



PERSONNEL AND
READINESS

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

JUL 23 2018

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

Dear Mr. Chairman:

The enclosed report is in response to section 703(c)(1) of the National Defense Authorization Act for Fiscal Year 2017 (Public Law 114-328), "Military Medical Treatment Facilities (MTFs)" which requests the Department to submit an update to the Military Health System (MHS) Modernization Study, to address the restructuring or realignment of MTFs.

Section 703 directs a comprehensive transformation of the MHS by including standardization of the way we determine capabilities in our medical centers, hospitals and ambulatory care centers. The enclosed MHS Modernization Study update provides the current status of recommendations made in the original MHS Modernization Study, the development of capability criteria responsive to section 703(a) in the legislation, and a detailed assessment of 32 inpatient facilities and 79 stand-alone outpatient clinics. The MHS Modernization Study update provides both the facility capability framework as well as the scope of the implementation plan required in section 703(d).

Thank you for your interest in the health and well-being of our Service members, veterans, and their families. A similar letter is being sent to the other congressional defense committees.

Sincerely,

A handwritten signature in black ink that reads "Robert L. Wilkie".

Robert L. Wilkie

Enclosure:
As stated

cc:
The Honorable Jack Reed
Ranking Member



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WASHINGTON, D.C. 20301-4000

JUL 23 2018

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

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cc:
The Honorable Adam Smith
Ranking Member



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JUL 23 2018

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

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cc:
The Honorable Patrick J. Leahy
Vice Chairman



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UNDER SECRETARY OF DEFENSE

4000 DEFENSE PENTAGON
WASHINGTON, D.C. 20301-4000

The Honorable Rodney P. Frelinghuysen
Chairman
Committee on Appropriations
U.S. House of Representatives
Washington, DC 20515

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Robert L. Wilkie

Enclosure:
As stated

cc:
The Honorable Nita M. Lowey
Ranking Member

REPORT TO THE CONGRESSIONAL DEFENSE COMMITTEES

Section 703 of the National Defense Authorization Act for Fiscal Year 2017

(Public Law 114-328)

“Military Medical Treatment Facilities”



The estimated cost of this report or study for the Department of Defense is approximately \$1,101,000.00 in Fiscal Years 2017-2018. This includes \$166,000 in expenses and \$935,000 in Department of Defense labor.
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Executive Summary

The purpose of this report is to meet the requirements of section 703(c)(1) of the National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2017 (Public Law 114–328). This report consolidates a number of efforts that define a framework for the implementation plan described in section 703(d).

Section 703 of NDAA FY 2017 directs the Secretary of Defense, in collaboration with the Secretaries of the Military Departments, to complete three primary lines of effort:

- Apply criteria for medical centers, hospitals, and ambulatory care centers (ACCs) specified in 10 United States Code (U.S.C.) §1073d.
- Update the Military Health System (MHS) Modernization Study no later than 270 days after enactment.¹
- Provide an implementation plan to identify future facility designations and describe planned changes to facility capability sets.

A committee comprised of Military Department and Defense Health Agency (DHA) representatives and chaired by the Deputy Assistant Secretary of Defense for Health Readiness Policy and Oversight (DASD(HRP&O)) supported the preparation of this report. This report does not include facility-based recommendations. Data will be considered in relation to the application of Congressional direction in Title 10 U.S.C. §1073d and development of section 703(d) implementation plans.

This report notes challenges in applying Title 10 U.S.C. §1073d facility criteria. Specifically, a complete evaluation of network adequacy would require DoD to contact network providers at the local level and determine their willingness and capacity to accept additional military beneficiary workload.

Additional effort is required to make fully informed decisions on facility restructuring and/or realignment. DHA must develop a consistent definition of network adequacy that standardizes data presented in contractor network adequacy reports and better supports the application of Title 10 U.S.C. §1073d(c) and (d) requirements.

To address Title 10 U.S.C. §1073d(c) and (d) requirements, going forward, DoD will use the same four-step process employed in the 2015 Modernization Study:

1. Define the possible opportunities for modeling capability sets;
2. Identify specific opportunities for modifying capability sets;
3. Conduct detailed review and investigation;

¹ DoD submitted the MHS Modernization Study Team Report to Congress in May 2015 in response to section 713 of the Carl Levin and Howard P. ‘Buck’ McKeon National Defense Authorization Act of Fiscal Year 2015 (P.L. 113-291).

4. Decide on future capability sets and facility designations.

This report establishes a framework to complete steps one and two. Steps three and four will be completed during implementation planning. The findings discussed in this report represent potential opportunities for modifying capabilities.

This report will cover the background leading up to the NDAA FY 2017 section 703(c) requirements, present the methodology used in interpreting and applying the criteria enumerated in section 703(c), explain the findings in terms of both opportunities and constraints, and provide a framework for the next steps and implementation plan.

A market concept, built around a central inpatient facility with outlying outpatient clinics, could be used to leverage natural patient referral patterns. This would promote efficiency and increase medical specialist access to the patient population required to maintain critical wartime medical skills. The market concept generalizes the multi-Service market concept and can be applied to both multi-Service and single-Service markets. A key part of the implementation planning process is designing an integrated system of care utilizing capabilities at multiple facilities in the purchased and direct care sectors.

Scope of the Effort

This report addresses 36 inpatient and 312 outpatient facilities located in the United States (U.S.), and includes a detailed assessment of 32 inpatient facilities (Table 6, Table 7) and 79 stand-alone outpatient clinics (Table 13). Of the four inpatient facilities not assessed, two were excluded because they were isolated and inpatient services were required, one facility was transitioning to an ambulatory care clinic, and one facility was part of a Department of Defense (DoD)/ Department of Veterans Affairs (VA) partnership. The remaining 233 outpatient clinics supported nearby inpatient facilities and are included in the facilities' assessments.^{2, 3}

Medical Center Evaluation

This report identifies 17 multi-service markets containing 21 military treatment facilities (MTFs) with the potential to sustain a medical center (Table 6). Market-level assessment for medical centers is appropriate, as these facilities will serve as referral centers for the most complex direct care in the market. These opportunities will be further reviewed in the implementation plan. Any realignment or restructure decisions will be made after careful consideration of Service readiness/mission requirements, the ability of local health care to accept increased demand, opportunities to increase MTF demand, the investments required, and all other elements specified in section (d)(2) of section 703.

² The scope of this report does not include occupational health or veterinary clinics as well as hospitals transitioned as a result of the MHS Modernization Study.

³ Analysis ultimately excluded inpatient facilities at Ft. Irwin and Twenty-Nine Palms, CA, which were designated as isolated facilities in the MHS Modernization Study. The Lovell Federal Health Care Center was not evaluated as it is part of a DoD/VA cooperative venture. The MTF at Mountain Home Air Force Base transitioned from inpatient to ambulatory care-only status in 2017.

Hospital Evaluation

DoD's application of Title 10 U.S.C. §1073d(c) criteria identified 11 inpatient markets that did not meet the criteria defined for a medical center (Table 7). These 11 markets were evaluated against Title 10 U.S.C. §1073d(c) hospital criteria. Of these 11 inpatient markets, 8 did not meet the application of the cost effectiveness measure, and 5 showed the network to be adequate to absorb inpatient workload. Overall, four MTFs were not cost effective and had potentially inadequate local networks. This information will be assessed against force sustainment and readiness needs, medical force generation requirements, and additional locally-developed purchased care details in the final DoD implementation plan.

Ambulatory Care Center Evaluation

This report evaluates the ambulatory care centers based on Title 10 U.S.C. §1073d criteria. Fifty-four of the seventy-nine clinics evaluated were considered to have potential for further assessment in the implementation plan as they had at least one clinical service that might be available in the local health care system (Table 8). This evaluation included network assessments by the TRICARE Regional Offices (TRO) of the local network's ability to absorb the current workload of each clinic by outpatient specialty. The cost effectiveness metric used Medicare standardized pricing of the workload accomplished in the MTF. Preliminary analysis suggests there may be some financial efficiencies to be gained. These potential gains will be evaluated against more detailed assessments of the local markets and Service member readiness needs in the final DoD implementation plan. For the majority of the areas being analyzed, MHS clinics are not cost competitive, with exceptions in the areas of internal medicine subspecialties and optometry.

Demand Model Results

DoD conducted two enterprise-wide demand assessments: a readiness-based assessment and an economic assessment using the methodologies from the 2015 Modernization Study.⁴

The provider productivity approach used in the 2015 Modernization Study provided an incomplete assessment of the capability to meet mission-critical requirements because this metric was only indirectly related to readiness.

Building on efforts to maintain the expeditionary readiness clinical skill set, the combat casualty care team communities (general and orthopedic surgery, emergency and critical care medicine, and anesthesia) have developed an innovative expeditionary-focused knowledge, skills, and abilities (KSAs) approach.⁵ This approach is still being evaluated for its ability to assess clinical readiness, but promises the ability of a quantification of garrison practice relative to the KSAs proposed for the expeditionary environment. DoD continues to validate the KSAs with a goal of

⁴ Department of Defense, Report on Military Health System Modernization: Response to Section 713 of the Carl Levin and Howard P. "Buck" McKeon National Defense Authorization Act for Fiscal Year 2015 (P.L. 113-291).

⁵ "Military Health System Clinician Readiness: General Surgery Pilot Report," Elster, DoD Report, October 2017.

potentially applying this approach across the other clinical specialties, and is currently piloting the general and orthopedic surgery KSAs at selected MTFs with preliminary results available in summer 2018.

A key table in the MHS Modernization Study Team Report is recreated in Table 1 below. Table 1 compares outputs of the productivity model from FY 2013 to FY 2016. In general, the MHS has increased its provider productivity over time. However, it is unclear whether increased productivity will translate into readiness to perform specific skills in a combat environment.

Table 1. Productivity Demand Shortfall for Selected Specialties – Comparison of FY 2013 to FY 2016

Selected Specialties	Difference (Accommodate Auth)*		Change from 2013 to 2016*
	FY 2013 Data	FY 2016 Data	
Cardiac/Thoracic Surgery	-38	-35	3
General Surgery	12	-21	-33
Peripheral Vascular Surgery	-26	-20	6
Pulmonary Disease	-26	-9	17
Colon and Rectal Surgery	-10	-9	1
Nephrology	-15	-6	9
Neurological Surgery	-12	-5	7
Plastic Surgery	-15	-4	11
Pediatric Surgery	-4	-3	1
Endocrinology	-4	-1	3
Hematology and Oncology	-3	12	15
Gastroenterology	3	13	10
Urology	1	15	14
Orthopedic Surgery	-32	19	51
Cardiology	-20	46	66

RED: Reduction of providers placed from FY 2013

GREEN: Increase of providers placed from FY 2013

Source: Provider Demand Model

*Placed equals total number of providers derived from model with adequate workload available to meet the 40 percent of the relevant CY 2012 Medical Group Management Association benchmark median specialty; Authorized is the number of funded specialist billets; Positive numbers are better.

Figure 3 and Table 3 in the body of this report demonstrate that DoD has made progress in increasing the productivity of its providers.

This report evaluates the requirements outlined in NDAA section 703(c). A change in the structure or alignment of MTFs can only be made after careful consideration of Service readiness/mission requirements, local health care capacity to accept increased demand, ability to increase demand at the MTF, and the investments required. This additional analysis and its subsequent results will be guided by the framework laid out in this report.

A key finding of this report is the lack of a consistent and comprehensive approach for determining if the total direct care patient workload of an MTF can be absorbed into the surrounding local health care system. More work is needed to develop and refine TRICARE contracts to allow for a consistent assessment of network adequacy allowing for the assessment of absorbing MTF patient demand. For certain specialties or types of cases, MTFs may be

required to pay for patient travel in order to capture complex, readiness-generating cases that might have otherwise been referred outside of the direct care system (DCS).

Part 1: Background

Introduction

In FY 2013, the Assistant Secretary of Defense for Health Affairs (ASD(HA)) announced the Quadruple Aim of the MHS:⁶ increased readiness, better health, better care, and lower cost. Readiness is the key aim at the center 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).



The MHS, through the Military Departments and DHA, develops the readiness capabilities of our medical force by leveraging the MTFs of the DCS as the training and clinical currency platform for our military health care providers. This supports both a ready medical force and promotes a medically ready force by assessing and documenting the current medical readiness of Service members and providing health care to warfighters, their family members, and other eligible beneficiaries through the DCS MTFs. The MHS also provides health care to beneficiaries by purchasing contracted care through 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 provides an update to the MHS's effort to balance mission and cost, expanding beyond prior efforts by employing a more readiness-focused approach to MTF capabilities.⁷

This report fulfills the requirements of section 703(c) of the NDAA for FY 2017 (Public Law 114–328), and provides a framework for the application of criteria described in Title 10 U.S.C. 1073d.

Report Directive

Section 703 of the NDAA for FY 2017 directed the Secretary of Defense, in collaboration with the Secretaries of the Military Departments, to complete three primary lines of effort:

- Define a framework for applying criteria for medical centers, hospitals, and ACCs specified in Title 10 U.S.C. §1073d.
- Update the MHS Modernization Study no later than 270 days after enactment.⁸

⁶ Military Health System Innovation Plan 2012.

⁷ Pilot programs evaluating this analytical construct are underway, though the methodology may change as it is assessed and refined.

⁸ DoD submitted the MHS Modernization Study Team Report to Congress in May 2015 in response to section 713 of the Carl Levin and Howard P. 'Buck' McKeon National Defense Authorization Act of Fiscal Year 2015 (P.L. 113-291).

- Provide an implementation plan to identify future facility designations and describe planned changes to facility capability sets.

Given the broad scope of the effort, DoD provided the Congressional Defense Committee an interim response on October 29, 2017.⁹ This report completes the requirements of section 703(c), “Update of Study,” by:

- Developing a framework for applying Title 10 U.S.C. §1073d facility criteria,
- Developing and applying a readiness-based construct for evaluating expeditionary clinical readiness, and
- Updating the analysis evaluating MHS support for providers.

Section 703 provides the MHS with a strategic opportunity to reevaluate the MTF’s balance between readiness and benefit missions, and to continue to identify opportunities to enhance the DCS’s ability to support its readiness mission. This report will inform the development of section 703(d) implementation plans.

Assumptions, Exclusions, and Key Definitions

Assumptions

The report includes the following high-level assumptions:

- The MHS provides high quality, safe patient care.
- The Services will allocate uniformed personnel to meet readiness and MTF needs.
- Maximizing certain types of care to beneficiaries in our MTFs supports the medical force readiness and training mission.
- Medical readiness examinations for military personnel in occupations with special medical clearance requirements, including flight, nuclear, dive, and other military-specific occupations, will be performed by the MHS. Military Departments will have the discretion to do these examinations outside an MTF setting.
- MHS inpatient facilities serve as key readiness generating platforms. If a hospital is required to meet the medical force readiness mission, the MHS will continue to operate the hospital.
- Where health care demand is insufficient to meet benchmarks for DoD’s uniformed specialty providers, partnerships with the VA or civilian organizations (as per P.L. 114-328 sections 706, 708, and 717) may be employed to support medical force clinical readiness.
- Where possible, this report will use a clinical readiness construct to evaluate a facility rather than provider efficiency.

⁹ Section 703 of the National Defense Authorization Act for FY 2017, (PL 114-328) “Military Treatment Facilities Interim Report, October 29, 2017.

- Given the complexities of allocating multi-service market (MSM) health care demand to individual Service MTFs, this report will be at the MHS level rather than the Service-specific level.
- The analysis will use Centers for Medicare and Medicaid Services (CMS) criteria for identifying hospitals versus ambulatory (outpatient) health care.¹⁰

Exclusions

This report completes three assessments to comply with section 703(c) of the NDAA for FY 2017. The scope of this report varies at times across its three components; however, all sections share the following features.

First, all three assessments are intended to inform decisions made in the section 703(d) implementation plans. While this report may identify potential opportunities and establish decision frameworks, decisions on realignments or restructurings of MTFs will be described in the section 703(d) implementation plan.

Second, the focus of this report is on all facilities that deliver direct patient care in the Defense Health Program (DHP)-funded treatment facilities in the U.S. Treatment facilities in U.S. territories or other sovereign nations were excluded.

Finally, some MTFs provide care to non-DoD beneficiaries and receive reimbursement. These patients can include beneficiaries of the VA, Coast Guard, Public Health Service (PHS), National Oceanic and Atmospheric Administration (NOAA), emergency patients and others from local communities. This analysis includes patient workload from all of these users of the DCS.¹¹

The three components of this report place the following additional boundaries on the analysis:

Applying Title 10 U.S.C. §1073d facility criteria exceptions

In defining a framework for the facility criteria, this report is focused on MTF clinical functions. Installation support of health-related, non-patient care activities, including occupational and environmental health, food protection, aerospace medicine, and animal medicine, are excluded from the analysis.¹² Primary care and dental care also are not included. Dental care is not mentioned in section 1073d. The statute specified that the Secretary needed to determine if the limited specialty care provided at hospitals and ambulatory care clinics was cost-effective, so primary care was not analyzed.

Inpatient MTFs are evaluated at the market level. This application of the criteria assumes that inpatient facilities will serve as referral centers for more complex care. As a result, ACCs falling within an inpatient MTF's market are not separately evaluated, but instead treated as one

¹⁰ For a non-exhaustive list of high-level CMS requirements, see Table 9 in Appendix C: Data Tables.

¹¹ Including inputs from section 717 of NDAA 2017 (P.L. 114-328).

¹² Second Interim Report to Congress on Section 1073c, Title 10 USC.

integrated delivery system with the inpatient MTF. If an ACC is the largest facility in the market, the committee applies ACC criteria as a stand-alone clinic.

Force structure used for this report

As was done in the Modernization Study Team Report,¹³ this report used the authorized force structure to assess gaps between MTF capabilities and medical force clinical readiness requirements. The authorized force structure is typically less than the total medical force requirement provided in section 721 of the NDAA for FY 2017.

Key Definitions

MTFs: Facilities dedicated to providing health care to DoD-eligible beneficiaries, staffed and run by DoD personnel. For the purposes of the analysis, MTFs are divided into three categories (medical centers, hospitals, and ACCs), utilizing Title 10 U.S.C. §1073d facility criteria. Medical centers and hospitals provide inpatient and outpatient services, with medical centers providing more specialized care. ACCs provide only outpatient services.

Inpatient services support patients whose conditions demand they remain under medical care for more than 24 hours; outpatient services generally include appointments and procedures requiring a patient stay of less than 24 hours.

MTF Market: An MTF market includes one or more MTFs irrespective of Service affiliation. Markets may include a single inpatient facility and several ACCs that would refer specialty cases to the inpatient facility. Markets vary in size from very large, such as the San Antonio market, to smaller single-Service markets such as Eglin Air Force Base (AFB)/Hurlburt AFB to single-MTF markets such as Scott AFB. Of special interest in this report were markets with overlapping areas of influence (an inpatient 40-mile catchment area with a clinic's 20-mile Provider Requirement Integrated Specialty Model (PRISM)¹⁴ area) allowing for natural referral patterns that would enhance the acuity, diversity, and volume of the workload available to the referral center. The use of these expanded health care markets will enable the MHS to adopt a broader regionalization strategy, in part to implement satellite centers of excellence as specified in section 703(a)(3) of the NDAA for FY 2017. For purposes of this report, analyses are conducted on inpatient and stand-alone clinical markets. The list of markets and their included MTFs is provided in Appendix F.

MHS: The MHS is an integrated health care delivery system composed of two parts: the DCS and Purchased Care.

- The DCS includes the care that is provided to DoD beneficiaries in MTFs.
- Purchased care is contracted health care outside of an MTF that provides or supplements care to beneficiaries that is either unavailable in the DCS or falls outside the MTF market area.

¹³ MHS Modernization Study Team Report. pp. 16-22.

¹⁴ Provider Requirement Integrated Specialty Model (PRISM).

Beneficiaries: DoD beneficiaries include Active Duty (AD) and retired Service members and their families, as well as eligible Reserve Component members. In addition, the MHS serves beneficiaries who reimburse DoD for their care under specific agreements (e.g. VA, Coast Guard, PHS, NOAA, civilian emergency care, etc.).

Linkages to Other NDAA for FY 2017 Sections

The NDAA for FY 2017 contains several provisions from other sections with the potential to influence or serve as input to the section 703 responses. Some analyses on the interrelated sections of the NDAA for FY 2017 were completed in time for inclusion in this response, while others are still being addressed and may influence the implementation plan.

2015 Modernization Study Team Report

In 2013, the Deputy Secretary of Defense directed the ASD(HA)¹⁵ to “conduct a bottom-up review of military medical capabilities and requirements,” and “provide recommendations that will address, at a minimum, the areas of personnel (military, civilian, and contractors), infrastructure, and business process with the intent of implementing best practices and increasing MHS efficiency and effectiveness both when deployed and in garrison.” The prime objective was to maximize force readiness with efficient employment of resources (financial, human capital, etc.) to meet evolving missions and DoD budget challenges. The final MHS Modernization Study was signed in May 2015 and assessed U.S. and overseas inpatient MTF specialty care, as well as primary care enrollment.

The 2015 MHS Modernization Study developed several recommendations, including (1) to better define metrics and processes to assess medical provider and force readiness, (2) to establish productivity benchmarks for MHS providers, and (3) to transition capabilities of eight smaller MHS hospitals to clinics (“right-sizing”). That study included two components; the first was a provider demand model¹⁶ that was intended to assess the ability of the MHS to provide a designated workload to uniformed providers. The study estimated the quantity of care required to support benchmarked productivity levels for each MTF market and compared that to the available demand in each market to identify opportunities to optimize productivity. This model highlighted a potential challenge because beneficiary health care demand was not sufficient to meet benchmarks for many of DoD’s uniformed specialty providers. In the second component, the study sought to provide a process for inpatient MTFs to develop business cases that explored key parameters such as mission, beneficiary demand, and local health care system capacity. This second component resulted in recommendations for the transition of eight inpatient facilities into outpatient and birthing centers, with an estimated annual net savings of \$366 million (M).

¹⁵ Resource Management Decision of the Department of Defense MP-D-01.

¹⁶ Formerly called the Provider Allocation Model (PAM).

Government Accountability Office (GAO) Recommendations

The GAO evaluated the 2015 Modernization Study for its adherence to generally accepted research standards. The GAO acknowledged that the study's recommendations would "position DoD, over time, to take actions to improve the effectiveness and efficiency of the MHS."¹⁷ However, the GAO also recommended that DoD address the following in future modernization studies:

1. **“Conduct a new analysis of the required personnel that mitigates known limitations.”** The GAO highlighted that future studies should mitigate analysis limitations of the required number of uniformed and civilian medical personnel. For example, the study should explain how issues with the military Services' workforce models affect results and include civilian personnel levels.

Response: Because the FY 2016 Health Manpower Personnel Data System (HMPDS) report produced by the Defense Manpower Data Center (DMDC) was not approved at the time analytic work began for this update to the 2015 Modernization Study, the analysis that follows used both FY 2015 authorized uniformed provider personnel as well as Service projections for a limited set of specialty providers. The authorized personnel used were DHP-funded billets. Although the model could accommodate civilian medical personnel, only uniformed personnel were included to focus the analysis on the DCS' ability to support its medical force.

2. **“Identify and mitigate limitations regarding the standard for maintaining providers' clinical skills.”** Future studies should identify or mitigate limitations concerning assessments of the requirements necessary to maintain the clinical currency of uniformed providers, especially if there are concerns regarding the accuracy of the data used.

Response: “Data Quality” and “Adjustments” sections have been included in Appendix E to address data limitations and improvements. This report also introduces a new concept for evaluating clinical readiness and currency to address limitations with prior metrics.

3. **“Develop a strategy for achieving goals for transferring health care to DoD facilities and increasing productivity.”** The study established goals for transferring health care from the purchased care system into the DCS and for increasing provider productivity. The study should explain the strategy to achieve these goals.

¹⁷ Government Accountability Office, Report to Congressional Committees: Defense Health Care Reform: DOD Needs Further Analysis of the Size, Readiness, and Efficiency of the Medical Force, GAO-16-820, September 2016.

Response: This report establishes estimates of transferring health care from DoD's purchased care network into the DCS. Strategies to achieve forecasted demand estimates will be included in the subsequent section 703 implementation plan.

4. “Modify DoD’s model to reflect the military service of the physicians and MTFs.”

The Provider Demand Model (PDM) assumed uniformed providers were interchangeable and did not account for military-service ownership of the hospitals.

Response: Many large and important MHS markets are staffed by multi-service uniformed clinicians, (e.g. the NCR). In these key markets, allocation of patient population is problematic as enrollments or clinician assignments may not align with Service facility affiliation.

5. “Describe steps taken to assess the reliability of data.” The study presented did not provide sufficient information about the team’s efforts to assess the reliability of the data used.

Response: Data Sources and “Data Quality” and “Adjustments” sections have been included in Appendix E of this report to address these concerns.

