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

PERSONNEL AND
READINESS

11 SEP 2017

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

Dear Mr. Chairman:

The enclosed report is in response to section 725(c)(1) of the National Defense Authorization Act (NDAA) for Fiscal Year 2016 (Public Law 114–92), which requires the Secretary of Defense to submit a report on the pilot program to allow a covered beneficiary under the TRICARE program access to urgent care visits without the need for a preauthorization for such visits.

The pilot was implemented in the Continental United States, Alaska, and Hawaii beginning May 23, 2016. In an effort to encourage beneficiaries to obtain care in the most appropriate care setting and reduce spending, the pilot eliminated the requirement for a referral or prior authorization for up to two urgent care visits per year. The incorporation of the Nurse Advice Line (NAL) was required and used in this pilot to direct covered beneficiaries seeking access to care to the source of the most appropriate level of health care required to treat the medical conditions of the beneficiaries, including urgent care under the pilot program.

The enclosed report includes urgent care data analysis associated with the NDAA reporting requirements. At this early point in the pilot, the study has yet to identify substantive changes in the use of urgent care by covered beneficiaries. However, there is a noticeable decrease in the number of emergency department visits that could have been treated in an urgent care setting, suggesting a cost savings. The data also demonstrates the impact of the NAL, specifically how effective it is in directing beneficiaries to the appropriate facility care setting.

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,

AM Kurta

A. M. Kurta
Performing the Duties of the Under Secretary of
Defense for Personnel and Readiness

Enclosure:
As stated

cc:
The Honorable Jack Reed
Ranking Member

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

PERSONNEL AND
READINESS

11 SEP 2017

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

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Sincerely,

A. M. Kurta
Performing the Duties of the Under Secretary of
Defense for Personnel and Readiness

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 $303,000.00 in Fiscal Years 2016 - 2017. This includes $289,000.00 in expenses and $14,000.00 in DoD labor.
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2017

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Executive Summary

This report is the first of three reports required by section 725(c)(1) of the National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2016 (Public Law 114–92). The NDAA for FY 2016, requires the Secretary of Defense to submit a report on the pilot program to allow a covered beneficiary under the TRICARE program access to urgent care visits without the need for a preauthorization for such visits. Beginning May 23, 2016, the pilot program began in the continental United States, Alaska, and Hawaii and eliminated the need for an urgent care referral for up to two visits per FY for TRICARE Prime enrollees. At present, active duty members (except those in TRICARE Prime Remote) are excluded from the pilot. The pilot encourages the use of the Nurse Advise Line (NAL) to guide enrollees to the most appropriate level of health care.

This first report includes urgent care data analysis associated with the NDAA reporting requirements. The initial analysis has not identified substantive changes in urgent care use by TRICARE Prime enrollees. However, there is a noticeable decrease in the number of emergency department visits, which reflects a monthly cost reduction of approximately $194,000. This analysis should be viewed with caution as it only covers the first six months of the pilot, (May – November) and beneficiaries may not have been fully aware of the expansion of the urgent care benefit during this time. It also does not include the winter months, a period when urgent care (and emergency room) typically is highest.

The data demonstrates the positive impact of the NAL in directing beneficiaries to the appropriate facility care setting. For example, of the callers who visited an urgent care facility, 28 percent had the intention of visiting an emergency department, but were redirected after calling the NAL. Data analysis shows that 96 percent of Prime beneficiaries used less than two urgent care visits during this first 6 months of the pilot, suggesting that two urgent care visits without a referral would be an appropriate number of visits allowed each year. This will be reviewed and adjusted as needed on an annual basis. Finally, beneficiary surveys reveal that 93 percent of beneficiaries who participated in the pilot are satisfied with the increased access to care under the pilot.

Background

Health care services acquired in an emergency department (ED) are significantly more expensive than services, which can be provided at an urgent care center (UCC). If a beneficiary's condition or symptoms require resources that can only be acquired in an ED, higher costs are expected and appropriate. However, a number of beneficiaries visit the ED in lieu of a UCC, despite exhibiting symptoms that could be appropriately addressed in a UCC. These ED visits create unnecessary costs as ED resources are disproportionate to the magnitude of treatment required for a given beneficiary's symptoms and illness.

It is possible, that overall costs incurred by the Defense Health Agency can be reduced through policy measures that encourage beneficiaries to obtain care in the setting most appropriate to their condition. Previously, beneficiaries enrolled in TRICARE Prime had to obtain a referral from their primary care manager to visit a UCC in the purchased care sector, but a referral is not required for ED visits. As a result, a number of patients were deterred from visiting a UCC and consequently visited the ED despite their symptoms and illness not warranting a visit to the ED. There is a reasonable expectation that a policy that allowed beneficiaries direct access to an UCC in purchased care would 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 at urgent care facilities if they are not required to first obtain a referral before visiting a UCC)[1,2].

Beginning May 23, 2016, a pilot program was implemented in order to assess the impact achieved by removing the requirement for a referral for up to two visits annually. The purpose of the urgent care pilot is to determine if the elimination of the requirement to obtain a referral for urgent care visits and the use of the NAL will improve access to care. It also serves as a cost-reducing initiative, promoting a more efficient utilization of resources and enabling service care providers to offer beneficiaries care of the utmost quality.

This initiative also aligns with recent trends within the civilian sector: Civilian UCCs have been steadily expanding at an estimated rate of 300 facilities per year.[3] The proliferation of UCCs is indicative of a number of obstacles to obtaining health care that can be ameliorated by UCCs. It is worth noting many patients choose UCCs over primary care because it is faster than obtaining a primary care appointment[4]. Thus, physicians and investors alike are capitalizing on the growing demand for more UCCs to facilitate quick and more convenient care.

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[1] 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.

[2] According to a Deloitte Consulting LLP study, analysis suggests that the ED visit rates are lower in regions with higher UCC concentration. Study based on ER visits data from the American Heart Association (AHA), and UCC locations at zip-code level from the Urgent Care Association of America (UCAOA).

