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

PERSONNEL AND
READINESS

FEB 19 2020

The Honorable James M. Inhofe
Chairman
Committee on Armed Services
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

This letter transmits the Department's response to section 703(d) of the National Defense Authorization Act for Fiscal Year 2017 (Public Law 114–328).

The enclosed report provides the Department's recommendations for changes in military treatment facilities to meet the criteria established in 10 U.S.C. § 1073d.

Thank you for your interest in the health and well-being of our Service members, veterans, and their families. Identical letters are being sent to the other congressional defense committees. The Department looks forward to working with you to implement these recommendations.

Sincerely,

Matthew P. Donovan
Performing the Duties of the Under Secretary of
Defense for Personnel and Readiness

Enclosure:
As stated

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

PERSONNEL AND
READINESS

FEB 19 2020

The Honorable Jack Reed
Ranking Member
Committee on Armed Services
United States Senate
Washington, DC 20510

Dear Senator Reed:

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PERSONNEL AND
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FEB 19 2020

The Honorable Adam Smith
Chairman
Committee on Armed Services
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

This letter transmits the Department's response to section 703(d) of the National Defense Authorization Act for Fiscal Year 2017 (Public Law 114–328).

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PERSONNEL AND
READINESS

FEB 19 2020

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

Dear Representative Thornberry:

This letter transmits the Department's response to section 703(d) of the National Defense Authorization Act for Fiscal Year 2017 (Public Law 114–328).

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PERSONNEL AND
READINESS

FEB 19 2020

The Honorable Richard C. Shelby
Chairman
Committee on Appropriations
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

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

PERSONNEL AND
READINESS

FEB 1 9 2020

The Honorable Patrick J. Leahy
Vice Chairman
Committee on Appropriations
United States Senate
Washington, DC 20510

Dear Senator Leahy:

This letter transmits the Department's response to section 703(d) of the National Defense Authorization Act for Fiscal Year 2017 (Public Law 114–328).

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WASHINGTON, D.C. 20301-4000

PERSONNEL AND
READINESS

FEB 19 2020

The Honorable Nita M. Lowey
Chairwoman
Committee on Appropriations
U.S. House of Representatives
Washington, DC 20515

Dear Madam Chairwoman:

This letter transmits the Department's response to section 703(d) of the National Defense Authorization Act for Fiscal Year 2017 (Public Law 114–328).

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OFFICE OF THE UNDER SECRETARY OF DEFENSE
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PERSONNEL AND
READINESS

FEB 19 2020

The Honorable Kay Granger
Ranking Member
Committee on Appropriations
U.S. House of Representatives
Washington, DC 20515

Dear Representative Granger:

This letter transmits the Department's response to section 703(d) of the National Defense Authorization Act for Fiscal Year 2017 (Public Law 114–328).

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Matthew P. Donovan
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Defense for Personnel and Readiness

Enclosure:
As stated

REPORT TO THE CONGRESSIONAL DEFENSE COMMITTEES

SECTION 703 OF THE NATIONAL DEFENSE AUTHORIZATION ACT FOR FISCAL YEAR 2017
(PUBLIC LAW 114-328)

"Restructuring and Realignment of Military Medical Treatment Facilities"

19 FEBRUARY 2020

The estimated cost of this report or study for the Department of Defense (DoD) is approximately $ 2,522,000. This includes $ 1,042,000 in expenses and $ 1,480,000 in DoD labor.
Report/Study Cost Estimate (7-9916B1E)

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Executive Summary

The Military Health System (MHS) is the most comprehensive military medical enterprise in the world. Its goal is to ensure a medically ready force to execute the National Defense Strategy, and a ready medical force to support our armed forces throughout the world.

This report summarizes the Department's decisions to align Military Treatment Facilities (MTFs) to increase the readiness of our operational and medical forces. (See section 703(d)(1) of the National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2017 (Public Law 114–328)). These decisions have been reviewed and accepted by the Secretary of Defense, and reflect the Department's underlying principle to improve the readiness of our force, while ensuring all beneficiaries have access to high-quality medical care.

The decisions in this report were based on an initial screening of 343 MTFs identified as providing healthcare services in the United States. The report contains analysis that is independent of other initiatives that will have an impact on manpower. From the 343 MTFs initially assessed, 77 were identified for further assessment. The assessment was completed using agreed upon methods by Department senior leadership including:

- Use of comprehensive data on MTF performance.
- Government and independent commercial assessments of local market capabilities and capacities.
- Data call identifying MTF readiness and mission requirements.
- Input from Service and local medical facility leadership and staff.
- On-site assessments when required.

The assessment identified: 50 MTFs for right-sizing, 21 with no change, and six deferred for further review. (See chart at the end of Executive Summary identifying the 50 right-sized MTFs).

This report provides a strategic framework for MTF realignment and restructuring that will be supplemented by more detailed implementation plans that include a timeline for achieving the planned end state along with estimates of implementation costs and any savings that may result. The Department will continue to evaluate MTFs for additional changes in delivery patterns using the methods described in this report.

The increased demand from the beneficiary population transitioning to local networks is the key driver of MTF implementation timelines. Most MTFs will need to follow a measured approach by transitioning beneficiary populations gradually to care from commercial providers.

During the transition, some local markets may be challenged to absorb the additional MTF beneficiary demand. As demand grows, the expectation is that new entrants to the market will increase network capacity. However, this expectation will be carefully managed during the transition and, if during implementation, local networks are challenged to absorb demand, the Department will revise its implementation plan. Markets are expected to transition MTF eligibles to the network at different rates and, in certain markets, the transition could take several years.

The MHS will generate an assessment of the implementation costs associated with each MTF transition and potential cost savings associated with shifting the workload to the network.

During the Department's assessment of MTFs, key conclusions related to implementation of the MTF transitions were developed:

Patient Access

1. *Care Coordination*: Transitioning MTF enrollees to the network will require facilitation of care and access within appropriate standards between the Managed Care Support Contractor (MCSC), and the network provider.
2. *Case Management*: Procedures for MTF case-managed patients who are shifted to the network will be reviewed to ensure there are no gaps in case management or qualification hurdles for case management under MCSC requirements.
3. *Exceptional Family Member Program (EFMP)*: Careful monitoring will take place for the potential increase in the administrative workload associated with supporting EFMP MTF eligibles and their families who may be transitioned to the network for Primary Care.
4. *Reductions in Installation Resources and Amenities*: Significant effort and consideration will be given to ensure reducing resources and amenities that installations offer to AD and their dependents is sufficiently mitigated.
5. *Virtual Health*: Virtual health capabilities could enhance access to care and would allow MTFs to provide healthcare services that are otherwise scarce.
6. *Civilian Provider Willingness to Accept TRICARE*: To mitigate concerns regarding civilian providers' willingness to accept TRICARE, greater coordination with MCSC will be conducted.
7. *Standardizing Support for Women's Health*: The scope of women's health services should be clearly defined based on population size; standard staffing models should be developed to support women's health.

System Enablers and MTF Capabilities

1. *Transmission of Health Records Between Military and Civilian Providers*: Maintaining complete health records for MTF eligibles will require increased monitoring and coordination between military and civilian providers.
2. *Facility Optimization*: Right-sizing MTFs' physical footprints or finding alternative uses for the space could increase cost savings in the long-term of the transition.
3. *Force Generation and Sustainment Considerations*: The MHS and Services must determine how to continue supporting medical training programs that were previously located at those MTFs.
4. *Urgent Care Clinics (UCC) / Freestanding Emergency Room (ER)*: Emergent/Urgent care is an important capability for MTFs supporting a large training component and must be accessible on or near the installation.
5. *Medical Holding Beds*: The MHS should establish a policy that addresses medical hold and patient monitoring capabilities for trainees, cadets and other Active Duty Service members (ADSM) who must convalesce, but do not require inpatient care.

6. *Market Availability of Mental Health Care (Inpatient and Outpatient)*: The MHS will address market shortages of mental health capabilities through expanding virtual health and retaining some direct care mental health capabilities.
7. *Occupational Health*: Occupational Health is a critical service for all MTFs and will be maintained for all AD, civilian employees, and contractors who require it.
8. *Base Plan Strategic Impacts*: The Continental United States Patient Distribution Plan will be reassessed to reflect the future-state of MHS capabilities once implemented.

Manpower and Staffing

Right-Sizing MTF Staff: The MHS will develop standard staffing models that align to the recommended future state

The framework for assessing MTF realignment and restructuring was designed to be repeatable and scalable so that all MTFs across the MHS enterprise could be reviewed as the Department continues to adjust the MHS infrastructure to better support operational readiness requirements.

FY17 NDAA SEC 703 MILITARY TREATMENT FACILITY (MTF) RIGHTSIZING BREAKDOWN

MILDEP	State	MTF	Decision
AF	TEXAS	AF-C-17th MEDGRP-GOODFELLOW	Transition the 17th Medical Group Goodfellow outpatient facility to an Active Duty only and Occupational Health clinic (AD/OH). All base support functions and pharmacy workload supporting all beneficiaries will be maintained.
AF	LOUISANA	AF-C-2nd MEDGRP-BARKSDALE	Transition 2nd Medical Group Barksdale outpatient facility to an Active Duty (AD) only and Occupational Health clinic (AD/OH). All base support functions and pharmacy workload supporting all beneficiaries will be maintained.
AF	ALABAMA	AF-C-42nd MEDGRP-MAXWELL	Transition the 42nd Medical Group-Maxwell outpatient facility to an Active Duty only and Occupational Health clinic (AD/OH). All base support functions and pharmacy workload supporting all beneficiaries will be maintained.
AF	DELAWARE	AF-C-436th MEDGRP-DOVER	Transition the 436th Medical Group-Dover outpatient facility to an Active Duty only and Occupational Health clinic (AD/OH). All base support functions and pharmacy workload supporting all beneficiaries will be maintained.
AF	FLORIDA	AF-C-45th MEDGRP-PATRICK	Transition the 45th Medical Group-Patrick outpatient facility to an Active Duty only and Occupational Health clinic (AD/OH). All base support functions and pharmacy workload supporting all beneficiaries will be maintained.
AF	MASSACHUSETTS	AF-C-66th MEDSQ-HANSCOM	Transition the 66th Medical Squadron-Hanscom outpatient facility to an Active Duty only and Occupational Health clinic (AD/OH). All base support functions and pharmacy workload supporting all beneficiaries will be maintained.
AF	FLORIDA	AF-C-6th MEDGRP-MACDILL	Transition the 6th Medical Group, MacDill outpatient facility to an Active Duty only with Occupational Health clinic (AD/OH). All base support functions and pharmacy workload supporting all beneficiaries will be maintained.
AF	GEORGIA	AF-C-78th MEDGRP-ROBINS	Transition the 78th Medical Group-Robins outpatient facility to an Active Duty only and Occupational Health clinic (AD/OH). All base support functions and pharmacy workload supporting all beneficiaries will be maintained.
AF	TEXAS	AF-C-7th MEDGRP-DYESS	Transition the 7th Medical Group-Dyess outpatient facility to an Active Duty only and Occupational Health clinic (AD/OH). All base support functions and pharmacy workload supporting all beneficiaries will be maintained
AF	NEW JERSEY	AF-C-87th MEDGRP JBMDL-MCGUIRE	Transition the 87th Medical Group-McGuire outpatient facility to an Active Duty only and Occupational Health clinic (AD/OH). All base support functions and pharmacy workload supporting all beneficiaries will be maintained.
AF	FLORIDA	AF-CB-BRANDON COMM CLINIC-MIL (Sabal Park)	Sabal Park Clinic will close once all patients are transferred to the network.

MILDEP	State	MTF	Decision
AF	VIRGINIA	AF-H-633rd MEDGRP JBLE-LANGLEY	Transition AF-H-633rd Medical Group-Langley to an ambulatory surgery center (ASC) and outpatient clinic. All base support functions and pharmacy workload supporting all beneficiaries will be maintained.
Army	MARYLAND	AHC BARQUIST-DETRICK	Transition Barquist Army Health Clinic outpatient facility to an Active Duty only and Occupational Health clinic (AD/OH). Active Duty Family Members (ADFM) will be enrolled as necessary to round out the physician panels and maintain readiness. All base support functions and pharmacy workload supporting all beneficiaries will be maintained.
Army	PENNSYLVANIA	AHC FILLMORE-NEW CUMBERLAND	Transition Fillmore Army Health Clinic outpatient facility to an Active Duty only with Occupational Health clinic (AD/OH). Active Duty Family Members (ADFM) will be enrolled as necessary to round out the physician panels and maintain readiness. All base support functions and pharmacy workload supporting all beneficiaries will be maintained.
Army	ALABAMA	AHC FOX-REDSTONE ARSENAL	Transition Army Health Clinic Fox-Redstone outpatient facility to an Active Duty only and Occupational Health clinic (AD/OH). All base support functions and pharmacy workload supporting all beneficiaries will be maintained.
Army	VIRGINIA	AHC KENNER-LEE	Transition Kenner Army Health Clinic outpatient facility to an Active Duty only and Occupational Health clinic (AD/OH). Kenner AHC should maintain extended care hours to include weekend and holiday half-hours. All base support functions and pharmacy workload supporting all beneficiaries will be maintained.
Army	MARYLAND	AHC KIRK-ABERDEEN PRVNG GD	Transition Kirk Army Health Center outpatient facility to an Active Duty only and Occupational Health clinic (AD/OH). All base support functions and pharmacy workload supporting all beneficiaries will be maintained.
Army	VIRGINIA	AHC MCDONALD-EUSTIS	McDonald Army Health Clinic has already begun the transition from an ambulatory surgery center (ASC) to an outpatient facility with significant specialty services. The 703 Decision supports the transition.
Army	CALIFORNIA	AHC MONTEREY	Army Health Clinic Monterey has already transitioned to a primarily Active Duty (AD) only clinic (currently 96 non-AD enrollees receiving care at AHC Monterey). The 703 Decision supports the transition.
Army	KANSAS	AHC MUNSON-LEAVENWORTH	Munson AHC has already suspended surgical capabilities. The 703 Decision supports the official transition from an ambulatory surgery center to an outpatient clinic.
Army	ILLINOIS	AHC ROCK ISLAND ARSENAL	Transition Army Health Clinic Rock Island Arsenal outpatient facility to an Active Duty only with Occupational Health clinic (AD/OH). Active Duty Family Members (ADFM) will be enrolled as necessary to round out the physician panels and maintain readiness. All base support functions and pharmacy workload supporting all beneficiaries will be maintained.

MILDEP	State	MTF	Decision
Army	HAWAII	AMC TRIPLER-SHAFTER	Tripler will be considered for recapitalization of the aging platform with the final location and capability dependent on further analysis of Hawaii market capabilities and military demand.
Army	KANSAS	AMH FARRELLY AHC-RILEY	Farrelly Health Clinic has already transitioned from an outpatient facility to Active Duty (AD) only (Soldier-Centered Medical Home). The 703 Decision supports this transition.
Army	TEXAS	BLDG 36000-HOOD	Building 36000 previously housed the Fort Hood Medical Home closed in 2018; presently has a sleep lab in support of Carl R Darnall Army Medical Center (CRDAMC). The 703 Decision supports the transition.
Navy	NEW JERSEY	BMC COLTS NECK EARLE	Transition the Branch Health Clinic Colts Neck Earle outpatient facility to an Active Duty only and Occupational Health clinic (AD/OH). All base support functions and pharmacy workload supporting all beneficiaries will be maintained.
Navy	NEW JERSEY	BMC LAKEHURST	NBHC Lakehurst will be scoped to Occupational Health, Industrial Hygiene, and Preventive Medicine only. This is in line with planned and Navy approved clinic transition pre-dating 703 WG activities. Beneficiaries currently enrolled at NBHC Lakehurst are shifting to alternative military sites or the network.
Marine Corps	CALIFORNIA	BMC SAN ONOFRE MCB	Branch Health Clinic San Onofre is in the process of transitioning to an Active Duty (AD) only clinic. The 703 Decision supports the transition.
Army	GEORGIA	CBMH NORTH COLUMBUS-BENNING	Community Based Medical Home North Columbus-Benning outpatient clinic to close its capabilities.
Army	TEXAS	CHARLES MOORE HLTH CLN-HOOD	The Charles Thomas Moore Health Clinic has already transitioned to a Solider Centered Medical Home (SCMH) serving Active Duty only. The 703 Decision supports the transition.
Army	CALIFORNIA	COMMUNITY M HLTH SVC-IRWIN	Weed Army Community Hospital has already absorbed the workload of the Department of Behavioral Health at Fort Irwin and has closed. The 703 Decision supports the transition.
DHA	NORTH CAROLINA	JOEL CLINIC-BRAGG	Transition Joel Health Clinic outpatient facility to an Active Duty only with Occupational Health clinic (AD/OH). All base support functions and pharmacy workload supporting all beneficiaries will be maintained
Army	MARYLAND	KIMBROUGH AMBULATORY CARE CLINIC	Transition KACC from an Ambulatory Surgery center to an outpatient facility serving eligible beneficiaries.
DHA	GEORGIA	NBHC ALBANY	Transition Naval Branch Health Clinic Albany outpatient facility to an Active Duty only with Occupational Health clinic (AD/OH). Active Duty Family Members (ADFM) will be enrolled as necessary to round out the physician panels andmaintain readiness. All base support functions and pharmacy workload supporting all beneficiaries will be maintained.

