavior Inventory (PDDBI) is a measure that is designed to assist in the assessment of various domains related to ASD. Additionally, the PDDBI is a measure that is designed to assess the effectiveness of treatments for children with pervasive developmental disabilities, including ASD, in terms of response to interventions. The outcome measure scores are completed and submitted to the Contractors by eligible providers authorized under the ACD who completed an evaluation of each beneficiary's symptoms related to ASD at the time of assessment. The Vineland-3 and SRS-2 are required every two years and the PDDBI is required every six months.

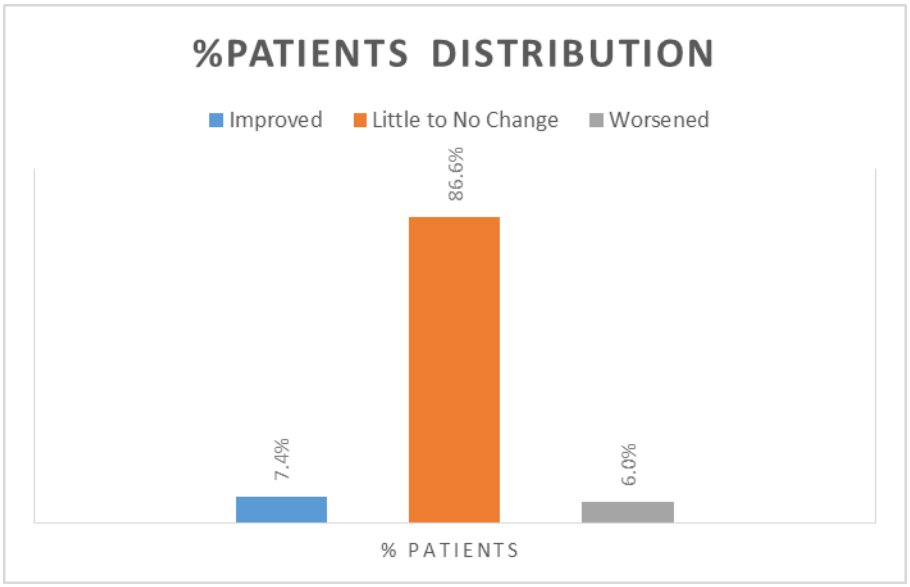
This report is the third reporting quarter since the start of health care delivery and the seventh reporting quarter since the outcome measures requirement took effect. This report provides the first quarter of reporting where two sets of scores are able to be compared:

Of the 16,277 beneficiaries currently enrolled in the ACD, approximately 14,000 beneficiaries had at least one completed and submitted outcome measure. Of those 14,000 beneficiary files, this report reviews and analyzes 1,577 beneficiaries with usable scores for comparison of the PDDBI only. Many beneficiary scores noted "0," indicating an incomplete or an unable to answer sections of the PDDBI based on a variety of factors (i.e., direction to not complete a section if the child is non-verbal). Additionally, this number (1,577) represents beneficiaries from only the west region, as the current contract requirements did not specify

reporting scores by outcome measure form type (parent versus teacher form). Therefore, while the east region Contractor complied with the reporting requirements, east region beneficiary data cannot be used for this reporting period for a comparison due to an inability to determine which forms (parent versus teacher) were reported. The government will correct this requirement in an upcoming contract modification.

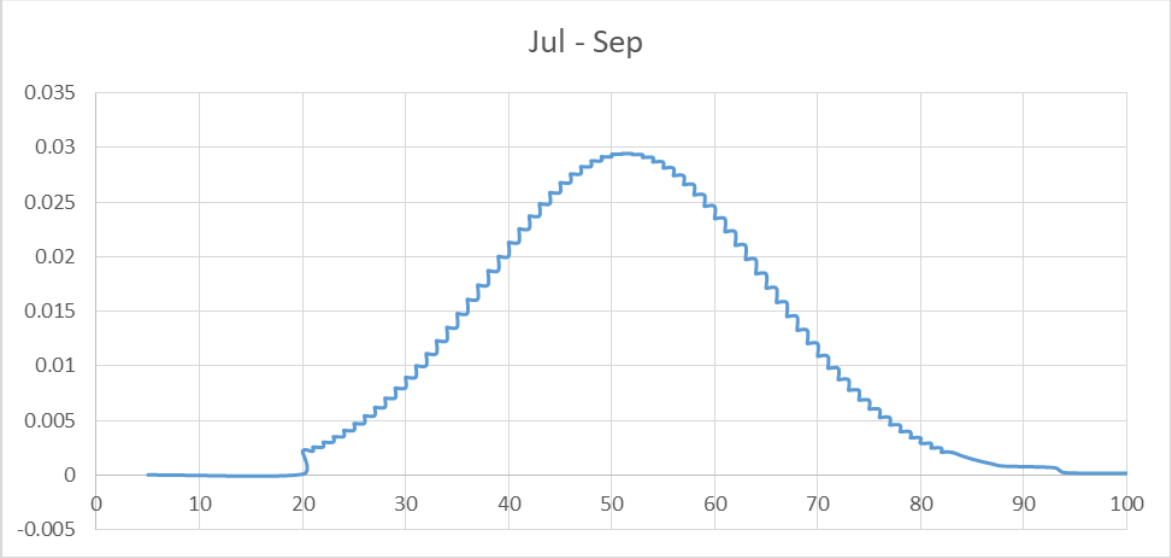
Based on the Autism Composite Score on the parent form of the PDDBI (which is a measure of lack of appropriate social communication skills along with repetitive/ritualistic behaviors), approximately 87 percent (1,365) of beneficiaries made little to no change in their symptom presentation after six months of ABA services (647 or 41 percent of the population had no change in PDDBI - parent score; 718 or 45 percent had less than one Standard Deviation (SD) change in PDDBI - parent score). Of significance, six percent of the population had a decline of one SD or more indicating worsening symptom presentation after six months of ABA services. Only seven percent of the sample had improvement (1 SD or better) in symptom presentation after six months of ABA services. See Figure 1 for the distribution of change scores.