[3] UCAOA

[4] Urgent Care survey results indicate that 70 percent of urgent care patients chose urgent care because it was faster than finding an appointment with their primary care provider.

Section 725 of the NDAA for FY 2016 requires the Secretary of Defense to carry out a pilot program to allow a covered beneficiary under the TRICARE program access to urgent care visits without the need for a preauthorization for such visits within 180 days of enactment. In addition, the NAL must be incorporated into the pilot, but cannot be a prerequisite for the self-referral of urgent care visits under the pilot. The statute also requires a total of three reports related to the project and measurement of several outcome metrics.

Methodology

In order to accurately evaluate the relevant data associated with NDAA reporting requirements, the data was compiled on every beneficiary visit at a UCC, ED, and primary care provider for FY 2015, FY 2016, and FY 2017 (October and November). Furthermore, a number of additional variables have been monitored to assist in the analysis process. This includes, the month in which the visit occurred, whether the visit occurred at a Military Treatment Facility (MTF) or through a Managed Care Support Contractor (MCSC), 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 urgent care use by covered beneficiaries in MTFs and the TRICARE purchased care provider network.*

   The volume of care for all eligible beneficiaries is reported, including urgent care (UC), primary care (PC), ED care, and emergency room recapturable care (ERR). This data is used to populate volume statistics by sector, direct care (DC) versus purchased care (PSC). In addition, the volume, cost, and utilization of care for beneficiaries enrolled to an MTF or MCSC is reported. Utilization numbers are derived by dividing the number of visits by the number of enrollees. The utilization rate is then displayed per 1,000 enrollees to normalize the data.

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 emergency rooms.*

   Beneficiary volume is attained from Military Health System (MHS) databases. These are then used to populate volume statistics, including: MTF versus MCSC, or PSC versus DC. In conjunction with enrollee totals, volume statistics are then used to calculate utilization numbers.

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

   Inappropriate use of medical care in emergency rooms is analyzed first by distinguishing between ED visits. All ED visits are given a specific code which reveals information about 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 adequately treated at a UCC.[5] Visits with these codes are disaggregated from overall ED visits in order to document inappropriate use of medical care in EDs.

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 medical treatment facilities and the TRICARE purchased care provider network.*

NAL calls are monitored and results are reported to yield a number of data points which are used to determine the extent to which the NAL impacted both UC and ED use. NAL data was documented from calls, and key variables were identified for further analysis. Key variables such as the caller's chief complaint and age were documented. 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 their final disposition are analyzed. The pre-intent captures what the caller would have done, or where they would have gone, had they 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.[6] 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 a facility appropriately suited to their specific circumstances.

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

Cost savings to DoD were determined by examining the decrease in ERR during the time period of the pilot and applying the average cost of UCC and ED visits to the change.

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

Using volume data, the average number of UCC visits per beneficiary can be ascertained. This number provides insight into the frequency at which beneficiaries utilize UCCs and assists in determining an appropriate amount of visits that should be available to beneficiaries without requiring preauthorization.

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

The satisfaction levels of covered beneficiaries were assessed via survey. A phone survey was conducted by Zogby Analytics on behalf of the DoD TRICARE program. Survey respondents were beneficiaries who visited, or had a child who visited, a UCC.[7] Results are from surveys conducted between July and October of 2016.

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[5] Procured using procedure codes 99281 and 99282

[6] It is assumed that a patient pursued the type of care they stated they would during the call.

[7] 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.*

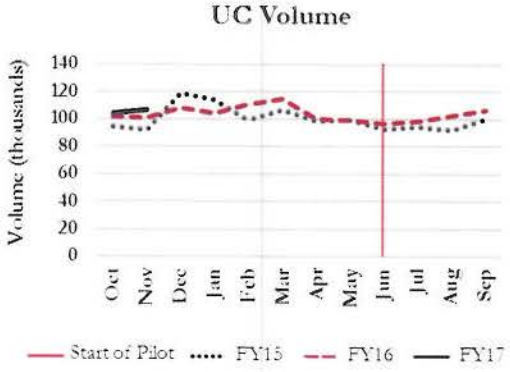
Urgent care statistics have been monitored across FY 2015, FY 2016, and FY 2017 (October and November). Charts A1, A2 and A3 display the volume (i.e., number of visits) by fiscal month across FY 2015, FY 2016 and FY 2017 in both DC and PSC sites. The pilot program was implemented May 23, 2016, and the vertical red line denotes the point at which the pilot was implemented. The FY 2016 figures beyond the line, represent points in time during where the pilot has been in effect.

The FY 2015 to FY 2017 UC volume results yield no major fluctuations prior to the pilot's inception. These results also demonstrate that the volume has remained stable since the pilot began. Ultimately, at this early stage, there is no discernable difference between pre- and post-pilot UC volume numbers. This analysis should be viewed with caution as it only covers the first six months of the pilot, (May – November 2016) and beneficiaries may not have been fully aware of the expansion of the urgent care benefit during this time.

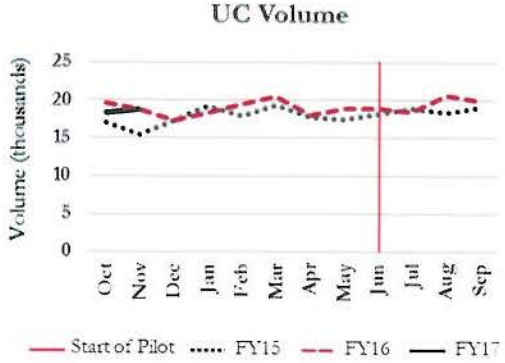
Analyzing the data by fiscal month also helps to account for additional factors that may influence volume figures, such as seasonality effects. It is possible that the number of UC visits fluctuates depending on the time of the year, and thus post-pilot figures must be compared with pre-pilot figures from the same time of year. As evidenced in chart A1, there was an increase of UC visits during the winter months of FY 2015. Most notably, December and January FY 2015 experienced unusually high volume. It would not be appropriate to compare those numbers with the post-pilot figures that exist at this time, all of which are from summer months.