MILDEP	State	MTF	Decision
Navy	VIRGINIA	NBHC DAHLGREN	Transition Naval Branch Health Clinic Dahlgren outpatient facility to an Active Duty only with Occupational Health clinic (AD/OH). All base support functions and pharmacy workload supporting all beneficiaries will be maintained.
Navy	CONNECTICUT	NBHC GROTON	Transition Naval Branch Health Clinic Groton outpatient facility to an Active Duty and Active Duty Family Members (ADFM) only and Occupational Health clinic (AD/OH). All base support functions and pharmacy workload will be maintained.
Navy/ Marine Corps	MARYLAND	NBHC INDIAN HEAD	Transition Branch Health Clinic Indian Head outpatient facility to an Active Duty only and Occupational Health clinic (AD/OH). All base support functions and pharmacy workload supporting all beneficiaries will be maintained.
Navy	MISSISSIPPI	NBHC MERIDIAN	Transition NBHC Meridian outpatient facility to an Active Duty only and Occupational Health clinic (AD/OH). Active Duty Family Members (ADFM) will be enrolled as necessary to round out the physician panels and maintain readiness. All base support functions and pharmacy workload will be maintained.
Navy	LOUISANA	NBHC NAS BELLE CHASSE	Transition Naval Branch Health Clinic Belle Chasse outpatient facility to an Active Duty only and Occupational Health clinic (AD/OH). Active Duty Family Members (ADFM) will be enrolled as necessary to round out the physician panels and maintain readiness. All base support functions and pharmacy workload supporting all beneficiaries will be maintained.
Navy	TENNESSEE	NBHC NSA MID-SOUTH	Transition Naval Branch Health Clinic Mid-South outpatient facility to an Active Duty only and Occupational Health clinic (AD/OH). All base support functions and pharmacy workload will be maintained.
Navy	NEW HAMPSHIRE	NBHC PORTSMOUTH	Transition Naval Branch Health Clinic Portsmouth outpatient facility to an Active Duty only and Occupational Health clinic (AD/OH). All base support functions and pharmacy workload will be maintained.
Navy	CALIFORNIA	NBHC RANCHO BERNARDO	The Medical Home Port Team transferred from NBHC Rancho Bernardo to NBHC Miramar on June 1, 2018. Operations at NBHC Rancho Bernardo stopped on June 1, 2018 including the Pharmacy, Lab, and Physical Therapy services. The 703 Decision supports the transition.
Marine Corps	SOUTH CAROLINA	NH BEAUFORT 1	Transition Naval Hospital Beaufort to an ambulatory surgery center (ASC) and outpatient clinic with medical holding bed capability located and sized to the requirement to assure appropriate care to those recruits that exceed the care capabilities of the recruit recovery unit.

MILDEP	State	MTF	Decision
Navy	TEXAS	NHC CORPUS CHRISTI	Transition Branch Health Clinic Corpus Christi outpatient facility to an Active Duty only and Occupational Health clinic (AD/OH). All base support functions and pharmacy workload supporting all beneficiaries will be maintained.
Navy	RHODE ISLAND	NHC NEW ENGLAND	Transition Naval Health Clinic New England outpatient facility to an Active Duty only and Occupational Health (AD/OH) clinic. All base support functions and pharmacy workload will be maintained.
Navy	MARYLAND	NHC PATUXENT RIVER	Transition Naval Health Clinic Patuxent River outpatient facility to an Active Duty only and Occupational Health clinic (AD/OH). All base support functions and pharmacy workload supporting all beneficiaries will be maintained.
Marine Corps	NORTH CAROLINA	NMC CAMP LEJEUNE	The 703 Decision supports the Naval Medical Center Camp Lejeune's plan to enhance capabilities to become a Level II trauma center by demonstrating the ability to initiate definitive care for all injured patients and provide 24-hour immediate coverage by general surgeons, as well as coverage by the specialties of orthopedic surgery, neurosurgery, anesthesiology, emergency medicine, radiology, and critical care. Additional capabilities required for NMCCL to become a Level II trauma center may include meeting tertiary care needs such as cardiac surgery, hemodialysis, and microvascular surgery and providing trauma prevention and continuing education programs for staff.
DHA	NORTH CAROLINA	ROBINSON CLINIC-BRAGG	Transition Robinson Health Clinic outpatient facility to an Active Duty only with Occupational Health clinic (AD/OH). All base support functions and pharmacy workload supporting all beneficiaries will be maintained
Army	WASHINGTON	SCMH OKUBO-JBLM	Soldier Centered Medical Home Okubo has already transitioned to an Active Duty (AD) only clinic. The 703 Decision supports this transition.
Army	FLORIDA	SOUTHCOM CLINIC-GORDON	Transition Army Health Clinic SOUTHCOM's outpatient facility to an Active Duty only and Occupational Health clinic (AD/OH). Under the Secretarial Designee Status Request for Medical Care, Active Duty Foreign National Mission Partners assigned to perform duties at SOUTHCOM would continue to be eligible to receive healthcare services from the clinic while their dependents will be transitioned to network healthcare providers. Active Duty Family Members (ADFM) will be enrolled as necessary to round out the physician panels and maintain readiness. All base support functions and pharmacy workload supporting all beneficiaries will be maintained.
Army	COLORADO	TMC ROBINSON-CARSON	USAMEDDAC Fort Carson completed the transition of TMC Robinson-Carson to an Active Duty only clinic on April 26, 2019. The 703 Decision supports the transition.

1.0. Overview

1.1. NDAA Background

In FY 2013, the ASD(HA) announced the Quadruple Aim of the MHS[1]: increased readiness, better health, better care, and lower cost. Increased readiness is the central aim of all MHS initiatives. The dual readiness mission includes maintaining a force that has the medical capability to support deployed operations (ready medical force), and Service members who are medically ready to deploy (medically ready force).

Figure 1. MHS Quadruple Aim

The MHS, through the Military Departments and DHA, develops the readiness capabilities of our medical force by leveraging the MTF of the Direct Care System (DCS) as the training and clinical currency platform for our military health care providers. This supports a ready medical force and promotes a medically ready force by assessing and documenting the current medical readiness of Service members and by providing healthcare to warfighters, their family members, and other eligible MTF eligibles through the DCS MTFs. The MHS also provides healthcare to enrollees through purchased care and the TRICARE network. The challenge in today's environment is to achieve a proper balance between meeting readiness requirements and managing the total cost of health care in the direct and purchased care systems.

This report summarizes one of MHS's efforts to balance mission and cost, expanding beyond prior efforts by employing a more readiness-focused approach to MTF capabilities.[2] Going forward, the department will continue development of select use cases examining additional alternative delivery methods to further increase MHS value. This report substantially fulfills the requirements of section 703(d) of the NDAA for FY 2017, to "…submit to the congressional defense committees an implementation plan to restructure or realign the military medical treatment facilities pursuant to section 1073d of title 10, United States Code, as added by subsection (a)."[3] DoD will address the remaining elements specified in the statute in MTF-specific detailed implementation plans for affected facilities.

While the report provides network assessments and other information for each MTF, it does not include detailed implementation plans. Detailed implementation plans will be completed through coordination of the MTFs, DHA, Military Departments, and the TRICARE Health Plan (THP) as a follow-on activity.

[1] Military Health System Innovation Plan 2012
[2] 2015 MHS Modernization Study
[3] Added by FY17 NDAA (Public Law 114–328), Sec. 703 "Military Medical Treatment Facility"

1.2. 703 Workgroup (WG) Background

To conduct the MTF assessments a Section 703 Workgroup was chartered consisting of representatives from HA, DHA, Joint Staff, the Services, and THP. This workgroup was organized to:

- Develop MTF-specific capability and capacity options by applying decision criteria and analytic tools to assess MTFs against installation mission, ready medical force, and operational force requirements
- Conduct a comprehensive MTF review, utilizing all available information including the capacity and capabilities of the local network to support healthcare delivery to MTF eligibles in the MTF market
- Prepare a Use Case for each MTF, highlighting its value to the installation, Service operational, and medical missions and readiness
- Supporting Senior DoD Leadership's review of Use Cases to finalize the scope and capabilities of care decisions for all United States-based MTFs
- Develop and test a model for expanding efforts beyond the initial MTFs reviewed
- Prepare and coordinate the section 703(d) of NDAA for FY 2017 required report to Congress

2.0. Scope

2.1. Scope of the Effort

To address the requirements of section 703 of the NDAA for FY 2017 the DoD assessed capabilities at IP and OP MTFs in the United States. To meet Congressional timelines, the DoD applied screening criteria (section 3.1) to identify a subset of MTFs of initial interest. This process identified 73 MTFs – 13 IP hospitals and 60 OP clinics – for initial assessment by screening 343 MTFs (36 inpatient/307 clinics) identified as providing healthcare services. Per the Services' request, three OP clinics and one (1) IP hospital were added to the scope of this assessment. This report includes a detailed assessment of 71 IP and OP MTFs with decisions on the remaining six MTFs are deferred. The assessment included a wide range of OP clinics (e.g., Ambulatory Surgical Centers, Ambulatory Care Centers, Occupational Health Clinics, Behavioral Health Clinics, etc.) in the scope of the analysis and report.
This report applies the framework provided in 10 U.S.C. § 1073d[4] to identify opportunities for realignment or restructuring with the following elements:

(A) With respect to each MTF –

i. Whether the facility will be realigned or restructured under the plan;
ii. Whether the functions of such facility will be expanded or consolidated;
iii. The justifications for such realignment or restructuring, including an assessment of the capacity of the civilian health care facilities located near such facility;
iv. A comprehensive assessment of the health care services provided at the facility;

[4] ibid

v. A description of the current accessibility of covered beneficiaries to health care services provided at the facility and proposed modifications to that accessibility, including with respect to services provided;
vi. A description of the current availability of urgent care, emergent care, and specialty care at the facility and in the TRICARE provider network in the area in which the facility is located, and proposed modifications to the availability of such care;
vii. A description of the current level of coordination between the facility and local health care providers in the area in which the facility is located and proposed modifications to such a level of coordination; and
viii. A description of any unique challenges to providing health care at the facility, with a focus on challenges relating to rural, remote, and insular areas, as appropriate.

Certain elements were not included in this report because further clarification of the requirements will be a part of the detailed implementation plans to include:

vi. The costs of such realignment or restructuring;
vii. A description of any changes to the military and civilian personnel assigned to such facility as of the date of the plan;
viii. A timeline for such realignment or restructuring.

The following subsections of section 703(d)(2) of the NDAA for FY 2017 (Public Law 114–328) also contain relevant elements that will be addressed in implementation plans if necessary:

(B) A description of the relocation of the graduate medical education (GME) programs and the residency programs
(C) A description of the plans to assist members of the Armed Forces and covered beneficiaries with travel and lodging, if necessary, in connection with the receipt of Specialty Care services at regional centers of excellence designated under subsection (b)(4) of such section 1073d
(D) A description of how the Secretary will carry out subsection (b)

The Department recognizes that the analysis and changes are not independent from other ongoing resource planning and transition activities and these decisions will inform the Department's medical reform efforts.

The scope of this report includes all U.S. MTFs. The Use Case process can serve as a template to eventually apply across all DoD MTFs. Similar to those included in this report, subsequent Use Cases will provide a comprehensive assessment of the healthcare services provided at each MTF facilitating identification of and decision-making on opportunities for restructuring.

2.2. Structure of the Report

The report is structured to follow the process that the 703 WG developed to assess the MTFs:

- Identifying Initial Opportunities (section 3.0) – The 703 WG developed a screening process and criteria to identify opportunities for restructuring MTF capabilities. Section 3.0 describes the screening methodology that identified MTFs for further assessment.
- Use Cases (section 4.0) – The Use Cases were developed to document the relevant information on each MTF, as well as input from the installation and MTF on mission requirements. The Use Cases contain three key components: Site Visit and Trip Report, installation and MTF Description, and a description of the Healthcare Market Surrounding MTF. Section 4.0 describes Use Cases in detail.
- Conclusions and Decisions (section 5.0) –Section 5.0 documents the Department's decision process results and the high-level findings.

3.0. Key Definitions

The following Table 1 through Table 3 include definitions of terms for understanding this report and MHS Network Assessment:

Facility

Table 1. Facility Definitions

Term	Description
Active Duty/Occupational Health (AD/OH) Clinic	AD/OH Clinics are MTFs/OP Facilities that provide needed health services only to Active Duty Service Members (AD) and care provided to civilian employees related to their employment.[5] This includes, but is not limited to, the services below: • Pharmacy and OH services remain to support installation and MTF eligibles • Other clinical services (e.g., Flight Medicine, Mental Health, Optometry, Physical/Occupational Therapy) will be appropriately sized to serve AD population
Military Medical Treatment Facility	Defense Health Program (DHP) funded facilities dedicated to providing health care to MTF eligibles, staffed and run by DoD personnel.[6] MTFs may make administrative adjustments as needed to address additional responsibilities (e.g., Geographically Separated Units)
OP Clinic	An MTF that provides OP Primary Care and limited specialty services to enrolled and MTF eligibles

[5] Contingent on establishment of standardized policy, AD/OH Clinics may enroll non-AD MTF eligibles as needed to maintain clinical readiness of the MTF's providers

[6] For the purposes of this report, MTFs are divided into three categories (Inpatient Facility, Outpatient Facility, Active Duty/Occupational Health Only Clinic), utilizing 10 U.S.C. § 1073d facility criteria

Benefit

Table 2. Benefit Definitions

Term	Description
Enrollees[7]	For the purposes of this report, beneficiaries and enrollees have the same meaning. Recognizing the changes in the statute beginning in 2018, the Enrollees are defined as individuals who have been determined to be entitled to or eligible for medical benefits, and therefore are authorized to receive treatment in the MHS. Reimbursable Secretarial Designees are not enrollees.
Managed Care Support Contractor (MCSC)	Each TRICARE region has an MCSC who is responsible for administering the TRICARE program. The MCSCs establish the TRICARE provider networks and conduct provider education. Humana is the MCSC in the East Region and HealthNet is the MCSC in the West Region of the U.S.
Network	Commercial and government providers of Primary Care and Specialty Care in the area surrounding an MTF that could potentially provide contracted care to MTF eligibles. The TRICARE Network refers to the subset of those providers with whom TRICARE is currently contracted
TRICARE HEALTH PLAN (THP)	THP is responsible for comprehensive program development, oversight, and management of the TRICARE Program, supporting the Military Services in implementation of TRICARE by providing beneficiary information, centralized administration, program and contract management for health care services
TRICARE Program[8]	The TRICARE program is established for the purpose of implementing a comprehensive managed health care program for the delivery and financing of health care services across the MHS (includes direct and purchased care)

Other

Table 3. Other Definitions

Term	Description
Knowledge, Skills, and Abilities (KSA)	KSAs are the specialty-specific Knowledge, Skills, and Abilities utilized by the expeditionary clinician (e.g., General Surgery, Orthopedic Surgery, Critical Care, Emergency Medicine, and others as developed by the DoD). DoD is using KSAs to assess medical providers' patient care workload at MTFs to determine their expeditionary clinical currency and competency, and to determine if additional readiness training may be needed prior to deployment
Military Health System (MHS)	For purposes of this report, the MHS is an integrated healthcare delivery system composed of two (2) parts: Direct Care System (DCS) and Purchased Care • DCS includes care that is provided to DoD MTF eligibles in DoD-owned MTFs. This care is referred to as direct care • Purchased Care is contracted health services outside of an MTF that provides, or supplements care to MTF eligibles • MHS also includes medical education, training programs, and clinical research the bulk of which occurs in MTFs

[7] 32 CFR § 199.3 - Eligibility
[8] 32 CFR § 199.17 - TRICARE program

Term	Description
MTF Market	For the purposes of this report, MTF markets are geographically defined areas that would include MTFs and purchased care resources tailored to address the healthcare needs of MTF eligibles. Note: The report defines markets differently from the DHA market construct
MTF Portfolio	MTF Portfolios are reports that provide a consistent, annual compilation of purchased and direct care demand data in MTF markets. Each Portfolio includes data relevant to the healthcare operations of the MTF including population/enrollment, workload, staffing, and relative cost comparisons.
Use Case	Use Cases are standard packages developed by the 703 WG and include: • The installation and MTF mission requirements and contributions to mission readiness • Input from the installation and MTF via a Site Visit Trip Report and Mission Briefs • Analysis of the civilian provider market surrounding the MTF • Department decisions for the realignment or restructuring of MTF capabilities

4.0. Assumptions

The report includes the following assumptions:

- The MHS provides high-quality, timely and safe patient care.
- The Services will prioritize uniform personnel assignments to meet readiness requirements and consider MTF requirements.
- Optimizing MTF capabilities allows for the redirection of medical resources to address higher-priority readiness and mission needs.
- MTFs can serve as key readiness-generating platforms.
- Present-day level of support to Combatant Commands will continue.
- Eligible Active Duty family enrollees dis-empaneled from an MTF will not be liable for co-pays for care delivered in the local healthcare network.
- Enrollees will not be dis-empaneled from the MTF until the MCSC identifies a by-name PCM in the network.
- Local healthcare markets around MTFs are generally balanced for current demand with limited ability to absorb additional demand immediately.
- Population growth creates demand for healthcare services and providers will increase enrollment or new providers will enter the market to match the demand.
- It will take time for the supply and demand in a market to reach a balance, therefore transition MTF eligible to commercial providers may require two (2)-to-three (3) plus years to complete depending on local healthcare market conditions and number of enrollees dis-empaneled.
- Private sector providers will meet the healthcare demand at the current rates of TRICARE reimbursement. However, smaller markets with limited payer mixes may be less likely to absorb lower reimbursement rates.
- Urgent, emergent, and Specialty Care will be available to enrollees either in the MTF or the purchased care network (covered in network assessments).

