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

PERSONNEL AND
READINESS

JUL - 1 2022

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

Dear Mr. Chairman:

The Department's response to section 718 of the William M. (Mac) Thornberry National Defense Authorization Act for Fiscal Year 2021 (Public Law 116–283), on Modifications to Implementation Plan for Restructure or Realignment of Military Medical Treatment Facilities; House Report 116–453, pages 336-337, accompanying H.R. 7617, the Department of Defense Appropriations Bill, 2021, on Descoping Military Treatment Facilities; the Joint Explanatory Statement, page 703, accompanying H.R. 133, the Consolidated Appropriations Act, 2021 (Public Law 116–260), on Restructuring Military Treatment Facilities; and House Report 117–88, page 332, accompanying H.R. 4432, the Department of Defense Appropriations Bill, 2022, on Descoping Military Treatment Facilities, is enclosed. The report provides the Department's plan detailing how the Department of Defense (DoD) will undertake a multi-year program to reshape operations at military medical treatment facilities (MTFs) for the purposes of increasing the readiness of our operational and medical forces while not diminishing quality and access for TRICARE beneficiaries.

The report represents the collaborative efforts of the Office of the Assistant Secretary of Defense for Health Affairs, Military Departments, Joint Staff, and Defense Health Agency. The report provides a comprehensive explanation of how DoD will undertake a multi-year program to reduce operations at 33 MTFs in addition to the 12 MTFs that have already completed transition activities and 3 that were removed as a result of the reassessment performed under section 718. Our focus on the coronavirus disease 2019 (COVID-19) pandemic response prevented us from submitting the report to Congress earlier.

The Department is committed to adjusting the timing, location, and scope of these changes as necessary to address conditions in local health care provider networks, installation mission requirements, and operational plans. In addition, as the impacts of the COVID-19 response continue to be defined, the Department will adjust the plan to ensure continuity of care for affected beneficiary populations. The Department will complete all statutory requirements prior to taking actions to reduce operations at any of the MTFs specified in this plan. These requirements include direct communication with affected beneficiaries, the provision of continuity of care transition plans, and the holding of public forums for beneficiaries to discuss their concerns regarding proposed transition to civilian providers through the TRICARE program. The transition efforts described in the attached will not commence until after the required 180-day period following the submission of this report. Additionally, this plan serves as

a certification to the congressional defense committees that affected beneficiaries will be able to access health care services through the purchased care component of the TRICARE program, as required by section 718.

Thank you for your continued strong support for the health and well-being of our Service members and families. I am sending similar letters to the other congressional defense committees.

Sincerely,

Gilbert R. Cisneros, Jr.

Enclosure:
As stated

cc:
The Honorable Mike D. Rogers
Ranking Member

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

PERSONNEL AND
READINESS

JUL - 1 2022

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

Dear Mr. Chairman:

The Department's response to section 718 of the William M. (Mac) Thornberry National Defense Authorization Act for Fiscal Year 2021 (Public Law 116–283), on Modifications to Implementation Plan for Restructure or Realignment of Military Medical Treatment Facilities; House Report 116–453, pages 336-337, accompanying H.R. 7617, the Department of Defense Appropriations Bill, 2021, on Descoping Military Treatment Facilities; the Joint Explanatory Statement, page 703, accompanying H.R. 133, the Consolidated Appropriations Act, 2021 (Public Law 116–260), on Restructuring Military Treatment Facilities; and House Report 117–88, page 332, accompanying H.R. 4432, the Department of Defense Appropriations Bill, 2022, on Descoping Military Treatment Facilities, is enclosed. The report provides the Department's plan detailing how the Department of Defense (DoD) will undertake a multi-year program to reshape operations at military medical treatment facilities (MTFs) for the purposes of increasing the readiness of our operational and medical forces while not diminishing quality and access for TRICARE beneficiaries.

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Gilbert R. Cisneros, Jr.

Enclosure:
As stated

cc:
The Honorable James M. Inhofe
Ranking Member

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

PERSONNEL AND
READINESS

JUL - 1 2022

The Honorable Rosa L. DeLauro
Chair
Committee on Appropriations
U.S. House of Representatives
Washington, DC 20515

Dear Madam Chair:

The Department's response to section 718 of the William M. (Mac) Thornberry National Defense Authorization Act for Fiscal Year 2021 (Public Law 116–283), on Modifications to Implementation Plan for Restructure or Realignment of Military Medical Treatment Facilities; House Report 116–453, pages 336-337, accompanying H.R. 7617, the Department of Defense Appropriations Bill, 2021, on Descoping Military Treatment Facilities; the Joint Explanatory Statement, page 703, accompanying H.R. 133, the Consolidated Appropriations Act, 2021 (Public Law 116–260), on Restructuring Military Treatment Facilities; and House Report 117–88, page 332, accompanying H.R. 4432, the Department of Defense Appropriations Bill, 2022, on Descoping Military Treatment Facilities, is enclosed. The report provides the Department's plan detailing how the Department of Defense (DoD) will undertake a multi-year program to reshape operations at military medical treatment facilities (MTFs) for the purposes of increasing the readiness of our operational and medical forces while not diminishing quality and access for TRICARE beneficiaries.

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Sincerely,

Gilbert R. Cisneros, Jr.

Enclosure:
As stated

cc:
The Honorable Kay Granger
Ranking Member

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

PERSONNEL AND
READINESS

JUL - 1 2022

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

Dear Mr. Chairman:

The Department's response to section 718 of the William M. (Mac) Thornberry National Defense Authorization Act for Fiscal Year 2021 (Public Law 116–283), on Modifications to Implementation Plan for Restructure or Realignment of Military Medical Treatment Facilities; House Report 116–453, pages 336-337, accompanying H.R. 7617, the Department of Defense Appropriations Bill, 2021, on Descoping Military Treatment Facilities; the Joint Explanatory Statement, page 703, accompanying H.R. 133, the Consolidated Appropriations Act, 2021 (Public Law 116–260), on Restructuring Military Treatment Facilities; and House Report 117–88, page 332, accompanying H.R. 4432, the Department of Defense Appropriations Bill, 2022, on Descoping Military Treatment Facilities, is enclosed. The report provides the Department's plan detailing how the Department of Defense (DoD) will undertake a multi-year program to reshape operations at military medical treatment facilities (MTFs) for the purposes of increasing the readiness of our operational and medical forces while not diminishing quality and access for TRICARE beneficiaries.

The report represents the collaborative efforts of the Office of the Assistant Secretary of Defense for Health Affairs, Military Departments, Joint Staff, and Defense Health Agency. The report provides a comprehensive explanation of how DoD will undertake a multi-year program to reduce operations at 33 MTFs in addition to the 12 MTFs that have already completed transition activities and 3 that were removed as a result of the reassessment performed under section 718. Our focus on the coronavirus disease 2019 (COVID-19) pandemic response prevented us from submitting the report to Congress earlier.

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Sincerely,

Gilbert R. Cisneros, Jr.

Enclosure:
As stated

cc:
The Honorable Richard C. Shelby
Vice Chairman

Report to Congressional Defense Committees

In response to section 718 of the William M. (Mac) Thornberry National Defense Authorization Act for Fiscal Year 2021 (Public Law 116–283), on Modifications to Implementation Plan for Restructure or Realignment of Military Medical Treatment Facilities; House Report 116–453, pages 336-337, accompanying H.R. 7617, the Department of Defense Appropriations Bill, 2021, on Descoping Military Treatment Facilities; the Joint Explanatory Statement, page 703, accompanying H.R. 133, the Consolidated Appropriations Act, 2021 (Public Law 116–260), on Restructuring Military Treatment Facilities; and House Report 117–88, page 332, accompanying H.R. 4432, the Department of Defense Appropriations Bill, 2022, on Descoping Military Treatment Facilities

June 2022

The estimated cost of this report or study for the Department of Defense (DoD) is approximately $46,000 in Fiscal Years 2021 - 2022. This includes
$0 in expenses and $46,000 in DoD labor.

Report/Study Cost Estimate (8-22F3697)

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Executive Summary

As directed in section 703 of the National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2017, the Secretary of Defense submitted to the congressional defense committees, in February 2020, a Section 703 Master Implementation Plan detailing how the Department of Defense (DoD) will undertake a multi-year program to reshape operations at military medical treatment facilities (MTFs) for the purposes of increasing the readiness of our operational and medical forces while not diminishing quality and access for TRICARE beneficiaries.

Section 718 of the NDAA for FY 2021 amended section 703 of the NDAA for FY 2017. Section 718 requires the Secretary of Defense to submit a revised Section 703 Master Implementation Plan that includes "with respect to each affected military medical treatment facility, a description of—

(i) the elements required for health care providers to accept and transition covered beneficiaries to the purchased care component of the TRICARE program;

(ii) a method to monitor and report on quality benchmarks for the beneficiary population that will be required to transition to such component of the TRICARE program; and

(iii) a process by which the Director of the Defense Health Agency will ensure that such component of the TRICARE program has the required capacity."

Section 703 directed the Secretary of Defense to submit to the congressional defense committees an implementation plan to restructure or realign MTFs.

In response to Section 718, the Department is submitting this revised Section 703 Master Implementation Plan. The Plan responds to the 3 elements listed above and details how DoD will undertake a multi-year program to reduce operations at 33 MTFs in addition to the 12 MTFs that have already completed transition activities, and 3 that were removed as a result of the reassessment performed under section 718. The purpose of this program is to increase the readiness of military medical staff by allowing them to be concentrated at medical platforms that have the volume and complexity of medical cases required to maintain medical skills.

- Twenty-nine MTFs will generally transition non-active duty Service member (NADSM) Primary Care to the purchased care component of the TRICARE program (which includes the TRICARE provider network and the TRICARE for Life program). Each of these 29 MTFs currently serve as outpatient (OP) clinics; they will transition to support active duty Service members (ADSMs) and serve as occupational health clinics in support of the installation. All locations will enroll active duty family members (ADFMs) as appropriate for provider skill sustainment.

- Two MTFs will transition from an inpatient facility to an ambulatory surgery clinic.