6. “Include in accompanying cost estimates an appropriate level of detail.” DoD estimated a net annual savings of \$366M from implementing the recommendations in the 2015 Modernization Study. The study was also required to include additional details concerning the calculation and data reliability of estimated savings.

Response: This report assesses the as-is U.S. DCS. The subsequent section 703 implementation plan will include planned MTF restructurings or realignments, in addition to cost estimates, with details concerning their calculation.

Status of the MHS

The MHS faces the challenge of addressing the dual mission of supporting readiness and providing health care to beneficiaries. Managing these missions and controlling cost-growth have been focuses of the MHS and the Service medical organizations. Key to the MHS’ central readiness mission is the preparation of surgical and medical teams to competently care for deployed forces, as well as sustain forces forward-deployed and in garrison.

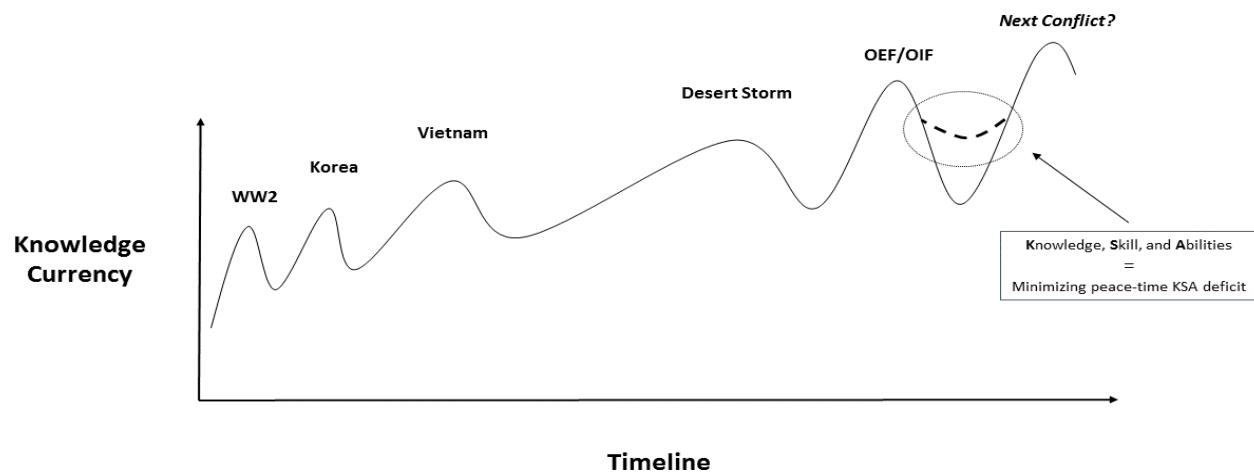
This report describes a subset of the MHS’ efforts to address these challenges. First, it speaks to the challenge of ensuring clinical readiness and introduces a new data-driven, clinician-led initiative to develop a methodology to sustain deployment-relevant skills, beginning with the

combat casualty care team specialties.¹⁸ Second, it describes efforts to balance cost with readiness by converting facility capabilities and establishing new programs to improve provider productivity.

The Challenge of Preparing for Readiness

Despite the importance of medical force readiness to the MHS mission, maintaining and measuring readiness has long been a challenge. For many clinicians, nurses, ancillary, and medical support personnel, the main driver of clinical currency has been the recent conflicts themselves. The primary responsibility of the military expeditionary clinician is to provide life-saving and limb-preserving care at the leading edge of the casualty continuum of care. The goal of this care is to optimize outcomes as the patient moves along the evacuation chain from point of injury to rehabilitation. The deployed operations in Afghanistan and Iraq were important in sustaining some clinician expeditionary skills. As major kinetic operations decrease, maintaining these skills becomes more challenging. During an interwar period where there is a reduced need for combat casualty care, the retention of the hard-won expeditionary KSAs becomes more difficult to sustain. Figure 1 conceptually illustrates clinical knowledge currency ebbing with conflicts, as skills are developed and maintained in expeditionary environments and gradually fade during interwar periods.

Figure 1. Evolution of Knowledge Skill Currency across Conflicts¹⁹



Peacetime practice is becoming increasingly subspecialized, whereas expeditionary practice requires more general skills, particularly for surgical specialists. Elective surgical practice is increasingly more focused on minimally invasive techniques that are often ill-suited for casualty care in an austere environment.

¹⁸ Combat casualty care team includes: general surgery, orthopedic surgery, emergency medicine, anesthesia, critical care, and nursing.

¹⁹ Joint Forces Quarterly (Issue 76), National Defense University Press, 2016.

Maintenance of expeditionary medical skills requires both currency and clinical readiness in the expeditionary environment embedded within the pre-deployment (direct care) system for all the members of the combat casualty care team. Several efforts have been made in the past to address this shortfall and elements of these competencies with some Service-specific success, but these efforts have not provided a data-driven consensus approach for the MHS.

As part of this effort, the combat casualty care team community has produced an innovative readiness-focused construct to assess and quantify pre-deployment practice relative to the KSAs necessary in the expeditionary environment. This new method for quantifying readiness represents a change in the ability to match beneficiary health care episodes directly to clinical readiness requirements. This links MTF-based practice to downrange care, extracting the expeditionary ‘value’ of the care. As a result, for the first time, the MHS potentially has a measure that will more directly assess the DCS’ ability to meet its ready medical force mission, rather than rely solely on indirect readiness measures, like the provider productivity targets used in the 2015 Modernization Study.

Recognizing that the Services ultimately have the responsibility of determining the deployability of individuals, DoD is engaged in a detailed and exhaustive review of the KSA methodology to ensure that the outcomes of applying the methodology will adequately support current medical force readiness. For the surgical community, a proof of concept is underway to test the use of KSAs in the MTF clinical environment with preliminary results expected in summer 2018. Studies are underway examining the use of simulation programs to enhance learning opportunities and obtaining KSAs.

Efforts to Balance Cost with Readiness

The MHS has undertaken several efforts to balance cost with readiness over the last 15 years, ranging from restructuring MTF capabilities to improving MTF performance and increasing DCS utilization. Prior initiatives to restructure MTF capabilities included the Base Realignment and Closure (BRAC) process in 2005, which aimed to address excess infrastructure issues. The implementation of the BRAC recommendations resulted in a significant consolidation of inpatient capacity in the largest DoD medical markets and a reduction in smaller hospitals.²⁰

Facility Transitions

Since the 2015 Modernization Study, efforts have been focused on implementing its recommendations by transitioning eight MTFs into outpatient-only facilities as shown in Table 2. Service implementation of some of these inpatient transitions was delayed by restrictions in the NDAA for FY 2015.²¹ As of this report, DoD had decided not to transition the hospitals at Forts Polk and Riley based on the Army’s assessment of network capacities and hospital performance capabilities. Detailed analysis of local conditions determined that civilian facilities were not

²⁰ 2005 Defense Base Closure and Realignment Commission Report, Volume I, September 8, 2005.

²¹ Public Law 113-291, “Carl Levin and Howard P. ‘Buck’ McKeon National Defense Authorization Act for Fiscal Year 2015,” section 713.

capable of absorbing the additional birthing workload from Ft. Polk. At Ft. Riley, a cost savings assessment determined that conversion to a birthing center would not improve cost effectiveness. Service narratives describing the transitions resulting from the study are provided in Appendix B.

After the Modernization Study Team Report designated the 366th Medical Group at Mountain Home, Idaho, an isolated inpatient facility, the local civilian hospital was certified. The Air Force is transitioning the inpatient facility to outpatient-only care.

Table 2. 2015 Modernization Study MTF Results Status

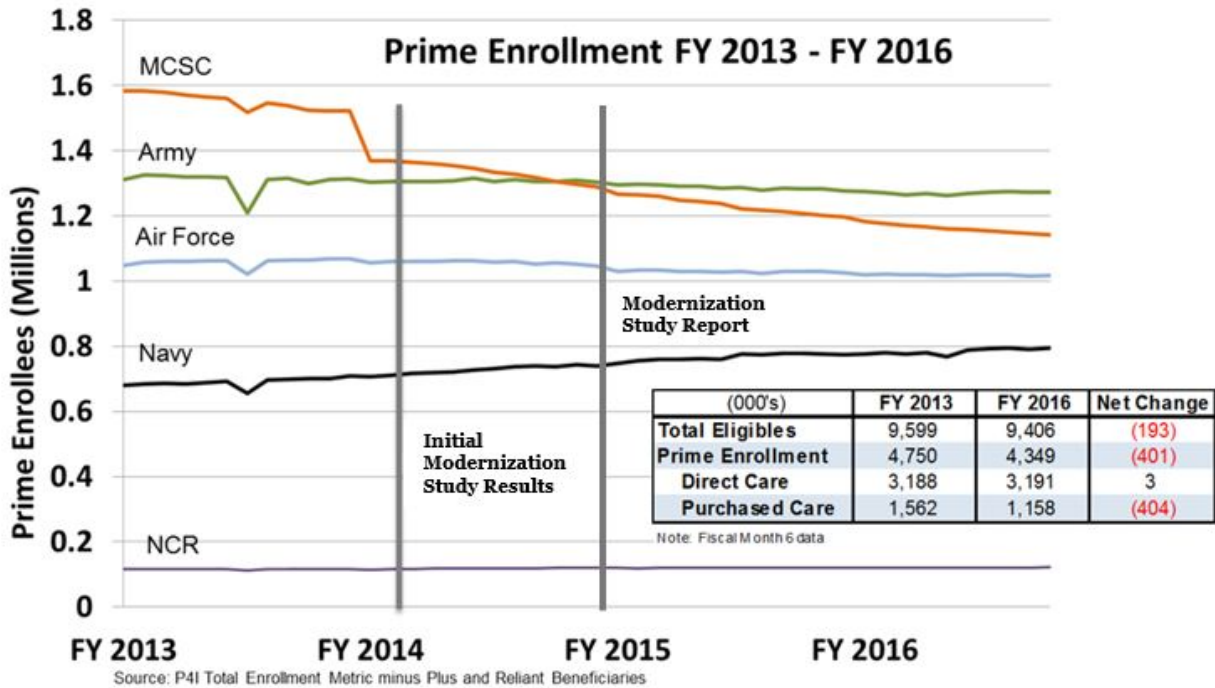
MTF	Modernization Recommendation	Progress to Date
Ft. Sill, OK	<ul style="list-style-type: none"> Transition to Ambulatory Surgery Center (ASC) 	<ul style="list-style-type: none"> Completed transition included additional reduction to an ACC due to further Army cost and readiness analysis.
Ft. Jackson, SC	<ul style="list-style-type: none"> Transition to ACC 	<ul style="list-style-type: none"> Complete
Ft. Knox, KY	<ul style="list-style-type: none"> Transition to ASC 	<ul style="list-style-type: none"> Complete
Ft. Riley, KS	<ul style="list-style-type: none"> Transition to ASC and birthing center 	<ul style="list-style-type: none"> Based on cost analysis, this transition has been put on hold
Ft. Polk, LA	<ul style="list-style-type: none"> Transition to ACC 	<ul style="list-style-type: none"> Based on cost analysis and access to birthing in the local community, this transition has been put on hold
Naval Health Clinic Lemoore, CA	<ul style="list-style-type: none"> Transition to ASC 	<ul style="list-style-type: none"> Complete with urgent care center
Naval Health Clinic Oak Harbor, WA	<ul style="list-style-type: none"> Transition to ACC and birthing center 	<ul style="list-style-type: none"> Complete with implementation of an urgent care clinic
Naval Hospital Beaufort, SC	<ul style="list-style-type: none"> Transition to ASC 	<ul style="list-style-type: none"> Complete; maintains a 24-hour medical hold capability for recruits unable to return to the barracks

Changes in Beneficiary Enrollment

Figure 2 shows that changes in the enrollment patterns of military health care beneficiaries have led to a reduction in the number of Prime enrollees (eligible beneficiaries who are most likely to seek care through the DCS). Fewer beneficiaries have remained eligible for DoD medical care since FY 2013 as the number of AD Service members has fallen, accompanied by a resulting decline in family members.²² In particular, Prime enrollment to the Managed Care Support Contractor (MCSC) has declined by 25.9 percent since FY 2013 (Figure 2), due in part to a reduction of Prime service areas under the current TRICARE contract in FY 2013 and, to a lesser extent, MCSC Prime enrollees transitioning from purchased care to direct care.

²² 2017 Evaluation of the TRICARE Program: Fiscal Year 2017 Report to Congress, May 2017. p. 12.

Figure 2. Prime Enrollment



Initiatives to Enhance DCS Utilization

Despite the decline in overall eligible beneficiaries, Service medical organizations have implemented changes in assignment processes and initiatives to increase workload available to uniformed clinical specialists. These efforts continue with full impacts not expected to be realized until FY 2018, due to several factors such as the Planning, Programming, Budget and Execution process, reassignment timing, and the ability to attract patients with increasingly complex needs. Nonetheless, the Services have shown improvement in increasing the complexity of workload available, improving average inpatient case mix index by six percent since FY 2014.²³

Army Medicine launched significant initiatives to improve MTF performance and to attract workload currently performed in purchased care. These initiatives include:

- The Financial Accountability and Recovery Mission (FARM) evaluates an MTF's effective utilization and stewardship of resources to achieve efficient delivery of health care and targeted levels of business operations performance. The FARM employs the Operating Company methodology to assess an MTF's business practices, identify variances (good and bad), implement business practice standards, and align resources to

²³ Case Mix Index (CMI) is a measure of clinical complexity and diversity maintained by the Centers for Medicare and Medicaid Services (CMS). It is the average DRG relative weight for that hospital, calculated by summing the DRG weights for all discharges and dividing by the number of discharges. Source: FY16 Inpatient MTF Portfolios from Inpatient Workload CMI Cost Tab. Excludes non-U.S. MTFs.

improve the MTF's ability to achieve performance expectations, thus increasing the value of health care delivery.

- The Integrated Resourcing and Incentive System has incorporated the first U.S. Army Medical Command (MEDCOM) zero-based flexible budget system using the financial system and MTF Performance Plan framework to align cost to outcomes. This system developed a basis of budget allocation for the \$6.5 billion (B) DHP dollars into precise service line and programs while considering standardized cost, volume of multivariable outputs, and outcomes generated by the multiple medical services and program areas.
- The Medical Readiness Assessment Tool (MRAT) improves leader insight on unit-level medical risk and enables clinicians to efficiently provide accurate individual-level readiness assessments to commanders. The MRAT supports Army Medicine's transformation from a health care system to a system for health by identifying at-risk soldiers earlier than previously feasible, improving evaluative quality, and enabling clinicians to better engage patients.
- Clinical Excellence Training has created a standardized methodology to provide training and common understanding across the entire Army MEDCOM. These training sessions occur for command teams, analysts, non-commissioned officers, and specified providers such as dentists, nurse methods analysts, and physical therapists.

These processes are expected to result in measurable increases in both inpatient and outpatient medical workload, and will improve clinician medical readiness essential to Army operational readiness and reduce health care expenditures.

Prior to the 2015 Modernization Study, Navy Medicine completed its own study, known as the “Continental United States (CONUS) Hospital Study,” aimed at identifying opportunities to achieve closer alignment of limited resources to market-level demand signals for health care services with the ultimate goal of achieving greater balance between accomplishing the mission described previously and the cost of accomplishing that mission. Though the two studies shared some common objectives, they were distinct initiatives applying different models. Nine MTFs were targeted for some degree of adjustment, to include adjusting the number of inpatient beds, adjusting Navy line staffing, restructuring of graduate medical education (GME) programs, and increasing enrollment, surgical utilization, and intensive care unit admissions. Additionally, some emergent, urgent, and immediate care capabilities were realigned to better match the patient case mix. Although some MTFs experienced similar changes, these changes were unique to the circumstances identified in each MTF market. The recommendations related to Navy MTFs within the Modernization Study formed a subset of the CONUS Hospital Study recommendations. By implementing its change plan of the CONUS Hospital Study, Navy Medicine addressed changes to its CONUS MTFs directed by the Under Secretary of Defense for Personnel and Readiness.

In 2014, the Air Force Medical Service (AFMS) launched the Facility Assessment and Comprehensive Evaluation (FACE) process. The FACE process consists of a cross-functional

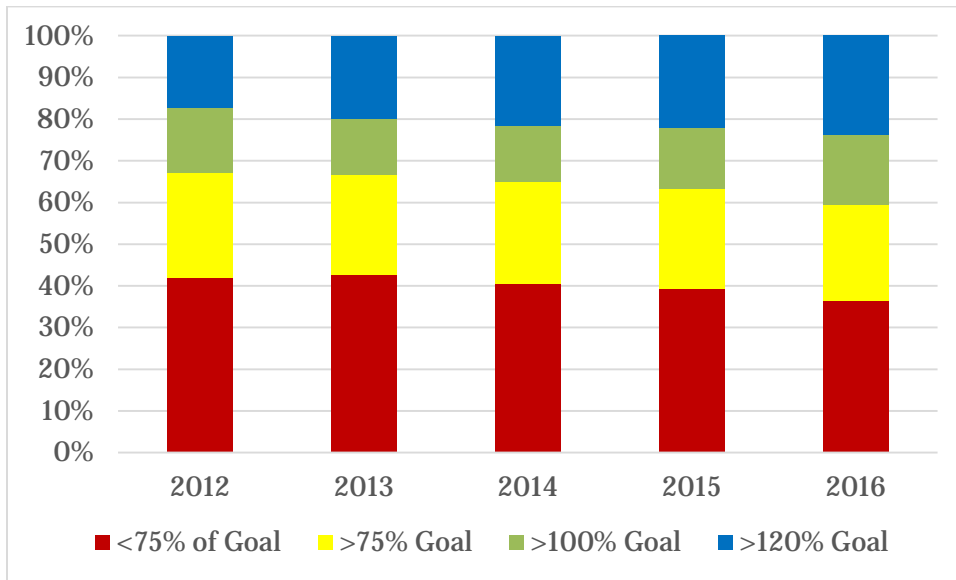
team of subject matter experts to assist MTFs in achieving the goal of optimizing both direct care and purchased care delivery while supporting the Air Force mission, maintaining medical readiness, and providing trusted care, anywhere. FACE team members work, in a collaborative effort with MTF staff, to make progress in improving performance toward the MHS Modernization Study goals. The team helps MTFs uncover shortfalls and establish recommendations for initiatives while utilizing a very rigorous follow-up process. In the end, the FACE process works to continuously improve MTF performance with data-driven recommendations. The AFMS continues to enhance efficiencies through the use of the FACE process.

Provider Productivity Performance

The 2015 Modernization Study report introduced provider productivity targets. These targets were based upon provider aggregate work relative value units (wRVUs), a measure that quantifies the time, skill, and intensity of providing a clinical service.²⁴ The MHS adopted provider productivity as an enterprise metric. Since 2012, the MHS has managed against this metric with mixed success. The percentage of providers performing less than 75 percent of their productivity target has decreased by approximately six percentage points from FY 2012 through FY 2016, while the percentage of providers performing more than 120 percent of their productivity target has increased by approximately seven percentage points (See Figure 3). This is not to suggest that the productivity target, 40 percent of the Medical Group Management Association (MGMA) median by specialty, establishes a preferred DoD benchmark for provider productivity. Of the 15 specialties analyzed in the prior Modernization Study, 11 recorded an increase in provider productivity since FY 2012, with a 7-percentage point increase in productivity across all 15 specialties (Table 3).

²⁴ Provider productivity is measured using provider aggregate work RVUs. Provider aggregate work RVUs are standard factors and provide a relative measure of the level of professional time, skill, training and intensity to provide a given clinical service and are aggregated in a health care record. RVUs are defined by the Centers for Medicare and Medicaid Services and modified for MHS specific procedures. The productivity benchmarks are set at 40% of the FY12 MGMA median wRVUs by specialty or better.

Figure 3. Percent of Providers Relative to Modernization Productivity Goal: FY 2012-FY 2016



Source: Provider Productivity Partnership for Improvement (P4I) Metric Set 12-17Q1 – MHS Performance Dashboard

Goal: 100% of providers meet the productivity target

Productivity Target: 40% of the wRVUs of the FY2012 Medical Group Management Association (MGMA) median by specialty

Note: Includes all AD Skill Type 1 Specialty Providers. Excludes providers with less than 120 RVUs in the measured year.

Table 3. MHS Providers Meeting Productivity Metrics: FY 2012 vs. FY 2016

Selected Specialties	FY12	FY16
Cardiac/Thoracic Surgery	23%	10%
General Surgery	23%	22%
Peripheral Vascular Surgery	8%	14%
Pulmonary Disease	11%	23%
Colon and Rectal Surgery	23%	25%
Nephrology	19%	13%
Neurological Surgery	13%	25%
Plastic Surgery	32%	26%
Pediatric Surgery	22%	30%
Endocrinology	20%	44%
Hematology and Oncology	17%	49%
Gastroenterology	35%	41%
Urology	36%	50%
Orthopedic Surgery	26%	35%
Cardiology	19%	26%
Selected Specialties Total	24%	31%

Green: Increase since FY12 baseline

Red: Reduction since FY12 baseline

Source: Provider Productivity P4I Metric Set 12-17Q1

Goal: 100% of providers meet the productivity target

Productivity Target: 40% of the wRVUs of the 2012 median by specialty

Note: Includes only AD Physician Specialty Providers. Excludes specialties not analyzed in the 2015 Modernization Study.

Excludes providers with less than 120 RVUs in the measured year. Does not include deployed workload.

Part 2: Methodology

Introduction

In December 2016, DoD established a committee comprised of Service and DHA representatives, chaired by the DASD(HRP&O), to develop recommendations to respond to section 703 of the NDAA for FY 2017 requirements in support of the Under Secretary of Defense for Personnel and Readiness. DHA and Services' analytical communities and contract support were utilized to build the analytics infrastructure. This ensured the methodology used in the report was transparent, comprehensive, and data-driven. Throughout the report building process, there was ongoing coordination with the teams tasked with addressing interrelated sections of the NDAA for FY 2017, including sections 706, 708, 717, 721, 725, and 749.

In conducting this analysis, make-versus-buy assessments utilized knowledge gained from the 2015 Modernization Study. Although the MHS has conducted these evaluations at individual MTFs, it has limited experience conducting assessments at a centralized, enterprise-level across all of its facilities. The challenge with centralized analysis is local factors have significant impacts on the availability and quality of care. Whether the local purchased care network can absorb the workload of a clinic may depend upon such local nuances as knowing how many purchased care providers are accepting new patients or the providers' proximity to retirement. Therefore, while the centralized assessment may identify potential opportunities, more analysis is needed.

In order to address section 703(c) and (d) requirements, the report utilizes the same four-step process employed in the 2015 Modernization Study:

1. Define the opportunities for modifying capability sets;
2. Identify the opportunities for modifying capability sets;
3. Conduct further review and investigation; and
4. Decide on future capability sets and facility designations.

This report establishes a framework to complete steps one and two. Steps three and four will be included in the implementation plan.

The subsequent sections of the report methodology detail the definitions of step one that aid in the identification of potential opportunities. It consists of two parts:

- Facility Requirements: the decision framework developed for the application of Title 10 U.S.C. §1073d facility requirements;
- PDM: analysis of the DCS using a productivity floor to evaluate economic effectiveness.

To completely appreciate the methods employed by each assessment, it is important to be aware of the data sources and data adjustments employed; this information can be found in Appendices D, E, and F of this document.

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

To operationalize the criteria for medical centers, hospitals, and ACCs, measurable definitions for each requirement were established, with the intention of identifying opportunities for changes in facility capabilities. Within this framework, the implementation plan will specify the designation of each facility, given existing capabilities and infrastructure, future mission needs, and other regional opportunities or partnerships.

Medical Center

The medical center criteria enumerated in Title 10 U.S.C. §1073d(b) were used to define a framework for designating facility type. All criteria were assessed at the market level to determine if each market could potentially sustain a medical center. Market-level assessment for medical centers is appropriate, as these facilities will serve as referral centers for the most complex direct care in the market. The assessment was completed only on markets with existing inpatient MTFs, using data from FY 2016. After careful analysis, the following definitions were used for the remainder of this report:

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 outpatient-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 outpatient-only facilities serving as referral sources for the inpatient facilities. Beneficiary populations include aggregate populations in health care markets.

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 and outside referrals pertain to specialty care for anyone not enrolled to that MTF.

Trauma Capabilities: As stated in Title 10 U.S.C. 1073d (b), a medical center must have “level one or level two trauma care capabilities.” For the purposes of this assessment, the committee defined “trauma capabilities” as performance of sufficient²⁵ DCS workload in the five combat casualty care team (CCCT) specialties: anesthesiology, critical care/trauma medicine, emergency medicine, general surgery, and orthopedic surgery.

Tertiary Care: Facilities 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 specialties of the CCCT. Therefore, an MTF is

²⁵ 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 40% of the FY12 Medical Group Management Association median wRVU by specialty.

considered to have tertiary care capabilities if that MTF performed sufficient²⁶ DCS workload across 20 specialties required by the ACS at Level I or Level II trauma centers, beyond the CCCT specialties.²⁷

GME Programs: Medical centers serve as a key training platform for uniformed providers. The classification approach includes both GME and graduate dental education (GDE) programs. Therefore, a medical center market must operate at least two resident GME or 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.

