



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

**PERSONNEL AND  
READINESS**

The Honorable John McCain  
Chairman  
Committee on Armed Services  
United States Senate  
Washington, DC 20510

JUN 14 2018

Dear Mr. Chairman:

The enclosed represents the final congressional reporting requirement regarding section 725 of the National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2016 (Public Law 114-92), which requires the Secretary of Defense to provide an annual report on the Pilot Program on Urgent Care under the TRICARE Program.

The pilot was implemented in the Continental United States, Alaska, and Hawaii beginning May 23, 2016. The pilot eliminated the requirement for a referral or prior authorization for up to two urgent care visits per year. Section 704 of the NDAA for FY 2017 (Public Law 114-328), amended section 1077a of title 10, United States Code, which authorized access to urgent care without the need for preauthorization for such services; this change prompted the Director, Defense Health Agency, to change TRICARE policy to allow unlimited self-referred urgent care visits for TRICARE Prime enrollees, other than most Active Duty Service members, with an effective date of January 1, 2018. As part of the January 1, 2018, implementation of section 701 of the NDAA for FY 2017, the purpose of the pilot has been incorporated into the basic TRICARE program. The aforementioned policy change effectively made the pilot obsolete with an end date of December 31, 2017.

This final report to Congress includes urgent care data analysis which fulfills the remaining reporting requirements of section 725 of the NDAA for FY 2016. With caveats, the analysis has identified an increase in urgent care use and a decrease in emergency care use by covered beneficiaries. The data also demonstrates how effective the nurse advice line is in directing beneficiaries to the appropriate level of care (i.e., urgent vs. emergent). Finally, beneficiary surveys reveal beneficiaries are satisfied with the increased access to care under the pilot.

A similar letter is being sent to the Chairman of the Committee on Armed Services of the House of Representatives. Thank you for your interest in the health and well-being of our Service members, veterans, and their families.

Sincerely

A handwritten signature in black ink that reads "Robert L. Wilkie".

Robert L. Wilkie

Enclosure:  
As stated

cc:  
The Honorable Jack Reed  
Ranking Member



PERSONNEL AND  
READINESS

**UNDER SECRETARY OF DEFENSE**  
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The Honorable William M. "Mac" Thornberry  
Chairman  
Committee on Armed Services  
U.S. House of Representatives  
Washington, DC 20515

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Robert L. Wilkie

Enclosure:  
As stated

cc:  
The Honorable Adam Smith  
Ranking Member



**Response to Section 725 of the National Defense Authorization Act  
for Fiscal Year 2016 (Public Law 114-92)**

**Report to Congress**



**Evaluation of the Pilot Program on Urgent Care under the  
TRICARE Program**

The estimated cost of this report or study for the Department of Defense (DoD) is approximately \$303,000 in Fiscal Years 2017 - 2018. This includes \$296,000 in expenses and \$6,700 in DoD labor.

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**June 2018**

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## Executive Summary

This report represents the final report required by section 725 of the National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2016 (Public Law 114–92). Section 725 required the Department of Defense (DoD) to carry out an urgent care pilot program for a period of three years. Beginning May 23, 2016, the pilot program started in the United States and eliminated the need for an urgent care (UC) referral for up to two visits per FY for eligible covered beneficiaries.<sup>1</sup> The pilot encouraged the use of the Nurse Advice Line (NAL) to guide enrollees to the most appropriate level of health care. However, section 704 of the NDAA for FY 2017, amended section 1077a of title 10, United States Code, which authorized access to urgent care without the need for preauthorization for such services; this change prompted the Director, Defense Health Agency (DHA), to change TRICARE policy. As of January 1, 2018, the UC benefit has been expanded to allow unlimited self-referred UC visits for the covered beneficiary population.<sup>2</sup> As part of the implementation of section 701 of the NDAA for FY 2017, the purpose of the pilot has been incorporated into the basic TRICARE program. The pilot program has been terminated. This report includes UC data analysis, which fulfills the remaining reporting requirements of section 725 of the NDAA for FY 2016. This will be the last report related to the UC pilot program.

This report provides UC data analysis based on the NDAA reporting requirements. The initial analysis has identified preliminary changes in UC and emergency department (ED) use by covered beneficiaries. Within private sector care (PSC), UC encounter volume rose by 13 percent from FY 2016 to FY 2017, and ED encounter volume fell by 6 percent during the same time period. Furthermore, total PSC UC non-pharmaceutical costs rose 33 percent from FY 2016 to FY 2017, although PSC UC costs per visit remained significantly lower than PSC ED costs per visit; however, these changes cannot be attributed solely to the pilot and its associated benefit.<sup>3</sup>

The data in this report also demonstrate the positive impact of the NAL in directing covered beneficiaries to the appropriate care setting. For example, of the callers who intended to visit an ED facility, 72 percent were directed to less resource-intensive care centers. Additionally, data analysis shows that more than 98 percent of covered beneficiaries used two or fewer UC visits during the first sixteen months of the pilot. Beneficiary surveys reveal that 92 percent of beneficiaries who participated in the pilot are satisfied with the increased access to care under the pilot.

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<sup>1</sup> Covered beneficiaries in this report refer to beneficiaries covered by the UC benefit in the United States; this is all MTF and MCSC Prime Enrollees, excluding Active Duty, and Guard/Reserve on Active Duty. Some Active Duty Service members enrolled in TRICARE Prime Remote are eligible for this benefit, but these beneficiaries account for .1 percent of the total population.

<sup>2</sup> Section 704 of the NDAA for FY 2017, implemented by the Interim Final Rule (199.17(n)(2)(iii)(B)) authorizes the Director to establish the TRICARE Prime referral requirement for urgent care visits. TRICARE policy (Chapter 8, Section 5) was changed to allow unlimited self-referred urgent care visits for covered beneficiaries with an effective date of January 1, 2018. The aforementioned policy change effectively made this pilot obsolete with an end date of January 1, 2018.

<sup>3</sup> On average, private sector care emergency department costs \$362.77 (\$456.51 versus \$93.74) more than private sector care urgent care per visit.

## Background

Health care services acquired in ED are significantly more expensive than services which can be provided in UC. If a beneficiary's condition or symptoms require resources that can only be provided in an ED, higher costs are expected and appropriate; however, there are many ED visits in which the beneficiary's condition is less severe and could be appropriately addressed in UC. These ED visits create unnecessary costs, as ED resources are disproportionate to the magnitude of treatment required for the given symptoms and illness.

Overall costs incurred by the Military Health System (MHS) may be reduced through policy measures that encourage covered beneficiaries to obtain care in the settings most appropriate to their conditions.<sup>4</sup> Previously, covered beneficiaries had to obtain referrals from their primary care managers to visit PSC UC, but referrals were not required for ED visits. As a result, a number of patients were deterred from visiting UC, and consequently visited the ED, despite less severe symptoms or illness. There is a reasonable expectation that a policy which allows covered beneficiaries direct access to PSC UC will greatly improve access, patient satisfaction, and provide significant cost-saving implications (i.e., a portion of patients currently treated at EDs would instead be appropriately treated in UC if they are not required to first obtain a referral).<sup>5,6</sup>

Section 725 of the NDAA for FY 2016 (Public Law 114–92), required the DoD to implement an UC pilot to assess the impact of removing the requirement for a PSC UC referral for up to two visits annually. In addition, the NAL must be incorporated into the pilot, but cannot be a prerequisite for the self-referral of UC visits. This pilot program began on May 23, 2016, and its purpose is to determine if the elimination of the requirement to obtain a referral for PSC UC, along with the use of the NAL, will improve access to care. It also promotes a more efficient utilization of resources and enables service care providers to offer covered beneficiaries care of the utmost quality.

