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

**PERSONNEL AND READINESS**

SEP - 4 2024

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

Dear Mr. Chairman:

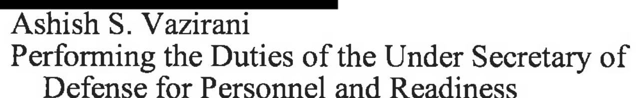
The Department's response to House Report 118–125, page 208, accompanying H.R. 2670, the National Defense Authorization Act for Fiscal Year 2024, "Report on Affects to Beneficiaries from the Change in Policy Regarding Reimbursement for Providers of Applied Behavior Analysis in Schools and Community Settings," is enclosed.

TRICARE covers a wide range of medically necessary and appropriate services for patients with a diagnosis of autism spectrum disorder (ASD). The Autism Care Demonstration (ACD) offers clinically necessary and appropriate Applied Behavior Analysis (ABA) services for all eligible TRICARE-enrolled beneficiaries diagnosed with ASD under the limited demonstration authority. On March 23, 2021, the Defense Health Agency published comprehensive revisions to the ACD that focus on improving management and controls, maximizing clinical outcomes, and supporting families participating in the ACD. Included in these revisions were the reiteration and clarification of the scope of authorized ABA services, including ABA services in school and certain community settings, as those types of services are considered non-clinical/non-covered.

This report describes the scope of coverage for ABA services under the ACD and clarifies that coverage did not change nor were services terminated. Rather, the March 2021 policy update reiterated existing policy and clarified the scope of authorized TRICARE cost-sharing for clinically appropriate ABA services under the ACD in school and community settings. As one of the goals of the demonstration is to determine whether ABA services meet the definition for proven medical care, continuing to reimburse for non-clinical/non-covered services undermines the overall program goals.

Thank you for your continued strong support of our Service members, veterans, and their families.

Sincerely,



Ashish S. Vazirani
Performing the Duties of the Under Secretary of
Defense for Personnel and Readiness

Enclosure:
As stated

cc:
The Honorable Adam Smith
Ranking Member

# Report to the Committee on Armed Services of the House of Representatives

# Report on Affects to Beneficiaries from the Change in Policy Regarding Reimbursement for Providers of Applied Behavior Analysis in Schools and Community Settings

## September 2024

The estimated cost of this report or study for the Department of Defense is approximately $2,400 in Fiscal Year 2024. This includes $0 in expenses and $2,400 in DoD labor.
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## INTRODUCTION

This report is in response to House Report 118–125, page 208, accompanying H.R. 2670, the National Defense Authorization Act for Fiscal Year (FY) 2024, which requests a report to the Committee on Armed Services of the House of Representatives on "Affects to Beneficiaries from the Change in Policy regarding Reimbursement for Providers of Applied Behavior Analysis in Schools and Community Settings." Specifically, this report is requested to address:

> (1) the scientific and analytical basis for having terminated these school and community services in the March 2021 TRICARE Operations Manual;
> (2) an assessment of how the change in policy directly affects beneficiaries, including: (a) the number of beneficiaries affected by the change in policy; (b) what services were terminated as a result of this policy change; (c) overall cost savings; and (d) the affects a service member's deployment has on the remaining spouse's requirement to take on the sole management and education of a child with autism;
> (3) cost estimates to reinstate the policy; and
> (4) why Applied Behavior Analysis (ABA) does not meet the Department of Defense's hierarchy of evidence to support medical necessity.

## BACKGROUND

The TRICARE Basic (i.e., medical) benefit covers a wide range of medically necessary and appropriate services for beneficiaries with the diagnosis of Autism Spectrum Disorder (ASD) including, but not limited to, physical therapy (PT), occupational therapy (OT), speech therapy (ST), medication management, and psychotherapy. The Defense Health Agency (DHA), under the TRICARE program authority to cost share on claims for private sector care, currently covers clinically necessary and appropriate Applied Behavior Analysis ("ABA") services for TRICARE covered beneficiaries diagnosed with ASD outside the statutorily defined TRICARE Basic (i.e., medical) benefit, as the scientific research and evidence currently available for ABA services does not meet the Agency's definition for proven medical care. ABA services are offered in accordance with the Agency's separate (and limited) demonstration authority found in 10 U.S.C. § 1092, as implemented by 32 CFR § 199.1(o).

