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TRICARE  
MANAGEMENT ACTIVITY

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**PUBLICATIONS SYSTEM CHANGE TRANSMITTAL  
FOR  
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The TRICARE Management Activity has authorized the following addition(s)/revision(s).

**CHANGE TITLE:** NATIONAL DEFENSE AUTHORIZATION ACT (NDAA) FISCAL YEAR (FY) 2010, SECTION 702, EXPANSION OF EARLY ELIGIBILITY BENEFIT FOR RESERVE AND NATIONAL GUARD (NG) FAMILY MEMBERS FROM 90 TO 180 DAYS

**CONREQ:** 15452

**PAGE CHANGE(S):** See page 2.

**SUMMARY OF CHANGE(S):** This change expands the maximum period of early eligibility TRICARE from 90 to 180 days for members of the Reserve and NG who are issued delayed-effective-date active-duty orders.

**EFFECTIVE AND IMPLEMENTATION DATE:** Upon direction of the Contracting Officer.

This change is made in conjunction with Aug 2002 TPM, Change No. 151 and Aug 2002 TRM, Change No. 144.

  
Reta M. Michak  
Director, Operations Division

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WHEN PRESCRIBED ACTION HAS BEEN TAKEN, FILE THIS TRANSMITTAL WITH BASIC DOCUMENT.

**CHANGE 134**  
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**REMOVE PAGE(S)**

**CHAPTER 20**

Table of Contents, pages i through iv  
Section 5, pages 1 through 10  
Section 6, pages 1 through 3  
Section 7, pages 1 through 3  
Section 8, pages 1 and 2  
Section 9, pages 1 through 4  
Section 10, pages 1 through 14  
Section 11, pages 1 through 7  
Section 12, pages 1 through 3  
Addendum A, pages 1 through 4

**INSERT PAGE(S)**

Table of Contents, pages i through iv  
Section 5, pages 1 through 3  
Section 6, pages 1 through 3  
Section 7, pages 1 and 2  
Section 8, pages 1 through 4  
Section 9, pages 1 through 14  
Section 10, pages 1 through 7  
Section 11, pages 1 through 3  
★ ★ ★ ★ ★ ★  
Addendum A, pages 1 through 4

DEMONSTRATIONS

SECTION	SUBJECT
<b>1</b>	<b>GENERAL</b> 1.0. Purpose Of And Authority For Demonstrations 2.0. Organization 3.0. Restrictions On Scope Of Benefits Furnished Under Demonstration Projects
<b>2</b>	<b>DEPARTMENT OF DEFENSE CANCER PREVENTION AND TREATMENT CLINICAL TRIALS DEMONSTRATION</b> 1.0. Purpose 2.0. Background 3.0. Policy 4.0. Applicability 5.0. General Description Of Administrative Process 6.0. TMA And Contractor Responsibilities 7.0. Claims Processing Requirements FIGURE 20-2-1 Sample Of Authorization Letter To Be Issued To Institution Verifying TRICARE Eligibility For Said Patient To Be Enrolled In NCI Sponsored Studies FIGURE 20-2-2 Sample Of Authorization Letter For DoD Cancer Prevention And Treatment Clinical Trials Demonstration FIGURE 20-2-3 Sample Of Denial Letter For DoD Cancer Prevention And Treatment Clinical Trials Demonstration FIGURE 20-2-4 Sample Of Notification Letter To Be Issued To Geographical Contractor Of Patient's Enrollment In The DoD Cancer Prevention And Treatment Clinical Trials Demonstration
<b>3</b>	<b>DEPARTMENT OF DEFENSE IN-UTERO FETAL SURGICAL REPAIR OF MYELOMENINGOCELE CLINICAL TRIAL DEMONSTRATION</b> 1.0. <i>Purpose</i> 2.0. <i>Background</i> 3.0. <i>Policy And Eligibility</i> 4.0. <i>Applicability</i> 5.0. <i>General Description Of Administrative Process</i> 6.0. <i>ASD(HA) Responsibilities</i> 7.0. <i>The Biostatistics Center (BCC)</i> 8.0. <i>Participating MOMS Centers</i> 9.0. <i>TMA And Contractor Responsibilities</i> 10.0. <i>Claims Processing Requirements</i> FIGURE 20-3-1 <i>Demonstration Protocol</i>

SECTION	SUBJECT
<b>4</b>	<b>OPERATION NOBLE EAGLE/OPERATION ENDURING FREEDOM RESERVIST AND NATIONAL GUARD BENEFITS DEMONSTRATION</b> 1.0. Purpose 2.0. Background 3.0. Policy 4.0. Evaluation 5.0. Effective Dates
<b>5</b>	<b>DEPARTMENT OF DEFENSE WEIGHT MANAGEMENT DEMONSTRATION</b> 1.0. Purpose 2.0. Background 3.0. Policy And Eligibility 4.0. Managed Care Support Contractor (MCSC) Responsibility 5.0. Applicability 6.0. ASD(HA) Responsibilities 7.0. Effective Date
<b>6</b>	<b>DEPARTMENT OF DEFENSE TOBACCO CESSATION DEMONSTRATION</b> 1.0. Purpose 2.0. Background 3.0. Policy And Eligibility 4.0. Managed Care Support Contractor (MCSC) Responsibility 5.0. Applicability 6.0. ASD(HA) Responsibilities 7.0. Effective Date
<b>7</b>	<b>DEPARTMENT OF DEFENSE ALCOHOL ABUSE PREVENTION AND EDUCATION DEMONSTRATION</b> 1.0. Purpose 2.0. Background 3.0. Eligibility 4.0. Operation
<b>8</b>	<b>TRICARE DEMONSTRATION PROJECT FOR THE STATE OF ALASKA - CRITICAL ACCESS HOSPITAL (CAH) PAYMENT RATES</b> 1.0. Purpose 2.0. Background 3.0. Policy <i>FIGURE 20-8-1</i> Critical Access Hospitals (CAHs) In Alaska And Their CCRs On Or After July 1, 2007 <i>FIGURE 20-8-2</i> Critical Access Hospitals (CAHs) In Alaska And Their CCRs On Or After July 1, 2008 <i>FIGURE 20-8-3</i> Critical Access Hospitals (CAHs) In Alaska And Their CCRs On Or After July 1, 2009 4.0. MCSC Responsibility 5.0. Effective Date

SECTION	SUBJECT
<b>9</b>	<b>DEPARTMENT OF DEFENSE (DoD) ENHANCED ACCESS TO AUTISM SERVICES DEMONSTRATION</b> 1.0. Purpose 2.0. Background 3.0. Definitions 4.0. Providers 5.0. EIA Provider Requirements 6.0. Beneficiary Eligibility Requirements 7.0. BP Requirements 8.0. Policy 9.0. Reimbursement 10.0. Required Reports 11.0. Additional MCSC Responsibilities 12.0. Applicability 13.0. Exclusions 14.0. Effective Date
<b>10</b>	<b>WEB-BASED TRICARE ASSISTANCE PROGRAM (TRIAP) DEMONSTRATION</b> 1.0. Purpose 2.0. Authority 3.0. Background 4.0. Definitions 5.0. Policy 6.0. Minimum Requirements For Delivery of TRIAP Services 7.0. General 8.0. Funding 9.0. Authorized Providers 10.0. Eligibility 11.0. MCSC Responsibility 12.0. TRICARE Management Activity (TMA) Responsibility 13.0. Effective Date 14.0. Monthly Reports 15.0. Exclusions
<b>11</b>	<b>TRICARE SOUTH REGION UNITED STATES COAST GUARD (USCG) ACCESS TO CARE (ATC) DEMONSTRATION FOR TRICARE PRIME/TRICARE PRIME REMOTE (TPR) BENEFICIARIES</b> 1.0. Purpose 2.0. Background 3.0. Policy And Eligibility 4.0. General Description Of Administrative Process 5.0. Assistant Secretary Of Defense (Health Affairs) (ASD(HA)) And TRI-CARE Management Activity (TMA) Responsibilities 6.0. Managed Care Support Contractor (MCSC) Responsibilities 7.0. Applicability 8.0. Exclusions 9.0. Effective Date

**TRICARE OPERATIONS MANUAL 6010.51-M, AUGUST 1, 2002**  
CHAPTER 20 - DEMONSTRATIONS

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<b>SECTION</b>	<b>SUBJECT</b>
<b>ADDENDUM A</b>	<b>PARTICIPATION AGREEMENT FOR AUTISM DEMONSTRATION CORPORATE SERVICES PROVIDER (ACSP)</b>

## DEPARTMENT OF DEFENSE WEIGHT MANAGEMENT DEMONSTRATION

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### 1.0. PURPOSE

This demonstration will allow the Department of Defense (DoD) to determine the efficacy and acceptability of pharmacotherapy and distance behavioral interventions in producing and maintaining clinically significant weight loss in an at-risk overweight or obese individual. The Weight Management Demonstration (hereby referred to as the Demonstration) will also provide information that will enable DoD to determine whether to seek a change in statute to authorize, as part of the TRICARE benefit, behavior modification either alone or with pharmacotherapy for the treatment of patients that are overweight or obese.

### 2.0. BACKGROUND

**2.1.** Obesity is the seventh leading cause of preventable death in the United States contributing to more than 112,000 deaths annually. All segments of the DoD population demonstrate upward weight trends with approximately 13 percent of active duty, 34 percent of non-active duty, and 19 percent of dependent DoD adolescents classified as obese according to the National Institutes of Health. Many high volume, high cost medical conditions, including diabetes, heart disease, back and joint pain, asthma, some cancers, and sleep apnea are related to obesity.

**2.2.** According to the Centers of Disease Control and Prevention, in the four demonstration states, there are 315,000 eligibles in total. Out of the 315,000 eligibles, approximately 71,000 Prime enrollees are age 18 and older, and approximately 45,000 Prime enrollees meet the definition for overweight or obese.

**2.3.** Under TRICARE, the treatment of obesity, as a sole medical condition, is excluded by law [10 U.S.C. 1079(a)(11)]. As a result, TRICARE policy is limited to proven surgical interventions for individuals with associated medical conditions (i.e., hypertension, cholecystitis, narcolepsy, diabetes mellitus, pickwickian syndrome (and other severe respiratory diseases), hypothalamic disorders, and severe arthritis of the weight-bearing joints). TRICARE does not cover non-surgical treatment of obesity or morbid obesity for dietary control or weight reduction (i.e., nutritional or behavioral counseling or weight loss medication).

**2.4.** One of the priorities of the Assistant Secretary of Defense for Health Affairs (ASD(HA)) is to establish a uniform weight management program for TRICARE Prime enrollees in the Military Health System (MHS). Therefore, on July 6, 2005 (Vol 70, No 38888), the Federal Register announced a demonstration project in which the DoD will provide TRICARE reimbursement for Prime enrollees (excluding active duty members and those

enrolled in special programs) residing in Indiana, Illinois, Michigan and Ohio to receive weight management intervention for the treatment of obesity.

