SUPPORTING STATEMENT – PART A

A. JUSTIFICATION

1. Need for the Information Collection

This request is for reinstatement, with change, of a previously approved collection for which approval has expired. This submission modifies the request and justification for the survey approved May 16, 2005 under OMB control number 0720-0031 and extended 3/29/2012 to finalize our survey under current guiding Congressional legislation and to meet recent legislation extending the information collection. The original legislation directing this information collection was Section 723 National Defense Authorization Act (NDAA) for FY 2004, and modified by Section 711 NDAA 2006 (requiring collection from 2005-2007), subsequently amended by Section 711 of FY2008 NDAA (P.L. 110-181 requiring collection from 2008-2011), and extended by Section 721 of FY2012 NDAA, (Public Law (PL) 112-81 requiring collection from 2012-2015). The Department of Defense has complied with previous congressional requirements through the survey described herein, hopes to begin the final year in 2015 and finalize the 2012-2015 collection around May 2016. Section 712 of NDAA 2015 has extended the requirement to conduct the survey from 2017 through 2020. Funding and contractual efforts will likely result in beginning the 2020 survey fielding the end of calendar year 2020 with completion and analysis by mid-2021.

The original guiding legislation (Section 723 of the NDAA for FY04) required the Department to survey civilian physicians to assess the extent to which they accepted patients using the TRICARE indemnity and preferred provider-like options known as Standard or Extra. The Department obtained OMB licensure with intention of completing the survey from 2005-2007. Intervening 2006 legislation modified the survey requirement by adding in specific questions of providers related to their awareness of the TRICARE program in general, and their acceptance of Medicare patients. The FY 2008 legislation reaffirmed the continued need to survey providers' acceptance of TRICARE Standard/Extra patients, and extended and expanded the scope of the survey requirement to:

a) Continue provider surveys until 2011;

b) Expand the target provider population to include non-physician mental health providers (e.g. psychologists, social workers, mental health counselors, etc.).

c) Include surveys of beneficiaries in addition to surveys of physicians and mental health care providers (licensed separately under Washington Headquarters Services with RCS number; and

d) Survey a random sample of providers, stratified to include in each year 20 geographic areas where the TRICARE Prime benefit option is offered, as well as 20 where it is not. TRICARE Prime Service Areas (PSAs) are those geographic areas where the TRICARE managed care support contractors (MCSCs) offer the TRICARE Prime benefit through established networks of providers. Survey must include areas with concentrations of reservists, who, with their families, may also be eligible for care under TRICARE if activated, or if enrolled to a TRICARE offering for reservists. The survey sample was also required to prioritize areas identified by beneficiary and provider organizations.

The extended legislation required the Department to establish benchmarks for primary and specialty care providers (including mental health providers) to determine adequacy of providers available to TRICARE-eligible beneficiaries. The Government Accountability Office (GAO) was required to review the processes, procedures and analyses used by DoD to determine the adequacy of the number of health care and mental health care providers available to TRICARE-eligible beneficiaries. GAO have evaluated the data collection and security processes with respect to conformance with OMB guidelines, and concurred with our methodology and processes.

As noted above, the reason for this modification is to complete the previously approved four-year survey and to meet new congressional requirements in Section 712 of NDAA 2015 extending the survey for the four-year period from 2017 through 2020. Extracts of governing legislation are attached: Section 723 of the NDAA for FY04 requiring the Department of Defense to survey civilian physicians (Attachment 1); Section 711 of the FY06 NDAA requiring additional questions (Attachment 2); Section 711 of the FY08 NDAA reflecting the extension of survey requirements (Attachment 3); Section 721 of the FY 12 NDAA (Attachment 4, and Section 712 of the FY15 NDAA (Attachment 5).–

The Department has complied with previous requirements and completed the round of surveys from 2008-2011. A summary report of these results is provided in Attachment 6. The Department will comply with requirements under Section 712 of NDAA for 2015 by designing a new survey with a revised sample design, using the same questionnaire fielded in 2008 – 2011, by the same data collection methods.

This submission requests approval of the survey questionnaire (and supporting telephone script) as shown in Attachment 7 (a-physician, b- behavioral health provider surveys, with an estimated total number of 50,000 surveys and maximum of 4,167 burden hours (an increase in the overall approved burden hours previously submitted of 40,000 surveys and 3,333 burden hours, calculated at 100% returns and 5 minutes/survey).