Hospital

In addition to providing inpatient care to beneficiaries, MHS hospitals serve as key readiness-generating platforms for the uniformed medical force. As with medical centers, hospital MTFs were evaluated as markets, with overlapping clinics viewed as referral drivers to the market direct care hospital system and a key component of the MHS' integrated care continuum. The following hospital criteria definitions are used in this report:

Cost Effective: To assess the cost effectiveness of inpatient 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 health care 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: The TROs conducted a network assessment that examined whether the current local network could absorb the current inpatient MTF workload without anticipated risk to meeting TRICARE network access standards.²⁸ This network assessment analyzed whether DoD beneficiaries would have access to the same specialty care if the MTF's inpatient 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

²⁶ 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 40% of the 2012 MGMA median wRVU by specialty.

²⁷ 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.

²⁸ 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.

transition in the implementation plan required for section 703(d). The assessment focused on four different inpatient capabilities: inpatient services, medical care, surgical care, and obstetric/gynecologic care.

In partnership with the MCSCs, the TROs led the network capability assessment. MCSCs leveraged several proprietary data resources including network adequacy, drive time, and access to care 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. The TROs reviewed the MCSCs' evaluations, occasionally adopting a more conservative final evaluation given the TRO'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 TROs, making it difficult to generalize results.

ACC

This assessment focused on the ACC that provide outpatient care outside of an inpatient market. These stand-alone clinics typically serve smaller DoD beneficiary populations, while filling gaps in local civilian health care.

The following ACC criteria definitions were used in this report:

Cost Effective: Because the health care provided inside an MTF is frequently distinct from care provided by the local private sector, making a direct cost comparison between the two workloads is difficult. While the scope of this analysis addressed the cost effectiveness of health care 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 outpatient care provided in ACCs, a "Super RVU" (SRVU) method was developed to compare the actual production cost of direct care to a geographically specific projection of purchased care cost based on standard factors. Direct care professional services are assessed by workload and practice expense RVUs, adjusted by the appropriate Geographic Practice Cost Index (GPCI), then compared to the actual cost to produce the care to determine if the MTFs are cost efficient.²⁹

The SRVU method was compared to a method that measures the full cost per RVU in direct care against the amount paid per RVU in purchased care within a facility's PRISM area, because direct care and actual purchased care may not actually be comparable. A PRISM's purchased care could cover workload or procedures not available in direct care. The SRVU method avoids this difficulty by directly comparing the cost of an MTF's actual workload in direct and purchased care. The differences between the two methods are shown in Table 4. The

²⁹ The Centers for Medicare and Medicaid Services establishes a GCPI for every Medicare payment locality.

differences between the two methods affected 10 clinics shown in Table 5 where the cost per RVU method suggests the clinic is cost efficient and the SRVU method does not.

While the scope of this analysis addressed the cost efficiency of health care delivery, the MHS has not yet developed or implemented methodologies that allow for analysis of cost effectiveness relative to clinical and readiness outcomes.

Table 4. Comparison of Cost Effectiveness Methods.

		Direct Care		Purchased Care	
		SRVU Method	Cost per RVU Method	SRVU Method	Cost per RVU Method
Workload	Facility APC	Included	Not Included	The SRVU Method does not include Purchased Care Data.	Not Included
	Work RVUs	Included	Included		Included
	PE RVUs	Included	Included		Included
	Malpractice RVUs ¹	Not Included	Not Included		Not Included
Expenses	Facility	Included	Included	This method estimates Purchased Care Cost using CMS Conversion Factors.	Not Included
	Lab	Not Included	Included		Included ²
	Rad	Not Included	Included		Included ²
	Pharmacy	Not Included	Included		Included
	Malpractice ¹	Not Included	Not Included		Included
How is cost efficiency determined?				SRVU Cost Ratio < 1	Cost per RVU Ratio < 1

¹Malpractice is not a component of Direct Care workload/expenses.

²May not include all non-inpatient related Lab/Rad.lev

Table 5. ACCs with Differences between Cost Effectiveness Methods.

Name	Military Service
AHC YUMA PROVING GROUND	A
SOUTHCOM CLINIC-GORDON	A
AF-C-47th MED GRP-LAUGHLIN	F
AF-C-325th MED GRP-TYNDALL	F
AF-C-61st MED GRP-LOS ANGELES	F
AF-C-49th MED GRP-HOLLOMAN	F
AF-C-42nd MED GRP-MAXWELL	F
NHC CHARLESTON	N
NBHC NSA MID-SOUTH	N
NBHC NAS BELLE CHASE	N

Network Capability: As with hospitals, the TROs conducted a network assessment that examined whether the current local network could absorb the current outpatient MTF workload without anticipated risk to meeting TRICARE network access standards. Distinct from the hospital assessment, the TROs/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

The methodology used to conduct this assessment varied across the TRICARE regions. TRO West performed the network analysis, leveraging MCSC network adequacy and days to care reports, combined with local knowledge of the purchased care network's capability. In contrast, the MCSCs for the North and South regions conducted this assessment employing a similar process to the one used for the hospital assessment.

Provider Productivity: PDM

PDM Overview

The PDM (Provider Demand Model), formerly known as the Provider Allocation Model, was utilized in the initial Modernization Study to assess the balance between the overall demand and provider inventory of the MHS, and to demonstrate the overall economic efficiency of the MHS at a single point in time. It seeks to model the allocation of uniformed medical personnel across direct care MTFs to meet productivity floors in as few locations as possible. The PDM cannot be used to assess the Service-managed distribution of providers to an MTF because it does not include local considerations such as mission and local health care capabilities, nor does it assess the clinical readiness of the military medical force.

For more specifics on the methodology employed by the PDM, refer to the MHS Modernization Study Team Report submitted to Congress in May 2015 in response to section 713 of P.L. 113-291. The following methodology section describes changes to the PDM, but does not provide an exhaustive review of the model methodology. Data sources and data adjustments can be found in Appendices E and F.

Changes in Methodology from the Modernization Study Team Report

In this implementation, health care demand is estimated and then allocated against set provider consumption, employing similar beneficiary categories and demand estimation methodologies. The model examines 28 inpatient markets with hospitals or medical centers and 79 standalone clinic-only markets.³⁰ Military provider distributions were modeled in order of their overall population to the point that either the demand is exhausted (insufficient demand) or the inventory of uniformed providers is fully allocated (demand exceeds inventory).

³⁰ NH Twenty-nine Palms and ACH Weed-Irwin are excluded from this analysis because they are isolated inpatient MTFs.

As previously noted, the uniformed providers addressed in the model focused on the MHS' largest and most resource constrained product lines. Productivity floors in terms of annualized wRVUs were established for each specialty; they were set to 40 percent of the specialty's 2012 MGMA median wRVU total.^{31, 32} This analysis maintained the prior study's assumption of a recapture of 30 percent of the difference between an MTF market and the best performing MTF market for that specialty for Prime beneficiaries, 15 percent for non-Prime, and 7.5 percent for TRICARE for Life (TFL) as the floor.

Updates to the PDM since 2015 include:

Updated data: The model now utilizes FY 2015 DoD beneficiary data with Service specific projections for selected specialties, FY 2014-16 clinical workload data, FY 2016 authorized force structure, and current (as of September 2017) facility lists. See Appendix E for more detail on data sources.

Stable Population Assumption: The 2015 Modernization Study projected a decline in the DoD beneficiary population when estimating demand. This report assumed that the DoD beneficiary population would remain stable, and used FY 2016 population estimates to forecast future demand.

Adjustment for referral workload to prevent double counting demand: If a beneficiary received care at an MTF that is not his/her home market, the workload from that encounter was allocated to the treatment market and deducted from demand in the patient's home market. This adjustment was made to prevent double counting of workload across markets, while still giving the MTF credit for the referrals it typically receives.

Mapping new MTFs to Markets: Since the MHS has continued to expand the number of clinics, adjustments were required to ensure that the new locations were mapped to the appropriate markets. Without these adjustments, significant workload would have been geographically assigned to the new clinics and excluded from surrounding markets. This analysis also mapped all demand associated with beneficiaries living within a clinic's PRISM area to a market, if the clinic's PRISM area overlapped at all with a market's catchment area. The 2015 Modernization Study only mapped workload into a market if the beneficiary lived within the boundaries of the market. This shift slightly expanded the geographic reach of a market to a health care market.

Updated facility transitions: Some facilities have transitioned from hospitals to clinics since the 2015 Modernization Study, in part due to that study's findings. This analysis updates those facilities to only assign demand from beneficiaries within their PRISM area (20 miles around a clinic) rather than their catchment area (40 miles around a hospital).

³¹ Median MGMA RVUs are from the Medical Group Management Association, *Physician Compensation and Production Survey*, 2012 Report Based on 2011 Data.

³² Beginning in FY18, productivity floors will be set to 50% of the specialty's MGMA median wRVU total.

Mapping New Health Insurance Portability and Accountability Act (HIPAA) Taxonomies: An additional adjustment was the mapping of new HIPAA provider taxonomy codes to the standard DoD occupational codes. The allocation of military providers is based on the least common denominator, which is the DoD occupational codes. As new provider HIPAA taxonomy codes are added by the medical industry, it is necessary to assign them to appropriate DoD occupational codes so that the HIPAA-associated workload is not lost.

Part 3: Results and Findings

While Part 2 described how DoD defines Title 10 U.S.C. §1073d criteria for medical centers, hospitals, and ACCs, Part 3 provides the results of that application on the MHS's current state of the MTFs. We have included an update of the Modernization Study results, assessing the DCS' ability to sustain the readiness and provider productivity of MHS uniformed providers for selected specialties. In doing so, the report identifies potential opportunities for further analysis in the implementation plan.

Medical Center Evaluation

In developing a framework for applying the medical center §1073d(b) criteria, an evaluation of all MHS markets with inpatient facilities was conducted. The following 17 inpatient markets were identified as having the potential to sustain a Medical Center (See Table 4). This information will inform the implementation plan. The final recommendation will be made after careful consideration of Service readiness/mission requirements, local health care ability to accept increased demand, ability to increase MTF demand, the investments required, and all elements specified in section 703(d) of the NDAA for FY 2017. Some potential medical center markets that currently do not provide all 25 of the tertiary care and trauma specialties included in the criteria may require additional investments to enhance capabilities. As part of the implementation plan, any market DoD decides not to sustain as a medical center will undergo evaluation against the §1073d hospital criteria.

Table 4. Potential Medical Centers Evaluated Against Medical Center Criteria³³

Market Information	Medical Center Criteria				
	Population	Referrals	Tertiary Care	Trauma Capabilities	GME/GDE Programs
	MSM Name/MTF Name	Beneficiaries in Catchment Area Plus	Total Referral Encounters	ACS Trauma Specialties (out of 20)	CCCT Specialties (out of 5)
NATIONAL CAPITAL REGION WALTER REED NATL MIL MED CNTR FT BELVOIR COMMUNITY HOSP-FBCH	500,830	728,859 450,059 278,800	19 19 18	5 5 5	57/10 55/10 2/0
TIDEWATER AF-H-633rd MED GRP LANG-EUSTIS NMC PORTSMOUTH	470,033	527,416 71,009 456,407	20 13 20	5 5 5	13/4 0/1 13/3
SAN DIEGO NH CAMP PENDLETON NMC SAN DIEGO	411,045	651,492 160,953 490,539	19 12 19	5 5 5	22/5 2/2 20/3
PUGET SOUND AMC MADIGAN-LEWIS NH BREMERTON	308,659	356,858 295,752 50,156	19 19 10	5 5 4	24/2 24/2 0/0
SAN ANTONIO AMC BAMC-FSH	246,043	619,744 619,744	20 20	5 5	35/1 35/1
FORT BRAGG AMC WOMACK-BRAGG	203,859	354,072 354,072	15 15	5 5	3/3 3/3
HAWAII AMC TRIPLER-SHAFTER	188,871	415,830 415,830	20 20	5 5	14/2 14/2
NMC CAMP LEJEUNE	173,000	197,779	13	5	1/1
AMC DARNALL-HOOD	159,237	313,845	13	5	4/1
AMC WILLIAM BEAUMONT-BLISS	119,628	300,076	18	5	4/1
AF-MC-60th MED GRP-TRAVIS	117,722	92,475	20	5	6/1
AF-H-96th MED GRP-EGLIN	103,678	95,432	19	4	1/1
AF-MC-99th MED GRP-NELLIS	91,853	55,822	16	5	3/1
ACH MARTIN-BENNING	91,411	145,578	13	4	1/1
AMC EISENHOWER-GORDON	77,248	188,615	19	5	5/4
AF-MC-88th MED GRP-WRIGHT-PAT	69,103	61,082	18	5	6/1
MISSISSIPPI DELTA AF-MC-81st MED GRP-KEESLER	55,684	56,680 56,680	15 15	4 4	2/2 2/2

Hospital Evaluation

Using DoD’s application of Title 10 U.S.C. §1073d(c) criteria, the 11 inpatient markets that did not meet the criteria to be considered potential medical center markets are listed in Table 5 below. Included in Table 5 are the TRO’s network assessments on the local network’s ability to absorb inpatient services, medical services, surgical services, and obstetric/gynecologic services. Also included is an assessment of cost effectiveness using a comparison of a cost per MS-Diagnosis Related Group (DRG) Relative Weighted Product³⁴ in the MTF versus the billed charges available to DoD in local health care facilities. Finally, the table includes an evaluation of these facilities against medical center criteria, confirming their relatively lower suitability as potential medical center markets.

³³ VA-DoD partnership at James A. Lowell HFCC was excluded. Evaluation within each market is based on FY16 performance of Inpatient MTFs and associated civilian-DoD external resource sharing agreements.

³⁴ Relative weighted product is a standard workload factor published by the Centers for Medicare and Medicaid Services.

While the scope of this analysis addressed the cost effectiveness of health care delivery, the MHS has not yet developed nor widely adopted methodologies that allow for analysis of cost effectiveness relative to clinical and readiness outcomes.

The importance of some of these hospitals serving as readiness generating platforms, as well as their ability to produce patient value in terms of outcomes per dollar spent, will be further explored as a part of the section 703(d) implementation planning process.

Table 5. Potential Hospitals Evaluated Against Hospital Criteria

Market Information	Medical Center Criteria					Hospital Criteria					
MSM Name/ MTF Name	Population	Referrals	Tertiary Care	Trauma Capabilities	GME/GDE Programs	TRICARE Network's Ability to Absorb MTF Workload				Cost Effectiveness: Cost/Paid per MS-RWP	
	Beneficiaries in Catchment Area Plus	Total Referral Encounters	ACS Trauma Specialties (out of 20)	CCCT Specialties (out of 5)	Number of Programs	Inpatient Services	Medical Services	Surgical Services	OB Services	Direct Care	Purchased Care
COLORADO SPRINGS <i>ACH EVANS-CARSON</i>	177,998	186,790	14	5	1	Green	Yellow	Yellow	Green	\$10,496	\$8,564
JACKSONVILLE <i>NH JACKSONVILLE</i>	164,360	128,713	13	5	1	Green	Green	Green	Green	\$17,050	\$9,048
ACH BLANCHFIELD-CAMPBELL	109,401	186,141	12	4	1	Green	Green	Green	Green	\$12,430	\$7,161
ACH WINN-STEWART	95,942	141,901	11	4	0	Green	Green	Green	Green	\$12,303	\$7,725
NH PENSACOLA	70,799	48,741	13	3	0	Green	Green	Green	Green	\$23,025	\$7,340
ANCHORAGE, AK <i>AF-H-673rd-ELMENDORF</i>	56,373	68,907	13	4	0	Green	Yellow	Green	Green	\$16,906	\$15,180
ACH IRWIN-RILEY	55,752	132,903	8	4	0	Green	Yellow	Yellow	Green	\$9,386	\$7,267
ACH LEONARD WOOD	42,640	89,788	9	5	0	Green	Yellow	Yellow	Green	\$10,510	\$20,404
ACH KELLER-WEST POINT	36,412	28,717	9	4	1	Green	Green	Green	Green	\$8,180	\$12,123
ACH BAYNE-JONES-POLK	30,195	56,327	7	4	0	Red	Red	Red	Red	\$16,285	\$6,530
FAIRBANKS, AK <i>ACH BASSETT-WAINWRIGHT</i>	28,959	48,698	8	5	0	Red	Yellow	Yellow	Yellow	\$18,752	\$24,858

TRICARE Network capability to Absorb MTF Workload:

Green: No anticipated problems meeting workload 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.

Cost Efficiency:

Blue: Relatively lower cost/paid per MS-RWP in FY16

Source: FY16 MTF Inpatient Portfolios; Total Cost

Findings: The TRO network assessment report above, based on initial data, does not appear to be mature enough to be used for centralized decision-making. Without a prior approved framework for applying an enterprise-wide assessment of network adequacy, the report reflects coordination with the TROs to conduct this analysis. Contractual constraints reduced the consistency of the network analyses between the three TRICARE markets. The network assessments were conducted using a varied mixture of analyses, local knowledge, and direct contact with hospitals as deemed necessary by the MCSC. A key challenge in assessing network adequacy rests on the choices of local providers to expand their practices to include additional TRICARE patients. Because the MHS has limited influence over non-DoD providers, the MHS cannot guarantee that providers are willing or able to increase their capacity to provide care to MHS beneficiaries. In many cases, direct contact with the potential providers is required to ascertain whether the network can increase capacity to provide care that would meet TRICARE standards. Additional effort is required to validate that the networks can absorb the MTF workload without a reduction in access times and quality of care. To address this, DHA should consider developing a consistent definition of network adequacy that standardizes data presented in contractor network adequacy reports and will better support application of Title 10 U.S.C. 1073d(c) and (d) requirements. Table 5 identifies those markets that are most likely to offer opportunities for further review of modifying MTF capabilities.

ACC Evaluation

After application of Title 10 U.S.C. §1073d(d) criteria, Table 8 below displays the estimated network ability to absorb MTF workload by location. Cost effectiveness calculations for assessed clinics are provided in Appendix C, Table 15. As previously indicated, these data provide potential opportunities for further assessment to include ability of local health care providers to accept MTF demand.

Table 8. Potential ACC Opportunities

Facility	Clinic Specialty	Encounters	Evaluated Visits	RVU	Estimated Network Ability to Absorb Workload
AF-C-14th MED GRP-COLUMBUS	OB/GYN CLINIC	170	0	51	Green
AF-C-14th MED GRP-COLUMBUS	PT/OT	3,278	1,121	7,459	Yellow
AF-C-14th MED GRP-COLUMBUS	BEHAVIORAL HEALTH CLINIC	3,270	751	4,983	Red
AF-C-17th MED GRP-GOODFELLOW	PEDIATRIC CLINIC	6,672	4,753	11,320	Green
AF-C-17th MED GRP-GOODFELLOW	OB/GYN CLINIC	4,373	3,621	7,331	Green
AF-C-17th MED GRP-GOODFELLOW	PT/OT	4,378	1,663	10,502	Green
AF-C-17th MED GRP-GOODFELLOW	BEHAVIORAL HEALTH CLINIC	5,950	3,388	8,544	Red
AF-C-19th MED GRP-LITTLE ROCK	PT/OT	5,867	2,437	15,005	Green
AF-C-19th MED GRP-LITTLE ROCK	PEDIATRIC CLINIC	12,844	8,746	17,810	Yellow
AF-C-19th MED GRP-LITTLE ROCK	BEHAVIORAL HEALTH CLINIC	8,909	4,895	14,426	Red
AF-C-19th MED GRP-LITTLE ROCK	OB/GYN CLINIC	2,781	1,136	5,289	Yellow
AF-C-20th MED GRP-SHAW	BEHAVIORAL HEALTH CLINIC	13,721	6,928	20,059	Green
AF-C-20th MED GRP-SHAW	OB/GYN CLINIC	3,897	3,145	8,092	Green
AF-C-20th MED GRP-SHAW	PT/OT	5,933	1,729	17,569	Green
AF-C-20th MED GRP-SHAW	PEDIATRIC CLINIC	12,168	7,945	15,584	Yellow
AF-C-22nd MED GRP-MCCONNELL	PT/OT	3,594	1,160	8,160	Green
AF-C-22nd MED GRP-MCCONNELL	PEDIATRIC CLINIC	5,513	3,053	7,201	Yellow
AF-C-22nd MED GRP-MCCONNELL	OB/GYN CLINIC	5,279	2,838	8,837	Yellow
AF-C-22nd MED GRP-MCCONNELL	BEHAVIORAL HEALTH CLINIC	8,434	2,163	14,769	Yellow
AF-C-23rd MED GRP-MOODY	OB/GYN CLINIC	4,644	2,148	5,059	Green
AF-C-23rd MED GRP-MOODY	PT/OT	5,262	2,016	14,067	Green
AF-C-23rd MED GRP-MOODY	PEDIATRIC CLINIC	15,508	8,140	13,656	Yellow
AF-C-23rd MED GRP-MOODY	BEHAVIORAL HEALTH CLINIC	9,334	4,216	17,716	Yellow
AF-C-27th SPCLOPS MDGRP-CANNON	PT/OT	6,961	2,734	16,630	Green
AF-C-27th SPCLOPS MDGRP-CANNON	OB/GYN CLINIC	4,877	2,116	5,396	Green
AF-C-27th SPCLOPS MDGRP-CANNON	PEDIATRIC CLINIC	14,656	8,488	18,531	Yellow

Facility	Clinic Specialty	Encounters	Evaluated Visits	RVU	Estimated Network Ability to Absorb Workload
AF-C-27th SPCLOPS MDGRP-CANNON	BEHAVIORAL HEALTH CLINIC	14,612	7,048	23,916	Yellow
AF-C-28th MED GRP-ELLSWORTH	PT/OT	4,419	1,900	8,737	Green
AF-C-28th MED GRP-ELLSWORTH	PEDIATRIC CLINIC	7,374	3,357	6,937	Yellow
AF-C-28th MED GRP-ELLSWORTH	BEHAVIORAL HEALTH CLINIC	7,834	3,110	12,643	Yellow
AF-C-28th MED GRP-ELLSWORTH	OB/GYN CLINIC	1,681	1,203	4,403	Yellow
AF-C-2nd MED GRP-BARKSDALE	PEDIATRIC CLINIC	20,681	10,770	26,043	Green
AF-C-2nd MED GRP-BARKSDALE	PT/OT	12,361	3,955	32,774	Green
AF-C-2nd MED GRP-BARKSDALE	OB/GYN CLINIC	1,958	1,563	5,151	Green
AF-C-2nd MED GRP-BARKSDALE	ORTHOPEDIC CLINIC	1,285	716	2,098	Green
AF-C-2nd MED GRP-BARKSDALE	BEHAVIORAL HEALTH CLINIC	11,610	7,928	18,990	Yellow
AF-C-30th MED GRP-VANDENBERG	PEDIATRIC CLINIC	9,122	5,672	13,139	Red
AF-C-30th MED GRP-VANDENBERG	BEHAVIORAL HEALTH CLINIC	3,777	1,234	8,274	Yellow
AF-C-30th MED GRP-VANDENBERG	PT/OT	3,422	1,255	9,824	Green
AF-C-319th MED GRP-GRAND FORKS	PT/OT	3,281	1,379	8,567	Green
AF-C-319th MED GRP-GRAND FORKS	PEDIATRIC CLINIC	5,159	3,535	6,632	Yellow
AF-C-319th MED GRP-GRAND FORKS	BEHAVIORAL HEALTH CLINIC	5,224	1,369	6,780	Yellow
AF-C-319th MED GRP-GRAND FORKS	OB/GYN CLINIC	2,565	1,110	3,010	Yellow
AF-C-325th MED GRP-TYNDALL	PEDIATRIC CLINIC	12,916	8,928	19,631	Green
AF-C-325th MED GRP-TYNDALL	OB/GYN CLINIC	3,298	1,584	3,768	Green
AF-C-325th MED GRP-TYNDALL	PT/OT	2,451	934	4,747	Green
AF-C-325th MED GRP-TYNDALL	BEHAVIORAL HEALTH CLINIC	8,821	3,593	16,425	Yellow
AF-C-341st MED GRP-MALMSTROM	PEDIATRIC CLINIC	12,839	7,284	18,590	Yellow
AF-C-341st MED GRP-MALMSTROM	BEHAVIORAL HEALTH CLINIC	5,339	2,130	10,096	Yellow
AF-C-341st MED GRP-MALMSTROM	OB/GYN CLINIC	2,733	2,032	5,581	Red
AF-C-341st MED GRP-MALMSTROM	PT/OT	3,297	1,653	8,886	Green
AF-C-355th MED GRP-DM	PEDIATRIC CLINIC	20,912	10,964	25,871	Yellow
AF-C-355th MED GRP-DM	BEHAVIORAL HEALTH CLINIC	16,432	10,121	29,218	Yellow
AF-C-355th MED GRP-DM	OB/GYN CLINIC	7,217	3,733	9,372	Yellow
AF-C-355th MED GRP-DM	ALLERGY CLINIC	1,171	836	3,997	Yellow
AF-C-355th MED GRP-DM	PT/OT	16,406	6,484	40,538	Green
AF-C-355th MED GRP-DM	ORTHOPEDIC CLINIC	3,588	3,401	8,186	Green
AF-C-375th MED GRP-SCOTT	PAIN MANAGEMENT CLINIC	166	9	210	Green
AF-C-375th MED GRP-SCOTT	ORTHOPEDIC CLINIC	383	370	803	Green