**2.5.** The Weight Management Demonstration project is planned for three years and is currently funded for one year. Evaluation for additional funding will be prepared as needed. The Demonstration will continue based on outcome measures related to utilization rates, weight loss rates, and success of pharmacotherapy.

### **3.0. POLICY AND ELIGIBILITY**

**3.1.** Effective October 1, 2005, the Demonstration is authorized for overweight (Body Mass Index (BMI > 25)) non-active duty TRICARE Prime enrollees, who are age 18 to 64, residing in Ohio, Michigan, Indiana, or Illinois.

**3.2.** The Demonstration does not apply to active duty members or those TRICARE-eligible beneficiaries enrolled in special programs (i.e., ECHO) available through TRICARE.

### **4.0. MANAGED CARE SUPPORT CONTRACTOR (MCSC) RESPONSIBILITY**

**4.1.** The MCSC shall enroll eligible beneficiaries into the Demonstration through the Defense Online Enrollment System (DOES) based on applications received from the Demonstration Contractor. The MCSC is not required to verify or validate enrollment information. Rather, the MCSC is simply the data entry portal for reporting the enrollment to the Defense Enrollment Eligibility Reporting System (DEERS). The MCSC shall accomplish the required data entry within 5 calendar days of receiving an approved enrollment application from the Demonstration Contractor. Enrollments that cannot be effected because of ineligibility on DEERS or because of invalid or incomplete information shall be returned to the Demonstration Contractor with an explanation of the problem within 5 calendar days of receipt of the application.

**4.2.** The MCSC shall disenroll beneficiaries and make changes as necessary. The MCSC shall notify the Demonstration Contractor of any changes in status from DEERS.

**4.3.** The MCSC shall provide Pharmacy Data Transaction Service (PDTS) with a weekly list of all enrollments completed during the week. The list will include: beneficiary's name, beneficiary's social security number (SSN), sponsor's name, sponsor's SSN, beneficiary's address and date of enrollment into the Demonstration. The weekly list shall be e-mailed to [pdts.ameddcs@amedd.army.mil](mailto:pdts.ameddcs@amedd.army.mil).

**4.4.** DoD will cost-share all medical care required as a result of participation in the weight management demonstration. This includes physician visits for medical management and prescription pharmacotherapy through the TRICARE Mail Order Pharmacy (TMOP).

**4.5.** The MCSC shall process claims and allow TRICARE benefits for otherwise covered health care services (i.e., physician visit, medication management visit, etc.) related to the treatment of obesity. Normal TRICARE Prime cost-sharing applies.

**5.0. APPLICABILITY**

The provisions of this demonstration are limited to those TRICARE-eligible beneficiaries as stated above in [paragraph 3.1](#).

**6.0. ASD(HA) RESPONSIBILITIES**

ASD(HA) is the designated Executive Agent for the Demonstration project. They shall designate a project officer in the Office of the DASD (Clinical Services) for the Demonstration. The project officer shall provide clinical oversight and ongoing program management of the Demonstration.

**7.0. EFFECTIVE DATE**

This demonstration is effective for claims for services provided on or after October 1, 2005.



## DEPARTMENT OF DEFENSE TOBACCO CESSATION DEMONSTRATION

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### 1.0. PURPOSE

This demonstration will allow the Department of Defense (DoD) to determine the efficacy and acceptability of a telephone-based tobacco cessation quitline and pharmacotherapy in producing and maintaining tobacco cessation. The Tobacco Cessation Demonstration (hereby referred to as the Demonstration) will also provide information that will enable DoD to determine whether to authorize telephone-based tobacco cessation counseling alone or with pharmacotherapy as part of the TRICARE benefit.

### 2.0. BACKGROUND

**2.1.** Tobacco use is the leading cause of preventable death in the United States. It is responsible for 440,000 deaths annually nationwide, including 14,000 in the DoD. The case for an expanded and comprehensive approach to DoD tobacco cessation is compelling. With estimated medical costs from tobacco use that exceed \$1.6 billion per year and the observation of an alarming increase in smoking prevalence among young active duty, the need for a global and effective DoD strategy has never been greater.

**2.2.** Research indicates tobacco use has a negative impact on readiness during wartime (e.g., 20-50 percent reduction in night vision; rapid nicotine withdrawal affects cognitive functioning and visual acuity; significant decrement in tracking and longer reaction times). Tobacco use also (1) puts individuals at greater risk for pneumonia, asthma, and lung disease; (2) results in more hospitalization and lost work in young active duty; (3) degrades performance on physical fitness tests; and (4) increases likelihood of sustaining musculoskeletal injuries.

**2.3.** Substantial research confirms that pharmacotherapy, proactive telephone quitlines, and individual/group counseling are effective interventions. According to the Centers for Disease Control and Prevention (CDC), smokers are more likely to utilize telephone counseling than group and individual counseling. High intensity interventions are more effective than lower intensity ones. The tobacco cessation demonstration will provide the opportunity to test the effectiveness of potential benefit changes in the DoD population.

**2.4.** One of the priorities of the Assistant Secretary of Defense for Health Affairs (ASD(HA)) is to establish a uniform tobacco cessation program for TRICARE Prime enrollees in the Military Health System (MHS). Therefore, on July 6, 2005 (Vol 70, No 38888), the Federal Register announced a demonstration project in which the DoD will provide TRICARE reimbursement for tobacco cessation services for TRICARE beneficiaries who meet the eligibility requirements outlined in [paragraph 3.1](#). The scope of services available through this demonstration will include: (1) the availability of a proactive toll-free telephone quitline; (2) the availability of a web-based tobacco cessation information resource; (3)

prescription pharmacotherapy and physician visits, with normal co-pays; and (4) unlimited numbers of quit attempts. This demonstration project is being conducted under the expanded HMO Uniform Benefit of the [32 CFR 199.18\(b\)\(2\)](#).

**2.5.** The Tobacco Cessation Demonstration project is planned for three years and is currently funded for one year. Evaluation for additional funding will be prepared as needed. The Demonstration will continue based on outcome measures related to utilization rates, quit rates, and success of pharmacotherapy.

### **3.0. POLICY AND ELIGIBILITY**

**3.1.** Effective October 1, 2005, the Demonstration is authorized for TRICARE eligible beneficiaries enrolled in Prime, 18-64 years of age, and who are non-Medicare entitled and reside in the identified zip code areas of the demonstration. The demonstration area includes an area greater than 40 miles from inpatient military treatment facilities (MTFs) in Colorado, Minnesota, Missouri, and Kansas.

**3.2.** The Demonstration does not apply to those TRICARE-eligible beneficiaries enrolled in special programs (e.g., ECHO) available through TRICARE.

### **4.0. MANAGED CARE SUPPORT CONTRACTOR (MCSC) RESPONSIBILITY**

**4.1.** The MCSC shall enroll eligible beneficiaries into the Tobacco Cessation Demonstration through Defense Online Enrollment System (DOES) based on applications received from the Demonstration contractor. The MCSC is not required to verify or validate enrollment information. Rather, the MCSC is simply the data entry portal for reporting the enrollment to Defense Enrollment Eligibility Reporting System (DEERS). The MCSC shall accomplish the required data entry within 7 calendar days of receiving an approved enrollment application from the demonstration contractor. Enrollments that cannot be effected because of ineligibility on DEERS or because of invalid or incomplete information shall be returned to the demonstration contractor with an explanation of the problem within 7 calendar days of receipt of the application.

**4.2.** The MCSC shall provide the Pharmacy Data Transaction Service (PDTS) with a weekly list of all enrollments completed during the week. The list will include: beneficiary's name, beneficiary's social security number (SSN), sponsor's name, sponsor's SSN, beneficiary's address, and date of enrollment into the Demonstration. The weekly list shall be e-mailed to [pdts.ameddcs@amedd.army.mil](mailto:pdts.ameddcs@amedd.army.mil).

**4.3.** DoD will cost-share all medical care required as a result of participation in the tobacco cessation demonstration. This includes physician visits for medical management and prescription pharmacotherapy through the TRICARE Mail Order Pharmacy (TMOP).

**4.4.** The MCSC shall process claims and allow TRICARE benefits for otherwise covered health care services (i.e. physician visits, medication management visits, prescription pharmaceuticals, etc.) related to tobacco cessation. Normal TRICARE Prime co-pays for provider visits and prescription pharmacotherapy will apply under this Demonstration. No co-pays will be assessed for Quitline services or web-based tobacco cessation information.

**4.5.** The MCSC shall disenroll demonstration participants upon notification of loss of eligibility by DEERS (due to a change in DEERS status or relocation outside of the demonstration area), upon notification of completion of treatment, or upon termination of the demonstration (whichever comes first).

**4.6.** The MCSC shall notify the demonstration contractor of any DEERS status changes for demonstration participants which could affect eligibility for the demonstration.

**5.0. APPLICABILITY**

The provisions of this demonstration are limited to those TRICARE-eligible beneficiaries and active duty service members as stated above in [paragraph 3.1](#).

**6.0. ASD(HA) RESPONSIBILITIES**

ASD(HA) is the designated Executive Agent for the Demonstration project. They shall designate a project officer in the Office of the DASD (Clinical Services) for the Demonstration. The project officer shall provide clinical oversight and ongoing program management of the Demonstration.

**7.0. EFFECTIVE DATE**

This Demonstration is effective for claims for services provided on or after October 1, 2005.



## DEPARTMENT OF DEFENSE ALCOHOL ABUSE PREVENTION AND EDUCATION DEMONSTRATION

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### 1.0. PURPOSE

The purpose of this demonstration is to test the efficacy of web-based training in the avoidance of abusive behaviors related to alcohol consumption. This section is for information only.

### 2.0. BACKGROUND

**2.1.** Web-based alcohol prevention education courses represent a new and innovative approach to education that active duty members can relate to and feel comfortable with. Such an approach combines proven science-based teaching with the latest web-based media technologies. Available courses offer potentially engaging and easy to follow audio-visual productions including streaming video, interactive assignments and case studies, self assessments, customized feedback about current drinking levels, as well as final examinations. These courses also offer the benefit of being available at any time for the user. Additionally, due to the very nature of the internet, such programs also have the potential to provide researchers with a wealth of data that can help determine the outcomes of the program.