Extending analysis beyond overall visits, Figures A4, A5, and A6 display the utilization (i.e., number of visits per 1,000 enrollees) by fiscal month from FY 2015 to FY 2017, at both MTFs and in MCSC enrollment sites. There is no discernable difference between pre and post pilot figures at this point in time. The FY 2015 and FY 2016 volume numbers are extremely similar through summer and early fall thus far. It remains to be seen whether the effects of the pilot program will become more evident as the benefit becomes more ubiquitously known and whether beneficiaries will visit UCCs with increasing frequency.

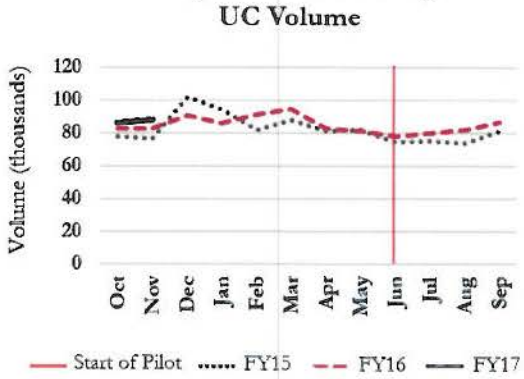
A1. Combined (DC & PSC) Volume *(All Beneficiaries)*



A2. Direct Care Volume *(All Beneficiaries)*

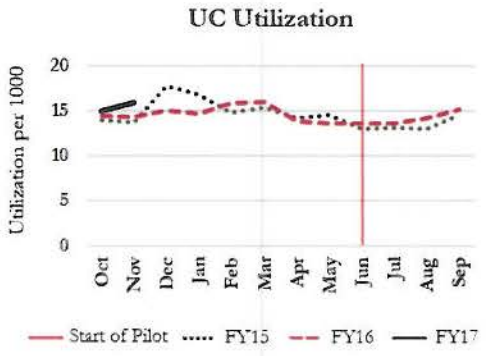


A3. Purchased Care Volume *(All Beneficiaries)*

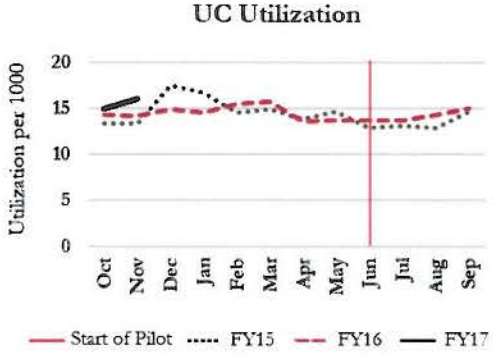


When interpreting these charts, please note that the vertical axis scales differ.

A4. Combined Utilization *(MTF & MCSC Enrollees[8])*

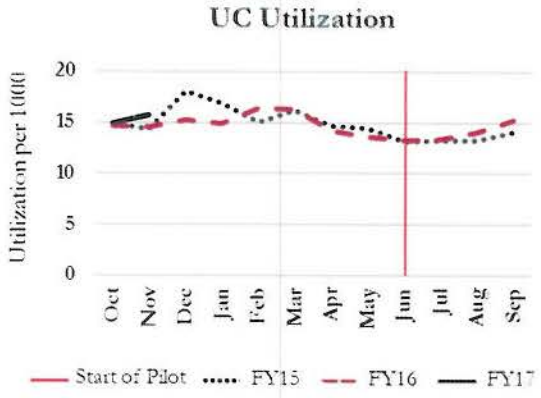


A5. MTF Enrollee Utilization



[8] MTF = Enrollment Site Military Service = A, F, N, P; MCSC = Enrollment Site Military Service = M

A6. MCSC Enrollee Utilization



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 emergency rooms*

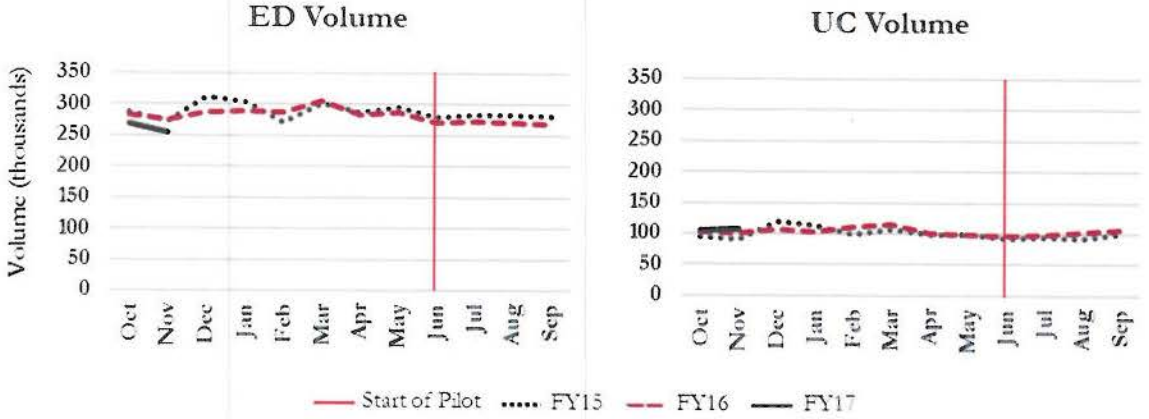
While the UC volume and utilization figures have not experienced any substantial changes since the pilot's initiation, ED figures have fluctuated slightly (Figures B1-B3). ED volume numbers have decreased in the months since the pilot was implemented. Overall, ED volume figures trended downward. However, closer analysis reveals the overall trend was driven by a decrease within PSC. In DC, the same downward trend was not evident; volume numbers remained stable in the immediate months after the pilot began.

Despite the downward trend in ED volume throughout the pilot's implementation, there are no changes in UC figures that coincide with the pilot or the downward trend in ED volume.

