Defense Health Agency

PROCEDURAL INSTRUCTION

NUMBER 6025.11
October 9, 2018

Healthcare Operations (HCO)

SUBJECT: Processes and Standards for Primary Care Empanelment and Capacity in Medical Treatment Facilities (MTFs)

References: See Enclosure 1.

1. PURPOSE. This Defense Health Agency-Procedural Instruction (DHA-PI), based on the authority of References (a) through (c), and in accordance with the guidance of References (d) through (k), establishes the Defense Health Agency's (DHA) procedures to describe processes and standards for calculating and adjusting primary care empanelment and MTF empanelment capacity, authorized adjustments for leadership roles by Component and accounting for Defense Health Program (DHP)-funded Primary Care Managers (PCMs) in MTFs.

2. APPLICABILITY. This DHA-PI applies to:

a. OSD, the Military Departments, the Office of the Chairman of the Joint Chiefs of Staff and the Joint Staff, the Office of the Inspector General of the DoD, the Defense Agencies, and all other organizational entities within the DoD (referred to collectively in this DHA-PI as the "DoD Components").

b. DoD MTFs, which deliver healthcare services to eligible beneficiaries and to which beneficiaries are empaneled.

3. POLICY IMPLEMENTATION. It is the Defense Health Agency's (DHA) instruction, pursuant to References (c) through (n), that:

a. Approved processes and standards identified in this DHA-PI will be used to calculate and adjust primary care empanelment and establishes processes to be implemented to avoid dis-empanelment of beneficiaries from MTFs.

b. This DHA-PI identifies the minimum primary care empanelment per PCM by specialty and identifies criteria for maximizing primary care empanelment capacity to optimize PCM resources across the direct care system.

c. MTFs will account for PCMs using the standard processes identified in this DHA-PI.

d. MTFs will apply Service Component-authorized standard empanelment adjustments for leadership roles. The empanelment associated with any additional local adjustments will be accrued to other MTF PCMs.

e. This DHA-PI will replace DHA-IPM 17-003 (Reference m).

4. RESPONSIBILITIES. See Enclosure 2.

5. PROCEDURES. See Enclosure 3.

6. RELEASABILITY. **Cleared for public release**. This DHA-PI is available on the Internet from the Health.mil site at: http://www.health.mil/dhapublications.

7. EFFECTIVE DATE. This DHA-PI:

a. Is effective upon signature.

b. Will expire 10 years from the date of signature if it has not been reissued or cancelled before this date in accordance with DHA-PI 5025.01 (Reference (a)).

R. C. BONO
VADM, MC, USN
Director

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ENCLOSURE 1

REFERENCES

(a) DHA-Procedural Instruction 5025.01, "Publication System," August 21, 2015, as amended
(b) DoD Instruction 6000.14, "DoD Patient Bill of Rights and Responsibilities in the Military Health System (MHS)," September 26, 2011, as amended
(c) Health Affairs Policy 11-005, "TRICARE Policy for Access to Care," February 23, 2011
(d) Code of Federal Regulations, Title 32, Part 199, "Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)," July 1, 2015
(e) Health Affairs Policy 09-015, "Policy Memorandum Implementation of the 'Patient-Centered Medical Home' Model of Primary Care in MTFs," September 18, 2009
(f) TRICARE Operations Manual, April 1, 2015[1]
(g) TRICARE Policy Manual, April 1, 2015[2]
(h) DoD Directive 5136.01, "Assistant Secretary of Defense for Health Affairs (ASD(HA))," September 30, 2013, as amended
(i) DoD Directive 5136.13, "Defense Health Agency (DHA)," September 30, 2013, as amended
(j) DHA-Interim Procedures Memorandum 18-001, "Standard Appointing Processes, Procedures, Hours of Operation, Productivity, Performance Measures and Appointment Types in Primary, Specialty, and Behavioral Health Care in Medical Treatment Facilities (MTFs)," July 3, 2018
(k) DHA-Procedural Instruction 6025.03, "Standard Processes and Criteria for Establishing Urgent Care (UC) Services and Expanded Hours and Appointment Availability in Primary Care in Medical Treatment Facilities (MTFs) to Support an Integrated Health Care System (IHCS)," January 30, 2018
(l) USD P&R Memo, "Enhancing Military Health System Performance," March 6, 2014
(m) DHA-Interim Procedures Memorandum 17-003 "Accounting For Defense Health Program (DHP) Primary Care Managers (PCMs)," June 21, 2018.
(n) DoD Instruction 1312.1, "Occupational Information Collection and Reporting," January 28, 2013

[1]This reference can be found at: http://manuals.tricare.osd.mil/.
[2]This reference can be found at: http://manuals.tricare.osd.mil/.