**2.2.** This project will enhance Service-level Alcohol Prevention Education Program by providing another option for alcohol prevention education. The case of an expanded and innovative Department of Defense (DoD) approach to alcohol prevention education is compelling. According to the 2002 Department of Defense "Survey of Health Related Behaviors Among Military Personnel," trends in alcohol consumption between 1982 and 1998 were showing great promise. Over this period, heavy alcohol consumption had declined by 36 percent, members facing serious consequences from alcohol consumption declined by 54 percent, and productivity losses from alcohol consumption declined by 60 percent. However, between 1998 and 2002, alarming trends have begun to emerge erasing many of the gains made in the late 1980s and 1990s. Heavy alcohol consumption increased by 27 percent. Additionally, for the first time, binge drinking was measured in the 2002 survey, and DoD rates of 18-25 year old active duty binge drinkers (53%) exceed civilian binge drinkers in the same age group (44%).

**2.3.** Research of the literature and studies conducted within the Military Health System (MHS) indicate the impact of heavy alcohol use. Estimated excess medical costs to DoD for active duty heavy drinkers are \$364 M per year. According to the DoD Task Force Report on Care for Victims of Sexual Assault, alcohol use contributes to 50 percent of alleged sexual assaults by service members. Based on a review of active duty suicide data, alcohol was a factor in approximately 29 percent of all DoD suicides. In review of active duty private motor vehicle fatalities, alcohol contributed to 20-25 percent of those fatalities (civilian rate 40%). The DoD administratively separates more than 700 members per year for alcohol-related

reasons. Research indicates alcohol reduces productivity by at least 1,764 FTEs/year (treatments, illness, hospitalization, and duty losses). All these issues directly impact force readiness.

**2.4.** One of the priorities of the Assistant Secretary of Defense for Health Affairs (ASD(HA)) is to establish a uniform inexpensive web-based alcohol prevention education program for active duty in the MHS.

**2.5.** The Alcohol Prevention Education Program is planned for two years and is currently funded for one year. Evaluation for additional funding will be prepared as needed. The Demonstration will continue based on outcome measures related to utilization rates, alcohol abuse rates, and who will need a continuum of services.

### **3.0. ELIGIBILITY**

Effective October 1, 2005, the Demonstration is authorized for all active duty members.

### **4.0. OPERATION**

The Alcohol Abuse Prevention and Education Demonstration will be operated by a Demonstration Contractor. No Managed Care Support Contractor involvement is required.

## TRICARE DEMONSTRATION PROJECT FOR THE STATE OF ALASKA - CRITICAL ACCESS HOSPITAL (CAH) PAYMENT RATES

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### 1.0. PURPOSE

Under this demonstration project, TRICARE will reimburse Critical Access Hospitals (CAHs) in the state of Alaska in a similar manner as they are reimbursed under Medicare. This demonstration project will test adopting a Medicare-like CAH reimbursement methodology prior to nationwide implementation, in those states that have established State Flex Programs. It will also test CAH provider participation in TRICARE, beneficiary access to care, cost of health care services, military medical readiness, morale and welfare. This demonstration will be conducted under statutory authority provided in 10 U.S.C. 1092.

### 2.0. BACKGROUND

**2.1.** Hospitals are authorized TRICARE institutional providers under 10 U.S.C. 1079(j)(2) and (4). Under 10 U.S.C. 1079(j)(2), the amount to be paid to hospitals, Skilled Nursing Facilities (SNFs), and other institutional providers under TRICARE, “shall be determined under joint regulations... which provide that the amount of such payments shall be determined to the extent practicable in accordance with the same reimbursement rules as apply to payments to providers of services of the same type under [Medicare].” Under [32 CFR 199.14\(a\)\(1\)\(ii\)\(D\)\(1\)](#) through [\(9\)](#) it specifically lists those hospitals that are exempt from the Diagnosis Related Groups (DRG)-based payment system. CAHs are not listed as excluded, thereby making them subject to the DRG-based payment system. CAHs are not listed as exempt, because at the time this regulatory provision was written, CAHs were not a recognized entity.

**2.2.** Legislation enacted as part of the Balanced Budget Act (BBA) of 1997 authorized states to establish State Medicare Rural Hospital Flexibility Programs, under which certain facilities participating in Medicare could become CAHs. CAHs represent a separate provider type with their own Medicare conditions of participation as well as a separate payment method. Since that time, a number of hospitals, acute care and general, as well as Sole Community Hospitals (SCHs), have taken the necessary steps to be designated as CAHs. Since the statutory authority requires TRICARE to apply the same reimbursement rules as apply to payments to providers of services of the same type under Medicare to the extent practicable, TRICARE must proceed with publication of a proposed and final rule to exempt CAHs from the DRG-based payment system and adopt a method similar to Medicare principles for these hospitals when it becomes practicable to implement. The purpose of the demonstration is to test implementation immediately for CAHs in the state of Alaska.

TRICARE OPERATIONS MANUAL 6010.51-M, AUGUST 1, 2002

CHAPTER 20, SECTION 8

TRICARE DEMONSTRATION PROJECT FOR THE STATE OF ALASKA -  
CRITICAL ACCESS HOSPITAL (CAH) PAYMENT RATES

**3.0. POLICY**

**3.1.** Otherwise covered services and supplies provided by CAHs in the state of Alaska shall be reimbursed for inpatient and outpatient facility services at the lesser of the billed charge or on the basis of 101% of their allowable and reasonable costs. That is, an overall inpatient Cost-To-Charge Ratio (CCR) and overall outpatient CCR, obtained from data on the hospital's most recent Medicare cost report will be multiplied by the billed charge; the resulting amount will be increased by 1%. This amount shall be compared to the billed charge and the lesser of the two shall be paid to the provider.

**3.2.** The following inpatient CCRs shall be effective for inpatient admission on or after July 1, 2007. The outpatient CCRs shall be effective for outpatient facility services with dates of service on or after July 1, 2007.

**FIGURE 20-8-1 CRITICAL ACCESS HOSPITALS (CAHs) IN ALASKA AND THEIR CCRs ON OR AFTER JULY 1, 2007**

NAME	INPATIENT CCR	OUTPATIENT CCR
Valdez Regional Health Authority (VRHA)	2.1029	1.3978
Providence Seward Medical & Care Center (PSMCC)	0.6799	0.7674
Sitka Community Hospital (SCH)	1.0100	0.8098
Petersburg Medical Center (PMC)	0.9762	0.8901
Wrangell Medical Center (WMC)	0.9445	0.7574
Providence Kodiak Island Medical Center (PKIMC)	0.6992	0.6079
Cordova Community Medical Center (CCMC)	1.0544	1.3456
Norton Sound Health Corporation (NSHC)	1.0438	1.1183
Ketchikan General Hospital (KGH)	0.5770	1.1669

**3.3.** The following inpatient CCRs shall be effective for inpatient admission on or after July 1, 2008. The outpatient CCRs shall be effective for outpatient facility services with dates of service on or after July 1, 2008.

**FIGURE 20-8-2 CRITICAL ACCESS HOSPITALS (CAHs) IN ALASKA AND THEIR CCRs ON OR AFTER JULY 1, 2008**

NAME	INPATIENT CCR	OUTPATIENT CCR
Valdez Regional Health Authority (VRHA)	1.5739	1.2364
Providence Seward Medical & Care Center (PSMCC)	0.9906	0.6405
Sitka Community Hospital (SCH)	1.0852	0.8717
Petersburg Medical Center (PMC)	0.8958	0.8895

TRICARE OPERATIONS MANUAL 6010.51-M, AUGUST 1, 2002

CHAPTER 20, SECTION 8

TRICARE DEMONSTRATION PROJECT FOR THE STATE OF ALASKA -  
CRITICAL ACCESS HOSPITAL (CAH) PAYMENT RATES

**FIGURE 20-8-2 CRITICAL ACCESS HOSPITALS (CAHS) IN ALASKA AND THEIR CCRs ON OR AFTER JULY 1, 2008 (CONTINUED)**

NAME	INPATIENT CCR	OUTPATIENT CCR
Wrangell Medical Center (WMC)	0.8391	0.7346
Providence Kodiak Island Medical Center (PKIMC)	0.6340	0.5586
Cordova Community Medical Center (CCMC)	0.6026	0.8697
Norton Sound Health Corporation (NSHC)	1.0967	0.8851
Ketchikan General Hospital (KGH)	0.6827	0.6711

**3.4.** The following inpatient CCRs shall be effective for inpatient admission on or after July 1, 2009. The outpatient CCRs shall be effective for outpatient facility services with dates of service on or after July 1, 2009.

**FIGURE 20-8-3 CRITICAL ACCESS HOSPITALS (CAHS) IN ALASKA AND THEIR CCRs ON OR AFTER JULY 1, 2009**

NAME	INPATIENT CCR	OUTPATIENT CCR
Valdez Regional Health Authority (VRHA)	1.2016	1.0547
Providence Seward Medical & Care Center (PSMCC)	1.4354	0.5837
Sitka Community Hospital (SCH)	1.1056	0.9757
Petersburg Medical Center (PMC)	1.1803	0.9506
Wrangell Medical Center (WMC)	1.0363	0.8314
Providence Kodiak Island Medical Center (PKIMC)	0.6655	0.6249
Cordova Community Medical Center (CCMC)	0.8913	0.9032
Norton Sound Health Corporation (NSHC)	0.9716	0.8385
Ketchikan General Hospital (KGH)	0.6504	0.6304

**3.5.** The TRICARE Management Activity (TMA) shall provide a list of CAHs in the state of Alaska to the MCSC and the inpatient and outpatient CCRs to be used for this demonstration. The CCRs shall be updated on an annual basis using the most recent CCRs for each hospital. TMA shall provide the updated inpatient and outpatient CCRs to the contractor and the updated inpatient and outpatient CCRs shall be effective as of July 1 of each respective year, with the first update occurring effective July 1, 2008.

**3.6.** Payment for TRICARE covered outpatient services provided by physicians and other non-institutional individual professional providers in the state of Alaska shall be reimbursed in accordance with the **Federal Register** (FR) notice published on November 20, 2006 (71 FR 67112-67113). That is, TRICARE will adopt a rate that is 1.35 times the current TRICARE allowable rate. These rates are included in the CHAMPUS Maximum Allowable Charge (CMAC) file that is provided to each of the Managed Care Support Contractors (MCSCs).

**3.7.** The TRICARE cost-shares, copayments, and deductibles applicable to hospitals shall also apply to the services provided by CAHs under this demonstration.

**3.8.** The CAH portion of the state of Alaska demonstration excludes those Indian Health Service (IHS) facilities that are also CAHs. IHS facilities will continue to be reimbursed the DRG or the negotiated rate for inpatient care, the lower of the billed charge or negotiated rate for outpatient facility care, and the CMAC rates for Alaska for care rendered by individual professional providers.

#### **4.0. MCSC RESPONSIBILITY**

The MCSC for the state of Alaska shall price and process inpatient and outpatient facility claims under this demonstration using the reimbursement methods described in [paragraph 3.0](#).

