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

PERSONNEL AND READINESS

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

JUL 30 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 first quarter report for FY 2019 that covers data from October 2018 to December 2018.

This is the fourth submission of ACD data under the new T2017 TRICARE contracts. 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 on January 1, 2019, 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

JUL 30 2019

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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.

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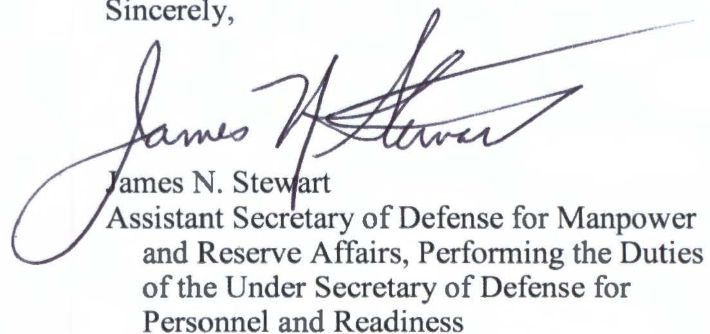

James N. Stewart
Assistant Secretary of Defense for Manpower and Reserve Affairs, Performing the Duties of the Under Secretary of Defense for Personnel and Readiness

Enclosure:
As stated

cc:
The Honorable William M. "Mac" Thornberry
Ranking Member

Report to Congressional Armed Services Committees

The Department of Defense Comprehensive Autism Care Demonstration Quarterly Report to Congress First Quarter, Fiscal Year 2019

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 $6,150 for the 2019 Fiscal Year. This includes $0 in expenses and $6,150 in DoD labor.
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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 Department 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 (MCSCs) with oversight from the Government, hereinafter referred to as the MCSCs, and represents the timeframe from October 1, 2018 through December 31, 2018. This is the fourth 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 16,044 beneficiaries currently receive Applied Behavior Analysis (ABA) services through the ACD as of December 31, 2018. Total ACD program expenditures were $268.3M for FY 2017 and $313.7M FY 2018. The number of ABA providers accounted for as of December 31, 2018 is 33,451. The average wait time from the date of referral to the first appointment for ABA services is exceeding the 28-day access standard for specialty care despite efforts by the MCSCs. Several localities, as noted in Table 3 below, exceed the access standard and the MCSCs are continuing to recruit new providers and connect beneficiaries with appropriate services. As the Government continues to work closely with the Contractors, some factors impacting the lag times: are beneficiaries changing providers after an initial referral and authorization are made, and parental choice to wait for a specific provider (with a wait list due to time of day, i.e., after school and evenings). The Government is working with the MCSCs, particularly in the East Region, to identify additional reasons for the increase in localities exceeding the 28-day standard. To address the areas exceeding the 28-day limit, the MCSCs' clinical and provider relations teams are working closely to increase the number of TRICARE providers and working directly with families who may not have activated their referral to initiate services. The number of ABA providers continues to grow as evidenced by a 10 percent increase since the last quarterly report. 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 on a second set of data is available. While the findings are of concern, as 73.5 percent of beneficiaries saw little to no change in symptom presentation after 6 months of ABA services with an additional 15 percent of beneficiaries demonstrating worsening symptoms, 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 Department will provide an update in subsequent reports and a comprehensive analysis after the conclusion 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 to support beneficiaries diagnosed with ASD and their families. For example, Fort Belvoir Community Hospital has initiated an Autism Resource Clinic to connect families with local resources and provide support. 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. <u>The Number of New Referrals with Authorization for ABA Services Under the Program</u>

The number of new referrals with an authorization for ABA services under the ACD during the period of October 1, 2018 through December 31, 2018, was 1,858. This was a decrease from the previous quarter (2,062). A breakdown by state is included in Table 1.