ENCLOSURE 2

RESPONSIBILITIES

1. DIRECTOR, DHA. Under the authority, direction, and control of the Under Secretary of Defense for Personnel and Readiness and the Assistant Secretary of Defense for Health Affairs, and in accordance with Reference (c), the Director, DHA, will:

a. Assign responsibility for tracking compliance with the standard processes and criteria outlined in this DHA-PI to the Deputy Assistant Director, Healthcare Operations (DAD, HCO)

b. Support the Military Medical Departments, Markets, Defense Health Regions (DHRs) and MTFs by ensuring systems are in place to collect data and measure compliance with this DHA-PI.

c. Exercise authority, as outlined in Reference (i), over the National Capital Region (NCR).

d. Approve manpower adjustments to civilian and contractor PCMs and corresponding support staff to maximize direct care system empanelment capacity and optimize MHS resources.

e. Approve MTF requests to involuntarily dis-empanel beneficiaries from MTF PCMs to network PCMs as well as any requests to direct in beneficiaries from network PCMs to MTF PCMs.

f. Fill contract and civilian positions at MTFs, which are under the direct authority of DHA.

g. Ensure standardized application of the DoD Occupation Codes.

2. DAD, HCO. The DAD, HCO, will:

a. Monitor compliance with this DHA-PI.

b. Monitor MTF capacity and empanelment by PCM through DHA Clinical Business Operations (CBO).

c. Ensure PCM empanelment and capacity retrieved from centralized systems are accurately updated on the MHS Performance Dashboard.

d. Make recommendations to the Director, DHA on manpower adjustments to civilian and contractor PCMs and make recommendations to adjust active duty manpower to maximize direct care system empanelment capacity and avoid beneficiary dis-empanelment from MTFs through the Market or the DHRs, as applicable.

3. CHIEF, TRICARE HEALTH PLAN. The Chief, TRICARE Health Plan will:

a. Conduct network market assessments to evaluate whether markets around MTFs can absorb additional Prime enrollees if the beneficiaries are to be dis-empaneled from the MTF.

b. Coordinate with the Managed Care Support Contractors (MCSCs) on market assessments or on any needed actions by the MCSCs to increase network capacity to absorb dis-empaneled beneficiaries from the MTFs.

c. Provide recommendations to the DAD, HCO on the scarcity of PCM resources in MTF markets to inform potential decisions to increase direct care PCM resources in those markets.

d. Coordinate with the MCSCs on any MCSC Clinical Support Agreements requested by the MTFs through the Markets or DHRs, as applicable.

4. CHIEF, DHA CBO. The Chief, DHA CBO will:

a. Monitor compliance with the standards and standard processes in this DHA-PI.

b. Monitor MTF capacity and average empanelment.

c. Update PCM empanelment and capacity retrieved from centralized systems on the MHS Performance Dashboard.

d. Make recommendations to the DAD, HCO on manpower adjustments to active duty, civilian and contractor PCMs to maximize direct care system capacity based on demand.

e. Evaluate MTF average empanelment and enrollment capacity performance based on standard processes and objective criteria in Paragraph 11.

f. Coordinate with the Market or DHR on MTF compliance with this DHA-PI on any MTF requests to involuntarily dis-empanel beneficiaries.

g. Coordinate and make recommendations to the DAD, HCO on Market or DHR requests to involuntarily dis-empanel beneficiaries from MTFs.

h. Report to the DAD, HCO and the Enterprise Solutions Board (ESB) on compliance with this DHA-PI and coordinate recommendations with the Patient Centered Care Operations Board (PCCOB).

5. MARKETS AND DHRS. The Markets and DHRs will:

a. Recommend adjustments and reallocation of excess PCM resources if capacity exists but empanelment demand in the MTF's market does not exist.

b. Assess MTF capacity and compliance with this DHA-PI at least annually or as needed and coordinate results and any recommendations with DHA CBO.

c. Coordinate MTF requests to involuntarily dis-empanel beneficiaries with DHA, CBO using the processes outlined in this DHA-PI.

d. Provide strategic expertise and help arrange temporary support for MTFs with PCM shortages.