- Two MTFs will close.

DoD estimates the Implementation Plan will guide the transition of approximately 155,000 NADSM Military Health System (MHS) beneficiaries who currently receive care at MTFs to civilian providers through the TRICARE program.

Section 718 Detailed Requirements

As noted above, section 718 required detailed descriptions of three specific planning elements. Complete responses are included in Section 2.0 of this report. Brief summaries are provided below:

(i) The elements required for health care providers to accept and transition covered beneficiaries to the purchased care component of the TRICARE program.

The TRICARE Managed Care Support Contractors (MCSCs) are responsible for managing the TRICARE network of primary care managers (PCMs). The MCSC, Humana Military (Humana), performed a Network Assessment in the fall of 2020 and confirmed its ability to support all estimated transitioning beneficiaries with existing network providers. In a scenario when the existing network providers cannot support all estimated transitioning beneficiaries, the MCSC will identify new PCMs. The additional providers that meet certain criteria (proximity, availability, quality) will be invited to apply to be a TRICARE authorized provider. All TRICARE authorized providers must be certified under 32 CFR § 199.17 and must have their certification verified by the TRICARE Provider Certification Office.

The Defense Health Agency (DHA) will support the transition of affected beneficiaries transitioning to the network by providing network providers with the enrollee's clinical summaries and medical records. The MCSC also provides all network PCMs with comprehensive materials that orient them to the TRICARE benefit and tools on how to operate successfully within the MHS.

(ii) A method to monitor and report on quality benchmarks for the beneficiary population that will be required to transition to such component of the TRICARE program.

The TRICARE MCSC operates a Clinical Quality Management Program (CQMP) that monitors quality and safety measures. The CQMP demonstrates how the MCSC's goals and objectives, leadership, structure, and operational components are designed to achieve the efficient and effective provision of timely access to high quality health care. As part of the CQMP, the MCSC provides a CQMP Plan with goals and objectives followed by a CQMP Annual Report describing the results of the quality activities performed during each program year.

DHA will administer multiple surveys to all transitioned beneficiaries. The first survey will be released 2 weeks after transition to collect immediate information regarding the transition and access to care experience; a second survey will be released 6 months after transition to review progress. These surveys will help DHA immediately address concerns and inform future MTF re-scoping efforts.

(iii) A process by which the Director of the Defense Health Agency will ensure that such component of the TRICARE program has the required capacity.

DHA undertook new Network Assessments from October to December 2020 for each facility considered for rescoping under section 703. The MTFs being considered for downsizing to ADSMs only and Occupational Health (AD/OH) Clinics are all OP clinics; therefore, the Network Assessments focused on primary care and OP services. Given the urgency to complete

the assessments in a reasonable time, DHA analyzed PCMs within a 30-mile radius of each MTF instead of analyzing PCMs within a 30-minute drive of each beneficiary's residence. The Network Assessments validated additional capacity with existing network PCMs. Capacity was considered adequate when the assessment validated there were enough network PCMs to absorb 120 percent of the MTF non-active duty beneficiaries expected to transition to the network.

This report also serves as the Secretary's certification that affected beneficiaries, as described in section 718, will be able to access affected health care services through the purchased care component of the TRICARE program.

1.0. Introduction

Section 718 of the NDAA for FY 2021 amended section 703 of the NDAA for FY 2017. Section 718 requires the Secretary of Defense to submit a revised Section 703 Master Implementation Plan that includes "with respect to each affected military medical treatment facility, a description of—

(i) the elements required for health care providers to accept and transition covered beneficiaries to the purchased care component of the TRICARE program;

(ii) a method to monitor and report on quality benchmarks for the beneficiary population that will be required to transition to such component of the TRICARE program; and

(iii) a process by which the Director of the Defense Health Agency will ensure that such component of the TRICARE program has the required capacity."

Section 703 directed the Secretary of Defense to submit to the congressional defense committees an implementation plan to restructure or realign MTFs. This report was submitted to the congressional defense committees on February 19, 2020.

This report provides a revised Section 703 Master Implementation Plan and directly responds to requirements (i), (ii), and (iii) of section 718. The Plan details how the DoD will undertake a multi-year program to reduce operations at 33 MTFs for the purposes of increasing the readiness of our operational and medical forces as required by section 703 and section 718, while not diminishing quality and access for TRICARE beneficiaries.

DoD estimates the Implementation Plan will guide the transition of approximately 155,000 NADSM MHS beneficiaries who currently receive care at MTFs to civilian providers through the TRICARE program. Section 718 requires DoD to wait 180 days following the delivery of this plan, which also serves as a certification to the congressional defense committees that affected beneficiaries will be able to access health care services through the purchased care component of the TRICARE program. DoD assumes implementation will begin in FY 2023 and will be complete by September 30, 2026.

1.1. Background

On February 19, 2020, the DoD delivered a report to the congressional defense committees titled, "Restructuring and Realigning of Military Medical Treatment Facilities," in response to the section 703 requirement. With the readiness mission as the primary driver, the Department's report presented decisions to reduce operations at 48 MTFs and to expand or recapitalize operations at 2 others. These decisions reflect the Department's underlying principle to improve the readiness of our force while ensuring all beneficiaries have access to high-quality medical care.

After the Department delivered the report to the congressional defense committees, the Government Accountability Office (GAO) reviewed the Department's proposed restructuring actions and made six recommendations to improve implementation.[1] DoD continues to work through a Corrective Action Plan to address the GAO's recommendations.

In parallel with the GAO's review, and prior to the onset of the national coronavirus disease 2019 (COVID-19) pandemic response, DHA initiated additional, detailed planning and execution activities at the direction of the Assistant Secretary of Defense for Health Affairs (ASD(HA)) and in coordination with Military Medical Departments. In part, DHA's additional planning addressed impacts from ongoing Military Department (MILDEP)-driven military medical manpower reductions and realignments (as reported in the section 719 of the NDAA for FY 2019 report to the congressional defense committees[2]) and other changes made to the scope of operations at subject MTFs.

DoD paused all transition efforts on April 2, 2020, to ensure adequate resources were available to support the COVID-19 pandemic response. In September 2020, DHA reinitiated Section 703 planning and coordination efforts under the direction of ASD(HA) and with full participation of the Military Medical Departments. As part of this effort, the DHA and Military Medical Departments worked collaboratively to revalidate the recommendations for each MTF included in the original Section 703 Report. The revalidation, described in detail in Annex D, considered changes to local health care system capacities and capabilities, and changes in MTF staffing requirements. These planning efforts have embraced the recommendations from the GAO and have taken into consideration the new requirements included in Section 718.

1.2. Scope / Overview

The original Section 703 Master Implementation Plan presented decisions to reduce operations at 48 MTFs and expand operations at 2 MTFs. As of May 2019, transition activities at 12 of those MTFs had already been completed.[3] As a result of the reassessment completed under section 718, three MTFs were removed from the Section 703 Master Implementation Plan in December 2021[4]. Actions to expand operations at two MTFs have been deferred as DHA and the

[1] GAO-20-371 "Defense Health Care – Additional Information and Monitoring Needed to Better Position DoD for Restructuring Medical Treatment Facilities," May 2020.
[2] Report to the Congressional Defense Committees: Section 719 of the National Defense Authorization Act for Fiscal Year 2020 (Public Law 116–92), April 30, 2020.
[3] Army Health Clinic (AHC) McDonald-Eustis, AHC Monterey, AHC Munson-Leavenworth, AMH Farrelly-Riley, BLDG 36000 Hood, Charles Moore Health Clinic Hood, Community Mental Health SVC Irwin, SCMH Okubo JBLM, Troop Medical Clinic Robinson-Carson, Branch Medical Clinic (BMC) Lakehurst, BMC San Onofre MCB, and NBHC Rancho Bernardo
[4] Three MTFs were removed from the Section 703 Master Implementation Plan in December 2021: Kimbrough

MILDEPs conduct additional reviews and assessments.[5]

This revised Section 703 Master Implementation Plan considers required activities to complete transition activities at the remaining Section 703 Master Implementation Plan's 33 MTFs:

- Twenty-nine MTFs will generally transition NADSM Primary Care to the purchased care component of the TRICARE program (which includes the TRICARE provider network and the TRICARE for Life program). Each of these 29 MTFs currently serve as OP clinics; they will transition to support ADSM and serve as occupational health clinics in support of the installation. All locations will enroll ADFMs as appropriate for provider skill sustainment. The process for selecting NADSMs will be locally determined and included in the individual MTF implementation plan.

- Two MTFs will transition from an inpatient facility to an ambulatory surgery clinic.

- Two MTFs will close.

All of the 33 remaining Section 703 Master Implementation Plan MTFs are in TRICARE's East Region; all impacted beneficiaries will transition to the purchased care component of the TRICARE program (which includes the TRICARE provider network and the TRICARE for Life program).

Note: Paragraph (a) of section 703 of the NDAA for FY 2017, described four MTF constructs: Medical Centers, Hospitals, Ambulatory Care Centers, and Satellite Centers. The actions described in this report use the term "AD/OH Clinic" to denote a type of "Ambulatory Care Center." The AD/OH Clinics will operate in accordance with the requirements specified in section 703, as enacted at 10 U.S.C. § 1073d.

The Department is currently in Phase 2 of a three-phase implementation process:

- Phase 1 – Revalidate assumptions and data in coordination with the Service Medical Departments (October 1, 2020 – December 31, 2020)

- Phase 2 – Refresh DHA, Market, and MTF planning efforts (January 1, 2021 – September 30, 2022)

- Phase 3 – Execute implementation (FY 2023 – NLT September 30, 2026)

The Department will execute a conditions-based implementation strategy. DHA will establish conditions-based criteria for every milestone at each MTF; the Department will only transition MTFs once established criteria are met. Beneficiary Transition Cells (BTCs) at each MTF will manage and report on progress. The Department commits to transparency throughout implementation; transition plans, schedules, and risk-mitigation strategies will be shared with impacted communities and other relevant stakeholders.

Ambulatory Care Center(KACC)-Meade, AHC Joel-Bragg, and AHC Robinson-Bragg.