Table 1

State	New Referrals with Authorization
AK	17
AL	25
AR	3
AZ	24
CA	211
CO	87
CT	5
DC	4
DE	5
FL	138
GA	107
HI	81
IA	0
ID	2
IL	18
IN	10
KS	38
KY	30
LA	32
MA	12
MD	53
ME	2
MI	14
MN	1
MO	14
MS	14
MT	2
NC	120
ND	1
NE	5
NH	0
NJ	12
NM	11
NV	31
NY	17
OH	10
OK	28
OR	1
PA	6
RI	4
SC	41
SD	1
TN	41
TX	225
UT	13
VA	231
VT	0
WA	113
WI	6
WV	0
WY	9
Total	**1,858**

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

As of December 31, 2018, the total number of beneficiaries participating in the ACD was 16,044, a decrease from the last reporting period (16,277). A breakdown by state is included in Table 2 below.

Table 2

State	Total Beneficiaries Participating
AK	170
AL	246
AR	27
AZ	276
CA	1926
CO	871
CT	54
DC	23
DE	39
FL	1391
GA	796
HI	578
IA	15
ID	10
IL	198
IN	108
KS	277
KY	256
LA	136
MA	61
MD	7
ME	432
MI	72
MN	21
MO	190
MS	124
MT	26
NC	1189
ND	6
NE	87
NH	8
NJ	116
NM	77
NV	227
NY	104
OH	119
OK	168
OR	19
PA	86
RI	26
SC	299
SD	14

TN	314
TX	1814
UT	211
VT	0

VA	1845
WA	1088
WI	30
WV	6

WY	31
Total	**16,044**

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

For 25 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, which is a slight decrease from the previous quarter (30 states). However, for this reporting period, 26 states are beyond the access standard. At this time, causative key factors include beneficiaries changing providers after authorized to one provider, beneficiary preference on appointment time, and families choosing a provider with a wait list. The data also appears to be skewed upwards due to outliers; 12 states have modes beyond the access standards. The data for Connecticut and Maine was also reviewed to better understand the increase in wait times. Each average was based on only one child in each state. The beneficiary in Maine changed providers after 2 months due to a clinic closing, there was a delay in Extended Care Health Option registration, and the beneficiary had to obtain a second authorization. For the beneficiary in Connecticut, the delay was due to beneficiary choice for a specific time slot of evenings and weekends. To address the outliers, improvement in processes, such as proactive outreach to beneficiaries, has been initiated and a review of data for the next quarter is underway. ABA providers are directed not to accept beneficiaries for whom they cannot implement the recommended treatment plan within the 28-day access standard. The MCSCs 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 MCSCs continue to work diligently building provider networks and will continue to monitor states and locations where provider availability is an issue. 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	0
AL	30
AR	70
AZ	16
CA	23
CO	25
CT	162
DE	57
DC	39
FL	27
GA	45
HI	25
IA	0
ID	0
IL	48
IN	42
KS	24

KY	44
LA	28
MA	166
MD	45
ME	0
MI	38
MN	0
MO	24
MS	64
MT	2
NC	58
ND	0
NE	37
NH	0
NJ	33
NM	35
NV	30
NY	73
OH	52
OK	40
OR	0
PA	31
RI	21
SC	30
SD	0
TN	24
TX	35
UT	32
VA	32
VT	0
WA	32
WV	0
WI	0
WY	16

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 3,253, a slight decrease from the last reporting period (3,316). A breakdown by state is included in Table 4 below.

Table 4

State	Practices Accepting New Beneficiaries
AK	13
AL	52
AR	9
AZ	14
CA	202
CO	56
CT	19
DC	3
DE	4
FL	754
GA	110
HI	19
IA	2
ID	5
IL	159
IN	135
KS	16
KY	71
LA	92
MA	19
MD	3
ME	53
MI	131
MN	2
MO	78
MS	14

MT	4
NC	47
ND	4
NE	5
NH	17
NJ	28
NM	16
NV	4
NY	59
OH	53
OK	14
OR	5
PA	63
RI	3
SC	66
SD	1
TN	105
TX	398
UT	17
VA	192
VT	1
WA	37
WV	3
WI	87
WY	2
Total	**3,253**

5. <u>The Number of Practices No Longer Accepting New Patients Under the Program</u>