This initiative also aligns with recent trends within the civilian sector; civilian UC facilities have been steadily expanding at an estimated rate of 300 facilities per year through 2017.<sup>7</sup> The proliferation of UC facilities is indicative of a number of obstacles to obtaining health care that can be ameliorated. Many patients choose UC over primary care because it is faster than obtaining a primary care appointment.<sup>8</sup> Thus, physicians and investors alike are capitalizing on the growing demand for more UC facilities to enable quick and convenient care.

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<sup>4</sup> Covered beneficiaries in this report refer to beneficiaries covered by the UC benefit in the United States; this is all MTF and MCSC Prime Enrollees, excluding Active Duty, and Guard/Reserve on Active Duty. Some Active Duty Service members enrolled in TRICARE Prime Remote are eligible for this benefit, but these beneficiaries account for .1 percent of the total population.

<sup>5</sup> A Deloitte Consulting LLP study was conducted on 2015 NHIS data and concluded that, of ED visitors, 41 percent cited lack of another place to go as reason for their ED visit.

<sup>6</sup> According to a Deloitte Consulting LLP study, analysis suggests that the ED visit rates are lower in regions with higher UC facility concentration. Study based on ER visits data from the American Heart Association, and UC facility locations at zip-code level from the Urgent Care Association of America.

<sup>7</sup> "About Urgent Care." Urgent Care Association of America. <http://www.ucaoa.org/mpage/services>.

<sup>8</sup> Our Urgent Care Patient Experience Survey results indicate that 69 percent of UC patients chose UC because it was faster than finding an appointment with their primary care provider.

Section 725 of NDAA for FY 2016 also requires a total of three reports related to the UC pilot and measurement of several outcome metrics; this is the final of those reports. More recently, section 704 of the NDAA for FY 2017 (Public Law 114–328), implemented by the Interim Final Rule (199.17(n)(2)(iii)(B)), authorized covered beneficiaries to access UC facilities without the need for preauthorization. As of January 1, 2018, the UC benefit has been expanded to allow unlimited self-referred PSC UC visits for the covered beneficiary population. Because of this expansion, the pilot program has been terminated, and this will be the last report related to the UC pilot program. Moving forward, the same metrics will continue to be monitored internally to ensure a comprehensive understanding of the impact of the benefit’s full implementation.

## Methodology

In order to accurately evaluate the relevant data associated with NDAA reporting requirements, data was compiled for covered beneficiary visits in UC and ED in FY 2015, FY 2016, and FY 2017. A number of variables were monitored to assist in the analysis process. These variables include: the month in which the visit occurred, whether the visit occurred at a military treatment facility (MTF) or in PSC, the enrollment site of the beneficiary, the catchment area of the beneficiary, the age group of the beneficiary, the gender of the beneficiary, beneficiary category, and the full cost of the visit. This data was utilized to address the following information requirements put forth by Congress:

- A. *An analysis of UC use by covered beneficiaries in MTFs and the TRICARE purchased care provider network*

Covered beneficiary volume is attained from MHS databases.<sup>9</sup> These data are then used to populate the following volume statistics: beneficiaries enrolled to the MTF versus the Managed Care Support Contractor (MCSC), and PSC versus direct care (DC).<sup>10</sup> In conjunction with enrollee totals, volume statistics are then used to calculate utilization numbers. Utilization numbers are derived by dividing the number of visits by the number of covered beneficiaries. The utilization rate is then displayed per 1,000 enrollees to normalize the data.

*Utilization per 1000 Enrollees = (Number of Visits / Number of Enrollees) \* 1000.*

- B. *A comparison of UC use by covered beneficiaries to the use by covered beneficiaries of EDs in military MTFs and the TRICARE purchased care provider network, including an analysis of whether the pilot program decreases the inappropriate use of medical care in EDs*

Inappropriate use of medical care in EDs is analyzed first by distinguishing between ED visits. All ED visits are given a specific code that classifies the complexity of care provided at the visit. Of the codes, MHS leadership has designated two to be associated with symptoms that do not warrant an ED visit; an ED visit given one of the two codes could have been appropriately treated in UC, and is referred to as an emergency room recapturable (ERR) visit.<sup>11</sup> ERR visits are disaggregated from overall ED visits in order to document inappropriate use of medical care in EDs.

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<sup>9</sup> Military Health System Management Analysis and Reporting Tool (M2).

<sup>10</sup> MTF Enrollee: Enrollment Site Military Service = A, N, F, P; MCSC Enrollee: Enrollment Site Military Service = M; DC: Treatment took place in DC facility, Source = CAPER; PSC: Treatment took place in a PSC facility, Source = TEDNI.

<sup>11</sup> ERR procedure codes are 99281 and 99282.



*C. A determination of the extent to which the NAL of the Department affected both UC and ED use by TRICARE Prime enrollees in military MTFs and the TRICARE purchased care provider network*

NAL calls are monitored, and results are analyzed to determine the extent to which the NAL impacts both UC and ED use. NAL data is documented from calls, and key variables, such as the caller's chief complaint and age, are documented for further analysis. However, two specific variables provide the primary insight into the impact of the NAL on UC and ED use. In order to assess the true impact, the caller's pre-intent and final disposition are analyzed. The pre-intent captures what the caller would have done, or where he or she would have gone, had he or she not called the NAL. Possible choices include UC, ED, and self-care. The final disposition indicates the patient's decision on type of care or next steps after conversing with the nurse.<sup>12</sup> By examining these two variables, it can be determined to what degree the NAL altered a patient's initial intentions and to what degree the NAL contributed to cost savings and appropriate care by redirecting patients to facilities appropriately suited to their specific circumstances.

*D. An analysis of any cost savings to the Department realized through the pilot program*

Cost savings to the DoD were determined by conducting a net cost calculation, which examines the change in PSC ED costs and PSC UC costs during the time period of the pilot. PSC ED and UC pharmacy costs are also included to provide further context of total costs.<sup>13,14</sup>

*E. A determination of the optimum number of UC visits available to covered beneficiaries without preauthorization*

Using volume data, the number of UC visits per covered beneficiary can be ascertained. This number provides insight into the frequency at which beneficiaries utilize UCs, and assists in determining an appropriate amount of visits that should be available to beneficiaries without requiring preauthorization. Section 704 of the NDAA for FY 2017 expanded the UC benefit to authorize covered beneficiaries to access UC facilities without the need for preauthorization for an unlimited number of visits.

*F. An analysis of the satisfaction of covered beneficiaries within the pilot program*

The satisfaction levels of covered beneficiaries were assessed via a phone survey conducted by Zogby Analytics on behalf of the DoD TRICARE program. Survey respondents were beneficiaries who visited, or had a child who visited, an UC facility.<sup>15</sup> Results are from surveys conducted between July 2016 and September of 2017.

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<sup>12</sup> It is assumed that a patient pursued the type of care they stated they would during the call.

<sup>13</sup> PSC Costs include a 13% increase to account for overhead burdening.

<sup>14</sup> Pharmacy costs based on the source of associated visit, and related to prescriptions filled within one day of an associated UC or ER visit.

