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

PERSONNEL AND READINESS

The Honorable Roger F. Wicker
Chairman
Committee on Armed Services
United States Senate
Washington, DC 20510

APR 2 0 2026

Dear Mr. Chairman:

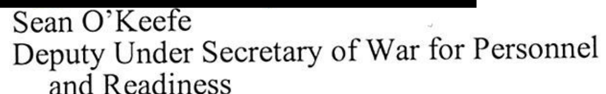
The Department's response to Senate Report 114–49, pages 157-158, accompanying S. 1376, the National Defense Authorization Act for Fiscal Year (FY) 2016, "Annual Report on Autism Care Demonstration Program," is enclosed.

The Autism Care Demonstration (ACD) offers Applied Behavior Analysis (ABA) services for all TRICARE-eligible beneficiaries diagnosed with autism spectrum disorder. ABA services are not limited by the beneficiary's age, dollar amount spent, or number of services provided. The ACD began July 25, 2014, and was originally set to expire on December 31, 2018. The Department extended the demonstration until December 31, 2028 to determine the appropriate characterization of ABA services as a medical treatment or other modality under the TRICARE program's coverage requirements.

In FY 2024, ACD participation and total cost continued to increase (17,603 total beneficiaries; $518.9 million). The FY 2024 analysis noted similar findings to the FY 2023 data analysis in that more beneficiaries had made improvements, although still small, after receiving clinically appropriate ABA. As with the previous year's findings, regression analysis found that adherence to treatment hours, parental stress, and baseline functioning were significant predictors of clinical outcomes. These findings represent analyses regarding ACD program oversight rather than the efficacy of the ABA services.

Thank you for your continued strong support for our Service members and their families. I am sending a similar letter to the Committee on Armed Services of the House of Representatives.

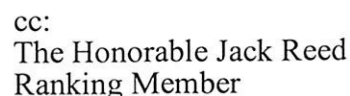
Sincerely,



Sean O'Keefe
Deputy Under Secretary of War for Personnel
and Readiness

Enclosure:
As stated

cc:
The Honorable Jack Reed
Ranking Member



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PERSONNEL AND READINESS

APR 20 2026

The Honorable Mike D. Rogers
Chairman
Committee on Armed Services
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

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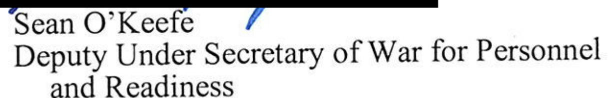

Sean O'Keefe
Deputy Under Secretary of War for Personnel and Readiness

Enclosure:
As stated

cc:
The Honorable Adam Smith
Ranking Member

Report to the Committees on Armed Services of the Senate and the House of Representatives

Annual Report on Autism Care Demonstration Program

April 2026

The estimated cost of this report or study for the Department of War (DoW) is approximately $15,000 in Fiscal Year 2025. This includes $0 in expenses and $15,000 in DoW labor.
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INTRODUCTION

This report is in response to Senate Report 114–49, pages 157-158, accompanying S. 1376, the National Defense Authorization Act for Fiscal Year (FY) 2016, which requests a report on the results of the Comprehensive Autism Care Demonstration (ACD). This report is based on FY 2022-2023 claims data and is the tenth of these annual reports.

> The annual report should include a discussion of the evidence regarding clinical improvement of children with [Autism Spectrum Disorder (ASD)] receiving [Applied Behavior Analysis (ABA)] therapy and a description of lessons learned to improve administration of the demonstration program. In the report, the Department should also identify any new legislative authorities required to improve the provision of autism services to beneficiaries with ASD.

BACKGROUND

TRICARE covers multiple services for beneficiaries diagnosed with ASD. ABA services are covered under the ACD, but other services under the TRICARE benefit include, but are not limited to: speech and language pathology (SLP); occupational therapy (OT); physical therapy (PT); medication management; psychological testing; and psychotherapy. ABA services authorized under the ACD that address the core symptoms of ASD are not limited by the beneficiary's age, dollar amount spent, number of years of services received, or number of sessions provided; however, ABA services must be driven by clinical necessity. Non-clinical ABA services, or ABA services not targeting the core symptoms of ASD, are not authorized under the ACD. All ABA services continue to be provided through the private sector.