[5] Tripler Army Medical Center (AMC) and Naval Medical Center Camp Lejeune.

Revalidation and implementation planning has been guided by local health care systems' ability to accept additional primary care and specialty care workload. If conditions and criteria cannot be met or risks cannot be appropriately mitigated, DHA and the Military Medical Departments, through the ASD(HA), will provide options for the Secretary of Defense to maintain the readiness of the force and deliver the health care benefit. This process will ensure that affected beneficiaries will be able to access health care services through the purchased care component of the TRICARE program.

The revised Section 703 Master Implementation Plan will serve as a transparent, dynamic, and iterative guide to accomplish statutory requirements and Departmental directives. Working in close collaboration with the Military Medical Departments, DHA will ensure updates are published and communicated to stakeholders across the Department.

2.0. Elements Required by Section 718 for NDAA for FY 2021

Section 718 of the NDAA for FY 2021 amended section 703 of the NDAA for FY 2017. Section 718 requires the Secretary of Defense to submit a revised Section 703 Master Implementation Plan that includes "with respect to each affected MTF, a description of—

(i) the elements required for health care providers to accept and transition covered beneficiaries to the purchased care component of the TRICARE program;

(ii) a method to monitor and report on quality benchmarks for the beneficiary population that will be required to transition to such component of the TRICARE program; and

(iii) a process by which the Director of the Defense Health Agency will ensure that such component of the TRICARE program has the required capacity."

Responses to each of these specific items are provided in the sections below.

2.1. (i) The elements required for health care providers to accept and transition covered beneficiaries to the purchased care component of the TRICARE program.

The Department understands two distinct questions in this requirement:

1) What criteria did DHA use to evaluate network providers prior to transitioning beneficiaries from the MTF to a network provider?

The TRICARE MCSCs are responsible for managing the TRICARE network of PCMs. At the time of the Network Assessment, October – November 2020, the MCSC identified network PCMs within a 30 mile radius of the installation. Next, the MCSC evaluated potential appointment availability. Providers were asked if they have a first available appointment for a new patient within a week, as well as within a month. Additionally and continuously, the MCSC evaluates the providers' Healthcare Effectiveness Data and Information Set (HEDIS®) quality measures. Beneficiaries will be able to select quality providers through the MSCS's online provider directory. The online provider directory will populate with quality providers located closest to the address the beneficiary submits to the online provider directory. The PCMs'

quality scoring evaluates the quality of care delivered by PCMs and specialists utilizing an array of quality measures (e.g., National Committee for Quality Assurance (NCQA), Centers for Medicare and Medicaid Services (CMS), and modified National Quality Forum (NQF) measures).

In late 2020, the MCSC reported that it was able to support all estimated transitioning beneficiaries with existing network providers. Additionally, the MCSC can invite more providers who meet the criteria listed above (proximity, availability, quality) to apply for the TRICARE network. The MCSC TRICARE Provider Certification Office must verify a provider meets all requirements of 32 CFR § 199 as well applicable contact requirements before admitting a provider to the network. In addition to validating the provider's credentials, the TRICARE Provider Certification Office will also evaluate the provider's clinic association to ensure the provider's business is in good standing. The MCSC can negotiate network agreements with fully qualified providers. Transitioning beneficiaries choosing to enroll in TRICARE Prime have the freedom to request any PCM in the network with availability, including newly added PCMs. Beneficiaries choosing to enroll in TRICARE Select can seek care from any TRICARE network provider, while TRICARE for Life beneficiaries can enroll to any primary care provider participating in the TRICARE for Life program.

2) What will a network provider require from the Direct Care System (DCS) to successfully transition beneficiaries?

DHA will support the transition of TRICARE Prime enrollees to the network by providing network PCMs with the enrollee's clinical summaries and medical records. The MCSC also provides all network PCMs with comprehensive material that orients them to the TRICARE benefit and tools on how to operate successfully within the MHS. These education and network resources are provided online and include referral and authorization management, electronic claim submission, claim status, preapproved formularies, rules for durable medical equipment, and self-service tutorials focused on working with the MCSC and working within the MHS.

2.2. (ii) A method to monitor and report on quality benchmarks for the beneficiary population that will be required to transition to such component of the TRICARE program.

The TRICARE MCSC operates a CQMP that monitors quality and safety measures. The CQMP demonstrates how the MCSC's goals and objectives, leadership, structure, and operational components are designed to achieve the efficient and effective provision of timely access to high quality health care. As part of the CQMP, the MCSC provides a CQMP Plan with goals and objectives followed by a CQMP annual report describing the results of the quality activities performed during each program year.

Using the most current NQF Serious Reportable Events, CMS Hospital-Acquired Conditions, Agency for Healthcare Research and Quality (AHRQ) Patient Safety Indicators (PSIs), and any other DHA required indicator/event, the MCSC identifies, tracks, trends, and reports interventions to resolve the Potential Quality Issues (PQIs) and Quality Issues.

- AHRQ PSIs help assess the incidence of adverse events and in-hospital complications

and identify issues that might need further study. PSIs provide information on potentially avoidable safety events that represent opportunities for improvement in care delivery. More specifically, they focus on potential in-hospital complications and adverse events following surgeries, procedures, and childbirth.

- AHRQ PQIs are population-based indicators that capture all cases of potentially preventable complications that occur in a given population either during a hospitalization or in a subsequent hospitalization. PQIs can be used to identify admissions that might have been avoided through access to high-quality OP care.

- HEDIS® is a collection of standardized performance measures developed by the NCQA to objectively measure, report, and compare quality across health plans. The majority of people are enrolled in plans that report HEDIS®, making HEDIS® one of health care's most widely used performance improvement tools. HEDIS® measures are available on the Military Health Service Population Health Portal for both direct care and private sector care empaneled beneficiaries.

- CMS Hospital Compare is a consumer-oriented website that provides information on how well hospitals provide recommended care to their patients. The MCSCs utilize the reported data to evaluate and analyze institutional performance for each network facility in the respective region, and the MCSC provides a report of the analysis.

Quality measures serve multiple purposes including, but not limited to, highlighting potential quality concerns, ensuring care meets safety and quality standards, selecting health plans/providers, and identifying gaps in health care delivery. Quality measures are monitored, by the MCSC and DHA, prospectively, concurrently, and retrospectively to assure patient safety and identify quality of care issues.

Additionally, the DoD surveys TRICARE beneficiaries in order to receive candid comments about their health care experience. The Joint Outpatient Experience Survey (JOES) is a standardized survey tool which focuses on the beneficiary experience inside MTFs. Modeled on the Consumer Assessment of Healthcare Providers and Systems clinician and group survey, the Joint Outpatient Experience Survey Clinician (JOES-C) is a monthly survey that collects beneficiary views of OP care recently received within the MTFs and through the TRICARE network in the United States. Both JOES and JOES-C are approved and licensed scientific surveys designed to assess the experiences of a large sample of patients, ensure data is representative of specific populations, and enable comparisons across multiple factors.

The patient experience is multifaceted and may include provider communications, access to care, patient engagement, care coordination, and health knowledge. The patient experience is linked to health outcomes such as medication adherence and self-management skills. Additionally, access to care is essential for ensuring the health and well-being of TRICARE beneficiaries.

To supplement MCSC reporting, DHA also administers the TRICARE Quality Monitoring Contract (TQMC), through which DHA conducts quarterly reviews to validate the appropriateness of the MCSCs' quality of care and utilization review decisions. Each MCSC transmits requested copies of medical records and case documentation. The estimated number of

medical records (including inpatient and OP care) selected varies depending upon the health care region involved and the TQMC's selection criteria. Medical records are requested periodically throughout the year. The MCSCs provide written responses to all TQMC findings stating agreement, partial agreement, or non-concurrence with each discrepancy; responses include supporting rationale and proposed follow-up actions to address the issues.

Specific to the MTFs rescoping under the revised Section 703 Master Implementation Plan

DHA will administer multiple surveys to all transitioned beneficiaries. The first survey will be released two weeks after transition to collect immediate information regarding the transition and access to care experience; a second survey will be released 6 months after transition to review progress. These surveys will help DHA immediately address concerns and inform future MTF rescoping efforts.

Note on the Next Generation TRICARE Managed Care Support Contracts (T-5)

Under the Next Generation T-5 contract, MCSCs will be required to report data at the individual facility and provider level. The Government will have the ability to assign particular metrics inside identified measure sets and may change benchmarks and/or thresholds/goals each option year. Additionally, a wider variety of measure sets will be utilized. As the T-5 contract is solicited, awarded, and activated, DHA will seek opportunities to leverage these expanded abilities to capture more detailed information on the performance of providers during and after the section 703 transition process.

2.3. (iii) A process by which the Director of the Defense Health Agency will ensure that such component of the TRICARE program has the required capacity.

DHA undertook new Network Assessments from October to December 2020 for each facility considered for re-scoping under section 703. The MTFs being considered for downsizing to AD/OH Clinics are all OP clinics; therefore, the Network Assessments focused on primary care and OP services. Given the urgency to complete the assessments in a reasonable time, DHA analyzed PCMs within a 30-mile radius of each MTF instead of analyzing PCMs within a 30-minute drive of each beneficiary's residence. The Department believes this approach provided the most conservative assessment, and it helped standardize the methodology between Prime Service Areas (PSAs). As implementation planning continues and execution begins, DHA will apply the 30-minute drive time from residence to PCM to ensure beneficiaries have adequate access.

The Network Assessments:

- **Validated capacity.** Capacity was considered adequate when the assessment validated there were enough network PCMs to absorb 120 percent of the MTF non-active duty beneficiaries expected to transition to the network.

- **Leveraged interview scripts.** Reassessment scripts were followed to collect/confirm PCM information such as whether the provider was accepting new patients, enrollment maximums, the third next available appointment for an existing patient, and the first available appointment for a new patient.

- **Found provider hesitance.** Due to the changing nature of conditions related to COVID-19, some practices were noncommittal regarding accepting new patients.

- **Confirmed pandemic status.** Claims were pulled against all PCMs to validate the practice was still open and the provider was submitting claims throughout the pandemic.