6. MTF COMMANDERS AND DIRECTORS. MTF Commanders and Directors will:

a. Comply with the standards and processes in this DHA-PI.

b. Manage overall MTF empanelment to ensure empanelment remains at the minimum per PCM by specialty and increase or decrease MTF empanelment capacity based on resources and other criteria identified as this DHA-PI.

c. Employ standard processes/mitigation strategies when access standards and other criteria are not met at the current average empanelment per PCM to avoid beneficiary dis-empanelment. Mitigation strategies include such things as ensuring providers are available and meet scheduled appointment requirements in Reference (j), implementing expedited privileging of new PCMs, maximizing virtual health/secure messaging options, complying fully with first call resolution processes to include use of network Urgent Care (UC) clinics to meet acute care patient needs and are exploring the use of Medical Q-Coded Services (MQS) contracts and other strategies discussed in Paragraph 13 of this DHA-PI.

d. Monitor MTF empanelment to ensure empanelment does not fall below the minimum average empanelment per PCM.

e. Monitor MTF beneficiary empanelment demand in the MTF Market and increase MTF empanelment capacity with current manpower resources based on criteria in Paragraph 11, if capable.

f. Make recommendations to the Market or DHR Commander or Director on additional manpower required if additional beneficiary empanelment demand exists in the Market, the MTF has met all objective criteria but the MTF cannot increase empanelment with current resources.

g. Make recommendations to the Market or DHR Commander or Director on reallocation of excess PCM resources if capacity exists, all objective criteria are met but additional empanelment demand in the MTF's Market does not exist through either voluntary or involuntary empanelment.

h. Assign PCMs appropriately using standard information systems to classify the PCM accurately and to account for available time and ensure PCM's Health Insurance Portability and Accountability Act Taxonomy Codes are correctly applied.[3,4]

i. Utilize standardized DoD Occupation Codes in accordance with Reference (n).

j. Approve beneficiary requests to be voluntarily dis-empaneled from the MTF based on existing TRICARE criteria.

k. Submit requests to involuntarily dis-empanel beneficiaries from MTFs to network PCMs, as well as any requests to involuntarily empanel beneficiaries, from network PCMs to MTF PCMs to DHA through the Market or DHR.

7. CHIEF, DHA MEDICAL EXPENSE AND PERFORMANCE REPORTING SYSTEM (MEPRS) OFFICE. The Chief, DHA MEPRS office will:

a. Ensure the Expense Assignment System Version IV Service Unique Occupation Codes for DoD Occupation Code Mapping Tables are send to the Medical Data Repository.

b. Collaborate with the Markets, DHRs and Services through the MEPRS Sub-Working Group to resolve Service-unique Occupation Codes Map mapping to the standardized DoD Occupation Codes.

[3] https://data.cms.gov/browse?q=taxonomy&sortBy=relevance
[4] http://www.wpc-edi.com/reference/codelists/healthcare/health-care-provider-taxonomy-code-set/

ENCLOSURE 3

PROCEDURES

1. OVERVIEW. This DHA-PI establishes uniform processes, standards, and accountability for calculating and adjusting primary care empanelment and capacity, accounting for DHP-funded PCMs, standard empanelment adjustments for leadership roles in MTFs by Component and establishes standard processes and criteria for empanelment assessment and potential resource reallocation.

2. TIMELINE. Full compliance with this DHA-PI is required 60 days from signature for all MTFs, including those in enhanced Multi-Service Markets.

3. GOVERNANCE. The DHA CBO will coordinate with the PCCOB and report to the ESB on compliance and related responsibilities outlined in Enclosure 2.

4. PCM DEFINITION

a. PCMs are those providers with a panel of assigned beneficiaries who are assigned to a clinic which is DHA-funded and to a MEPRS code whose 3rd level identifier indicates a primary care product line (Family Medicine, Internal Medicine, Pediatrics, Adolescent Medicine, Primary Care Graduate Medical Education (GME), and Flight/Aviation/Undersea/Personnel Reliability Clinics and Operational Medicine). This DHA-PI also applies to providers in Women's Health clinics if the provider has a panel of beneficiaries assigned for the purposes of providing primary care. Individuals working in internal medicine subspecialties or pediatric subspecialties are not PCMs.

b. PCMs may be active duty, contractor, or GS (or General Pay) pay plan civilians.

(1) For active duty and GS/General Pay civilians, assigned individuals will be counted.

(2) For contract PCMs, individuals will be counted based on Defense Medical Human Resource System-internet (DMHRSi) "available" reporting.

(3) PCMs are physicians, nurse practitioners, and physician assistants with an empanelment of one or greater, who are not borrowed labor.