- Cost effectiveness and local market ability to absorb additional demand will be finalized in detailed implementation plans.
- Non-GME training and education will be addressed in the detailed implementation planning process

5.0. Identifying Initial Opportunities

Given the number of the MTFs in the MHS, the Department developed a screening process that identified initial opportunities in the U.S., based on the application of criteria provided in the report required by section 703(c) of the NDAA for FY 2017 and submitted to Congress on July 23, 2018.

5.1. Screening Process for Identifying Initial Opportunities

Introduction

In December 2018, the 703 WG developed a screening process to apply the criteria set forth in section 703(b) of the NDAA for FY 2017 and the methods described in the section 703(c) of the NDAA for FY 2017 report to Congress to screen 343 MTFs (36 inpatient/307 clinics) identified as providing healthcare services located in the United States. This process identified 73 MTFs where the screening process suggested a transition of capabilities might be possible. In conducting this analysis, make-versus-buy assessments utilized knowledge gained from the 2015 Modernization Study provided to Congress on May 29, 2015[9].

Performing a centralized, enterprise-level assessment of individual MTFs can be challenging because local factors have significant impacts on the availability and quality of care. Whether the local purchased care network can absorb the transitioned workload may depend upon such local nuances as knowing how many purchased care providers are accepting new patients or the providers' proximity to retirement. While the centralized assessment identified potential opportunities, additional analysis was needed for a comprehensive understanding of the network and MTF mission dynamics.

Application of 10 U.S.C. § 1073d Facility Criteria

Measurable definitions for the requirements of Medical Centers, Hospitals, and OP clinics were established to apply 10 U.S.C. § 1073d criteria as described in the section 703(c) of the NDAA for FY 2017 report to Congress. The screening algorithm applied these criteria and thresholds based on current facility classification. The objective was to identify those MTFs that presented as candidates for capability transitions for additional detailed review.

Medical Center and Hospital Assessment Definitions

The Medical Center and Hospital criteria enumerated in 10 U.S.C. § 1073d(b) were used to define a screening framework for inpatient facilities. The assessment was completed on U.S.-

[9] "Military Health System Modernization Study Team Report," May 29, 2015.

based markets with existing IP MTFs, using data from FY 2017. A market-level assessment of support for IP MTFs was conducted, where surrounding outpatient MTFs could serve as referral centers for complex patient care to the central IP MTF that measurably supports clinical readiness. The following definitions were used for the remainder of the IP assessment description:

Table 4. Hospital and Medical Center Criteria Definitions

Term	Description
Population	DoD uses two concepts to define populations centered on an MTF. A 40-mile radius catchment area, centered on an IP facility, encompasses its beneficiary population. A 20-mile radius Provider Requirement Integrated Specialty Model (PRISM) area, centered on an OP-only facility, defines its beneficiary population. In cases where the PRISM and catchment areas overlap, the beneficiary populations are consolidated into a single healthcare market with the OP-only facilities serving as referral sources for the IP MTFs. To identify MTFs needing additional analysis, geographic relationships between MTF eligibles was supplemented with AD enrollment information. The AD population information was used to define minimum capabilities required at an installation to support the line mission.
Referrals	Referrals include the specialty workload provided to MTF eligibles within an MTF. • Internal referrals pertain to the Specialty Care for those enrolled to the MTF • Outside referrals pertain to Specialty Care for anyone not enrolled to that MTF The screening algorithm evaluated referrals from OP to IP MTFs for the critical wartime specialties. The integrated networks between clinics and hospitals was determined to be valuable in preventing leakage of readiness valued workload outside of the DCS.
Trauma Capabilities	As stated in 10 U.S.C. § 1073d (b), a Medical Center must have "Level I or Level II trauma care capabilities." For the purposes of this assessment, the committee defined "trauma capabilities" as performance of sufficient[10] DCS workload in the five critical wartime specialties: Anesthesiology, Critical Care / Trauma Medicine, Emergency Medicine, General Surgery, and Orthopedic Surgery.
Tertiary Care	MTFs with tertiary care capabilities provide more complex, specialized care. In the MHS context, tertiary care is often associated with addressing the complex, specialized needs of trauma patients, beyond the core trauma critical wartime specialties. Therefore, an MTF is considered to have tertiary care capabilities if that MTF performed sufficient[11] DCS workload across 20 specialties required by the American College of Surgeons (ACS) at Level I or Level II trauma centers, beyond the critical wartime specialties[12].

[10] Until a readiness metric is available, sufficient workload is defined as having performed sufficient (wRVUs) in direct care facilities to support 80% of a provider in that specialty. A single provider's workload is defined as 50% of the FY17 Medical Group Management Association (MGMA) median wRVU by specialty.

[11] Sufficient workload is defined as having performed sufficient wRVUs in direct care facilities to support 80% of a provider in that specialty, where a single provider's workload is 50% of the 2017 MGMA median wRVU by specialty.

[12] Tertiary Care Specialties: Cardiology, Gastroenterology, Infectious Disease, Internal Medicine, Nephrology, Obstetrics/Gynecology, Ophthalmology, Otorhinolaryngology, Pulmonary Disease, Radiology, Urology, Cardiac/Thoracic Surgery, Neurological Surgery, Plastic Surgery, Vascular Surgery, Physical/Rehabilitation Medicine, Audiology and Speech, Physical/Occupational Therapy, Dietician, and Social Work. Adapted from the American College of Surgeons' Committee on Trauma manual, "Resources for the Optimal Care of the Injured Patient 2014." The committee notes that this is not intended to be a complete list of all clinical capabilities required for Level I or II trauma center verification by the ACS.

Term	Description
Readiness/GME Programs	The classification approach includes both GME and graduate dental education (GDE) programs. Therefore, an MTF must operate at least two resident programs. Accreditation standards for GME and GDE programs are set by the Accreditation Council for Graduate Medical Education and the Commission on Dental Accreditation, respectively. For the purposes of the screening analysis, Family Practice GME was not included in the GME/GDE analysis of IP MTFs
Cost Effectiveness	To assess the cost effectiveness of IP care, a cost per Medicare severity relative weighted product (MS-RWP) was used. This method was chosen because the MHS does not calculate professional services workload related to this care in the same format as purchased care. While the scope of this analysis addressed the cost effectiveness of healthcare delivery, the MHS has not yet developed nor widely adopted methodologies that allow for analysis of cost effectiveness relative to clinical and readiness outcomes
Network Capability	THP conducted a current-state network assessment to examine whether the as-is local network could absorb the IP MTF workload without anticipated risk to meeting TRICARE network access standards.[13] This network assessment analyzed whether DoD enrollees would have access to the same Specialty Care if the MTF's IP services ceased to exist, assuming no change to the TRICARE network's providers. As the network absorbs more care, this drives requirements for longer patient travel times that may impact the local military mission. This would be assessed in a detailed review of markets identified for transition in the implementation plan required for section 703(d). The assessment focused on four different IP capabilities: IP services, medical care, surgical care, and obstetric/gynecologic care In partnership with the MCSCs, THP led the network capability assessment. MCSCs leveraged several proprietary data resources including network adequacy, drive-time, and Access-To-Care (ATC) reports. They contacted their provider network services to determine if local civilian facilities could absorb workload currently performed at MTFs. The MCSCs provided an evaluation of the degree of risk associated with the network absorbing MTF workload, based upon their expert judgment and other proprietary decision frameworks. THP reviewed the MCSCs' evaluations, occasionally adopting a more conservative final evaluation given the THP's local knowledge and expertise. Due to the constraints of the TRICARE contract, specific details of the MCSC analysis are not available. The assessment methodology varied between MCSCs, making it difficult to generalize results

OP Clinic Assessment Definitions

The OP clinic screening process thresholds were based on the most efficient facility type to meet the needs of the mission and cost. These stand-alone clinics typically serve smaller DoD beneficiary populations and filling gaps in local civilian healthcare. The following definitions were used for the remainder of the OP clinic assessment description:

[13] TRICARE Access Standards include appointment wait time and drive-time standards. Appointment wait time should not exceed 7 days for routine care and 4 weeks for specialty or referred care. Drive-time should not exceed 30 minutes from home for routine care and 60 minutes from home for referred or specialty care. "TRICARE Policy for Access-to-care." HA Policy: 11-005.

Table 5. OP Clinic Criteria Definitions

Term	Description
Readiness/Installation Support	To provide effective medical capability to support each installation, readiness thresholds were established based on 1) the volume of referral care to critical wartime specialties, 2) size of AD population, and 3) the mission of the installation. An installation's requirements for medical readiness services, such as Primary Care, occupational, and environmental health services were considered.
Network Capability	As with hospitals, the THP conducted a network assessment that examined whether the current local network could absorb the current OP MTF workload without anticipated risk to meeting TRICARE network access standards. Distinct from the hospital assessment, the THP/MCSCs conducted this analysis at the individual specialty-level. The additional cost from an increase in lost duty time due to travel to a network appointment was not included in time away from work.[14] The methodology used to conduct this assessment varied across the TRICARE regions. West Region performed the network analysis, leveraging MCSC network adequacy and days to care reports, combined with local knowledge of the purchased care network's capability. Other MCSCs conducted this assessment employing a similar process to the one used for the hospital assessment.
Cost Effectiveness	While the scope of this analysis addressed the cost effectiveness of healthcare delivery, the MHS has not yet developed nor widely adopted methodologies that allow for analysis of cost effectiveness relative to clinical and readiness outcomes. To address the cost effectiveness requirement for OP care provided in OP clinics, unit cost was compared between direct care and purchased care

Facility Assessment Matrix

The facility assessment matrix (Figure 2) was used as a screening tool to identify opportunities for further evaluation. The screening process used centralized data sources, standardized thresholds based on industry standards when available, and quantified criteria that aligned with readiness priorities. The model examined 36 IP markets with Hospitals or Medical Centers and 307 standalone clinic-only markets in the U.S. The full offering of tertiary care specialties was not required in this screening to sustain an IP facility. Additionally, the screening criteria did not include consideration of the physical plant and level of maintenance backlog. The screening identified three MTFs that were added for detailed review based on the need for upcoming major facility projects or planned capability upgrades: Naval Medical Center San Diego (NMCSD), Army Medical Center (AMC) Tripler-Shafter, and Naval Medical Center (NMC) Lejeune. Each of these added MTFs had opportunities to align future strategy and the site's planned capital structure. NMCSD and AMC Tripler have near-term recapitalization projects and programmed sustainment, restoration, and modernization (SRM) expenses of $296M and $521M, respectively, through FY24. NMC Lejeune is currently a Level III Trauma Center with projected near-term projects costing $87M through FY24. For these reasons, these MTFs were identified as "Recapitalization Opportunities."

[14] Lack of information on time away from work for military personnel related to medical appointments for the member or their families precluded a quantitative assessment of these impacts.

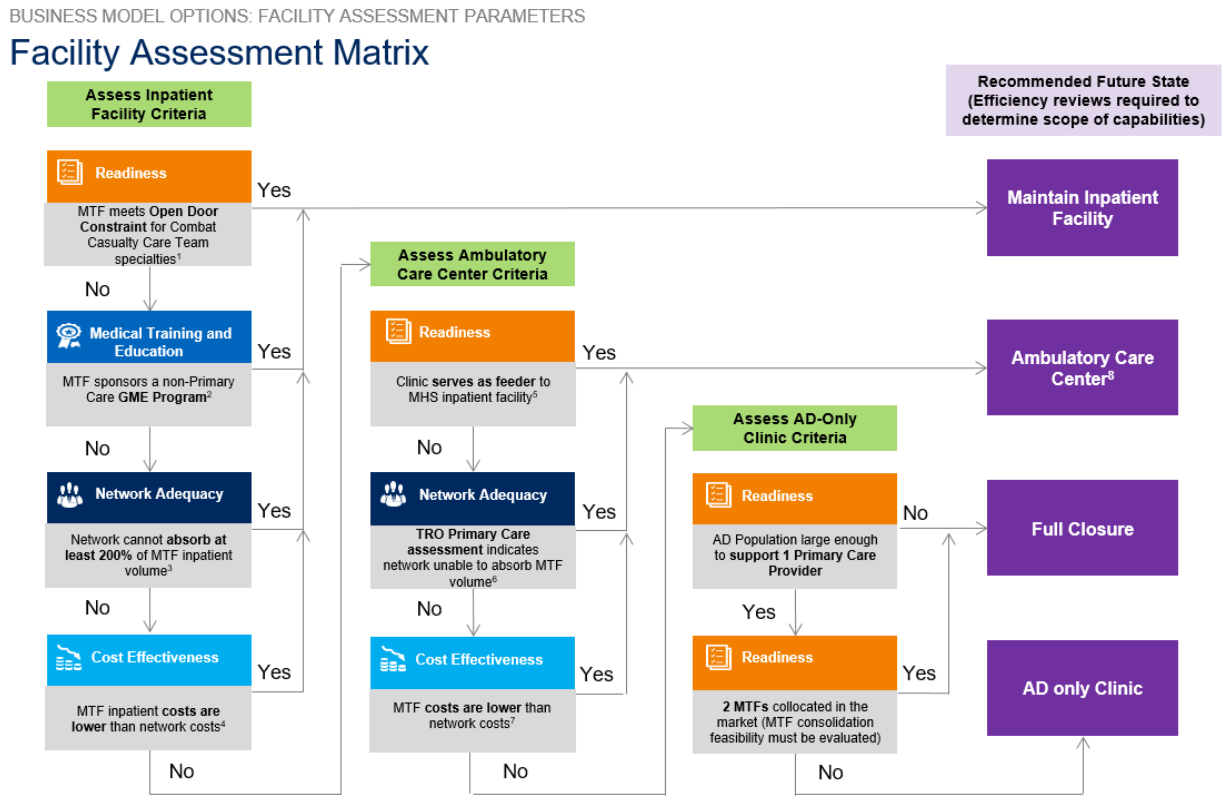


Figure 2. Facility Assessment Matrix

IP Screening Criteria

The screening algorithm quantified the definitions in 10 U.S.C. § 1073d. The ordering of the assessment matrix was based on NDAA for FY 2017 language and priorities. For this reason, the assessment matrix started with a readiness assessment for every facility type. If a facility's current capability could support readiness thresholds, no additional evaluation was required. However, all MTFs were evaluated on all criteria for thoroughness. For IP MTFs, readiness was defined as a force generation platform with GME programs other than Family Practice residencies or a critical role in maintaining a Ready Medical Force and Medically Ready Force. Network Adequacy was the second evaluation factor based on combination of civilian network capacity estimates and THP market evaluations. Finally, Cost Effectiveness was based on previous unit-cost analysis. A facility was recommended for further review if it did not meet or exceed any of the following criteria:

Table 6. IP Screening Criteria

Screening Criteria	Description
Medical Readiness	The focus for Medical Readiness was a facility's ability to sustain both the expectations for clinical volume for the most critical physician specialties; and the existing GME programs. Baseline workload levels had to support a minimum number of providers through KSAs and Medical Group Management Association (MGMA) relative value unit (RVU) benchmarks required for the critical wartime specialties. Section 708 of the NDAA for FY 2017 directed the establishment of a Joint Trauma Education and Training Directorate. It identified the following critical wartime specialties specifically: Emergency Medicine, Trauma and General Surgery, Critical Care, Anesthesiology, and Orthopedic Surgery.

Screening Criteria	Description
	The screening criteria further defined this as physicians in the specialty areas of General Surgery, Emergency Medicine, Orthopedics, and Critical Care Medicine. Due to data limitations, Anesthesia was not evaluated separately.[15] The analysis assumed if a minimum number of surgeons could be supported, then Anesthesia would also be supported. The concept of open-door thresholds[16] from the 2015 Modernization Study were applied to ensure facility workload volumes were large enough to maintain viable services. The KSA thresholds were based on the work of the multi-service working groups. The MGMA RVU thresholds were set at 50% of the MGMA Median[17] to align with current MHS performance measures. An additional 25% productivity buffer was added to the derived MGMA target to ensure providers would have adequate demand to meet minimal thresholds in a real-world environment. GME and GDE programs are essential to the MHS's ability to sustain pipelines of uniform physicians. The screening criteria required the presence[18] of one or more non-Family Practice GME/GDE programs. Accreditation standards for GME and GDE programs are set by the Accreditation Council for Graduate Medical Education and the Commission on Dental Accreditation, respectively. The screening criteria did not include Family Practice GME programs because the MHS Family Practice mission could potentially be addressed through partnerships with civilian academic institutions. This assumption is based on data from the National Resident Matching Program (NRMP). The 2017 Main Resident Match Results and Data report identified 141 unfilled Family Medicine Postgraduate Year (PGY) 1 Positions[19] the MHS could explore for potential placement of uniform trainees
Network Adequacy	IP network adequacy/capability assessments reviewed the ability of the local market to absorb current IP MTF workload within TRICARE network access standards. The minimum criteria for acute IP hospitals was based on combination of factors to include the number of beds, the estimated remaining capacity and distance parameters rather than just the number of facilities. The requirement was for the local market to absorb 200% of the MTF IP, bed-days workload between two or more Joint Commission accredited civilian hospitals. The two or more standard was required to reduce risk if one facility became unavailable. Additionally, the facilities had to be within 40 miles to maintain access standards. Local hospital IP capacity was based on data from the American Hospital Association (AHA) 2017 Annual Survey Database. Licensed bed-counts and historical admissions volume were used to estimate remaining capacity

[15] All workload data was based on FY17 Comprehensive Ambulatory/Professional Encounter Record (CAPER) files from M2
[16] Open Door Threshold for each specialty were applied as: General Surgery (2 FTEs), Emergency Medicine (2), Orthopedics (2) and Critical Care Medicine (1)
[17] MGMA thresholds were based on the MGMA 2016 Provider Compensation Report, based on 2015 data
[18] Presence of GME/GDE programs was based on 2017 GME data call through DHA J7 Education & Training
[19] The Match: Results and Data 2017 Main Resident Match. Pg. 8. Table 2 Matches by Specialty and Applicant Type, 2017. In 2019, there were 280 unfilled family medicine residency positions

Screening Criteria	Description
Costs Effectiveness	The cost effectiveness screening is to ensure that care can continue to be delivered within the DCS when it is more effective to do so than to outsource the care to the local market. A per unit comparison between direct and purchased care costs served as the cost effectiveness measure for this evaluation. This approach does not consider readiness or quality outcomes associated with the delivery of care. The MHS has not yet developed nor widely adopted methodologies that allow for analysis of cost effectiveness that incorporate variable clinical and readiness outcomes. Consistent with the method outlined in the NDAA for FY 2017 section 703(c) Report to Congress cost effectiveness considered the marginal difference between the cost to deliver one unit of care in the DCS and the amount paid per unit of care in the network. Instead of raw workload counts, nationally accepted standard weighted values were used as the workload basis. For IP, this weighted workload is the Medicare severity diagnosis related group's relative weighted product

OP Clinic Screening Criteria

The screening criteria for OP clinics was based on Ready Medical Force, Medically Ready Force, Network Adequacy, and Cost Effectiveness. These criteria were quantified differently from IP MTFs because of the scope of services and ability to integrate into an IP facility's clinical referral market. Potential future state facility types were: OP clinics open to all MTF eligibles, AD/OH Clinic, and Full Closure. OP clinics could include surgical and other specialty capabilities. AD/OH Clinic could include additional installation support services such as Occupation Health. All clinics were fully evaluated against the screening algorithm, regardless of their known contribution to medical readiness and installation support. However, adjustments were made to results for these considerations.