Beyond capacity, the Network Assessments also reviewed Quality, Access to Specialty Care, Access to Urgent Care, and Complaints/Grievances.

- **Quality.** Using Humana's Active Health data supplemented with the MHS' Population Health Portal data, individual PCM provider quality quartiles were calculated from a composite score derived from the following four HEDIS® measures: 1) breast cancer; 2) cervical cancer; 3) colon cancer; and 4) hemoglobin A1C. Each PCM's quartile represents how they compare to other PCMs in the Humana provider network for that PSA. Since HEDIS® measures do not apply to the pediatric population, pediatricians were excluded from this calculation. In addition, PCMs with insufficient enrollment were also notincluded in this calculation.

- **Access to Specialty Care.** The last three Access Standards reports were utilized to determine the network average drive time and network average days to care for each specialty service provided at the MTF (i.e., mental health, physical therapy, and optometry).

- **Urgent Care.** Urgent care centers were identified within 30 miles of each MTF in order to assess the ability of beneficiaries to access same day care.

- **Complaints/Grievances.** The number of complaints/grievances for appointment wait time and availability and office wait time was also captured. While these metrics do not delineate between PCM and specialty care, the measure provides some feedback on the accessibility of the provider network.

Network Assessment results are provided in Annex D of this report.

Revised Section 703 Master Implementation Plan

On behalf of the Secretary of Defense, the DHA will undertake a multi-year program to reduce operations at 33 MTFs for the purposes of increasing the readiness of operational and medical forces as required by section 703 of the NDAA for FY 2017. This is in addition to the 12 MTFs that have already completed transition activities.

As part of the effort to reduce operations, DHA will transition approximately 155,000 NADSM MHS beneficiaries who currently receive care at MTFs to civilian providers through the TRICARE program. DHA intends to initiate implementation activities in FY 2023, with a goal of completing implementation activities by September 30, 2026.

All 33 MTFs impacted by this effort are currently located in the TRICARE Health Plan's (THP) East Region. The implementation actions directed in this Implementation Plan reflect the results of revalidation and assessment of MTF operations and the TRICARE MCSC network. DHA completed the revalidation and assessment in coordination with the impacted MTFs, MILDEPs, and Humana.[6]

The ASD(HA) will use existing MHS Governance forums to evaluate progress in executing the transition against established criteria.

2.4. Required Actions

In coordination with the MILDEPs and the Military Medical Departments, DHA will implement the transition activities listed in Table 1 below. The table provides and is sorted by the historic MILDEP alignment for each MTF.

Table 1: Required Actions by MILDEP Alignment and MTF[7]

MILDEP	MTF	State	Required Actions
ARMY	AHC Kirk- Aberdeen Proving Ground	MD	Transition OP facility to an **AD/OH**. **Enroll ADFM** as appropriate for provider skill sustainment. Maintain all base support functions. Maintain current pharmacy capacity; provide pharmacy, laboratory and radiology services to all beneficiaries.
ARMY	AHC Fox-Redstone Arsenal	AL	Transition OP facility to an **AD/OH**. **Enroll ADFM** as appropriate for provider skill sustainment. Maintain all base support functions. Maintain current pharmacy capacity; provide pharmacy, laboratory, and radiology services to all beneficiaries.

[6] For additional information regarding the analyses completed prior to this revalidation and assessment, please see the report to Congress, "Restructuring and Realigning Military Medical Treatment Facilities," February 20, 2020. This plan is the supplement to that report to Congress, which provided a strategic framework for MTF realignment and restructuring.

[7] Medical specialties' requirements will be validated using provider generated workload measured in Relative Value Units or RVUs, and respective Staff Planning Factors (SPF). Some minor adjustments will be made for readiness authorizations. These factors will determine if the MTF will retain all or some of the same specialty care.

MILDEP	MTF	State	Required Actions
ARMY	AHC Barquist-Detrick	MD	Transition OP facility to an **AD/OH**. **Enroll ADFM** as appropriate for provider skill sustainment. Maintain all base support functions. Maintain current pharmacy capacity; provide pharmacy, laboratory, and radiology services to all beneficiaries.
ARMY	AHC Rock Island Arsenal	IL	Transition OP facility to an **AD/OH**. **Enroll ADFM** as appropriate for provider skill sustainment. Maintain all base support functions. Maintain current pharmacy capacity; provide pharmacy, laboratory, and radiology services to all beneficiaries.
ARMY	SOUTHCOM Clinic-Gordon	FL	Transition OP facility to an **AD/OH**. **Enroll ADFM** as appropriate for provider skill sustainment. Maintain all base support functions. Maintain current pharmacy capacity; provide pharmacy, laboratory, and radiology services to all beneficiaries. Under the Secretarial Designee Status Request for Medical Care, provide healthcare services at the AD/OH Clinic to Active Duty Foreign National Mission Partners assigned to perform duties at SOUTHCOM. Transition dependents to network healthcare providers.
ARMY	AHC Kenner-Lee	VA	Transition OP facility to an **AD/OH**. **Enroll ADFM** as appropriate for provider skill sustainment. Maintain all base support functions. Maintain current pharmacy capacity; provide pharmacy, laboratory, and radiology services to all beneficiaries.
ARMY	AHC Fillmore-New Cumberland	PA	Transition OP facility to an **AD/OH**. **Enroll ADFM** as appropriate for provider skill sustainment. Maintain all base support functions. Maintain current pharmacy capacity; provide pharmacy, laboratory, and radiology services to all beneficiaries.
ARMY	Community Based Medical Home (CBMH)-Columbus	GA	**Transition all beneficiaries and close clinic.** Beneficiaries will have the option to enroll at Martin ACH (if capacity permits) or to transition to the network.
AIR FORCE	AF-C-87th Medical Group (MEDGRP) JBMDL-McGuire	NJ	Transition OP facility to an **AD/OH**. **Enroll ADFM** as appropriate for provider skill sustainment. Maintain all base support functions. Maintain current pharmacy capacity; provide pharmacy, laboratory, and radiology services to all beneficiaries.
AIR FORCE	AF-C-42nd MEDGRP-Maxwell	AL	Transition OP facility to an **AD/OH**. **Enroll ADFM** as appropriate for provider skill sustainment. Maintain all base support functions. Maintain current pharmacy capacity; provide pharmacy, laboratory, and radiology services to all beneficiaries.
AIR FORCE	AF-C-45th MEDGRP- Patrick	FL	Transition OP facility to an **AD/OH**. **Enroll ADFM** as appropriate for provider skill sustainment. Maintain all base support functions. Maintain current pharmacy capacity; provide pharmacy, laboratory, and radiology services to all beneficiaries.
AIR FORCE	AF-CB-Sabal Park Clinic-MIL	FL	**Transition all beneficiaries to the network and close clinic.**

MILDEP	MTF	State	Required Actions
AIR FORCE	AF-C-78th MEDGRP-Robins	GA	Transition OP facility to an **AD/OH**. **Enroll ADFM** as appropriate for provider skill sustainment. Maintain all base support functions. Maintain current pharmacy capacity; provide pharmacy, laboratory, and radiology services to all beneficiaries.
AIR FORCE	AF-C-66TH MEDGRP-Hanscom	MA	Transition OP facility to an **AD/OH**. **Enroll ADFM** as appropriate for provider skill sustainment. Maintain all base support functions. Maintain current pharmacy capacity; provide pharmacy, laboratory, and radiology services to all beneficiaries.
AIR FORCE	AF-C-6th MEDGRP-MacDill	FL	Transition OP facility to an **AD/OH**. **Enroll ADFM** as appropriate for provider skill sustainment. Maintain all base support functions. Maintain current pharmacy capacity; provide pharmacy, laboratory, and radiology services to all beneficiaries.
AIR FORCE	AF-C-17th MEDGRP-Goodfellow	TX	Transition OP facility to an **AD/OH**. **Enroll ADFM** as appropriate for provider skill sustainment. Maintain all base support functions. Maintain current pharmacy capacity; provide pharmacy, laboratory, and radiology services to all beneficiaries.
AIR FORCE	AF-C-436th MEDGRP-Dover	DE	Transition OP facility to an **AD/OH. Enroll ADFM** as appropriate for provider skill sustainment. Maintain all base support functions. Maintain current pharmacy capacity; provide pharmacy, laboratory, and radiology services to all beneficiaries.
AIR FORCE	AF-C-7th MEDGRP-Dyess	TX	Transition OP facility to an **AD/OH**. **Enroll ADFM** as appropriate for provider skill sustainment. Maintain all base support functions. Maintain current pharmacy capacity; provide pharmacy, laboratory, and radiology services to all beneficiaries.
AIR FORCE	AF-C-2nd MEDGRP-Barksdale	LA	Transition OP facility to an **AD/OH**. **Enroll ADFM** as appropriate for provider skill sustainment. Maintain all base support functions. Maintain current pharmacy capacity; provide pharmacy, laboratory, and radiology services to all beneficiaries.
AIR FORCE	AF-H-633rd MEDGRP JBLE-Langley	VA	Transition AF-H-633rd MEDGRP-Langley to **Ambulatory Surgery Center (ASC) and OP clinic**. Maintain all base support functions. Maintain current pharmacy capacity; provide pharmacy, laboratory, and radiology services to all beneficiaries.
NAVY	Naval Health Clinic (NHC) Patuxent River	MD	Transition OP facility to an **AD/OH**. **Enroll ADFM** as appropriate for provider skill sustainment. Maintain all base support functions. Maintain current pharmacy capacity; provide pharmacy, laboratory, and radiology services to all beneficiaries.
NAVY	Naval Branch Health Clinic (NBHC) Groton	CT	Transition OP facility to **AD/OH/ADFM**. Maintain all base support functions. Maintain current pharmacy capacity; provide pharmacy, laboratory, and radiology services to all beneficiaries.
NAVY	NBHC Naval Support Activity (NSA) Mid-South	TN	Transition OP facility to an **AD/OH**. **Enroll ADFM** as appropriate for provider skill sustainment. Maintain all base support functions. Maintain current pharmacy capacity; provide pharmacy, laboratory, and radiology services to all beneficiaries.