The ACD began July 25, 2014, and is currently authorized through December 31, 2028. Through the ACD, the Defense Health Agency (DHA) attempts to strike a balance between maximizing access to care while ensuring the highest level of quality and appropriateness of services for beneficiaries. The ACD ensures consistent ABA service coverage for all TRICARE-eligible beneficiaries, including active duty family members (ADFMs) and non-active duty family members (NADFMs) diagnosed with ASD. The Department is obtaining additional information about which services TRICARE beneficiaries are receiving under the ACD and how to target services providing the most benefit. The Department continues to collect comprehensive outcomes data to gain greater insight and understanding of the diagnosis of ASD in the TRICARE population.

DESCRIPTION OF THE ACD

The ACD offers only ABA services for all TRICARE-eligible beneficiaries diagnosed with ASD by an approved provider. ABA services under the ACD are authorized for the purpose of ameliorating the core symptoms of ASD (deficits in social communication and restrictive, repetitive behaviors). Under the ACD, a Board Certified Behavior Analyst (BCBA), BCBA-Doctorate, or other TRICARE-authorized provider who practices within the scope of his or her state licensure or state certification, referred to as an "authorized ABA supervisor," plans,

delivers, and supervises an ABA program. The authorized ABA supervisor can deliver ABA services under either the sole provider or tiered-delivery model.

The TRICARE Operations Manual (TOM) Chapter 18, Section 3, "Department of Defense (DoD) Comprehensive Autism Care Demonstration (ACD)," provides guidance to all TRICARE contractors on how to execute the benefit under the demonstration authority. The TOM describes: beneficiary eligibility, referral, and authorization requirements; provider eligibility requirements; outcome measure requirements; covered services and reimbursement rates; documentation requirements; exclusions; and TRICARE contractor responsibilities.

UTILIZATION TRENDS

The following information was generated using TRICARE private sector care claims data from the last 10 FYs (FY 2015 – FY 2024) for which full year data is available for the ACD. All claims data examined in this report were extracted from the Military Health System Data Repository (MDR) on August 1, 2025, and the results are based upon data entered into the MDR by that date. Updated historical data reflects additional claims filed following the data abstraction point. The following tables report data from FY 2019 – FY 2024. Historical data for previous FYs are available in previous annual reports.

TRICARE ACD Program Participants and Expenditures Per FY

At the end of FY 2024, there were 17,603 beneficiaries with a diagnosis of ASD participating in the ACD: 13,021 ADFMs and 4,582 NADFMs (Table 1). This number reflects a 54 percent increase in total participants from the FY 2015 level (11,461); a 42 percent increase for ADFMs (9,178) and a 100 percent increase for NADFMs (2,283). Each FY total number of participants does not represent cumulative participation. Rather, each FY represents the total number of unique beneficiaries who had a claim filed during that year.

Total Government costs for the ACD increased 182 percent from FY 2015 to FY 2021 ($161.5 million (M) in FY 2015 and $455.23M in FY 2021) and then decreased by 14 percent in FY 2022 from FY 2021 (Table 1). In FY 2023, total Government costs increased by 10.3 percent and then increased another 18.9 percent in FY 2024. The average cost per participant has increased a total of 109 percent from FY 2015 to FY 2024. The average cost per ACD participant (Table 1) increased from $14,091.00 in FY 2015 to $27,278.00 in FY 2021 but then decreased to $24,179 in FY 2022. In FY 2023, the average cost per ACD participant increased by 7.6 percent and then increased another 13.3 percent in FY 2024.

While the average paid cost per ACD participant was $29,481 in FY24, it is important to examine the distribution of paid claims. Across all beneficiary types, the 25th percentile of the paid amount per participant was only 18 percent of the average amount at $5,366. The median amount was 61 percent of the average amount at $17,896. The 75th percentile amount was $41,684, and the highest amount observed was $279,243. The 25th percentile of the ADFM paid amounts were 43 percent higher than NADFM paid amounts, and this difference shrinks to 14 percent for the 75th percentile (see Table 2).