Table 7. OP Clinic Screening Criteria

Screening Criteria	Description
Medical Readiness	The focus for Medical Readiness was to ensure that reducing an OP clinic's capability does not adversely impact key referral volumes at an IP MTF. Continuing with the specialties associated with readiness in the IP screening algorithm, clinics were considered to have an impact on readiness if they referred enough volume to an IP facility in any of the critical wartime specialties to the extent that it would jeopardize the readiness of even a single provider. Further, if the clinic contributed as part of a system of clinics, such as Community Based Medical Homes (CBMH), it was evaluated as part of that larger system and not by itself. This method was designed to protect against piecemeal impacts to readiness. For each clinic, the referral volume of RVU was compared to the single provider specialty target for each DoD Occupation Code. If the referral volume was greater than the specialty target for a single provider, the clinic was considered a referral feeder and therefore a contributor to readiness. If the referral volume was less than the specialty target, then it was further evaluated as part of a system of clinics (i.e., aggregated with other local clinics within the IP MTF's catchment). If the clinic system's aggregate volume was greater than the specialty target, the clinic was considered a referral feeder and contributor to readiness. Finally, if the clinic's individual referral volume was enough to drop at least one provider

Screening Criteria	Description
	below the specialty target in a given specialty, the clinic was considered a referral feeder and contributor to readiness. The multi-tiered approach allowed for the most lenient evaluation of referral volume contribution to a ready medical force for key readiness specialties
Network Adequacy	THP conducted a network assessment that examined whether the current local network could absorb the current OP MTF workload without anticipated risk to meeting TRICARE network access standards. Distinct from the hospital assessment, THP/MCSCs conducted this analysis at the individual specialty-level. The screening criteria considered the adequacy of Primary Care to include Family Practice, Internal Medicine, and Pediatric specialties on a scale of Green, Yellow, or Red:[20] • Green – No anticipated problems meeting demand with ATC standards • Yellow – Potential for increased appointment wait time and/or drive-time • Red – Anticipate exceeding appointment wait time and/or drive-time standards Primary Care networks were considered adequate if all four[21] of the Primary Care areas were assessed as Green or Yellow, while Red was considered inadequate. The screening algorithm did not consider assessments of non-Primary Care product lines as the goal was to complete detailed market assessments during Use Case development.
Costs Effectiveness	The OP MTF Portfolio data (FY17) were adopted for the survey. The ambulatory portfolio method aggregates workload and costs by product lines across beneficiary types. The provider aggregate total RVU is the most comparable MHS weighted workload for the purposes of cost comparison to the network because it adjusts for multiple procedures. The direct care workload uses the Patient Level Cost Accounting (PLCA) full costs. This includes fixed, administrative, and ancillary costs allocated to each product line through the PLCA method. Purchased care claims do not include facility charges nor their associated relative value unit workload. An additional 13% cost increase was attributed to the purchased care rates to account for overhead burdening associated with the MCSC. Very few sites outperformed the network rate. For ambulatory, this weighted workload is the provider aggregate total RVU. This comparison only evaluates a single facet of cost effectiveness on a per unit basis

Results and Conclusions

The framework for applying the Medical Center and Hospital section 1073d(b) criteria was applied to all MHS MTFs. Thirteen IP markets and 60 clinics were identified for further review and detailed Use Cases (See Tables 3.1-5 and 3.1-6). During the process, four additional MTFs were added by the Military Departments for assessment. In addition to the feeder requirement, clinics were evaluated based on contribution to medical readiness and installation support. These were primarily AD/OH Clinics and Occupational Health only clinics. Both readiness and mission support were held to a 95 percent threshold for percent of workload related to Occupational Health or AD care. The 95 percent threshold was selected as the upper bound of

[20] ACC Network Adequacy analysis was originally performed by THPs for the report in response to section 703(c)(1) of the NDAA FY17 and repurposed for the screening process.

[21] The THP/MCSC Primary Care specialties include: Primary Care, Family Practice, Internal Medicine and Pediatrics. The screening criteria looked for Green in all evaluated. If an evaluation was not provided for a specific specialty, it had no impact on overall adequacy assessment.

the interquartile range for the distribution of percent AD served at all sites. No common definition exists for capabilities in AD or Occupational Health only clinics. There are clinics that are named Troop Medical Clinics (TMC) but the data shows that they often serve non-AD MTF eligibles.

Initial Screening Evaluation Results

Table 8 through Table 10 list the MTFs that the screening process identified as opportunities for further assessment and development of Use Cases. These are the results of the application of the screening process and do not represent decisions covered in Section 5.2.

Table 8. IP Screening Evaluation Results

Facility Type	DMIS	DMIS Facility Name
IP	0049	ACH WINN-STEWART
IP	0060	ACH BLANCHFIELD-CAMPBELL
IP	0064	ACH BAYNE-JONES-POLK
IP	0052	AMC TRIPLER-SHAFTER
IP	0048	ACH MARTIN-BENNING
IP	0086	ACH KELLER-WEST POINT
IP	0042	AF-H-96th MEDGRP-EGLIN
IP	0120	AF-H-633rd MEDGRP JBLE-LANGLEY
IP	0126	NH BREMERTON
IP	0104	NH BEAUFORT
IP	0091	NMC CAMP LEJEUNE
IP	0029	NMC SAN DIEGO
IP	0038	NH PENSACOLA

Table 9. OP Screening Evaluation Results

Facility Type	DMIS	DMIS Facility Name
OP	0001	AHC FOX-REDSTONE ARSENAL
OP	0003	AHC LYSTER-RUCKER
OP	0122	AHC KENNER-LEE
OP	0247	AHC MONTEREY
OP	0308	AHC KIRK-ABERDEEN PRVNG GD
OP	0309	AHC BARQUIST-DETRICK
OP	0352	AHC DUNHAM-CARLISLE BARRACKS
OP	1617	TMC MEDICAL EXAM STATION-BLISS
OP	1649	SCMH OKUBO-JBLM
OP	6014	CHARLES MOORE HLTH CLN-HOOD
OP	6076	RUSSELL COLLIER HLTH CLIN-HOOD
OP	6095	CPT JENNFR MORENO PCC-BAMC-FSH
OP	7239	SOUTHCOM CLINIC-GORDON
OP	7293	TMC ROBINSON-CARSON
OP	7337	AMH FARRELLY AHC-RILEY
OP	0290	AHC ROCK ISLAND ARSENAL
OP	0441	AHC FILLMORE-NEW CUMBERLAND

Facility Type	DMIS	DMIS Facility Name
OP	1480	AMC MAMC ANNEX
OP	1587	TMC-MCWETHY-BAMC-FSH
OP	6030	COMBINED MED SVCS C-WAINWRIGHT
OP	6031	COMMUNITY M HLTH SVC-IRWIN
OP	6124	CBMH NORTH COLUMBUS-BENNING
OP	6199	MOUNTAIN POST BEHAVIORAL HC
OP	7198	NELSON MEDICAL CLINIC-KNOX
OP	7347	BLDG 36000-HOOD
OP	0004	AF-C-42nd MEDGRP-MAXWELL
OP	0036	AF-C-436th MEDGRP-DOVER
OP	0043	AF-C-325th MEDGRP-TYNDALL
OP	0045	AF-C-6th MEDGRP-MACDILL
OP	0046	AF-C-45th MEDGRP-PATRICK
OP	0051	AF-C-78th MEDGRP-ROBINS
OP	0055	AF-C-375th MEDGRP-SCOTT
OP	0062	AF-C-2nd MEDGRP-BARKSDALE
OP	0112	AF-C-7th MEDGRP-DYESS
OP	0114	AF-C-47th MEDGRP-LAUGHLIN
OP	0310	AF-C-66th MEDGRP-HANSCOM
OP	0326	AF-C-87th MEDGRP JBMDL-MCGUIRE
OP	0364	AF-C-17th MEDGRP-GOODFELLOW
OP	1946	AF-CB-BRANDON COMM CLINIC-MIL
OP	0035	NBHC GROTON
OP	0068	NHC PATUXENT RIVER
OP	0100	NHC NEW ENGLAND
OP	0107	NBHC NSA MID-SOUTH
OP	0118	NHC CORPUS CHRISTI
OP	0317	NBHC MERIDIAN
OP	0436	NBHC NAS BELLE CHASE
OP	1659	BMC SAN ONOFRE MCB
OP	0301	NBHC INDIAN HEAD
OP	0321	NBHC PORTSMOUTH
OP	0322	BMC COLTS NECK EARLE
OP	0386	NBHC DAHLGREN
OP	0401	BMC LAKEHURST
OP	0406	NBHC RANCHO BERNARDO
OP	0357	NBHC WPNSCEN CRANE
OP	0090	AF-C-4th MEDGRP-SJ
OP	7143	ROBINSON CLINIC-BRAGG
OP	7286	JOEL CLINIC-BRAGG
OP	7294	CLARK CLINIC-BRAGG
OP	0275	NBHC ALBANY
OP	0302	BMC CARDEROCK

Table 10. Additional MTFs

Facility Type	DMIS	DMIS Facility Name
OP	0121	AHC MCDONALD-EUSTIS
OP	0058	AHC MUNSON-LEAVENWORTH
OP	0069	KIMBROUGH AMB CAR CEN-MEADE
IP	0073	AF-MC-81st MEDGRP-KEESLER

6.0. Use Cases

The Department developed "Use Cases" to document and synthesize the quantitative and qualitative data that were collected through the interactions with the site, network assessments, and associated analyses. The Use Cases are the result of a more detailed assessment process and capture the key elements of all materials, provide a platform for the final MTF decisions, and a comprehensive and relevant picture of the facility and surrounding heath care markets. Supporting the mission of each installation and AD readiness is a primary MTF mission and inputs from headquarters and local military commanders was an important consideration in formulating MTF decisions[22]. The Use Case framework emphasizes the need to structure the MTFs' capabilities in a way to best support the installation's mission and readiness. A Use Case is organized into two volumes:

- Volume I includes the Executive Summary, installation and MTF Description, Healthcare Market Surrounding the MTF, Site Visit Trip Report (if applicable), and Supplemental Materials provided by the MTF (where applicable). Volume I is located in the Appendix (section 8.0) of this report
- Volume II includes the MTF Data Call, Relevant Section 703 Report Detail, THP Network Assessment, Network Insight™ Network Assessment, P4I Measures, JOES-C Data, installation and MTF mission briefs, and the FY 2019 MTF Portfolio[23]. Volume II is located as a separate file

The Use Case Executive Summary includes the final MTF decisions, an overview of the installation and MTF, and the key inputs from the site visit that impact the mission of the installation to include risks that would need to be addressed during detailed implementation planning and execution of the transition and network implications. The details of the installation and MTF Description and Healthcare Market Surrounding the MTF can be found in sections 4.2 and 4.3.

6.1. Site Visits and Trip Report

The 703 WG conducted fact-finding site visits to select MTF markets as shown in Table 11. These site visits informed the Department's understanding of installation requirements for the MTF, particularly where the MTF provides unique capabilities to the installation mission. The visits also validated the assessment of the ability of the local network to address changes in the

[22] Six MTFs were deferred pending further assessment and their corresponding Use Cases are not included in this report. Deferred MTFs include: Naval Medical Center San Diego, CA; Naval Hospital Bremerton, WA; Army Community Hospital Keller-West Point, NY, Army Community Hospital Martin Benning, GA; 81st Medical Group Keesler Medical Center, MS and Naval Clinic Pesacola, FL.

[23] Created and distributed by DHA J-5

MTF capabilities. A trip report produced from the site visits was included in the Use Case. Site visit topics included, but were not limited to, discussions on: base mission and component missions, partnerships (e.g., Resource Sharing Agreement (RSA), External Resource Sharing Agreement (ERSA), Training Affiliation Agreement (TAA), GME Partnerships, etc.), MTF capability and infrastructure, geographic considerations, and community impact. The process provided a template for further assessment of MTFs beyond those included in this report.

Site Visit Selection

In-person site visits were conducted for MTFs where the Service, installation, or MTF leadership requested a visit or if the original screening outcomes posed a question or concern. Virtual site visits were conducted for MTFs where the original screening outcomes were agreed with by the Service. All MTFs reviewed the draft Use Case prior to a virtual or on-site visit and, in some instances, a site visit was requested after the development of the Use Case due to the network assessment. Generally, no site visits occurred for MTFs where a capacity transition had occurred that was aligned with the Use Case analysis.

Table 11. List of MTF Site Visits

MTF	Service	Location	Site Visit
AF-C-17th MEDGRP-GOODFELLOW	Air Force	Goodfellow, TX	Virtual
AF-C-325th MEDGRP-TYNDALL	Air Force	Tyndall, FL	Virtual
AF-C-42nd MEDGRP-MAXWELL	Air Force	Montgomery, AL	Virtual
AF-C-78th MEDGRP-ROBINS	Air Force	Robins, GA	Virtual
AF-C-7th MEDGRP-DYESS	Air Force	Dyess, TX	Virtual
AF-H-633rd MEDGRP JBLE-LANGLEY	Air Force	Hampton, VA	Yes
AF-C-2nd MEDGRP-BARKSDALE	Air Force	Barksdale, LA	Yes
AF-C-375th MEDGRP-SCOTT	Air Force	Scott, IL	Yes
AF-C-436th MEDGRP-DOVER	Air Force	Dover, DE	Yes
AF-C-45th MEDGRP-PATRICK	Air Force	Patrick, FL	Yes
AF-C-47th MEDGRP-LAUGHLIN	Air Force	Del Rio, TX	Yes
AF-C-66th MEDSQ-HANSCOM	Air Force	Hanscom, MA	Yes
AF-C-6th MEDGRP-MACDILL	Air Force	Tampa, FL	Yes
AF-C-87th MEDGRP JBMDL-MCGUIRE	Air Force	Cookstown, NJ	Yes
AF-CB-BRANDON COMM CLINIC-MIL	Air Force	Brandon, FL	Yes
AF-H-96th MEDGRP-EGLIN	Air Force	Valparaiso, FL	Yes
AHC MONTEREY	Army	Monterey, CA	No
AMC MAMC ANNEX	Army	Tacoma, WA	No
AMC TRIPLER-SHAFTER	Army	Honolulu, HI	No
COMBINED MED SVCS C-WAINWRIGHT	Army	Fairbanks, AK	No
MOUNTAIN POST BEHAVIORAL HC	Army	Colorado Springs, CO	No
NELSON MEDICAL CLINIC-KNOX	Army	Fort Knox, KY	No
SCMH OKUBO-JBLM	Army	Tacoma, WA	No
TMC ROBINSON-CARSON	Army	Colorado Springs, CO	No
ACH BAYNE-JONES-POLK	Army	Vernon Parish, LA	Yes
ACH BLANCHFIELD-CAMPBELL	Army	Oak Grove, KY	Yes