(4) Resident empanelment will be captured and accrued to the attending staff and to the overall MTF enrollment; however, residents will not be counted in the number of PCMs.

c. Borrowed labor will not be included in the total count of MTF PCMs, even if they are empaneled. Part-time labor will be included. Part-time labor is defined as providers who are hired to work less than full-time.

d. Only empanelment to PCMs and appropriately identified residents will accrue to the MTF identified by the Defense Medical Information System Identifier of the provider's assignment.

e. Line-funded PCMs will not be included in the MTF average empanelment calculation. Beneficiaries empaneled to line-funded PCMs also will not be included in the MTF average empanelment calculation to ensure accurate accounting and parity between the calculated numerator and denominator.

f. Internal Medicine physicians who provide consultative services to other PCMs in order to avoid specialty referrals will be empaneled based on available PCM time.

5. PCM EMPANELMENT AND ENROLLMENT. The MHS utilizes an empanelment-based Patient-Centered Medical Home (PCMH) model of primary care. MTFs are resourced based on the standards identified in this DHA-PI to provide comprehensive, coordinated, integrated primary care within MHS Access Standards to patients empaneled to an MTF and to a specific PCM. The PCMH model of care views beneficiaries holistically and the PCM addresses the empaneled beneficiary's current health concerns, focuses on prevention and promotes wellness.

a. Enrollment. Enrollment refers to the plan in which the TRICARE beneficiary is enrolled. Beneficiaries are enrolled in TRICARE Prime or Plus. If beneficiaries in TRICARE Prime choose to be empaneled to the direct care system, the beneficiary is empaneled to a MTF PCM. All TRICARE Plus beneficiaries are empaneled to a PCM in the direct care system. Active Duty Service Members (ADSMs) are enrolled in TRICARE Prime and empaneled to the MTF-based on the ADSM's assigned duty station or other local agreements.

b. Empanelment. Beneficiaries enrolled in TRICARE Prime or Plus in the direct care system are empaneled to a specific MTF PCM by name in accordance with Reference (c). The PCM is accountable for coordinating and integrating empaneled beneficiaries' healthcare needs in primary or specialty care and within the direct or purchased care system. MTF PCM empanelment capacity is calculated based on the criteria and processes identified in this DHA-PI. The following beneficiary categories will be empaneled to PCMs:

(1) TRICARE Prime Empaneled to the MTF.

(2) TRICARE Plus Empaneled to the MTF. In general, beneficiaries aged 65 or above are enrolled in TRICARE Plus at MTFs to support GME and readiness clinical currency requirements.

(3) "Must Sees". ADSMs and other 'Must Sees' are classified as "pseudo enrollees." ADSMs include personnel from both the active and reserve components who are on active duty. ADSMs have the highest priority for care in MTFs in accordance with Reference (c), including

ADSMs who are not empaneled to the MTF. ADSMs who are not empaneled to the MTF may receive acute primary care in MTF ERs and UC clinics, acute and routine primary care in PCMH and for military-specific requirements including but not limited to Preventive Health Assessments, Line of Duty determinations and profile updates.

(a) The following categories are included in "Must Sees".

1. ADSMs assigned in the MTF's area of responsibility but who are not empaneled to the MTF.

2. ADSMs in training status.

3. Activated Guard and Reserve forces.

4. ADSMs enrolled in TRICARE Prime Remote or who are traveling on personnel or temporary duty status.

5. Foreign service members as stated in Reference (c).

6. Newborns in the United States who are less than 90 days old or overseas who are 120 days old and whose parent(s) is/are empaneled to the MTF.

(b) ADSMs who are traveling on official duty status or on personal leave may use MTF Emergency Rooms (ERs) and UC clinics for acute medical needs. The TRICARE Regional Contractors will arrange for other acute and routine primary care to be provided in the TRICARE network. If an ADSM prefers to be seen in the MTF, the MTF will provide acute and routine primary care. If specialty care is required, ADSMs will arrange specialty care through their unit medical officer or may be referred to specialty care if seen in the MTF ER or UC clinic or from MTF PCMs.

c. Space-Available Care. Because MTF PCMHs are resourced based on empanelment, DHA MTFs are expected to offer minimal or no space-available primary care at MTFs. The following categories are seen on a space-available basis, only. DHA will monitor the number of beneficiaries seen on a space-available basis in MTFs and may adjust empanelment capacity accordingly; routinely offering space-available care to non-ADSM beneficiaries implies available MTF empanelment capacity. The following categories are seen on a space-available basis, only.