To explain the annual participant expenditure increase from FY 2023 to FY 2024, the causal factors of costs were examined; namely: ACD patients, services per patient, and cost per service. This analysis focused on one-on-one ABA services (CPT code 97153) because they accounted for 78 percent of ACD Government costs in FY 2024. Overall, total one-on-one costs for CPT 97153 increased by 20.3 percent in FY 2024, from $336.1 million to $404.4 million. In allocating the causal factors of this increase for the entire United States, about one-quarter was due to an increase in patients, about one-third from an increase in services per patient, and nearly 40 percent from an increase in the paid amount per service. The large increase in paid amounts per service was due to the increase in TRICARE maximum allowable charges for CPT code 97153 for assistant behavior analysts and behavior technicians in May 2024. The maximum rates for these two categories or providers increased primarily due to large rate increases in many state Medicaid programs (which are a key factor in determining the maximum TRICARE reimbursement rates).

Table 1 – TRICARE ADFM/NADFM ACD Program Participants and Expenditures per FY

Year	Number of Participants	% Growth in Participants from Prior FY	Dollars in Millions	% Growth in Dollars from Prior FY	Dollars per Participant	% Growth in Dollars from Prior FY
ADFM Participants						
FY 2019	11,965	-	$288.90	-	$24,143	-
FY 2020	12,148	1.5%	$306.70	6.2%	$25,248	4.6%
FY 2021	12,415	2.2%	$347.50	13.3%	$27,987	10.8%
FY 2022	12,134	-2.3%	$301.40	-13.3%	$24,837	-11.3%
FY 2023	12,457	2.7%	$333.30	10.6%	$26,758	7.7%
FY 2024	13,021	4.5%	$394.30	18.3	$30,281	13.3%
NADFM Participants						
FY 2019	4,039	-	$87.00	-	$21,536	-
FY 2020	4,165	3.1%	$92.80	6.6%	$22,273	3.4%
FY 2021	4,274	2.6%	$107.80	16.2%	$25,220	13.2%
FY 2022	4,226	-1.1%	$94.20	-12.6%	$22,289	-11.6%
FY 2023	4,319	2.2%	$103.0	9.4%	$23,856	7.0%
FY 2024	4,582	6.1%	$124.7	21.0%	$27,207	14.0%
Total Participants						
FY 2019	16,004	-	$375.90	-	$23,485	-
FY 2020	16,313	1.9%	$399.50	6.3%	$24,488	4.3%
FY 2021	16,689	2.3%	$455.20	14.0%	$27,278	11.4%
FY 2022	16,360	-2.0%	$395.60	-13.1%	$24,179	-11.4%
FY 2023	16,776	2.5%	$436.40	10.3%	$26,011	7.6%
FY 2024	17,603	4.9%	$518.9	18.9%	$29,481	13.3%
Source: MDR Data as of August 1, 2025						

Table 2 – ACD Government Expenditures per Participant in FY 2024 by Quartile

Beneficiary Category	25th Percentile	50th Percentile	75th Percentile	Maximum Amount	Average
ADFM	$5,873	$18,846	$42,970	$272,057	$30,281
NADFM	$4,107	$14,988	$37,677	$279,243	$27,207
Total	$5,366	$17,896	$41,684	$279,243	$29,481

Annual Expenditure Ranges in FY 2024

In the past, there was interest in the percentage of ACD participants using ABA services who were exceeding the historical $36,000 FY cap on expenditures. While the ACD no longer has annual expenditure limits, the $36,000 cap can serve as a historical benchmark to evaluate the distribution of annual expenditures by ACD program beneficiaries.

In FY 2024, 29.3 percent of ACD participants (5,156 of 17,603) had expenditures exceeding $36,000 (see Table 3). Total paid amounts for participants with expenditures exceeding $36,000 annually amounted to $366.6 million in FY 2024 and this represented 70.6 percent of total ACD paid expenditures (but only 29.3 percent of ACD participants).

Table 3 – Number of ACD Participants by Annual Expenditure Ranges in FY 2024

Beneficiary Category	<$30K	$30-34.99K	$35-35.99K	$36.01-$99.99K	$100K+	Total
ADFM	8,309	640	110	3,284	678	13,021
NADFM	3,148	208	32	985	209	4,582
Total	11,457	848	142	4,269	887	17,603

Age Distribution of ACD Program Participants for FY 2024

The distribution by beneficiary age and category (ADFMs and NADFMs) using TRICARE ACD services during FY 2024 is generally consistent with previous years for beneficiary participation. Across both beneficiary categories, 98.8 percent of ACD beneficiaries are younger than age 21, and 89.0 percent are age 13 and younger. The median participant age is 7 years; the average age is 7.7 years; and the most common age (mode) of participating beneficiaries is 5 years. While almost half of the ADFM users are age 5 or less, only about one-quarter of NADFM users are under age 6. Roughly three quarters of all users were males among both the ADFM and NADFM populations during FY 2024.