The number of ABA practices who stopped accepting new TRICARE beneficiaries for ABA services under the program is 189, a slight increase from the last quarter (179). We reviewed the data and it appears part of this increase is related to providers being unable to accept new beneficiaries due to having a full caseload. It is also 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. 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	1
DC	0
FL	11
GA	18
HI	0
ID	0
IL	12
IN	1
IA	0
KS	0
KY	0
LA	0
MA	20
MD	0
ME	0
MI	2
MN	0
MO	1
MS	1
MT	0

NC	7
ND	0
NE	0
NH	0
NJ	2
NM	0
NV	0
NY	2
OH	0
OK	4
OR	0
PA	2
RI	1
SC	1
SD	0
TN	1
TX	93
UT	0
VT	0
VA	6
WA	0
WV	0
WI	1
WY	0
Total	**189**

6. <u>The Average Number of Treatment Sessions Required by Beneficiaries</u>

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. This number does not represent the intensity of services or correlation to treatment outcomes. The averages in Table 6 did not account for a claims lag 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, we are unable to make conclusions 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	6
AL	7
AR	5
AZ	4
CA	5
CO	6
CT	7
DC	3
DE	4
FL	7
GA	6
HI	5
IA	4
ID	7
IL	6
IN	20
KS	5
KY	8
LA	8
MA	6
MD	6
ME	4

MI	8
MN	6
MO	5
MS	4
MT	5
NC	7
ND	2
NE	4
NH	2
NJ	4
NM	5
NV	4
NY	7
OH	7
OK	8

OR	8
PA	7
RI	3
SC	7
SD	8
TN	7
TX	8
UT	5
VT	0
VA	5
WA	7
WV	11
WI	6
WY	4

7. Health-Related Outcomes for Beneficiaries Under the Program

The Department 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 MCSCs 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 6 months.

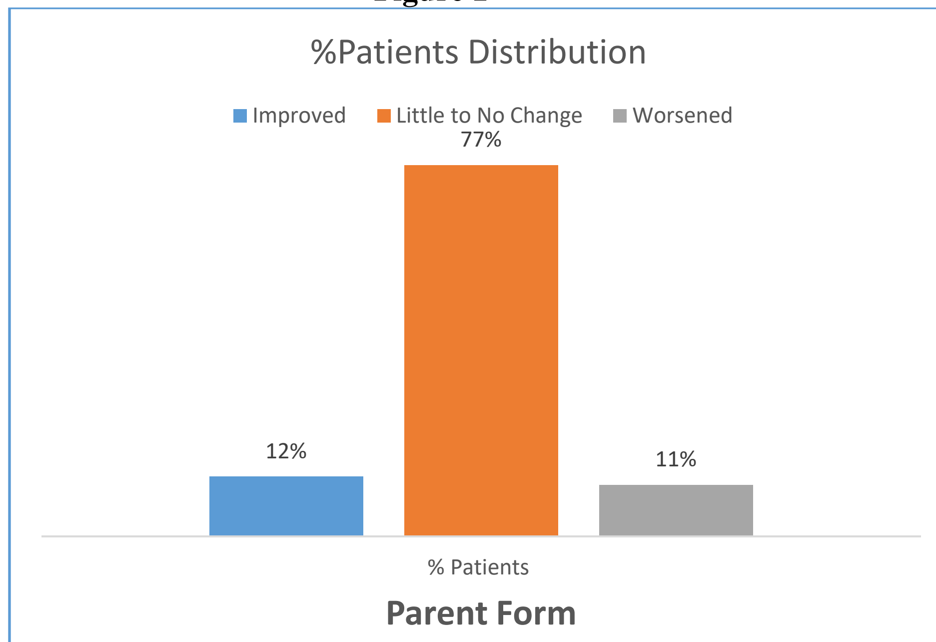
This report is the fourth reporting quarter since the start of health care delivery and the eighth reporting quarter since the outcome measures requirement took effect. This report provides the second quarter of reporting where two sets of scores are able to be compared, however this is a second set of beneficiaries, separate from the previous quarter:

Of the 16,044 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 651 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 (651) 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 MCSC complied with the reporting requirements, we are unable to use the East Region beneficiary data for this reporting period for a comparison since we are not able to determine what forms (Parent versus Teacher) were reported. The Government will correct this requirement in an upcoming contract modification.