<sup>15</sup> The survey script used by TRICARE representatives can be found in Appendix 2.

## Results and Analysis Discussion

### A. *An analysis of UC use by covered beneficiaries in MTFs and the TRICARE purchased care provider network*

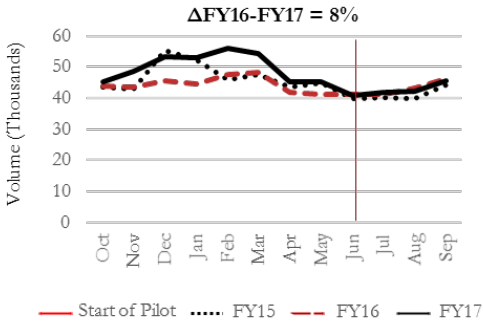
UC statistics have been monitored across FY 2015, FY 2016, and FY 2017. Charts A1, A2, and A3 display the volume (i.e., number of visits) by fiscal month in both DC and PSC sites for covered beneficiaries. The pilot program was implemented on May 23, 2016, and the vertical red line denotes the point at which the pilot was implemented in FY 2016. The FY 2016 figures beyond the vertical line, and all FY 2017 numbers, represent points in time after implementation of the pilot.

UC volume experienced no major fluctuations prior to the pilot's inception. However, volume has changed slightly since the pilot began, with combined DC and PSC UC volume up 8 percent from FY 2016 to FY 2017. This upward trend is driven by the increase in PSC volume. DC UC volume decreased 9 percent from FY 2016 to FY 2017, while PSC UC volume increased 13 percent from FY 2016 to FY 2017.

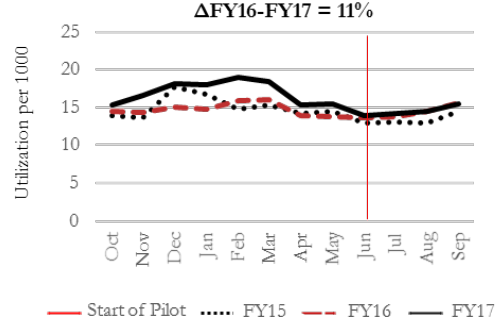
Analyzing the data by fiscal month also helps to account for additional factors that may influence volume figures, such as seasonality effects. It is possible that the number of UC visits fluctuates depending on the time of the year, and post-pilot figures must be compared with pre-pilot figures from the same time of year. As evidenced in Chart A1, there was an increase of UC visits during the winter months of all three years. Most notably, December FY 2015 and February FY 2017 experienced unusually high volume that contributed to increased annual totals.

Extending analysis beyond overall visits, Figures A4, A5, and A6 display the UC utilization (i.e., number of visits per 1,000 enrollees) by fiscal month from FY 2015 to FY 2017 for covered beneficiaries enrolled to both the MTF and the MCSC. There are discernable increases in FY 2017 utilization figures. MTF enrollee and MCSC enrollee utilization increased 9 percent and 15 percent, respectively, from FY 2016 to FY 2017.

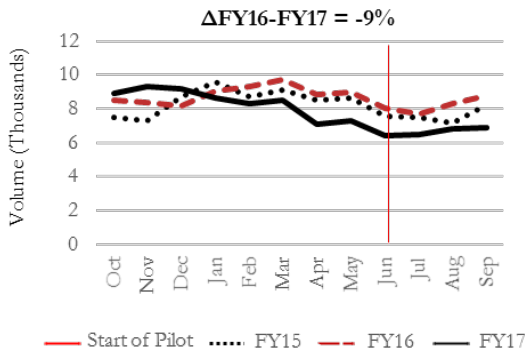
**A1. Combined DC & PSC UC Volume**  
(Covered Beneficiaries)



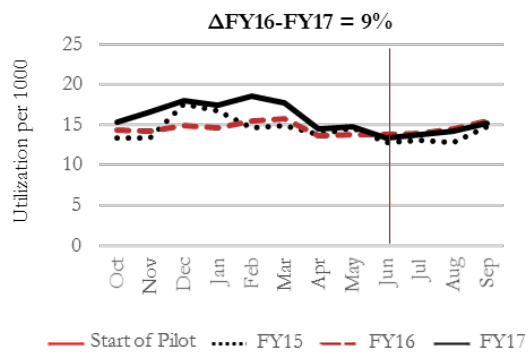
**A4. Combined DC & PSC UC Utilization**  
(Covered Beneficiaries)



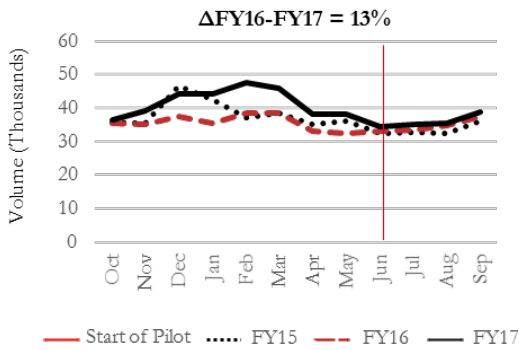
**A2. DC UC Volume**  
(Covered Beneficiaries)



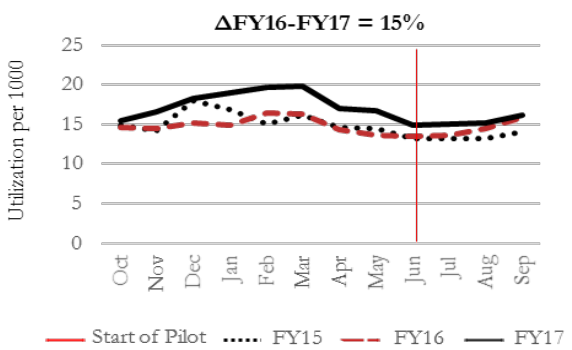
**A5. Combined DC & PSC UC Utilization**  
(MTF Enrollees)



**A3. PSC UC Volume**  
(Covered Beneficiaries)



**A6. Combined DC & PSC Utilization**  
(MCSC Enrollees)



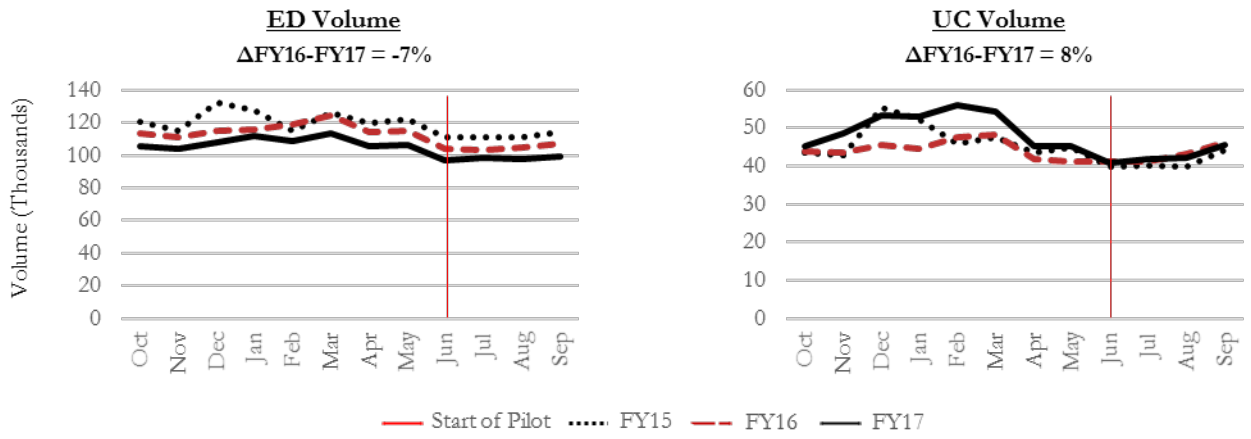
*B. A comparison of UC use by covered beneficiaries to the use by covered beneficiaries of EDs in military MTFs and the TRICARE purchased care provider network, including an analysis of whether the pilot program decreases the inappropriate use of medical care in EDs*

Combined DC and PSC ED volume figures have decreased 7 percent from FY 2016 to FY 2017 (Figure B1), and closer analysis reveals a downward trend was evident in both DC and PSC, independently. DC volume decreased by 9 percent from FY 2016 to FY 2017 (Figure B2), while PSC volume decreased 6 percent from FY 2016 to FY 2017 (Figure B3).