Utilization Trends of One-on-One ABA Services Hours Per Week for FY 2024

To undertake an analysis of hours per week of ABA services, one-on-one 15-minute service units (CPT code 97153) were divided by four to determine ABA service hours for each patient during FY 2024. The MDR data was made available by month during FY 2024. Total ABA hours were divided by the number of months that a particular patient had ABA services to calculate service hours per month for each patient. To calculate hours per week, service hours per month were divided by 4.345 (365/12/7). Average and quartile weekly hours of one-on-one services were then calculated by age categories and TRICARE contract region.

For both regions, the highest weekly average utilization rates occurred in the age 4 and age 5 categories with an average of 10.2 hours per week of CPT code 97153. Average hours per week dropped consistently for those older than age 5. For those ages 13 and older, hours per week dropped to the lowest average to 5.2 hours per week.

Utilization of Family Treatment Guidance Services under the ACD

A total of 14,898 of 17,603 ACD users (84.6 percent) had parents or guardians who used family treatment guidance services (CPT code 97156) during FY 2024 with 15.4 percent of parents or guardians who had no claims filed for family treatment guidance services. The use rate was only slightly higher for ADFMs at 84.7 percent (11,023 of 13,021 users) versus 84.6 percent for NADFMs (3,875 of 4,582 users). The use of family treatment guidance services did not vary substantially across age categories but nonetheless the use rates were the lowest for parents or guardians of children age 3 and younger (73.5 percent), increased to the highest level at age 5 (87.3 percent), and then declined slightly to 85.4 percent for children ages 10-12. Family treatment guidance services represented 3.5 percent of total ACD expenditures ($18.2 million/$518.9 million) in FY 2024, and this percentage tends to increase with the age of the patient. The age group 13 and older had the highest percentage (5.8 percent) while those ages 3 or younger had the lowest percentage (2.6 percent).

Hours of service per month for the 14,792 patients receiving family treatment guidance averaged 1.1 hours during the months in which the patients received any services in the ACD. There were only minor deviations from this amount by beneficiary and age categories. Average treatment hours per month were as low as 0.8 for NADFMs ages 3 and younger and as high as 1.4 hours per month for NADFMs ages 13 and older.

Family treatment guidance hours per month are similar by quartile across age groups. At the 25th percentile, average treatment hours per month are 0.3 across all age categories. At the 50th percentile, average family guidance treatment hours per month vary between 0.5 and 0.6 per month, while at the 75th percentile average treatment hours per month vary between 0.9 and 1.2 hours per month. Maximum amounts are quite large and vary between 14.9 hours (age 5) and 34.9 hours per month (ages 13+) as indicated in Table 4.

Table 4 – FY 2024 Average Hours of Family Treatment Guidance (CPT Code 97156) for ACD Patients by Quartile for Different Age Groups

Agge	25th Percentile	50th Percentile	75th Percentile	Maximum Amount	Average Hours
3 or Younger	0.0	0.5	0.9	16.0	0.7
4	0.3	0.6	1.0	17.7	0.9
5	0.3	0.6	1.0	14.9	0.9
6-7	0.3	0.6	1.0	19.0	0.8
8-9	0.3	0.6	1.0	34.2	0.9
10-12	0.3	0.5	1.0	25.5	0.9
13+	0.3	0.6	1.2	34.9	1.2
Grand Total	0.3	0.6	1.0	34.9	0.9

Expenditures for Additional Services Utilized by ACD Users

In addition to the $518.9M in FY 2024 expenditures for ABA services, these beneficiaries also utilized relatively large amounts of TRICARE medical services for PT, SLP, and OT in both the private sector and the direct care system. Further, beneficiaries diagnosed with ASD in the ACD also used the retail pharmacy, TRICARE Mail Order Pharmacy, and direct care pharmacy for prescription medications to treat behaviors affecting the symptoms of ASD, Attention Deficit Hyperactivity Disorder, and related mental health conditions. Of the 17.603 TRICARE beneficiaries who participated in the ACD during FY 2024, 56.7 percent (9.989) also utilized $55.03M in PT, SLP, and OT services (private sector care paid amounts and direct care full cost amounts) and 64.1 percent (11,286) used $19.1M in prescription medications.