MILDEP	MTF	State	Required Actions
NAVY	NHC Corpus Christi	TX	Transition OP facility to an **AD/OH**. **Enroll ADFM** as appropriate for provider skill sustainment. Maintain all base support functions. Maintain current pharmacy capacity; provide pharmacy, laboratory, and radiology services to all beneficiaries.
NAVY	NBHC Portsmouth	NH	Transition OP facility to an **AD/OH**. **Enroll ADFM** as appropriate for provider skill sustainment. Maintain all base support functions. Maintain current pharmacy capacity; provide pharmacy, laboratory, and radiology services to all beneficiaries.
NAVY	NBHC Naval Air Station Belle Chasse	LA	Transition OP facility to an **AD/OH**. **Enroll ADFM** as appropriate for provider skill sustainment. Maintain all base support functions. Maintain current pharmacy capacity; provide pharmacy, laboratory, and radiology services to all beneficiaries.
NAVY	NBHC Dahlgren	VA	Transition OP facility to an **AD/OH**. **Enroll ADFM** as appropriate for provider skill sustainment. Maintain all base support functions. Maintain current pharmacy capacity; provide pharmacy, laboratory, and radiology services to all beneficiaries.
NAVY	NBHC Indian Head	MD	Transition OP facility to an **AD/OH**. **Enroll ADFM** as appropriate for provider skill sustainment. Maintain all base support functions. Maintain current pharmacy capacity; provide pharmacy, laboratory, and radiology services to all beneficiaries.
NAVY	NHC New England	RI	Transition OP facility to an **AD/OH**. **Enroll ADFM** as appropriate for provider skill sustainment. Maintain all base support functions. Maintain current pharmacy capacity; provide pharmacy, laboratory, and radiology services to all beneficiaries.
NAVY	NBHC Meridian	MS	Transition OP facility to an **AD/OH**. **Enroll ADFM** as appropriate for provider skill sustainment. Maintain all base support functions. Maintain current pharmacy capacity; provide pharmacy, laboratory, and radiology services to all beneficiaries.
NAVY	NBHC Albany	GA	Transition OP facility to an **AD/OH**. **Enroll ADFM** as appropriate for provider skill sustainment. Maintain all base support functions. Maintain current pharmacy capacity; provide pharmacy, laboratory, and radiology services to all beneficiaries.
NAVY	BMC Colts Neck Earle	NJ	Transition OP facility to an **AD/OH**. **Enroll ADFM** as appropriate for provider skill sustainment. Maintain all base support functions. Maintain current pharmacy capacity; provide pharmacy, laboratory, and radiology services to all beneficiaries.
NAVY	Naval Hospital (NH) Beaufort	SC	Transition NH to **ASC and OP clinic**. Maintain all base support functions. Maintain current pharmacy capacity; provide pharmacy, laboratory, and radiology services to all beneficiaries.

2.5. Schedule

DHA will execute the transition in three groups with Group 1 and Group 2 beginning in early FY 2023, and Group 3 beginning on or about October 2, 2023. Each group is comprised of MTFs with a diverse range of expected complexity and geographies to mitigate against resource

requirements exceeding resource availability at any time during execution. DHA will stagger transition initiation within each Group over the course of the year to further mitigate overtaxing resources devoted to ongoing mission requirements. Complexity is defined by the number of beneficiaries transitioning to the TRICARE network per the number of PCMs currently supporting TRICARE in the PSA surrounding the MTF. To ensure a steady and successful transition process, DHA assumes that the higher the ratio of transition beneficiaries (new enrollees) per PCM, the longer the transition will take. Specifically, DHA assumes each transition will take between 1 and 4 years based on the following:

- 1 year: New Enrollees per Network PCM Estimate < 50
- 2 years: New Enrollees per Network PCM Estimate 50 to 100
- 3 years: New Enrollees per Network PCM Estimate 101 to 150
- 4 years: New Enrollees per Network PCM Estimate >150

Table 2 below provides a detailed breakdown of MTF by grouping, expected transition duration, and forecasted completion date.

Table 2: Group Assignments and Schedule for Transition Activities

MTF	Group	Start Date	Duration	End Date
AF-H-633rd MEDGRP JBLE-Langley	1	FY23Q2	1 Year	FY24 Q1
CBMH North Columbus-Benning	1	FY23Q2	1 Year	FY24 Q1
AHC Fox-Redstone Arsenal	1	FY23Q2	4 Years	FY26 Q4
AHC Kenner-Lee	1	FY23 Q2	4 Years	FY26 Q4
AF-CB-Sabal Park Clinic-MIL	1	FY23 Q2	4 Years	FY26 Q4
AF-C-6th MEDGRP-MacDill	1	FY23 Q2	4 Years	FY26 Q4
NHC Patuxent River	1	FY23 Q2	4 Years	FY26 Q4
AHC Barquist-Detrick	1	FY23 Q2	4 Years	FY26 Q4
AHC Kirk-Aberdeen Proving Ground	1	FY23 Q2	4 Years	FY26 Q4
NH Beaufort	1	FY23 Q2	4 Years	FY26 Q4
AHC Fillmore-New Cumberland	1	FY23 Q2	4 Years	FY26 Q4
AF-C-87th MEDGRP JBMDL-McGuire	1	FY23 Q2	4 Years	FY26 Q4
AF-C-42nd MEDGRP-Maxwell	1	FY23 Q2	4 Years	FY26 Q4
NBHC Groton	1	FY23 Q2	4 Years	FY26 Q4
AF-C-436th MEDGRP-Dover	2	FY23 Q3	3 Years	FY26 Q2
AF-C-45th MEDGRP- Patrick	2	FY23 Q3	3 Years	FY26 Q2
AF-C-17th MEDGRP-Goodfellow	2	FY23 Q3	3 Years	FY26 Q2
NHC Corpus Christi	2	FY23 Q3	3 Years	FY26 Q2

MTF	Group	Start Date	Duration	End Date
AF-C-78th MEDGRP-Robins	2	FY23 Q4	3 Years	FY26 Q3
AF-C-66TH MEDGRP-Hanscom	2	FY23 Q4	3 Years	FY26 Q3
NBHC Portsmouth	2	FY23 Q4	3 Years	FY26 Q3
NBHC NSA Mid-South	2	FY23 Q4	3 Years	FY26 Q3
AF-C-7th MEDGRP-Dyess	2	FY23 Q4	2 Years	FY25 Q3
AF-C-2nd MEDGRP-Barksdale	2	FY23 Q4	2 Years	FY25 Q3
NBHC Dahlgren	3	FY24 Q1	2 Years	FY26 Q1
AHC Rock Island Arsenal	3	FY24 Q1	2 Years	FY25 Q4
NBHC Indian Head	3	FY24 Q2	2 Years	FY26 Q2
NBHC NAS Belle Chasse	3	FY24 Q2	2 Years	FY26 Q1
NHC New England	3	FY24 Q2	2 Years	FY26 Q1
SOUTHCOM Clinic-Gordon	3	FY24 Q3	1 Year	FY25 Q2
NBHC Albany	3	FY24 Q3	1 Year	FY25 Q2
NBHC Meridian	3	FY24 Q3	1 Year	FY25 Q2
BMC Colts Neck Earle	3	FY24 Q3	1 Year	FY25 Q2

2.6. Process

DHA, the MILDEPs, and the MTFs will follow a standard three-phase process to plan and execute each MTF Transition. A standardized process will support the development and use of shared planning and reporting templates, reduce variation, and offer opportunities to collect and account for lessons learned.

2.6.1. Phase I: Planning

DHA will continue to lead enterprise-wide planning efforts, completing detailed guidance for managing manpower, facilities, medical training, and strategic communications requirements and impacts.

DHA will work with each MTF to develop an implementation plan based on the instructions provided in Annex B (MTF Implementation Planning Guidance). The MTF implementation plan will identify a conditions-based critical path for the execution of the transfer of beneficiary care to ensure that affected beneficiaries will be able to access affected health care services through the purchased care component of the TRICARE program.

Each MTF's completed plan will be reviewed and communicated through the formal MHS Governance process.

2.6.2. Phase II: Initiation

DHA will initiate the formal transition process by issuing Warning Orders to each impacted MTF as soon as final decisions have been made. The Warning Order will initiate the planning process at each MTF; it will include a draft timeline of actions (hiring freeze, stop new empanelment, initial strategic communication plan). DHA will issue a corresponding Operation Order at least 3 months before transition execution. DHA will develop an Operation Order in coordination with each MTF; each Operation Order will include the detailed instructions on the how, who, and when the MTF will execute transition actions (engaging stakeholders, working with MCSC to identify PCMs, transitioning MTF staff).

2.6.3. Phase III: Execution

Each MTF will execute transition activities in accordance with the approved implementation plan and in compliance with all legal requirements. MTFs will seek direction from DHA as issues and risks are identified.

To ensure that MTFs are successfully progressing along their respective Implementation Plan, DHA will hold monthly Integrated Progress Review (IPR). To prepare for these IPRs, MTFs will highlight recent accomplishments, key upcoming milestones, pending decisions/dependencies, and key risks or issues that may affect their ability to accomplish their tasks. MTF quad charts will be synthesized and presented in the monthly IPR meetings so that DHA/Military Medical Department leaders can mitigate risks and collectively ensure progress continues.

DHA and the Military Medical Departments will jointly assess and report the status of implementation milestones against the conditions-based criteria to validate when each MTF has fully rescoped to the appropriate section 703 end state and appropriate beneficiary categories have been transferred to the network. Existing MHS governance structures will assess plan execution to include the status of each MTF based on transition updates provided by DHA and MILDEP inputs. This assessment will inform completion of critical milestones. Existing MHS governance structures will also identify and assess risks and issues related to the transition, and coordinate mitigation efforts, as feasible.

2.7. Roles and Responsibilities

The successful implementation of section 703 actions will require coordinated actions by leaders across the MHS.