(1) TRICARE for Life (TFL). TFL beneficiaries aged 65 and over who are not enrolled in TRICARE Plus may be seen in MTF PCMH on a space-available basis, only. TFL beneficiaries also may use MTF ERs, UC clinics and ancillary services including laboratory and pharmacy.

(2) TRICARE Select. Beneficiaries who have elected to use TRICARE Select may receive care at a MTF PCMH on a space available basis, only. TRICARE Select beneficiaries may receive care at the MTF ER or UC clinic, if available.

(3) Non-Enrolled Beneficiaries. Beneficiaries who have elected not to be enrolled in either Prime or Select may receive care at a MTF on a space-available basis, only. Non-enrolled beneficiaries may receive care at the MTF ER or UC clinic, if available.

(4) Eligible Family Members Enrolled in TRICARE Prime Remote. Eligible family members enrolled in TRICARE Prime Remote may use MTF ERs and UC clinics for acute medical needs. The TRICARE Regional Contractors will arrange for other acute and routine primary care to be provided in the TRICARE network. If specialty care is required, beneficiaries in this category may be referred to specialty care if seen in MTF ERs or UC clinics or, if recommended, by a network primary care provider.

(5) Other Categories. Other patient categories may be seen at the MTF in accordance with Reference (c), and the Secretarial Designee program.

6. STANDARD EMPANELMENT PER PCM AND MTF EMPANELMENT CAPACITY

a. PCM Full-Time Equivalent (FTE) Rates. All active duty and GS employee PCMs are considered 1.0 FTEs for calculation purposes. Contract PCMs will be counted based on DMHRSi "available" reporting if part-time or as 1.0 FTE if full-time. Actual empanelment per PCM will be modified by the MTF Commander or Director based on approved leadership role adjustments in Paragraph 8 of this DHA-PI. Empanelment associated with other adjustments approved by the MTF Commander or Director not identified in Paragraph 8 will be allocated to other MTF PCMs. Processes and empanelment impacts for non-standard reasons are discussed in Paragraph 9.

b. Standard Empanelment per PCM FTE. The standard empanelment per 1.0 FTE PCM by specialty are provided below and in Appendix A of this DHA-PI. Increased empanelment beyond the upper limit of the ranges below are authorized by the MTF Commander or Director on a permanent or surge basis. Empanelment also will be assessed by the Service, Market leadership or intermediate command based on criteria in Paragraph 11 of this DHA-PI in order to optimize MHS resources and maximize direct care system empanelment capacity:

(1) Family Medicine and Pediatrics: 1,100 – 1,300. MTFs will balance panel acuity internally.

(2) Internal Medicine: Standard internal medicine empanelment per PCM varies based on the clinic Johns Hopkins Individual Disease Burden Index (IBI) without non-users on Carepoint MHS Population Health Portal (MHSPHP)[5].

(a) IBI greater than 3.0: 850 – 927.

(b) IBI greater than 2.5 and less than or equal to 3.0: 900 – 982.

(c) IBI greater than 2 and less than or equal to 2.5: 950 – 1,036.

[5] https://carepoint.health.mil/SitePages/Detail.aspx?detailId=7073

(d) IBI less than or equal to 2.0: 1,100 – 1,200.

(3) Operational Medicine (all types, non-lined funded): 550 – 650, assigned unit strength or at the Commander/Director discretion.

c. Service PCM Adjustments to MTF Readiness Platforms. Services may choose to assign additional primary care providers to MTFs in Markets with high demand and which are expected to yield a robust case mix of beneficiaries with high acuity relative to other MTFs in the MTF's peer group based on MTF IBI without non-users in the Carepoint MHSPHP to support clinical currency and readiness training requirements.

(1) The Services will coordinate with DHA CBO on the number of additional providers and associated support staff to be assigned to the MTF.

(2) Providers added as Non-Empaneled Medical Officers (NEMOs) to MTF Readiness Platforms will be leveraged for the following purposes:

(a) To expand MTF empanelment capacity and to deliver care to beneficiaries not empaneled to the MTF and who wish to be seen on a space-available basis.

(b) To fulfill preceptor duties for readiness Knowledge, Skills and Ability training requirements for the MTF's PCMs and for PCMs on temporary duty to the MTF to obtain needed readiness training and for non-GME training at the MTFs for other providers.

(c) To serve as a pool of providers to fill short-term PCM availability gaps at other MTFs as recommended to DHA CBO by the Markets or DHRs, as applicable. NEMOs will not have an assigned panel of beneficiaries.