Table 5 – Government Expenditures for PT/OT/SLP and Prescription Medication for TRICARE ADFM/NADFM ACD Program Participants

Year	PT/SLP/OT Services	Prescription Medications	Total
Total Participant Expenditures			
FY 2019	$51,307,581	$16,420,784	$67,728,365
FY 2020	$51,337,206	$20,408,875	$71,746,081
FY 2021	$58,943,928	$17,518,502	$76,462,430
FY 2022	$53,607,961	$17,119,932	$70,727,893
FY 2023	$53,495,856	$20,823,382	$74,319,236
FY 2024	$54,960,526	$19,075,092	$74,035,618
Source: MDR Data as of August 1, 2025			

DISCUSSION OF THE EVIDENCE REGARDING CLINICAL IMPROVEMENT OF CHILDREN DIAGNOSED WITH ASD RECEIVING ABA SERVICES

Previous annual reports have discussed the status of the research literature regarding ABA services. While DHA continues to monitor the literature, there have been no significant advances in ABA research with regards to defining dose-response (including intensity, frequency, or duration), standardized clinical outcome measures, or determining for whom ABA is most effective and what clinical outcomes could be expected as a result of ABA interventions. As of now, ABA services do not meet the TRICARE hierarchy of reliable evidence standard for proven medical care.[1]

The ACD requires the administration and reporting of three norm-referenced, valid, and reliable outcome measures: the Vineland Adaptive Behavior Scale – Third Edition (Vineland-3), which is a measure of adaptive behavior functioning; the Social Responsiveness Scale, Second Edition (SRS-2), which is a measure of social impairment associated with ASD; and the Pervasive Developmental Disorder Behavior Inventory (PDDBI), which is a measure designed to assist in the assessment of various domains related to ASD. Additionally, the PDDBI is a

[1] Title 32, Code of Federal Regulations, Part 199.2(b), Definition of “Reliable Evidence.”

measure designed to assess the impact of treatments for children with pervasive developmental disorders, including ASD, in terms of response to interventions.

For the ACD, all measures are administered, scored, and interpreted by the rendering provider who has purchased the measure under their license or credential. Neither the TRICARE contractors nor DHA administers, scores, or interprets the data. The following is a summary of observations of the data collected from these outcome measures that were submitted to the TRICARE contractors per the requirements of the TOM. As DHA is not conducting research, no determinations of the effectiveness of any intervention can be made. Rather, these findings provide information about participating beneficiaries, clinical presentation over time based on parent report, and the best way to manage and oversee clinical care for the diagnosis of ASD. Summaries of past observations can be found in previous annual reports.

ACD Outcome Measures – Discussion of Current Findings (FY 2024)

The purpose of this section is to summarize the findings of analyses of outcome measures for patients who participated in the ACD for the first time during FY 2022-2024 and received ACD services during FY 2024.

The three outcome measures included in this analysis are the PDDBI, Vineland-3, and SRS-2. All three outcome measures are required to be administered to all ACD participants as defined in TOM Chapter 18, Section 3. Academic reviews of these three tests have concluded they are reliable, valid, and useful tools to assess beneficiaries diagnosed with ASD. One literature review of outcome measures mentions that both PDDBI and SRS are two of twelve measures that are considered most valid in examining outcomes for young children diagnosed with ASD.[2] Another review concluded that Vineland-3 should be considered the gold standard for outcome assessments in patients with ASD.[3]

This analysis focuses on ACD patients ages 1.5 to 18.5 years who received services in FY 2024. The dataset included an initial population of 21,353 unique patients participating in the ACD program in FY 2024, 38 percent of whom had enrolled in the ACD prior to FY 2022. Of the entire sample, 13,338 had enrolled during FY 2022-2024. The dataset was filtered to a population of 5,289 unique patients who enrolled (for the first time) in the ACD program in FY 2022-2024, had at least two completed PDDBI tests during FY 2022-2024, and were authorized for ACD care services for at least 120 days before the final PDDBI test. From this population, cohorts for the PDDBI (n=5,289), SRS-2 (n=2,798), and Vineland-3 (n=2,718) were created. The PDDBI cohort is comprised of 2,410 patients from the previous FY22-23 analyses that continued care into FY 2024 and 2,879 patients newly meeting the required criteria for analysis during FY 2024.