2.7.1. ASD(HA)

The ASD(HA) is responsible for the successful reduction in scope and size of MTFs in accordance with 10 U.S.C. § 1073d and for the facilitation of DHA's and the Military Medical Departments' activities to achieve full execution. Specifically, the ASD(HA) will:

- Inform the Secretary of Defense, relevant Office of the Secretary of Defense Components, and senior MILDEP leadership of the formulation, execution, and sustainment of this plan.

- Provide oversight and alignment of all MHS activities through MHS Governance.

- Communicate DoD intent and direction to DHA to ensure alignment of DHA's planning and execution efforts.

- Establish strategic objectives and goals for the transition of the MTFs and ensuring DHA develops an implementation plan.

- In coordination with the Surgeons General of the MILDEPs and the Director, DHA, define measurable objectives for MTF restructuring transitions, establish and apply thresholds and goals for each objective, and evaluate progress and challenges.

- In coordination with the Surgeons General of the MILDEPs and the Director, DHA, conduct sensitivity analysis of the relative value of MTF-provided care compared to civilian- provided care under varying assumptions, and document that information for decision- makers to inform recommendations on future MTF restructuring decisions.

2.7.2. Director, DHA

DHA directs and oversees the implementation execution. Specifically, the Director, DHA will:

- Establish a Program Management Office to monitor and manage detailed milestones as well as metrics and additional goals and objectives that need to be accomplished.

- Execute key tasks, subtasks, functions, and sub-functions for transitioning 33 MTFs as detailed in each MTF's approved implementation plan.

- Provide headquarters-level support to the MTF, Market, and MILDEP elements as needed to perform the agreed-upon functions during the execution phase.

- Adhere to all timelines and requirements for the execution of the Plan, reporting all progress against conditions-based criteria for transition, actively communicating risk, and coordinating mitigations with the Military Medical Departments.

- Collect, aggregate, and analyze current resourcing plans and other data from all Markets and MTFs to identify opportunities for harvesting additional effectiveness and efficiencies throughout the transition.

- Collect complete and accurate information about the quality of available civilian health care in proximity to its MTFs; assess that information to inform recommendations for future MTF restructuring decisions.

- Collect complete and accurate information about the extent to which current health care providers within the TRICARE network meet access-to-care standards; assess that information to inform recommendations on future MTF restructuring decisions.

- Collect complete and accurate information about the extent to which non-network civilian health care providers could be incorporated into the TRICARE network to meet access-to-care standards in terms of drive time; assess that information to inform recommendations on future MTF restructuring decisions.

- Provide transparent communication to the Military Medical Departments.

- Provide risk assessment and management of the continuous delivery of healthcare during transition.

- Provide manpower, facilities, and cost review and analysis as necessary prior to, throughout, and post-transition of the 33 MTFs to ensure mission requirements are sustained.

- Coordinate ongoing network adequacy assessments with the applicable Markets and MCSC.

- Oversee civilian personnel and human resources execution tasks as necessary.

- Monitor the alignment of MHS-wide activities in support of the above.

2.7.3. MILDEPs

The Military Medical Departments will support DHA execution of this revised Section 703 Master Implementation Plan and the individual MTF implementation plan(s). Specifically, the Military Medical Departments will:

- Provide support to DHA to reduce operations at the 33 MTFs, following the market construct. Support will continue until all section 703 MTFs have completed their MTF implementation plans and beneficiaries have transferred to a Network PCM, as described in Annex B.

- Provide as much notice as is feasible to DHA of any potential or projected personnel changes that may affect MTF health care delivery capabilities.

- Provide as much notice as is feasible to DHA of the medical readiness requirements of Military Medical Department operational and medical forces.

- Adhere to all timelines and requirements for transitioning MTFs as outlined in Table 2, reporting all progress against conditions-based criteria for transfer, actively communicating risk, and coordinating mitigations with DHA.

- Adhere to all timelines and requirements within this plan.

2.7.4. Joint Responsibilities

During the execution phase, DHA and the MILDEPs will jointly execute the following in order to complete the section 703 transition:

- Use existing MHS Governance structures to assess and report implementation status.

- Develop and provide a joint strategic communications message on the transition.

Conclusion

Section 703 of the NDAA for FY 2017 was amended by section 718 of the NDAA for FY 2021. As required by section 718, the Department revised the Section 703 Master Implementation Plan, specifically responding to the three elements listed in section 718, detailing how DoD will undertake a multi-year program to reduce operations at 33 MTFs, and certifying that affected beneficiaries will be able to access affected health care services through the purchased care component of the TRICARE program. Additionally, DoD estimates the Implementation Plan will guide the multi-year transition of approximately 155,000 NADSM MHS beneficiaries who currently receive care at MTFs to civilian providers through the TRICARE program. The purpose of this program is to increase the readiness of our operational and military medical forces while not diminishing the quality and access to care received by our TRICARE beneficiaries.

ANNEX A: Leaders' Intent

Key leaders within the Department are aligned on implementing the actions described in this implementation plan:

Under Secretary of Defense for Personnel and Readiness

The revised Section 703 Master Implementation Plan is intended to support the Secretary of Defense's three Lines of Effort: 1) restoring military readiness as we build a more lethal force; 2) strengthening alliances and attracting new partners; and 3) bringing business reforms to the DoD. It is the intent of the Under Secretary of Defense for Personnel and Readiness to maximize the medical readiness of operational and medical forces, while optimizing the effectiveness and efficiency of the delivery of high-quality health care to authorized beneficiaries. This undertaking will ensure a medically ready force to execute the National Defense Strategy, and a ready medical force to support our armed forces.

ASD(HA)

The intent of the ASD(HA) is to better align medical infrastructure with the primary purpose of MTFs – to generate ready medical forces, help ensure medically ready combat forces, and deliver quality care for beneficiaries when alternatives are not available. The Department's phased deployment plan executes congressional guidance set forth in Title VII of the NDAA for FY 2017, as amended by the NDAA for FY 2021, and seeks to support an integrated system of readiness and health by restructuring operations at 33 MTFs. Restructuring includes transitioning 2 inpatient MTFs to ASCs, 29 MTFs to AD/OH clinics and closing 2 MTFs. All 29 AD/OH clinics may enroll ADFM as appropriate for provider skill sustainment.

Director, DHA

DHA is working closely with the MILDEPs to reach our shared vision of a better MHS. DHA's goal is to foster a culture of innovation and collaboration that will accelerate the evolution of health care and the MHS. DHA, partnered with the MILDEPs, is fully committed to promoting the medical readiness of the armed forces and fostering the readiness of our medical force. Our vision is to unify the MHS in improving this readiness mission while delivering world-class, efficient, and accessible health care. The future operating environment will feature strong partnerships with stakeholders across the MHS in order to responsively advance the Department's operational and medical missions, instill widespread business reforms that will optimize the delivery of care, and implement initiatives to increase readiness and lethality of the force.

DHA's primary goal is to ensure continued implementation of the provisions of section 703 of the NDAA for FY 2017, as modified by section 718 of the NDAA for FY 2021. DHA's challenge is to implement these provisions, while advancing the MHS Quadruple Aim of improved readiness, lower cost, better care, and better health. In response to this challenge, the revised Section 703 Master Implementation Plan encompasses the Department's proposed multi-year implementation of restructured operations at 33 MTFs in a manner that mitigates the gaps and risks identified in the execution of this plan.

Success is defined as DHA safely and efficiently transitioning beneficiaries from the impacted 33 MTF sites to the TRICARE managed care provider networks, as well as workforce management of all military and civilian medical staff within these facilities.

Through implementation, DHA is providing mitigations against primary risks as referenced in the Section 703 Report to Congress related to its execution. These risks have been addressed as described below:

- **Stakeholder Consternation.** Strategic Communication engagements targeting community leaders, installation leaders/staff, Military Service Organizations and Veterans Service Organizations, and affected population.

- **Network Adequacy.** Regular monitoring of network capacity will be assessed with pauses in beneficiary transition until the network can accommodate or halt transition if the network is saturated.

- **Transitioning MTF enrollees case managed by the MTF.** All case managed patients will be reviewed by the MCSC's clinical team to ascertain if the individual meets the MCSC's case management requirements. If so, the patient will be enrolled into the MCSC program. If not, a transition plan will be developed for the patient to follow and discuss with their new network PCM.

- **Transitioning MTF enrollee with multiple medical co-morbidities.** A warm hand off will be established with the new network PCM to include a copy of the patient's medical record which contains the patient's preventive and chronic care flowsheet.

- **Transitioning MTF enrollee needing care during transition.** The MTF enrollee will receive care at the MTF until assigned a new network PCM. If care is needed urgently, the patient will have access to local urgent care/emergent care centers.

- **Transitioning MTF staff.** Transitioning military staff to MTFs or civilian partnerships that will provide a higher caseload and broader case mix will provide more opportunities to build and sustain medical skills and proficiency to meet Knowledge, Skills, and Abilities (KSA) requirements. Civilian staff, in coordination with labor management and employee relations teams, will shift their efforts to active duty beneficiaries, occupational health, or other human resource approved options.

ANNEX B: MTF Implementation Planning

MTFs impacted by the section 703 actions will take the following actions to prepare for required transition activities. DHA will continue to lead enterprise-wide planning efforts, completing detailed guidance for managing manpower, facilities, medical training, and strategic communications requirements and impacts.

Key Concepts

- The MHS is the most comprehensive military medical enterprise in the world.
- The MHS' 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.
- The MHS' commitment to beneficiaries' health care is not changing. While the location where care is received may change, access to quality health care will be provided.

Community Outreach. In accordance with the Strategic Communications Plan, the DHA Strategic Communications Office, local Public Affairs Office, MCSC, and each MTF will:

- Conduct round table events with MTF leaders, staff, and local network partners to explain the changes happening at the MTF.
- Conduct Town Hall events in the community.