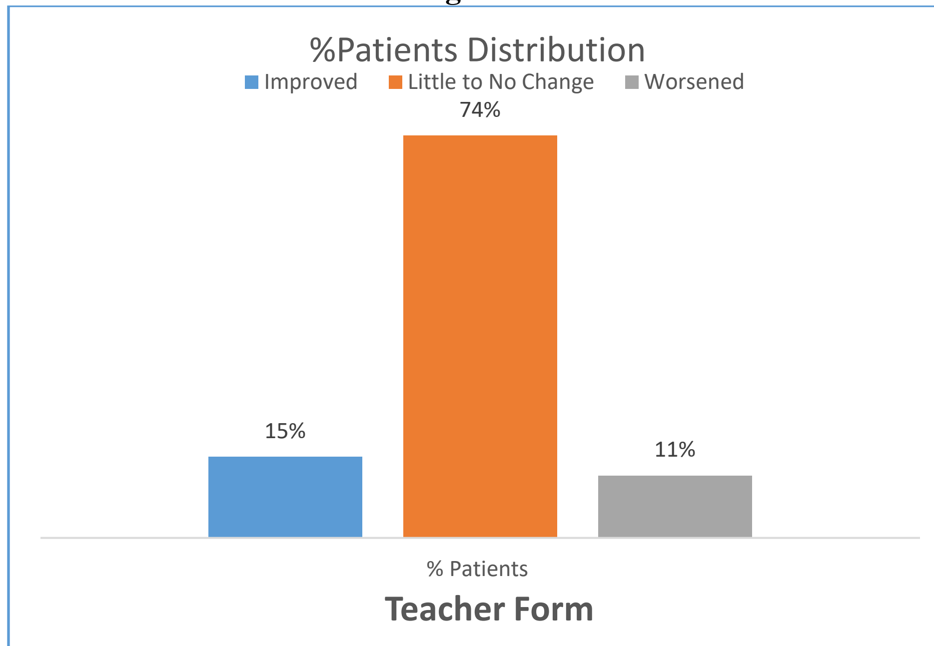
Based on the Autism Composite Score on the Parent Form of the PDDBI (which is a measure of lack of appropriate social communication skills along with repetitive/ritualistic behaviors), approximately 77 percent (291 total comparable Parent Forms) of beneficiaries made little to no change in their symptom presentation after six months of ABA services (31 or 10 percent of the population had no change in PDDBI - Parent score; 192 had less than one Standard Deviation (SD) change in PDDBI- Parent score). Of significance, 11 percent of the population had a decline of one SD or more indicating worsening symptom presentation after six months of ABA services. Only 12 percent of the sample had improvements (1 SD or better) in symptom presentation after 6 months of ABA services. See Figure 1 for the distribution of change scores for the Parent score.

Figure 1



By comparison, based on the Autism Composite Score on the Teacher Form of the PDDBI, approximately 74 percent (439 total comparable Teacher Forms) of beneficiaries made little to no change in their symptom presentation after six months of ABA as determined by the Teacher Form (typically completed by the Board Certified Behavior Analysts (BCBA)). Of significance, 15 percent of the beneficiaries had a decline of 1 SD or more indicating worsening symptom presentation after six months of ABA services. Only 11 percent had improvements (1 SD or better) in symptom presentation after 6 months of ABA services. See Figure 2 for the distribution of change scores for the Teacher score.

Figure 2



Also reviewed was the concordance/discordance between Parent and Teacher (or BCBA) completed forms of this quarter's score submission. Of the 651 beneficiaries pulled for this analysis, 576 beneficiaries had both Parent and Teacher forms submitted for this reporting quarter. Approximately 57 percent of the completed Parent and Teacher forms were within 10 points or 1 SD of one another suggesting that there was agreement in slightly more than half of the T-scores for the Autism Composite Score regarding the perception of symptom presentation. According to the research regarding the PDDBI, there is a high degree of interrater reliability between Parent and Teacher form. This discrepancy in TRICARE beneficiaries continues to require further exploration. See Figure 3 for the distribution of scores for the Parent Form and Figure 4 for the Teacher Form.