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[2] See McConachie, H., Parr, et al., "Systematic Review of Tools to Measure Outcomes for Young Children with Autism Spectrum Disorder," Health Technology a\Assessment (Winchester, England), 2015,19(41), 1–506.
[3] See Ridout, S. and Eldevik, S., "Measures Used to Assess Treatment Outcomes in Children with Autism Receiving Early and Intensive Behavioral Interventions: A Review," Review Journal of Autism and Developmental Disorders, 2024; (11); 607-619.

Changes in parental stress scores, using the Parenting Stress Index, Fourth Edition, Short Form (PSI-4-SF) and Stress Index for Parents of Adolescents (SIPA), were also both used as independent variables in the outcomes' regression models as well as outcome variables. A total of 4,928 patients had at least two PSI-4-SF scores and 244 patients had at least two SIPA scores.

A comparison of the characteristics of the final PDDBI, Vineland-3, and SRS-2 samples of ACD patients with the total patients who were enrolled during FY 2024 and who had at least one PDDBI administration noted that there was a slightly higher percentage of patients in the under age 6 category in the PDDBI (65.0 percent), Vineland-3 (67.3 percent), and SRS-2 (64.5 percent) cohorts than in the entire sample (58.4 percent). All other characteristics of both populations were very similar. These distribution differences should not impart bias to the results of this study.

A multi-variate linear regression model approach was used to evaluate the reported outcomes of these three measures. The dependent (outcome) variable in these regressions for each of the three measures was the change in outcome measure scores from baseline intake to the last test score found for each eligible ACD participant. One model evaluated the percentage change in scores, and the other model evaluated the absolute score change for each patient receiving ABA services in the ACD.

To determine the independent variables in the regression equation, existing academic research was examined. Systematic reviews have found that several independent control variables have been found to be significantly associated with outcome measures including: 1) intensity of services provided (20-40 hours per week); 2) duration of services provided; 3) patient symptom severity; 4) age of the patient when services started; 5) parental involvement; 6) parental stress; and 7) type of services provided (ABA or other).[4]

This analysis attempted to control for important independent variables that may influence outcomes as well as additional demographic variables (e.g., patient sex). A key independent policy variable discussed in the literature is treatment intensity, such as receiving services for 20-40 hours per week. In the ACD, each child is assessed by an authorized ABA supervisor, and a clinically appropriate level of care is recommended by that provider, which is then authorized by the TRICARE contactor. This analysis defined intensity using the individual patient's "adherence" to the treatment plan which was defined as an individual patient's actual ABA hours as a percentage of authorized ABA hours as specified in each patient's approved treatment plan. This intensity variable isolates the needs of each individual patient (as determined by the provider's evaluation and subsequent authorized hours of ABA).

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[4] See the following three systematic reviews: Eckes, Theresa, et. al, "Comprehensive ABA-based interventions in the treatment of children with autism spectrum disorder—a meta-analysis," *BMC Psychiatry;* 2023; 23:133; 1-19; Makrygianni, M.K. and Reed P., "A meta-analytic review of the effectiveness of behavioral early intervention programs for children with Autistic Spectrum Disorders, *Research in Autism Spectrum Disorders,* October-December 2010, 4:4; 577-593; and Makrygianni, M.K., et. al, "The effectiveness of applied behavior analytic interventions for children with autism spectrum disorder: a meta-analytic study," *Research in Autism Spectrum Disorders;* 2018; 51; 18-31.

Other independent regression variables used in this analysis were a series of experimental (changes in parental stress, baseline test scores of patient severity, duration of treatment) and demographic (age, patient sex, region, etc.) variables.

ACD 2024 Analysis Findings

A key finding in the data analysis was that overall average scores improved for all three measures from baseline to the last test taken by patients. On average, scores improved by 4.7 percent (3.5 points) for PDDBI, by 5.1 percent (3.1 points) for Vineland, and 0.4 percent (1.0 points) for SRS. While these scores note improvements, score changes alone do not inform clinical or statistical significance.

