Extended Care Health Option (ECHO)

for medical and behavioral health diagnosis and ECHO Home Health Care (EHHC)

General information about ECHO

The TRICARE Extended Care Health Option (ECHO) is available to **active duty family members** who have severe physical or moderate to severe mental disabilities. All services or benefits under the basic TRICARE program are excluded from ECHO. A determination that a beneficiary is not eligible for ECHO is considered a factual determination based on a requirement of the law or regulation and as such is not appealable.

Eligibility criteria

- Available only to Active Duty Family Members (ADFMs) who have a qualifying condition
- To be eligible you **must** register for TRICARE ECHO and enroll in your sponsor's service branch's Exceptional Family Member Program (EFMP)
- Qualifying conditions include:
  - Moderate or severe mental retardation
  - A serious physical disability
  - An extraordinary physical or psychological condition of such complexity that the beneficiary is homebound

Cost-sharing

E-1 – E-5	$25	**O-5**	$65
E-6	$30	**O-6**	$75
E-7 and O-1	$35	**O-7**	$100
E-8 and O-2	$40	**O-8**	$150
E-9, W-1, W-2 and O-3	$45	**O-9**	$200
W-3, W-4 and O-4	$50	**O-10**	$250

- Cost-shares have been set by the government. ECHO requires payment of only one monthly cost-share by the sponsor.
- ECHO Home Health Care (EHHC) benefit is limited to the amount TRICARE will pay annually if the ECHO-eligible beneficiary resided in a Skilled Nursing Facility (SNF).
- EHHC benefits are only available if rendered in the beneficiary's home. The beneficiary must be homebound and require two or more skilled services per eight hour shift/day.
- In no case will payment be made in advance for services not yet rendered.
- Member may request a monthly pro-ration of the ECHO benefit for expensive durable equipment but not for transportation.
- Public facility available services must be used prior to ECHO.

Conditions that could qualify for ECHO for behavioral health disorders

- Mental retardation
- Autistic spectrum disorders

Procedures for obtaining benefits

- Submit:
  - ECHO Enrollment form. The beneficiary's Primary Care Manager (PCM) must complete, sign, and date the back side or second page
  - *Public Facility Use Verification* form (not required for EHHC)
  - Sponsor's branch of service's official EFMP enrollment documentation
- Mail or fax to Humana Military
- If eligibility is confirmed, the sponsor will receive written notification of the ECHO registration and authorizations for ECHO services
- Periodic review and reevaluation will be conducted by a dedicated case manager

Examples of covered services and supplies:

- As a general rule, the services and supplies covered under ECHO are those that contribute to the habilitation and rehabilitation of the handicapped dependent and are not a benefit under basic TRICARE
- Institutional care (primarily for long term residential care in private nonprofit, public or state institutions or facilities, schools for deaf and blind)
- Durable Medical Equipment (DME)
- Home healthcare (**skilled** care and **homebound** status are required)
- Professional services (must be licensed within the jurisdiction in which services are provided)
- Special tutoring (private tutoring to supplement a public education or special education enhancement program is not covered.)
- Training and special education (can not exceed high school level)
- Transportation (covers to and from public or private nonprofit facilities. Carpooling required whenever necessary. Public transportation ticket price is reimbursable)

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Examples of noncovered services:

- Alteration (refers to living space and permanent fixtures to accommodate medical equipment)
- Homemaker, sitter or companion services
- Dental care
- FDA non-approved drugs and medications
- Any care or facility outside the United States
- Meals, motels or tips
- Any service currently provided as a benefit under basic TRICARE program
- Therapeutic absences from an inpatient facility
- Domiciliary care
- Custodial care
- Additional or special charges for excursions
- Services for a beneficiary aged three to 21 that are written in the beneficiary's special education Individual Educational Plan (IEP).

Request for TRICARE benefits under Extended Care Health Option (ECHO) for behavioral health diagnosis and ECHO Home Health Care (EHHC)

Public reporting burden for this collection of information is estimated to average 30 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing the collection of information.

Authority:	32 CFR 199.5
Principal purpose:	To determine eligibility for the ECHO program
Routine uses(s):	To locate and correspond with sponsor, determine appropriateness and cost of care, and issue written approvals and authorize payment of claims.
Disclosure:	Voluntary; however, failure to provide complete information may result in the denial of benefits.

Part I: Instructions to sponsor

- All information on both sides of this form must be completed prior to approval for payment of benefits.
- ECHO benefits are limited to TRICARE-eligible active duty family members with moderate or severe mental retardation or a serious physical disability. Exceptional Family Member Program enrollment is mandatory. Beneficiary must be homebound and require more than two (2) skilled services per eight hour shift in order to receive EHHC benefits. EHHC requires a physician-certified plan of care.
- Under ECHO, the sponsor pays an initial share of the monthly cost according to sponsor's pay grade (see table below); the amount paid by the government will not exceed $36,000 per fiscal year unless the beneficiary is enrolled in EHHC. EHHC is subject to a fiscal year cap.

Sponsor pay grade	Amount per month	Sponsor pay grade	Amount per month	Sponsor pay grade	Amount per month
E-1 through E-5	$25	E-9, O-3, W-1, W-2	$45	O-7	$100
E-6	$30	W-3, W-4 and O-4	$50	O-8	$150
E-7 and O-1	$35	O-5 and W-5	$65	O-9	$200
E-8 and O-2	$40	O-6	$75	O-10	$250

Part II: Sponsor information

Sponsor name (last, first, MI)**:**			
Rank & pay grade:	**Service branch:**	**SSN:**	
Military street address:			
City:		**State:**	**ZIP:**
Military phone:		**Ext:**	
Home street address:			
City:		**State:**	**ZIP:**
Home phone:			

PART III: Patient information

Patient name (last, first, MI)**:**		
DOB (yy/mm/dd)**:**	**Relationship to sponsor** (i.e. son, daughter, spouse)**:**	
Home street address:		
City:	**State:**	**ZIP:**
Home phone:		
Signature of sponsor, patient or legally responsible person:		
Relationship to patient (i.e. mother, father)**:**	**Date** (yy/mm/dd)**:**	

Part IV: Provider information

Brief medical history, diagnosis (use ICD code), present condition and limitations:	
Recommendation/orders:	
Physician's name:	**Phone:**
Physician's signature:	**Date** (yy/mm/dd)**:**
Military phone:	**Ext:**

Fax completed form to:
Humana Military
C/O ECHO/EHHC Program
1-877-200-0401

Public facility use certification

Beneficiary name (last, first, MI)**:**

Sponsor SSN:

Service(s) being requested:

Describe the extent, type, frequency and funding of requested available service (ABA therapy, respite, etc)**:**

Name and title of public official:

Public agency's name:	**Phone:**
Signature of public official:	**Date:**

Fax completed form to:
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