The purpose of the Autism Care Demonstration (ACD) is to further analyze and evaluate the appropriateness of ABA services under the TRICARE program. Although the field of behavior analysis is making significant strides, currently there are no established uniform ABA coverage standards that are adopted across all healthcare funding sources. The ACD seeks to establish appropriate provider qualifications for the proper diagnosis of ASD and for the provision of ABA services, assess the feasibility and advisability of establishing a beneficiary cost-share for ABA services for ASD, and develop more efficient and appropriate means of increasing access and delivery of ABA services under the TRICARE program while creating a viable economic model and maintaining administrative simplicity. The overarching goal of this demonstration is to analyze, evaluate, and compare the quality, efficiency, convenience, and cost effectiveness of ABA services under the TRICARE program.

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. Generally, all ABA services continue to be provided through the private sector care system under the demonstration.

The TRICARE Operations Manual (TOM) Chapter 18, Section 4, "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 contractor responsibilities. The ACD ensures consistent ABA service coverage for all eligible TRICARE-enrolled beneficiaries, including active duty family members (ADFMs) and non-ADFMs, diagnosed with ASD.

## THE 2021 ACD POLICY UPDATE

DHA published a comprehensive revision to the ACD on March 23, 2021. Despite widespread misperception and mischaracterization, the comprehensive revision did not change the services that were covered under the demonstration. Rather, policy updates were the result of 3 years of work reviewing process and program evaluations including several audits (the TRICARE Quality Management Audits), reports (Department of Defense (DoD) Office of Inspector General (OIG) reports[1,2]), and clinical records reviews (conducted by the Managed Care Support Contractors (MCSCs)), addressing questions and comments from stakeholders (ABA providers, advocates, and families), monitoring research, and incorporating lessons learned such as the need for more intensive program oversight and education. For example, the DoD OIG reports found evidence of improperly paid claims, which led to recoupment. However, DHA found evidence of continued improperly paid claims, which resulted in enhanced policy revisions that included conducting comprehensive medical reviews on all treatment plans and enhanced audits on medical documentation. Each revision was carefully evaluated to ensure that the update aligned with the authority and goals of the demonstration. These revisions are concentrated on the best clinical outcomes for each beneficiary participating in the ACD.

The revision provides enhanced beneficiary and family support, incorporates all appropriate services and resources into a comprehensive plan, improves outcomes, encourages parental involvement, and improves utilization management controls. The update also expands coverage of certain Adaptive Behavior Services (i.e., relevant Current Procedural Terminology codes) for the delivery of ABA services to TRICARE-eligible beneficiaries diagnosed with

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[1] 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.
[2] 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.

ASD. These revisions focus on improving the quality of, and access to, care and services, and management and accountability of the TRICARE contractors and the ABA providers.

## (1) THE SCIENTIFIC AND ANALYTICAL BASIS FOR HAVING TERMINATED THESE SCHOOL AND COMMUNITY SERVICES IN THE MARCH 2021 TRICARE OPERATIONS MANUAL

As noted above, the available research regarding ABA services does not meet the Agency's definition for proven medical care as it does not meet the hierarchy of reliable evidence standards (see below for additional information). The ABA research that is available typically defines an "early and intensive intervention" model that offers continuous delivery of instructions, prompts, responses, and reactions to those responses with multiple repetitions of delivering teaching trials with systematic data collection throughout the duration of the session. ABA services authorized under the ACD require a high frequency of delivering opportunities to teach new foundational skills in a one-to-one structured setting.

By contrast, the school setting does not have the structured design to offer multiple opportunities for teaching new skills during the school day. Rather, the school is a naturalistic environment where a behavior technician (BT) must wait for an occurrence of a behavior before being able to implement any intervention. The school setting does not afford the BT the opportunity to continuously deliver instructions, prompts, and reinforcements with a one-to-one structure. Therefore, in this setting, the BT is functioning as a shadow, aide, or support for the student.

Additionally, TRICARE is not authorized to cover academic or educational related services under the benefit. For comparison, PT, OT, ST, and counseling services provided in the school setting are also not covered by TRICARE. Rather, if a student requires support services in the school setting, an Individualized Education Program (IEP) would be developed under the authority of the Individuals with Disabilities Education Act (IDEA) to address the appropriate supports for the academic environment. Of note, these services too require one-to-one dedicated time and space to address the goals. Even if such research does exist to support ABA services delivered throughout the academic day, it would still be out of scope for TRICARE coverage similar to school-provided PT, OT, ST, and counseling services.