MTF	Service	Location	Site Visit
ACH WINN-STEWART	Army	Liberty County, GA	Yes
AHC BARQUIST-DETRICK	Army	Frederick, MD	Yes
AHC DUNHAM-CARLISLE BARRACKS	Army	Carlisle, PA	Yes
AHC FILLMORE-NEW CUMBERLAND	Army	New Cumberland, PA	Yes
AHC FOX-REDSTONE ARSENAL	Army	Huntsville, AL	Yes
AHC KENNER-LEE	Army	Petersburg, VA	Yes
AHC KIRK-ABERDEEN PRVNG GD	Army	Aberdeen, MD	Yes
AHC LYSTER-RUCKER	Army	Fort Rucker, AL	Yes
AHC MCDONALD-EUSTIS	Army	Newport News, VA	Yes
AHC MUNSON-LEAVENWORTH	Army	Leavenworth, KS	Virtual
AHC ROCK ISLAND ARSENAL	Army	Rock Island, IL	Yes
AMH FARRELLY AHC-RILEY	Army	Manhattan, KS	Yes
BLDG 36000-HOOD	Army	Killeen, TX	Yes
CBMH NORTH COLUMBUS-BENNING	Army	Columbus, GA	Yes
CHARLES MOORE HLTH CLN-HOOD	Army	Killeen, TX	Yes
COMMUNITY M HLTH SVC-IRWIN	Army	Fort Irwin, CA	Yes
CPT JENNFR MORENO PCC-BAMC-FSH	Army	San Antonio, TX	Yes
KIMBROUGH AMB CAR CEN-MEADE	Army	Hanover, MD	Virtual
RUSSELL COLLIER HLTH CLIN-HOOD	Army	Killeen, TX	Yes
SOUTHCOM CLINIC-GORDON	Army	Doral, FL	Yes
TMC MEDICAL EXAM STATION-BLISS	Army	El Paso, TX	Yes
TMC-MCWETHY-BAMC-FSH	Army	San Antonio, TX	Yes
BMC CARDEROCK	DHA	West Bethesda, MD	No
AF-C-4th MEDGRP-SJ	DHA	Goldsboro, NC	Yes
CLARK CLINIC-BRAGG	DHA	Fort Bragg, NC	Yes
JOEL CLINIC-BRAGG	DHA	Fort Bragg, NC	Yes
NBHC ALBANY	DHA	Albany, GA	Yes
ROBINSON CLINIC-BRAGG	DHA	Fort Bragg, NC	Yes
BMC SAN ONOFRE MCB	Navy	San Diego County, CA	No
NBHC CRANE	Navy	Crane, IN	No
NBHC RANCHO BERNARDO	Navy	San Diego, CA	No
NBHC GROTON	Navy	Groton, CT	Virtual
NBHC MERIDIAN	Navy	Meridian, MS	Virtual
NBHC NSA MID-SOUTH	Navy	Millington, TN	Virtual
NBHC PORTSMOUTH	Navy	Kittery, ME	Virtual
NHC NEW ENGLAND	Navy	Newport, RI	Virtual
NMC CAMP LEJEUNE	Navy	Jacksonville, NC	Virtual
BMC COLTS NECK EARLE	Navy	Colts Neck, NJ	Yes
BMC LAKEHURST	Navy	Lakehurst, NJ	Yes
NBHC DAHLGREN	Navy	Dahlgren, VA	Yes
NBHC INDIAN HEAD	Navy	Indian Head, MD	Yes
NBHC NAS BELLE CHASSE	Navy	Belle Chasse, LA	Yes

MTF	Service	Location	Site Visit
NH BEAUFORT	Navy	Beaufort, SC	Yes
NHC CORPUS CHRISTI	Navy	Corpus Christi, TX	Yes
NHC PATUXENT RIVER	Navy	Patuxent River, MD	Yes

Site Visit Planning

Prior to each site visit, Service representatives worked with the point-of-contact (POC) at the site to develop a schedule for the visit which included a brief with the installation command, a brief with the MTF command, and a tour of the mission critical element(s) of the MTF. The installation also provided data on the medical capabilities by responding to a Data Call intended to highlight the scope of the installation mission requirements that would impact MTF capacities and capabilities. Base and MTF mission briefs were included as read-ahead materials and discussed during the visit. These materials and additional research and analysis of the installation were assembled in a Trip Package that was given to the members of the 703 WG delegation to provide insight to the mission requirements prior to being on-site and to facilitate the discussion during the site visit.

Additionally, the 703 WG provided read-aheads to the site in advance of the visit. These materials included an agenda for the meeting with the Base and MTF command, an overview of the 703 WG charter, the purpose of the visit, delegation biographies, a THP and an independent government assessment of the healthcare market surrounding the MTF (section 4.2). The read-aheads allowed the MTF and base leadership to review the analysis and respond to the local healthcare network assessment.

Site Visit

The delegation for each site visit which included the 703 WG Lead, 703 WG Service Representative(s), Service Intermediate or Headquarter (HQ) Representative(s) (optional), THP Representative(s) and additional administrative support. This group met with the installation Commander or Deputy and MTF Commander, at a minimum, to discuss the base or MTF mission and the potential impact from a change in enrollment. At some sites there were several Command briefs due to the presence of several subordinate (child) commands that the MTF supported. The 703 WG visit team met with groups of ADFM, at the discretion of the MTF and installation leadership, to hear concerns from this group of stakeholders and gain an understanding of how the MTF supports different groups of MTF eligibles, as well as the services these groups value most. The tours of the MTF and installation mission element(s) helped the delegation to see and document the mission requirements for the MTF.

Trip Report

The output from the site visit was a Trip Report that documented all aspects of the trip, including the installation mission brief, MTF brief, and the tour of the facilities. The main purpose of the Trip Report was to capture the installation and MTF's perceived risks of implementing a transition of capacity and their understanding of the healthcare market surrounding the MTF. Trip Reports were drafted within five (5) days of the site visit and distributed to the MTF and

installation for review and to provide additional feedback and supplemental information that had been requested during the visit. Once the feedback was received, the final Trip Report was updated. The Trip Report was included in the Use Case to capture the voice of the customer to better understand the mission impact of potential changes and assessment of the local healthcare network.

6.2. Installation and MTF Description

For each selected site, the 703 WG requested specific details and information from both the installation and the MTF commands. Requested items included an installation mission brief and MTF mission brief detailing mission, vision, goals, history, priorities, and organizational structures. These mission briefs also included information on operational capabilities, units supported, unit mission, regional and disaster readiness, support of civil institutions, and community partnerships. Utilization of various services and encounters were also included along with medical education details, if applicable.

A data call detailing assigned deployment capabilities and personnel as well as installation affiliated clinic locations, missions, and medical units assigned to that mission. The data call also included information on line mission elements, assigned personnel and medical hold capabilities, if applicable.

MTF data portfolios were reviewed to identify assigned FTEs as well as number of buildings/beds, and average encounters counts by clinical service line. The portfolios provided data relevant to the healthcare operations of each MTF including population/enrollment, workload, staffing, and relative cost comparisons.

6.3. Healthcare Market Surrounding the MTF

In general, at least two formal network assessments were included in each Use Case, one from THP and another from an independent government contractor with experience and tools used for providing network assessments to commercial health care systems. Some MTFs and Services provided their own additional network assessment.

6.3.1. THP Network Assessment Assumptions

THP's analysis of the network latent capacity assumes that existing Primary Care Providers (PCP) maintain nearly full panels and have limited capacity for new patients. According to the MGMA and for the THP analysis, PCPs maintain a panel of approximately 2000 patients. THP assumed that a PCP could increase their panel size up to 2.5 percent (49 new patients) easily, 2.5 percent to 5 percent (50-99 new patients) with moderate difficulty, and greater than 5 percent (100 or more new patients) with great difficulty.

Example: Camp Swampy has 10,000 non-AD MTF eligibles who may be dis-empaneled from the MTF and empaneled to the TRICARE network. The MCSC currently has 110 contracted PCPs within 15 miles of the MTF and 100 are accepting new patients. THP also assumed that the MCSC could expand their network by contracting 50 percent of the non-network PCPs in the

area. There are 100 non-network PCPs in the same area, so THP assumes that the MCSC could contract 50 of them.

10,000 MTF eligibles ÷ (100 existing PCPs + 50 new PCPs) = 66.7 additional MTF eligibles per PCP (moderate difficulty)

Methodology

Primary Care

TRICARE network adequacy for Primary Care depends on two factors:

1. The number of contracted PCPs accepting new patients
2. The latent capacity of each PCP to empanel additional patients

To determine the number of PCPs within the network, the MCSC provided the number of Primary Care providers located within a 15-mile driving distance of the MTF for urban areas, and within a 30-mile driving distance for rural areas, based on mapping software parameters. This distance was determined using mapping software and is consistent with the 30-minute drive-time standard for Primary Care. While not all MTF eligibles live near an MTF, the MTF address was the best available proxy for estimating drive distances.

To further refine the number of PCPs available to empanel new patients, THP excluded those PCPs that were on record with the MCSC as not accepting new patients. THP also assumed that the MCSC could expand their network by contracting 50 percent of the non-network PCPs in the area. The independent government assessment (Network Insight assessment) provided the total number of PCPs within the same 15 (urban) or 30 (rural) mile driving distances. The Network Insight assessment also indicated if the PCPs accepted Medicare and were therefore likely to accept TRICARE if recruited by the MCSC.

Specialty Care

Most OP MTFs considered by the Department had only Primary Care, or Primary Care and a limited number of specialties (e.g., Physical Therapy, Behavioral Health, Gynecology, etc.). Specialty Care has a 60-minute drive-time standard from physical address to specialist location. Using the MTF address as the best proxy for the beneficiary home address, the network assessments used 40 miles (urban) and 55 miles (rural) to approximate drive-time. THP based the TRICARE network adequacy for Specialty Care on the average time from referral placement to the first date of service. The standard for Specialty Care access is 28 days. For any specialty service averaging less than 28 days, THP anticipated no problems continuing to meet access standards (labeled green). For any specialty service averaging greater than 28 days, THP anticipated the potential for problems meeting access or drive-time standards (labeled yellow).

IP Care

For assessment of MTF IP capability, THP worked with the respective MCSC to evaluate the capacity and quality of civilian hospitals in the local network. THP noted the number of civilian network hospitals within the 60-minute drive-time of the MTF, listing their annual admissions, births, IP days, daily census, and number of beds by specialty. Special consideration was given to geographic barriers such as bodies of water, tunnels, bridges, and mountainous terrain. The analysis considered the impact on the network hospitals if all admissions were shifted to the nearby hospitals. For example, closing IP services at Fort Polk would require the surrounding network facilities to absorb approximately 1,200 admissions, increasing the network admissions by 57 percent if spread among nearby Byrd Regional Hospital and Beauregard Memorial Hospital hospitals. In most cases, with Fort Polk being an exception, the local network would not be challenged to accept the additional admissions.

The assessment specifically included labor and delivery capacity at the network hospitals, performing call-outs to determine if the civilian hospitals could meet the demand. For example, if Army Community Hospital Blanchfield at Fort Campbell closed IP services, obstetric deliveries (1,862 in 2018) would be expected to occur in Tennova and Jenny Stuart hospitals closest to the MTF, increasing their annual deliveries by 267 percent. When contacted, the Tennova and Jenny Stuart leadership reported that they could not meet the projected demand without substantial costs. In all cases, THP considered the risk involved with driving long distances or across geographical barriers to deliver.

THP compared TRICARE IP Satisfaction Survey scores between the MTF and local network hospital when possible. In addition, THP considered quality and safety ratings of the network hospitals, from Leapfrog and Hospital Compare. The assessment also considered the availability of OP surgical specialties that could be affected by IP closure. This assessment was based on the Specialty Care methodology described above.

The overall assessment of IP MTFs was based on a combination of the factors above. However, labor and delivery services were the limiting factor in most cases.

Data Quality Discussion

All network assessments were reviewed by the THP analyst, an additional THP staff member, and the 703 WG for accuracy. Furthermore, all analyses were standardized to ensure the methodology was providing a means of stratifying risk amongst the various MTFs. The sensitivity of the methodology in identifying 14 high-risk networks (rather than all high-risk or no high-risk) lent credibility to the analyses.

The THP team worked closely with the contractor's Network Insight team that was developing a commercial network assessment to ensure commonality of terminology and driving distances.

Assessment Limitations

The THP network assessments are a "snapshot in time" based on MCSC reports of the number of providers contracted and the number accepting new patients. PCPs often do not contact the MCSC when they are closed to new patients. The available number of PCPs included in the analysis may be higher than the actual.

It is difficult to anticipate how quickly a market will add providers in the face of increased demand. Therefore, the THP assessment is only an estimate of the ability of a market to meet new demand for care.

The THP assessment driving distances were centered around an MTF location. Actual driving distances are based on the beneficiary residence, meaning some MTF eligibles would have to drive farther for network care, but many (those living off the installation) would have shorter driving distances.

The analysis of network hospitals to take on labor and delivery was based on communication with providers to verify OB information. Due to financial incentives, network hospitals may overstate their true capacity to accommodate new demand.

6.3.2. Independent Commercial Assessment (Network Insight)

The Network Insight assessment provided an independent scenario-based assessment of the ability of the commercial healthcare provider market to support demand for services from impacted MTF eligibles at each MTF being evaluated for transition or closure. Each assessment contains three sections: Facility/Beneficiary Identification and Proposed Scenario, Network Adequacy Analysis, and Targeted Physician Profiles.

Facility/Beneficiary Identification and Proposed Scenario

Facility/Beneficiary Identification and Proposed Scenario identified the facility being evaluated and the scenario being proposed, defined the geography (30- and or 60-minute drive-time boundary as stipulated by MHS ATC standards) for analysis, and identified the amount and density by zip code of current TRICARE MTF eligibles impacted by the proposed scenario. The impacted beneficiary population was calculated based on the proposed scenario for the MTF, as outlined in Table 12[24,25,26,27]:

[24] All population (DEERS) data, except where GENESIS implementation is underway, filtered for FY=18. 'Medicare Eligible' = TFL + Plus Populations. Where GENESIS implementation underway, filtered for FY=17. 'Medicare Eligible' = TFL + Plus Populations

[25] To assess OP specialties offered at an MTF: FY18 CAPER by MEPRS2 or MEPRS3 (B only) at TMT DMIS ID

[26] OP Workload for Medicare Eligible pulled from CAPER: TMT DMIS ID, Pseudo Person ID, MEPRS2 and MEPRS3 (B Only), & Encounters WHERE Elig. Group = L OR ACV Group = Plus.

[27] OP Workload for Medicare Eligible pulled from CAPER: TMT DMIS ID, Pseudo Person ID, MEPRS2 and MEPRS3 (B Only), & Encounters WHERE Elig. Group = L OR ACV Group = Plus

Table 12. Impacted Population Definitions

Scenario	Description	Impacted Beneficiary Calculation
IP → OP	IP capabilities removed, only OP/ambulatory capabilities remain (including ASC)	**IP:** All Prime + Reliant + Medicare Eligible (IP) (Catchment Area ID)
IP → Close	Closure of IP facility	**IP:** All Prime + Reliant + Medicare Eligible (IP Workload) (Catchment Area ID) **Specialty OP:** All Prime + Reliant + Medicare Eligible (OP Workload) (Catchment Area ID) **PC:** Non-AD MTF Prime + Plus (PRISM Area ID)
OP with Significant OP Specialty Care/ASC → OP	Transition from significant OP / ASC capabilities available to all MTF eligibles, to only OP capabilities remain	**Specialty OP:** All Prime + Reliant + Medicare Eligible (OP Workload) (MTF Service Area ID)
OP with Significant OP Specialty Care/ASC → AD/OH Only	Transition from significant OP capabilities available to all MTF eligibles to OP AD/OH Only	**Specialty OP:** All Prime + Reliant + Medicare Eligible (OP Workload) (MTF Service Area ID) **PC:** Non-AD MTF Prime + Plus (PRISM Area ID)
OP with Limited Specialty Care (Physical Therapy, Optometry, Occupational Health) → AD/OH Only	Transition from OP / ambulatory clinic to Service Member and Occupational Health-only facility	**Specialty OP (if applicable):** MTF Prime + Reliant + Medicare Eligible (OP Workload) (MTF Service Area ID) **PC:** Non-AD MTF Prime + Plus (PRISM Area ID)
OP with Limited Specialty Care (PT, Optometry, Occ Health) → Close	Closure of OP / ambulatory clinic	**Specialty OP (if applicable):** MTF Prime + Reliant + Medicare Eligible (OP Workload) (MTF Service Area ID) **PC:** MTF Prime + Plus + Reliant (PRISM Area ID)
AD/OH Only → Close	Closure of AD/OH 0nly facility	**PC:** Active Duty

If the impacted beneficiary population was less than 10 percent of total population within the drive-time standards, then the projected demand for services within the commercial market was determined to not be materially impacted. To estimate the geographic market within a 30 and or 60-minute drive-time of MTFs, the following assumptions were used:[28]

- **Urban Areas:** Assumed an average driving speed of 30 Miles Per Hour (MPH), and thus a 15-mile radius around the zip code of the MTF was determined as the geographic market for Primary Care and a 40-mile radius around the zip code of the MTF was determined as the geographic market for Specialty Care
- **Rural Areas:** Assumed an average driving speed of 60 MPH, and thus a 30-mile radius around the zip code of the MTF was determined as the geographic market for Primary Care and a 55-mile radius around the zip code of the MTF was determined as the geographic market for Specialty Care

[28] MTFs located within Metropolitan Statistical Areas (MSAs), as defined by the U.S. Office of Management and Budget (OMB), were assumed to be located in urban areas, with all other MTFs not located within MSAs assumed to be located in rural areas

Population data collected from Defense Enrollment Eligibility Reporting System (DEERS) was used to determine the breakout of MTF eligibles by location (within or outside the 30 and or 60-minute drive-time radius) and age group. Population data was further utilized to generate geospatial analyses to map out the density of MTF eligibles by zip code against the 30 and or 60-minute drive-time radius and provider locations.

Network Adequacy Analysis

Network Adequacy analysis evaluated the complement of providers currently practicing within the defined geography, provided transparency into the 5-year trend for forecasted demand by specialty, and identified the presence of shortages and or surpluses in the commercial market that could impact the network's ability to provide adequate ATC for the potentially impacted TRICARE MTF eligibles.

