



OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, DC 20301-1200

MAY 26 2009

HEALTH AFFAIRS

The Honorable Carl Levin
Chairman, Committee on Armed Services
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

The enclosed report responds to the Joint Explanatory Statement accompanying S. 3001, the National Defense Authorization Act for Fiscal Year 2009, which requests the Secretary of Defense to submit a report on the status of implementing the TRICARE Enhanced Access to Autism Services Demonstration Project. Specifically, this report includes: (1) the numbers of autistic children served; (2) the type and frequency of services provided; (3) the number of available providers by region; and (4) whether reimbursement levels are sufficient to retain qualified providers in TRICARE networks.

This report also provides background information about the demonstration, discusses challenges to its implementation, and also provides the current status of the demonstration.

Preliminary results of the demonstration reveal that a significant number of beneficiaries are now receiving services designed to treat autism and that there is an increase in service provider participation.

Thank you for your continued support of the Military Health System.

Sincerely,

A handwritten signature in cursive script, reading "Ellen P. Embrey".

Ellen P. Embrey
Performing the Duties of the
Assistant Secretary of Defense
(Health Affairs)

Enclosure:
As stated

cc:
The Honorable John McCain
Ranking Member



OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, DC 20301-1200

MAY 26 2009

HEALTH AFFAIRS

The Honorable John P. Murtha
Chairman, Subcommittee on Defense
Committee on Appropriations
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

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cc:
The Honorable C.W. Bill Young
Ranking Member



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MAY 26 2009

HEALTH AFFAIRS

The Honorable Ben Nelson
Chairman, Subcommittee on Personnel
Committee on Armed Services
United States Senate
Washington, DC 20510

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cc:
The Honorable Lindsey O. Graham
Ranking Member



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WASHINGTON, DC 20301-1200

MAY 26 2009

HEALTH AFFAIRS

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

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cc:
The Honorable John M. McHugh
Ranking Member



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WASHINGTON, DC 20301-1200

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HEALTH AFFAIRS

The Honorable Daniel K. Inouye
Chairman, Committee on Appropriations
United States Senate
Washington, DC 20510

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Enclosure:
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cc:
The Honorable Thad Cochran
Ranking Member



OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, DC 20301-1200

MAY 26 2009

HEALTH AFFAIRS

The Honorable Susan Davis
Chairwoman, Subcommittee on Military Personnel
Committee on Armed Services
U.S. House of Representatives
Washington, DC 20515

Dear Madam Chairwoman:

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cc:
The Honorable Joe Wilson
Ranking Member



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The Honorable Thad Cochran
Ranking Member



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MAY 26 2009

HEALTH AFFAIRS

The Honorable David R. Obey
Chairman, Committee on Appropriations
U.S. House of Representatives
Washington, DC 20515

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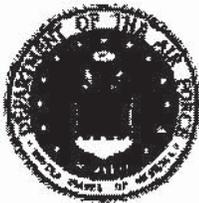
Sincerely,

Ellen P. Embrey
Performing the Duties of the
Assistant Secretary of Defense
(Health Affairs)

Enclosure:
As stated

cc:
The Honorable Jerry Lewis
Ranking Member

Report to Congress



Fiscal Year 2009

Report on the Status of Implementation of the Department of Defense (DoD)
Enhanced Access to Autism Services Demonstration

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I. Executive Summary

The Department of Defense implemented the DoD Enhanced Access to Autism Services Demonstration [the “Demonstration”] on March 15, 2008. This project was designed to broaden the pool of providers of services that seek to remediate the effects of autism spectrum disorder. The purpose of this report is to:

- Provide background information on the Demonstration;
- Chronicle key milestones in the development of the Demonstration, to include public notification, policy changes, barriers to implementation and follow-on strategies; and
- Provide the current utilization of the Demonstration.

The Department modified the corporate provider class to further its overall goal of providing increased access to autism treatment services. This modification expanded the pool of “hands on” providers, to include, “tutors,” who are now authorized to provide intensive interventions authorized by TRICARE.

A short-term review of the Demonstration indicated that the Department’s primary goal was hampered by requirements such as: the psychological testing of beneficiaries, a labor-intensive process for authorization of providers, burdensome reporting requirements that failed to add value to understanding the on-going results of the Demonstration, and reimbursement rates that were found unacceptable by providers who otherwise appeared willing to participate in the Demonstration.

In response, the Department, along with its industry partners, conducted an extensive review of those requirements. The result was a complete rewrite and reissue of the Demonstration guidance within the TRICARE Operations Manual. After those changes were modified into the managed care support contracts, the demonstration was, in effect, “re-started.”

The revitalized Demonstration has seen an increase in participation by providers and beneficiaries. However, it will take additional experience with the Demonstration to determine the efficacy of the expanded provider model.