Additionally, as a result of several audits, reports, and clinical records reviews, DHA found that ABA services rendered in the school setting were not consistent with the authorized scope of continuously delivered clinically appropriate ABA services but rather BTs functioned as the student's shadow, aide, or support throughout the duration of the school day. These types of services, where BTs serve in these roles, are non-covered/non-clinical services and are beyond the scope of ABA services covered under the ACD. Similarly, ABA services in certain community settings, where the ABA provider is supporting the family and not actively and continuously delivering ABA services, do not align with the goals and authority of the ACD. While these types of non-clinical activities have always been excluded from coverage under the ACD (first addressed in July 2014), these examples verified that DHA had to address and clarify the components of ABA services that were improperly rendered and billed.

However, the policy continues to include a provision for the MCSCs to authorize limited, short-term, focused delivery of supervisor-rendered ABA services that are clinically necessary and appropriate in the school setting that target specific behavior deficits or excesses. Additionally, the authorized ABA supervisor may render clinically appropriate services in certain community settings with prior authorization.

## (2) AN ASSESSMENT OF HOW THE CHANGE IN POLICY DIRECTLY EFFECTS BENEFICIARIES:

The following subsections report data on only services in the school setting, as community settings do not have a designated "Place of Service" on the Centers for Medicare and Medicaid Code Set.[3] While "Place of Service: Other" (PoS 99) was likely used for community-based services, DHA has no way to know for certain that no other services reported PoS 99 that were not rendered in an office/clinic (PoS 11) or a home (PoS 12). Therefore, there is no mechanism for analyzing claims data that isolates services in the community setting.

Also, data is available for only FY 2015 through 2021. During this analysis, it was discovered that some claims were improperly paid in FY 2022, as they were non-compliant with the policy. Therefore, the MCSCs took action to process recoupments for these unauthorized services. As a result, FY 2022 data is incomplete and unavailable for inclusion in time for this report.

### (a) The Number of Beneficiaries Effected by the Change in Policy

As noted above, the 2021 policy update reiterated and clarified the scope of authorized ABA services, including those services considered non-clinical/non-covered. This clarification resulted in a decline in the number of beneficiaries receiving non-covered services rendered by BTs in the school setting. Table 1 represents the year-over-year count of unique ACD beneficiaries who received services in the school setting. This table also provides perspective on the total number of participating beneficiaries in the respective FY as well as the percentage of school users in comparison to the total number of ACD participant.

Table 1 – Number of Unique ACD Participants with at Least One Unit of Services in the School Setting per FY

| Fiscal Year | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|---|---|---|
| # of School User | 674 | 813 | 944 | 1,066 | 1,316 | 1,267 | 838 |
| Total ACD Participant | 11,461 | 13,391 | 14,027 | 14,948 | 16,001 | 16,312 | 16,667 |
| % of School Users | 5.8% | 6.1% | 7.1% | 7.1% | 8.2% | 7.8% | 5% |
| Source: Military Health System (MHS) Data Repository (MDR) - Data as of June 29, 2022 | | | | | | | |

[3] https://www.cms.gov/medicare/coding-billing/place-of-service-codes/code-sets.

With the low number of ACD participants year-after-year receiving services in the school setting, it is important to understand the utilization of these non-covered services. Although there are some variations by State and by year, the overall average number of hours per beneficiary per week of ABA services in the school setting was 6.3 hours or approximately one hour per school day per beneficiary who used school services.

(b) What Services Were Terminated as a Result of This Policy Change

While DHA understands the perception that services were terminated, there was no actual change in coverage authority. Rather, clarification of the excluded non-clinical services was provided in the 2021 policy update specifying that non-clinical BT services (i.e., shadow or support services) in school and certain community settings continues to be excluded as those types of services are outside the scope of the ACD. This clarification of scope of covered services was deemed critical to the oversight and management of the ACD.

As noted above, it is important to note that should supports be required for the student to participate in their education in the school setting, that those services are required to be provided by the school in accordance with the IDEA via the child's IEP.