2. Use of the Information

The survey will gather data on providers (physicians and mental health providers) to assess the extent to which they are aware of the overall TRICARE program, accept new TRICARE Standard patients specifically, and the extent to which these physicians accept Medicare patients. The information gathered through this project will be used to generate reports to address the legislative requirements specified in Section 711 of the FY08 NDAA and Section 721 of the FY 2012 NDAA. Information resulting from the collection efforts of this project will assist DoD in developing policies and initiatives to improve TRICARE beneficiaries' access to civilian providers. The results of the previous survey efforts have been briefed to, or provided in written communication to the Defense Health Agency and senior DoD personnel, TRICARE Regional Office Directors and their staff, members of Congress, selected state leaders and selected medical societies, staff members of the Government Accountability Office, TRICARE Beneficiary Groups, at the Military Health Service (MHS) Conferences. The results have also

been referenced in public media such as the Military Officers Association of America. None of these audiences have ever been provided information that would permit them to identify individual providers, but instead were briefed using aggregate measures of provider knowledge or behavior within specific analysis groups such as health care markets or provider areas of specialization. For example, contents of briefings include the percentage of respondents aware of TRICARE or accepting new TRICARE standard patients or reasons for TRICARE acceptance (e.g. "reimbursement-related issues) across the US or within particular states or medical specialties (e.g. Surgeons).

3. Use of Information Technology

A multi-mode data collection method will be used, beginning with a mailed survey with internet option, followed by a telephone survey. The mail survey may be returned by mail or by facsimile (fax). These options have been made available since FY 2008, when the internet option was added to the mail and telephone surveys. In the most recent year (2014), 56.2 percent of responses were obtained by mail, 3.3 percent by fax, 5.9 percent by internet, and 34.6 percent by telephone.

4. Non-duplication

There is no duplication of the data collection effort. No other DoD survey addresses these issues. This effort replaces/continues the previously approved survey, and, as such, will not duplicate its efforts.

5. Burden on Small Business

This collection of information may involve small business or other small entities, as many office-based providers operate as single or small-group practices. In particular, many non-physician practices are family run, however, the Congressional legislation clearly requires surveys of non-physician, mental health providers. Efforts to minimize burden, which apply to all respondents include directing mailings and telephone contacts to office addresses and billing managers as much as possible. This information collection will not have a significant economic impact on any or a substantial number of small businesses or other small entities.

6. Less Frequent Collection

The survey methodology responds directly to the requirements levied by the annual survey as directed by Congress. It is no more frequent than the minimum directed. As directed by Congress, in each year the survey sample includes providers from at least 20 TRICARE Prime Service Areas (PSA) and 20 geographic areas that do not offer the TRICARE Prime benefit. As in the previous study, geographic areas to be surveyed are both purposively and randomly selected. In addition to local estimates, the design permits precise regional and national estimates of provider acceptance measures to be calculated. The intent of this

methodology is to avoid surveying all providers in all market areas by capitalizing on randomized selection of location and provider where possible, and by surveying providers who do not change locations only once in a four year period.

7. Paperwork Reduction Act Guidelines

Collection will be conducted in a manner consistent with the guidelines delineated in 5 CFR 1320.5(d)(2).

8. Consultation and Public Comments

a. The 60-day Federal Register Notice for this collection of information was published on Friday, January 2, 2015. (Vol. 80, page 1627). No public comments were received.

b. Before beginning the continued survey effort directed by Congress in the FY 2012 NDAA, we consulted with members of various professional societies to learn about their interest in the survey and the accuracy of sources used for the sample frame in the survey conducted from 2008 – 2011. As a result, we augmented the sources of contact information for mental health providers to include data from professional societies for licensed clinical social workers, pastoral counselors and psychiatric nurse practitioners. We also consulted with beneficiary groups, provider representatives and MCSCs concerning the need for this survey, and the utility of briefing materials prepared from survey results.

9. Gifts or Payment

None

10. Confidentiality

Provide the Privacy Act System of Records Notice (SORN) ID number and title and address whether or not a Privacy Impact Assessment has been accomplished. Include a copy of the SORN and the PIA in the information collection package.

Civilian providers selected for the sample receive complete confidentiality, except as required by law. Respondent names will not be released when results are reported, or when response data is provided to the government. This assurance is also provided in the telephone script and in the mail and internet-based instruments. The relevant statutory authority for protection of identifiable data within DoD and the Federal Government is the Privacy Act of 1974. This survey does not request any Protected Health Information (as defined by HIPAA), and the data being collected are not patient or beneficiary-specific. Further, the sample frame is assembled from publicly available provider data sources.

11. Sensitive Questions

There are no questions of a sensitive nature on the survey instrument.