#### **4.1. Out-Of-Jurisdiction Claims**

**4.1.1.** In the event the MCSC for the state of Alaska receives an out-of-jurisdiction claim, the MCSC shall price the claim using the methods described in [paragraph 3.0](#). Once the claim has been priced, the claim shall be forwarded to the appropriate contractor based on the jurisdiction provisions found in [Chapter 8, Section 2](#).

**4.1.2.** In the event that a north or south MCSC or other TRICARE contractor receives a claim from one of the CAHs under this demonstration, the claim shall be sent to the MCSC for the state of Alaska to be priced using the provision of this demonstration. Once the claim has been priced by the state of Alaska MCSC, the claim shall be forwarded to the appropriate contractor based on the jurisdiction provisions found in [Chapter 8, Section 2](#). The claim shall be sent to the fax number 1-715-843-8435, Attn: CAH Processing.

#### **5.0. EFFECTIVE DATE**

**5.1.** The portion of the state of Alaska demonstration that provides for 1.35 times the current TRICARE allowable rate took effect on February 1, 2007.

**5.2.** The enhanced portion of the state of Alaska demonstration that provides for 101% of reasonable costs for inpatient and outpatient facility reimbursement to CAHs shall be effective for inpatient admissions on and after July 1, 2007, and for outpatient facility services with dates of service on or after July 1, 2007.

**5.3.** The CAH portion of the demonstration will expire on November 30, 2009. Requirements of this section as related to the CAH portion of the demonstration cease at 12:00 midnight on November 30, 2009, except for claims for patients admitted prior to 12:00 midnight on November 30, 2009. The demonstration retains responsibility for these claims until the beneficiary is discharged from the CAH. For information on CAH reimbursement, see the TRICARE Reimbursement Manual (TRM), [Chapter 15, Section 1](#).

## DEPARTMENT OF DEFENSE (DoD) ENHANCED ACCESS TO AUTISM SERVICES DEMONSTRATION

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### 1.0. PURPOSE

The Enhanced Access to Autism Services Demonstration (“Demonstration”) provides TRICARE reimbursement for Educational Interventions for Autism Spectrum Disorders (EIA). This Demonstration will enable the Department of Defense (DoD) to determine whether:

- There is increased access to these services;
- The services are reaching those most likely to benefit from them;
- The quality of those services is meeting a standard of care currently accepted by the professional community of providers, including the Behavior Analyst Certification Board (BACB); and
- Requirements are met for State licensure and certification where such exists.

### 2.0. BACKGROUND

**2.1.** The Military Health System (MHS) includes 59 military hospitals, over 350 military health clinics, and an extensive network of private sector health care partners, that provides medical care for more than nine million beneficiaries, including Active Duty Service Members (ADSMs) and Active Duty Family Members (ADFMs).

**2.2.** Autistic Spectrum Disorders (ASD) affect essential human behaviors such as social interaction, the ability to communicate ideas and feelings, imagination, and the establishment of relationships with others.

**2.3.** A number of EIA services, such as Applied Behavior Analysis (ABA), have been introduced to ameliorate the negative impact of autism. Currently, ABA is the only EIA service accepted within the MHS as having been shown to reduce or eliminate specific problem behaviors and teach new skills to individuals with ASD. ABA therapy is rendered by TRICARE-authorized providers as a Special Education benefit under the Extended Care Health Option (ECHO). Only those individuals who are licensed or certified by a State or certified by the BACB (<http://www.bacb.com>) as a Board Certified Behavior Analyst (BCBA) or a Board Certified Assistant Behavior Analyst (BCaBA) are eligible to be TRICARE-authorized providers of ABA.

**2.4.** The Demonstration allows TRICARE reimbursement for EIA services, referred to as Intensive Behavioral Interventions in the Federal Register Demonstration Notice (72 FR 68130, December 4, 2007), delivered by paraprofessional providers under a modified Corporate Services Provider (CSP) model.

### **3.0. DEFINITIONS**

#### **3.1. Applied Behavior Analysis (ABA)**

A well-developed discipline with a mature body of scientific knowledge, established standards for evidence-based practice, distinct methods of service, recognized experience and educational requirements for practice, and identified sources of requisite education. Information regarding the content of ABA is contained in the BACB Behavior Analysis Task List, available at <http://www.bacb.com/Downloadfiles/AutismTaskList/708AutismTaskListF.pdf>.

#### **3.2. Autism Spectrum Disorders (ASD)**

**3.2.1.** Collective term indicating Autistic Disorder (AD), Childhood Disintegrative Disorder (CDD), Asperger's Syndrome (AS), and Pervasive Developmental Disorder Not Otherwise Specified (PDDNOS) as defined by the American Psychiatric Association's (APA's) Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR).

**3.2.2.** Significant symptoms associated with ASD include communication and social behavior deficits, and behaviors concerning objects and routine.

**3.2.2.1.** Communication deficits include a lack of speech, especially when associated with the lack of desire to communicate and lack of nonverbal compensatory efforts such as gestures.

**3.2.2.2.** Social Skills Deficits. Children with ASD demonstrate a decreased drive to interact with others and share complementary feeling states. Children with ASD often appear to be content being alone, ignore their parents' and others' bids for attention with gestures or vocalizations and seldom make eye contact.

**3.2.2.3.** Restricted, Repetitive, and Stereotyped Patterns of Behavior, Interests, and Activities. Children with ASD can demonstrate atypical behaviors in a variety of areas including peculiar mannerisms, unusual attachments to objects, obsessions, compulsions, self-injurious behaviors, and stereotypes. Stereotypes are repetitive, nonfunctional, atypical behaviors such as hand flapping, finger movements, rocking, or twirling.

#### **3.3. Behavior Plan (BP)**

A written assessment of the objectives and goals of behavior modification and the specific evidence-based practices and techniques to be utilized. Requirements for the BP are specified in [paragraph 7.0](#).

### **3.4. Educational Interventions for Autism Spectrum Disorders (EIA)**

Individualized interventions, as specified in the BP, to systematically increase adaptive behaviors and modify maladaptive or inappropriate behaviors. Under the Demonstration, only ABA, as defined by the BACB, is authorized and reimbursable.

### **3.5. EIA Progress Report (EPR) And Updated BP**

A report of the individual's progress towards achieving the behavioral goals and objectives specified in the BP. The report also revises the BP to reflect new or modified goals, objectives and strategies. Requirements for the EPR and the updated BP are specified in [paragraphs 7.2.](#) and [7.3.](#), respectively.

### **3.6. Functional Behavioral Assessment And Analysis**

The process of identifying the variables that reliably predict and maintain problem behaviors. The functional behavioral assessment and analysis process typically involves:

- Identifying the problem behavior(s); and
- Developing hypotheses about the antecedents and consequences likely to trigger or support the problem behavior; and
- Performing an analysis of the function of the behavior by testing the hypotheses.

### **3.7. Individuals With Disabilities Education Act (IDEA)**

Public Law 108-446, December 3, 2004 (20 U.S.C. 1400 et seq.): The United States law that entitles all children, including those with a disability, to a Free Appropriate Public Education (FAPE).

### **3.8. Individualized Family Service Plan (IFSP)**

A multidisciplinary assessment and plan that specifies the unique strengths, services and resources needed by an infant or toddler (age zero to three years) with a developmental disability or who is at risk for such, and his/her family.

### **3.9. Individualized Education Program (IEP)**

A multidisciplinary assessment and plan that specifies the objectives, goals and related services associated with providing a FAPE to a child with a disability.

### **3.10. Special Education**

Specially designed instruction to meet the unique FAPE needs, as specified in the IEP, of a child with a disability,

## **4.0. PROVIDERS**

### **4.1. Primary Care Provider (PCP)**

A collective reference within the Demonstration to:

**4.1.1.** A Primary Care Manager (PCM) under the TRICARE Prime or TRICARE Prime Remote for Active Duty Family Member (TPRADFM) programs; and

**4.1.2.** TRICARE-authorized family practice, general medicine, internal medicine, and pediatric physicians under the TRICARE Standard program; and

**4.1.3.** A Military Treatment Facility (MTF) provider or team of providers or a network provider to whom a beneficiary is assigned for primary care services at the time of enrollment in TRICARE Prime.

### **4.2. Autism Demonstration Corporate Services Provider (ACSP)**

An individual, corporation, foundation, or public entity that meets the TRICARE definition of a CSP under [32 CFR 199.6\(e\)\(2\)\(ii\)\(B\)](#) that predominantly renders services of a type uniquely allowable under the ECHO and which meets the requirements specified in [paragraph 5.1](#).

### **4.3. EIA Supervisor**

An individual TRICARE authorized provider meeting the requirements specified in [paragraph 5.2](#) who provides supervisory oversight of EIA Tutors.

### **4.4. EIA Tutor**

An individual who meets the requirements specified in [paragraph 5.3](#) and delivers EIA services to TRICARE beneficiaries under the supervision of an EIA Supervisor. EIA Tutors work one-on-one with children in accordance with the BP and gather behavioral data necessary for the EIA Supervisor to evaluate the effectiveness of the BP. An EIA Tutor may not conduct behavioral evaluations, establish a child's BP, or submit claims for services provided to TRICARE beneficiaries.

### **4.5. Specialized ASD Provider**

A TRICARE authorized provider who is a:

- Physician board-certified or board-eligible in behavioral developmental pediatrics, neurodevelopmental pediatrics, pediatric neurology or child psychiatry; or
- Ph.D. clinical psychologist working primarily with children.

**5.0. EIA PROVIDER REQUIREMENTS**

**5.1. ACSPs shall:**

**5.1.1.** Submit evidence to the Managed Care Support Contractor (MCSC) that professional liability insurance in the amounts of one million dollars per claim and three million dollars in aggregate, unless State requirements specify greater amounts, is maintained in the ACSP's name.

**5.1.2.** Submit claims to the appropriate MCSC using the assigned Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes specified in [paragraph 9.0](#).