Facility	Clinic Specialty	Encounters	Evaluated Visits	RVU	Estimated Network Ability to Absorb Workload
AF-C-375th MED GRP-SCOTT	ALLERGY CLINIC	691	681	560	Green
AF-C-375th MED GRP-SCOTT	DERMATOLOGY CLINIC	2,268	1,694	7,743	Green
AF-C-375th MED GRP-SCOTT	PT/OT	13,266	4,178	31,308	Green
AF-C-375th MED GRP-SCOTT	BEHAVIORAL HEALTH CLINIC	13,455	4,110	24,577	Green
AF-C-375th MED GRP-SCOTT	OB/GYN CLINIC	16,928	8,707	32,464	Green
AF-C-375th MED GRP-SCOTT	PEDIATRIC CLINIC	17,869	14,121	23,513	Green
AF-C-375th MED GRP-SCOTT	INTERNAL MEDICINE CLINIC	21,284	11,394	14,158	Green
AF-C-377th MED GRP-KIRTLAND	PEDIATRIC CLINIC	18,688	9,747	23,159	Yellow
AF-C-377th MED GRP-KIRTLAND	BEHAVIORAL HEALTH CLINIC	11,349	3,504	22,025	Red
AF-C-377th MED GRP-KIRTLAND	OB/GYN CLINIC	3,512	2,332	5,394	Yellow
AF-C-377th MED GRP-KIRTLAND	ALLERGY CLINIC	887	881	1,315	Red
AF-C-377th MED GRP-KIRTLAND	PT/OT	15,116	5,211	34,448	Green
AF-C-412th MED GRP-EDWARDS	PEDIATRIC CLINIC	7,422	5,466	13,591	Yellow
AF-C-412th MED GRP-EDWARDS	OB/GYN CLINIC	3,326	2,197	5,482	Yellow
AF-C-412th MED GRP-EDWARDS	BEHAVIORAL HEALTH CLINIC	10,028	1,370	10,413	Yellow
AF-C-412th MED GRP-EDWARDS	PT/OT	3,793	1,439	10,603	Green
AF-C-42nd MED GRP-MAXWELL	PEDIATRIC CLINIC	19,922	12,337	28,158	Green
AF-C-42nd MED GRP-MAXWELL	PT/OT	11,969	3,134	24,175	Green
AF-C-42nd MED GRP-MAXWELL	OB/GYN CLINIC	3,500	3,042	9,111	Green
AF-C-42nd MED GRP-MAXWELL	BEHAVIORAL HEALTH CLINIC	6,857	2,592	12,619	Red
AF-C-436th MED GRP-DOVER	OB/GYN CLINIC	3,357	1,613	5,892	Green
AF-C-436th MED GRP-DOVER	PT/OT	4,736	1,420	9,737	Green
AF-C-436th MED GRP-DOVER	BEHAVIORAL HEALTH CLINIC	10,261	5,464	17,068	Green
AF-C-436th MED GRP-DOVER	PEDIATRIC CLINIC	12,381	6,635	17,015	Green
AF-C-45th MED GRP-PATRICK	PEDIATRIC CLINIC	13,338	7,647	17,164	Green
AF-C-45th MED GRP-PATRICK	BEHAVIORAL HEALTH CLINIC	9,308	3,472	17,788	Green
AF-C-45th MED GRP-PATRICK	PT/OT	4,509	1,779	8,881	Green
AF-C-45th MED GRP-PATRICK	OB/GYN CLINIC	2,130	1,339	3,744	Green
AF-C-460th MED GRP-BUCKLEY	PEDIATRIC CLINIC	6,657	3,591	7,865	Yellow
AF-C-460th MED GRP-BUCKLEY	BEHAVIORAL HEALTH CLINIC	7,497	3,395	12,477	Yellow
AF-C-460th MED GRP-BUCKLEY	PT/OT	3,531	920	7,341	Green
AF-C-47th MED GRP-LAUGHLIN	PEDIATRIC CLINIC	3,643	3,217	8,626	Green
AF-C-47th MED GRP-LAUGHLIN	BEHAVIORAL HEALTH CLINIC	2,309	562	3,956	Red

Facility	Clinic Specialty	Encounters	Evaluated Visits	RVU	Estimated Network Ability to Absorb Workload
AF-C-49th MED GRP-HOLLOMAN	PEDIATRIC CLINIC	12,231	6,774	16,030	Yellow
AF-C-49th MED GRP-HOLLOMAN	BEHAVIORAL HEALTH CLINIC	10,647	5,268	21,599	Yellow
AF-C-49th MED GRP-HOLLOMAN	INTERNAL MEDICINE CLINIC	5,956	2,319	4,985	Yellow
AF-C-49th MED GRP-HOLLOMAN	PT/OT	6,582	2,225	19,562	Green
AF-C-49th MED GRP-HOLLOMAN	OB/GYN CLINIC	2,033	1,266	2,995	Green
AF-C-509th MED GRP-WHITEMAN	PEDIATRIC CLINIC	15,263	9,625	18,712	Yellow
AF-C-509th MED GRP-WHITEMAN	BEHAVIORAL HEALTH CLINIC	8,716	4,907	16,101	Green
AF-C-509th MED GRP-WHITEMAN	OB/GYN CLINIC	2,992	2,034	4,240	Green
AF-C-509th MED GRP-WHITEMAN	PT/OT	3,714	1,487	9,444	Green
AF-C-55th MED GRP-OFFUTT	PEDIATRIC CLINIC	21,889	14,046	33,614	Yellow
AF-C-55th MED GRP-OFFUTT	INTERNAL MEDICINE CLINIC	11,484	5,797	11,158	Yellow
AF-C-55th MED GRP-OFFUTT	DERMATOLOGY CLINIC	3,684	2,624	12,509	Yellow
AF-C-55th MED GRP-OFFUTT	OTOLARYNGOLOGY CLINIC	2,982	2,608	8,188	Yellow
AF-C-55th MED GRP-OFFUTT	ALLERGY CLINIC	480	474	195	Yellow
AF-C-55th MED GRP-OFFUTT	OPHTHALMOLOGY CLINIC	2,030	312	9,669	Yellow
AF-C-55th MED GRP-OFFUTT	BEHAVIORAL HEALTH CLINIC	17,953	10,700	36,493	Green
AF-C-55th MED GRP-OFFUTT	OB/GYN CLINIC	12,426	6,409	26,103	Green
AF-C-55th MED GRP-OFFUTT	PT/OT	19,082	5,166	41,631	Green
AF-C-55th MED GRP-OFFUTT	ORTHOPEDIC CLINIC	4,614	4,247	11,833	Green
AF-C-55th MED GRP-OFFUTT	GENERAL SURGERY CLINIC	1,323	1,150	2,496	Green
AF-C-56th MED GRP-LUKE	PEDIATRIC CLINIC	23,236	15,115	35,898	Yellow
AF-C-56th MED GRP-LUKE	BEHAVIORAL HEALTH CLINIC	14,535	9,113	32,329	Yellow
AF-C-56th MED GRP-LUKE	INTERNAL MEDICINE CLINIC	15,192	6,555	15,504	Yellow
AF-C-56th MED GRP-LUKE	OB/GYN CLINIC	9,417	5,152	12,973	Yellow
AF-C-56th MED GRP-LUKE	ORTHOPEDIC CLINIC	4,695	4,027	9,878	Yellow
AF-C-56th MED GRP-LUKE	ALLERGY CLINIC	4,722	3,848	9,075	Yellow
AF-C-56th MED GRP-LUKE	GENERAL SURGERY CLINIC	2,046	1,114	3,442	Yellow
AF-C-56th MED GRP-LUKE	PT/OT	13,336	2,963	27,665	Green
AF-C-5th MED GRP-MINOT	PEDIATRIC CLINIC	19,529	10,168	25,044	Yellow
AF-C-5th MED GRP-MINOT	BEHAVIORAL HEALTH CLINIC	11,858	6,580	19,531	Yellow
AF-C-5th MED GRP-MINOT	OB/GYN CLINIC	3,373	2,524	7,194	Green
AF-C-5th MED GRP-MINOT	PT/OT	2,840	1,237	6,879	Green
AF-C-61st MED GRP-LOS ANGELES	PEDIATRIC CLINIC	6,360	5,039	12,862	Yellow

Facility	Clinic Specialty	Encounters	Evaluated Visits	RVU	Estimated Network Ability to Absorb Workload
AF-C-61st MED GRP-LOS ANGELES	BEHAVIORAL HEALTH CLINIC	5,935	1,317	6,805	Yellow
AF-C-61st MED GRP-LOS ANGELES	PT/OT	3,617	692	10,854	Green
AF-C-628th MED GRP-CHARLESTON	PEDIATRIC CLINIC	9,375	7,940	14,078	Green
AF-C-628th MED GRP-CHARLESTON	PT/OT	7,144	3,382	17,308	Green
AF-C-628th MED GRP-CHARLESTON	OB/GYN CLINIC	53	52	9	Green
AF-C-628th MED GRP-CHARLESTON	BEHAVIORAL HEALTH CLINIC	9,744	3,158	14,962	Yellow
AF-C-66th MED GRP-HANSCOM	BEHAVIORAL HEALTH CLINIC	4,315	1,379	8,262	Green
AF-C-66th MED GRP-HANSCOM	PEDIATRIC CLINIC	6,420	3,036	7,309	Green
AF-C-6th MED GRP-MACDILL	BEHAVIORAL HEALTH CLINIC	19,745	11,290	30,014	Green
AF-C-6th MED GRP-MACDILL	PEDIATRIC CLINIC	15,105	7,423	19,380	Green
AF-C-6th MED GRP-MACDILL	INTERNAL MEDICINE CLINIC	13,213	4,769	9,318	Green
AF-C-6th MED GRP-MACDILL	PT/OT	18,724	4,623	39,084	Green
AF-C-6th MED GRP-MACDILL	ORTHOPEDIC CLINIC	4,202	3,963	10,727	Green
AF-C-6th MED GRP-MACDILL	ALLERGY CLINIC	3,959	3,553	6,597	Green
AF-C-6th MED GRP-MACDILL	DERMATOLOGY CLINIC	2,890	2,437	9,294	Green
AF-C-6th MED GRP-MACDILL	OB/GYN CLINIC	3,258	2,345	6,141	Green
AF-C-6th MED GRP-MACDILL	GENERAL SURGERY CLINIC	696	597	1,295	Green
AF-C-6th MED GRP-MACDILL	OPHTHALMOLOGY CLINIC	3,858	584	15,841	Green
AF-C-6th MED GRP-MACDILL	OTOLARYNGOLOGY CLINIC	268	265	699	Green
AF-C-71st MED GRP-VANCE	PEDIATRIC CLINIC	4,556	2,827	7,097	Yellow
AF-C-71st MED GRP-VANCE	BEHAVIORAL HEALTH CLINIC	3,156	776	5,145	Yellow
AF-C-72nd MED GRP-TINKER	BEHAVIORAL HEALTH CLINIC	16,420	7,368	26,359	Green
AF-C-72nd MED GRP-TINKER	PEDIATRIC CLINIC	9,861	6,098	19,988	Green
AF-C-72nd MED GRP-TINKER	OB/GYN CLINIC	6,442	4,104	10,511	Green
AF-C-72nd MED GRP-TINKER	PT/OT	9,326	2,718	25,040	Green
AF-C-72nd MED GRP-TINKER	GENERAL SURGERY CLINIC	2,331	1,630	3,736	Green
AF-C-72nd MED GRP-TINKER	ORTHOPEDIC CLINIC	659	632	1,794	Green
AF-C-72nd MED GRP-TINKER	INTERNAL MEDICINE CLINIC	2,408	1,028	1,719	Yellow
AF-C-75th MED GRP-HILL	PEDIATRIC CLINIC	16,469	9,353	26,502	Yellow
AF-C-75th MED GRP-HILL	BEHAVIORAL HEALTH CLINIC	14,032	7,564	27,952	Green
AF-C-75th MED GRP-HILL	OB/GYN CLINIC	5,341	3,884	8,048	Green
AF-C-75th MED GRP-HILL	PT/OT	6,525	2,651	14,469	Green
AF-C-78th MED GRP-ROBINS	PEDIATRIC CLINIC	12,775	7,548	18,114	Green

Facility	Clinic Specialty	Encounters	Evaluated Visits	RVU	Estimated Network Ability to Absorb Workload
AF-C-78th MED GRP-ROBINS	PT/OT	5,765	2,563	12,296	Green
AF-C-78th MED GRP-ROBINS	OB/GYN CLINIC	2,933	1,693	5,993	Green
AF-C-78th MED GRP-ROBINS	BEHAVIORAL HEALTH CLINIC	8,376	3,353	13,848	Yellow
AF-C-7th MED GRP-DYESS	PEDIATRIC CLINIC	13,575	11,001	18,346	Green
AF-C-7th MED GRP-DYESS	PT/OT	14,532	4,708	30,738	Green
AF-C-7th MED GRP-DYESS	OB/GYN CLINIC	5,562	3,618	5,799	Green
AF-C-7th MED GRP-DYESS	BEHAVIORAL HEALTH CLINIC	8,649	4,282	16,259	Yellow
AF-C-82nd MED GRP-SHEPPARD	PEDIATRIC CLINIC	12,790	7,574	14,115	Green
AF-C-82nd MED GRP-SHEPPARD	BEHAVIORAL HEALTH CLINIC	9,463	5,857	24,392	Green
AF-C-82nd MED GRP-SHEPPARD	OB/GYN CLINIC	5,027	3,809	9,799	Green
AF-C-82nd MED GRP-SHEPPARD	INTERNAL MEDICINE CLINIC	9,563	3,787	9,217	Green
AF-C-82nd MED GRP-SHEPPARD	PT/OT	9,863	3,586	25,823	Yellow
AF-C-87th MED GRP-MCGUIRE	OB/GYN CLINIC	5,567	3,439	6,893	Green
AF-C-87th MED GRP-MCGUIRE	PT/OT	16,620	4,741	39,743	Green
AF-C-87th MED GRP-MCGUIRE	BEHAVIORAL HEALTH CLINIC	17,319	6,854	29,164	Green
AF-C-87th MED GRP-MCGUIRE	PEDIATRIC CLINIC	22,045	16,182	32,672	Green
AF-C-90th MED GRP-FE WARREN	PEDIATRIC CLINIC	12,963	6,860	16,674	Yellow
AF-C-90th MED GRP-FE WARREN	BEHAVIORAL HEALTH CLINIC	5,746	1,898	10,362	Green
AF-C-90th MED GRP-FE WARREN	PT/OT	4,902	1,545	10,391	Green
AF-C-92nd MED GRP-FAIRCHILD	PEDIATRIC CLINIC	11,493	6,010	14,263	Yellow
AF-C-92nd MED GRP-FAIRCHILD	BEHAVIORAL HEALTH CLINIC	6,758	2,490	11,602	Yellow
AF-C-92nd MED GRP-FAIRCHILD	OB/GYN CLINIC	2,451	1,397	4,298	Yellow
AF-C-92nd MED GRP-FAIRCHILD	PT/OT	8,276	2,916	17,006	Green
AF-C-97th MED GRP-ALTUS	PEDIATRIC CLINIC	7,107	5,677	11,926	Yellow
AF-C-97th MED GRP-ALTUS	BEHAVIORAL HEALTH CLINIC	4,812	1,019	7,197	Yellow
AF-C-9th MED GRP-BEALE	PEDIATRIC CLINIC	9,506	6,054	13,537	Yellow
AF-C-9th MED GRP-BEALE	BEHAVIORAL HEALTH CLINIC	7,487	2,565	13,211	Yellow
AF-C-9th MED GRP-BEALE	OB/GYN CLINIC	1,084	799	2,363	Yellow
AF-C-9th MED GRP-BEALE	PT/OT	2,830	997	6,913	Green
AF-CB-BRANDON COMM CLINIC-MIL	PEDIATRIC CLINIC	19,428	11,722	24,705	Green
AF-CB-BRANDON COMM CLINIC-MIL	INTERNAL MEDICINE CLINIC	17,768	5,271	10,456	Green
AF-CB-BRANDON COMM CLINIC-MIL	OB/GYN CLINIC	2,506	2,032	5,043	Green

Facility	Clinic Specialty	Encounters	Evaluated Visits	RVU	Estimated Network Ability to Absorb Workload
AF-CB-BRANDON COMM CLINIC-MIL	ORTHOPEDIC CLINIC	162	146	424	Green
AHC DUNHAM-CARLISLE BARRACKS	BEHAVIORAL HEALTH CLINIC	2,565	398	6,241	Green
AHC DUNHAM-CARLISLE BARRACKS	PT/OT	5,234	1,244	12,598	Green
AHC DUNHAM-CARLISLE BARRACKS	GASTROENTEROLOGY CLINIC	1	1	0	Green
AHC DUNHAM-CARLISLE BARRACKS	PULMONARY DISEASE CLINIC	1	0	0	Green
AHC DUNHAM-CARLISLE BARRACKS	PRIMARY CARE CLINIC	1	0	0	Green
AHC FOX-REDSTONE ARSENAL	BEHAVIORAL HEALTH CLINIC	6,937	2,605	21,251	Yellow
AHC FOX-REDSTONE ARSENAL	PT/OT	6,203	1,395	11,468	Green
AHC GUTHRIE-DRUM	DERMATOLOGY CLINIC	2,559	1,497	5,238	Red
AHC GUTHRIE-DRUM	ORTHOPEDIC CLINIC	11,231	9,524	18,611	Yellow
AHC GUTHRIE-DRUM	PAIN MANAGEMENT CLINIC	13,734	5,288	25,312	Red
AHC GUTHRIE-DRUM	OB/GYN CLINIC	19,710	7,673	38,885	Red
AHC GUTHRIE-DRUM	PRIMARY CARE CLINIC	30,542	8,055	45,688	Yellow
AHC GUTHRIE-DRUM	BEHAVIORAL HEALTH CLINIC	34,549	15,707	77,085	Yellow
AHC GUTHRIE-DRUM	PT/OT	51,278	17,791	102,073	Red
AHC IRELAND-KNOX	OPHTHALMOLOGY CLINIC	953	148	3,761	Green
AHC IRELAND-KNOX	INTERNAL MEDICINE CLINIC	955	377	1,464	Green
AHC IRELAND-KNOX	GENERAL SURGERY CLINIC	1,465	1,060	4,342	Green
AHC IRELAND-KNOX	CARDIOLOGY CLINIC	2,761	1,784	7,527	Green
AHC IRELAND-KNOX	DERMATOLOGY CLINIC	7,774	3,594	22,107	Green
AHC IRELAND-KNOX	OB/GYN CLINIC	8,533	4,644	18,592	Green
AHC IRELAND-KNOX	ORTHOPEDIC CLINIC	12,498	8,828	24,628	Green
AHC IRELAND-KNOX	BEHAVIORAL HEALTH CLINIC	28,948	10,375	79,318	Green
AHC IRELAND-KNOX	PEDIATRIC CLINIC	31,033	19,151	46,331	Green
AHC IRELAND-KNOX	PT/OT	39,214	11,621	80,299	Green
AHC IRELAND-KNOX	PRIMARY CARE CLINIC	58,720	24,268	54,695	Green
AHC IRELAND-KNOX	ALLERGY CLINIC	17,522	7,138	40,745	Red
AHC KIRK-ABERDEEN PRVNG GD	BEHAVIORAL HEALTH CLINIC	3,640	622	5,767	Green
AHC KIRK-ABERDEEN PRVNG GD	PT/OT	4,088	1,491	7,721	Green
AHC LYSTER-RUCKER	PT/OT	23,520	5,550	46,044	Green
AHC LYSTER-RUCKER	BEHAVIORAL HEALTH CLINIC	10,607	3,811	27,473	Green
AHC MONCRIEF-JACKSON	URGENT CARE CLINIC	15,846	15,540	36,206	Yellow

Facility	Clinic Specialty	Encounters	Evaluated Visits	RVU	Estimated Network Ability to Absorb Workload
AHC MONCRIEF-JACKSON	ORTHOPEdic CLINIC	6,209	4,639	13,316	Yellow
AHC MONCRIEF-JACKSON	PRIMARY CARE CLINIC	53,925	1,689	244,558	Yellow
AHC MONCRIEF-JACKSON	DERMATOLOGY CLINIC	1,646	1,227	4,610	Yellow
AHC MONCRIEF-JACKSON	PT/OT	31,361	10,436	60,256	Green
AHC MONCRIEF-JACKSON	BEHAVIORAL HEALTH CLINIC	12,046	5,772	33,260	Green
AHC MONCRIEF-JACKSON	OB/GYN CLINIC	4,162	3,344	10,861	Green
AHC MONCRIEF-JACKSON	GENERAL SURGERY CLINIC	1,541	1,219	4,567	Green
AHC MONCRIEF-JACKSON	OTOLARYNGOLOGY CLINIC	782	675	2,786	Green
AHC MONCRIEF-JACKSON	PEDIATRIC CLINIC	2	2	6	Green
AHC MONCRIEF-JACKSON	OPHTHALMOLOGY CLINIC	8	1	0	Green
AHC MONTEREY	PT/OT	6,832	3,038	16,159	Green
AHC MONTEREY	BEHAVIORAL HEALTH CLINIC	8,256	3,036	20,983	Green
AHC MONTEREY	PRIMARY CARE CLINIC	484	297	482	Green
AHC MUNSON-LEAVENWORTH	ORTHOPEdic CLINIC	8,916	5,137	19,208	Yellow
AHC MUNSON-LEAVENWORTH	INTERNAL MEDICINE CLINIC	9,341	4,575	8,609	Yellow
AHC MUNSON-LEAVENWORTH	OB/GYN CLINIC	4,856	2,167	8,848	Yellow
AHC MUNSON-LEAVENWORTH	PT/OT	21,341	6,087	40,681	Green
AHC MUNSON-LEAVENWORTH	BEHAVIORAL HEALTH CLINIC	11,689	4,352	27,313	Green
AHC MUNSON-LEAVENWORTH	GENERAL SURGERY CLINIC	5,601	2,863	12,079	Green
AHC R W BLISS-HUACHUCA	PRIMARY CARE CLINIC	17,656	11,216	32,710	Yellow
AHC R W BLISS-HUACHUCA	BEHAVIORAL HEALTH CLINIC	7,480	2,508	22,774	Yellow
AHC R W BLISS-HUACHUCA	OB/GYN CLINIC	46	0	398	Yellow
AHC R W BLISS-HUACHUCA	PT/OT	14,580	4,627	34,561	Green
AHC R W BLISS-HUACHUCA	ORTHOPEdic CLINIC	715	487	1,285	Green
AHC REYNOLDS-SILL	PRIMARY CARE CLINIC	78,727	19,373	218,930	Yellow
AHC REYNOLDS-SILL	BEHAVIORAL HEALTH CLINIC	30,080	7,724	64,447	Yellow
AHC REYNOLDS-SILL	PULMONARY DISEASE CLINIC	3,142	1,686	25,946	Yellow
AHC REYNOLDS-SILL	OPHTHALMOLOGY CLINIC	2,625	570	12,449	Yellow
AHC REYNOLDS-SILL	URGENT CARE CLINIC	21,455	18,757	45,383	Green
AHC REYNOLDS-SILL	PT/OT	39,448	11,808	75,523	Green
AHC REYNOLDS-SILL	ORTHOPEdic CLINIC	12,267	9,102	31,903	Green
AHC REYNOLDS-SILL	OB/GYN CLINIC	11,193	2,914	17,682	Green
AHC REYNOLDS-SILL	DERMATOLOGY CLINIC	3,424	2,214	10,055	Green

