THE ASSISTANT SECRETARY OF DEFENSE

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HEALTH AFFAIRS

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MEMORANDUM FOR SURGEON GENERAL OF THE ARMY
SURGEON GENERAL OF THE NAVY
SURGEON GENERAL OF THE AIR FORCE

SUBJECT: Access to Care and Referral Times

Access to care for our beneficiaries is a top priority of the Military Health System (MHS). It has come to our attention that there may be variation in how the access to care and referral time standards, published in 32 CFR 199.17, are being applied throughout the MHS, especially comparing revised financing regions to non-revised financing regions. All enrolled beneficiaries (including active duty members), regardless of their location, should be accorded access to care according to the standards published in the CFR. While there are differing opinions from the Lead Agents on how best to implement these standards, this memorandum provides clarification to allow consistent application of the access to care standards, regardless of the enrollee's location.

1. Access to care standards state a Prime beneficiary must be provided a specialty care appointment within four weeks/28 days. When does the clock start to measure this?

"Wait time" begins from the date the TRICARE Service Center/Health Care Finder, a military treatment facility (MTF), or a provider is contacted for an appointment either by the patient or the referring provider.

32 CFR 199.17(p)(5)(ii) states that "wait time for an appointment for a specialty care referral shall not exceed four weeks." To meet the Access to Care (ATC) standards, the MTF or the managed care support contractor (MCSC) would, upon being contacted by either the patient or the referring provider, have to offer a specialty care appointment within four weeks of the date of that request.

Patients should be strongly encouraged to contact the MTF or MCSC within seven days after a provider initiates a referral to obtain the needed medical care as promptly as possible. Providers are responsible to inform patients of the necessity to seek timely appointments to ensure continuity of care.

This letter rescinds the policy statement on access to care and referral times in HA Policy Letter 97-023, dated 15 Jan 97. The previous reference to a "one-month" access standard for specialty care referrals is replaced with "four weeks."

2. Can a patient refuse an available MTF appointment within access to care standards so he/she can obtain care in the contractor's network?

The MTF needs only to offer one MTF appointment within the access to care standards to fulfill its duty to provide care within the access standards. However, if multiple and convenient appointment choices are available, whenever possible the patient should be offered more than one option that meets the ATC standard. Moreover, if the patient is unable to accept the initial appointment offered, the patient should be offered the next available appointment thereafter. Appointing staff should be trained to use ATC measurement features of CHCS to accurately document timeliness of services and patient refusals of appointments within access standards.

Once offered an MTF appointment within standards, the patient may choose to exercise their point of service option should civilian care still be desired. The standards are meant to require certain conduct of MTFs and MCSCs *for the benefit of the beneficiary.*

3. Based on an individual provider's professional judgment, can access to care standards be waived for certain specialty referrals?

A provider's professional judgment cannot waive the standards. There is no provision for waiving the standards, which are fixed by regulation and incorporated into the MCSC contracts. While the provider cannot relieve any entity of its obligations under the ATC standards, the provider can, exercising his or her professional judgment, advise the patient of his or her opinion that a condition is amenable to a greater than four-week wait for an appointment time. If the patient accepts that opinion, the patient would have the option of declining timely offered appointments as discussed above.

4. Should waivers of access to care standards for certain low-density medical specialties be allowed on a case-by-case basis?

A contractor may request exceptions to the requirement to make specialty services available within the network if they are not sufficiently available in the area to make inclusion practical. However, absent such an exception, the contractor is bound by the network adequacy standards. If the network is legally and contractually adequate, but there still is no ability to provide an appointment in the MTF or network within four weeks, the appropriate solution is to refer the patient to an out-of-network provider (see 32 CFR 199.17(n)(2)) within the ATC standards or to give the patient the option, with the referring provider's concurrence, of waiting for an in-network appointment.

5. Does a provider have the authority to determine what type of service/category of care is provided to a beneficiary even though the requesting patient indicated that his/her need is of a more urgent nature?

MTF and TRICARE authorized providers have the authority to determine what category of care (acute or routine) is required for a given health care need, even if it is different from the patient's original request. In other words, if the patient calls in for an acute appointment and a provider determines, based upon his or her own training, experience, and appropriate criteria that

a routine appointment is merited, the routine appointment will be offered. The provider should document the logic behind the decision in the patient's medical record.

In the circumstance that a beneficiary calls for an appointment and speaks only with a booking clerk and there is no interaction with a health care provider, every effort should be made to accommodate the beneficiary's determination of the classification of care, i.e., if the beneficiary requests an acute appointment and one is available, it should be offered.

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