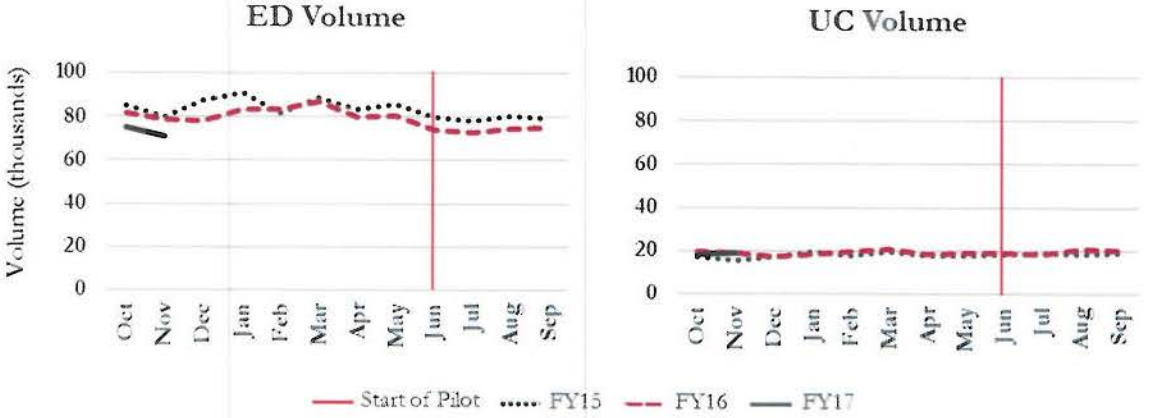
In regard to inappropriate use of medical care in emergency rooms, Figure B4 captures those ED visits which were assigned one of the two aforementioned codes, each of which designates that the ED visit could have been adequately treated at a UCC. While the volume within the PSC is extremely low, the volume of ERR visits in DC reveals a precipitous drop in visits following the pilot's implementation. Between May and June, the number of ERR visits decreased by nearly 10 percent. Volume continued to decrease throughout July and August, albeit at a much smaller rate.

While this coincidental timing and decrease in ERR visits cannot be attributed entirely to the pilot program, it bodes well for the overall state of inappropriate use of emergency departments. As time progresses and additional data is attained, ED visits will be monitored.

B1. Combined (DC & PSC) Volume
(All Beneficiaries)

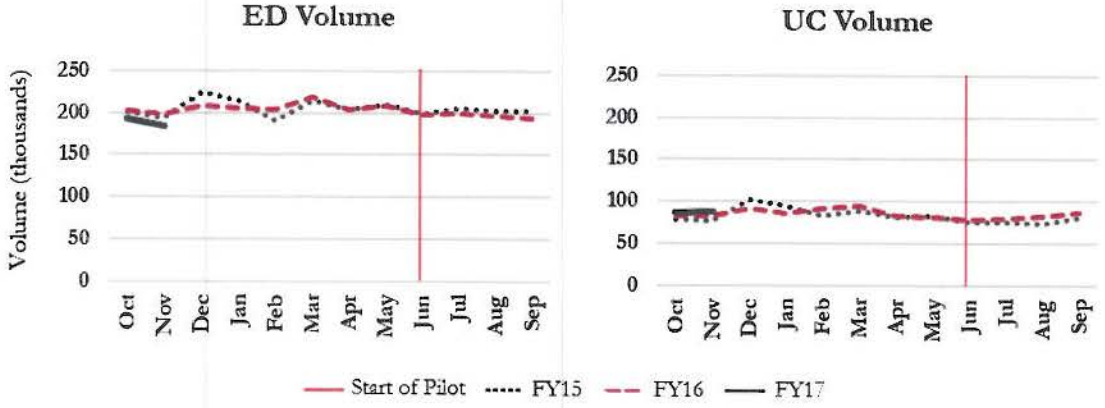


B2. Direct Care Volume[9]
(All Beneficiaries)

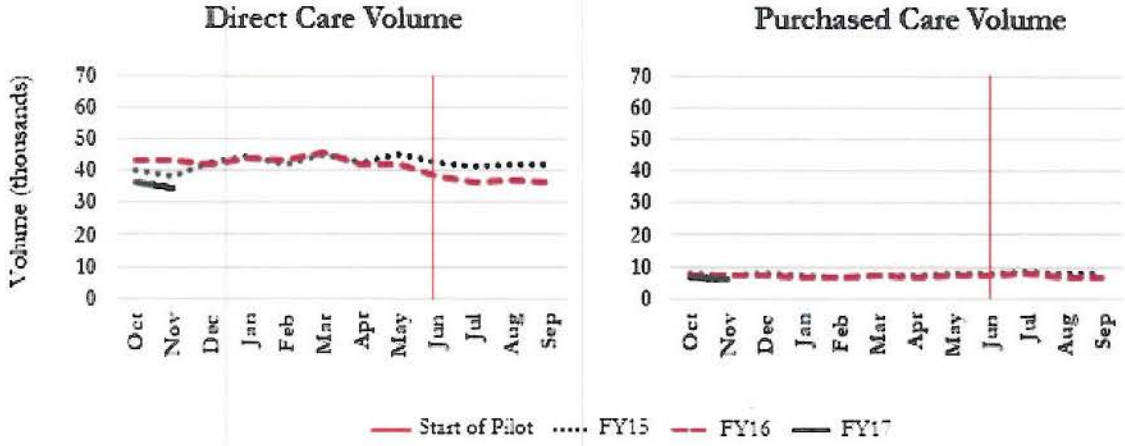


[9] Treatment took place in direct care facility (Direct Care = CAPER)

B3. Purchased Care Volume[10]
(All Beneficiaries)



B4. Emergency Care Recapturable Volume[11]
(All 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.*