7. MHS STANDARD ADJUSTMENTS. Authorizations for PCMs defined in Paragraph 4 are based on the empaneled population. Depending on the MTF's scope, PCMs may have a mixture of inpatient, outpatient, operational/readiness and GME and non-GME training responsibilities. When calculating target MTF empanelment, the following standard adjustments will be utilized. All MTFs will comply with the following standard adjustments, if applicable to the MTF's scope.

a. Standard Leadership Adjustment. Each MTF will receive a six percent adjustment to account for standard leadership roles discussed in Paragraph 8 of this DHA-PI and in Appendices B-E.

b. Inpatient and GME Adjustments. Inpatient adjustments are based on the MTF size and scope. Inpatient adjustments are mutually exclusive; a MTF with inpatient capabilities will only receive one of the three inpatient adjustments in Paragraph 7.b.(1)-(3) below. MTFs with full-time hospitalists to whom patients have not been empaneled and who are improperly counted in "A" MEPRS codes will receive one less adjustment for each improperly counted hospitalist to the numbers below. Additional GME adjustments are outlined in Paragraph 12. Until DHA

determines a set inpatient/GME adjustment for each MTF, MTFs will comply with the inpatient/GME deductions below. When specific adjustments by MTF are approved, this DHA-PI will be amended and the adjustments below will be superseded.

(1) 2.5 FTE PCMs for a small bedded MTF or community hospital.

(2) 5.0 FTE PCMs for a MTF with a residency program or medium-sized bedded MTF.

(3) 10 FTEs PCMs for a medical center.

(4) 1 FTE PCM for MTFs with a Phase 2 Physician Assistant training program.

c. DHP-Funded Operational PCM Adjustment. All DHP-funded operational PCMs (e.g. flight surgeons, undersea medicine providers, etc.) will be counted as a 0.50 FTE with a minimum empanelment of 550. While counted as a 0.50 FTE with a minimum empanelment of 550, in reality, DHA-funded operational PCMs will be empaneled to see the number of beneficiaries in the assigned unit.

d. "Must See" Adjustments. Visits by "Must See" non-empaneled patients will translate to a FTE adjustment for each MTF by dividing the number of non-empaneled visits to primary care in the last rolling 12 months by the MHS average utilization rate to be provided annually by DHA. This process will generate a number of "pseudo enrollees"; the number of pseudo enrollees will be converted to a FTE, divided by minimum empanelment of 1,100 or the average MTF empanelment if higher and then deducted from the MTF's FTE denominator. The PCM adjustment for "Must Sees" will be calculated annually.

8. ADJUSTMENTS FOR LEADERSHIP ROLES

a. Adjustments for Leadership Roles. Until a standard set of leadership role adjustments are developed, each MTF will comply with their current Service-specific standard leadership adjustments. Parent-level MTFs will receive an adjustment of six percent to account for the leadership roles discussed below and in the referenced appendices.

(1) Army Adjustments and Roles. Army-specific leadership adjustments are in Appendix B of this DHA-PI.

(2) Navy Adjustments and Roles. Navy-specific leadership adjustments are in Appendix C of this DHA-PI.

(3) Air Force Adjustments and Roles. Air Force-specific leadership adjustments are in Appendix D of this DHA-PI.

(4) NCR MD Adjustments and Roles. NCR MD-specific leadership adjustments are Appendix E of this DHA-PI.

b. Approved leadership adjustments will be deducted from the MTF's average empanelment per PCM or the average MTF empanelment if higher, per specialty.

c. When standard direct care leadership role adjustments are developed, this DHA-PI will be amended, and the adjustments below will be superseded.

9. MTF EMPANELMENT CAPACITY, AVERAGE EMPANELMENT PER PCM AND EMPANELMENT DISTRIBUTION

a. MTF Empanelment Capacity. Standard MTF empanelment capacity is calculated by multiplying the total number of authorized PCMs by the standard empanelment per PCM by specialty in Paragraph 6, less inpatient/GME adjustments in Paragraph 7 "Must See" adjustments and a six percent adjustment for approved leadership roles in Paragraph 8. An example of a MTF capacity calculation is at Appendix G.

b. Average MTF Empanelment per PCM. The average MTF empanelment per PCM is calculated by dividing the total number of empaneled beneficiaries by the total number of PCM FTEs. The total number of PCM FTEs will include deductions for standard inpatient/GME adjustments in Paragraph 7 "Must See" adjustments and a six percent adjustment for approved leadership roles in Paragraph 8.

c. Additional Non-Standard Adjustments Approved By The MTF Commander Or Director.