IBM Truven Health database was leveraged to assess the network adequacy within the commercial market. The IBM Truven Health database provides a count of the number of physicians for every U.S. zip code within the country. In addition, physician counts are aggregated by their primary specialty and the site — office or hospital — of practice. To provide zip code-level data, the source database counted each physician as a full-time equivalent (FTE), and assumed equal allocation of a percentage of one FTE to each known physician address. The physician addresses are filtered before FTE calculation based on data quality criteria to promote an accurate count.[29]

To construct the physician demand estimates and population-based visit rates for all payers in the hospital and private office settings, IBM Truven Health uses an extensive supply of proprietary claims, public claims, and Federal surveys. These overall visit rates reflect local patterns of healthcare demand and access to physicians, in every U.S. County. Forecasted rates also include the impact of Healthcare Reform on utilization. Use rates were applied to demographic projections by zip code to assume physician visits for 2018 through 2028. Physician productivity models based on the Truven Health Physician Claims Database were used to convert visit estimates into numbers of physicians demanded for 2018 through 2028. County-level Physician Supply and Demand figures used in the Network Adequacy analysis are inclusive of the entire county, regardless of whether the entire county lies within the 30- or 60-minute drive-time standard.

[29] Truven Physician Planning Source Notes, July 2018

Supply (Low – High)

Specialty Rollup	Specialty	Total	Autauga	Elmore	Lowndes	Montgomery *
Primary Care	General/Family Practice	143	17	17	1	108
Primary Care	Internal Medicine	99	10	6	0	83
Primary Care	Pediatrics	47	1	2	0	44

Demand (Low – High)

Specialty Rollup	Specialty	Total	Autauga	Elmore	Lowndes	Montgomery *
Primary Care	General/Family Practice	165	27	40	4	94
Primary Care	Internal Medicine	116	19	29	3	65
Primary Care	Pediatrics	59	9	14	1	35

Shortage (High – Low) / Surplus (Low – High)

Specialty Rollup	Specialty	Total	Autauga	Elmore	Lowndes	Montgomery *
Primary Care	General/Family Practice	(22)	(10)	(23)	(3)	14
Primary Care	Internal Medicine	(17)	(9)	(23)	(3)	18
Primary Care	Pediatrics	(12)	(8)	(12)	(1)	9

*County in which MTF is located

Figure 3. Sample Network Insight Supply and Demand Table

County-level Physician Supply and Demand data from Truven Health was used to calculate projected surpluses / shortages of Primary Care and key Specialty Care providers in counties containing zip codes within the 30- and or 60-minute drive-time radius. Easy Analytic Software Inc. (EASI) Demographic data was used to calculate population growth rates over the past 5 years (2014 – 2018) and projected population growth rates over the next 5 years (2019 – 2023).

Targeted Physician Profiles

Targeted Physician Profiles provided insight into the availability and willingness of the commercial network providers to accept TRICARE MTF eligibles. Provider likelihood to accept TRICARE MTF eligibles was determined based on the following criteria and assumptions:

- Currently Contracted – provider organization has a history of submitting In-Network claims to TRICARE per TRICARE claims data
- High Likelihood – provider organization has a history of submitting Out-of-Network claims to TRICARE per TRICARE claims data[30]
- Medium Likelihood – provider organization is accepting Medicare and or Medicaid per SK&A by IQVIA and Physician Compare practice data

[30] The current MCSCs providing claims processing services for the TRICARE for Life (TFL) beneficiary designation do not provide an "In-Network" designation during the claims process. Thus, these providers' claims were assumed to be out-of-network by default

- Low Likelihood – provider organization does not have a history of accepting Government Sponsored Health Plan patients per SK&A by IQVIA and Physician Compare practice data

Third party licensed data sources, SK&A by IQVIA, and publicly available data sources, Physician Compare, were used to generate profiles of physician practices within the 30- and/or 60-minute drive-time radius including details such as specialty, site physician count, monthly extended hours (outside of 9AM – 5PM), hospital alignment, and health system alignment. TRICARE claims data was additionally used to determine whether providers have a history of submitting In-Network or Out-of-Network claims to TRICARE, while SK&A by IQVIA and Physician Compare provider data was used to determine whether providers accept Medicare and or Medicaid Health Plans.

Provider identification methods mirror beneficiary identification criteria for the different MTF scenarios. PRISM ID was used as the geographic area for OP MTFs while Catchment Area was used for IP MTFs. In situations where no providers could be identified for an MTF, the MTFs' parent MTF was used as a proxy.

Data Quality Discussion

Except where otherwise specified, all data analyzed to identify MHS MTF eligibles, providers, and specialties was collected from the MHS MART (Management Analysis and Reporting Tool) (M2)[31], the DHA's key ad-hoc query tool designed to analyze clinical, population, and financial data.

MHS beneficiary population was collected from DEERS, which reports person-level demographic data, updated monthly, off M2. Beneficiary data was validated against DHA-approved MTF Portfolio data to detect any significant deviations from expected numbers. Key definitions as it pertains to beneficiary identification are as follows:

- PRISM: PRISM area represents an approximately 20-mile radius surrounding stand-alone MTFs (designated by a DMIS ID). A beneficiary's PRISM area in DEERS is based on their zip code and sponsor's Military Service and is assigned the DMIS ID of the identified MTF
- Catchment Area ID: Represents an approximately 40-mile radius around bedded IP MTFs or non-catchment area. A beneficiary's Catchment area in DEERS is based on their zip code and sponsor's Military Service and is assigned the DMIS ID of the identified MTF
- Enrollment Site ID: The DMIS ID of the MTF where the beneficiary is enrolled
- MTF Service Area: Represents an approximately 40-mile radius around bedded and un-bedded Authorized TRICARE Enrollment Sites

TRICARE claims data used consists of two M2 databases: TRICARE Encounter Data – Institutional (TED-I) and TRICARE Encounter Data – Non-Institutional (TED-NI). TED-NI

[31] The 703 WG did not assess the overall quality of data within M2 when performing Network Assessments. To the extent that there are data quality issues within the data sets, that would affect the results of the Network Assessments.

was the key data source utilized to identify providers who submitted claims for care provided within the applicable geographic area (i.e., PRISM, Catchment, MTF Service, or Enrollment Site ID). The TED-I data was leveraged to further identify providers, but specifically those who submitted claims for IP care within the applicable geographic area. The Comprehensive Ambulatory/Professional Encounter Record (CAPER) and Standard IP Data Record (SIDR) were both used to identify the highest volume specialties at MTFs.

Throughout the development of draft assessments, the team reviewed with TRICARE and Service leadership and analysts to obtain and incorporate any essential feedback, whether quantitative or qualitative.

Adjustments for Data Gaps

Certain MTFs do not have empaneled MTF eligibles via PRISM ID, MTF Service Area ID, and/or Catchment ID. For those MTFs, impacted MTF eligibles are calculated with Enrollment ID using the same criteria (All Prime, MTF Prime, non-AD MTF Prime, Reliant, Plus, Medicare Eligible). MTFs using this methodology are as follows:

- AF-C-325th MEDGRP-TYNDALL
- AHC MONTEREY
- AHC DUNHAM-CARLISLE BARRACKS
- NBHC NAS BELLE CHASSE
- TMC MEDICAL EXAM STATION-BLISS
- BMC SAN ONOFRE MCB
- Fort Hood Clinics (CHARLES MOORE HLTH CLN-HOOD, RUSSELL COLLIER HLTH CLIN-HOOD, and BLDG 36000-HOOD)
- Fort Bragg Clinics (ROBINSON CLINIC-BRAGG, JOEL CLINIC-BRAGG, and CLARK CLINIC-BRAGG)

Assessment Limitations

The Network Insight™ assessment methodology combines contractor-provided data, publicly available data, and MHS provided data with proprietary algorithms to help assess civilian market capacity for primary, specialty, and IP care.

The limitations include that the assessment:

- Provides projections of the future of market based on a snapshot at the time of initial analysis, but cannot predict the future of a market due to potential shifting macro or microeconomic considerations
- Estimates the capacity of the civilian market to accept new patients based on available data and can project surpluses or shortages within a reasonable degree of probability, but cannot determine actual capacity
- Indicates whether a provider has accepted TRICARE or government-sponsored health insurance previously, but cannot determine if the provider will continue to accept TRICARE MTF eligibles and how many they would accept

- Estimates average drive-time based on geographic considerations, but does not identify actual geographic and man-made barriers to drive-time (bridges, traffic lights, etc.)

6.4. Impacts to Military and Civilian Personnel

As part of the requirements of the section 703(d) of NDAA for FY 2017 FTE impact figures were estimated for each facility. The specific breakdown for each MTF can be found in section 5.2. FTE impact figures were imputed from the cost difference between the facility baseline and end state, which was converted into FTE by dividing the cost difference by the relevant military or civilian salary. Military salaries were defined at the Service-level and Civilian salaries at the MTF-level – in both cases an average across Skill Types was taken. This approach was necessary since the model estimated the impact to labor cost by scaling the baseline cost directly, rather than by estimating the impact to the FTE number.

The exception to the preceding imputation logic was for clinical FTEs, the impact to which was directly incorporated into the model to estimate labor savings. In this case, the FTE impact was taken directly from the model output.

6.5. Regional Interdependency Analysis

A Regional Interdependency Analysis was conducted to appropriately assess the network where there are overlapping catchment areas that impacts the same type of care. To identify impacted regions, the following criteria were applied:

1. MTFs considered for this analysis were those in the same geographic region (i.e., overlapping catchment areas) and with an MTF under assessment with the same type of care (e.g., Primary Care).
2. If the MTF has already undergone a transition that aligned with the screening outcome (e.g., transitioning to AD only or closure), it was not considered in the Regional Analysis, because the network has already absorbed the impacted population.

At Fort Bragg Joel Health Clinic-Bragg and Robinson Health Clinic-Bragg overlap and have the same impacted type of care and patient population (non-AD), but the impacted (non-AD) patients will be sent to Clark Clinic-Bragg.

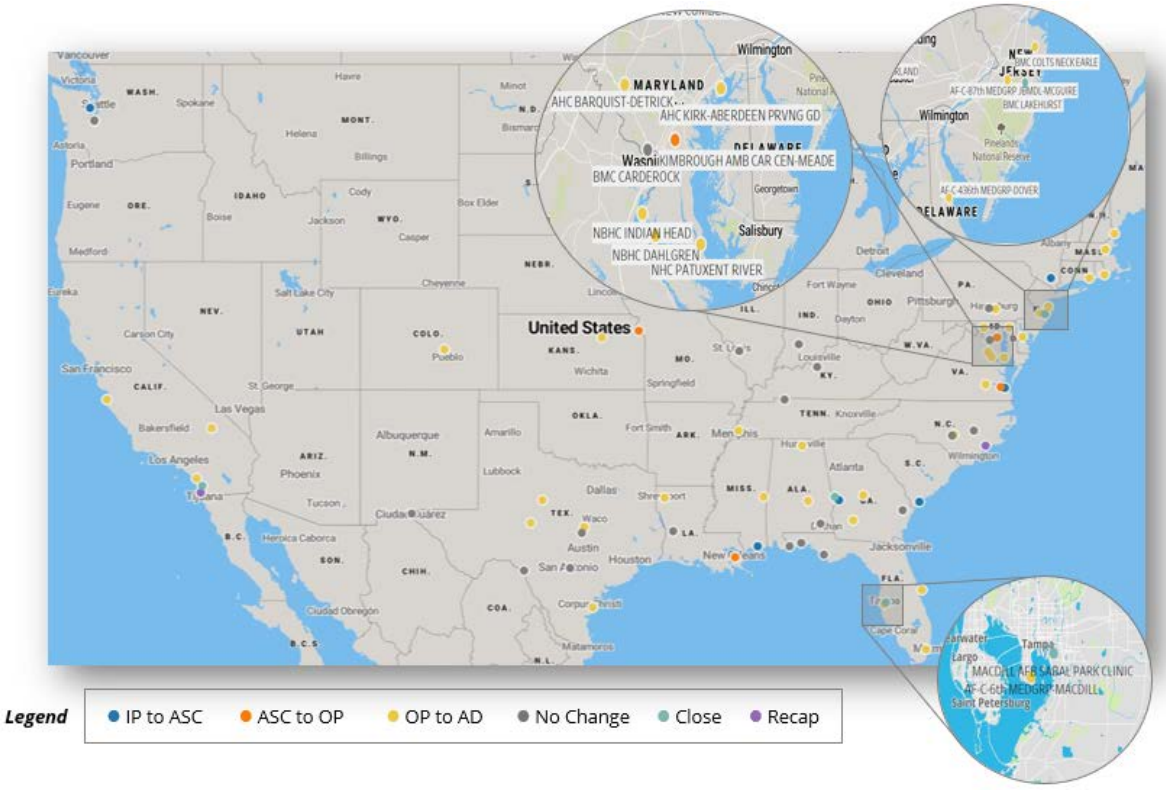
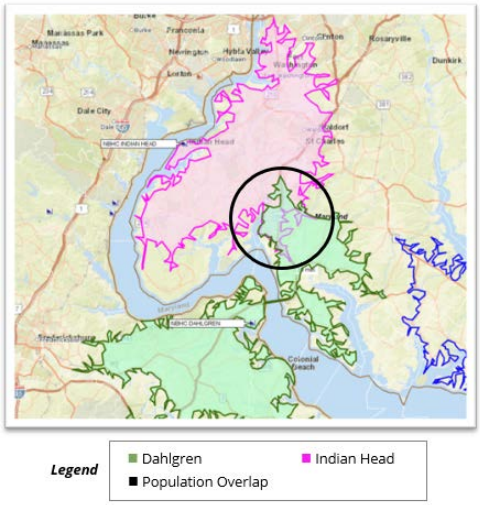


Figure 4. Regional & Market Interdependencies[32]

This process identified three regions that required further analysis to understand the network's ability to absorb TRICARE MTF eligibles:

The National Capitol Region (NCR) Multi-Service Market (MSM)

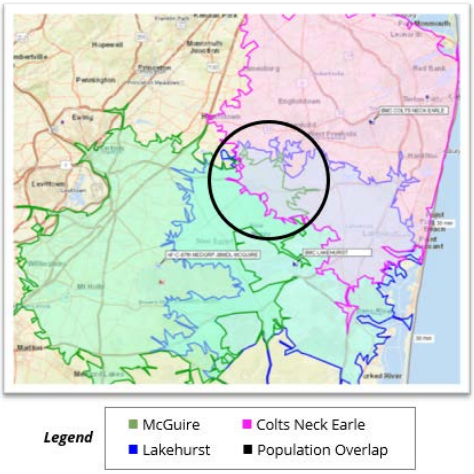
There is a slight overlap in PRISM area population (~300 MTF eligibles) between Branch Health Clinic (BHC) Indian Head and BHC Dahlgren, representing a very small fraction of demand for Primary Care in the market. The two clinics are separated by a bridge, requiring additional effort to travel from one service area to another. Networks in both areas are adequate to accommodate the increased demand.



[32] Combined Medical Services – Wainwright (Alaska) and AMC Tripler – Shafter (Hawaii) were evaluated but are not pictured due to map size

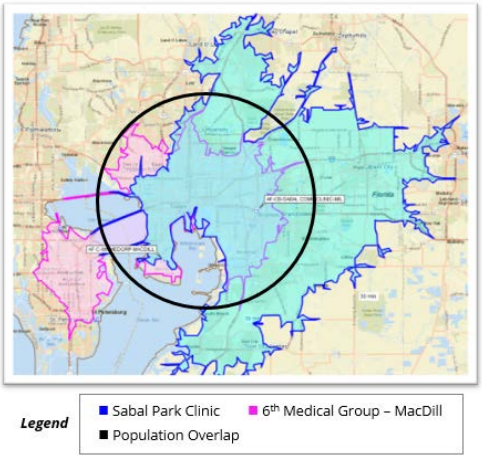
New Jersey

The population overlap of the MTFs in New Jersey is minimal – approximately 56 MTF eligibles in Ocean County and approximately 16 MTF eligibles in Monmouth County between BHC Colts Neck Earle and Joint Base McGuire-Dix-Lakehurst. [33] In Monmouth County, surpluses in Internal Medicine and Pediatrics are projected. There are projected shortages driven by population growth in General / Family Practice in Monmouth County and Primary Care specialties in Ocean County but will likely be addressed by new market entrants. The enrollment of additional MTF eligibles to the network would depend on current capacity of network providers, Humana network expansion, and potentially the entry of additional physicians into the market.



Tampa, Florida

There is relatively significant network overlap for the 6th Medical Group-MacDill and Sabal Park Clinic PRISM area. Sabal Park Clinic's patient population is comprised of ~99 percent non-AD, indicating that the 6th Medical Group-MacDill would absorb a very small portion of Sabal Park Clinic's workload. A shortage of General / Family Practice providers is predicted in Hillsborough County, where there is considerable overlap of the 6th Medical Group-MacDill and Sabal Park Clinic populations. Enrollment of additional MTF eligibles to the network would depend on current capacity of network providers, Humana network expansion, and potentially the entry of additional physicians into the market.



Overall, the regional assessments determined that overlap between commercial markets and referral patterns between the MTFs was limited and would not have a material effect on the available capacity of healthcare in the market or the ability of the MTF to perform key readiness functions in the future.

6.6. Emergency Room and Urgent Care Market Capabilities

Emergency Room services may be impacted when NH Beaufort and AF-H-633rd MEDGRP JBLE-Langley inpatient capabilities are transitioned to ASCs. NH Beaufort is situated in a market with eight civilian Emergency Departments that collectively saw more than 280,000 visits in 2017. AF-H-633rd MEDGRP JBLE-Langley sits in a market with nine civilian Emergency Departments, accounting for more than 430,000 visits in 2017. These civilian markets should be able to absorb the current MTF Emergency Department workload.

[33] Lakehurst Naval Health Clinic is shown on the map but not included in the analysis as it has already transitioned to an Active Duty only clinic

None of the outpatient MTFs transitioning to AD only offer Urgent Care Services. However, two of those clinics – NHC New England and NHC Patuxent River – do offer Primary Care After Hours Services. There is one Urgent Care provider within 25 miles of NHC New England, and four within 25 miles of NHC Patuxent River.