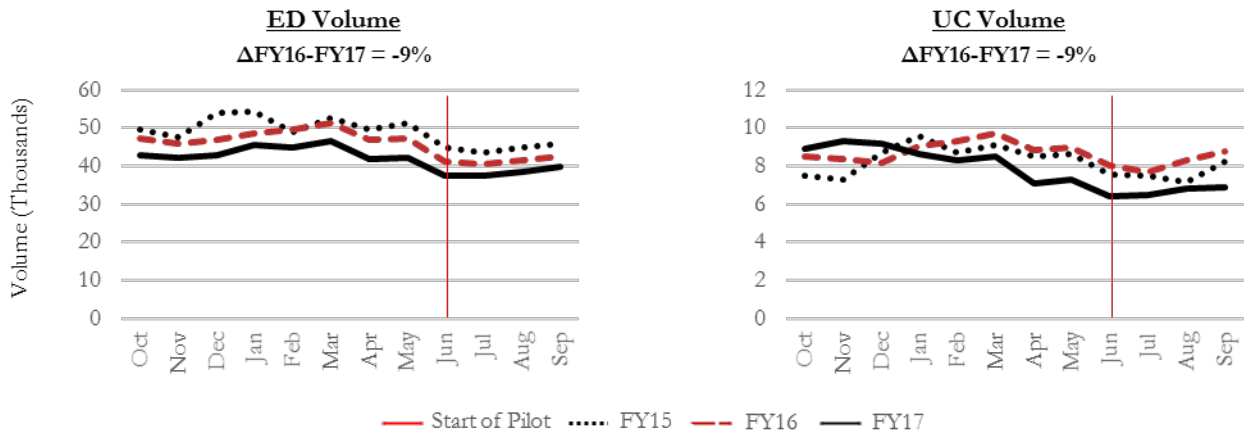
In regard to inappropriate use of medical care in EDs, Figure B4 captures those ED visits which were assigned one of two procedure codes (99281 or 99282), each of which designates that the ED visit could have been appropriately treated at an UC. While the volume within the PSC is extremely low, the volume of ERR visits in DC reveals a precipitous drop following the pilot's implementation. This drop continues throughout FY 2017, with the volume for each month in FY 2017 being lower than its corresponding month in FY 2016.

While this coincidental timing and decrease in ERR visits cannot be attributed entirely to the pilot program, the decrease is an emerging trend in utilization indicative of improving optimization of ED resources likely due, at least in part, to increased access to UC. As time progresses and additional data is attained, ED, ERR, and UC visits will continue to be monitored.