BTC. In coordination with DHA, MTF, and MCSC, a BTC will be established at each MTF to facilitate a comprehensive transition of care from MTF to a network civilian provider/Medicare provider and ensure each beneficiary has a practical understanding of the transition. The BTC will include:

- MTF Staff – Enrollment, Primary Care Medical Home (PCMH) Teams, Medical Records, Public Affairs, Beneficiary Counseling and Assistance Coordinator, Case Managers.
- MCSC Staff – Enrollment, Clinical Operations, Beneficiary Services, Referral/Authorizations, Provider Contracting, Health System Manager/Market Director, VP, Government Services, Consumer Experience.
- DHA Staff – Market Integration Division (MID), THP Division, Healthcare Optimization Division, Communications Division, Analytics and Evaluation Division.

Determine Impacted MTF Beneficiaries. Each MTF will determine Prime/Plus empanelment:

- Number of TRICARE Plus (TPlus) beneficiaries;
- Empanelment by beneficiary category and age group (0-17, 18-64, and 65+); and
- Number of Prime case managed and/or enrolled in the Exceptional Family Member Program (EFMP).

Each MTF will create a Decision Matrix for Beneficiary Groups based on these statistics. The MTF must be ready to share with the MCSC and new PCMs the beneficiaries' current medical problems, current referrals, any upcoming appointments/services and medications. If the beneficiary is in a care management program, the MTF must share case type and complexity with the MCSC.

Each beneficiary group may have multiple clusters depending on how many are in each group. For example, there may be 1,000 empaneled TPlus beneficiaries, requiring the MTF to break the group into two clusters to allow for a smoother transition process. Beneficiaries will be sorted into the following groups:

- TPlus: TRICARE-eligible and not enrolled in a TRICARE Prime Plan, the U.S. Family Health Plan or a civilian or Medicare Health Maintenance Organization; or a dependent parent or parent-in-law;
- Non-utilizers/ancillary only utilizers;
- Retirees / Retiree Family Members / Others (RET/RETFM/OTH) with a Drive Distance > 30 minutes;
- RET/RETFM/OTH in Case Management Program;
- RET/RETFM/OTH classified as High Utilizers;
- RET/RETFM/OTH in Adjusted Clinical Group (ACG) Resource Utilization Bands (RUBs) 4 (High) and 5 (Very High);
- RET/RETFM/OTH in continual behavioral health (BH) treatment;
- RET/RETFM/OTH – All Others;
- ADFM with a Drive Distance > 30 minutes;
- ADFM in Case Management Program or EFMP;
- ADFM classified as High Utilizers;
- ADFM ACG RUBs 4 / 5;
- ADFM in continual BH treatment; and
- ADFM All Others.

Transition families together. If one member of the family is in a higher Beneficiary Group, then the entire family should transition as one unit.

The MTF will work with the MCSC to monitor:

- The MCSC adjusts provider networks and services as necessary to compensate for changes in MTF capabilities and capacities, including those resulting from downsizing and/or closures.

- The MCSC participates in DHA/MTF facilitated meetings in order to partner and assist with the transition of care from the MTF to the civilian network.

- The MCSC updates network Assessments, including:

  - Determine network capacity in impacted PSAs.

  - Utilizing Beneficiary Groupings, identify network PCMs/Medicare providers within 30 miles of beneficiaries' address.

  - Ensure PCMs are loaded correctly.

  - Confirm quality PCMs based on steerage model.

  - Contact quality PCMs to determine capacity and appointment availability.

  - Conduct outreach to non-network PCMs to join network, if needed.

  - Provide weekly network reports of capacity and access to care.

Medical Operations. Working with BTC and the Beneficiary Groupings, each MTF will assess the case/care management needs of the transitioning population to ascertain the best PCMs are identified in the selection process. The MTF will transition beneficiaries from MTF case/care management to the MCSC's case/care management programs, as applicable.

Referral Management. Working with BTC, each MTF will identify referrals and authorizations that will need to transition to new PCM, and the MTF will confirm authorized care does not result in beneficiaries incurring unnecessary "point of service" fees.

Enrollment. Working with BTC, each MTF will process enrollment changes by Beneficiary Group/cluster, update the MCSC Enrollment Assignment Rules for enrollment to the MTF (enrollment freeze), and provide weekly enrollment reports of progress to the BTC.

ANNEX C: Strategic Communications / Beneficiary Education Plan

The Department is committed to informing beneficiaries of changes to where they may receive their healthcare, and DHA will work with the MCSC to help individuals find new providers. To ensure awareness of changes directed by this report, the MHS will execute an informational campaign to inform and support beneficiaries on pending changes to the DCS at both the enterprise and local levels. The MHS will tailor the campaign to impacted MTFs and their local areas using an array of tactics, speakers, and communication channels.

The communication campaign will include the following tactics:

- DHA will release news articles announcing planned changes for MTFs across the enterprise and for each location.
- Localized news article will be released for each MTF impacted by restructuring.
- DHA, with the ASD(HA), will host a roundtable with Military Service Organizations and Veterans Service Organizations. The Surgeons General of the MILDEPs will be invited to participate.
- DHA, with the ASD(HA), will host a media roundtable. The Surgeons General of the MILDEPs will be invited to participate.
- In conjunction with DHA, MILDEP medical leaders, market leadership and installation leadership, and local MTF leadership will host town hall events at each impacted MTF preparing for changes.
- DHA will share details of changes, timelines, and other impacts via Health.mil, TRICARE.mil, MTF websites, social media platforms, media engagements, etc.
- Impacted beneficiaries will be provided written notification informing them of upcoming changes and help connect them with a new network provider.
- TRICARE MCSC will inform and share details regarding upcoming changes with patients via their websites, email, and other means unique to each region.
- DHA will provide the TRICARE MCSC with talking points and frequently asked questions to answer phone calls, emails, or other communications from beneficiaries concerning changes in their care.
- MTF patient advocates and customer support staff will receive talking points and frequently asked questions and answers to assist them in responding to beneficiaries' concerns. The TRICARE MCSC will support beneficiaries to help them navigate changes and assist in transitions of care to network providers.

DHA will work with each MTF to develop an information campaign plan specific to their location and available communication channels.

ANNEX D: Section 703 Revalidation Results

Overview of MTF revalidation assessment of each of the 35 MTFs

The annex describes the methodology and assessment for the process DHA and Military Medical Departments used for the revalidation of the 36 MTFs to account for changes in both MTF staffing requirements and in the local healthcare systems' capacities and capabilities

DHA created a Revalidation Tool with the following data pre-populated:

- List of section 703 MTFs and final section 703 recommendation for rescoping;
- Empanelment numbers by beneficiary category;
- Military Staff Impact;
- Civilian Staff Impact;
- Contractor Staff Impact; and
- Impacted Specialties.

DHA Tasked Services to validate data provided in the Revalidation Tool and to provide current information on the following:

- Validate initial analysis and calculations;
- Any portion of original section 703 actions that have already been initiated;
- Mission or Readiness-related changes; and
- Number of case-managed patients.

DHA and Military Medical Departments conducted a review of analysis with discussions on MILDEP concerns and have removed the following three MTFs from the final section 703 decision list:

- KACC-Meade.
  - KACC is a key component for the National Capital Region's (NCR) readiness generation and maintaining military medical personnel KSAs and is a critical component to the NCR's current operative capabilities.
- AHC Joel-Bragg and AHC Robinson-Bragg clinics.
  - Womack AMC implemented an Integrated Medical Home, an integration of PCMH, Soldier Centered Medical Home (SCMH), and CBMH, across all primary care services to ensure access to quality care, prioritize Soldier Readiness, provide a

training platform and increase cost efficiency at Fort Bragg. This implementation included the empaneled beneficiaries at both Robinson and Joel Health Clinics.

- Joel Health Clinic had already descoped due to the Integrated Medical Home implementation; however, with the space requirements for the Residency programs (family medicine, internal medicine, general surgery and orthopedic surgery), pediatrics as well as pediatric programs, such as EFMP, was moved to the vacant Joel Health Clinic.

DHA and Military Medical Departments Review of Analysis.

This analysis did not represent the viewpoint of the installation commanders or MILDEPs and the results of the initial review of the analysis were presented to the Military Personnel Executive Working Group, Deputies Enterprise Solutions Board and Enterprise Solutions Board.

DHA met with the Military Medical Departments to review the revalidated MTF data as well as Humana's network assessments in order to get agreement with the assessments and methodology as well as discuss any service concerns of any of the 36 MTFs on the list.

Network Assessment Methodology

The Assessment evaluated PCM Capacity Risk based on excess network capacity and new beneficiaries per PCM.

- **Low risk:** >60 percent excess network capacity and/or each PCMs would have to accept <50 new patients/beneficiaries.
- **Medium risk:** 50-59 percent excess network capacity and/or each PCMs would have to accept 50-79 new patients/beneficiaries.
- **Moderate risk:** 40-49 percent excess network capacity and/or each PCMs would have to accept 80-100 new patients/beneficiaries.
- **High risk:** 30-39 percent excess network capacity and/or each PCMs would have to accept 101- 199 new patients/beneficiaries.
- **Very high risk:** <30 percent excess network capacity and/or each PCMs would have to accept >200 new patients/beneficiaries.

DHA determined higher risk transitions should be accorded longer transition periods to ensure the transitions do not negatively impact the ability of the Network to support the additional beneficiary workload. For planning purposes, DHA has used the following assumptions for the number of years required to execute transitions:

- 1 year: New Enrollees per Network PCM Estimate < 50.
- 2 years: New Enrollees per Network PCM Estimate 50 to 100.

- 3 years: New Enrollees per Network PCM Estimate 101 to 150.

- 4 years: New Enrollees per Network PCM Estimate >150.

The Assessment also evaluated Appointment Availability:

- 1st available Appointment New Patient: percentage of PCMs contacted who have acknowledged appointment availability for new patients within 1 week and 1 month.

- 3rd Next Appointment Established Patient: percentage of PCMs contacted who have acknowledged third next appointment availability for established patients within 1 week.

This information is only available via call-outs and can vary depending on the circumstances surrounding the time period of the call (i.e., COVID-19, school physicals, etc.).

Additional metrics evaluated through the Assessment included:

- **Quality Providers:** Percentage of PCMs scoring in the top quartile based on available HEDIS® measures.