(1) MTF Commander or Director Flexibility. Specific empanelment for individual PCMs may be adjusted and balanced locally under the authority of the MTF Commander or Director to accommodate provider skills and experience, local missions and temporary staffing issues including maternity leave, abeyance and other circumstances.

(2) Empanelment Reallocation. The empanelment associated with local non-standard adjustments will be reallocated to other PCMs in the MTF.

d. Empanelment Distribution. MTFs will distribute empanelment by adjusting for leadership roles in Paragraph 8 and then distributing the balance to remaining PCMs. An example of PCM empanelment distribution is in Appendix H.

10. INCREASES TO STANDARD EMPANELMENT PER PCM TO INCREASE MTF EMPANELMENT CAPACITY

a. Increases to Standard Empanelment per PCM beyond Standard Ranges. Increased empanelment beyond the upper limit of the ranges below are authorized by the MTF Commander or Director and assessed by the Service, Market or DHR based on criteria in Paragraph 11 of this DHA-PI in order to optimize MHS resources and maximize direct care system capacity. MTFs seeking to increase empanelment beyond the upper limit must also consider the adequacy of PCM support staff.

b. Market or Defense Health Region Capacity Assessment. The Market or DHR, as applicable, will assess MTF capacity based on the processes and standards identified in this DHA-PI.

(1) If the MTF is meeting the standard performance criteria in Paragraph 11, the MTF will increase empanelment capacity incrementally to ensure access and quality standards are met for empaneled beneficiaries.

(2) If the MTF is not meeting criteria in Paragraph 11, the Market or DHR will coordinate with DHA CBO on recommendations to optimize capacity and on strategies outlined in Paragraph 13 of this DHA-PI, if warranted.

11. STANDARD OBJECTIVE CRITERIA FOR ADJUSTING EMPANELMENT CAPACITY OR EMPANELMENT PER PCM

a. Standard Objective Criteria. MTFs' capacity will be assessed based on the standards identified below. Markets, DHRs and MTFs will use the following standard objective criteria in assessing MTF empanelment capacity, PCM resources and MTF efficiency.

(1) Satisfaction with Getting Care When Needed. Data are available on the MHS Dashboard on Carepoint and on the Joint Outpatient Experience Survey website.[6]

(2) Percent Primary Care Leakage including Percent Leakage to MTF or Market ERs and UC clinics. Data are available on the MHS Dashboard and the PCMH Access page on Sharepoint.[7]

(3) Average Days to Third Next 24-Hour and Future Appointments. Data are available on the MHS Dashboard on Carepoint [8] and the TRICARE Operations Center (TOC).[9]

(4) Number of Scheduled, Planned Face-to-Face and Virtual Encounters per Week in the Composite Healthcare System or MHS GENESIS as identified in Reference (j). Data are available on the Direct Access Reporting Tool (DART) on Carepoint.[10]

(5) Provider Availability.

(6) Number of days per week the MTF is open. Data are available on the DART on Carepoint.

(7) MTF operating hours. Data are available on the DART on Carepoint.

[6] https://joesreports.com/
[7] https://info.health.mil/hco//clinicsup/hsd/pcpcmh/sitepages/home.aspx
[8] https://carepoint.health.mil/sites/MHSP4I/SitePages/Home.aspx?filtertype=exec
[9] https://info.health.mil/staff/analytics/atcreports/Pages/apptreports.aspx
[10] https://carepoint.health.mil/sites/DART/SitePages/Home.aspx

(8) MHS Quality Measures on the MHS Dashboard on Carepoint. Data are available on the MHS Dashboard and the MHSPHP on Carepoint.[11]

b. MTF and Market or DHR Assessment. The Market or DHR will assess MTF and clinic empanelment, capacity and performance compared to criteria in Paragraph 11 on an annual basis and ensure strategies in Paragraph 13 are fully explored and/or implemented, as needed. An assessment checklist of the minimum number of items on which a MTF will be evaluated is provided in Appendix F.

(1) The MTF Commander or Director will provide an assessment to the Market or DHR if changes in MTF empanelment capacity or in the number of PCMs or if implementation of short or long-term strategies in Paragraph 13 are recommended.

(2) The Market or DHR will approve increases in MTF empanelment capacity based on the criteria in Paragraph 11 or may distribute resources or empanelment based on the findings of the assessment.