II. Background

a) Initial Report to Congress

The John Warner National Defense Authorization Act for Fiscal Year 2007, Section 717, required the Department to develop a plan within the authority of the Extended Care Health Option (ECHO) to provide services to military dependent children with autism. Section 717 focused on the development of TRICARE requirements for education, training, and supervision for service providers; the ability to identify the availability and distribution of those providers; and procedures to ensure that such services provided by the Department supplement those available through other public sources.

In response to Section 717, the “Department of Defense Report and Plan on Services to Military Dependent Children with Autism” was submitted to Congress in July 2007. In addition to meeting the requirements of Section 717, the report outlined a proposed demonstration that would test the feasibility of expanding the definition of providers of autism treatment services to include those not meeting the strict guidelines of the current departmental regulations.

*b) Autism: Definition, Prevalence, and Treatment*¹

Definition

Autism spectrum disorders² (ASD) affect essential human behaviors, such as social interaction, the ability to communicate ideas and feelings, imagination, and the establishment of relationships with others. Autistic disorders vary in age of onset and severity of symptoms. ASD manifestations can differ considerably among children and within an individual child over time. Even though there are strong and consistent commonalities, especially in social deficits, there is no single behavior that is always typical of any autistic spectrum disorder, and no behavior that would automatically exclude an individual child from a diagnosis of autism.

ASDs generally have lifelong effects on how children learn to be social beings, take care of themselves, and participate in the community. In many cases, ASD occurs along with mental retardation and language disorder. Thus, educational planning must

¹ This section substantially borrows from the National Research Council (2001) *Educating Children with Autism* Committee on Educational Interventions for Children with Autism. Catherine Lord and James P. McGee, eds. Division of Behavioral and Social Sciences and Education. Washington, DC: National Academies Press.

² In this report, autism spectrum disorders is used to refer to autistic disorder; pervasive developmental disorder, not otherwise specified (PDD-NOS); and Asperger’s Disorder, in accordance with the *Diagnostic and Statistical Manual of Mental Disorders, 4th ed.* (DSM-IV) of the American Psychiatric Association. The terms autism spectrum disorders and autism are used interchangeably.

address both the needs typically associated with ASD and those needs associated with accompanying disabilities.

Prevalence

The prevalence of ASD under the current widely accepted definition in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR) has been debated in recent years. A recent report by the Centers for Disease Control and Prevention (CDC)³ found, in its review of information available in 14 states, that 6.6 per 1,000 – approximately 1 in 152 – children eight years of age had ASD. For comparison, Down Syndrome, the most commonly identified cause of mental retardation, occurs in about 1 in 800 births. Juvenile diabetes, a common childhood disorder, occurs in about 1 in 400 to 500 children and adolescents. Finally, according to the National Cancer Institute, autism is more common than childhood cancer, and has a prevalence rate of 1 in 6,600 children.

Treatment

In general, education is currently the primary form of treating autism; this is true for children, parents, and teachers. A number of modalities and intensive interventions have been introduced to provide education on autism. While many approaches to intervention have been widely disseminated, few have withstood the test of time and formal peer-reviewed studies with strong design. However, the consensus across comprehensive intervention programs favors: early entry into an intervention program; active engagement in intensive instructional programming for the equivalent of a full school day, including services that may be offered in different sites, for a minimum of five days a week with full-year programming; the use of planned teaching opportunities, organized around relatively brief periods of time for the youngest children (e.g., 15- to 20-minute intervals); and sufficient amounts of adult attention in one-to-one or very small group instruction to meet individualized goals.⁴

Applied behavior analysis (ABA), a systematized process of collecting data on a child's behaviors and using a variety of behavioral conditioning techniques to teach and reinforce desired behaviors while extinguishing harmful or undesired behaviors, is one of the best studied and most widely used interventions. As defined by the Behavior Analyst Certification Board (BACB), "Applied behavior analysis is the science in which

³ Rice, Catherine. (2007) *Prevalence of Autism Spectrum Disorders – Autism and Developmental Disabilities Monitoring Network, 14 Sites, United States, 2002*. Morbidity and Mortality Weekly Report Surveillance Summaries, 56(SS01);12-38, February 9, 2007.

⁴ For further information please see National Research Council (2001) *Educating Children with Autism*. Committee on Educational Interventions for Children with Autism, page 6 and Chapters 5-12.

procedures derived from the principles of behavior are systematically applied to improve socially significant behavior to a meaningful degree and to demonstrate experimentally that the procedures employed were responsible for the improvement in behavior.” Practically speaking, it is the application of behavioral principles to shape behaviors and teach new skills in an individual. Intervention programming that employs an ABA approach attempts to understand skill and behavior strengths and deficits; to structure the learning environment; systematically teach discrete, observable steps that define a skill; and to teach generalization and maintenance of newly learned skills. Time-limited, focused ABA methods have been shown to reduce or eliminate specific problem behaviors and teach new skills to individuals with autism.

c) Military Health System Coverage of Autism Services

TRICARE Basic Program

TRICARE, the health plan of the Military Health System, is an entitlement program, governed by statute (Title 10, Chapter 55) and regulation (32 Code of Federal Regulations, Part 199), which are implemented through the TRICARE Policy, Operations, Reimbursement, and Systems Manuals. As a general rule, the TRICARE Basic Program covers medically or psychologically necessary and appropriate procedures, devices, drugs, and certain preventive services that are proven safe and effective and considered the standard of care in the United States, unless such care is expressly excluded from coverage by statute, regulation, or policy.