The following independent variables were statistically significant (after controlling for all other available independent variables):

- **Adherence.** Greater adherence to the provision of authorized ABA services was associated with improved scores across all three tests. However, these improvements were only significant for the Vineland and SRS analyses.

- **Parental Stress.** Reductions in parental stress over the treatment period were associated with improved test scores at statistically significant levels across all three measures.

- **Patient Severity at Baseline.** Patients with the most severe conditions at baseline (prior to ABA services) improved the most over the treatment period at significant levels for the PDDBI and SRS tests, while the opposite trend was observed for the Vineland test.

- **Duration of Services.** The duration of treatment (as measured by days the patient was authorized to receive ABA services between their first and last test, for each of the three tests) was a significant positive predictor of outcomes for the PDDBI. However, this variable was insignificant in the Vineland model (and dropped from analysis as such), and a significant negative predictor of outcomes in the SRS model.

- **Age of Patient at End of Service Provision.** Research has generally indicated that the younger patients show the greatest potential for outcome improvements. However, the results of this analysis are conflicting. Age group was not a significant predictor of outcomes for the PDDBI model. For the Vineland model, age group 6-10 appears to be associated with the greatest improvements; however, this finding is only significant in the absolute change model. Finally, there appears to be a significant stepwise association[5] between age and outcomes in the SRS model.

[5] SRS scores increasingly improved for each age group, with age group 14+ associated with the greatest gains on the SRS.

ACD 2024 Summary of Findings

The results of all three outcomes measures are consistent, suggesting that enrollment in the ACD program and adherence to treatment plans for ABA services is associated with better outcomes for children with ASD. Further, all three results are consistent in that reductions in household stress levels are associated with better ASD outcomes.

While these results present a consistently optimistic picture regarding increased adherence to authorized treatment and reduced household stress, caution is recommended in interpreting these results. At best, the regression equations examined in this analysis explain only 20 percent of the variation in changes in test scores. While the results of this current analysis are suggestive, the possibility exists that they could have been biased and are not conclusive because it was not possible to conduct a randomized controlled trial. Additionally, there is no information to know if these changes are clinically significant.

ACD 2024 Analysis Limitations

While this current analysis attempts to correct for many of the shortcomings of prior DHA analyses, the analysis also has limitations. Some of these limitations are:

First, the primary dependent variable measured is the change in total PDDBI, Vineland-3, or SRS-2 score. All PDDBI and Vineland-3 administrations, as well as some SRS-2 administrations, were parent-completed. In general, parents are not professional ABA service providers who can objectively provide an outside measure of a patient's current state or progress. While this analysis attempts to partially control for factors inside of the home (changes in stress level), it is unclear how much bias is introduced by using parent evaluated PDDBI scores compared with scores from professionals. DHA could analyze changes in the "teacher" evaluated PDDBI scores; however, baseline scores are not collected therefore limiting the type of analysis that could be completed.

Second, the data set includes cases where the same respondent did not make both the baseline and final PDDBI, Vineland-3, or SRS-2 evaluation. In 15.1 percent of the cases (798 cases), a different respondent was listed on the final PDDBI. For the Vineland-3 and SRS-2 cohorts, 13.0 and 15.4 percent did not have the same respondent for baseline and final tests, respectively. Different respondents can have different evaluations of the same child at different points in time. While it would be ideal for the same respondent to make both evaluations, a dummy variable was created to control for cases where different respondents made PDDBI, Vineland-3, or SRS-2 evaluations at baseline and later.

Third, the gold standard for program evaluations is a randomized controlled trial because it allows one to evaluate the independent effects of the experimental question. In the present analysis, there is no comparison group (control group) to determine whether PDDBI, Vineland-3, or SRS-2 score changes are associated with ABA services, placebo, non-ABA treatments or other associated factors that could not be controlled. As noted earlier, DHA is not conducting research under the ACD and therefore is not able to rectify this limitation.

Fourth, this review period consists of FY 2022-2024 and is limited to patients who entered the program in FY 2022 or later. As such, the longer-term effects of these services could not be addressed. Continuing to assess these cohorts in future years could assess the longer-term impact of ACD participation.