**5.1.3.** Submit to the MCSC all documents necessary to support an application for designation as a TRICARE ACSP; and

**5.1.4.** Enter into a Participation Agreement (Addendum A) approved by the Director, TRICARE Management Activity (TMA) or designee; and

**5.1.5.** Employ directly or contract with EIA Supervisors and/or EIA Tutors; and

**5.1.6.** Certify that all EIA Supervisors and EIA Tutors employed by or contracted with the ACSP meet the education, training, experience, competency, supervision and Demonstration requirements specified herein; and

**5.1.7.** Comply with all applicable organizational and individual licensing or certification requirements that are extant in the State, county, municipality, or other political jurisdiction in which EIA services are provided under the Demonstration; and

**5.1.8.** Maintain employment or contractual documentation in accordance with applicable Federal, State, and local requirements and corporate policies regarding EIA Supervisors and EIA Tutors; and

**5.1.9.** Comply with all applicable requirements of the Government designated utilization and clinical quality management organization for the geographic area in which the ACSP provides EIA services; and

**5.1.10.** Comply with all other requirements applicable to TRICARE-authorized providers.

**5.2. EIA Supervisor shall:**

**5.2.1.** Have a current, unrestricted State-issued license to provide ABA services; or

**5.2.2.** Have a current, unrestricted State-issued certificate as a provider of ABA services; or

**5.2.3.** Have a current certification from the BACB (<http://www.bacb.com>) as either a BCBA or a BCaBA where such state-issued license or certification is not available; and

- 5.2.4.** Enter into a Participation Agreement (Addendum A) approved by the Director, TMA or designee; and
- 5.2.5.** Employ directly or contract with EIA Tutors; and
- 5.2.6.** Report to the MCSC within 30 days of notification of a BACB sanction issued to the EIA Supervisor for violation of BACB disciplinary standards ([http://www.bacb.com/pages/prof\\_standards.html](http://www.bacb.com/pages/prof_standards.html)) or notification of loss of BACB certification. Loss of BACB certification shall result in termination of the Participation Agreement with the EIA Supervisor with an effective date of such notification. Termination of the Participation Agreement by the MCSC may be appealed to the TMA in accordance with the requirements of [Chapter 14](#) and
- 5.2.7.** Ensure that the quality of the services provided by EIA Tutors meet the minimum evidence-based standards as indicated by the current BACB Task List, the BACB Professional Disciplinary Standards, the BACB Guidelines for Responsible Conduct for Behavior Analysts, and current BACB rules and regulations; and
- 5.2.8.** Maintain all applicable business licenses and employment or contractual documentation in accordance with Federal, State, and local requirements and the EIA Supervisor's business policies regarding EIA Tutors; and
- 5.2.9.** Meet all applicable requirements of the states in which they provide EIA services, including those of states in which they provide remote supervision of EIA Tutors and oversee EIA services provided where the beneficiary resides; and
- 5.2.10.** Cooperate fully with a designated utilization and clinical quality management organization which has a contract with the DoD for the geographic area in which the provider does business; and
- 5.2.11.** Comply with all other applicable requirements to TRICARE-authorized providers.
- 5.3.** EIA Tutor:
- 5.3.1.** Prior to providing EIA services under the Demonstration, shall have completed 40 hours of classroom training in ABA techniques in accordance with the BACB Guidelines for Responsible Conduct for Behavior Analysts (<http://www.bacb.com>), undergone a criminal background check as specified in [paragraph 5.4.3.](#); and
- Completed a minimum of 12 semester hours of college coursework in psychology, education, social work, behavioral sciences, human development or related fields and be currently enrolled in a course of study leading to an associate's or bachelor's degree by an accredited college or university; or
  - Completed a minimum of 48 semester hours of college courses in an accredited college or university; or

- A High School diploma or GED equivalent and have completed 500 hours of employment providing ABA services as verified by the ACSP.

**5.3.2.** Receive no less than two hours direct supervision per month from the EIA Supervisor with each beneficiary the Tutor provides services to and in accordance with the BACB Guidelines for Responsible Conduct for Behavior Analysts. Remote supervision through the use of real time methods is authorized. For the purpose of this paragraph, “real-time” is defined as the simultaneous “live” audio and video interaction between the Supervisor and the Tutor by electronic means such that the occurrence is the same as if the individuals were in the physical presence of each other. Such is usually done by electronic transmission over the internet.

#### **5.4. Provider Background Review**

**5.4.1.** The MCSC shall obtain a Criminal History Review, as specified in [Chapter 4, Section 1, paragraph 10.0.](#), for ACSPs who are individual providers with whom the MCSC enters into a Participation Agreement.

**5.4.2.** ACSPs, other than those specified in [paragraph 5.4.1.](#), shall:

**5.4.2.1.** Obtain a Criminal History Review of EIA Supervisors whom the ACSP employs directly or with whom the ACSP enters into a contract.

**5.4.2.2.** Obtain a Criminal Background Check of EIA Tutors whom the ACSP employs directly or with whom the ACSP enters into a contract.

**5.4.3.** The EIA Supervisor shall obtain a Criminal Background Check of EIA Tutors the Supervisor employs directly or with whom the Supervisor enters into a contract to supervise the EIA Tutor. The Criminal Background Check of EIA Tutors shall:

**5.4.3.1.** Include current Federal, State, and County Criminal and Sex Offender reports for all locations the EIA Tutor has resided or worked during the previous 10 years; and

**5.4.3.2.** Be completed prior to the EIA Tutor providing services to TRICARE beneficiaries.

#### **6.0. BENEFICIARY ELIGIBILITY REQUIREMENTS**

**6.1.** TRICARE beneficiaries who request participation in the Demonstration shall:

**6.1.1.** Be at least 18 months of age; and

**6.1.2.** Be registered in the ECHO; and

**6.1.3.** Have been diagnosed with an ASD specified in [paragraph 3.2.](#) by a TRICARE-authorized PCP or Specialized ASD Provider; and

**6.1.4.** Provide the MCSC with the beneficiary’s IFSP or the IEP documenting that the beneficiary is receiving Early Intervention Services or Special Education and that adequate EIA services are not available through the IDEA.

**NOTE:** If the child is home schooled or enrolled in a private school and not required by State law to have an IEP, the child's PCP or Specialized ASD Provider must certify to the MCSC that the child requires participation in the Demonstration.

**6.2.** Eligibility for benefits under the Demonstration ceases as of 12:01 a.m. of the day after:

- The Demonstration ends; or
- Eligibility for the ECHO program ends.

**6.3.** Absence of eligibility for the Demonstration does not preclude beneficiaries from receiving otherwise allowable services under ECHO or the TRICARE Basic program.

## **7.0. BP REQUIREMENTS**

The initial BP, the EPR, and updated BP shall be developed by the ACSP directing the delivery of EIA services and shall include the name/title/address of the preparer and the elements specified in paragraphs 7.1. through 7.3. to the extent applicable.

**7.1.** The initial BP shall include:

**7.1.1.** The beneficiary's name, date of birth, date the Functional Behavioral Assessment and Analysis was completed, sponsor's Social Security Number (SSN), name of the referring provider, background and history, goals and objectives, parental training, summary and recommendations.

**7.1.2.** Background and history shall include:

**7.1.2.1.** Information that clearly demonstrates the beneficiary's condition, diagnosis, and family history; and

**7.1.2.2.** How long the beneficiary has been receiving EIA services; and

**7.1.2.3.** Identification of any services or therapies being received through community resources (e.g., state waiver programs, Medicaid, services available through a Regional or Community Center); and

**7.1.2.4.** How the ACSP will coordinate EIA services with available community services; and

**7.1.3.** Goals and objectives of the EIA services shall include:

**7.1.3.1.** A detailed description of the targeted skills and behaviors that will be addressed through the EIA sessions and the objectives that will be measured, which may include:

- Communication skills
- Mental health issues
- Vocational skills

- Adaptive skills
- Motor skills
- Academic skills
- Cognitive skills
- Developmental skills
- Behavior skills
- Social skills
- Medical and quasi-medical issues

**7.1.3.2.** Administration of any diagnostic tests that will assess skill acquisition or behavior modification; and

**7.1.3.3.** The frequency and method of assessing the beneficiary's progress towards achieving the goals and objectives.

**7.1.4.** Parental training shall be included in the BP. Parental training shall be provided while billable EIA services are being provided to the beneficiary. The BP shall include a detailed plan that specifies how parents will be trained to:

**7.1.4.1.** Implement and reinforce skills and behaviors; and

**7.1.4.2.** Receive support to implement strategies within a specified setting.

**7.1.5.** Summary and recommendations of the BP shall include the extent of parent/caregiver involvement that will be expected to support the plan.

**7.1.6.** The initial BP shall be reviewed and updated by the ACSP at six-month intervals and submitted to the MCSC for review and authorization of EIA services.

**7.2.** The EPR shall include:

**7.2.1.** Beneficiary's name, date of birth, inclusive dates of the evaluation period, sponsor's SSN, name of the referring provider; and

**7.2.2.** A summary of the child's progress; and

**7.2.3.** A summary of the child's challenges to meet the goals and objectives; and

**7.2.4.** A summary of parent/caregiver participation in implementing the BP during the evaluation period.

**7.2.5.** Recommendations for continued EIA services.

**7.3.** The updated BP shall include:

**7.3.1.** The data elements specified in [paragraph 7.1.](#); and

**7.3.2.** The dates of the plan being updated; and

**7.3.3.** The number of EIA hours of services to be provided each month by the EIA Supervisor and the EIA Tutor.

**7.4.** The ACSP shall provide an information copy of the BP, the EPR, and the updated BP to the beneficiary's PCP or ASD Specialized provider, within 10 calendar days of completion.

## **8.0. POLICY**

**8.1.** Under the Demonstration, TRICARE will reimburse ACSP's only for EIA services that meet the minimum standards established by the current BACB Task List, the BACB Professional Disciplinary Standards, the BACB Guidelines for Responsible Conduct for Behavior Analysts, and current BACB rules and regulations when rendered by providers who meet all applicable requirements specified herein.

**8.2.** All EIA services under this Demonstration require prior written authorization by the Director, TMA or designee.

**8.3.** The following are eligible for reimbursement under the Demonstration:

**8.3.1.** Evaluation of a beneficiary using the Functional Behavioral Assessment and Analysis.

**8.3.2.** Development of the initial BP, the EPR, and the updated BP.

**8.3.3.** EIA services rendered directly to a TRICARE beneficiary on a one-on-one basis. Group EIA sessions are not a TRICARE benefit.

**8.3.4.** EIA services rendered jointly, in-person, during directly supervised fieldwork of the EIA Tutor by the EIA Supervisor. Only the services provided by the Supervisor will be reimbursed as specified in [paragraph 9.1](#).

**8.3.5.** Quarterly, in-person meetings between the EIA Supervisor and the beneficiary's primary caregivers.

**8.4.** The allowed cost of services provided by this demonstration on or after October 14, 2008 accrue to the government's maximum fiscal year share of providing benefits in accordance with the TRICARE Policy Manual (TPM) [Chapter 9](#), (except ECHO Home Health Care (EHC)), of \$36,000.

## **9.0. REIMBURSEMENT**

**9.1.** Claims for Demonstration services will be submitted by the ACSP on a Centers for Medicare and Medicaid (CMS) 1500 (08/05) as follows:

**9.1.1.** Functional Behavioral Assessment and Analysis.

**9.1.1.1.** During the first month the beneficiary is enrolled in the Demonstration, the ACSP will be authorized and reimbursed by the MCSC for not more than four hours for conducting the initial Functional Behavioral Assessment and Analysis and establishing the initial BP.