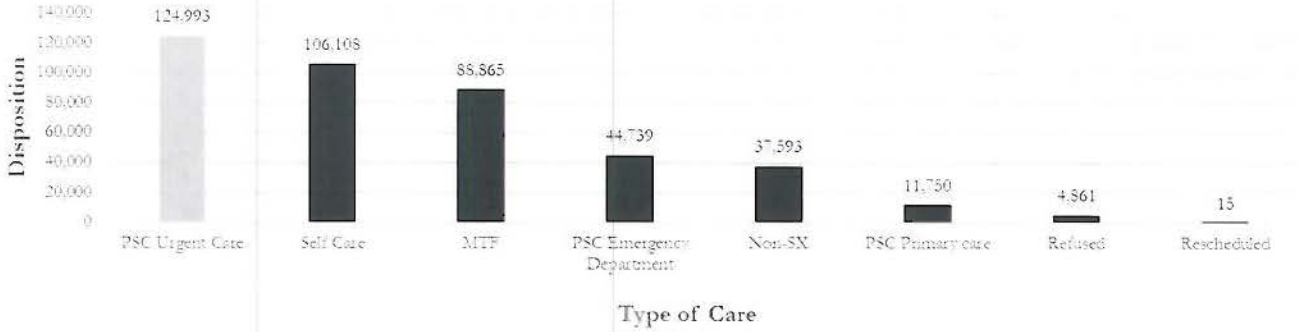
Figure C1 depicts the distribution of dispositions for all calls. It demonstrates that the plurality of callers agreed to visit a UCC upon call completion.[12] This contextual information is necessary in analyzing a potential cause and effect relationship between the NAL and use of both UC and ED.

[10] Treatment took place in private sector care (Private Sector Care = TEDNI)
[11] Emergency Care Recapturable = Procedure Code = 99281, 99282
[12] Of note, the MTF category does not distinguish between the types of care provided at the MTF

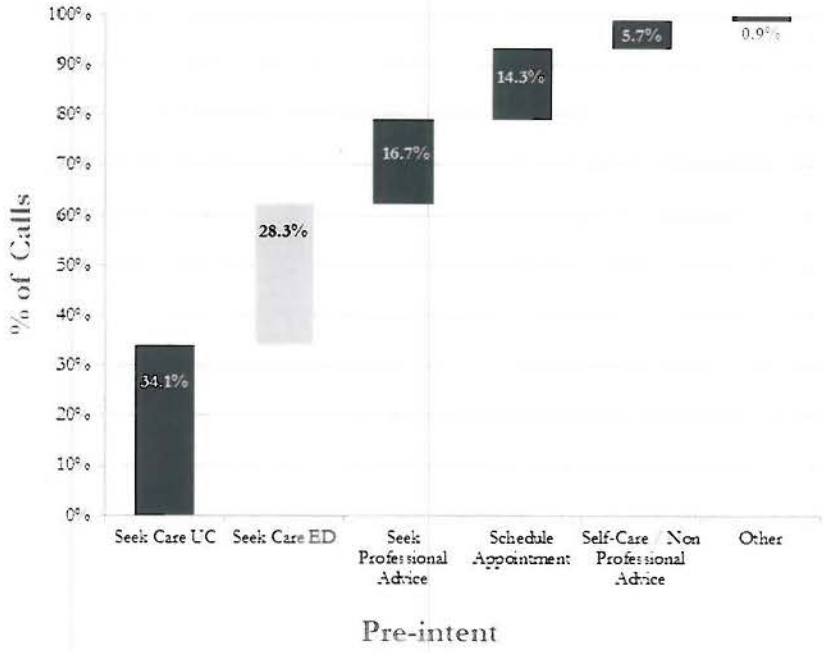
Figure C2 displays a breakdown of pre-intentions for NAL calls that ended with an urgent care disposition. That is, callers who indicated, at the end of the call, that they planned to visit an UCC. This data reveals that approximately 28.3 percent of callers intended to visit the ED, but chose to visit a UCC after speaking with an NAL representative. This suggests that the NAL is effective in redirecting beneficiaries to a facility that is most appropriately suited for addressing their symptoms or illness. It is possible the NAL call prompted cost savings by redirecting patients to a UCC; had they visited the ED, the costs incurred with such a visit could have been disproportionately high given the relative severity of their symptoms or illness. The graph also demonstrates that approximately only a third of those callers who agreed to visit a UCC had originally intended to do so.

Figure C3 displays a breakdown of pre-intentions for NAL calls that ended with an ED disposition, meaning callers indicated, at the end of the call that they planned to visit an ED. While only a third of calls with UCC dispositions had pre-intentions of visiting urgent care, nearly one half of callers who agreed to visit the ED had intended to do so prior to the call. The graph also reveals that 16.9 percent of callers who decided to visit the ED had originally intended to visit a UCC, suggesting that the magnitude of their symptoms or illness required an ED, and the NAL was able to redirect them to a more appropriate facility.

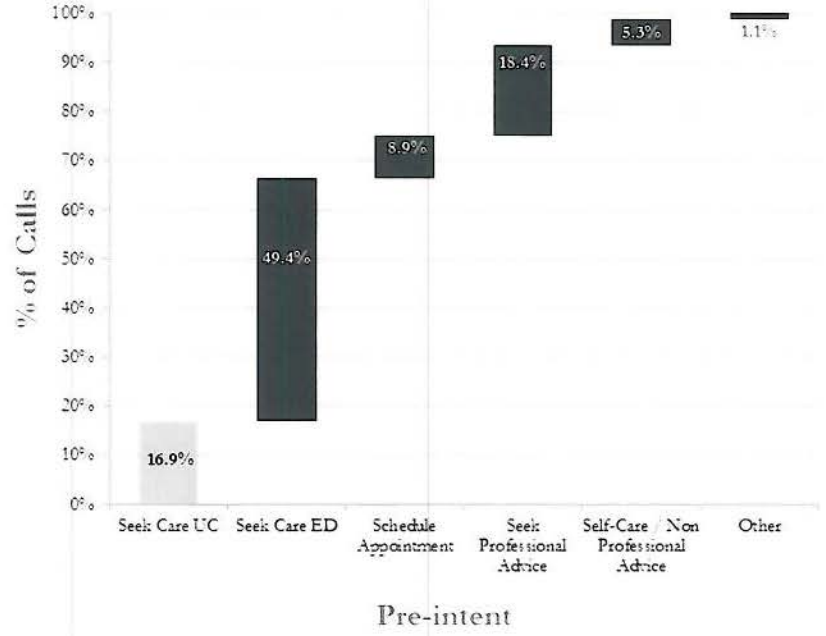
C1. FY16 NAL Disposition Distribution



C2. FY16 UC Disposition by Pre-intent[13]