## B1. Combined (DC & PSC) Volume (Covered Beneficiaries)

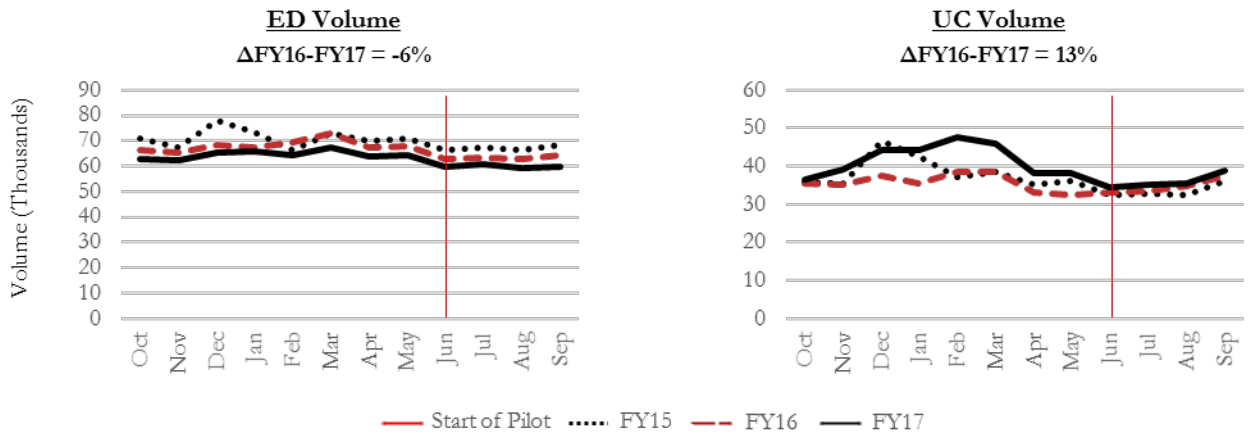


## B2. DC Volume (Covered Beneficiaries)

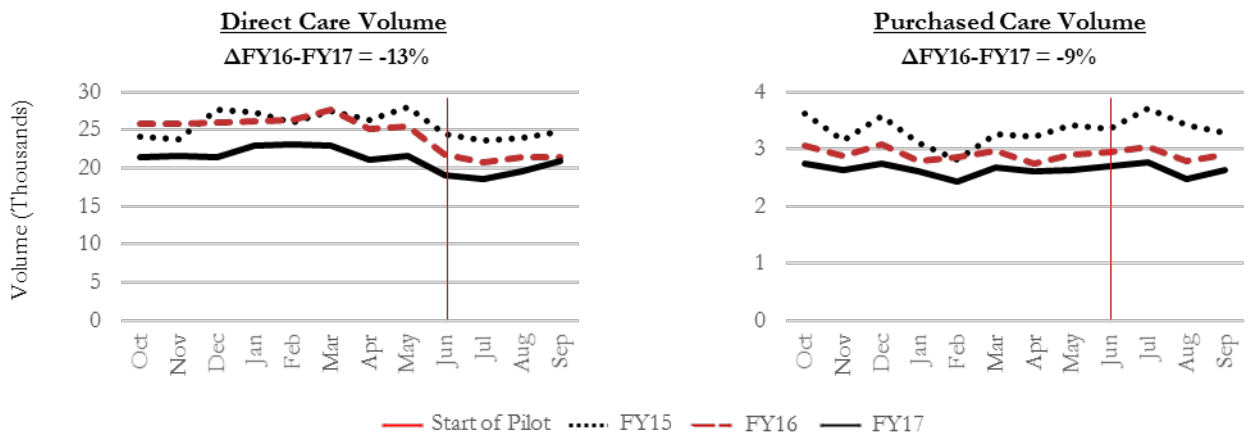




### B3. PSC Volume (Covered Beneficiaries)



### B4. ERR Volume (Covered Beneficiaries)



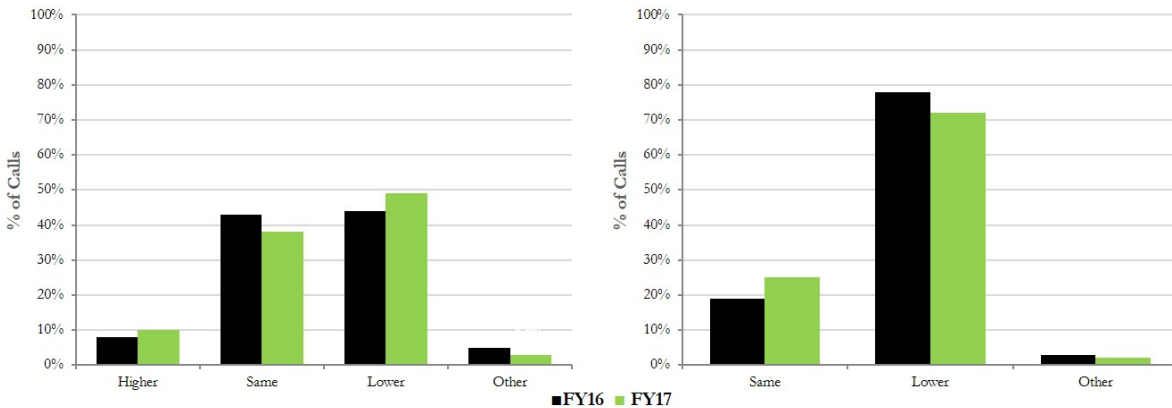
C. A determination of the extent to which the NAL of the Department affected both UC and ED use by TRICARE Prime enrollees in military MTFs and the TRICARE purchased care provider network

Figure C1 depicts the distribution of resulting dispositions for UC pre-intents (left) and ED pre-intents (right) for FY 2016 and FY 2017. The resulting dispositions are categorized as either: “Higher”, “Same”, “Lower”, or “Other”. “Higher” indicates that the covered beneficiary received care that required more resources than that of his or her pre-intent after calling the NAL (e.g., UC to ED). “Same” indicates that the covered beneficiary received care that required equal resources after calling the NAL. “Lower” means the covered beneficiary received care that required fewer resources than that of his or her pre-intent after calling the NAL (e.g., UC to Self-Care). This contextual information is necessary in analyzing a potential cause-and-effect relationship between the NAL and use of either UC or ED.

For callers with the pre-intent of UC in FY 2017, 38 percent received the “Same” intensity of care, while 49 percent received a “Lower” intensity care. Fewer callers in FY 2017 received the “Same” intensity of care than in FY 2016; however, the results are mixed. Two percent more of callers received a “Higher” intensity care while five percent of callers received a “Lower” intensity care. For callers with a pre-intent of ED in FY 2017, 72 percent received a “Lower” intensity of care; this is a slight decrease from 78 percent in FY 2016.

These results suggest that the NAL was effective in redirecting beneficiaries to intensity-appropriate facilities, which could result in potential cost savings; the costs incurred from high intensity care could be reduced if the underlying disposition is addressed by a less resource intensive facility.

**C1. FY 2016–FY 2017 NAL Disposition Distribution**



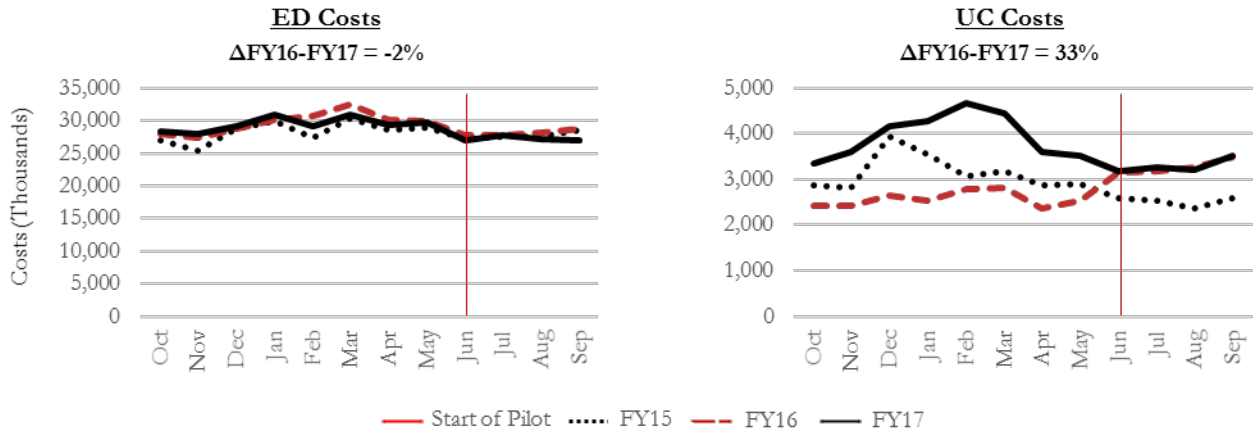
UC Pre-intent Resulting Dispositions	ER Pre-intent Resulting Dispositions
<b>Higher:</b> ED, ED – Network, ED – Non-Network	<b>Higher:</b> N/A
<b>Same:</b> UC – Network, UC/ED – MTF, UC, UC – Non-Network	<b>Same:</b> ED, ED – Network, ED – Non-Network
<b>Lower:</b> Self Care, MTF, UC – Self-referred, PCP, Non-SX, Refused, Referred to PCM, MCSC, PCM	<b>Lower:</b> UC – Network, UC/ED – MTF, UC, UC – Non-Network, Self Care, MTF, UC – Self-referred, PCP, Non-SX, Refused, Referred to PCM, MCSC, PCM
<b>Other:</b> Unknown, NA, Transfer to AC, Reschedule, Cancel	<b>Other:</b> Unknown, NA, Transfer to AC, Reschedule, Cancel

*D. An analysis of any cost savings to the Department realized through the pilot program*

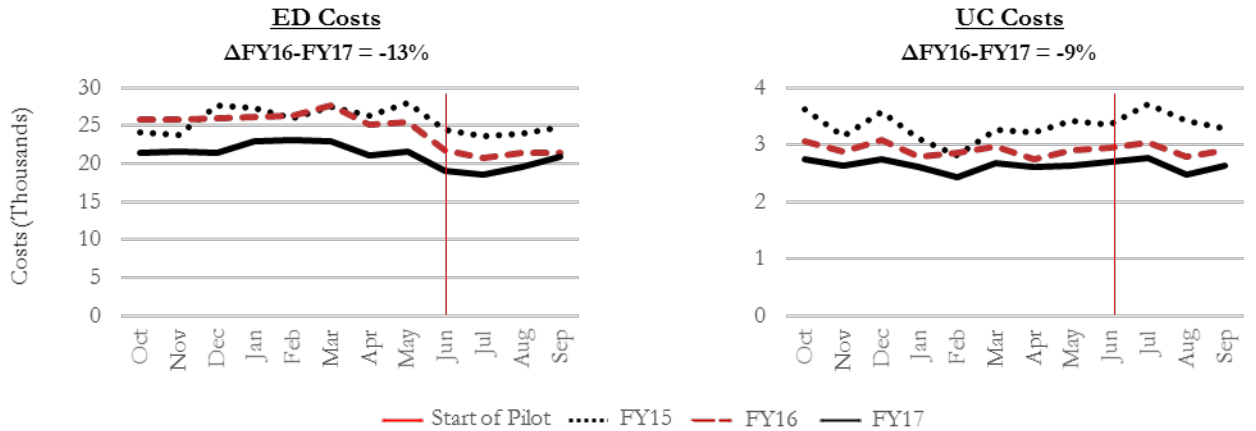
Figures D1 and D2 highlight the cost trends for both ED and UC across PSC and DC, from FY 2015 to FY 2017. Most notably, PSC UC costs increased 33 percent from FY 2016 to FY 2017, due to a large rise in the first half of FY 2017. During the latter half of FY 2017, costs were more closely aligned with corresponding months in FY 2016. While PSC UC costs rose substantially by 33 percent, DC UC costs decreased 9 percent from FY 2016 to FY 2017.