**9.1.1.2.** The Functional Behavioral Assessment and Analysis and initial BP will be invoiced using HCPCS code "S5108, Home care training to home care client, per 15 minutes."

**9.1.1.3.** Reimbursement for the Functional Behavioral Assessment and Analysis includes the intellectual work and diagnostic evaluation required to establish the initial BP.

**9.1.1.4.** Reassessment of established Demonstration participants will be conducted as part of the ACSP's routine supervision services and is not separately reimbursable.

**9.1.2.** EIA Services rendered jointly by an EIA Supervisor and an EIA Tutor, in-person, during directly supervised fieldwork of the Tutor by the Supervisor, will be invoiced using HCPCS code "S5108, Home care training to home care client, per 15 minutes."

**9.1.3.** EIA services provided directly by an EIA Tutor will be invoiced using HCPCS code "H2019, Therapeutic behavioral services, per 15 minutes."

**9.1.4.** Development of the required EPR and updated BP will be invoiced using CPT<sup>1</sup> code 99080, "Special reports such as insurance forms, more than the information conveyed in the usual medical communications or standard reporting form."

**9.1.5.** Conducting the required quarterly progress meetings with the TRICARE beneficiary's caregivers will be invoiced using CPT<sup>1</sup> code 90887, "Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible person, or advising them how to assist patient."

**9.2.** Reimbursement of claims in accordance with [paragraphs 9.1.1.](#) through [9.1.5.](#) will be the lesser of:

- The CHAMPUS Maximum Allowable Charge (CMAC); or
- \$125 per hour for services provided by the EIA Supervisor and \$50 per hour for services provided by the EIA Tutor; or
- The negotiated rate; or
- The billed charge.

## **10.0. REQUIRED REPORTS**

**10.1.** MCSCs shall submit the following aggregated reports:

### **10.1.1. Monthly**

**10.1.1.1.** The number and percent of total participating beneficiaries by sex, age group (18 months-3 years, 4-6 years, 7-10 years, over 10 years), and sponsor's branch of Service.

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**10.1.1.2.** The number of beneficiaries qualifying for the demonstration, by State, who were not receiving EIA services as of the end of that month due to lack of EIA Supervisors or EIA Tutors.

**10.1.1.3.** The “rolling-total” number of hours paid through the demonstration for EIA services provided in accordance with [paragraphs 9.1.2.](#) and [9.1.3.](#) per beneficiary.

**10.1.2. Quarterly**

**10.1.2.1.** The number of EIA Supervisors and EIA Tutors, by State.

**10.1.2.2.** The number of EIA Supervisors with 0-4, 5-9, 10-14, 15-19, and 20 or more EIA Tutors, by State.

**10.1.2.3.** The number of, and the reasons why beneficiaries seeking participation in the Demonstration do not meet eligibility criteria, by State.

**10.1.3. Semi-Annual**

**10.1.3.1.** The name and SSN of the sponsor of each beneficiary who received services under the Demonstration; including the total number of the sponsor’s dependents who received or are receiving EIA Services under the Demonstration.

**10.1.3.2.** Number and percentage of compliance audits, as specified in [paragraph 11.5.](#), that resulted in an outcome of “Fail”.

**10.2. Report Requirements**

**10.2.1.** Reports of EIA services provided per beneficiary are based on the Date of Service (DOS) regardless of the date claims for such services are processed.

**10.2.2.** Monthly reporting periods cover the first day of the month through the end of the month.

- The first monthly report covers the period August 1 through August 31, 2008.

**10.2.3.** Quarterly and semi-annual reporting periods are based on the fiscal year.

- The first quarterly report covers the period July 1 through September 30, 2008.
- The first semi-annual report covers the period March 1 through September 30, 2008.

**10.2.4.** Reports shall be submitted in Microsoft Excel format by the 15th calendar day of the month following the end of the reporting period via the government’s Performance Assessment Tracking (PAT) system.

## 11.0. ADDITIONAL MCSC RESPONSIBILITIES

The MCSC shall:

11.1. Consider and advise beneficiaries of the availability of community based or funded programs and services, when authorizing Demonstration benefits.

11.2. Maintain all documents related to the Demonstration in accordance with [Chapter 2](#).

11.3. Forward to the "gaining" MCSC all Demonstration related documents within 10 calendar days of being notified that a beneficiary is transferring to a location under the jurisdiction of another MCSC.

11.4. Review the beneficiary's BP prior to authorizing Demonstration services.

**NOTE:** The Functional Behavioral Assessment and Analysis specified in [paragraph 9.1.1](#) will be authorized by the MCSC prior to development of the BP.

11.5. Conduct annual audits on at least 20% of each ACSP's EIA Tutors for compliance with the requirements specified in [paragraph 5.3](#). Upon determining non-compliance with one or more EIA Tutor qualification requirements, the MCSC will immediately initiate a compliance audit of all EIA Tutors employed by or contracted with that ACSP.

## 12.0. APPLICABILITY

12.1. This Demonstration is limited to TRICARE beneficiaries who meet the requirements specified in [paragraph 6.0](#).

12.2. This Demonstration is limited to the 50 United States and the District of Columbia.

12.3. All provisions of the ECHO program apply to the Demonstration unless specifically modified by the Federal Register Demonstration Notice (72 FR 68130, December 4, 2007) or by this Section.

## 13.0. EXCLUSIONS

TRICARE will not cost-share:

13.1. Training of EIA Tutors as specified in [paragraph 5.3.1](#).

13.2. Charges for program development, administrative services, and the assessment required for developing the EPR and updating the BP.

13.3. More than one Enhanced Access to Autism Services Demonstration service provided to the same beneficiary during the same time period, such as is the case of the supervision of the Tutor specified in [paragraph 5.3.2](#).

13.4. Training of parents specified in [paragraph 7.1.4](#).

**14.0. EFFECTIVE DATE**

This Demonstration is effective for claims for services provided in accordance with this Section during the period March 15, 2008 through March 14, 2012.

## WEB-BASED TRICARE ASSISTANCE PROGRAM (TRIAP) DEMONSTRATION

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### 1.0. PURPOSE

The purpose of this demonstration is to test the use of web-based technologies to get information and Employee-Assistance Program (EAP)-like Behavioral Health (BH) services to our beneficiaries to determine if it increases the effectiveness and efficiency of identifying those who need medically necessary mental health care and in identifying their medical mental health needs earlier and in getting them referred or getting them access to the appropriate level of mental health care more effectively. We are also interested in learning if providing this level of care reduces a later need for mental health care. In addition, this will enable the Department of Defense (DoD) to determine whether:

- The availability to provide web-based EAP-like counseling is a valid mechanism to improve access in rural or underserved areas.
- There is acceptance and use of this delivery system by eligible beneficiaries.
- It is feasible to offer this service on a permanent basis.

### 2.0. AUTHORITY

**2.1.** Section 1092, Chapter 55, Title 10 of the United States Code (USC) allows the Secretary of Defense to conduct studies and demonstration projects. This section also specifies that the Secretary may enter into contracts with public or private organizations to conduct these studies and demonstrations.

**2.2.** In the House Report 2638 DoD Appropriations Act for Fiscal Year (FY) 2009 Joint Explanatory Statement (p.405), Congress stated: "An area of particular interest is the provision of appropriate and accessible counseling of service members and their families who live in locations that are not close to Military Treatment Facilities (MTFs), other Military Health System (MHS) facilities or TRICARE providers. Web-based delivery of counseling has significant potential to offer counseling to personnel who otherwise might not be able to access it. Therefore, the Department is directed to establish and use a web-based Clinical Mental Health Services Program as a way to deliver critical clinical mental health services to service members and their families in rural areas." The ability to provide web-based TRICARE Assistance Program (TRIAP) services is a valid mechanism to augment the basic TRICARE mental health benefit to provide short-term counseling options.

### 3.0. BACKGROUND

**3.1.** The DoD currently provides a robust program of mental health care for our Active Duty Service Members (ADSMs) and their families. In addition, the Department offers

Military One Source which provides multiple, currently 12, face-to-face BH non-medical counseling sessions for each issue faced by a beneficiary. For those needing medical treatment, BH care is provided in MTFs or through the TRICARE program.

**3.2.** The Managed Care Support Contractors (MCSCs) currently provide an array of text and multi-media based educational materials targeting pre-deployment, deployment, and post-deployment adjustment concerns. They also have BH Provider Locator and Appointment Assistant Centers staffed with licensed counselors, or beneficiary service representatives and customer service representatives to provide first and second level support, triage, and make appropriate BH referrals and locate providers for beneficiaries. This demonstration project will expand access to on-line contact options including web-based e-mail and video-conferencing to those eligible as indicated in this section to provide TRIAP services which are not otherwise covered as TRICARE authorized medically necessary mental health services.

#### **4.0. DEFINITIONS**

**4.1.** Interactive Telecommunications System. Interactive telecommunications systems are defined as multimedia communications equipment that includes, at a minimum, audio-video equipment permitting two-way, real time service or consultation involving the beneficiary and counselor as appropriate to the BH needs of the patient. Telephone services excluded by [32 CFR 199.4\(g\)\(52\)](#) do not meet the definition of interactive telecommunications services.

**4.2.** TRIAP Counseling. The DoD goal for professional, web-based assistance services is to provide ADSMs and their families, TRICARE Reserve Select (TRS) enrollees, and Transitional Assistance Management Program (TAMP) beneficiaries with an avenue for private, non-reportable discussion of personal life issues such as family difficulties and pressures, crisis intervention, anxiety, and self-esteem on a one-to-one basis in the context of a confidential relationship with a licensed professional.

**4.3.** TRIAP Services. Private, non-reportable discussions of personal life issues such as dealing with relationships, crisis intervention, stress management, family issues, parent-child communications, family separations, anxiety, and self-esteem on a one-to-one basis in the context of a confidential relationship with a licensed professional.

#### **5.0. POLICY**

**5.1.** TRIAP services will be provided to ADSMs and their spouses of any age, and their family members 18 years of age or older, and those beneficiaries enrolled in TRS and TAMP 18 years of age or older. A full range of private, confidential, counseling services via the web, including on-line video chat to address current and emerging needs.

**5.2.** Generally, the TRIAP services will support ADSMs and their families, TRS enrollees, and TAMP beneficiaries as it:

- Makes expert short term, TRIAP services available on demand.
- Helps cope with normal reactions to abnormal/adverse situations.

- Assesses and delivers short-term, solution-focused counseling for situations resulting from commonly occurring life circumstances such as deployment stress, relationships, personal loss, and parent-child communications.
- Provides an avenue for private, non-reportable discussion of personal life issues such as family difficulties and pressures, crisis intervention, anxiety, self-esteem, loneliness, and critical life decisions on a one-on-one basis in the context of a confidential relationship.