C3. FY16 ED Disposition by Pre-intent[14]



[13] That is, a distribution of the pre-intentions of those callers who agreed to visit UC upon call's end.
[14] That is, a distribution of the pre-intentions of those callers who agreed to visit the ED upon call's end.

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

Figures D1and D2, highlight the cost trends for both ED and UC across PSC and DC, throughout FY 2015, FY 2016, and two months of FY 2017. The graphs portray the lack of a significant change since the pilot's inception. Both ED and UC costs remain relatively unchanged. Thus, there is no insight to be gained with respect to cost savings due to the pilot. However, there are other metrics which document potential cost savings.

Figure D3 emphasizes the discrepancy between ERR costs and UC costs. ERR visits are derived from ED visits with a specific code which denotes that the visit could have been adequately treated at a UCC. However, despite being associated with less severe symptoms, ERR visits incur disproportionately high costs due to the overhead costs in EDs.

Figure D2 also demonstrates that the average ERR visit incurs costs that are 473 percent higher, or $298.00, than the average UC visit.[15] [16] In order to establish a cost savings metric, the cost differential between these two types of visits can be compared in accordance with ERR volume, and more specifically, the downward trend in ERR volume since the pilot's inception.

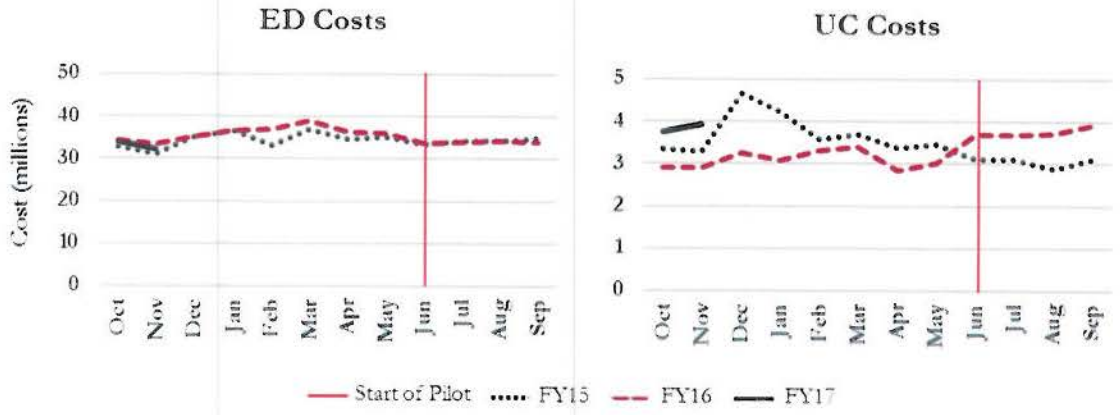
Throughout the pilot's implementation, ERR volume has consistently been 10 percent lower per month than it was prior to the pilot. If this reduction were to continue for an entire FY, the savings realized by the pilot due to fewer ERR visits would be approximately $2.3M. This figure is attained from the ensuing calculations:

> The average monthly volume of PSC ERR visits is approximately 6,521. A 10 percent reduction would see 652 fewer visits per month. That is, 652 beneficiaries would visit a UCC, PC clinic, or other lower level of care, a more appropriate facility given their symptoms or illness. As a UCC visit is on average $298.00 less expensive, the average monthly savings would be $194,300.00 ($298*652), assuming all patients in this group utilized a UCC instead of the ED. This calculation is dependent on a number of assumptions, including the notion that the pilot is directly responsible for a 10 percent reduction in ERR visits, and ERR visits will continue to remain lower than pre-pilot figures.

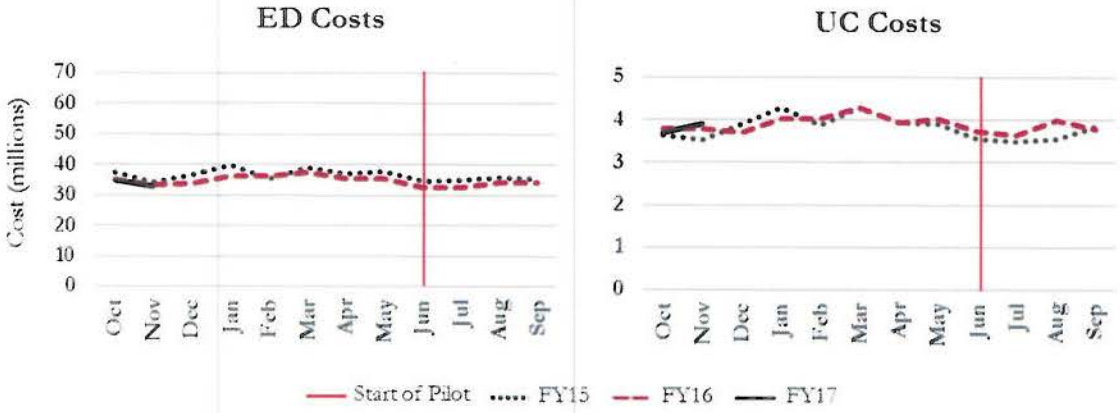
[15] Data excludes Active Duty members and Guard/Reserve on Active Duty Guard/Reserve on Active Duty (Ben Cat ≠ ACT, GRD)

[16] While there may be UC visits with minor symptoms or illnesses that influence UC costs to appear cheaper, no distinction or code is assigned to UC visits, and thus it is not feasible to disaggregate UC visits. For the purposes of this cost analysis, the average cost of all UC visits is compared with the average cost of all ERR visits.