(c) Overall Cost Savings

The Department understands the term "cost savings" to mean any money that would have otherwise been incurred under the ACD for these non-clinical/non-covered services. Table 2 represents the total cost of services in the school setting, by provider type, per FY. Table 2 also reports the percentage of BT services in the school setting compared to the total cost of the ACD per FY.

Table 2 – Paid Amounts (in Millions) for ABA Services in the School Setting Per FY

| Fiscal Year | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 |
|---|---|---|---|---|---|---|---|
| Authorized ABA Supervisor | $1.15 | $1.60 | $1.71 | $2.77 | $3.97 | $3.32 | $3.30 |
| BT | $2.04 | $2.61 | $2.70 | $3.51 | $5.65 | $5.40 | $4.88 |
| Other | $0.05 | $0.09 | $0.03 | $0.01 | $0.03 | $0.01 | $0.00 |
| Total Paid Amounts for School Services | $3.24 | $4.30 | $4.44 | $6.29 | $9.65 | $8.73 | $8.18 |
| Total ACD Paid Amount | $162.14 | $232.15 | $268.62 | $320.24 | $375.94 | $400.21 | $450.83 |
| % of Total Paid for BT School Services | 1.25% | 1.12% | 1.00% | 1.09% | 1.50% | 1.34% | 1.08K% |
| Source: MDR - Data as of June 29, 2022 | | | | | | | |

As noted in Table 2, 57 percent of the total cost of school services incurred ($26,787,857) were rendered by BTs for an average of $3,826,836 annually. In comparison with the total cost of all services rendered under the ACD annually, BT services in the school setting incurred an expense of 1.21 percent on average per FY. The coronavirus disease 2019 (COVID-19) pandemic affected school utilization in 2020 and 2021. Therefore, for an estimate of costs avoided under the ACD in 2022, the estimate should use the last full academic year, pre-COVID-19, for comparison. In this year, 8.2 percent of ACD beneficiaries were school users and services rendered by BTs in the school setting were approximately $5.65 million. Using the 1.5 percent for total claims paid amount for 2019, we anticipate that 2022 would see a cost avoided of $6.76 million as a result of no longer reimbursing BT services in school settings.

(d) The Effects a Service Member's Deployment has on the Remaining Spouse's Requirement to Take on the Sole Management and Education of a Child with Autism

Claims data collected for this analysis and report represents services rendered to the identified beneficiary. Additionally, there are no claims data that identify Service Member deployments nor any correlation to utilization of any healthcare service. Therefore, the Department does have the data to answer this question. Also, any impact regarding beneficiaries who are home-schooled would not be captured in the data as home-schooling is neither a covered service nor a PoS: School. However, the average number of hours rendered in the school setting per beneficiary per week suggests a negligible impact on the parent as the beneficiary is receiving services in the school setting.

DHA implemented the parent stress measures as a way to capture parent stress levels and to address appropriate treatment needs or referrals to appropriate services. These measures were implemented August 2021. Therefore, there is no comparison data prior to the 2021 policy update to evaluate this small population of beneficiaries who received services in the school setting. However, the Department will monitor responses on the parent stress measures to identify if there is any increase in reported stress levels as a function of clarifying the ACD policy.

## (3) COST ESTIMATE TO REINSTATE THE POLICY

The 2021 policy update did not terminate any authorized ABA services nor were any new services excluded. Rather, the 2021 policy update reiterated existing policy and clarified the scope of covered services under the authority of the demonstration. However, if the Department were directed to reimburse for non-clinical/non-covered BT services under the ACD such as shadow, support, or aide services in the school setting, the Department could use only the preexisting number to provide such an estimate, which as calculated in the previous section would be approximately $6.76 million.

**(4) WHY APPLIED BEHAVIOR ANALYSIS (ABA) DOES NOT MEET THE DEPARTMENT OF DEFENSE'S HIERARCHY OF EVIDENCE TO SUPPORT MEDICAL NECESSITY**

As commonly used in the larger health industry, "medical necessity/medically necessary" refers simply to the treatments or services that a licensed provider considers to be the general standard of care for medical practice in the United States. It is limited only by the scope of a provider's license, or a commercial health plan's coverage rules. Generally, that usual meaning of "medical necessity/medically necessary" also serves as the standard of care applicable to the direct care component of the TRICARE program at military medical treatment facilities.