Facility	Clinic Specialty	Encounters	Evaluated Visits	RVU	Estimated Network Ability to Absorb Workload
AHC REYNOLDS-SILL	GENERAL SURGERY CLINIC	3,120	2,035	7,874	Green
AHC REYNOLDS-SILL	OTOLARYNGOLOGY CLINIC	2	0	0	Green
AHC ROCK ISLAND ARSENAL	PRIMARY CARE CLINIC	15,824	7,682	17,979	Green
AHC YUMA PROVING GROUND	PRIMARY CARE CLINIC	2,257	1,283	3,355	Red
AHC-GREELY	PRIMARY CARE CLINIC	427	358	600	Yellow
BMC COLTS NECK EARLE	PRIMARY CARE CLINIC	5,267	3,618	9,081	Green
BMC COLTS NECK EARLE	GASTROENTEROLOGY CLINIC	1	1	0	Green
BMC LAKEHURST	PRIMARY CARE CLINIC	5,177	3,335	7,687	Green
BMC YUMA	BEHAVIORAL HEALTH CLINIC	3,099	1,366	10,991	Yellow
BMC YUMA	PT/OT	3,717	1,099	7,908	Green
NBHC EL CENTRO	PRIMARY CARE CLINIC	4,149	2,938	7,066	Yellow
NBHC FALLON	BEHAVIORAL HEALTH CLINIC	696	376	1,990	Red
NBHC GROTON	PRIMARY CARE CLINIC	3,915	841	2,899	Green
NBHC GROTON	GENERAL SURGERY CLINIC	5,084	4,170	10,654	Green
NBHC GROTON	PT/OT	10,894	2,110	22,572	Green
NBHC GROTON	BEHAVIORAL HEALTH CLINIC	18,162	7,468	30,266	Green
NBHC MERIDIAN	BEHAVIORAL HEALTH CLINIC	731	234	1,311	Green
NBHC MERIDIAN	PRIMARY CARE CLINIC	131	0	0	Green
NBHC NAS BELLE CHASE	PT/OT	4,549	1,352	11,775	Green
NBHC NAS BELLE CHASE	BEHAVIORAL HEALTH CLINIC	2,275	1,202	4,614	Green
NBHC NSA MID-SOUTH	BEHAVIORAL HEALTH CLINIC	984	154	1,497	Red
NBHC NSA MID-SOUTH	PT/OT	3,573	843	7,148	Green
NBHC NSA MID-SOUTH	PRIMARY CARE CLINIC	899	495	836	Green
NBHC PORT HUENEME	PRIMARY CARE CLINIC	2,132	784	4,688	Yellow
NBHC PORT HUENEME	PT/OT	6,263	1,233	18,520	Green
NBHC PORT HUENEME	BEHAVIORAL HEALTH CLINIC	1,035	365	3,925	Green
NBHC PORTSMOUTH	PRIMARY CARE CLINIC	1,197	429	834	Green
NBHC PORTSMOUTH	PT/OT	1,436	134	4,339	Green
NBHC PORTSMOUTH	BEHAVIORAL HEALTH CLINIC	1,457	707	3,529	Green
NH BEAUFORT	GENERAL SURGERY CLINIC	1,892	842	5,052	Yellow
NH BEAUFORT	ORTHOPEDIC CLINIC	8,384	7,526	24,437	Green
NH BEAUFORT	URGENT CARE CLINIC	5,609	5,598	12,092	Green
NH BEAUFORT	BEHAVIORAL HEALTH CLINIC	10,063	5,239	19,418	Green

Facility	Clinic Specialty	Encounters	Evaluated Visits	RVU	Estimated Network Ability to Absorb Workload
NH BEAUFORT	PT/OT	12,355	3,043	26,519	Green
NH BEAUFORT	DERMATOLOGY CLINIC	401	371	848	Green
NHC LEMOORE	BEHAVIORAL HEALTH CLINIC	6,967	4,062	14,129	Yellow
NHC LEMOORE	ORTHOPEDIC CLINIC	3,496	2,826	9,132	Yellow
NHC LEMOORE	PRIMARY CARE CLINIC	2,794	704	1,753	Yellow
NHC LEMOORE	OB/GYN CLINIC	8,315	4,284	19,105	Green
NHC LEMOORE	PT/OT	14,638	3,965	36,008	Green
NHC LEMOORE	GENERAL SURGERY CLINIC	2,682	2,136	6,808	Green
NHC OAK HARBOR	PEDIATRIC CLINIC	15,724	12,498	30,036	Yellow
NHC OAK HARBOR	PRIMARY CARE CLINIC	4,909	3,737	17,709	Yellow
NHC OAK HARBOR	PULMONARY DISEASE CLINIC	1	0	2	Red
NHC OAK HARBOR	CARDIOLOGY CLINIC	1	0	0	Yellow
NHC OAK HARBOR	GASTROENTEROLOGY CLINIC	1	0	0	Red
NHC OAK HARBOR	BEHAVIORAL HEALTH CLINIC	12,375	6,297	25,616	Green
NHC OAK HARBOR	OB/GYN CLINIC	9,510	3,503	19,407	Green
NHC OAK HARBOR	ORTHOPEDIC CLINIC	3,521	3,064	6,417	Green
NHC OAK HARBOR	PT/OT	8,496	2,746	18,940	Green
NHC OAK HARBOR	GENERAL SURGERY CLINIC	867	830	1,833	Green
NHC CHARLESTON	BEHAVIORAL HEALTH CLINIC	5,288	1,520	14,342	Yellow
NHC CHARLESTON	DERMATOLOGY CLINIC	773	402	1,840	Yellow
NHC CHARLESTON	PT/OT	12,870	2,406	38,882	Green
NHC CHARLESTON	CARDIOLOGY CLINIC	955	524	2,811	Green
NHC CORPUS CHRISTI	BEHAVIORAL HEALTH CLINIC	2,687	677	5,213	Red
NHC CORPUS CHRISTI	PT/OT	5,785	1,466	13,638	Green
NHC NEW ENGLAND	OPHTHALMOLOGY CLINIC	34	0	136	Green
NHC NEW ENGLAND	OTOLARYNGOLOGY CLINIC	924	781	2,417	Green
NHC NEW ENGLAND	DERMATOLOGY CLINIC	1,895	1,473	5,932	Green
NHC NEW ENGLAND	GENERAL SURGERY CLINIC	2,685	1,446	5,501	Green
NHC NEW ENGLAND	ORTHOPEDIC CLINIC	5,823	3,543	10,296	Green
NHC NEW ENGLAND	BEHAVIORAL HEALTH CLINIC	6,461	3,832	12,936	Green
NHC NEW ENGLAND	PT/OT	8,056	2,990	22,329	Green
NHC NEW ENGLAND	PRIMARY CARE CLINIC	12,207	6,902	18,137	Green
NHC PATUXENT RIVER	BEHAVIORAL HEALTH CLINIC	5,081	2,072	10,578	Green

Facility	Clinic Specialty	Encounters	Evaluated Visits	RVU	Estimated Network Ability to Absorb Workload
NHC PATUXENT RIVER	PEDIATRIC CLINIC	1	0	0	Green
NHC PATUXENT RIVER	CARDIOLOGY CLINIC	1	0	1	Green
NHC PATUXENT RIVER	PT/OT	13,205	1,505	18,644	Green
NHCL EVERETT	BEHAVIORAL HEALTH CLINIC	1,376	249	3,891	Yellow
NHCL EVERETT	PT/OT	5,127	1,790	11,200	Green
SOUTHCOM CLINIC-GORDON	BEHAVIORAL HEALTH CLINIC	2,486	381	4,461	Green

*Green: TRO anticipated that network can address MTF workload within access to care standards.

Findings: As with the hospital evaluation, the network assessment report above is not mature enough for centralized decision-making. Additional effort will be needed to confirm these networks can absorb MTF workload in compliance with TRICARE access and quality standards. These clinics will be further reviewed in the implementation plan before a final decision about capability changes is made. A comprehensive assessment of the effectiveness of the DCS would require an analysis of the efficiency of health care delivery in outpatient markets, with respect to clinical and readiness outcomes. While the scope of this analysis addressed the effectiveness of health care delivery, the MHS has not yet developed or widely adopted systems allowing for the integration of outcomes in such an analysis.

The ACC cost assessment reveals the MHS ACCs are not cost-competitive relative to the private sector when assessed using the SRVU methodology. The MHS ACCs are cost-competitive in the areas of optometry, internal medicine specialties (as opposed to internal medicine primary care), and dermatology affecting 20 outpatient MTFs. These data highlight opportunities for further assessment of the potential for transitioning capacity out of the MTFs, as shown in Appendix C, Table 8. This table also provides the ACC assessments by product line that did not suggest the networks were adequate to absorb the MTF workload. In order to fully assess costs, AD travel expenses must be included. Currently, these expenses are not funded by the DHP.

Demand Model Results

As shown in Table 6, the PDM indicates there was insufficient demand to place all uniformed providers at the 40 percent of 2012 MGMA Median wRVU floor. Ten specialties demonstrated a demand shortfall ranging from only 1 to 35 uniformed providers. However, when compared to 2013 results in Table 7, the MHS has improved the demand shortfall across 14 specialties, especially for orthopedic surgery and cardiology. The number of authorized providers in these

specialties has increased by 45 since 2013, which suggests the reduction in the demand shortfall has been driven by demand growth rather than declining physician requirements.

Table 6. Updated Comparison of Authorized Uniformed Providers to MHS Modeled Capacity (RVUs) FY 2016 Data

Selected Specialties	Number of Uniformed Providers		
	Authorized	Modelled Number MHS can Accommodate	Difference (Accommodate Auth)
Cardiac/Thoracic Surgery	41	6	-35
General Surgery	245	224	-21
Peripheral Vascular Surgery	36	16	-20
Pulmonary Disease	82	73	-9
Colon And Rectal Surgery	13	4	-9
Nephrology	34	28	-6
Neurological Surgery	37	32	-5
Plastic Surgery	32	28	-4
Pediatric Surgery	9	6	-3
Endocrinology	28	27	-1
Hematology And Oncology	48	60	12
Gastroenterology	73	86	13
Urology	84	99	15
Orthopedic Surgery	293	312	19
Cardiology	99	145	46

Demand Shortfall

Source: Uniformed Provider Demand Model

*Placed equals total number of providers derived from model with adequate workload available to meet productivity goal by specialty; Authorized is the number of funded specialist billets; Positive numbers are better.

Table 7. Demand Shortfall for Selected Specialties (RVUs) – Comparison of FY 2013 to FY 2016

Selected Specialties	Difference (Accommodate - Auth)*		Change from 2013 to 2016*	
	FY 2013 Data	FY 2016 Data		
Cardiac/Thoracic Surgery	-38	-35	3	<p>RED: Reduction of providers placed from FY 2013</p> <p>GREEN: Increase of providers placed from FY 2013</p>
General Surgery	12	-21	-33	
Peripheral Vascular Surgery	-26	-20	6	
Pulmonary Disease	-26	-9	17	
Colon and Rectal Surgery	-10	-9	1	
Nephrology	-15	-6	9	
Neurological Surgery	-12	-5	7	
Plastic Surgery	-15	-4	11	
Pediatric Surgery	-4	-3	1	
Endocrinology	-4	-1	3	
Hematology and Oncology	-3	12	15	
Gastroenterology	3	13	10	
Urology	1	15	14	
Orthopedic Surgery	-32	19	51	
Cardiology	-20	46	66	

Source: Provider Demand Model

*Placed equals total number of providers derived from model with adequate workload available to meet productivity goal by specialty; Authorized is the number of funded specialist billets; Positive numbers are better.

Findings: DoD is actively exploring mechanisms to increase DCS demand for uniformed physicians. As a result of the Modernization Study Team Report, DoD has increased the enrollment of beneficiaries in the MTFs. These efforts should continue and focus on beneficiaries needing specialty care. The NDAA for FY 2017 provides DoD with a variety of new mechanisms to increase uniformed physician workload, through section 706 process and the section 717 authority. DoD is exploring these options to enhance physician readiness.

There is an additional need to improve MHS coding quality. Any future assessment of the performance of the DCS will be dependent on the accuracy and completeness of coded workload, so it becomes even more important for this information to be effectively documented

and managed. DHA should explore options to modernize its coding practice and consider consolidating coding into a central function or contract.

Part 4: Implementation Plan Development

Implementation Plan

Section 703(d) requires the Secretary develop an implementation plan to restructure or realign the MTFs pursuant to Title 10 U.S.C. §1073d. The implementation plan will take into account inputs from the Military Departments and DHA. The Military Departments and DHA will take the criteria and methods provided in this report and use them to define the capabilities required to support medical force readiness on an MTF by MTF basis through the following four-step process:

1. Define the opportunities for modifying capability sets;
2. Identify the opportunities for modifying capability sets;
3. Conduct further review and investigation;
4. Decide on future capability sets and facility designations.

Steps three and four will be part of the implementation plan. Findings presented in this report represent opportunities for further review that will naturally occur as a part of the implementation plan development.

DHA, in coordination with the Military Departments, will perform Steps three and four. The overall framework and methodologies put forth in this report will be applied consistently. In carrying out Steps three and four of the aforementioned process, DoD will follow the process below:

- Each of the 36 inpatient and 79 stand-alone outpatient MTFs previously defined in this report will be evaluated for realignment, restructure, functional expansion or functional consolidation, as per the requirements in section 703(d)(2)(A)(i) and (ii).
- For those MTFs where the Services deem a restructuring or realignment is necessary, DoD will respond to the additional requirements enumerated in section 703(d).
- For those MTFs where the methodologies provided in this report would suggest one capability set, but DoD would like to apply a different one, DoD will provide an explanation of the decision based on:
 - Medically ready force requirements;
 - Need for ready medical force sustainment (for inpatient facilities only);
 - Network adequacy; and
 - Service mission requirement.

As DoD identifies potential opportunities for restructuring or realignment, it will be necessary to conduct further analysis at the local level. In order for a network to be assessed as having the ability to absorb MTF workload, the MHS will need to engage local network providers. DoD will also assess the viability of the Medical Centers identified to become either Level I or Level II trauma centers, if they do not already hold that designation.

Appendix A: Acronym List

Acronym	Definition
ACC	Ambulatory Care Center
AF	Air Force
AFB	Air Force Base
ACH	Army Community Hospital
AD	Active Duty
AHLTA	Armed Forces Health Longitudinal Technology Application
AMC	Army Medical Center
ASC	Ambulatory Surgery Center
BRAC	Defense Base Closure and Realignment
BUMED	US Navy Bureau of Medicine and Surgery
CAPER	Comprehensive Ambulatory/Professional Encounter Record Detail
CCCT	Combat Casualty Care Team
CHCS	Composite Health Care System
CMS	Centers for Medicare and Medicaid Services
DASD	Deputy Assistant Secretary of Defense
DCS	Direct Care System
DEERS	Defense Enrollment Eligibility Reporting System
DHA	Defense Health Agency
DMDC	Defense Manpower Data Center
DHP	Defense Health Program
DoD	Department of Defense
FHCC	James A. Lovell Federal Healthcare Center
FY	Fiscal Year
GAO	Government Accountability Office
GDE	Graduate Dental Education
GME	Graduate Medical Education
HA	Health Affairs

Acronym	Definition
KSA	Knowledge, Skills, and Abilities
M2	MHS Management and Analysis Reporting Tool
MDR	Military Health System Data Repository
MCSC	Managed Care Support Contractor
MEPRS	Medical Expense and Performance Reporting System
MHS	Military Health System
MSM	Multi-Service Market
MS-RWP	Medical Severity—Relative Weighted Product
MTF	Military Medical Treatment Facility
NA	Not Applicable
NCR	National Capital Region
NDAA	National Defense Authorization Act
NH	Naval Hospital
NOAA	National Oceanic and Atmospheric Administration
OB/GYN	Obstetrics and Gynecology
PDM	Provider Demand Model
PHS	Public Health Service
PRISM	Provider Requirement Integrated Specialty Model
SDD	Solution Delivery Division
SRVU	Super Relative Value Unit
TED	TRICARE Encounter Data
TJC	The Joint Commission
TRO	TRICARE Regional Office
VA	Department of Veterans Affairs
wRVU	Work Relative Value Unit

Appendix B: Service Narratives

Component Observations on MTF Transitions

Army: After notifying Congressional Committees, the Army Secretariat authorized the Surgeon General to move forward with the realignment of Army MTFs at Forts Sill, Knox, and Jackson. The U.S. Army MEDCOM directed its subordinate commands to close inpatient services at these Army installations by December 2016. Lessons learned will be published in a subsequent after-action report once hospital transitions are completed.

Navy: In December 2015, Navy Medicine launched an after-action assessment of the impact of these changes within the targeted MTFs and across the system. This assessment highlighted a number of successes and lessons learned. Navy Medicine achieved \$37.2M in cost avoidance through an overall reduction of civilian and contract personnel. Of note, the nine targeted MTFs achieved accelerated increases in enrollment and slowed growth in total expenses relative to other MTFs not targeted in the CONUS hospital study. MTFs where emergency departments were transitioned to Urgent Care Centers (UCCs) experienced a decrease in inpatient admissions, care volume, and clinical case mix. While improving elements of cost effectiveness, there were also increasing challenges with preserving clinical skills and medical force readiness. Navy Medicine is prospectively analyzing and addressing these outcomes may involve further adjustments over time, potentially including transition of emergency and urgent care services, operating room (OR) utilization, and clinical skill retention.

Air Force: Air Force did not have MTF transitions related to the MHS Modernization Study. However, the Air Force is transitioning the hospital at Mountain Home AFB, ID (formerly an isolated MTF) to a clinic as the local hospital has expanded its capabilities and achieved national certification.

Appendix C: Data Tables

Table 8. ACC Network Assessments Not Indicating Adequate Network Capacity

Facility	Clinic Specialty	Encounters	Evaluated Visits	RVU	Network Capabilities with Absorbed Workload
AF-C-14th MED GRP-COLUMBUS	BEHAVIORAL HEALTH CLINIC	3,270	751	4,983	Red
	PT/OT/CHIRO	3,278	1,121	7,459	Yellow
AF-C-17th MED GRP-GOODFELLOW	BEHAVIORAL HEALTH CLINIC	5,950	3,388	8,544	Red
AF-C-19th MED GRP-LITTLE ROCK	BEHAVIORAL HEALTH CLINIC	8,909	4,895	14,426	Red
	OB/GYN CLINIC	2,781	1,136	5,289	Yellow
	PEDIATRIC CLINIC	12,844	8,746	17,810	Yellow
AF-C-20th MED GRP-SHAW	PEDIATRIC CLINIC	12,168	7,945	15,584	Yellow
AF-C-22nd MED GRP-MCCONNELL	BEHAVIORAL HEALTH CLINIC	8,434	2,163	14,769	Yellow
	OB/GYN CLINIC	5,279	2,838	8,837	Yellow
	PEDIATRIC CLINIC	5,513	3,053	7,201	Yellow
AF-C-23rd MED GRP-MOODY	BEHAVIORAL HEALTH CLINIC	9,334	4,216	17,716	Yellow
	PEDIATRIC CLINIC	15,508	8,140	13,656	Yellow
AF-C-27th SPCLOPS MDGRP-CANNON	BEHAVIORAL HEALTH CLINIC	14,612	7,048	23,916	Yellow
	PEDIATRIC CLINIC	14,656	8,488	18,531	Yellow
AF-C-28th MED GRP-ELLSWORTH	BEHAVIORAL HEALTH CLINIC	7,834	3,110	12,643	Yellow
	OB/GYN CLINIC	1,681	1,203	4,403	Yellow
	PEDIATRIC CLINIC	7,374	3,357	6,937	Yellow
AF-C-2nd MED GRP-BARKSDALE	BEHAVIORAL HEALTH CLINIC	11,610	7,928	18,990	Yellow
AF-C-30th MED GRP-VANDENBERG	BEHAVIORAL HEALTH CLINIC	3,777	1,234	8,274	Yellow
	PEDIATRIC CLINIC	9,122	5,672	13,139	Red
AF-C-319th MED GRP-GRAND FORKS	BEHAVIORAL HEALTH CLINIC	5,224	1,369	6,780	Yellow
	OB/GYN CLINIC	2,565	1,110	3,010	Yellow
	PEDIATRIC CLINIC	5,159	3,535	6,632	Yellow
AF-C-325th MED GRP-TYNDALL	BEHAVIORAL HEALTH CLINIC	8,821	3,593	16,425	Yellow
AF-C-341st MED GRP-MALMSTROM	BEHAVIORAL HEALTH CLINIC	5,339	2,130	10,096	Yellow
	OB/GYN CLINIC	2,733	2,032	5,581	Red
	PEDIATRIC CLINIC	12,839	7,284	18,590	Yellow

Facility	Clinic Specialty	Encounters	Evaluated Visits	RVU	Network Capabilities with Absorbed Workload
AF-C-355th MED GRP-DM	ALLERGY CLINIC	1,171	836	3,997	Yellow
	BEHAVIORAL HEALTH CLINIC	16,432	10,121	29,218	Yellow
	OB/GYN CLINIC	7,217	3,733	9,372	Yellow
	PEDIATRIC CLINIC	20,912	10,964	25,871	Yellow
AF-C-377th MED GRP-KIRTLAND	ALLERGY CLINIC	887	881	1,315	Red
	BEHAVIORAL HEALTH CLINIC	11,349	3,504	22,025	Red
	OB/GYN CLINIC	3,512	2,332	5,394	Yellow
	PEDIATRIC CLINIC	18,688	9,747	23,159	Yellow
AF-C-412th MED GRP-EDWARDS	BEHAVIORAL HEALTH CLINIC	10,028	1,370	10,413	Yellow
	OB/GYN CLINIC	3,326	2,197	5,482	Yellow
	PEDIATRIC CLINIC	7,422	5,466	13,591	Yellow
AF-C-42nd MED GRP-MAXWELL	BEHAVIORAL HEALTH CLINIC	6,857	2,592	12,619	Red
AF-C-460th MED GRP-BUCKLEY	BEHAVIORAL HEALTH CLINIC	7,497	3,395	12,477	Yellow
	PEDIATRIC CLINIC	6,657	3,591	7,865	Yellow
AF-C-47th MED GRP-LAUGHLIN	BEHAVIORAL HEALTH CLINIC	2,309	562	3,956	Red
AF-C-49th MED GRP-HOLLOMAN	BEHAVIORAL HEALTH CLINIC	10,647	5,268	21,599	Yellow
	PEDIATRIC CLINIC	12,231	6,774	16,030	Yellow
AF-C-509th MED GRP-WHITEMAN	PEDIATRIC CLINIC	15,263	9,625	18,712	Yellow
AF-C-55th MED GRP-OFFUTT	ALLERGY CLINIC	480	474	195	Yellow
	DERMATOLOGY CLINIC	3,684	2,624	12,509	Yellow
	OPHTHALMOLOGY CLINIC	2,030	312	9,669	Yellow
	OTOLARYNGOLOGY CLINIC	2,982	2,608	8,188	Yellow
	PEDIATRIC CLINIC	21,889	14,046	33,614	Yellow
AF-C-56th MED GRP-LUKE	ALLERGY CLINIC	4,722	3,848	9,075	Yellow
	BEHAVIORAL HEALTH CLINIC	14,535	9,113	32,329	Yellow
	GENERAL SURGERY CLINIC	2,046	1,114	3,442	Yellow
	OB/GYN CLINIC	9,417	5,152	12,973	Yellow
	ORTHOPEDIC CLINIC	4,695	4,027	9,878	Yellow
	PEDIATRIC CLINIC	23,236	15,115	35,898	Yellow
AF-C-5th MED GRP-MINOT	BEHAVIORAL HEALTH CLINIC	11,858	6,580	19,531	Yellow
	PEDIATRIC CLINIC	19,529	10,168	25,044	Yellow
AF-C-61st MED GRP-LOS ANGELES	BEHAVIORAL HEALTH CLINIC	5,935	1,317	6,805	Yellow

Facility	Clinic Specialty	Encounters	Evaluated Visits	RVU	Network Capabilities with Absorbed Workload
	PEDIATRIC CLINIC	6,360	5,039	12,862	Yellow
AF-C-628th MED GRP-CHARLESTON	BEHAVIORAL HEALTH CLINIC	9,744	3,158	14,962	Yellow
AF-C-71st MED GRP-VANCE	BEHAVIORAL HEALTH CLINIC	3,156	776	5,145	Yellow
	PEDIATRIC CLINIC	4,556	2,827	7,097	Yellow
AF-C-75th MED GRP-HILL	PEDIATRIC CLINIC	16,469	9,353	26,502	Yellow
AF-C-78th MED GRP-ROBINS	BEHAVIORAL HEALTH CLINIC	8,376	3,353	13,848	Yellow
AF-C-7th MED GRP-DYESS	BEHAVIORAL HEALTH CLINIC	8,649	4,282	16,259	Yellow
AF-C-82nd MED GRP-SHEPPARD	PT/OT/CHIRO	9,863	3,586	25,823	Yellow
AF-C-90th MED GRP-FE WARREN	PEDIATRIC CLINIC	12,963	6,860	16,674	Yellow
AF-C-92nd MED GRP-FAIRCHILD	BEHAVIORAL HEALTH CLINIC	6,758	2,490	11,602	Yellow
	OB/GYN CLINIC	2,451	1,397	4,298	Yellow
	PEDIATRIC CLINIC	11,493	6,010	14,263	Yellow
AF-C-97th MED GRP-ALTUS	BEHAVIORAL HEALTH CLINIC	4,812	1,019	7,197	Yellow
	PEDIATRIC CLINIC	7,107	5,677	11,926	Yellow
AF-C-9th MED GRP-BEALE	BEHAVIORAL HEALTH CLINIC	7,487	2,565	13,211	Yellow
	OB/GYN CLINIC	1,084	799	2,363	Yellow
	PEDIATRIC CLINIC	9,506	6,054	13,537	Yellow
AHC FOX-REDSTONE ARSENAL	BEHAVIORAL HEALTH CLINIC	6,937	2,605	21,251	Yellow
AHC MONCRIEF-JACKSON	DERMATOLOGY CLINIC	1,646	1,227	4,610	Yellow
	ORTHOPEDIC CLINIC	6,209	4,639	13,316	Yellow
	URGENT CARE CLINIC	15,846	15,540	36,206	Yellow
AHC MUNSON-LEAVENWORTH	OB/GYN CLINIC	4,856	2,167	8,848	Yellow
	ORTHOPEDIC CLINIC	8,916	5,137	19,208	Yellow
AHC R W BLISS-HUACHUCA	BEHAVIORAL HEALTH CLINIC	7,480	2,508	22,774	Yellow
	OB/GYN CLINIC	46	0	398	Yellow
AHC REYNOLDS-SILL	BEHAVIORAL HEALTH CLINIC	30,080	7,724	64,447	Yellow
	OPHTHALMOLOGY CLINIC	2,625	570	12,449	Yellow
	PULMONARY DISEASE CLINIC	3,142	1,686	25,946	Yellow
BMC YUMA	BEHAVIORAL HEALTH CLINIC	3,099	1,366	10,991	Yellow
NBHC FALLON	BEHAVIORAL HEALTH CLINIC	696	376	1,990	Red
NBHC NSA MID-SOUTH	BEHAVIORAL HEALTH CLINIC	984	154	1,497	Red
NHC BEAUFORT	GENERAL SURGERY CLINIC	1,892	842	5,052	Yellow