D1. Cost Trends of Purchased Care for MTF & MCSC Enrollees



D2. Cost Trends of Direct Care for MTF & MCSC Enrollees



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

D3. FY16 UC vs. ERR Cost Analysis[17]

	Number of Visits	Sum of Full Cost	Average Cost per Visit
UC	768,909	$48,527,151	$63
ERR	78,253	$28,233,430	$361

	10% visit reduction per month[18]	Average UC Cost Saving	Total Cost Saving/Month

[17] Figures extracted solely from Private Sector Care and exclude Active Duty members and Guard/Reserve on Active Duty Guard/Reserve on Active Duty.

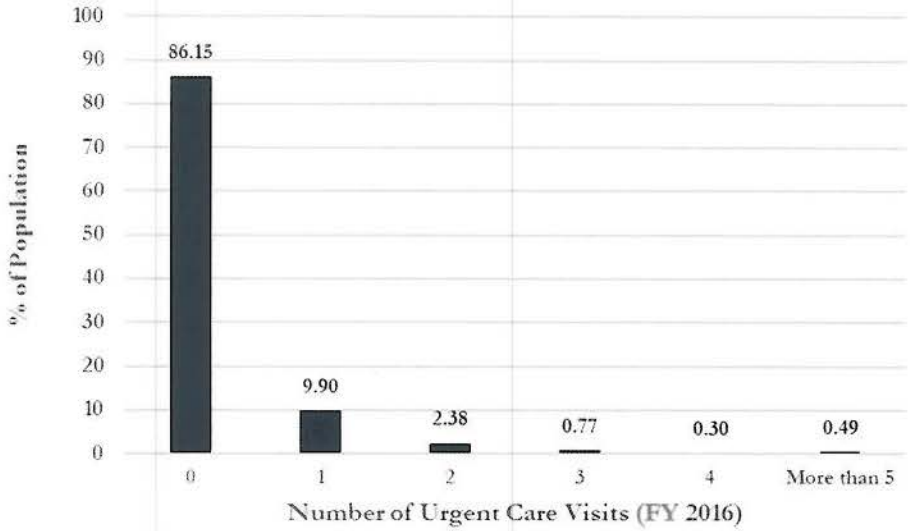
[18] Volume reduction based on trend analysis section B.4

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

Figure E1 shows that over 86 percent of beneficiaries did not utilize urgent care during FY 2016.[19] Furthermore, less than 2 percent of beneficiaries used more than two UCC visits.

In determining an optimum number of UC visits available to covered beneficiaries without preauthorization, these statistics should be taken into consideration. It appears the vast majority of beneficiaries are unlikely to utilize UCC more than two times in a given year. As such, any number of permitted visits beyond two may not be utilized often. Of note, this is also consistent with a previous Coast Guard demonstration that allowed up to four unmonitored urgent care visits per year; very few patients in that demonstration used two or more visits/year.

E1. FY16 Distribution of UC Visits per Enrollee (Direct Care & Purchased Care)



F. *An analysis of the satisfaction of covered beneficiaries with the pilot program.*[20]

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 PCM?" In response to this particular question (F1), 93 percent of respondents were either satisfied or very satisfied with the new benefit 5 percent had no opinion, while less than 2 percent were dissatisfied

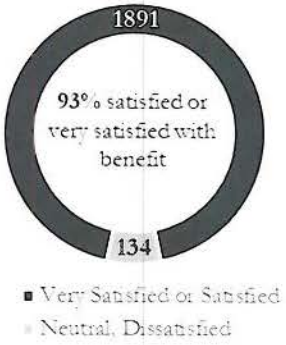
[19] When examining only those beneficiaries who visited a UCC at least one time, 90 percent visited one or two times in FY 2016

[20] Survey data F1-F3 was aggregated July 2016 to November 2016

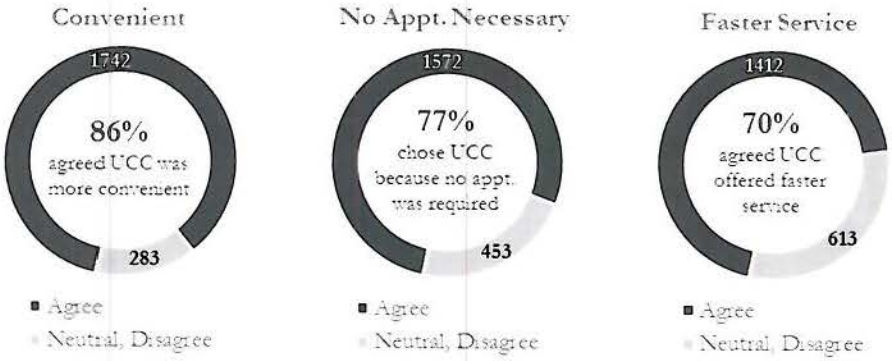
or very dissatisfied. These results suggest the overwhelming majority of beneficiaries are in fact satisfied with the new benefit.

Additional questions in the survey can provide further insight into beneficiaries' responses to the new benefit and urgent care services more broadly. When asked if they chose a UCC because it has convenient hours, 86 percent of respondents agreed or strongly agreed. When asked if they chose a UCC because it was faster than making an appointment with their primary care provider, 70 percent of respondents agreed or strongly agreed. When asked if they chose a UCC because no appointment was necessary, 77 percent of respondents agreed or strongly agreed. Respondents are associating positive attributes with UCCs to a degree, which suggests they would be satisfied with the ability to visit the UCC without an authorization because it is convenient. Chart F3, shows that most respondents would prefer to see their primary care physician.