- **Access to Care:** For specialty care provided at MTF, average days to care to network specialty providers meeting access standards ≤ 28 days. Most common specialty care at MTF clinics include Physical Therapy, BH, and Gynecological Services (GYN). BH includes Psychology, Psychiatry, and Social Work.

- **Safety:** For inpatient MTFs, reviewed safety scores from Leapfrog Hospital Safety Grade.

- **Patient Recommendation:** For inpatient MTFs, reviewed Hospital Compare ratings for Recommend Hospital and Overall Hospital and American Hospital Directory's Patient Experience Rating.

Table 3 below highlights assessment results by MTF.

Table 3: Network Assessment and Schedule for Transition Activities-OP Clinics

MTF	Network PCM Excess Capacity	New Enrollees / Net PCM	PCM Risk Score	Quality Score	1st Available within 1 month	3rd Next Appointment	Planned Execution Duration
AHC Kenner-Lee	17%	239.0	Very High	6%	56%	84%	4
CBMH North Columbus-Benning	23%	126.6	Very High	6%	64%	45%	3
AHC Fillmore-New Cumberland	21%	181.2	Very High	10%	50%	21%	4
AF-C-87th MEDGRP JBMDL-McGuire	21%	195.6	Very High	17%	74%	53%	4
AF-C-42nd MEDGRP-Maxwell	23%	162.3	Very High	21%	36%	58%	4
NHC Patuxent River	28%	201.7	Very High	9%	21%	54%	4
NBHC Groton	26%	194.2	Very High	62%	1%	58%	4
AF-C-45th MEDGRP-Patrick	29%	137.2	Very High	22%	42%	79%	3
AHC Kirk-Aberdeen Proving Ground	27%	168.5	Very High	21%	31%	43%	4
AF-CB-Sabal Park Clinic-MIL	19%	187.1	Very High	19%	76%	58%	4
AHC Fox-Redstone Arsenal	34%	153.9	High	17%	32%	61%	4
AHC Barquist-Detrick	37%	154.7	High	6%	43%	85%	4
AF-C-78th MEDGRP-Robins	45%	120.1	High	24%	56%	80%	3
NBHC NSA Mid-South	40%	116.6	High	10%	73%	82%	3
AF-C-66TH MEDGRP-Hanscom	45%	129.3	High	14%	33%	50%	3
NHC Corpus Christi	47%	107.3	High	20%	60%	58%	3
NBHC Portsmouth	51%	132.5	High	13%	1%	30%	3
AF-C-6th MEDGRP-MacDill	53%	100.3	High	13%	39%	51%	3
AF-C-17th MEDGRP-Goodfellow	58%	103.2	High	50%	42%	29%	3
AF-C-436th MEDGRP-Dover	62%	102.5	High	27%	35%	80%	3
NBHC NAS Belle Chasse	55%	97.7	Moderate	7%	93%	82%	2

MTF	Network PCM Excess Capacity	New Enrollees / Net PCM	PCM Risk Score	Quality Score	1st Available within 1 month	3rd Next Appointment	Planned Execution Duration
AF-C-7th MEDGRP-Dyess	57%	88.3	Moderate	18%	16%	68%	2
NBHC Dahlgren	74%	84.7	Moderate	0%	95%	26%	2
NBHC Indian Head	78%	53.7	Medium	50%	33%	33%	2
AF-C-2nd MEDGRP-Barksdale	67%	55.4	Medium	27%	56%	64%	2
NHC New England	72%	66.0	Medium	65%	31%	66%	2
AHC Rock Island Arsenal	75%	54.6	Medium	45%	11%	46%	2
NBHC Meridian	74%	49.7	Low	89%	41%	73%	1
SOUTHCOM Clinic-Gordon	80%	42.6	Low	35%	81%	39%	1
NBHC Albany	85%	27.3	Low	0%	20%	32%	1
BMC Colts Neck Earle	86%	38.2	Low	36%	56%	56%	1

Table 4: Inpatient Hospital Assessment and Schedule for Transition Activities-ASC and inpatient[8]

MTF	Leap Frog	Hospital Compare Recommend	Hospital Compare Overall	American Hospital Directory	OB Quality	Planned Execution Duration
NH Beaufort	2.33	3.00	2.75	2.75	n/a	3
AF-H-633rd MEDGRP JBLE-Langley	4.67	3.00	3.00	3.00	74%	2

Table 5: ATC Network Assessment-ASC and inpatient[9]

MTF	OB/GYN ATC	GenSurg ATC	Gastro ATC	OrthoSurg ATC	Podiatry ATC	Oral Max ATC
NH Beaufort	n/a	n/a	n/a	11.9	21.4	9.3
AF-H-633rd MEDGRP JBLE-Langley	24.3	11.9	16.9	12.9	21.5	n/a

[8] Hospital Ratings are an average of the rating scores of the nearby network hospitals (rating out of 5).
[9] Ortho Surgery, Podiatry, and Oral Maxillofacial Surgery ATC are NH Beaufort's active surgical External Resource Sharing Agreements.

ANNEX E: Definitions

Table 6: Definitions

Term	Description
Active Duty Only Clinic	MTFs/OP Facilities that provide services only to ADSM. A type of Ambulatory Care Center.
Ambulatory Care Center	OP care facilities with limited specialty care.
Beneficiaries	Individuals who have been determined to be entitled to or eligible for medical benefits and therefore are authorized to receive treatment in the MHS.
MCSC	Contracted organization responsible for administering the TRICARE program in a TRICARE region. The MCSCs establish the provider networks and conduct provider education. Currently, Humana Military is the MCSC in the East Region, and Health Net Federal Services is the MCSC in the West Region.
Market	Geographic region which includes one or more MTF(s) irrespective of Service affiliation. Markets may include a single inpatient facility and several OP facilities that would refer specialty cases to the inpatient facility. A complete list of Markets can be found at https://www.milsuite.mil/book/groups/reform-of-the-mhs-ndaa2017/content?filterID=contentstatus%5Bpublished%5D~category%5Bmarket-establishment-resources%5D.
MHS	An integrated health care delivery system composed of two parts: The DCS and Private Sector Care System (PSC). The DCS includes the care that is provided to DoD beneficiaries in MTFs. PSC manages contracted health care provided to beneficiaries that is unavailable in the DCS.
MTF	Facility dedicated to providing health care to DoD-eligible beneficiaries, staffed and run by DoD personnel. Per section 703 of the NDAA for FY 2017, MTFs are classified as Medical Centers, Hospitals, or Ambulatory Care Centers.
Network	Private sector Primary Care and Specialty Care providers operating in the geographic region surrounding an MTF potentially capable of providing care to TRICARE beneficiaries
Network Capability	The THP and MID conducted a network assessment with the MCSC that examined whether the current local network could absorb the current inpatient MTF workload without anticipated risk to meeting TRICARE network access standards. This network assessment analyzed whether DoD beneficiaries would have access to the same primary care or specialty care if they no longer had access to the MTF's primary care or inpatient services. 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 criteria for clinical quality and access.
OP Facility	MTFs that provide services that generally include appointments and procedures requiring a patient stay of less than 24 hours. A type of Ambulatory Care Center.

Population	DoD uses two concepts to define populations centered on an MTF. A 40-mile radius catchment area, centered on an inpatient facility, defines its beneficiary population. A 20-mile radius 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 health care market with the OP-only facilities serving as referral sources for the inpatient facilities. To identify facilities needing additional analysis, geographic relationships between beneficiaries was supplemented with ADSM enrollment information. The ADSM-only population information was used to ensure minimal capabilities remained to support the readiness and installation mission.
Referrals	Referrals include the specialty workload provided to beneficiaries within an MTF. Internal referrals pertain to the specialty care for those enrolled to the MTF while outside referrals pertain to specialty care for anyone not enrolled to that MTF. The screening algorithm evaluated referrals from OP to inpatient MTFs for the Combat Casualty Care Team Specialties.
THP	The health care program for uniformed Service members, retirees, and their families around the world.

ANNEX F: Acronym Glossary

Acronym	Definition
ACG	Adjusted Clinical Group
ADFM	active duty family member
AD/OH	active duty Service members only and Occupational Health
ADSM	active duty Service member
AHC	Army Health Clinic
AHRQ	Agency for Healthcare Research and Quality
AMC	Army Medical Center
ASC	Ambulatory Surgery Center
ASD(HA)	Assistant Secretary of Defense for Health Affairs
BH	behavioral health
BMC	Branch Medical Clinic
BTC	Beneficiary Transition Cell
CBMH	Community Based Medical Home
CMS	Centers for Medicare and Medicaid Services
COVID-19	coronavirus disease 2019
CQMP	Clinical Quality Management Program
DCS	Direct Care System
DHA	Defense Health Agency
DoD	Department of Defense
EFMP	Exceptional Family Member Program
FY	Fiscal Year
GAO	Government Accountability Office
GYN	Gynecological Services
HEDIS®	Healthcare Effectiveness Data and Information Set
JOES	Joint Outpatient Experience Survey
JOES-C	Joint Outpatient Experience Survey Clinician
IPR	Integrated Progress Review
KACC	Kimbrough Ambulatory Care Center
KSA	Knowledge, Skills, and Abilities
MCSC	Managed Care Support Contractor
MEDGRP	Medical Group
MHS	Military Health System
MID	Market Integration Division
MILDEP	Military Department
MTF	military medical treatment facility
NADSM	non-active duty Service member
NBHC	Naval Branch Health Clinic
NCQA	National Committee for Quality Assurance
NCR	National Capital Region
NDAA	National Defense Authorization Act
NH	Naval Hospital

NHC	Naval Health Clinic
NQF	National Quality Forum
NSA	Naval Support Activity
OP	outpatient
PCM	primary care manager
PCMH	Primary Care Medical Home
PQI	Potential Quality Issue
PSA	Prime Service Area
PSC	Private Sector Care
PSI	Patient Safety Indicator
RET/RETFM/OTH	Military Retirees / Retiree Family Members / Others
RUB	Resource Utilization Band
SCMH	Soldier Centered Medical Home
SPF	Staff Planning Factors
TPlus	TRICARE Plus
TQMC	TRICARE Quality Monitoring Contract
THP	TRICARE Health Plan