In contrast, the TRICARE program regulations for private sector services set a much higher standard for what constitutes "medically necessary" care for TRICARE cost-sharing. In short, to be "medically necessary" for TRICARE claims coverage purposes the care in question must be proven safe and effective by published science, and not merely based on the professional opinion of physicians. *See* 10 U.S.C. § 1079(a)(12), 32 CFR §§ 199.2 and 199.4(g)(15) (prohibiting TRICARE from paying for unproven medical care, e.g., care for which the safety and efficacy of the care has been established by reliable evidence.)

The hierarchy of reliable evidence prioritizes the strongest evidence with the most weight. While randomized controlled trials (RCTs) are not expressly stated in the reliable evidence definition, they are considered the gold standard when it comes to research design. Although there are some RCTs studying ABA, these studies have significant weaknesses, such as narrow scope of analysis, weak methodology, and inconsistent findings across studies. Additionally, technology assessments such as Hayes Inc[4] continue to find "[a]n overall low-quality body of evidence mainly from poor-quality studies suggests that [Intensive Behavioral Intervention] IBI improves intelligence or cognitive skills, visual-spatial skills, language skills, and adaptive behavior compared with baseline levels or other treatments. The evidence does not reflect any consensus as to whether the reported improvements are clinically significant; very few studies reported on the clinical significance of findings. No harms were reported in the reviewed literature. A paucity of evidence regarding the durability of treatment following treatment cessation, as well as uncertainty regarding optimal therapy parameters, preclude firm conclusions regarding the efficacy of IBI for ASD." Additionally, there are no medical organizations or professional standards that define optimal outcomes for ABA services including dose-response, what patient characteristics yield the best results, or clinically meaningful outcomes. Recent literature continues to highlight weaknesses in parameters for optimal care delivery: "…examining the effects of ABA in community-based early intervention programs has yet to be demonstrated. In addition, the optimal age to commence treatment and the number of treatment hours has still to be determined for effective treatment in early intervention programs." (Vietze & Lax, 2020)[5]; "Although ABA has demonstrated improvement in outcomes in several

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[4] Hayes, Inc. 2019. Comparative Effectiveness Review: Intensive Behavioral Intervention for Treatment of Autism Spectrum Disorder.

[5] Vietze, P., & Lax, L.E. 2020. Early Intervention ABA for Toddlers with ASD: Effect of Age and Amount. Current Psychology, 39(1):1234-1244.

reasonably designed studies, efficacious adoption, implementation, and maintenance of interventions for autism are variable in community settings." (Ostrovsky et al, 2022).[6]

DHA still has questions to answer regarding whether or not ABA services provided to TRICARE beneficiaries meet the reliable evidence standard for proven medical care. DHA's final benefit determination concerning the status of ABA will be informed by the results of a pending Congressionally Directed Medical Research Program study; the National Academies for Science, Medicine, and Engineering analysis; the analysis of program and clinical outcomes from the ACD; and the state of other available reliable evidence, such as new research findings on the efficacy of ABA based on well-controlled studies with clinically meaningful endpoints published in peer-reviewed research journals. Until DHA is in a position to make a final benefit determination, the Department intends to continue the ACD through 2028 and fully support the needs of our beneficiaries and their families as these sources of information become available.

## CONCLUSION

While behavior analytic strategies may be applied in a variety of settings and target an array of skills, the ACD is authorized to reimburse ABA providers who render ABA services that provide multiple opportunities for the continuous delivery of instructions, prompts, responses, and reactions to those responses that are clinically necessary and appropriate ABA services. The ACD sets specific parameters for covered services under DHA's demonstration authority. The ACD continues to authorize appropriate clinical ABA services in all appropriate settings; however, all TRICARE-authorized ABA services must be actively delivered, via continuous teaching trials, for the entire duration of the session to be reimbursed by TRICARE. The scope of coverage did not change, and no services were terminated from the ACD. Rather, the March 2021 policy update reiterated existing policy and clarified the scope of authorized TRICARE cost-sharing for clinically appropriate ABA services under the ACD in school and community settings. As one of the goals of the demonstration is to determine whether or not ABA services meet the definition of proven medical care, continuing to reimburse for non-clinical/non-covered services undermines the overall program goals.

[6] Ostrovsky, A., et al. 2023. Data-driven, client-centric applied behavior analysis treatment-dose optimization improves functional outcomes. World Journal of Pediatrics, 19(8): 753–760.