Facility	Clinic Specialty	Encounters	Evaluated Visits	RVU	Network Capabilities with Absorbed Workload
NHC LEMOORE	BEHAVIORAL HEALTH CLINIC	6,967	4,062	14,129	Yellow
	ORTHOPEDIC CLINIC	3,496	2,826	9,132	Yellow
NHC CHARLESTON	BEHAVIORAL HEALTH CLINIC	5,288	1,520	14,342	Yellow
	DERMATOLOGY CLINIC	773	402	1,840	Yellow
	PSYCHIATRY CLINIC	1,299	1,297	4,434	Yellow
	UNDERSEAS MEDICINE CLINIC	24,377	21,449	38,191	Red
NHC CORPUS CHRISTI	BEHAVIORAL HEALTH CLINIC	2,687	677	5,213	Red
NHCL EVERETT	BEHAVIORAL HEALTH CLINIC	1,376	249	3,891	Yellow

Table 9. High Level CMS Facility Requirements

To participate in Medicare, the CMS requires compliance with facility-specific Conditions of Participation (CoP), including, but not limited to:

	Hospital and Specialty Hospital	Psychiatric Hospital ¹	Critical Access Hospital (CAH)	Skilled Nursing Facility	Ambulatory Surgical Center
	Stay may be > 24 hours				Stay < 23hrs 59 mins
Medical Staff	Must staff M.D. or D.O.	Must staff M.D. or D.O. ²	Must staff M.D. or D.O	Must have a Medical Director	Must staff M.D. or D.O.
Nursing Services	24 hour nursing services with a Director of Nursing	24 hour nursing services with a Director of Psychiatric Nursing	24 hour nursing services (when IP is present) with a nurse leader	24 hour nursing services with a Director of Nursing	Licensed nursing staff
Medical Records	Maintain clinical records for at least 5 years	Maintain clinical records detailing the degree and intensity of treatment	Maintain clinical records for 6 years	Maintain 15 months of resident records	Maintain clinical records within state requirements
Pharmacy Services	On-site pharmacy	On-site pharmacy	On-site pharmacy	Employ or obtain the services of a licensed pharmacist	Administer safely at direction of licensed medical professional
Radiologic Services	Yes – must provide or obtain services	Yes – must provide or obtain services	Yes – must provide or obtain services	Yes – must provide or obtain services	No
Laboratory Services	Yes – must provide or obtain services	Yes – must provide or obtain services	Yes – must provide or obtain services	Yes – must provide or obtain services	No – needs procedures to obtain services
Governing Board	Yes	Yes	Yes	Yes	Yes
Food and Nutrition Services	Yes and must employ or consult with dietitian	Yes and must employ or consult with dietitian	Yes and may employ nutritional professional	Yes and must employ or consult with dietitian	No
Additional Services	Can provide IP, OP, surgical, anesthesia, ED and rehab services	Must provide social, psychological, and therapeutic services	Can provide IP, OP, surgical, and anesthesia services	Must provide room/bed, social services and program activities	No
Emergency Services	No	No	Yes- must provide 24 hours ED services	No	No

Notes: CMS does not have CoPs for Birthing Centers. Each state determines the conditions of participation and coverage for their Medicaid Programs.

This table is not exhaustive. See facility-specific State Operations Manuals for more details on CMS requirements.

1. Must comply with Hospital CoPs, in addition to specific inpatient psychiatric CoPs
2. Certified by the American Board of Psychiatry and Neurology or the American Osteopathic Board of Neurology and Psychiatry
3. CAHs are small, rural hospitals who are permitted additional flexibility with staffing requirements.

Source: CMS Medicare State Operations Manual: Appendix A, AA, L, PP, W

Table 10. Ambulatory Care Clinic Cost Effectiveness Results*

Facility	Military Service	Product Line	Direct Care Full Cost	Direct Care SRVU (GPCI)	Direct Care Full Cost / SRVU	Direct Care SRVU Cost Ratio
AF-C-14th MED GRP-COLUMBUS	F	MH	\$1,081,683	\$4,937	\$219	6.1
	F	OBGYN	\$2	\$61	\$0	0.0
	F	OPTOM	\$444,804	\$8,453	\$53	1.5
	F	ORTHO	\$570,965	\$6,326	\$90	2.5
AF-C-17th MED GRP-GOODFELLOW	F	IMSUB	\$46,742	\$511	\$92	2.6
	F	MH	\$1,776,766	\$7,856	\$226	6.3
	F	OBGYN	\$590,238	\$7,033	\$84	2.3
	F	OPTOM	\$431,772	\$7,893	\$55	1.5
	F	ORTHO	\$522,278	\$9,814	\$53	1.5
AF-C-19th MED GRP-LITTLE ROCK	F	IMSUB	\$35,329	\$1,018	\$35	1.0
	F	MH	\$2,422,666	\$13,641	\$178	5.0
	F	OBGYN	\$408,723	\$4,006	\$102	2.8
	F	OPTOM	\$652,327	\$12,780	\$51	1.4
	F	ORTHO	\$782,014	\$13,268	\$59	1.6
	F	OTHER	\$30,969	\$187	\$165	4.6
AF-C-20th MED GRP-SHAW	F	IMSUB	\$23,328	\$663	\$35	1.0
	F	MH	\$2,861,091	\$18,628	\$154	4.3
	F	OBGYN	\$414,020	\$7,688	\$54	1.5
	F	OPTOM	\$810,879	\$15,693	\$52	1.4
	F	ORTHO	\$845,725	\$18,997	\$45	1.2
AF-C-22nd MED GRP-MCCONNELL	F	IMSUB	\$26,881	\$744	\$36	1.0
	F	MH	\$1,805,110	\$11,511	\$157	4.4
	F	OBGYN	\$428,666	\$8,396	\$51	1.4
	F	OPTOM	\$425,158	\$7,543	\$56	1.6
	F	ORTHO	\$513,343	\$6,974	\$74	2.1
AF-C-23rd MED GRP-MOODY	F	IMSUB	\$29,685	\$894	\$33	0.9
	F	MH	\$2,192,499	\$14,802	\$148	4.1
	F	OBGYN	\$452,147	\$5,103	\$89	2.5
	F	OPTOM	\$641,324	\$10,282	\$62	1.7
	F	ORTHO	\$1,561,543	\$16,242	\$96	2.7
AF-C-27th SPCLOPS MDGRP-CANNON	F	IMSUB	\$44,944	\$978	\$46	1.3
	F	MH	\$2,690,728	\$22,083	\$122	3.4
	F	OBGYN	\$507,869	\$4,776	\$106	3.0
	F	OPTOM	\$671,039	\$17,870	\$38	1.0
	F	ORTHO	\$686,674	\$16,220	\$42	1.2
AF-C-28th MED GRP-ELLSWORTH	F	IMSUB	\$49,516	\$1,854	\$27	0.7
	F	MH	\$1,577,480	\$11,635	\$136	3.8

Facility	Military Service	Product Line	Direct Care Full Cost	Direct Care SRVU (GPCI)	Direct Care Full Cost / SRVU	Direct Care SRVU Cost Ratio
	F	OBGYN	\$614,417	\$4,588	\$134	3.7
	F	OPTOM	\$514,308	\$10,981	\$47	1.3
	F	ORTHO	\$507,991	\$8,927	\$57	1.6
AF-C-2nd MED GRP-BARKSDALE	F	IMSUB	\$22,145	\$80	\$276	7.7
	F	MH	\$2,207,829	\$14,629	\$151	4.2
	F	OBGYN	\$515,857	\$4,482	\$115	3.2
	F	OPTOM	\$697,259	\$21,533	\$32	0.9
	F	ORTHO	\$1,583,746	\$31,897	\$50	1.4
AF-C-30th MED GRP-VANDENBERG	F	IMSUB	\$22,949	\$705	\$33	0.9
	F	MH	\$1,658,411	\$8,064	\$206	5.7
	F	OPTOM	\$524,002	\$11,118	\$47	1.3
	F	ORTHO	\$531,138	\$10,211	\$52	1.5
AF-C-319th MED GRP-GRAND FORKS	F	MH	\$1,557,318	\$5,744	\$271	7.6
	F	OBGYN	\$224,733	\$2,886	\$78	2.2
	F	OPTOM	\$301,554	\$4,330	\$70	1.9
	F	ORTHO	\$586,373	\$9,040	\$65	1.8
AF-C-325th MED GRP-TYNDALL	F	IMSUB	\$87,538	\$287	\$305	8.5
	F	MH	\$1,774,112	\$15,198	\$117	3.3
	F	OPTOM	\$1,047,527	\$24,163	\$43	1.2
	F	ORTHO	\$518,632	\$5,272	\$98	2.7
AF-C-341st MED GRP-MALMSTROM	F	IMSUB	\$45,354	\$522	\$87	2.4
	F	MH	\$1,920,772	\$8,604	\$223	6.2
	F	OBGYN	\$399,079	\$4,951	\$81	2.3
	F	OPTOM	\$453,113	\$11,328	\$40	1.1
	F	ORTHO	\$501,602	\$9,108	\$55	1.5
AF-C-355th MED GRP-DM	F	IMSUB	\$204,580	\$2,493	\$82	2.3
	F	MH	\$2,658,298	\$22,224	\$120	3.3
	F	OBGYN	\$865,494	\$9,595	\$90	2.5
	F	OPTOM	\$769,226	\$24,407	\$32	0.9
	F	ORTHO	\$2,513,467	\$46,251	\$54	1.5
AF-C-375th MED GRP-SCOTT	F	DERM	\$560,628	\$6,769	\$83	2.3
	F	IMSUB	\$226,358	\$1,329	\$170	4.8
	F	MH	\$3,788,311	\$23,736	\$160	4.5
	F	OBGYN	\$2,977,116	\$30,623	\$97	2.7
	F	OPTOM	\$802,644	\$20,620	\$39	1.1
	F	ORTHO	\$1,522,428	\$31,527	\$48	1.3
	F	OTHER	\$11,986	\$340	\$35	1.0
AF-C-377th MED GRP-KIRTLAND	F	IMSUB	\$108,270	\$1,635	\$66	1.8

Facility	Military Service	Product Line	Direct Care Full Cost	Direct Care SRVU (GPCI)	Direct Care Full Cost / SRVU	Direct Care SRVU Cost Ratio
	F	MH	\$2,898,296	\$17,804	\$163	4.5
	F	OBGYN	\$447,610	\$5,133	\$87	2.4
	F	OPTOM	\$690,633	\$9,786	\$71	2.0
	F	ORTHO	\$1,496,998	\$32,771	\$46	1.3
AF-C-412th MED GRP-EDWARDS	F	IMSUB	\$31,049	\$634	\$49	1.4
	F	MH	\$1,909,071	\$9,802	\$195	5.4
	F	OBGYN	\$455,575	\$5,406	\$84	2.4
	F	OPTOM	\$562,675	\$11,748	\$48	1.3
	F	ORTHO	\$542,400	\$10,152	\$53	1.5
	F	OTHER	\$656,652	\$4,206	\$156	4.4
AF-C-42nd MED GRP-MAXWELL	F	IMSUB	\$19,865	\$182	\$109	3.0
	F	MH	\$1,639,791	\$11,798	\$139	3.9
	F	OBGYN	\$434,474	\$8,806	\$49	1.4
	F	OPTOM	\$687,948	\$18,150	\$38	1.1
	F	ORTHO	\$993,231	\$23,390	\$42	1.2
AF-C-436th MED GRP-DOVER	F	IMSUB	\$24,647	\$367	\$67	1.9
	F	MH	\$2,930,127	\$15,599	\$188	5.2
	F	OBGYN	\$335,368	\$5,916	\$57	1.6
	F	OPTOM	\$635,304	\$10,551	\$60	1.7
	F	ORTHO	\$704,969	\$11,728	\$60	1.7
AF-C-45th MED GRP-PATRICK	F	IMSUB	\$14,533	\$231	\$63	1.8
	F	MH	\$2,081,335	\$17,948	\$116	3.2
	F	OBGYN	\$458,776	\$4,609	\$100	2.8
	F	OPTOM	\$351,093	\$6,162	\$57	1.6
	F	ORTHO	\$603,195	\$9,550	\$63	1.8
AF-C-460th MED GRP-BUCKLEY	F	IMSUB	\$176,052	\$691	\$255	7.1
	F	MH	\$2,153,364	\$10,262	\$210	5.9
	F	OPTOM	\$482,823	\$8,860	\$54	1.5
	F	ORTHO	\$765,813	\$6,493	\$118	3.3
AF-C-47th MED GRP-LAUGHLIN	F	MH	\$964,099	\$3,299	\$292	8.2
	F	OPTOM	\$549,599	\$6,524	\$84	2.4
AF-C-49th MED GRP-HOLLOMAN	F	IMSUB	\$28,860	\$203	\$142	4.0
	F	MH	\$3,007,217	\$19,103	\$157	4.4
	F	OBGYN	\$268,477	\$2,867	\$94	2.6
	F	OPTOM	\$530,047	\$16,843	\$31	0.9
	F	ORTHO	\$756,293	\$18,975	\$40	1.1
AF-C-509th MED GRP-WHITEMAN	F	IMSUB	\$84,660	\$337	\$251	7.0
	F	MH	\$1,808,789	\$15,698	\$115	3.2

Facility	Military Service	Product Line	Direct Care Full Cost	Direct Care SRVU (GPCI)	Direct Care Full Cost / SRVU	Direct Care SRVU Cost Ratio
	F	OBGYN	\$313,166	\$4,952	\$63	1.8
	F	OPTOM	\$577,802	\$13,090	\$44	1.2
	F	ORTHO	\$416,655	\$8,840	\$47	1.3
AF-C-55th MED GRP-OFFUTT	F	DERM	\$531,475	\$11,476	\$46	1.3
	F	ENT	\$656,780	\$8,881	\$74	2.1
	F	IMSUB	\$88,708	\$1,025	\$87	2.4
	F	MH	\$3,012,000	\$34,159	\$88	2.5
	F	OBGYN	\$1,922,863	\$23,608	\$81	2.3
	F	OPTOM	\$1,675,853	\$24,301	\$69	1.9
	F	ORTHO	\$2,555,078	\$48,637	\$53	1.5
	F	OTHER	\$191,119	\$2,284	\$84	2.3
	F	SURG	\$513,946	\$2,259	\$227	6.4
AF-C-56th MED GRP-LUKE	F	IMSUB	\$776,813	\$9,450	\$82	2.3
	F	MH	\$3,681,416	\$27,399	\$134	3.8
	F	OBGYN	\$1,191,935	\$12,427	\$96	2.7
	F	OPTOM	\$536,629	\$12,281	\$44	1.2
	F	ORTHO	\$2,621,576	\$38,986	\$67	1.9
	F	SURG	\$593,224	\$3,212	\$185	5.2
AF-C-5th MED GRP-MINOT	F	IMSUB	\$12,686	\$479	\$26	0.7
	F	MH	\$2,638,019	\$16,335	\$161	4.5
	F	OBGYN	\$437,119	\$6,830	\$64	1.8
	F	OPTOM	\$673,798	\$15,807	\$43	1.2
	F	ORTHO	\$471,558	\$6,371	\$74	2.1
	F	OTHER	\$9,586	\$119	\$80	2.2
AF-C-61st MED GRP-LOS ANGELES	F	IMSUB	\$154,980	\$641	\$242	6.8
	F	MH	\$1,311,836	\$7,155	\$183	5.1
	F	OPTOM	\$445,909	\$12,645	\$35	1.0
	F	ORTHO	\$775,088	\$12,802	\$61	1.7
AF-C-628th MED GRP-CHARLESTON	F	IMSUB	\$87,418	\$566	\$154	4.3
	F	MH	\$3,248,491	\$13,744	\$236	6.6
	F	OBGYN	\$624	\$7	\$87	2.4
	F	OPTOM	\$430,109	\$8,384	\$51	1.4
	F	ORTHO	\$646,653	\$17,514	\$37	1.0
AF-C-66th MED GRP-HANSCOM	F	DERM	\$10,976	\$108	\$102	2.8
	F	MH	\$1,293,864	\$7,700	\$168	4.7
	F	OPTOM	\$503,733	\$10,003	\$50	1.4
AF-C-6th MED GRP-MACDILL	F	DERM	\$606,532	\$7,596	\$80	2.2
	F	ENT	\$82,566	\$539	\$153	4.3

Facility	Military Service	Product Line	Direct Care Full Cost	Direct Care SRVU (GPCI)	Direct Care Full Cost / SRVU	Direct Care SRVU Cost Ratio
	F	IMSUB	\$928,826	\$9,341	\$99	2.8
	F	MH	\$3,937,513	\$28,039	\$140	3.9
	F	OBGYN	\$652,594	\$7,092	\$92	2.6
	F	OPTOM	\$2,740,297	\$36,182	\$76	2.1
	F	ORTHO	\$3,462,013	\$54,026	\$64	1.8
	F	OTHER	\$176,294	\$1,399	\$126	3.5
	F	SURG	\$344,540	\$1,352	\$255	7.1
AF-C-71st MED GRP-VANCE	F	MH	\$1,452,689	\$4,759	\$305	8.5
	F	OPTOM	\$477,980	\$6,562	\$73	2.0
AF-C-72nd MED GRP-TINKER	F	IMSUB	\$6,758	\$133	\$51	1.4
	F	MH	\$3,830,291	\$24,461	\$157	4.4
	F	OBGYN	\$1,614,499	\$10,054	\$161	4.5
	F	OPTOM	\$1,026,959	\$25,629	\$40	1.1
	F	ORTHO	\$1,781,694	\$25,449	\$70	2.0
	F	OTHER	\$3,912,568	\$21,602	\$181	5.1
	F	SURG	\$792,055	\$3,304	\$240	6.7
AF-C-75th MED GRP-HILL	F	IMSUB	\$37,723	\$944	\$40	1.1
	F	MH	\$2,918,048	\$22,118	\$132	3.7
	F	OBGYN	\$595,568	\$6,633	\$90	2.5
	F	OPTOM	\$1,049,714	\$22,319	\$47	1.3
	F	ORTHO	\$801,812	\$14,071	\$57	1.6
	F	OTHER	\$3,785,207	\$22,811	\$166	4.6
AF-C-78th MED GRP-ROBINS	F	MH	\$2,555,753	\$12,985	\$197	5.5
	F	OBGYN	\$485,225	\$5,598	\$87	2.4
	F	OPTOM	\$558,338	\$10,181	\$55	1.5
	F	ORTHO	\$788,783	\$11,471	\$69	1.9
	F	OTHER	\$2,488,085	\$6,659	\$374	10.4
AF-C-7th MED GRP-DYESS	F	IMSUB	\$49,979	\$954	\$52	1.5
	F	MH	\$2,703,196	\$14,487	\$187	5.2
	F	OBGYN	\$376,029	\$5,643	\$67	1.9
	F	OPTOM	\$533,371	\$10,496	\$51	1.4
	F	ORTHO	\$1,387,993	\$27,523	\$50	1.4
AF-C-82nd MED GRP-SHEPPARD	F	IMSUB	\$25,418	\$315	\$81	2.3
	F	MH	\$3,566,982	\$22,752	\$157	4.4
	F	OBGYN	\$821,863	\$9,794	\$84	2.3
	F	OPTOM	\$949,692	\$12,800	\$74	2.1
	F	ORTHO	\$1,384,958	\$25,067	\$55	1.5
AF-C-87th MEDGRP JBMDL-MCGUIRE	F	IMSUB	\$69,123	\$99	\$698	19.5

Facility	Military Service	Product Line	Direct Care Full Cost	Direct Care SRVU (GPCI)	Direct Care Full Cost / SRVU	Direct Care SRVU Cost Ratio
	F	MH	\$3,054,272	\$25,281	\$121	3.4
	F	OBGYN	\$611,734	\$8,450	\$72	2.0
	F	OPTOM	\$813,984	\$19,649	\$41	1.2
	F	ORTHO	\$1,803,708	\$42,389	\$43	1.2
	F	OTHER	\$460,112	\$7,311	\$63	1.8
AF-C-90th MED GRP-FE WARREN	F	IMSUB	\$5,776	\$252	\$23	0.6
	F	MH	\$1,928,151	\$9,132	\$211	5.9
	F	OPTOM	\$672,404	\$14,255	\$47	1.3
	F	ORTHO	\$620,698	\$10,570	\$59	1.6
AF-C-92nd MED GRP-FAIRCHILD	F	IMSUB	\$11,934	\$106	\$113	3.2
	F	MH	\$2,772,952	\$9,818	\$282	7.9
	F	OBGYN	\$446,750	\$4,295	\$104	2.9
	F	OPTOM	\$439,713	\$12,669	\$35	1.0
	F	ORTHO	\$1,009,946	\$15,694	\$64	1.8
AF-C-97th MED GRP-ALTUS	F	MH	\$1,282,185	\$5,938	\$216	6.0
	F	OPTOM	\$562,573	\$7,125	\$79	2.2
AF-C-9th MED GRP-BEALE	F	IMSUB	\$9,829	\$7	\$1,390	38.8
	F	MH	\$1,836,993	\$11,812	\$156	4.3
	F	OBGYN	\$209,003	\$3,771	\$55	1.5
	F	OPTOM	\$418,451	\$11,170	\$37	1.0
	F	ORTHO	\$477,234	\$4,943	\$97	2.7
AF-CB-BRANDON COMM CLINIC-MIL	F	OBGYN	\$422,178	\$4,540	\$93	2.6
	F	ORTHO	\$71,855	\$572	\$126	3.5
AHC DUNHAM-CARLISLE BARRACKS	A	IMSUB	\$28,464	\$888	\$32	0.9
	A	MH	\$1,057,814	\$6,167	\$172	4.8
	A	OPTOM	\$755,196	\$12,375	\$61	1.7
	A	ORTHO	\$569,090	\$12,837	\$44	1.2
AHC FOX-REDSTONE ARSENAL	A	IMSUB	\$112,818	\$1,741	\$65	1.8
	A	MH	\$2,046,644	\$19,102	\$107	3.0
	A	OPTOM	\$1,089,627	\$19,318	\$56	1.6
	A	ORTHO	\$715,293	\$10,230	\$70	2.0
	A	OTHER	\$926,846	\$6,038	\$154	4.3
AHC GUTHRIE-DRUM	A	DERM	\$185,693	\$3,894	\$48	1.3
	A	IMSUB	\$496,601	\$7,460	\$67	1.9
	A	MH	\$6,912,077	\$73,039	\$95	2.6
	A	OBGYN	\$3,825,082	\$35,645	\$107	3.0
	A	ORTHO	\$6,867,139	\$112,432	\$61	1.7
	A	OTHER	\$2,399,128	\$34,758	\$69	1.9