## **6.0. MINIMUM REQUIREMENTS FOR DELIVERY OF TRIAP SERVICES**

**6.1.** If the beneficiary requests assistance services during the initial contact, the contractor shall determine the appropriate level of care required and direct the beneficiary accordingly. If appropriate and the beneficiary possesses the required hardware and software, video assistance services is an option that can be offered. However, the beneficiary must also be offered the alternative of face-to-face care if it is available. If video assistance services are not possible or not appropriate for the beneficiary's needs, referrals for care outside this demonstration to the MTF or network providers can be made (with appropriate authorization). Additionally, referrals can be made to Military One Source for telephonic or face-to-face counseling. If the provider determines that additional TRIAP services are necessary, the first follow-up session will be scheduled within three days of the initial intervention.

**6.2.** The contractor shall establish protocols and procedures for assessment, referral, and record keeping of beneficiaries in need of assistance services.

**6.3.** All employees, contractors, and subcontractors who will have access to beneficiary information will be advised of the confidential nature of the information, that the records are subject to the requirements of the Privacy Act of 1974, and to the extent applicable the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and that unauthorized disclosures of beneficiary information may result in the imposition of possible criminal penalties.

**6.4.** Contractor shall establish and maintain a record keeping system that is designed to protect the ADSM or family members' and others privacy and confidentiality, as appropriate and required for specific services. Although this TRIAP service is private and confidential, the contractor must keep utilization records which document that confidential and private services have been provided to Service members, their families, and others eligible for the Demonstration. The counselor must explain to the Service member, family member, or other that the personal identification information will be held in strictest confidence by the contractor. The contractor shall post the details of each contact on the record keeping system within three business days of the contact.

**6.5.** The contractor shall capture selective beneficiary contact and demographic information, to include ensuring that beneficiaries meet eligibility criteria, while ensuring beneficiary confidentiality, in a database and provide monthly reports detailing assistance services that includes at a minimum, the information necessary to provide monthly reports outlined in [paragraph 14.0](#).

**6.6.** The contractor shall maintain procedures for responding to Emergency, Urgent, and Non-Urgent calls. These procedures shall include an immediate response for Emergency situations, access to mental health counseling outside of this demonstration within one business day for Urgent calls, and access to web-based TRIAP services within three business days for Non-Urgent calls if the services cannot be provided immediately.

**6.7.** The contractor shall maintain a counseling model and process flow for triage purposes to determine if TRIAP services are appropriate.

## **7.0. GENERAL**

**7.1.** There are no referral and authorization requirements for web-based TRIAP services. TRICARE beneficiaries who are eligible for the Demonstration may access this care using Personal Computers (PCs). Current referral rules apply to medically necessary TRICARE authorized mental health care.

**7.2.** Web-based TRIAP services are available 24 hours a day, seven days a week.

**7.3.** Web-based interaction such as e-mails, online video chat, or video IM for TRIAP services is not limited to a certain number of interactions. E-mail may be used to make appointments for assistance services, if needed.

## **8.0. FUNDING**

This demonstration will be reimbursed using administrative funds. There are no claims to be filed.

## **9.0. AUTHORIZED PROVIDERS**

**9.1.** Web-based TRIAP services may be provided by mental health clinicians who are licensed and authorized to provide these web-based services. State laws must be complied with. In addition to TRICARE-authorized providers, counselors providing web-based TRIAP services could include independently licensed masters prepared clinicians, including, but not limited to, licensed psychotherapists, marriage and family counselors and licensed professional counselors.

**9.2.** The contractor will ensure that those providing counseling have knowledge of military family programs and knowledge of the unique cultural aspects of the military lifestyle.

## **10.0. ELIGIBILITY**

**10.1.** This demonstration is available to ADSMs, ADSM's spouses of any age, their family members 18 years of age or older, those enrolled in TRS, and TAMP beneficiaries. All must reside in the Continental United States (CONUS).

**10.2.** In the event that a beneficiary Outside the Continental United States (OCONUS) accesses TRIAP services, TRIAP personnel should encourage the beneficiary to utilize other outlets for similar counseling that have the ability for more immediate follow-up or

intervention if necessary. This includes military treatment facilities, combat stress control units, and supervisors/commanders. Military One Source services are available in both CONUS and OCONUS and are a viable referral option. If the TRIAP counselor believes that the ADSM is at-risk of any of the circumstances in which a DoD issuance requires health care providers to notify an ADSM's commander, the counselor shall obtain as much information as possible regarding the individual, Branch of Service, unit, a contact/call-back number, their location (as precisely as possible), closest MTF (if known) and command information. The TRIAP counselor shall then contact the ADSM's commander (or the commander's designee for receiving protected health information) and inform the commander or designee about the at-risk individual, in order to ensure he or she receives appropriate counseling/care. The circumstances triggering this requirement include but are not limited to serious risk of causing harm to oneself or others. The currently applicable DoD issuances are DoD 6025.18-R, C7.11.1 and Directive-Type Memorandum (DTM) 09-006, "Revising Command Notification Requirements to Dispel Stigma in Providing Mental Health Care to Military Personnel," July 2, 2009. The requirements of this DTM will be incorporated in DoD 6025.18-R or its successor issuance. In the event the counselor cannot obtain enough information to contact the ADSM's commander, the counselor shall then contact the appropriate Service Operations Center (Army Operations Center, Air Force Watch, Navy Watch Center, Coast Guard Operations Center, or Marine Corps Operations Center) for assistance. The Service Operations Center contact numbers are unclassified but sensitive and will be provided by the Contracting Officer's Representative (COR).

**10.3.** In the event reservists who lose TRICARE eligibility or are not enrolled in TRS access TRIAP services, TRIAP personnel should encourage the reservist to utilize other outlets for counseling such as community resources or the Veterans Administration if eligible.

## **11.0. MCSC RESPONSIBILITY**

**11.1.** An assessment made by a licensed professional at the BH Care Provider Locator and Appointment Assistance or Customer Service Staff to determine if web-based professional TRIAP services are appropriate for the beneficiary. If it is, the BH contact center will determine if the beneficiary has the necessary software and hardware (the most currently available technology that meets the requirements of this Demonstration) to support web-based care. If that is the case, the BH Care Provider Locator and Appointment Assistance or Customer Service Staff will instruct the beneficiary on accessing web-based counseling.

**11.2.** Referral to an appropriate level of care if the beneficiary does not have the necessary hardware or software, or requires care beyond the scope of this Demonstration. This level of care may include a MTF, or a TRICARE network or authorized provider.

**11.3.** A virtual resource library of electronic documents related to BH/mental health concerns, to include but not limited to suicide prevention, post-traumatic stress disorder, and depression.

**11.4.** A secure, web-based e-mail, online video chat and IM capability.

**11.5.** When a call is received from an ADSM, the TRIAP counselor shall ask if the caller is on the Personnel Reliability Program (PRP). The purpose of the PRP is to ensure that each person who performs duties involving nuclear weapons meets the reliability standards of the

PRP. Each person assigned to PRP duties is responsible for their reliability and is required to report any behavior or circumstance about themselves or others in the PRP that may be expected to result in degradation in job performance or personal reliability or an unsafe or insecure condition involving nuclear weapons and/or Nuclear Command and Control (NC2) material. If the member responds that he/she is on the PRP, the TRIAP counselor shall read the following statement reminding the member of his or her obligation to self-report any information that could be Potentially Disqualifying Information (PDI) before providing any counseling services.

“As a Personnel Reliability Program (PRP) certified or administrative qualified individual, you are personally responsible for advising your Certifying Official or supervisor of any factors that could have an adverse impact on your performance, reliability, or safety while you are performing PRP duties. This includes factors that impact your physical and mental wellness, your dependability, your personal financial circumstances, or other legal concerns. When you receive any type of medical/dental treatment or evaluation, to include mental health or family related counseling, you are personally responsible for reporting the treatment or evaluation to your Certifying Official and for providing appropriate documentation concerning the treatment or evaluation to the competent medical authority (CMA) at your military treatment facility responsible for consulting with the certifying official on this matter. Failure to make these notifications or to provide the appropriate documentation may cast doubt on your reliability and may violate the provisions of DoD Regulation 5210.42. If you have any questions regarding these requirements you should consult with your Certifying Official for more information.”

**11.6.** The TRIAP counselor shall document that the statement was read or that it could not be read for any reason including the person hanging up.

## **12.0. TRICARE MANAGEMENT ACTIVITY (TMA) RESPONSIBILITY**

An independent evaluation of the demonstration will be conducted. It will be performed retrospectively and use a combination of administrative and survey measures of BH care access to provide analyses and comment on the effectiveness of the demonstration in meeting this goal of improving beneficiary access to BH call centers by incorporating web-based technology.

## **13.0. EFFECTIVE DATE**

This demonstration project will be effective for services on or after August 1, 2009. The demonstration project will continue until March 31, 2012.

## **14.0. MONTHLY REPORTS**

By the 10th of each month, the contractor shall capture and report all service member, family member, TRS enrollee contacts by military service and installation, to include Guard and Reserve member affiliation. Specifically, the Duty Status, Rank, Installation and

Branch of Service of counseling participants, if applicable, type of counseling, number of sessions, and stratified by beneficiary category, rank and service. The type of counseling will be reported using **Diagnostic And Statistical Manual Of Mental Disorders, Fourth Edition** (DSM-IV-TR) "V" codes and descriptions. "V" codes shall not be used for reimbursement purposes.

**15.0. EXCLUSIONS**

Medical treatment including medication management and psychoanalysis.



## TRICARE SOUTH REGION UNITED STATES COAST GUARD (USCG) ACCESS TO CARE (ATC) DEMONSTRATION FOR TRICARE PRIME/TRICARE PRIME REMOTE (TPR) BENEFICIARIES

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### 1.0. PURPOSE

The purpose of the demonstration project is to determine if the elimination of the requirement to obtain a referral influences beneficiaries to seek care at less intensive health care resources such as a TRICARE authorized Urgent Care Center (UCC), rather than the Emergency Room (ER).

### 2.0. BACKGROUND

**2.1.** Access to primary health care for acute episodic primary care continues to be in high demand by TRICARE Prime beneficiaries. The TRICARE manual guidance and process by which Prime beneficiaries currently access primary health care is defined under the [32 CFR 199.17](#) and the TRICARE Policy Manual (TPM), [Chapter 1, Section 9.1](#). The current law and regulations require that Prime beneficiaries obtain a referral for primary or urgent care if they seek that care from someone other than their Primary Care Manager (PCM). As a result, when an enrollee needs urgent care after hours or when the PCM in the Military Treatment Facility (MTF) does not have available appointments they have been seeking care from civilian sources such as the ER or with a UCC, including Convenience Clinics (CCs).