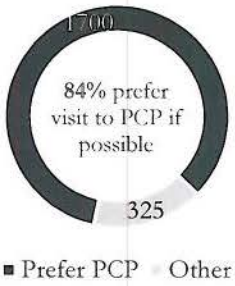
F1. Survey responses to the following question: "All things considered, how satisfied are you with this new benefit that allows you to choose an urgent care center without the need of a referral from TRICARE or your PCM?"[21]



F2. Motives for UCC Visit[22]



F3. Primary Care Preference[23]



[21] Satisfied = Very Satisfied, Satisfied; Neutral Dissatisfied = Very Dissatisfied, Dissatisfied, Not Sure
[22] Agree = Strongly Agree, Agree; Neutral, Disagree = Strongly Disagree, Disagree, Not Sure
[23] Prefer PCP = Strongly Agree, Agree; Other = Strongly Disagree, Disagree, No Opinion

Conclusion

At this stage of the Urgent Care Pilot, no clear impact on ED or UCC use has been identified. There is a downward trend in ED use and an upward trend in UCC use that began prior to the implementation of the pilot. In addition, the preliminary data suggests a reduction in ERR cost of approximately $2.3M a year. Data is insufficient to determine at this point whether these potential cost savings can be attributed to the implementation of the pilot program. However, we expect the results to be more evident in next year's report.

The data suggest that the NAL is effective in redirecting beneficiaries to a care setting that is most appropriately suited for addressing their symptoms or illness. Specifically, the data demonstrates that approximately only a third of those callers who indicated, at the end of the call, that they planned to visit an UCC had originally intended to do so. The data also reveals that 16.9 percent of callers who agreed to visit the ED had originally intended to visit a UCC, suggesting that the magnitude of their symptoms or illness required an ED, and the NAL was able to redirect them to a more appropriate facility.

Given that over 98 percent of beneficiaries used two or fewer urgent care visits in FY 2016, no change in the number of urgent care visits (two/year) allowed without authorization is planned at this time.

The UC Survey indicates very high levels of patient satisfaction with the new policy.

Appendix 1: Data Collected

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

1. Enrollee (enrolled to MTF or MCSC) Urgent Care, Patient Centered Medical Home (PCMH), and Emergency Department utilization (report by Service affiliation, enrollment site, catchment area, Alternate Care Value (ACV), ACV group, bencat, age group, network vs non-network provider)
    a. Urgent Care Visits/1000 enrollees
    b. PCMH Visits/1000 enrollees
    c. ED Visits/1000 enrollees
    d. ED Recapturable Visits/1000 enrollees
2. Enrollee workload (report by Service affiliation, enrollment site, catchment area, ACV, ACV group, bencat, age group, network vs non-network provider)
    a. Urgent Care Visits – MTF and Network, authorized and not authorized
    b. PCMH Visits – MTF and Network
    c. ED Visits – MTF and Network
    d. ED Recapturable Visits – MTF and Network
3. Nurse Advice Line Referrals (report by Service affiliation, enrollment site, catchment area, ACV, ACV group, bencat, age group, network vs non-network provider)
    a. Urgent Care Referrals – MTF and Network
    b. PCMH/Primary Care Referrals – MTF and Network
    c. ED Referrals – MTF and Network
4. Cost of Care (report by Service affiliation, enrollment site, catchment area, ACV, ACV group, bencat, age group, network vs non-network provider)
    a. ER Related Costs:
        i. ER Amount Charged for Prime Enrollees – MTF and Network
        ii. ER Amount Allowed
        iii. ER Amount Paid
        iv. ER Amount Paid by Beneficiary
        v. ER Amount Paid by OHI
        vi. ER Cost/1000 enrollees – Total, MTF, and Network
        vii. ER Cost/Visit – MTF and Network
    b. UC Related Costs:
        i. UC Total Charged for Prime Enrollees
        ii. UC Amount Allowed
        iii. UC Amount Paid
        iv. UC Amount Paid by Beneficiary
        v. UC Amount Paid by OHI
        vi. UC Cost/1000 enrollees
        vii. UC Cost/Visit
    c. Pharmacy Related Costs:
        i. Retail Network Costs
        ii. MTF Pharmacy Costs

5. Patient Satisfaction –
    a. Proposing phone survey of 450 Urgent Care Clinic Users from prior month
        i. Approximately 8-12 questions (See Appendix A)
        ii. Significant at the United States level (Continental United States (CONUS) plus Alaska and Hawaii)
        iii. Can be funded by existing contracts
        iv. Survey to begin during in July 2016

6. Quality - TBD

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.	☐	☐	☐	☐	☐
B2b	I chose this urgent care clinic because it has little-to-no co-pay.	☐	☐	☐	☐	☐
B2c	I chose this urgent care clinic because it was faster than making an appointment with my primary care provider.	☐	☐	☐	☐	☐
B2d	I chose this urgent care clinic because no appointment was necessary and I could just walk in for care.	☐	☐	☐	☐	☐
B2e	I chose this urgent care clinic because I trust the provider(s).	☐	☐	☐	☐	☐
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.	☐	☐	☐	☐	☐

B2g	If an appointment with my regular provider had been available, I would have used it instead of the urgent care clinic.	☐	☐	☐	☐	☐

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?

_____

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 Active Duty Family Members 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, Physician Assistants, Nurse Practitioners, and Certified Nurse Midwives can be considered Primary Care Providers and may be designated Primary Care Managers too.

Appendix 4: Acronyms

Acronym	Full Term
ACV	Alternate Care Value
CONUS	Continental United States
DC	Direct Care
ED	Emergency Department
ERR	Emergency Room Recoverable Cost
FY	Fiscal Year
MCSC	Managed Care Service Provider
MHS	Military Health System
MTF	Military Treatment Facility
NAL	Nurse Advice Line
NDAA	National Defense Authorization Act
PC	Primary Care
PCMH	Patient Centered Medical Home
PSC	Private Sector Care or Purchased Care
UC	Urgent Care
UCC	Urgent Care Center