Figure D3 further analyzes the increase in PSC UC costs and compares it with the potential savings of decreased ED costs. While PSC ED costs decreased by approximately \$5.2 million from FY 2016 to FY 2017, PSC UC costs increased by approximately \$11.2 million, leading to a net cost increase of approximately \$7 million. The chart also demonstrates that the cost per visit in PSC UC increased substantially (over 18 percent) between FY 2016 and FY 2017. Despite this increase, PSC UC visits cost roughly 20 percent of the cost of PSC ED visits. Figure D3 also demonstrates that PSC UC pharmacy unit costs decreased approximately 43 percent between FY 2015 and FY 2017.

## D1. Cost Trends of PSC for Covered Beneficiaries



## D2. Cost Trends of DC for Covered Beneficiaries



When interpreting these charts, please note that the vertical axis scales differ.

## D3. FY 2015-FY 2017 UC vs. ED Cost Analysis for Covered Beneficiaries

	FY15	FY16	FY17	$\Delta$ FY15-FY16	$\Delta$ FY16-FY17	$\Delta$ FY15-FY17
<b>VOLUME</b>						
UC	441,385	424,684	478,000	-16,701	53,316	36,615
ED	838,600	798,969	754,880	-39,631	-44,089	-83,720
<b>VISIT COST</b>						
UC	\$35,253,021	\$33,587,248	\$44,808,161	(\$1,665,773)	\$11,220,913	\$9,555,141
ED	\$337,421,816	\$349,841,999	\$344,607,475	\$12,420,183	(\$5,234,525)	\$7,185,658
<b>VISIT UNIT COST</b>						
UC	\$79.87	\$79.09	\$93.74	(\$0.78)	\$14.65	\$13.87
ED	\$402.36	\$437.87	\$456.51	\$35.50	\$18.64	\$54.14
<b>PHARMACY UNIT COST</b>						
UC	\$22.28	\$14.25	\$12.72	(\$8.03)	(\$1.53)	(\$9.56)
ED	\$18.30	\$14.44	\$14.59	(\$3.86)	\$0.15	(\$3.71)

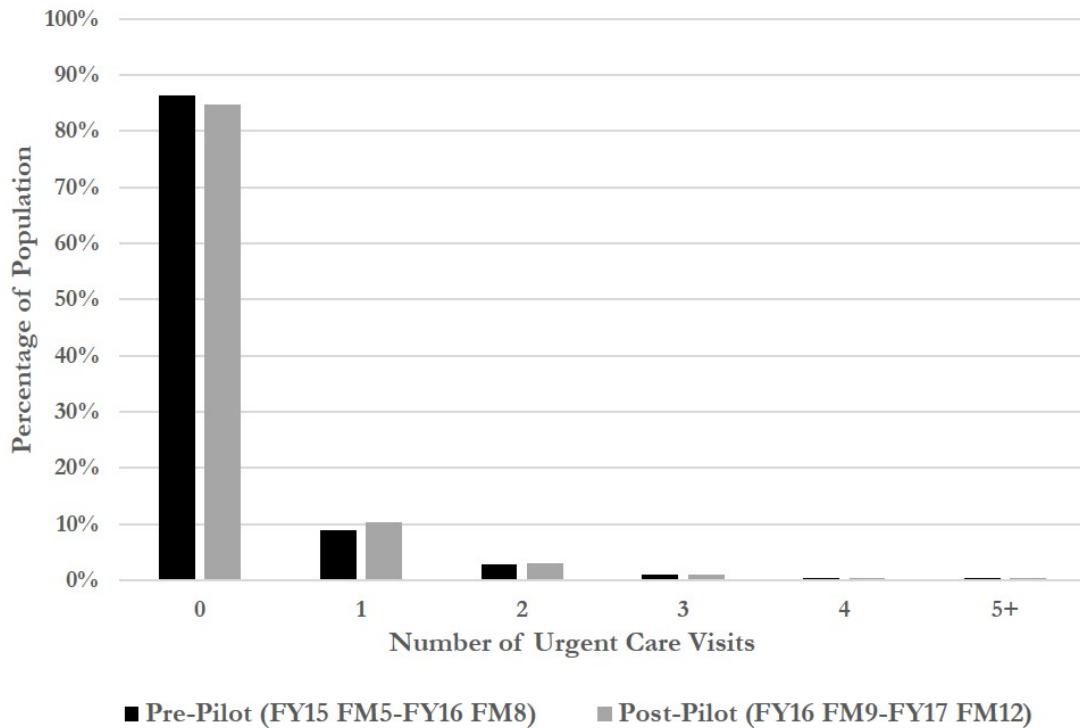
E. *A determination of the optimum number of UC visits available to covered beneficiaries without preauthorization*

Figure E1 shows that over 84 percent of covered beneficiaries did not utilize UC during the immediate 16 months following the pilot's implementation. Furthermore, less than 2 percent of covered beneficiaries visited UC more than two times.

In determining an optimum number of UC visits available to covered beneficiaries without preauthorization, the shape of this distribution is revealing. It appears the vast majority of covered beneficiaries are unlikely to utilize UC more than two times in a given year. This finding is consistent with a previous Coast Guard demonstration that allowed up to four unmonitored UC visits per year; very few patients in that demonstration used two or more visits per year.

Section 704 of the NDAA for FY 2017 authorized covered beneficiaries to access UC facilities without preauthorization. As of January 1, 2018, the UC benefit has been expanded to allow unlimited self-referred PSC UC visits for the covered beneficiary population.

**E1. Pre-Pilot & Post-Pilot Distribution of UC Visits per Covered Beneficiary (DC & PSC)**





*F. An analysis of the satisfaction of covered beneficiaries with the pilot program<sup>16</sup>*

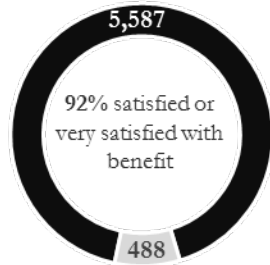
Within the survey, beneficiaries are asked the following: “All things considered, how satisfied are you with this new benefit that allows you to choose an urgent care center without the need of a referral from TRICARE or your primary care manager (PCM)?” In response to this particular question (Chart F1), 92 percent of respondents were either satisfied or very satisfied with the new benefit. These results suggest the overwhelming majority of beneficiaries are, in fact, satisfied with the new benefit.