LESSONS LEARNED

DHA is committed to ensuring all TRICARE-eligible beneficiaries diagnosed with ASD reach their maximum potential, and that all TRICARE-authorized treatment and services provided support this goal. Since the beginning of the ACD, DHA has made significant improvements to the program, such as increased access, implementation of recommendations in response to the DoD Office of Inspector General (OIG) reports[6,7], and collection and evaluation of outcomes measures. Additionally, the comprehensive update of the ACD, published March 23, 2021, focused not only on improving the quality, value, and access to care and services for beneficiaries diagnosed with ASD and their families, but also on improving the management and accountability of the TRICARE contractors, diagnosing providers, and ABA providers. DHA continues to monitor the impact of these revisions as well as address patient participation feedback.

Additionally, the publication of the National Academies of Sciences, Engineering, and Medicine's consensus report, "The Comprehensive Autism Care Demonstration: Solutions for Military Families," September 2025, provides valuable insights into the delivery of ABA services.

CONCLUSION

While the ACD provides the authority to reimburse for demonstration-authorized ABA services delivered to TRICARE-eligible beneficiaries diagnosed with ASD, the ACD is focused on providing comprehensive services to each beneficiary so that each participant reaches their maximum potential. The ACD policy focuses on the individual child and their family, and their unique needs by providing a dedicated point of contact to help navigate what can sometimes be an overwhelming system. This individualized focus offers the families a way to respond to the dynamic needs of the beneficiary throughout their participation in the ACD.

At the end of FY 2024, there were a total of 17,603 beneficiaries with a diagnosis of ASD participating in the ACD with a cost of $518.9M who also used an additional $74M in other medical services. ACD participation by beneficiary demographics reveal that 89.0 percent of ACD participants are age 13 years and younger, that the median age is 7 years, and that roughly three quarters of ACD participants are male.

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[6] DoD OIG Report: The Defense Health Agency Improperly Paid for Autism-Related Services to Selected Companies in the TRICARE South Region (Report No. DODIG-2017-064); Published: 10 MAR 2017; https://media.defense.gov/2017/Dec/19/2001858335/-1/-1/1/DODIG-2017-064.PDF.
[7] DoD OIG Report: TRICARE North Region Payments for Applied Behavior Analysis Services for the Treatment of Autism Spectrum Disorder (Report No. DODIG-2018-084); Published: 16 MAR 2018; https://media.defense.gov/2018/Mar/22/2001893494/-1/-1/1/DODIG-2018-084.PDF.

Considering the literature states that parental involvement in ABA services is critical to the long-term outcomes, DHA continues to monitor parent engagement trends. In FY 2021, 76 percent of ACD beneficiaries had parents or guardians who received family treatment guidance services with an average of 9.9 hours over the FY. In FY 2022, rates of parent or guardian receipt of family treatment guidance rose to 83 percent; however, the average number of hours decreased to 8.1. In FY 2023, rates of parent or guardian receipt of family treatment guidance was consistent with the previous FY at 83 percent. However, the average number of hours per year increased to 13.2. In FY 2024, rates of parent or guardian receipt of family treatment guidance rose to 84.7 percent with an average utilization rate of 1.1 hours per month. As noted in previous reports, parental engagement is critical as the beneficiary's needs evolve and the beneficiary transitions from one service to another occur. As parents learn and apply the principles of behavior analysis to new skills and settings, generalization and skill maintenance can endure. In the absence of consistently implementing techniques and principles, beneficiaries miss critical opportunities to expand on the learning and skill growth developed during the administration of ABA services.

The FY 2024 outcomes analysis continues to elevate the understanding of utilized services and the impact on ASD symptom presentation. Based on this analysis, it appears that more beneficiaries made progress, on average, than all previous reports. However, several limitations remain to the findings of these analyses.

The Department continues to improve and expand the programmatic oversight and analysis of the ACD. While the Department fully supports the continued research on the nature, scope, and effectiveness of ABA services, ASD requires a broader reach for lifetime management. Focusing on only one type of intervention may lead to missed opportunities for developmental growth for the individual and the family. The ACD policy focuses on addressing the specific needs of the individual beneficiary, either through identifying the appropriate medical and clinical services for the beneficiary or connecting families to the vast array of other programs and non-clinical resources when they are recommended. TRICARE continues to lead the Nation in developing an effective ASD program model.