**2.2.** In an effort to avoid over use of ER care and meet the demand for acute primary care, many facilities have expanded acute care hours within the MTFs or worked with the Managed Care Support Contractors (MCSCs) to utilize provider groups or UCCs in their network. However, these visits require an authorization. Seeking emergency care in an ER does not require authorization. Additionally, the cost of care in a civilian ER for non-emergent reasons is much higher than any other source of care.

### 3.0. POLICY AND ELIGIBILITY

**3.1.** Under this demonstration, the USCG Active Duty Service Members (ADSMs) and their family members enrolled in TRICARE Prime or TPR in the TRICARE South Region may access a TRICARE network or TRICARE authorized UCC without prior authorization for up to four urgent care visits per fiscal year, per individual, including services provided when the enrollee is out of the area, without incurring the usual Point of Service (POS) deductibles and cost-shares. Referral requirements for specialty care and inpatient authorizations shall remain as currently required by [Chapter 8, Section 5](#).

**3.2.** The contractor shall educate the ADSM USCG members and their family members to notify their PCM of any urgent/acute care visits outside the PCM within 24 hours of the visit

**TRICARE OPERATIONS MANUAL 6010.51-M, AUGUST 1, 2002**

CHAPTER 20, **SECTION 11**

TRICARE SOUTH REGION UNITED STATES COAST GUARD (USCG) ACCESS TO CARE (ATC)  
DEMONSTRATION FOR TRICARE PRIME/TRICARE PRIME REMOTE (TPR) BENEFICIARIES

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or the first business day following the visit and schedule follow-up treatment, if indicated, with their PCM.

**3.3.** If more than four visits allowed under the demonstration are used or if the active duty USCG member or their enrolled family members seek care from a non-network provider (other than a TRICARE authorized UCC), the usual POS deductible and cost-shares shall apply with the usual POS exceptions, which include:

- ADSMs;
- Newborns and adopted children during the first 60 days (120 days if overseas) after birth or adoption, emergency care, clinical preventive services from a network provider;
- The first eight outpatient Behavioral Health Care (BHC) visits to a network provider per fiscal year (October 1st - September 30th); and
- Beneficiaries with Other Health Insurance (OHI).

**4.0. GENERAL DESCRIPTION OF ADMINISTRATIVE PROCESS**

**4.1.** Referral (authorization) requirements for up to four urgent care visits per fiscal year, per individual, shall be waived for all TRICARE South Region USCG Prime enrolled ADSMs and Active Duty Family Members (ADFM) when services are rendered by a TRICARE network or TRICARE authorized UCC with the following primary specialty designations:

- Family Practice;
- Internal Medicine;
- General Practice;
- Pediatrician; and
- UCC or CC.

**NOTE:** In accordance with TPM, [Chapter 1, Section 9.1](#), Obstetricians/Gynecologists (OB/GYNs), Physician Assistants (PAs), Nurse Practitioners (NPs), and Certified Nurse Midwives (CNMs) can be considered Primary Care Providers (PCPs) and may be designated PCMs too.

**4.2.** All claims shall be vouchered and paid as prescribed by policy for underwritten and non-underwritten care.

**5.0. ASSISTANT SECRETARY OF DEFENSE (HEALTH AFFAIRS) (ASD(HA)) AND TRICARE MANAGEMENT ACTIVITY (TMA) RESPONSIBILITIES**

ASD(HA) is the designated Executive Agent for the demonstration project. The Medical Director of the TRICARE Regional Office-South (TRO-S) will be designated as the project officer for the demonstration.

**6.0. MANAGED CARE SUPPORT CONTRACTOR (MCSC) RESPONSIBILITIES**

**6.1.** The contractor shall verify the TRICARE eligibility of the patient on the Defense Enrollment Eligibility Reporting System (DEERS).

**6.2.** The contractor shall maintain sufficient staffing and management support services necessary to achieve and maintain compliance with all quantitative and qualitative standards for claims processing timeliness, claims inventory levels, claims control, and claims accuracy as required within the TRICARE manuals.

**6.3.** The contractor shall provide the Government (TRO-S) with the following monthly report:

- Data specific report (Branch of Service and Defense Medical Information System (DMIS)) of applicable cost summary by first service date that shows enrollment inpatient cost data, outpatient cost data (Per Member Per Month (PMPM)) and totals for 12 month running similar to Report # ZUHMCOIOR being currently provided to the Government by the TRO-S MCSC.

**7.0. APPLICABILITY**

This demonstration is limited to USCG ADSMs and their family members enrolled in TRICARE Prime and TPR in the 10 states that comprise TRICARE South Region.

**8.0. EXCLUSIONS**

This demonstration does not apply to referral requirements for specialty care and inpatient authorizations shall remain as currently required by [Chapter 8, Section 5](#).

**9.0. EFFECTIVE DATE**

This demonstration is effective for claims for services provided in accordance with this section for a 24 month period from the implementation date.



PARTICIPATION AGREEMENT FOR *AUTISM DEMONSTRATION*  
CORPORATE SERVICES PROVIDER (*ACSP*)

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\_\_\_\_\_  
NAME OF *ACSP*

\_\_\_\_\_  
*A*DDRESS:

\_\_\_\_\_  
TELEPHONE

\_\_\_\_\_  
*TAX IDENTIFICATION NUMBER OR SOCIAL SECURITY NUMBER (SSN)*

**ARTICLE 1**

**RECITALS**

**1.1 IDENTIFICATION OF PARTIES**

This Autism Demonstration Corporate Services Provider (ACSP) Participation Agreement ("Participation Agreement") is between the United States of America through the TRICARE Management Activity (TMA), a field activity of the Office of the Assistant Secretary of Defense (Health Affairs) OASD(HA) and \_\_\_\_\_, doing business as \_\_\_\_\_ (hereinafter "ACSP").

**1.2 AUTHORITY FOR ACSPs AS TRICARE-AUTHORIZED PROVIDERS**

The authority to designate ACSPs as authorized TRICARE providers resides with the Department of Defense (DoD) Demonstration authority under 10 U.S.C. 1092. This authority ceases upon termination of the Enhanced Access to Autism Services Demonstration Project ("Demonstration") as determined by the Director, TMA or designee.

**1.3 PURPOSE OF PARTICIPATION AGREEMENT**

The purpose of this Participation Agreement is to:

(a) Establish the undersigned ACSP as an authorized provider of Educational Interventions for Autism Spectrum Disorders (EIA) services;

(b) Establish the terms and conditions that the undersigned ACSP must meet to be an authorized provider under the Demonstration.

**ARTICLE 2**

**REFERENCES**

**2.1 REQUIREMENTS**

By reference, the requirements set forth in the TRICARE Operations Manual (TOM), [Chapter 20, Section 9](#), are incorporated into this Participation Agreement and shall have the same force and effect as if fully set out herein.

**2.2 GENERAL AGREEMENT**

The undersigned ACSP agrees to render appropriate EIA services to eligible beneficiaries as specified in the TOM, [Chapter 20, Section 9](#).

**TRICARE OPERATIONS MANUAL 6010.51-M, AUGUST 1, 2002**

CHAPTER 20, ADDENDUM A

**PARTICIPATION AGREEMENT FOR AUTISM DEMONSTRATION CORPORATE SERVICES PROVIDER (ACSP)**

**ARTICLE 3**

**REIMBURSEMENT**

**3.1** Claims for Demonstration services will be submitted on a Centers for Medicare and Medicaid Services (CMS) 1500 (08/05) by the ACSP in accordance with the TOM, *Chapter 20, Section 9, paragraph 9.0*.

**3.2** The ACSP shall:

(a) Submit claims to the appropriate TRICARE Managed Care Support Contractor in accordance with *paragraph 3.1* and the TOM, *Chapter 20, Section 9*; and

(b) Collect the monthly Sponsor cost-share specified in the TRICARE Policy Manual (TPM), *Chapter 9, Section 16.1*; and

(c) Not bill the sponsor/beneficiary for:

(1) Services for which the provider is entitled to TRICARE reimbursement;  
and

(2) Services that are denied due to provider non-compliance with all applicable requirements in the TOM, *Chapter 20, Section 9*.

**ARTICLE 4**

**TERM, TERMINATION, AND AMENDMENT**

**4.1 TERM**

The term of this agreement shall begin on the date this agreement is signed and shall continue in effect until terminated or superseded as specified herein.

**4.2 TERMINATION OF AGREEMENT BY TMA**

(a) The Director, TMA or designee, may terminate this agreement upon written notice, for cause, if the ACSP is found not to be in compliance with the provisions set forth in *32 CFR 199.6*, or is determined to be subject to the administrative remedies involving fraud, abuse, or conflict of interest as set forth in *32 CFR 199.9*. Such written notice of termination shall be an initial determination for purposes of the appeal procedures set forth in *32 CFR 199.10*.

(b) In addition, the Director, TMA or designee, may terminate this agreement without cause by giving the ACSP written notice not less than 45 days prior to the effective date of such termination.

**4.3 TERMINATION OF AGREEMENT BY THE ACSP**

The ACSP may terminate this agreement by giving the Director, TMA or designee, written notice not less than 45 days prior to the effective date of such termination. Effective the date of termination, the ACSP will cease being a TRICARE-authorized provider of Demonstration services. Subsequent to termination, an ACSP may be reinstated as a TRICARE-authorized provider of Demonstration services only by entering into a new Participation Agreement.

**4.4 AMENDMENT BY TMA**

(c) The Director, TMA or designee, may amend the terms of this Participation Agreement by giving 120 days notice in writing of the proposed amendment(s) except when necessary to amend this agreement from time to time to incorporate changes to 32 CFR 199. When changes or modifications to this agreement result from changes to 32 CFR 199 through rulemaking procedures, the Director, TMA or designee, is not required to give 120 days written notice. Any such changes to 32 CFR 199 shall automatically be incorporated herein on the date the regulation amendment is effective.

(b) An ACSP who does not accept the proposed amendment(s), including any amendment resulting from changes to 32 CFR 199 accomplished through rulemaking procedures, may terminate its participation as provided for in this Article. However, if the ACSP notice of intent to terminate its participation is not given at least 30 days prior to the effective date of the proposed amendment(s), the proposed amendment(s) shall be incorporated into this agreement for services furnished by the ACSP between the effective date of the amendment(s) and the effective date of termination of this agreement.

**ARTICLE 5**

**EFFECTIVE DATE**

**5.1 DATE SIGNED**

This Participation Agreement is effective on the date signed by the Director, TMA or designee.

**TMA**

**ACSP**

\_\_\_\_\_  
By: Typed Name and Title

\_\_\_\_\_  
By: Typed Name and Title

Executed on \_\_\_\_\_, 20\_\_