Additional questions in the survey can provide further insight into covered beneficiaries’ responses to the new benefit and UC services more broadly. When asked if they chose an UC facility because it has convenient hours, 86 percent of respondents agreed or strongly agreed. When asked if they chose an UC facility because it was faster than making an appointment with their PCM, 69 percent of respondents agreed or strongly agreed. When asked if they chose an UC facility because no appointment was necessary, 77 percent of respondents agreed or strongly agreed. Respondents are associating positive attributes with UC, which suggests they would be satisfied with the ability to visit the UC without an authorization because it is convenient; however, Chart F3 shows that most respondents would prefer to see their PCM.

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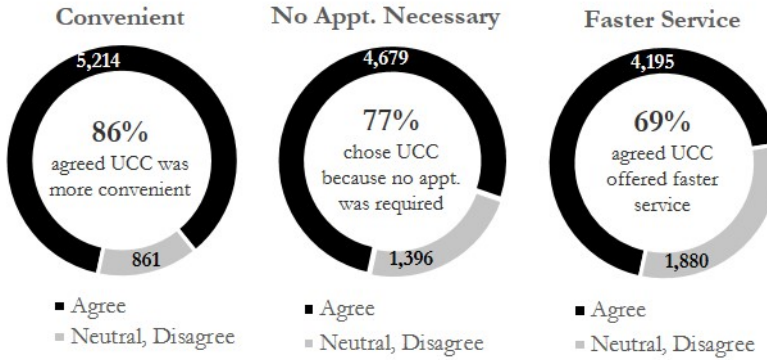
<sup>16</sup> Survey data F1-F3 was aggregated July 2016 to September 2017

**F1. Survey responses to the following question: “All things considered, how satisfied are you with this new benefit that allows you to choose an urgent care center without the need of a referral from TRICARE or your Primary Care Manager (PCM)?”<sup>17</sup>**



■ Very Satisfied or Satisfied  
 ■ Neutral, Dissatisfied

**F2. Motives for UC Visit<sup>18</sup>**

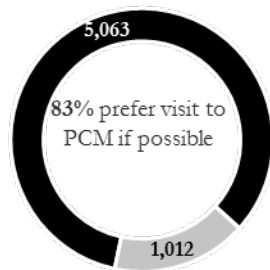


■ Agree  
 ■ Neutral, Disagree

■ Agree  
 ■ Neutral, Disagree

■ Agree  
 ■ Neutral, Disagree

**F3. Primary Care Preference<sup>19</sup>**



■ Prefer PCM   ■ Other

<sup>17</sup> Satisfied = Very Satisfied, Satisfied; Neutral Dissatisfied = Very Dissatisfied, Dissatisfied, Not Sure

<sup>18</sup> Agree = Strongly Agree, Agree; Neutral, Disagree = Strongly Disagree, Disagree, Not Sure

<sup>19</sup> Prefer PCP = Strongly Agree, Agree; Other = Strongly Disagree, Disagree, No Opinion

## **Conclusion**

Since the UC pilot's implementation on May 23, 2016, discernable increases were noted in overall UC volume and costs of 8 percent and 11 percent, respectively, occurred. Upon closer inspection, this upward trend is driven by PSC activity, as DC volume and costs decreased by 9 percent each from FY 2016 to FY 2017. ED volume, utilization, and costs also decreased from FY 2016 to FY 2017. Overall, the cost savings were offset by PSC UC costs, which rose by 33 percent, in part due to increased volume, but also because the cost per visit increased by more than 18 percent. However, PSC UC cost per visit is still significantly lower than ED cost per visit.

The data suggests that the NAL is effective in redirecting covered beneficiaries to a care setting that is most appropriately suited for addressing their symptoms or illness. Specifically, the data demonstrates that, of callers who intended to visit the ED, 72 percent planned to visit a facility that required fewer resources. The data also reveal that, of callers who intended to visit an UC, 10 percent agreed to visit a facility that required more resources, suggesting that they were directed to a facility that could adequately address their symptoms or illnesses.

An analysis of visitation pattern reveals that over 98 percent of covered beneficiaries used two or fewer urgent care visits in FY 2017, and the number of covered beneficiaries who never visited an UC facility dropped by 1.62 percent from pre-pilot to post-pilot. Furthermore, the UC survey indicates very high levels of patient satisfaction with the removal of the policy which required a referral in order to visit an UC facility. This satisfaction aligns with the decision to expand the benefit to allow unlimited self-referred UC visits for the covered beneficiary population as of January 1, 2018.

## Appendix 1: Data Collected

*In order to fully assess the impact of the pilot program and ensuing implications, the following data points are to be compiled to provide a foundation from which to conduct analysis.*

1. Volume: (reported by source, Service affiliation, enrollment, catchment area, plan type, beneficiary category, age group, gender, network vs non-network provider)
  - a. UC Visits – DC and PSC, referred and non-referred
  - b. Primary Care Visits – DC and PSC
  - c. ED Visits – DC and PSC
  - d. ED Recapturable Visits – DC and PSC
  
2. Utilization: (reported by source, Service affiliation, enrollment, catchment area, plan type, beneficiary category, age group, gender, network vs non-network provider)
  - a. UC Visits/1000 enrollees – DC and PSC, referred and non-referred
  - b. Primary Care Visits/1000 enrollees – DC and PSC
  - c. ED Visits/1000 enrollees – DC and PSC
  - d. ERR Visits/1000 enrollees – DC and PSC
  
3. Cost of Care: (reported by source, Service affiliation, enrollment, catchment area, plan type, beneficiary category, age group, gender, network vs non-network provider)
  - a. UC Related Costs, referred and non-referred:
    - i. UC Amount Paid by TRICARE - PSC
    - ii. UC Full Cost - DC
    - iii. UC Cost/1000 enrollees – DC and PSC
    - iv. UC Cost/Visit – DC and PSC
    - v. UC Cost/1000 enrollees – DC and PSC
    - vi. UC Cost/Visit – DC and PSC
  - b. Primary Care Related Costs:
    - i. Primary Care Amount Paid by TRICARE - PSC
    - ii. Primary Care Full Cost - DC
    - iii. Primary Care Cost/1000 enrollees – DC and PSC
    - iv. Primary Care Cost/Visit – DC and PSC
    - v. Primary Care Cost/1000 enrollees – DC and PSC
    - vi. Primary Care Cost/Visit – DC and PSC
  - c. ED Related Costs:
    - i. ED Amount Paid by TRICARE - PSC
    - ii. ED Full Cost - DC
    - iii. ED Cost/1000 enrollees – DC and PSC
    - iv. ED Cost/Visit – DC and PSC
  - d. ERR Related Costs:
    - i. ERR Amount Paid by TRICARE - PSC
    - ii. ERR Full Cost - DC
    - iii. ERR Cost/1000 enrollees – DC and PSC
    - iv. ERR Cost/Visit – DC and PSC
  - e. Pharmacy Related Costs:

- i. UC Pharmacy Costs – DC and PSC
  - ii. Primary Care Pharmacy Costs – DC and PSC
  - iii. ED Pharmacy Costs – DC and PSC
  - iv. ERR Pharmacy Costs – DC and PSC
- 4. NAL Referrals: (reported by intent of caller and disposition of call)
  - a. UC Referrals – DC and PSC
  - b. Primary Care Referrals – DC and PSC
  - c. ED Referrals – DC and PSC
- 5. Patient Satisfaction: (survey response to 8–12 questions, please see Appendix 2)
- 6. Quality: DHA TRICARE Policy and Benefits office is coordinating with the DHA Clinical and Business Operations Directorate to construct appropriate Healthcare Effectiveness Data and Information Set and other measures related to UC.