Facility	Military Service	Product Line	Direct Care Full Cost	Direct Care SRVU (GPCI)	Direct Care Full Cost / SRVU	Direct Care SRVU Cost Ratio
AHC IRELAND-KNOX	A	DERM	\$1,201,931	\$16,147	\$74	2.1
	A	ER	\$6,598,681	\$64,631	\$102	2.9
	A	IMSUB	\$5,109,357	\$61,882	\$83	2.3
	A	MH	\$6,552,070	\$72,494	\$90	2.5
	A	OBGYN	\$3,264,324	\$30,359	\$108	3.0
	A	OPTOM	\$2,575,406	\$48,267	\$53	1.5
	A	ORTHO	\$10,357,279	\$135,813	\$76	2.1
	A	OTHER	\$1,291,638	\$10,850	\$119	3.3
AHC KIRK-ABERDEEN PRVNG GD	A	SURG	\$2,838,231	\$22,725	\$125	3.5
	A	MH	\$1,059,743	\$5,832	\$182	5.1
	A	OPTOM	\$765,321	\$10,606	\$72	2.0
	A	ORTHO	\$568,679	\$8,212	\$69	1.9
AHC LYSTER-RUCKER	A	OTHER	\$1,001,387	\$3,702	\$271	7.6
	A	IMSUB	\$375,120	\$4,059	\$92	2.6
	A	MH	\$2,682,679	\$24,048	\$112	3.1
	A	OPTOM	\$1,337,142	\$23,563	\$57	1.6
	A	ORTHO	\$2,370,332	\$46,044	\$51	1.4
AHC MONCRIEF-JACKSON	A	OTHER	\$1,331,418	\$7,014	\$190	5.3
	A	DERM	\$437,139	\$4,056	\$108	3.0
	A	ENT	\$880,050	\$9,951	\$88	2.5
	A	IMSUB	\$86,369	\$1,709	\$51	1.4
	A	MH	\$3,031,397	\$27,526	\$110	3.1
	A	OBGYN	\$1,462,658	\$22,078	\$66	1.9
	A	OPTOM	\$706,086	\$21,038	\$34	0.9
	A	ORTHO	\$5,914,885	\$86,530	\$68	1.9
AHC MONTEREY	A	OTHER	\$1,521,344	\$15,444	\$99	2.8
	A	SURG	\$1,876,436	\$19,255	\$97	2.7
	A	MH	\$1,683,381	\$17,124	\$98	2.7
	A	OPTOM	\$613,122	\$14,763	\$42	1.2
AHC MUNSON-LEAVENWORTH	A	ORTHO	\$703,870	\$16,130	\$44	1.2
	A	OTHER	\$1,436,385	\$10,194	\$141	3.9
	A	IMSUB	\$88,980	\$2,920	\$30	0.9
	A	MH	\$2,902,573	\$23,943	\$121	3.4
	A	OBGYN	\$426,983	\$8,116	\$53	1.5
	A	OPTOM	\$981,158	\$15,776	\$62	1.7
AHC R W BLISS-HUACHUCA	A	ORTHO	\$8,195,356	\$110,771	\$74	2.1
	A	SURG	\$4,052,640	\$45,647	\$89	2.5
AHC R W BLISS-HUACHUCA	A	MH	\$2,519,830	\$21,420	\$118	3.3

Facility	Military Service	Product Line	Direct Care Full Cost	Direct Care SRVU (GPCI)	Direct Care Full Cost / SRVU	Direct Care SRVU Cost Ratio
	A	OPTOM	\$728,558	\$12,412	\$59	1.6
	A	ORTHO	\$2,682,309	\$28,322	\$95	2.6
	A	OTHER	\$518,915	\$2,143	\$242	6.8
AHC REYNOLDS-SILL	A	DERM	\$584,353	\$9,928	\$59	1.6
	A	ENT	\$173,479	\$2,537	\$68	1.9
	A	IMSUB	\$1,770,710	\$31,724	\$56	1.6
	A	MH	\$6,441,165	\$56,798	\$113	3.2
	A	OBGYN	\$3,004,554	\$27,032	\$111	3.1
	A	OPTOM	\$3,967,569	\$100,628	\$39	1.1
	A	ORTHO	\$9,388,141	\$156,169	\$60	1.7
	A	OTHER	\$666,260	\$6,765	\$98	2.8
	A	SURG	\$3,813,708	\$33,240	\$115	3.2
AHC ROCK ISLAND ARSENAL	A	OPTOM	\$50,091	\$587	\$85	2.4
	A	OTHER	\$268,281	\$2,493	\$108	3.0
AHC YUMA PROVING GROUND	A	OTHER	\$167,084	\$967	\$173	4.8
SOUTHCOM CLINIC-GORDON	A	MH	\$335,935	\$3,380	\$99	2.8
BMC COLTS NECK EARLE	N	OTHER	\$304,571	\$2,070	\$147	4.1
BMC LAKEHURST	N	OTHER	\$230,688	\$1,220	\$189	5.3
BMC YUMA	N	MH	\$803,710	\$10,489	\$77	2.1
	N	OPTOM	\$313,790	\$12,119	\$26	0.7
	N	ORTHO	\$237,805	\$7,103	\$33	0.9
	N	OTHER	\$129,900	\$1,829	\$71	2.0
NBHC ALBANY	N	OTHER	\$475,858	\$5,319	\$89	2.5
NBHC FALLON	N	MH	\$202,252	\$2,273	\$89	2.5
NBHC GROTON	N	MH	\$6,110,058	\$28,728	\$213	5.9
	N	OPTOM	\$1,533,172	\$30,092	\$51	1.4
	N	ORTHO	\$1,476,652	\$24,540	\$60	1.7
	N	OTHER	\$2,023,094	\$24,758	\$82	2.3
	N	SURG	\$2,670,476	\$14,841	\$180	5.0
NBHC KEY WEST	N	OPTOM	\$521,040	\$4,690	\$111	3.1
	N	OTHER	\$928,152	\$2,072	\$448	12.5
NBHC KINGSVILLE	N	OPTOM	\$28,766	\$880	\$33	0.9
	N	OTHER	\$306,364	\$489	\$627	17.5
NBHC MERIDIAN	N	MH	\$357,908	\$744	\$481	13.4
	N	OPTOM	\$342,995	\$4,271	\$80	2.2
	N	OTHER	\$139,489	\$464	\$301	8.4
NBHC NAS BELLE CHASE	N	MH	\$578,059	\$5,116	\$113	3.2
	N	OPTOM	\$363,892	\$9,433	\$39	1.1

Facility	Military Service	Product Line	Direct Care Full Cost	Direct Care SRVU (GPCI)	Direct Care Full Cost / SRVU	Direct Care SRVU Cost Ratio
	N	ORTHO	\$514,524	\$13,220	\$39	1.1
	N	OTHER	\$739,661	\$9,627	\$77	2.1
NBHC NAVWPNCEN CHINA LAKE	N	OTHER	\$918,779	\$1,832	\$501	14.0
NBHC NSA MID-SOUTH	N	MH	\$294,360	\$1,503	\$196	5.5
	N	OPTOM	\$487,227	\$10,747	\$45	1.3
	N	ORTHO	\$581,394	\$7,658	\$76	2.1
	N	OTHER	\$370,870	\$7,805	\$48	1.3
NBHC PORT HUENEME	N	MH	\$561,176	\$3,825	\$147	4.1
	N	OPTOM	\$438,342	\$10,377	\$42	1.2
	N	ORTHO	\$839,681	\$18,634	\$45	1.3
	N	OTHER	\$582,148	\$5,864	\$99	2.8
NBHC PORTSMOUTH	N	MH	\$524,124	\$2,915	\$180	5.0
	N	OPTOM	\$723,448	\$9,496	\$76	2.1
	N	ORTHO	\$308,328	\$4,245	\$73	2.0
	N	OTHER	\$2,587,000	\$19,192	\$135	3.8
NH BEAUFORT	N	DERM	\$20,400	\$730	\$28	0.8
	N	MH	\$2,600,898	\$17,661	\$147	4.1
	N	OPTOM	\$596,416	\$10,635	\$56	1.6
	N	ORTHO	\$7,940,513	\$74,011	\$107	3.0
	N	OTHER	\$1,432,059	\$23,610	\$61	1.7
	N	SURG	\$4,183,838	\$27,993	\$149	4.2
NHC LEMOORE	N	MH	\$2,137,344	\$10,844	\$197	5.5
	N	OBGYN	\$2,740,019	\$22,223	\$123	3.4
	N	OPTOM	\$1,023,013	\$19,257	\$53	1.5
	N	ORTHO	\$6,291,868	\$66,404	\$95	2.6
	N	OTHER	\$1,983,077	\$32,747	\$61	1.7
	N	SURG	\$3,481,001	\$19,478	\$179	5.0
NHC OAK HARBOR	N	IMSUB	\$47,130	\$1,792	\$26	0.7
	N	MH	\$3,097,964	\$20,612	\$150	4.2
	N	OBGYN	\$3,277,400	\$18,444	\$178	5.0
	N	OPTOM	\$669,043	\$16,298	\$41	1.1
	N	ORTHO	\$1,915,991	\$25,048	\$76	2.1
	N	OTHER	\$1,304,650	\$43,627	\$30	0.8
	N	SURG	\$306,271	\$2,007	\$153	4.3
NHC CHARLESTON	N	DERM	\$781,169	\$2,127	\$367	10.3
	N	IMSUB	\$742,587	\$3,890	\$191	5.3
	N	MH	\$2,089,443	\$16,923	\$123	3.4
	N	OPTOM	\$1,100,722	\$18,001	\$61	1.7
	N	ORTHO	\$1,743,581	\$38,501	\$45	1.3

Facility	Military Service	Product Line	Direct Care Full Cost	Direct Care SRVU (GPCI)	Direct Care Full Cost / SRVU	Direct Care SRVU Cost Ratio
	N	OTHER	\$1,662,237	\$31,361	\$53	1.5
NHC CORPUS CHRISTI	N	MH	\$2,085,053	\$5,291	\$394	11.0
	N	OPTOM	\$1,412,508	\$15,229	\$93	2.6
	N	ORTHO	\$1,090,377	\$12,245	\$89	2.5
	N	OTHER	\$1,554,954	\$17,440	\$89	2.5
NHC NEW ENGLAND	N	DERM	\$523,593	\$6,250	\$84	2.3
	N	ENT	\$385,808	\$2,302	\$168	4.7
	N	MH	\$1,925,228	\$12,171	\$158	4.4
	N	OPTOM	\$1,278,678	\$19,967	\$64	1.8
	N	ORTHO	\$1,996,578	\$27,157	\$74	2.1
	N	OTHER	\$2,436,022	\$35,493	\$69	1.9
	N	SURG	\$3,164,390	\$11,607	\$273	7.6
NHC PATUXENT RIVER	N	IMSUB	\$0	\$1	\$0	0.0
	N	MH	\$2,258,770	\$9,861	\$229	6.4
	N	OPTOM	\$552,962	\$9,875	\$56	1.6
	N	ORTHO	\$1,517,890	\$19,090	\$80	2.2
	N	OTHER	\$1,537,714	\$21,756	\$71	2.0
NHCL EVERETT	N	MH	\$229,739	\$3,701	\$62	1.7
	N	OPTOM	\$274,212	\$7,631	\$36	1.0
	N	ORTHO	\$600,207	\$11,156	\$54	1.5
	N	OTHER	\$790,009	\$6,081	\$130	3.6

*Cost efficiency threshold less than or equal to 1.0 suggests the MTF would be more cost efficient than local medical care.

Appendix D: Data Sources

Background

Within this report, the Military Health System Data Repository (MDR) and its derivative, the MHS Management Analysis and Reporting Tool (M2) served as the source of the clinical data for all analysis included in this study. The MDR data is gathered in real-time from the clinical operations at all MHS MTFs and is certified by the MTFs monthly. The MDR data includes restricted patient information. The M2 extracts data from the MDR, includes fewer fields, and covers only the current year plus the last five years of longitudinal data. The M2 is accessed through a simplified user interface improves its accessibility to management information. Enrollment information was compiled from the Defense Enrollment Eligibility Reporting System (DEERS) data stored in the M2.

Medical Center Data Sources

Table 11. Data Sources for Medical Center Evaluation

Criteria	Data Type	Data Source
Population	Population Counts	M2 FY 16 DEERS Person Detail, M2 FY 16 CAPER ³⁵
Referrals	Direct Care Referrals	M2 FY 16 CAPER
Trauma Capabilities	Combat Casualty Care Team specialties	M2 FY 16 CAPER, MGMA 2012 Annual Median wRVU
Tertiary Care	ACS Level I or II trauma center specialties	M2 FY 16 CAPER, MGMA 2012 Annual Median wRVU, M2 Radiology
GME Programs	GME Program Counts	2017 Graduate Medical Education Inventory provided by 749 Work Group via a data call to Service Representatives
GDE Programs	GDE Program Counts	2017 Graduate Dental Education Inventory provided by Service Representatives

Hospital Data Sources

Cost Effectiveness

The FY 2016 direct care and purchased care data used in this analysis was exported from the M2 Standard Inpatient Data Record Detail (SIDR), the TRICARE Encounter Data Institutional Detail, and the TRICARE Encounter Data Non-Institutional Detail (TEDNI), respectively.

³⁵ CAPER used to estimate additional demand from overseas beneficiaries.

Network Capability

The MCSC leveraged contractual reports on network adequacy, days to care, drive time, as well as other proprietary reports to inform network assessments. The MCSC supplemented this proprietary information with local knowledge by contacting their provider network services.

Ambulatory Care Center Data Sources

Cost Effectiveness

The FY 2016 direct care data used in this analysis was exported from the M2 Comprehensive Ambulatory/Professional Encounter Record Detail (CAPER). Additionally, the geographic and conversion factors used to adjust the direct care data were obtained from the CMS.

Network Capability

TRO West leveraged contractual reports on network adequacy, days to care, and drive time to identify risks. The TROs supplemented this proprietary information with local knowledge. TRO East utilized the same data sources as were used for hospital assessments.

PDM Data Sources

Beneficiary population Eligibility and Enrollment data were compiled from M2 based on the FY2016 reported information from DEERS. The DEERS database contains information on uniformed services members, U.S.-sponsored foreign military, DoD and uniformed services civilians, other personnel as directed by DoD, and their family members.

Personnel data is compiled from two sources. Since the FY 2016 HMPDS report produced by the DMDC had not been approved at the time of this report, this analysis used both FY 2015 authorized uniformed provider personnel as well as Service projections for a limited set of specialty providers. This includes authorized uniformed manpower by DoD occupational code. The clinical data used in this analysis was pulled from the MDR through the M2.

Appendix E: Data Quality and Adjustments

Background

For data residing in M2, the DHA/Decision Support and DHA/Solution Delivery Division (SDD) program offices have oversight and quality control responsibilities. They do not have oversight for the data as it is input into the DMDC (Defense Manpower Data Center), CHCS (Composite Health Care System)/AHLTA (Armed Forces Health Longitudinal Technology Application), and TED records. Those systems are standard DoD data systems and data quality is managed by their program offices. The DEERS is the repository of record for information about TRICARE beneficiaries. M2 receives a monthly data feed from the DEERS of all TRICARE eligible beneficiaries. SDD practice is to look for data anomalies or unexpected changes. The CHCS/ALHTA data comes from the MTFs via the enterprise's data repository which performs additional completeness, timeliness, and quality checks of the data upon receipt. Each data feed is checked by SDD against previous feeds on approximately 20 major fields. Deviance above a certain threshold for any one of these variables causes an investigation back to the source. The Services validate that the data is complete and accurate to the best of their knowledge.

The health care utilization data undergoes heavy scrutiny and review because of its use in almost all aspects of MHS analyses. The MHS routinely analyzes the data to ensure valid diagnosis codes are used (e.g., with the implementation of International Classification of Diseases, 10th revision, Clinical Modification (ICD-10-CM) codes, data is highly scrutinized, and issues/anomalies are reported back to the Services). Policies are set to ensure that inappropriate coding does not receive any weight (e.g., no licensed provider coded on a record for ambulatory surgery), adjustments are made to avoid over-counting credit (e.g., Evaluation and Management (E&M) coded with an ambulatory surgery), and other adjustments account for items such as discounting for multiple procedures and/or providers. For all data types (e.g., age groups, diagnosis groups, facility names, etc.), data are standardized. The direct care facility names, locations, type (hospital vs clinic, parent vs child), etc. are based on reference tables managed by the Defense Health Agency.

Data originating from "purchased care" sources must pass edits at the MCSC site before it is sent to TRICARE. The MCSC must follow all directions in all four manuals: Operations, Policy, Reimbursement, and Systems. When a TRICARE Encounter Data (TED) record is submitted to TRICARE it has to pass several hundred edits in order to be added to the TED database.

Decision Support and SDD are constantly working with the source systems to ensure timeliness of data submissions. Analysts' track record counts by Fiscal Year (FY) and Fiscal Month (FM) to ensure there are no gaps in submissions, and if there are, report back to the Services or directly

to the facility to investigate missing data. While checks are in place, some small percentage of the data has errors. Anomalies in the data are addressed as they are identified.

Medical Center

Population: In order to capture a complete picture of DCS utilizers, the population estimates include eligible DoD-beneficiaries in the market, an estimate of the overseas DoD-beneficiary population utilizes the U.S. MTFs, and the non-MHS population that used the MTFs in FY 2016. The beneficiary totals for the market may exceed the subtotals associated with each inpatient MTF listed below, as the market's boundaries may include area outside of an individual MTF's catchment area.

Referrals: Specialty encounter estimates rather than referrals were used to improve the comparability of this estimate across markets. Some MTF referral counts include 'administrative referrals' to primary care, which might overstate a market's specialty referral counts. Specialty encounters are visits to a specialty provider, whereas referrals to a specialty provider may be for a single visit or multiple visits. The importance of this parameter was the comparability of the relative size of referral workload across markets, not the total number of referrals. Thus, specialty encounter was used in the definition of a medical center.

Trauma and Tertiary Care Capabilities: To evaluate whether a market had a certain specialty, FY 2016 CAPER wRVUs of relevant providers were mapped to DoD Occupational Codes (or specialties) using a provider's primary HIPAA taxonomy. Providers with additional certifications or sub-specialties do not always update their primary HIPAA Taxonomy to associate with their current area of practice. For example, a pulmonologist with a critical care certificate can be primarily serving as a critical care intensivist, but be mapped to the pulmonology HIPAA Taxonomy. This is often the case for the Air Force's critical care intensivists because of the composition of the Air Force's deployed combat casualty care team. To account for this, the committee adjusted the specialties particularly prone to this issue, including critical care, physical/rehabilitation medicine, and infectious disease.

When relevant, each market also included workload from nearby DoD-civilian external resource sharing agreements, where DoD providers treat DoD beneficiaries in civilian facilities.

Additionally, due to data reporting concerns associated with Anesthesiology, Emergency Medicine, and Radiology, a different method was employed to assess whether the facilities in a market had these capabilities. Facilities or markets with enough general surgery workload to support 80 percent of a provider were assumed to also have anesthesiology. Facilities with workload in Emergency Room Clinics or in M2 Radiology Services were assumed to have these specialties.

GME/GDE Programs: The Air Force GME program counts included civilian-sponsored partnership programs at three facilities. The GDE program counts included all dental programs were allocated to the MTF, even if these programs were not based at the MTF.

Hospital

Cost Effectiveness

Direct care data includes all SIDR dispositions, both reported and inferred, with FY 2016 costs based on FY 2015 expenses but adjusted for inflation. Purchased care data includes information from acute facilities and professional services based on the provider catchment area, from TEDNI for inpatient care; claims for resource sharing, patients still in the hospital, and patients with other health insurance are not included in purchased care data. Paid amounts include a 13 percent increase for overhead burdening.

Network Capability

Under the constraints of the contract, the MCSC could not provide more details on how this assessment was conducted. Given the TROs knowledge of local conditions and their regular interactions with local MTF liaisons, the TROs reviewed the final assessments provided by the MCSC. In some cases, TRO West adopted a more conservative evaluation of the TRICARE network's ability to absorb MTF workload.

Ambulatory Care Center

Cost Effectiveness

Direct care professional services (work and practice expense RVUs) are adjusted with the respective GPCI. The facility charges, including services such as Same Day Surgery, Emergency Services, and Cardiac Catheterization utilize standard Ambulatory Payment Classification (APC) groups. To normalize a single value, the APC conversion factor is used to convert the value to RVUs with a standardized multiplier.

Additionally, a select number of locations have Locality Based Waivers that apply multiplication factors to the standard geographically adjusted CHAMPUS Maximum Allowable Charges values.³⁶

Network Capability

Under the constraints of the contract, the MCSC could not provide more details on how this assessment was conducted. The MCSC leveraged contractual reports on network adequacy, days to care, drive time, as well as other proprietary reports to inform network assessments. TRO

³⁶ Only Alaska has significant adjustments that in some cases allow for 500% of the standard factors.

West conducted this assessment without the support of the MCSC utilizing standardized reports provided by contractor (Network Adequacy Reports, Days to Care, Drive Time).

Provider Distribution Model

Adjustments to Inpatient Professional Record Reporting: The reporting of professional records allows tracking of specialty provider time against inpatient events. Direct care professional records were compared to inpatient records looking for significant procedure and/or evaluation and management codes to determine completeness of the reported data. This analysis indicated inconsistent recording of professional records matched to corresponding inpatient workload. In the 2015 Modernization Study, on average, the MHS missing records percentage was approximately 22 percent across a variety of specialties.³⁷ Since FY 2013, completion factors have improved across nearly every specialty to a missing record rate of 16 percent. Based on analysis of FY 2016 data, completion factors were developed and applied by market and provider specialty to complete the missing data. Detailed adjustments are provided in Table 12 below.

³⁷ For the model, the completion factor was limited to 50% as there was significant concern regarding making projections beyond that level. The National Capital Region had a 50% incompleteness percentage across specialties; a few specialties within individual markets had much higher incomplete percentages for specific specialties, such as 50% or greater.

Table 12. Completion Factor Adjustments Applied to Provider Workload*.