12. Respondent Burden, and its Labor Costs

a. Estimation of Respondent Burden

Under this modification the respondent burden remains at the previously approved level. The burden estimate assumes 50,000 eligible providers (including mental health) x 100% response rate (worse case basis for calculating burden, though actual response rate is between 40% and 50%) x 5 minutes = 4,167 hours.

If 100% respond using same response modes as survey fielded in 2014, burden will be distributed as follows:

Mode	Responses	Hours/Response	Total Hours
Mail (56.2% of 50,000)	28,100	.0833	2340.73
Fax (3.3%)	1,650	.0833	137.45
Internet (5.9%)	2,950	.0833	245.74
Telephone (34.6)	17,300	.0833	1441.09
Total	50,000	.0833	4166-7

If the prior response rate of 50% is used, burden will be distributed as follows:

Mode	Responses	Hours/Response	Total Hours
Mail (56.2% of 25,000)	14,050	.0833	1,171
Fax (3.3%)	825	.0833	69
Internet (5.9%)	1,475	.0833	123
Telephone (34.6)	8,650	.0833	721
Total	25,000	.0833	2,083

b. Labor Cost of Respondent Burden

The estimated average cost of this burden to providers for billing managers to answer the survey is $ 2.40. This estimate was based on an estimate of 5 minutes per completed survey (.0833 of an hour) and a conservative estimate of the average office manager/billing supervisor salary of = $60,000 ($28.85/hour). A Google search also reflects an hourly rate for billing managers in the United States ranging from $17.14/hour to $36.78/hour depending on region and experience (http://www.payscale.com/salary-calculator, web site accessed 3/5/2015). Total cost for one year will be approximately $10,000.

13. Respondent Costs Other Than Burden Hour Costs

a. Total capital and start-up costs annualized over the expected useful life of the item(s).

There are no start-up or capital costs to respondents.

b. Total operation and maintenance costs.

There are no O&M costs to respondents

14. Cost to the Federal Government

Costs of the survey going forward are estimated on the basis of costs incurred for the survey in previous years. The total cost to the Department of Defense includes contract management by the DoD contract officer is $561,000 per year, and contract support awarded for:

- The purchase of the physician and mental health provider databases,
- Development of sample frame and provider locater data, including address updates and corrections,
- Drawing a sample and preparing it for fielding
- Fielding the mail and telephone survey,
- Coding the internet survey option,
- Collection of the respondent data,
- Weighting of results including adjustments for non-response, and
- Documentation, analysis and presentation of results.

15. Reasons for Change in Burden

Compared to the previous approval of this collection, cost of acquiring the provider sample frame, labor costs and burden hours are estimated to increase. The increase in labor costs is due to a higher salary estimate for billing managers. The cost of acquiring sample and burden hours increase because of a larger sample size to accommodate a large drop-out rate of non-physician

behavioral health providers. Many of these specific providers are determined ineligible for the survey upon responding that they are in occupations where they cannot base willingness to accept TRICARE insurance because of their employment (e.g. social workers and psychologists working in schools or public health or other jobs where they treat patients assigned to them, such as school children) not because of preference of an insurance product.

16. Publication of Results

Information gathered through this project will be aggregated and analyzed to address the questions identified in previous legislation (Section 723 of the FY04 NDAA, and Section 711 of FY06 and FY08 NDAA) and current guiding legislation for this round of surveys from Section 721 FY 2012 NDAA. Briefings and a report including data from the most recent fielding period will be prepared and delivered to Office of the Assistant Secretary of Defense (Health Affairs)/Defense Health Agency (DHA) from June to September, 2015. The survey will next be fielded from October, 2015 to February, 2016. After respondent data collected during that fielding period is collated and quality controlled, it will be combined with the previously collected data and analyzed during the remainder of the fiscal year. An analytic file will be completed and analysis and reporting will begin by June, 2016. In addition to briefings presented to DHA leadership, MCSCs and provider and beneficiary representatives, a written report will also be submitted to DHA. The tabulations and statistical analyses planned are similar to those shown in Attachment 6. Results will be presented in briefings beginning in July, 2016 and the written report will be submitted in September, 2016. Response data will also be made available to GAO at their request if they are directed by Congress to report on survey results.

In future years, if the requirement to conduct the survey is extended, the survey will be fielded again in the autumn and winter of subsequent years and reported on a similar schedule.

17. Non-Display of OMB Expiration Date

Collection instruments will display the OMB expiration date for data collection through this project.

18. Exceptions to "Certification for Paperwork Reduction Submissions"

We request no exceptions to the certification statement in Item 19 of OMB Form 83-I.