TRICARE recognizes ASD as a neurobiological condition that requires both medical and educational management. For children with autism, the TRICARE Basic Program covers medically or psychologically necessary services, such as physician office visits, immunizations, psychological testing, and interventions such as speech therapy, physical therapy, and occupational therapy. However, the governing statute of the Basic Program (10 U.S.C. 1079(a)(9)) prohibits coverage of special education.

TRICARE Extended Care Health Option and Applied Behavior Analysis

As noted in the “Treatment” discussion above, and following the review of the applicable laws, regulations, literature, and the positions of other third-party payers, TRICARE established the position that ABA is an educational intervention that augments other services, medical in nature, to address the problems typically experienced by children with ASD. Consequently, TRICARE established coverage of ABA as a “special education” benefit within the Extended Care Health Option (ECHO) program. The ECHO provides eligible military family members with coverage for certain benefits not available in the TRICARE Basic Program, including special education, and which are not subject to the strict requirement that the requested services meet the “medical necessity” criterion of the Basic Program. As noted above, ABA is arguably the most widely

utilized structured teaching intervention employed to minimize the core features and associated deficits of ASD, maximize functional independence and quality of life, and alleviate family distress. Like TRICARE, the American Academy of Pediatrics considers ABA to be an educational intervention.

In accordance with applicable laws and regulations, TRICARE can reimburse only "TRICARE-authorized providers" for services rendered TRICARE beneficiaries. In the case of the ECHO, this requirement is relaxed to also allow reimbursement of providers of certain services who meet all applicable licensing or other regulatory requirements of the political jurisdiction where the ECHO benefit is rendered or in the absence of such licensing or regulatory requirements, alternative requirements as determined by the Director, TMA. Lacking such licensing or regulatory requirements for ABA services, the Department adopted BACB certification as demonstrating that the provider of ABA services possesses the education, training, and experience necessary to be reimbursed. The relative "newness" of the BACB and the industry of applied behavior analysis to treat ASD has resulted in a current shortage of qualified providers of ABA, thus impacting access.

d) The DOD Enhanced Access to Autism Services Demonstration

To increase access to ABA providers and to test the advisability and feasibility of allowing TRICARE reimbursement for ABA services delivered by non-professional providers, the Department developed a Demonstration centered on a modified corporate services provider model. The key features of this model were the use of:

- Individual Corporate Services Provider (ICSP) and Organizational Corporate Services Provider (OCSP);
- BCBA's and BCABA's as "supervisors" who have a contractual relationship with TRICARE, either individually or as an employee of or contracted with an OCSP;
- Non-certified individuals, i.e., "Tutors" and "Tutors-in-Training" as the "hands-on" providers of ABA; and
- Fixed reimbursement rates.

An outline of the Demonstration entitled, "Notice of an Autism Services Demonstration Project for TRICARE Beneficiaries Under the Extended Care Health Option Program" was published as a "Public Notice" in the Federal Register on December 4, 2007. [72 FR 68130]

Following development and publication of operational guidance in the TRICARE Operations Manual, the Demonstration was implemented on March 15, 2008.

III. Results to Date

The following Tables provide Demonstration utilization information.

Table 1. Number of Beneficiaries with Autism Spectrum Disorder Receiving Applied Behavior Analysis through ECHO Prior to the Demonstration (FY 2007) by Region¹

Region	Beneficiaries
North	298
South	247
West	159
TOTAL	704

Table 2. Number of Beneficiaries, Providers, Hours of Services by Region

Region	As Of	Beneficiaries Served	Supervisors / Tutors ²	Total Number of Hours of Services Provided by Supervisors and Tutors ³
North	30 August	15		556
	30 September	27	31 / 181	678
	30 November	65		2432
South	30 August	33		618
	30 September	48	41 / 125	980
	30 November	60		437
West	30 August	52		62
	30 September	94	54 / 387	79
	30 November	139		96

¹ Most recent data available prior to issuance of the current Demonstration operational guidance in the TRICARE Operations Manual.

² Total number of Supervisors and Tutors available to provide EIA Services.

³ Based on claims processed.

Information is not available regarding "whether reimbursement levels are sufficient to retain qualified providers in the TRICARE networks,"

IV. Conclusion

Table 2 indicates an increasing number of beneficiaries are receiving services designed to treat autism and an increase in provider participation.

The Department believes participation will continue to grow especially as the number of available Supervisors and Tutors increases.

We look forward to providing an updated status in July 2009.