7.0. Conclusions and Mitigations

7.1. Conclusions

Several conclusions emerged through the Identifying Initial Opportunities (section 3.0) and Use Case (section 4.0) development processes. These conclusions were not exclusive to a certain region, Service, or population size. The narratives below were developed from feedback received via site visits and discussions with service leadership. They are representative, but not exhaustive, descriptions of all MTFs that had similar experiences. These conclusions and mitigations are provided to inform the detailed implementation process to address key stakeholder concerns.

7.1.1. Patient Access Conclusions

Minimizing lost duty time for AD and those MTF eligibles who work on base (e.g., eligible retirees), as well as meeting TRICARE access-to-care standards for these populations and ADFM, are prime concerns for Service and MHS leadership. The conclusions related to potential impacts on these areas, as well as planned mitigations, are outlined below.

Care Coordination

MTFs are heavily involved in care coordination for many of their MTF eligibles. Care coordination is defined as "the deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services. Organizing care involves the marshalling of personnel and other resources needed to carry out all required patient care activities and is often managed by the exchange of information among participants responsible for different aspects of care."[34] While the MCSC is currently contractually required to provide support to MTF eligibles empaneled to the network, the quality of care coordination must be carefully monitored during and after MTF transitions. This includes coordination between civilian providers and between military and civilian providers. One Navy clinic reported that MTF eligibles who were attempting to find a PCP in the network but were turned away at several facilities. Although PCPs indicated through the MCSC that they were accepting TRICARE patients, they were in fact only accepting limited numbers. Care coordination risks are higher at MTFs that provide medical care to large transitory population because of the need to connect with previous PCPs or help the population find Specialty Care within TRICARE access to care standards. There was a consistent concern with the accuracy and currency of the MCSC listing of PCPs accepting TRICARE patients often delaying the first network primary care appointment and frustrating MTF eligibles.

[34] https://www.ahrq.gov/professionals/prevention-chronic-care/improve/coordination/atlas2014/chapter2.html

Planned Mitigation: Installations, MTFs, and the MCSCs will need to monitor care coordination efforts during transitions to accommodate the MTF eligibles engaging with commercial providers and facilitate access within TRICARE ATC standards.

Case Management

MTFs and MCSC's often provide case management to those being treated for chronic, high-risk, high-cost, catastrophic, or terminal illnesses. Case Management is a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote patient safety, quality of care, and cost-effective outcomes. If patients whose case is managed by the MTF are shifted to the network, they may experience a gap in case-management or may not qualify for case management under the MCSC requirements.

Planned Mitigation: Installations, MTFs, and the MCSC will monitor patients receiving case management services during the transitions and mitigate risk by developing a transition plan for those patients.

Exceptional Family Member Program (EFMP)

MTF decisions included in this report may shift a number of EFMP patients into the commercial provider network for Primary Care. This shift could make it more challenging to obtain the information necessary to understand and articulate the impact of the family member's care on the AD duty requirements. As more Primary Care is transitioned to the network, it could become more difficult to clear EFMP families for change of station, limiting career progression opportunities for the AD member or forcing them to leave family members behind at locations with available care. The commercial network surrounding the MTF may not be the best suited for providing healthcare services to this population and may not be aware of services and/or restrictions for certain overseas duty locations.

Planned Mitigation: Healthcare operations will be structured to provide support to EFMP patients in relevant markets. Because the Services provide oversight to EFMP, additional coordination with the DHA will be required to ensure the EFMP needs are met. Implementation plans should address the administrative workload associated with EFMP.

Reductions in Installation Resources and Amenities

Local mission and MTF leadership voiced concerns that reducing healthcare services available on base would make the base a less desirable place for military families to live, particularly considering reductions of, or erosion of quality in, other base resources (e.g., exchanges, commissaries, and housing). One Army installation experiences significant difficulties with civilian hires due to its remote location, with hiring actions taking an average of 260 days. The installation leadership believes this is part of a larger trend that is also reflected in the local community and they cannot rely on commercial PCPs entering the market to address potential shortages. MTF leadership is concerned that further limitations on services (i.e., limited access

to Primary Care for ADFM) will affect recruiting and could change the perception of the value of the military experience.

Planned Mitigation: The potential impact of reduced installation resources that families use, including healthcare, should be considered holistically when making enterprise-wide decisions. Installations will need to balance resources effectively to continue providing the access to high-quality resources that MTF eligibles have earned.

Impact of Lost Duty Time

Minimizing lost duty time is a chief concern of Line leadership. Although challenging to quantify, installation and MTF leadership at many MTFs expressed that hidden costs may be incurred if AD needed to accompany family members off-base for healthcare services, or if retirees who are employed by the installation went to the off-base network for healthcare services. If capabilities for specialty care or inpatient care are transferred further from the point of need, the Services are concerned with lost time impacts on training and mission performance that could increase trainee recycle rates and failure to complete training syllabuses, especially when multiple visits are required for complete and accurate soldier profiling. An Army clinic and Air Force clinic noted that patients who work on base and have to leave the base to get healthcare could miss at least a half day of work either due to the distance of providers or traffic in urban areas, which ultimately leads to a negative impact on the mission. In many cases, particularly on training bases, younger families may have a single car and transportation for a dependent off-base would cause the AD to miss more work or training time than if the dependent could be seen at the MTF. This concern was notably expressed at training installations that have IP MTFs. If the IP capability was removed, the result could be substantial lost duty time while transporting trainees to commercial IP facilities for escort instructors and buddy trainees that accompany the patient. The second-order impact of the lost duty time is a potential delay in the training of the other trainees (e.g., battle buddy, escorts).

Retirees and ADFM serve as installation civilian employees in roles that directly support the mission. In these instances, transitioning to an AD/OH Clinic would require retirees and ADFM civilian employees to travel off-base for medical care. When transitioning to an AD/OH Clinic, readiness and mission may be impacted due to the length of time mission-essential civilian workforce retirees are away from duty while receiving care in the local healthcare network. At one Army installation, there are approximately 1,200 civilian employee retirees who receive care at the MTF, many who work in support of the mission.

ADFM health is part of the AD readiness equation. For those families living on-base, convenient access to healthcare is often perceived by installation commanders as affecting AD mission performance.

Planned Mitigation: Develop an analysis of impacts of lost duty time relative to medical and other necessary appointments that quantifies the impacts and provides a construct for further assessment. Alternative transportation strategies to facilitate beneficiary access-to-care, while minimizing AD time away from duty or training should be investigated in the detailed implementation planning. Implementation of new strategies would require commensurate resourcing in order to be effective. Due to statutory requirements, MTFs cannot give preference

for MTF care to retirees and ADFM who live or work on base over those that do not and changing the policy would require changes to existing law.

Virtual Health

MTF eligibles empaneled to installations located in rural or remote areas can experience challenges accessing healthcare services if the MTF does not offer the service or they are not readily available in the network. Some MTFs have found virtual care to be helpful in maintaining and expanding access to relatively scarce services. At one Army MTF, soldiers and their family members are required to spend up to a full-day traveling to and from specialty appointments. This facility has adopted virtual health offerings as a way of mitigating access to care and the travel time required for healthcare services. An Air Force MTF has implemented virtual health solutions to address a shortage of in-house psychiatric providers and meet the demand for mental health services and could represent a bets practice for more rural MTFs.

Planned Mitigation: As the MHS continues to transform healthcare operations, further investment in virtual health may remediate impacts to the mission from lost duty time for healthcare services or shortages of in-house or network providers and integrate virtual and in person appointing.

Civilian Provider Willingness to Accept TRICARE

By law, TRICARE reimbursement rates are capped by the CHAMPUS Maximum Allowable Charges (CMAC)[35] which are tied to Medicare's allowable charges. These rates may be lower than reimbursement rates of private insurers, which can cause a disparity between the number of commercial providers in the market and the number of providers who are willing to accept TRICARE MTF eligibles as patients. Line and MTF leadership voiced concerns that, while there may be a projected population growth in the area and MCSC data indicates that the network can absorb additional TRICARE demand, those providers may not necessarily be willing to accept TRICARE MTF eligibles at the current rates. Leaders at one Air Force clinic noted that they believe providers in the local area are not accepting TRICARE patients due to the reimbursements rates, and ADFM would have trouble getting care without the MCSC recruiting a significant number of current non-network providers.

Planned Mitigation: To mitigate risks associated with network adequacy, the transition of MTF eligibles to the network will be deliberate and carefully monitored. Transitions will occur over a 2-to-5-year period, depending on network capability and capacity. If the MCSC encounters issues with network capacity, the transition plan will be modified to accommodate successful delivery of care within TRICARE access to care (ATC) standards.

Standardizing Support for Women's Health

Much of women's health is clustered under the obstetrics (OB) product line, but there are a variety of other services that female MTF eligibles require. Many basic women's health services are delivered by Primary Care and Family Medicine providers, although this support is variable

[35] https://health.mil/Military-Health-Topics/Business-Support/Rates-and-Reimbursement/TRICARE-Allowable-Charges

across MTFs. In the case of female AD, if basic women's health services are not available at the MTF they may have to seek care in the network.

Planned Mitigation: The MHS will conduct additional analysis to define the scope of services required for Women's Health and develop standard delivery models based on population characteristics to effectively support women's health.

7.1.2. System Enablers and MTF Capabilities Conclusions

Alterations to MTF capabilities and footprints via MTF decisions will impact the type of care MTFs are able to provide. Implications of these transitions are wide ranging, including potential impacts on readiness generation and sustainment, medical support for training missions, Occupational Health, and MTF operations.

Transmission of Health Records Between Military and Civilian Providers

During many site visits, leadership raised concerns that the lack of Electronic Health Record interoperability with commercial providers could potentially limit access to patient records for both military and civilian providers, and potentially lead to poorer health outcomes. An Army clinic expressed that the continuity of health records was an important factor to consider when comparing how the DCS and purchased care interact, and that the quality assurance of medical documentation appeared to be lower in the network.

Planned Mitigation: Develop more effective enforcement of requirements for network providers to provide clear and legible reports to the MTF. As more patients are transitioned to purchased care, additional administrative resources may be required to make sure medical records are accessible to network PCPs and are received from the patients' previous PCPs. Network provider access to accurate TRICARE medical record information must be monitored to promote safe and effective care.

Facility Optimization

MTFs will often have larger physical footprints than required by their current beneficiary populations and services offered. For example, some clinics visited were formerly IP facilities that have since been converted to OP clinics, but continue to maintain the same square footage of a small community hospital. This increases the fixed costs and measurably the cost effectiveness of the MTF. The MHS and DoD will need to explore options to use or reduce space.

Planned Mitigation: Options to mitigate the high fixed costs of running these MTFs include: 1) the facility could be renovated so that the physical footprint is equal to requirements of the facility; 2) the MHS and DoD could partner with other organizations to find alternative uses for the space such as co-locating with the Veterans Affairs hospitals or leasing it to commercial healthcare providers; or 3) the DoD could recapitalize with Military Construction (MILCON) replacement.

Force Generation and Sustainment Considerations

The military medical training programs (GM/GDE, enlisted medical training) are a key component of force generation and was used as an assessment criterion during the reviews. When an MTF's capabilities are reduced, the availability of MTF specialty services or higher-acuity cases will likely also be reduced. In order to maintain clinician readiness, these programs will have to be re-established at other MTFs or civilian partner facilities.

Planned Mitigation: As the transitions are implemented, the DHA will work with the Services to make sure military medical education programs, including residency programs and phase II training, are properly supported or re-established as necessary.

UCC/Freestanding ER

Installation and MTF commanders – particularly those with significant training missions – emphasized that if their MTFs were to lose IP capabilities, it was still important for the mission that AD and ADFM had access to an equivalent range of on-installation Urgent Care and ER services. For example, an ER allows patients who need emergent care to be stabilized before being transported to an IP facility and was mentioned as a requirement by mission commanders at Army training installations hosting IP MTFs to manage any potential injuries or illnesses that occur during the rigorous training courses that are hosted on the installation.

Planned Mitigation: MHS leadership will define criteria for both UCCs and freestanding ERs for the organization, and execute transitions based on these definitions.

Medical Holding Beds

IP MTFs, particularly those with training missions, often use IP beds to monitor patients who do not require IP care, but do require either periodic monitoring or assistance, or would have difficulty navigating multi-story dorms or barracks. Were these MTFs to undergo a transition in capabilities, these MTF eligibles would require an alternative arrangement to convalesce.

Planned Mitigation: The DoD will establish policies on a patient holding strategy and patient monitoring capability that does not require full IP capability.

Market Availability of Mental Health Care (IP and OP)

There is a lack of Mental Health providers and IP beds across the U.S. and the MHS. Existing shortages are aggravated for military populations, as market providers are often not practiced in treating conditions that are more common in military populations (e.g., post-traumatic stress disorder). Additionally, market providers may not accept TRICARE MTF eligibles or only accept a limited number of TRICARE MTF eligibles, which can further exacerbate the supply issues. One Air Force IP MTF currently has three available positions for psychiatrists but is unable to fill those positions, and they regularly experience 60-day wait times for appointments in the network. A Navy OP clinic has experienced delays of up to 6 months to make a mental health appointment in the network. The MTF recently obtained a psychiatrist because AD could

not receive timely care in the network. Another Navy OP clinic has sought innovative solutions and partnered with an Army medical center to receive telehealth appointments.

Planned Mitigation: MHS leadership will evaluate mental health capabilities market-by-market to develop a strategy for addressing demand. Anecdotal evidence has shown that Return to Duty rates for AD mental health cases is higher with MTF-based care compared to commercial providers. This warrants further evaluation to determine future strategies for MHS IP mental health implementation.

Occupational Health

Numerous installations manage ordnance for the Services or have an industrial component. OH is a critical part of the support provided to enhance employee safety and health and maintain a medically ready force in compliance with applicable Occupational Safety and Health Agency program guidance.

Planned Mitigation: Because of the demonstrated need across the enterprise, OH was considered as a mission critical service that will remain at all MTFs where required and provide services to anyone who is eligible (e.g., civilian employees who work on the installation).

Base Plan Strategic Impacts

United States Transportation Command Base Plan 9008-18 CONUS Patient Distribution Plan (CPDP) addresses CONUS patient distribution in support of large scale overseas contingency operations. It coordinates DoD and other United States Government strategic stakeholder efforts to care for and move patients from CONUS arrival to definitive medical care. The CPDP model identifies a network of regional "hubs," to initially receive casualties from overseas locations and deliver timely Specialty Care, and "spokes," to maintain casualty flow at the hubs while alleviating problems related to casualty bottlenecking at larger specialty MTFs. Spoke sites also allow the added benefit of providing locations for casualties to receive care closer to their home units and/or family members, offering additional support during treatment and recovery. The plan includes all DoD IP capabilities, including those that may transition to OP (Table 14), and calls for casualties to initially flow into DoD hospitals until available bed space is saturated, at which time casualty flow turns to VA and finally, to National Disaster Medical System (NDMS) facilities.

The loss of IP military hospital beds could lead to an earlier reliance on both VA and NDMS beds for DoD casualties. Earlier reliance on NDMS beds could impact the CPDP because they are the same resources the Department of Health and Human Services plans to use for reception and care of noncombatant evacuees.

Planned Mitigation: Additional planning will be required to account for the loss of beds, including arrangements to use VA and NDMS civilian IP beds. The Base Plan will need to be reassessed based on changes that occur as a result of MTF decisions.

7.1.3. Manpower and Staffing Conclusions

Right-Sizing MTF Staff

An implementation plan will be required to specify specific reductions in personnel and resources needed to implement future-state capabilities and beneficiary population. In addition, the MHS does not have established staffing models that would inform the detailed implementation plans.

Planned Mitigation: The DHA, in collaboration with the Military Departments, will establish standard staffing models to adopt to provide quality, cost-effective care and support mission requirements. This staffing model would facilitate the implementation planning process.

7.2. MTF Decisions.

The Department's Decisions for 71 MTFs in Table 14 and Table 16 below are based on: 1. Service, installation, and MTF inputs (including Trip Reports, Data Tools, direct Use Case feedback from and discussions with Service, MTF, and installation leadership), 2. THP and the Independent Government network assessments, and 3. Enterprise data (including MTF Portfolios, centrally available performance metrics).

If an MTF is not explicitly referenced in this report, then no action is being taken and there is no change required for those MTFs.

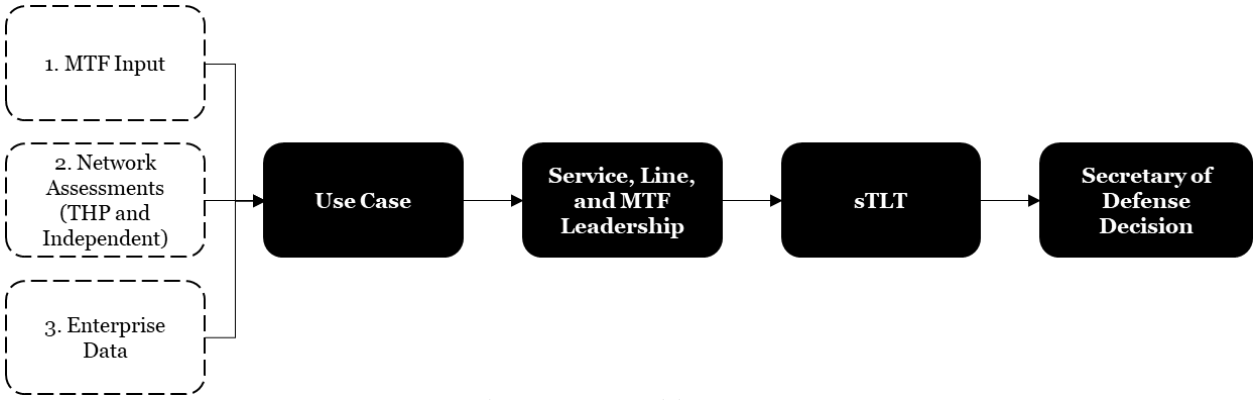


Figure 5. MTF Decision Process

The Use Cases were routed through the MTF and Military Department. (Figure 5) Feedback on the Use Case was provided by the Military Department within five business days. Upon receipt of feedback, the Use Case was revised, as appropriate, and reviewed by the Senior Transition Leadership Team (sTLT) made up of the Military Department Under Secretaries and Vice Chiefs of Staff, Vice Chairman, Joint Staff, Chief Management Officer, Under Secretary of Defense (Comptroller), Director, Cost Analysis and Program Evaluation, ASD(HA). The sTLT was chaired by the Under Secretary of Defense (Personnel and Readiness). The Use Cases were then presented to the Secretary of Defense for decision.