Figure 3

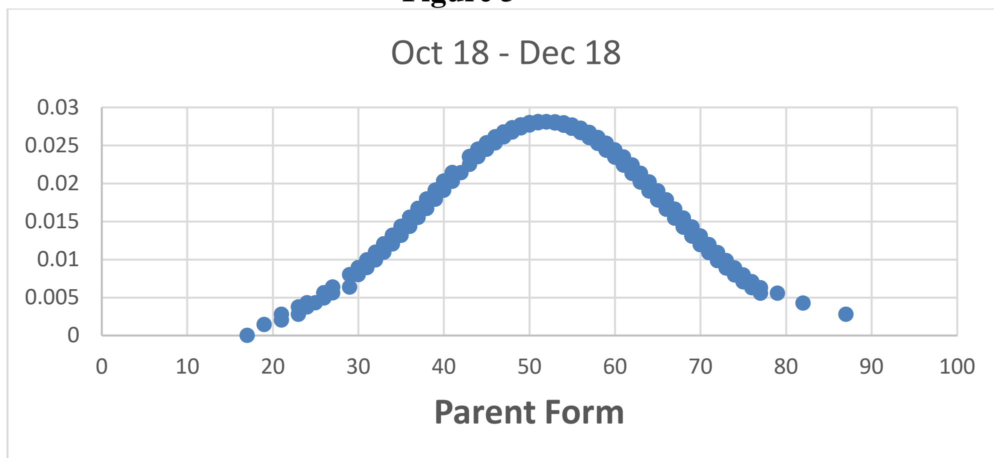
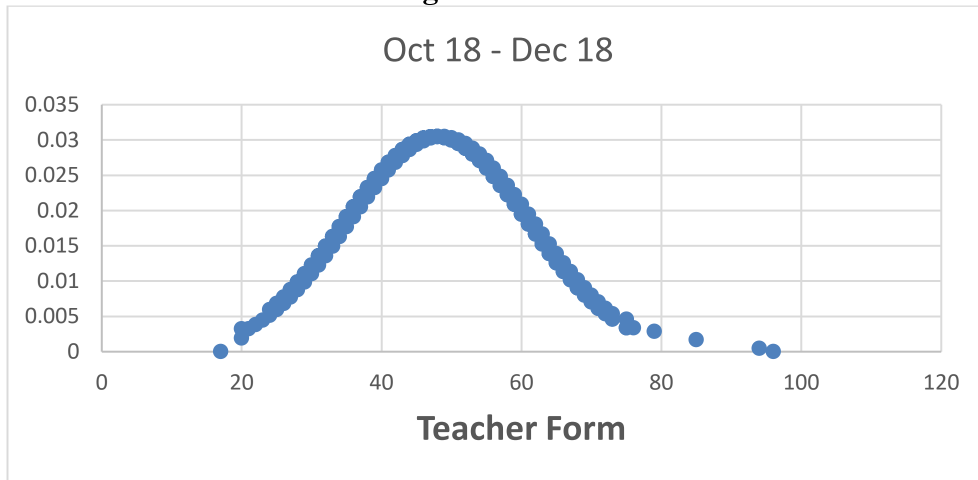


Figure 4



The MCSCs 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. TRICARE will continue to collect this data and analyze trends, as well as using these as one part of comprehensive treatment planning.

CONCLUSION

As evidenced in the above information, participation in the ACD by beneficiaries continues to remain steady. As of December 31, 2018, there were 16,044 beneficiaries participating in the ACD. The average wait time from referral to first appointment remains a challenge, but is being closely monitored and addressed by the MCSC with Government oversight. The MCSCs 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 MCSCs 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 MCSCs to begin collecting the outcome measures data for all ACD participants. This is the second reporting period that produced outcome measure scores that were eligible for analysis.

Based on this data, the majority of TRICARE beneficiaries (77 percent – Parent Form; 74 percent – Teacher Form) had little to no change in symptom presentation over the course of 6

months of ABA services, with an additional 11 percent (Parent Form) and 15 percent (Teacher Form) demonstrating worsening symptoms. 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 43 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 77 or 74 percent of the population saw little to no change, the DHA via the MCSCs will work with the providers to ensure effective treatment is being delivered.