Figure 1



PDDBI scores are reported as T-scores with a mean of 50 and a standard deviation of 10. Scores between 40 and 60 are considered within the average range for individuals diagnosed with ASD; a lower PDDBI score indicates less severe ASD symptomatology. Figure 2 displays the distribution of scores for this reporting period.

Figure 2



Also reviewed was the concordance/discordance between parent and teacher or Board Certified Behavior Analyst (BCBA) completed forms of this quarter's score submission. Of the 1,577 beneficiaries pulled for this analysis, 755 beneficiaries had both parent and teacher forms submitted for this reporting quarter. Approximately 60 percent of the completed parent and teacher forms were within 10 points or one SD of one another suggesting that there was agreement in more than half of the T-scores for the Autism Composite Score regarding the perception of symptom presentation. Of the remaining 40 percent where there was greater difference in scores (1 SD or greater), 70 percent of the parents scored worse symptom presentation than the teacher or BCBA. According to the research regarding the PDDBI, there is a high degree of interrater reliability between the parent and teacher forms. This discrepancy in TRICARE beneficiaries requires further exploration.

The Contractors use these scores, as well as other scores and data, to guide and engage ABA providers in identifying treatment plan development and adjustments that may be required to see improvements.

Of note, these findings should be interpreted with caution as the PDDBI is just one data point of many collected and reported. Additionally, caution should be used as there are no other factors considered in this summary such as age, symptom severity, number of hours of services, total duration of ABA services, other services, academic placement, etc.

PROGRAM UPDATES

TRICARE implemented new Category I CPT Codes titled Adaptive Behavior Services for the billing of ABA services on January 1, 2019. As with all CPT codes, these codes were developed by the American Medical Association for use in medical billing of specific procedures by qualified health care professionals. This change resulted in the elimination of reimbursement for supervision, as there is no Category I CPT code specifically for supervision of paraprofessional ABA providers by ABA supervisors. All other ABA services that are currently

covered will continue to be covered under the ACD without change. Additionally, TRICARE-specific supervision requirements were also eliminated; however, certifying and licensing bodies for behavior analysis continue to require supervision as a criteria for certification. This change now allows ABA supervisors more flexibility in meeting the certifying bodies' supervision requirements. The DHA anticipates that any lost revenue in supervision will, in many cases, be recaptured in new clients or more face-to-face time with beneficiaries.

The DHA's focus for implementing this change was to ensure no disruption to beneficiary care and to minimize the work required by providers related to this change. A communication plan, including multiple provider information sessions, materials posted to the health.mil web site, and information messages sent to the provider e-mail and GovDelivery lists accompanied this change. The DHA hosted five meetings throughout December 2018 and January 2019 addressing a variety of stakeholders including three provider information meetings (attendee total approximately 1,400), MTF meeting (attendee total approximately 250), briefing to the quarterly Military/Veterans Service Organizations, and two small group meetings with ABA stakeholders.

CONCLUSION

As evidenced in the above information, participation in the ACD by beneficiaries continues to grow. As of September 30, 2018, there were 16,277 beneficiaries participating in the ACD, the highest participation since ABA services were offered under TRICARE. The average wait time for all states from date of referral to first appointment is approximately 28 days. Geographic areas where access exceeds the 28-day standard are being addressed, as appropriate, by the Contractors with government oversight. The Contractors track every patient who has an authorization for ABA services to ensure they have an ABA provider who can render services within the access to care standards; this data is used at the state and local level, which will help identify areas with potential network deficiencies. For any beneficiary with an active authorization for ABA services who does not have an ABA provider, the Contractors continue to work to place those patients with a qualified provider as quickly as possible.

Determining health-related outcomes is an important requirement added to the ACD. A contract modification, effective January 1, 2017, provided direction for Contractors to begin collecting the outcome measures data for all ACD participants. This is the first reporting quarter that produced outcome measure scores that were eligible for analysis.

Based on this data, the majority of TRICARE beneficiaries (86 percent) had little to no change in symptom presentation over the course of six months of ABA services. It may be that more time is required to see change; however, input on treatment progress should be collected in short intervals so that time does not pass with ineffective treatment. Additionally, the 40 percent discrepancy in responses between parents and teacher/BCBA is also of note, suggesting DHA should explore the possible reasons for the wide range in perceptions of symptom presentation, to include evaluating the utility of the parent form and of this measure generally. Further analysis is required to observe trends and utility. While it is concerning that 86 percent of the population saw little to no change, the DHA via the Contractors will work with the providers to ensure effective treatment is being delivered.