Table 13. End States Definitions

Scenario	Description
No Change – IP	No Change decisions indicate the facility should maintain the status quo and will continue to manage the capabilities and MTF eligibles that currently exist
Ambulatory Surgery Center (ASC), OP Ambulatory Care with 24-hour Urgent Care (UC)	Transition IP MTFs to provide OP care only, to include ambulatory surgical services and 24-hour UC
ASC and OP Amb	Transition IP MTFs to provide OP care only, to include ambulatory surgical services
Upgrade to Trauma Center	Develop plan to enhance trauma capabilities in an effort to receive a higher-level trauma designation
Right-size for Recapitalization[36]	Develop a strategic plan for the recapitalization of assets and right-sizing medical centers' and outlying clinics' healthcare capabilities to better serve its existing and projected beneficiary population, as well as enhance provider readiness

Table 14. Inpatient MTF Decisions[37]

Medical Military Treatment Facility	MTF Decision	FTE Impact	
		MIL	CIV
ACH BAYNE-JONES-POLK	No Change - IP	--	--
ACH BLANCHFIELD-CAMPBELL	No Change - IP	--	--
ACH WINN-STEWART	No Change – IP	--	--
AF-H-633rd MEDGRP JBLE-LANGLEY	IP to ASC and OP Amb	182	28
AF-H-96th MEDGRP-EGLIN	No Change – IP	--	--
NH BEAUFORT	IP to ASC and OP Amb	120	62
AMC TRIPLER-SHAFTER	Right-size for Recapitalization	--	--
NMC CAMP LEJEUNE	Upgrade Trauma Center Status	--	--
		302	90

Table 15. OP End State Definitions

Scenario	Description
No Change – OP	No Change decisions indicate the facility should maintain the status quo and will continue to manage the capabilities and MTF eligibles that currently exist. For certain MTFs, the No Change should be re-evaluated once policies have been developed to address the conclusions in the report
AD/OH Clinic	Pharmacy and OH services remain to support installation and MTF eligibles. Other clinical services (e.g., Flight Medicine, Behavioral Health, Optometry, Physical/Occupational Therapy) will be appropriately sized to serve the AD population, and in some cases, ADFM may be included if necessary to fill out

[36] Right-size for Recapitalization decisions are pending market studies which will determine the MTFs scope and capabilities.
[37] This table does not include NH Pensacola, which has already transitioned to an ASC, and the five inpatient MTFs that were deferred pending further assessment

	physician panels. Administration adjustments will be made as needed to address additional responsibilities (e.g., geographically separated units)
Occ Health, IH, and Preventative Med	Provides Occupational Health, Industrial Hygiene, and Preventative Medicine to AD, civilian employees, and contractors who require it. These clinics may also provide Primary Care services to AD and ADFM if necessary to fill out physician panels

OP MTFs Decisions

Table 16. OP MTF Decisions[38]

Medical Military Treatment Facility	MTF Decision	FTE Impact	
		MIL	CIV
AF-C-17th MEDGRP-GOODFELLOW	OP to AD/OH Clinic	41	13
AF-C-2nd MEDGRP-BARKSDALE	OP to AD/OH Clinic	54	15
AF-C-325th MEDGRP-TYNDALL	No Change – OP	--	--
AF-C-375th MEDGRP-SCOTT	No Change – OP	--	--
AF-C-42nd MEDGRP-MAXWELL	OP to AD/OH Clinic	78	31
AF-C-436th MEDGRP-DOVER	OP to AD/OH Clinic	53	13
AF-C-45th MEDGRP-PATRICK	OP to AD/OH Clinic	50	32
AF-C-47th MEDGRP-LAUGHLIN	No Change – OP	--	--
AF-C-4th MEDGRP-SJ	No Change – OP	--	--
AF-C-66th MEDSQ-HANSCOM	OP to AD/OH Clinic	33	7
AF-C-6th MEDGRP-MACDILL	OP to AD/OH Clinic	84	21
AF-C-78th MEDGRP-ROBINS	OP to AD/OH Clinic	46	24
AF-C-7th MEDGRP-DYESS	OP to AD/OH Clinic	31	14
AF-C-87th MEDGRP JBMDL-MCGUIRE	OP to AD/OH Clinic	33	18
AF-CB-BRANDON COMM CLINIC-MIL → SABAL PARK CLINIC[39]	OP to Close	--	--
AHC BARQUIST-DETRICK	OP to AD/OH Clinic	13	23
AHC DUNHAM-CARLISLE BARRACKS	No Change – OP	--	--
AHC FILLMORE-NEW CUMBERLAND	OP to AD/OH Clinic	7	12
AHC FOX-REDSTONE ARSENAL	OP to AD/OH Clinic	15	71
AHC KENNER-LEE	OP to AD/OH Clinic	48	101
AHC KIRK-ABERDEEN PRVNG GD	OP to AD/OH Clinic	13	36
AHC LYSTER-RUCKER	No Change – OP	--	--
AHC MCDONALD-EUSTIS*	ASC to OP	--	--

[38] In some instances, MTFs will continue to see ADFM to round out physician panels.
[39] AF-CB-BRANDON COMM CLINIC-MIL closed in and was replaced by SABAL PARK CLINIC in 2019. When SABAL PARK was evaluated for the original Screening Outcome it was determined that the clinic should close. However, FTE impact was not assessed.
*Asterisk in Table 16 indicate that the MTF has already undergone transition.

Medical Military Treatment Facility	MTF Decision	FTE Impact	
		MIL	CIV
AHC MONTEREY*	OP to AD/OH Clinic	--	--
AHC MUNSON-LEAVENWORTH *	ASC to OP	--	--
AHC ROCK ISLAND ARSENAL	OP to AD/OH Clinic	3	7
AMC MAMC ANNEX	No Change – OP	--	--
AMH FARRELLY AHC-RILEY*	OP to AD/OH Clinic	--	--
BLDG 36000-HOOD*	OP to Close	--	--
BMC CARDEROCK	No Change – OP	--	--
BMC COLTS NECK EARLE	OP to AD/OH Clinic	2	1
BMC LAKEHURST*	Occ Health, IH, and Preventative Med	--	--
BMC SAN ONOFRE MCB*	OP to AD/OH Clinic	--	--
CBMH NORTH COLUMBUS-BENNING	OP to Close	17	34
CHARLES MOORE HLTH CLN-HOOD*	OP to AD/OH Clinic	--	--
CLARK CLINIC-BRAGG	No Change – OP	--	--
COMBINED MED SVCS C-WAINWRIGHT	No Change – OP	--	--
COMMUNITY M HLTH SVC-IRWIN*	OP to Close [40]	--	--
CPT JENNFR MORENO PCC-BAMC-FSH	No Change – OP	--	--
JOEL CLINIC-BRAGG[41]	OP to AD/OH Clinic	70	52
KIMBROUGH AMB CAR CEN-MEADE	ASC to OP	3	27
MOUNTAIN POST BEHAVIORAL HC	No Change – OP	--	--
NBHC ALBANY	OP to AD/OH Clinic	4	1
NBHC DAHLGREN	OP to AD/OH Clinic	7	3
NBHC GROTON	OP to AD/OH Clinic	58	39
NBHC INDIAN HEAD	OP to AD/OH Clinic	7	2
NBHC MERIDIAN	OP to AD/OH Clinic	6	3
NBHC NAS BELLE CHASSE	OP to AD/OH Clinic	15	7
NBHC NSA MID-SOUTH	OP to AD/OH Clinic	16	8
NBHC PORTSMOUTH	OP to AD/OH Clinic	24	12
NBHC RANCHO BERNARDO*	OP to AD/OH Clinic to Close	--	--
NBHC WPNSCEN CRANE	No Change – OP	--	--
NELSON MEDICAL CLINIC-KNOX	No Change – OP	--	--
NHC CORPUS CHRISTI	OP to AD/OH Clinic	81	35
NHC NEW ENGLAND	OP to AD/OH Clinic	92	41

[40] The DMIS ID 6031 that was previously associated with this clinic is currently utilized by the Family Advocacy Program (FAP) and has been absorbed into the main hospital's BH clinic.
[41] Estimated personnel impacts for the Robinson-Bragg clinic have been rolled into Joel Clinic-Bragg.

Medical Military Treatment Facility	MTF Decision	FTE Impact	
		MIL	CIV
NHC PATUXENT RIVER	OP to AD/OH Clinic	37	20
ROBINSON CLINIC-BRAGG	OP to AD/OH Clinic	--	--
RUSSELL COLLIER HLTH CLIN-HOOD	No Change – OP	--	--
SCMH OKUBO-JBLM*	OP to AD/OH Clinic	--	--
SOUTHCOM CLINIC-GORDON	OP to AD/OH Clinic	4	6
TMC MEDICAL EXAM STATION-BLISS	No Change – OP	--	--
TMC ROBINSON-CARSON*	OP to AD/OH Clinic	--	--
TMC-MCWETHY-BAMC-FSH	No Change – OP	--	--
		1045	729

7.3. Next Steps

Upon submission of this report, detailed implementation planning will begin with implementation beginning not less than 90-days later. Each MTF is in a unique situation that will require a nuanced plan and timeline designed specifically for their requirements and risks identified in the MTF-specific Use Cases.

Implementation Costs Estimations

Developing estimates of implementation costs proved to be difficult as information on implementation costs from past Base Realignment and Closure and other MTF transition actions was not available. In addition, industry sources were not able to provide implementation costs or metrics for calculating implementation costs. This being the case, the Department was not able to develop implementation costs without relying on substantial arbitrary factors. The 703 WG did evaluate potential drivers of implementation costs. As with industry, implementation costs will be defined through the detailed implementation planning process where timing of changes in personnel and transition of enrollees to purchased care can be closely defined and monitored.

Discussions with industry sources indicate that, unless there are accompanying facility changes, the transition costs are normally small and other factors (such as operational profitability) are more determinative on whether the transition of commercial-sector healthcare is sustainable. For the MTFs scaling up care coordination for an increased number of MTF eligibles and mismatches between increased purchased care costs and corresponding reductions of MTF personnel and operational costs, such as variable facility and supply costs, are implementation cost drivers. Scaling up care coordination for an increased number of MTF eligibles is apparently built into the current MCSC contract and there are no additional costs projected due to enhanced care coordination. Potentially substantial costs would be incurred as the MTF transitioned enrollees to the network faster than corresponding reductions in staffing and other operating costs could be generated at the transitioning MTF. This factor will be addressed during detailed implementation planning and monitored to provide a baseline for future analyses.

Detailed Implementation Plans

The DHA, Military Departments, MTFs, and THP/MCSCs will collaborate to develop detailed implementation plans for transition to the MTFs future-state, execute the plan, and monitor the implementation activities. The plans should integrate MTF decisions with various planning processes such the MHS Regional Plans, QPP considerations, PB-20, and section 702 of the NDAA for FY 2017 related initiatives and will include MTF-specific timelines for the transition effort and will address the key risks identified in the Use Cases.

Executing the detailed implementation plan will include several activities and may differ across MTFs, however there will be certain tasks that will be common across all MTFs experiencing a transition:

- Care Coordination and Case Management – To continue providing quality healthcare that meets access standards that MHS provides its MTF eligibles, MTFs that transition capabilities will work with their MCSC to changeover care coordination and case management of MTF eligibles who are being moved to the network. This includes helping with identifying commercial providers who are accepting TRICARE MTF eligibles and assisting the MTF eligibles to navigate the commercial healthcare network.
- Right-size Staffing Model – MTFs will need to work with the Military Departments and DHA to determine staffing models and provider requirements. The detailed implementation plan may need to develop a multi-year staffing plan to make sure the MTF continues to contribute to Medical Readiness and a Ready Medical Force.
- Strategic Communications – A major component of the detailed implementation plan should be strategic communications to stakeholders including but not limited to affected MTF eligibles, network healthcare providers and staff. The strategic communications plan will have to address not only the current beneficiary population but also potential incoming MTF eligibles who are relocating to the installation as part of a Permanent Change of Station, so they understand the scope of healthcare services that are available at the MTF for themselves and their dependents.

It is important to note that the successful implementation of the MTF decisions in many cases will depend on the expansion of the healthcare market surrounding the MTF. This means the detailed implementation plans will require a measured approach of moving empaneled MTF eligibles to the commercial network to allow the market to grow in response to the increase demand signal for healthcare services. The Department will evaluate the network adequacy and adjust the detailed implementation plan as necessary to maintain access to quality healthcare for TRICARE MTF eligibles affected by the transitions as well as assess the impact the transition has on local network access. Finally, HA will work closely with DHA and Military Departments to assure funding is balanced between Budget Activity Group (BAG) 1-Direct Care Health Delivery and BAG 2 – Purchased Care as venue of care changes at each impacted MTF.

Evaluation of Additional MTFs

The initial grouping of 77 MTFs provided a framework for reviewing MTFs for realignment or restructuring that incorporated lessons learned from previous MTF assessments. It also

developed processes and tools for completing comprehensive assessments of the healthcare capabilities and availability of healthcare in the market.

The assessment processes and Use Case development can be applied across the MHS enterprise as a model to continuously evaluate the DCS support for beneficiary care and clinical readiness. The Department will complete decisions on the six deferred MTFs (ACH Keller-West Point, ACH Martin-Benning, NMC San Diego, NH Bremerton, NH Pensacola and 81st MEDGRP-Keesler Medical Center) in the future.

Appendices

8.0. Acronym Glossary

Acronym	Definition
ACS	American College of Surgeons
AD	Active Duty
ADFM	Active Duty Family Members
ADSM	Active Duty Service Members
AHA	American Hospital Association
AMC	Army Medical Center
ASD(HA)	Assistant Secretary of Defense for Health Affairs
ATC	Access to Care
CAPER	Comprehensive Ambulatory/Professional Encounter Record
CMBH	Community Based Medical Home
CLRs	Clear and Legible Reports
CMAC	CHAMPUS Maximum Allowable Charges
CO	Commanding Officer
COA	Course of Action
CONUS	Continental United States
CPDP	Continental United States Patient Distribution Plan
DCS	Direct Care System
DEERS	Defense Enrollment Eligibility Reporting System
DHA	Defense Health Agency
DHP	Defense Health Program
DoD	Department of Defense
EASI	Easy Analytic Software Inc.
EFMP	Exceptional Family Member Program
ERSA	External Resource Sharing Agreement
FM	Family Member of Military Retiree
FTE	Full Time Equivalent
FY	Fiscal Year
GDE	Graduate Dental Education
GME	Graduate Medical Education
HA	Health Affairs
HQ	Headquarters
IP	Inpatient
JOES-C	Joint Outpatient Experience Survey – Consumer Assessment of Health Providers and Systems
KSA	Knowledge, Skills and Abilities
M2 (Medical Mart)	Military Health System Management Analysis and Reporting Tool
MCSC	Managed Care Support Contractor
MGMA	Medical Group Management Association
MHS	Military Health System
MILCON	Military Construction
MPH	Miles Per Hour

MS-RWP	Medicare severity relative weighted product
MTF	Military Medical Treatment Facility
NDAA	National Defense Authorization Act
NDMS	National Disaster Medical System
NMC	Naval Medical Center
NMCSD	Naval Medical Center San Diego
NRMP	National Resident Matching Program
OB	Obstetrics
OH	Occupational health
OP	Outpatient
OSD P&R	Office of the Secretary of Defense for Personnel and Readiness
OTH	Other Tricare Beneficiary
PCP	Primary Care Providers
PGY	Postgraduate Year
PLCA	Patient Level Cost Accounting
POC	Point of Contact
PRISM	Provider Requirement Integrated Specialty Model
RET	Military Retiree
RSA	Resource Sharing Agreement
RVU	Relative Value Unite
SIDR	Standard Inpatient Data Record
SRM	Sustainment, Restoration and Modernization
SSO	Small Market and Stand-Alone MTF Office
sTLT	Senior Transition Leadership Team
TAA	Training Affiliation Agreement
TED-I	TRICARE Encounter Data – Institutional
TED-NI	TRICARE Encounter Data – Non-Institutional
THP	TRICARE Health Plan
TMC	Troop Medical Clinic
U.S.	United States
VA	Department of Veteran's Affairs
wRVU	Work Relative Value Unit

9.0. Use Cases Volume I

The Use Cases are inclusive of the analysis and description of the installation, MTF and surrounding healthcare market and are provided in a separate file.

10.0. Use Cases Volume II

The Use Case Volume II includes the MTF Data Call, Relevant Section 703 Report Detail, THP Network Assessment, Network Insight™ Network Assessment, P4I Measures, Joint Outpatient Experience Survey – Consumer Assessment of Health Providers and Systems (JOES-C) Data, installation and MTF mission briefs, and the FY19 MTF Portfolio. Volume II is located in a separate file.