## Appendix 2: Urgent Care Patient Experience Survey

### INTRODUCTORY SCRIPT:

Hello, I'm \_\_\_\_\_ calling from Zogby Analytics, a research company conducting a survey for the Department of Defense TRICARE Program. May I please speak with (insert name of respondent)?

If yes → Continue to ELIGIBILITY VERIFICATION

If no → “Do you know when (Rank, Mr. or Ms. and Name) will be available?”

- i. If no time is given or they don't know → “Thank you for your time. I will call back later.”
- ii. If a time is given → “Thank you for your time. I will call back then.”
- iii. No such person → Thank you and terminate the interview
- iv. Refused → Thank you and terminate the interview

#### For Interviewer Only

Interviewer code -- Reason the sample member is not available

- Deceased
- Incapacitated
- Deployed and not available
- Temporarily unavailable, such as on vacation or on a business trip
- Relocated, new location unknown
- Incarcerated
- Refused call

Let me assure you that I am not selling anything. The purpose of this survey is to find out more about urgent care services used by TRICARE members. You can help make health services better for future members and their families by answering a few questions. The survey takes less than 10 minutes.

Since we have some questions about your health, I have to tell you that any information you provide is protected under the federal Privacy Act of 1974 and the Health Insurance Portability and Accountability Act of 1996. Answering the questions is voluntary; you may ask to skip any question that you do not want to answer and you can stop at any time. There is no penalty if you choose not to be in the survey; however, we hope that you will participate so that our report will be complete. Your answers will be confidential and any identifying information will be used only by the research team. I have to caution you, however, that if you threaten to harm yourself or others, we are required to notify appropriate authorities for action.

### A: ELIGIBILITY VERIFICATION:

A1. Our records indicate that you (...or your child....) had an urgent care visit at {**URGENT CARE PROVIDER/SITE**} on {**DATE OF VISIT**}. Is this correct?

- Yes → [IF YES, GO TO THE NEXT QUESTION A2]
- No → [IF NO, END SURVEY]
- Don't Know/Refused → [IF DK/REF, END SURVEY]

A2. Approximately what time of day was this visit? (If you don't remember the exact time please estimate to the closest hour

- A  6:01 a.m. – 9:00 a.m. (Early Morning)
- B  9:01 a.m. – 12 Noon (Mid-Morning)
- C  12:01 p.m. – 3:00 p.m. (Early Afternoon)
- D  3:01 p.m. – 6:00 p.m. (Mid Afternoon)
- E  6:01 p.m. - 9:00 p.m. (Early Evening)
- F  9:01 p.m. - Midnight (Evening)
- G  12:01 a.m. – 6:00 a.m. (Night time)

A3. Was this urgent care visit during the regular office hours offered by your primary care provider?

- Yes
- No
- Don't Know

Please answer all remaining questions about the recent visit at {URGENT CARE PROVIDER SITE} on {DATE OF VISIT}. When thinking about your answers, please do not include any other visits.

**B: BEGIN SURVEY:**

B1. Did you or someone else call the TRICARE advice nursing hotline before you sought these urgent care services?

- Yes → [IF YES, GO TO THE NEXT QUESTION B1a]
- No → [IF NO, GO TO QUESTION B2]
- Don't Know/Refused → [IF DK/RF, GO TO QUESTION B2]

B1a. Did the advice nurse instruct you to seek urgent care?

- Yes
- No
- Don't Know/Refused

B2. I am going to read you several statements and I'd like you to tell me whether you strongly agree, agree, disagree, or strongly disagree with each statement. If you don't have an opinion or the statement that I read doesn't apply to you, please just say so. These questions are all related to the urgent care visit that was received on {INSERT APPOINTMENT DATE HERE}.

	Statement	Strongly Agree	Agree	Disagree	Strongly Disagree	Not Sure
B2a	I chose this urgent care clinic because it has convenient hours.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B2b	I chose this urgent care clinic because it has little-to-no co-pay.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B2c	I chose this urgent care clinic because it was faster than making an appointment with my primary care provider.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B2d	I chose this urgent care clinic because no appointment was necessary and I could just walk in for care.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B2e	I chose this urgent care clinic because I trust the provider(s).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B2f	I went to this urgent care clinic because the problem needed the type of care that could only be delivered in this type of facility.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B2g	If an appointment with my regular provider had been available, I would have used it instead of the urgent care clinic.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**READ:** The Department of Defense has recently implemented a pilot program offering a new urgent care benefit under TRICARE. This new benefit provides up to two visits per year at no cost, to any civilian network urgent care center or primary care provider for urgent care. A referral, prior approval or non-availability statements are no longer required for those two urgent care or primary care visits.

B3. Were you aware of the new TRICARE benefit for urgent care visits when you visited the urgent care clinic on **{INSERT APPOINTMENT DATE HERE}**?

- Yes → [IF YES, GO TO QUESTION B4]
- No → [IF NO, GO TO QUESTION B5]
- Don't Know/Refused → [IF DK/REF, GO TO QUESTION B5]

B4. Please indicate the source for your information on the new TRICARE benefit for urgent care visits?

- The TRICARE website
- A Military Treatment Facilities' website
- Regional Contractor (Humana, Health Net, or United Healthcare) website
- TRICARE Service Center
- Military hospital health benefit advisor
- Spouse or Family Member
- Other military beneficiaries
- TRICARE Nurse Advice Line
- Through social medial (Facebook, twitter, etc.)
- Received an e-mail
- Through print media (poster, mailer, newsletter, formal letter)
- Other medical/hospital staff (doctor, nurse, social worker, etc.)
- Other (specify: \_\_\_\_\_)

B5. All things considered, how satisfied are you with this new benefit that allows you to choose an urgent care center without the need of a referral from TRICARE or your PCM?

- Very dissatisfied → [IF YES, GO TO QUESTION B5a]
- Dissatisfied → [IF YES, GO TO QUESTION B5a]
- Satisfied
- Very satisfied
- No Opinion

B5a. Could you please state the reason why you are dissatisfied with this new benefit?

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### **Appendix 3: Definition of Urgent Care**

1. Per TOM Chapter 8 Section 5, para. 1.4, urgent care is defined as...“Urgent care services are medically necessary services required for an illness or injury that would not result in further disability or death if not treated immediately, but does require professional attention within 24 hours.”
2. Data definition:
  - a. Referral (authorization) requirements for up to two urgent care visits per fiscal year, per individual, shall be waived for all ADFMs who are enrolled in TRICARE Prime or retirees and their family members who are enrolled in Prime within the 50 United States or The District of Columbia and for an uncapped number of visits for TOP enrollees traveling/seeking care in CONUS when services are rendered by a TRICARE network or TRICARE authorized UCC with the following primary specialty designations:
    - i. Family Practice,
    - ii. Internal Medicine,
    - iii. General Practice,
    - iv. Pediatrician, and
    - v. UCC or CC.
  - b. In accordance with TPM, Chapter 1, Section 8.1, 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.

## Appendix 4: Acronyms

<u>Acronym</u>	<u>Full Term</u>
DC	direct care
DHA	Defense Health Agency
DoD	Department of Defense
ED	emergency department
ERR	emergency room recapturable
FY	Fiscal Year
MCSC	Managed Care Support Contract
MHS	Military Health System
MTF	military treatment facility
NAL	Nurse Advice Line
NDAA	National Defense Authorization Act
PCM	primary care manager
PSC	private sector care
UC	urgent care