Markets	Inpatient		Ambulatory		Provider Workload Adjustment	
	Reported wRVU	Adjusted w/RVU	Reported wRVU	Adjusted w/RVU	Inpatient only	Combined Amb & Inpt
NBHC PORT HUENEME	482	622	34,788	34,788	29%	0.4%
NHC LEMOORE	691	786	109,279	109,279	14%	0.1%
0030 – NH TWENTYNINE PALMS	10,842	12,729	169,194	169,194	17%	1.0%
0035 – NBHC GROTON	500	562	101,541	101,541	13%	0.1%
0038 – NH PENSACOLA	13,418	16,004	324,558	324,558	19%	0.8%
0056 – JAMES A LOVELL FHCC	1,063	1,202	347,405	347,405	13%	0.0%
0068 – NHC PATUXENT RIVER	2,131	2,628	76,323	76,323	23%	0.6%
0091 – NMC CAMP LEJEUNE	65,289	76,402	913,699	913,699	17%	1.1%
0092 – NHC CHERRY POINT	4	4	1,567	1,567	9%	0.0%
0104 – NH BEAUFORT	1,735	2,025	150,563	150,563	17%	0.2%
0107 – NBHC NSA MID-SOUTH	284	332	30,654	30,654	17%	0.2%
0118 – NHC CORPUS CHRISTI	910	1,058	57,702	57,702	16%	0.3%
0212 – NBHC NAVWPNCEN CHINA LAKE	293	329	12,961	12,961	12%	0.3%
0217 – NBHC NAS POINT MUGU	221	262	16,087	16,087	19%	0.3%
0239 – NBHC EL CENTRO	369	429	4,589	4,589	16%	1.2%
0275 – NBHC ALBANY	87	106	7,243	7,243	22%	0.3%
0317 – NBHC MERIDIAN	40	44	12,968	12,968	12%	0.0%
0319 – NBHC FALLON	41	45	11,799	11,799	12%	0.0%
0321 – NBHC PORTSMOUTH	63	68	17,028	17,028	8%	0.0%
0322 – BMC COLTS NECK EARLE	141	167	7,464	7,464	18%	0.3%
0327 – AHC MCAFEE-WHITE SANDS MSL RAN	282	314	5,255	5,255	11%	0.6%
0328 – NBHC SARATOGA SPRINGS	148	185	8,473	8,473	25%	0.4%
0369 – NBHC KINGSVILLE	45	54	8,135	8,135	19%	0.1%
0370 – NBHC FORT WORTH	520	617	24,182	24,182	19%	0.4%
0517 – NBHC KEY WEST	71	84	13,298	13,298	18%	0.1%

Markets	Inpatient		Ambulatory		Provider Workload Adjustment	
	Reported wRVU	Adjusted w/RVU	Reported wRVU	Adjusted w/RVU	Inpatient only	Combined Amb & Inpt
0001 – AHC FOX-REDSTONE ARSENAL	258	305	77,266	77,266	18%	0.1%
0003 – AHC LYSTER-RUCKER	344	395	135,471	135,471	15%	0.0%
0004 – AF-C-42 nd MED GRP-MAXWELL	207	233	83,520	83,520	13%	0.0%
0008 – AHC R W BLISS-HUACHUCA	506	572	101,421	101,421	13%	0.1%
0009 – AF-C-56 th MED GRP-LUKE	915	1,057	148,261	148,261	16%	0.1%
0010 – AF-C-355 th MED GRP-DM	598	688	122,605	122,605	15%	0.1%
0013 – AF-C-19 th MED GRP-LITTLE ROCK	556	637	72,066	72,066	15%	0.1%
0015 – AF-C-9 th MED GRP-BEALE	1,051	1,195	50,413	50,413	14%	0.3%
0018 – AF-C-30 th MED GRP-VANDENBERG	154	185	38,052	38,052	21%	0.1%
0019 – AF-C-412 th MED GRP-EDWARDS	85	101	21,343	21,343	18%	0.1%
0036 – AF-C-436 th MED GRP-DOVER	513	630	66,258	66,258	23%	0.2%
0043 – Tyndall-Panama City	457	523	81,223	81,223	15%	0.1%
0046 – AF-C-45 th MED GRP-PATRICK	197	248	65,706	65,706	26%	0.1%
0050 – AF-C-23 rd MED GRP-MOODY	230	265	67,090	67,090	16%	0.1%
0051 – AF-C-78 th MED GRP-ROBINS	542	618	67,875	67,875	14%	0.1%
0055 – AF-C-375 th MED GRP-SCOTT	1,161	1,434	126,369	126,369	24%	0.2%
0058 – AHC MUNSON-LEAVENWORTH	650	752	125,491	125,491	16%	0.1%
0059 – AF-C-22 nd MED GRP-MCCONNELL	333	387	61,750	61,750	16%	0.1%
0062 – AF-C-2 nd MED GRP-BARKSDALE	535	681	94,805	94,805	27%	0.2%
0074 – AF-C-14 th MED GRP-COLUMBUS	40	45	24,005	24,005	13%	0.0%
0076 – AF-C-509 th MED GRP-WHITEMAN	234	311	67,014	67,014	33%	0.1%
0077 – AF-C-341 st MED GRP-MALMSTROM	495	548	58,496	58,496	11%	0.1%
0078 – AF-C-55 th MED GRP-OFFUTT	6,040	7,234	191,790	191,790	20%	0.6%
0083 – AF-C-377 th MED GRP-KIRTLAND	376	435	85,026	85,026	16%	0.1%

Markets	Inpatient		Ambulatory		Provider Workload Adjustment	
	Reported wRVU	Adjusted w/RVU	Reported wRVU	Adjusted w/RVU	Inpatient only	Combined Amb & Inpt
0084 – AF-C-49 th MED GRP-HOLLOMAN	661	763	65,456	65,456	16%	0.2%
0085 – AF-C-27 th SPCLOPS MDGRP-CANNON	425	515	78,112	78,112	21%	0.1%
0090 – AF-C-4 th MED GRP-SJ	437	519	61,787	61,787	19%	0.1%
0093 – AF-C-319 th MED GRP-GRAND FORKS	97	112	26,174	26,174	16%	0.1%
0094 – AF-C-5 th MED GRP-MINOT	158	185	73,783	73,783	17%	0.0%
0096 – AF-C-72 nd MED GRP-TINKER	443	514	108,643	108,643	16%	0.1%
0097 – AF-C-97 th MED GRP-ALTUS	132	155	35,009	35,009	17%	0.1%
0100 – NHC NEW ENGLAND	301	337	69,680	69,680	12%	0.1%
0106 – AF-C-28 th MED GRP-ELLSWORTH	176	210	64,911	64,911	20%	0.1%
0112 – AF-C-7 th MED GRP-DYESS	409	466	80,355	80,355	14%	0.1%
0113 – AF-C-82 nd MED GRP-SHEPPARD	173	197	75,620	75,620	14%	0.0%
0114 – AF-C-47 th MED GRP-LAUGHLIN	2,191	3,166	27,781	27,781	45%	3.3%
0119 – AF-C-75 th MED GRP-HILL	637	854	105,428	105,428	34%	0.2%
0128 – AF-C-92 nd MED GRP-FAIRCHILD	429	503	58,067	58,067	17%	0.1%
0129 – AF-C-90 th MED GRP-FE WARREN	52	56	54,553	54,553	8%	0.0%
0206 – Yuma	976	1,131	47,219	47,219	16%	0.3%
0247 – AHC MONTEREY	577	653	72,496	72,496	13%	0.1%
0248 – AF-C-61 st MED GRP-LOS ANGELES	1,116	1,295	51,033	51,033	16%	0.3%
0250 – AF-CB-60 th MED FLT-MCCLELLAN	1,747	2,007	23,743	23,743	15%	1.0%
0272 – AHC TUTTLE-HUNTER ARMY AIRFLD			153	153		0.0%
0290 – AHC ROCK ISLAND ARSENAL	140	163	11,352	11,352	16%	0.2%
0308 – AHC KIRK-ABERDEEN PRVNG GD	1,039	1,214	39,904	39,904	17%	0.4%
0310 – AF-C-66 th MED GRP-HANSCOM	295	341	31,494	31,494	16%	0.1%
0326 – McGuire-Dix	704	875	113,920	113,920	24%	0.1%

Markets	Inpatient		Ambulatory		Provider Workload Adjustment	
	Reported wRVU	Adjusted w/RVU	Reported wRVU	Adjusted w/RVU	Inpatient only	Combined Amb & Inpt
0330 – AHC GUTHRIE-DRUM	12,460	14,384	327,068	327,068	15%	0.6%
0338 – AF-C-71 st MED GRP-VANCE			24,104	24,104		0.0%
0352 – Dunham-Fillmore	442	533	61,666	61,666	21%	0.1%
0364 – AF-C-17 th MED GRP-GOODFELLOW	571	666	54,506	54,506	17%	0.2%
0436 – NBHC NAS BELLE CHASE	200	238	37,254	37,254	19%	0.1%
7200 – AF-C-460 th MED GRP-BUCKLEY	712	815	46,941	46,941	14%	0.2%
7239 – SOUTHCOM CLINIC-GORDON	858	1,008	27,832	27,832	17%	0.5%
0014 – AF-MC-60 th MED GRP-TRAVIS	44,540	53,639	311,750	311,750	20%	2.6%
0042 – AF-H-96 th MED GRP-EGLIN	36,458	44,082	530,691	530,691	21%	1.3%
0047 – AMC EISENHOWER-GORDON	55,887	68,058	594,954	594,954	22%	1.9%
0048 – ACH MARTIN-BENNING	36,776	43,731	494,437	494,437	19%	1.3%
0049 – ACH WINN-STEWART	33,937	38,967	616,775	616,775	15%	0.8%
0053 – AF-H-366 th MED GRP-MT HOME	3,556	4,198	57,324	57,324	18%	1.1%
0057 – ACH IRWIN-RILEY	26,892	31,677	399,758	399,758	18%	1.1%
0060 – ACH BLANCHFIELD-CAMPBELL	55,205	61,501	737,640	737,640	11%	0.8%
0064 – ACH BAYNE-JONES-POLK	17,080	21,040	217,878	217,878	23%	1.7%
0075 – ACH LEONARD WOOD	20,731	24,287	337,565	337,565	17%	1.0%
0079 – AF-MC-99 th MED GRP-NELLIS	28,648	35,745	395,501	395,501	25%	1.7%
0086 – ACH KELLER-WEST POINT	7,300	8,329	140,757	140,757	14%	0.7%
0095 – AF-MC-88 th MED GRP-WRIGHT-PAT	34,137	42,175	393,624	393,624	24%	1.9%
0108 – AMC WILLIAM BEAUMONT-BLISS	76,666	88,146	884,754	884,754	15%	1.2%
0110 – AMC DARNALL-HOOD	89,053	102,815	1,011,268	1,011,268	15%	1.3%
0131 – ACH WEED-IRWIN	6,233	7,441	97,463	97,463	19%	1.2%
0045 – MacDill-Brandon	1,269	1,445	221,135	221,135	14%	0.1%

Markets	Inpatient		Ambulatory		Provider Workload Adjustment	
	Reported wRVU	Adjusted w/RVU	Reported wRVU	Adjusted w/RVU	Inpatient only	Combined Amb & Inpt
0202 – AHC-GREELY	365	430	6,702	6,702	18%	0.9%
0404 – IA-BMC SUGAR GROVE	27	31	364	364	16%	1.1%
0061 – AHC IRELAND-KNOX	5,889	6,940	273,498	273,498	18%	0.4%
0098 – AHC REYNOLDS-SILL	11,000	12,922	342,060	342,060	17%	0.5%
National Capital Region	189,791	226,653	3,343,538	3,343,538	19%	1.0%
Tidewater	209,670	258,555	2,267,337	2,267,337	23%	2.0%
Fort Bragg	110,764	133,244	1,096,452	1,096,452	20%	1.9%
Charleston	535	619	165,188	165,188	16%	0.1%
Ft Jackson/Shaw	4,359	4,968	297,830	297,830	14%	0.2%
Mississippi Delta	10,455	13,217	302,358	302,358	26%	0.9%
San Antonio	210,516	264,716	2,042,201	2,042,201	26%	2.4%
Colorado Springs	68,558	78,640	1,200,465	1,200,465	15%	0.8%
San Diego	215,291	253,582	1,869,599	1,869,599	18%	1.8%
Puget Sound	194,493	236,965	1,879,717	1,879,717	22%	2.0%
Hawaii	129,855	163,161	1,573,194	1,573,194	26%	2.0%
Anchorage, AK	7,769	9,325	355,053	355,053	20%	0.4%
Fairbanks, AK	17,721	20,498	244,758	244,758	16%	1.1%
Jacksonville	36,635	43,472	596,445	596,445	19%	1.1%
MHS-wide Totals/Averages	2,142,761	2,575,630	31,756,149	31,756,149	20%	1.3%

*Based on FY2016 and beneficiary residence.

Adjustments to Authorized Uniformed Personnel: The authorized personnel used in the PDM model for Table 6 and Table 7 has been adjusted to eliminate any requirements that would have been allocated to the command-suite. These Commanding Officers, although uniformed providers, are not full-time employed in clinic work and thus are not counted as providers to place. The Authorized Uniformed Personnel has also been adjusted to exclude the billets needed at NH Twenty-Nine Palms and ACH Weed-Irwin. These facilities are isolated such that certain specialties must be maintained, regardless of meeting demand-based open the door floors. Therefore, the physicians required at these two facilities are removed both from the authorized numbers of providers available to be placed and from the demand estimates of modeled physicians.

Appendix F: MTF Market Descriptions

Market Name	MTFs in Market*
AHC FOX-REDSTONE ARSENAL	AHC FOX-REDSTONE ARSENAL
AHC LYSTER-RUCKER	AHC LYSTER-RUCKER
AF-C-42nd MED GRP- MAXWELL	AF-C-42nd MED GRP-MAXWELL
AHC R W BLISS-HUACHUCA	AHC R W BLISS-HUACHUCA
AF-C-56th MED GRP-LUKE	AF-C-56th MED GRP-LUKE
AF-C-355th MED GRP-DM	AF-C-355th MED GRP-DM
AF-C-19th MED GRP-LITTLE ROCK	AF-C-19th MED GRP-LITTLE ROCK
AF-MC-60th MED GRP-TRAVIS	AF-MC-60th MED GRP-TRAVIS
	AF-CB-60th MED FLT- MCCLELLAN
AF-C-9th MED GRP-BEALE	AF-C-9th MED GRP-BEALE
AF-C-30th MED GRP- VANDENBERG	AF-C-30th MED GRP- VANDENBERG
AF-C-412th MED GRP- EDWARDS	AF-C-412th MED GRP-EDWARDS
NBHC PORT HUENEME	NBHC PORT HUENEME
NHC LEMOORE	NHC LEMOORE
NH TWENTYNINE PALMS	NH TWENTYNINE PALMS
NBHC GROTON	NBHC GROTON
AF-C-436th MED GRP-DOVER	AF-C-436th MED GRP-DOVER
NH PENSACOLA	NH PENSACOLA
	NBHC NAS PENSACOLA
	NBHC MILTON WHITING FIELD
	NBHC NATTC PENSACOLA
AF-H-96th MED GRP-EGLIN	NBHC NTTC PENSACOLA
	AF-H-96th MED GRP-EGLIN
	NBHC NAVCOASTSYSC PANAMA CITY
	TMC 9-7TH SPECIAL FORCES- EGLIN
	AF-C-1st SPCL OPS MED- HURLBURT

Market Name	MTFs in Market*
AF-C-325th MED GRP-TYNDALL	AF-C-325th MED GRP-TYNDALL
AF-C-6th MED GRP-MACDILL	AF-C-6th MED GRP-MACDILL
AF-C-45th MED GRP-PATRICK	AF-C-45th MED GRP-PATRICK
AMC EISENHOWER-GORDON	AMC EISENHOWER-GORDON
ACH MARTIN-BENNING	ACH MARTIN-BENNING CBMH NORTH COLUMBUS-BENNING
ACH WINN-STEWART	ACH WINN-STEWART AHC TUTTLE-HUNTER ARMY AIRFLD CBMH RICHMOND HILL-STEWART
AF-C-23rd MED GRP-MOODY	AF-C-23rd MED GRP-MOODY
AF-C-78th MED GRP-ROBINS	AF-C-78th MED GRP-ROBINS
AF-H-366th MED GRP-MT HOME	AF-H-366th MED GRP-MT HOME
AF-C-375th MED GRP-SCOTT	AF-C-375th MED GRP-SCOTT
JAMES A LOVELL FHCC	JAMES A LOVELL FHCC NBHC NCTC INPR GREAT LAKES
ACH IRWIN-RILEY	ACH IRWIN-RILEY CBMH FLINT HILLS-RILEY
AHC MUNSON-LEAVENWORTH	AHC MUNSON-LEAVENWORTH
AF-C-22nd MED GRP-MCCONNELL	AF-C-22nd MED GRP-MCCONNELL
ACH BLANCHFIELD-CAMPBELL	ACH BLANCHFIELD-CAMPBELL CBMH SCREAMING EAGLE-CAMPBELL
AHC IRELAND-KNOX	AHC IRELAND-KNOX
AF-C-2nd MED GRP-BARKSDALE	AF-C-2nd MED GRP-BARKSDALE
ACH BAYNE-JONES-POLK	ACH BAYNE-JONES-POLK
NHC PATUXENT RIVER	NHC PATUXENT RIVER
AF-C-14th MED GRP-COLUMBUS	AF-C-14th MED GRP-COLUMBUS
ACH LEONARD WOOD	ACH LEONARD WOOD CBMH OZARK-LEONARD WOOD

Market Name	MTFs in Market*
AF-C-509th MED GRP-WHITEMAN	AF-C-509th MED GRP-WHITEMAN
AF-C-341st MED GRP-MALMSTROM	AF-C-341st MED GRP-MALMSTROM
AF-C-55th MED GRP-OFFUTT	AF-C-55th MED GRP-OFFUTT
AF-MC-99th MED GRP-NELLIS	AF-MC-99th MED GRP-NELLIS
AF-C-377th MED GRP-KIRTLAND	AF-C-377th MED GRP-KIRTLAND
AF-C-49th MED GRP-HOLLOMAN	AF-C-49th MED GRP-HOLLOMAN
AF-C-27th SPCLOPS MDGRP-CANNON	AF-C-27th SPCLOPS MDGRP-CANNON
ACH KELLER-WEST POINT	ACH KELLER-WEST POINT
NMC CAMP LEJEUNE	AF-C-4th MED GRP-SJ
	NMC CAMP LEJEUNE
	NHC CHERRY POINT
	BMC MCMH NEW RIVER-LEJEUNE
	BMC CAMP GEIGER MCB
AF-C-319th MED GRP-GRAND FORKS	AF-C-319th MED GRP-GRAND FORKS
AF-C-5th MED GRP-MINOT	AF-C-5th MED GRP-MINOT
AF-MC-88th MED GRP-WRIGHT-PAT	AF-MC-88th MED GRP-WRIGHT-PAT
AF-C-72nd MED GRP-TINKER	AF-C-72nd MED GRP-TINKER
AHC REYNOLDS-SILL	AHC REYNOLDS-SILL
AF-C-82nd MED GRP-SHEPPARD	AF-C-82nd MED GRP-SHEPPARD
AF-C-97th MED GRP-ALTUS	AF-C-97th MED GRP-ALTUS
NHC NEW ENGLAND	NHC NEW ENGLAND
NHC BEAUFORT	NHC BEAUFORT
	NBHC PARRIS ISLAND
NHC CHARLESTON	NHC CHARLESTON
AF-C-628th MED GRP-CHARLESTON	AF-C-628th MED GRP-CHARLESTON
AF-C-28th MED GRP-ELLSWORTH	AF-C-28th MED GRP-ELLSWORTH
NBHC NSA MID-SOUTH	NBHC NSA MID-SOUTH
AMC WILLIAM BEAUMONT-BLISS	AMC WILLIAM BEAUMONT-BLISS

Market Name	MTFs in Market*
	AHC MCAFEE-WHITE SANDS MSL RAN
	EAST BLISS CLINIC-BLISS
	MENDOZA SOLDIER FAM CC-BLISS
	CBMH-RIO BRAVO-BLISS
AMC DARNALL-HOOD	AMC DARNALL-HOOD
	CBMH HARKER HEIGHTS-HOOD
	CBMH KILLEEN-HOOD
	CBMH COPPERAS COVE-HOOD
AF-C-7th MED GRP-DYESS	AF-C-7th MED GRP-DYESS
AF-C-47th MED GRP-LAUGHLIN	AF-C-47th MED GRP-LAUGHLIN
NHC CORPUS CHRISTI	NHC CORPUS CHRISTI
AF-C-75th MED GRP-HILL	AF-C-75th MED GRP-HILL
AF-C-92nd MED GRP-FAIRCHILD	AF-C-92nd MED GRP-FAIRCHILD
AF-C-90th MED GRP-FE WARREN	AF-C-90th MED GRP-FE WARREN
ACH WEED-IRWIN	ACH WEED-IRWIN
FT BELVOIR COMMUNITY HOSP-FBCH	NBHC DAHLGREN
National Capital Region	AF-C-779th MED GRP-ANDREWS WALTER REED NATL MIL MED CNTR
	KIMBROUGH AMB CAR CEN-MEADE
	FT BELVOIR COMMUNITY HOSP-FBCH
	AHC MCNAIR-MYER-HENDERSON HALL
	DILORENZO TRICARE HEALTH CLIN
	NBHC INDIAN HEAD
	NHC ANNAPOLIS
	NHC QUANTICO
	AHC ANDREW RADER-MYER-HENDERSN

Market Name	MTFs in Market*
	AF-C-579th MED GRP-BOLLING
	NBHC ANDREWS AFB
	NBHC WASHINGTON NAVY YARD
	FAIRFAX HEALTH CENTER
	DUMFRIES HEALTH CENTER
AHC-GREELY	AHC-GREELY
AHC BARQUIST-DETRICK	AHC BARQUIST-DETRICK
AHC YUMA PROVING GROUND	AHC YUMA PROVING GROUND
NBHC NAVWPNCEN CHINA LAKE	NBHC NAVWPNCEN CHINA LAKE
NBHC NAS POINT MUGU	NBHC NAS POINT MUGU
NBHC EL CENTRO	NBHC EL CENTRO
AHC MONTEREY	AHC MONTEREY
AF-C-61st MED GRP-LOS ANGELES	AF-C-61st MED GRP-LOS ANGELES
BMC YUMA	BMC YUMA
NBHC ALBANY	NBHC ALBANY
AHC ROCK ISLAND ARSENAL	AHC ROCK ISLAND ARSENAL
AF-H-633rd MED GRP LANG-EUSTIS	AF-H-633rd MED GRP LANG-EUSTIS
	AHC MCDONALD-EUSTIS
	NMC PORTSMOUTH
	NBHC LITTLE CREEK
	NBHC NSY NORFOLK
	NBHC YORKTOWN
	NBHC DAM NECK
	NBHC OCEANA
	AHC-STORY
	NBHC NAVSTA SEWELLS
	NBHC CHESAPEAKE
	TRICARE OUTPATIENT CL VA BEACH
	TRICARE OUTPATIENT CHESAPEAKE
Tidewater	

Market Name	MTFs in Market*
	AHC KENNER-LEE
FORT BRAGG	AMC WOMACK-BRAGG
	AF-LS-43rd MED SQ-POPE AFB TROOP & FAMILY MED CL- BRAGG
	CBMH FAYETTEVILLE-BRAGG
	CBMH HOPE MILLS-BRAGG
	CBMH LINDEN OAKS-BRAGG
AHC KIRK-ABERDEEN PRVNG GD	AHC KIRK-ABERDEEN PRVNG GD
AF-C-66th MED GRP- HANSCOM	AF-C-66th MED GRP-HANSCOM
NBHC MERIDIAN	NBHC MERIDIAN
NBHC FALLON	NBHC FALLON
NBHC PORTSMOUTH	NBHC PORTSMOUTH
BMC COLTS NECK EARLE	BMC COLTS NECK EARLE
AF-C-87th MED GRP-MCGUIRE	AF-C-87th MED GRP-MCGUIRE
NBHC SARATOGA SPRINGS	NBHC SARATOGA SPRINGS
AHC GUTHRIE-DRUM	AHC GUTHRIE-DRUM
AF-C-71st MED GRP-VANCE	AF-C-71st MED GRP-VANCE
BMC MECHANICSBURG	BMC MECHANICSBURG
AHC DUNHAM-CARLISLE BARRACKS	AHC DUNHAM-CARLISLE BARRACKS
AF-C-17th MED GRP- GOODFELLOW	AF-C-17th MED GRP- GOODFELLOW
NBHC KINGSVILLE	NBHC KINGSVILLE
NBHC FORT WORTH	NBHC FORT WORTH
BMC LAKEHURST	BMC LAKEHURST
BMC SUGAR GROVE	IA-BMC SUGAR GROVE
NBHC NAS BELLE CHASE	NBHC NAS BELLE CHASE
AHC FILLMORE-NEW CUMBERLAND	AHC FILLMORE-NEW CUMBERLAND
Ft Jackson/Shaw	AF-C-20th MED GRP-SHAW
	AHC MONCRIEF-JACKSON
	CBMH MONCRIEF-JACKSON
NBHC KEY WEST	NBHC KEY WEST
Mississippi Delta	AF-MC-81st MED GRP-KEESLER
	NBHC GULFPORT
San Antonio	AMC BAMC-FSH

Market Name	MTFs in Market*
	AF-C-59th MDW-WHASC-LACKLAND
	AF-C-359 MDG-JBSA-RANDOLPH
	TAYLOR BURK H C-BAMC-BULLIS
	AF-CB-59th MDW-NRTH CNTRL CLN
	CBMH BAMC-WESTOVER
	CBMH BAMC-SCHERTZ
Colorado Springs	ACH EVANS-CARSON
	AF-C-10th MED GRP-ACADEMY
	AF-C-21st MED GRP-PETERSON
	AF-C-SCHRIEVER MED SQ-PETERSON
	CIV EMP HLTH CLINIC-PUEBLO
	CBMH PREMIER-CARSON
	CBMH MTN POST-CARSON
	NH CAMP PENDLETON
	BMC MCB CAMP PENDLETON
	BMC EDSON RANGE
	BMC CAMP DEL MAR
	BMC CAMP HORNO
	BMC CAMP LAS FLORES
	BMC CAMP LAS PULGAS
	BMC CHAPPO
	BMC MARGUARITA
San Diego	BMC SAN MATEO
	BMC SAN ONOFRE
	NMC SAN DIEGO
	NBHC MCRD SAN DIEGO
	NBHC NAS NORTH ISLAND
	BMC MCAS MIRAMAR
	NBHC CORONADO
	NBHC RANCHO BERNARDO
	NBHC NTC SAN DIEGO
	NBHC EASTLAKE

Market Name	MTFs in Market*
	NBHC NAVSTA SAN DIEGO
	BHC KEARNEY MESA
	BHC-CHULA VISTA
Puget Sound	AMC MADIGAN-LEWIS
	NH BREMERTON
	NHC OAK HARBOR
	AF-LS-62nd MED SQ-MCCHORD
	NBHC PUGET SOUND
	AHC-MCCHORD AFB
	WINDER FAMILY MEDICAL CL- JBLM
	NBHC SUBASE BANGOR
	CBMH MADIGAN-PUYALLUP
	CBMH SOUTH SOUND- MADIGAN
	NHCL EVERETT
Hawaii	AMC TRIPLER-SHAFTER
	NHC HAWAII
	NBHC NAVCAMS EASTPAC
	BMC MCAS KANEOHE BAY
	AF-C-15th MED GRP-HICKAM
	AHC SCHOFIELD BARRACKS
	SCMH SCHOFIELD BARRACKS
	NBHC MCB CAMP H.M. SMITH
	CBMH WARRIOR OHANA- SHAFTER
Anchorage, AK	AF-H-673rd-ELMENDORF
	THC RICHARDSON
Fairbanks, AK	ACH BASSETT-WAINWRIGHT
	AF-C-354th MED GRP-EIELSON
Jacksonville	NH JACKSONVILLE
	NBHC NAS JACKSONVILLE
	NBHC KINGS BAY
	NBHC MAYPORT
AF-CB-BRANDON COMM CLINIC-MIL	AF-CB-BRANDON COMM CLINIC-MIL

Market Name	MTFs in Market*
AF-C-460th MED GRP- BUCKLEY	AF-C-460th MED GRP-BUCKLEY
SOUTHCOM CLINIC-GORDON	SOUTHCOM CLINIC-GORDON

*Does not include Occupational Health Clinics