(3) The Market or DHR will make recommendations to DHA CBO if assistance from DHA is required for either long or short-term strategies in Paragraph 13.

(4) The Market or DHR will coordinate with DHA CBO at least annually on MTF capacity or if either permanent changes in the number of available PCMs or dis-empanelment is recommended.

12. GME

a. Empanelment to Program Directors and Assistant Program Directors is based on the civilian accreditation organization unless otherwise specified in Appendices B - E.

(1) Physician GME Programs. MHS physician GME programs will comply with the Accreditation Council for Graduate Medical Education (ACGME) requirements.

(a) Primary care physician residents are classified as Program Year (PGY) 1, 2 or 3.

(b) PGY 1, 2, and 3 resident empanelment and FTE workload accrue to the attending staff for calculation purposes.

(2) Physician Assistant Training Programs. MHS Physician Assistant education programs will comply with the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA) requirements.

b. GME adjustments are identified in Appendices B – E.

[11] https://carepoint.health.mil/sites/mhsphp/SitePages/MAINTABS.ASPX

13. STRATEGIES FOR ADDRESSING SHORT AND LONGER-TERM MTF EMPANELMENT CHALLENGES

a. Short-term Strategies of Six Months or Fewer. MTFs will notify the Market or DHR and implement short-term strategies when empanelment per PCM increases due to staffing shortfalls, readiness-related activities and other challenges and when access to care standards are not being met. Strategies include:

(1) Ensure the number of available, scheduled appointments per week for all full and part-time clinicians and days in clinic comply with standards in Reference (j). MTFs will ensure the required number of appointments per week per full and part-time clinician are planned in the Composite Healthcare System or in MHS GENESIS, if the MTF has deployed MHS GENESIS and that the clinician is available for the required number of days in clinic.

(2) Temporary Surge Operations. MTFs may implement temporary surge operations with existing staff if the period of increased empanelment per PCM is expected to be six months in duration or less. Temporary surge operations require current PCMs to meet the primary care needs of the beneficiaries empaneled to the MTF and the "Must See" population. During surge operations, MTFs may expect increased leakage to network UC clinics.

(3) Increased support and scheduled appointments for NEMOs, MTF command staff who also are privileged, credentialed primary care providers and existing Individual Mobilization Augmentees (IMAs) assigned to the MTF.

(4) Temporary Halt to New Empanelment. MTFs will temporarily stop empaneling additional non-ADSMs if the MTF previously was open to new empanelment.

(5) Shift empanelment to other PCMH clinics in the MTF with capacity or realign empanelment to clinics best able to maximize beneficiary access to care.

(6) Maximize use of PCMH enhanced access capabilities including Clinical Support Staff Protocols (CSSPs), the Nurse Advice Line (NAL) and expanded use of integrated PCMH team members including available integrated behavioral health providers, clinical pharmacists and physical therapists as well as Medical Management team members.

(7) Encourage staff to promote the use of secure messaging and TRICARE On-Line (TOL) for asynchronous communication with PCMH teams to increase clinic efficiency and reduce the number of telephone consults.

(8) Cease providing healthcare to Space-Available beneficiaries.

(9) Promote use of network UC clinics for self-limiting or minor acute illness.

(10) Permit limited cross-booking to other teams with open appointments on a short-term basis, especially for routine care for beneficiaries with chronic or complex medical needs.

(11) Temporary staffing, gap-fill contracts.

(12) Short-term manning assistance from the Services or the Markets.

(13) Short-term locum tenens or MQS contracts, if available.

(14) Coordinate with the TRO and MCSC to submit a Clinical Support Agreement for civilian PCM support for MTF empaneled beneficiaries.

(15) Short-term, extended primary care referrals to the network, which require coordination through the TRICARE Regional Office (TRO). Processes for referral to the network for primary care will comply with First Call Resolution processes in Reference (j).

(16) Communicate short-term challenges and availability of CSSPs, the NAL, TOL, integrated PCMH team members, availability of network UC clinics for acute needs, TOL and other implemented short-term strategies to beneficiaries using MTF social media, newsletters, secure messaging and other local installation modes of communication.

b. Longer-Term Strategies of More Than Six Months. If the period of increased empanelment per PCM is expected to be greater than six months, the MTF will continue applicable short-term strategies outlined in Paragraph 13.a. above and at the 60-day vacancy point also will contact the Market or DHR to coordinate assistance. The Market or DHR will coordinate with DHA CBO following assessment.

(1) The MTF will complete the self-assessment checklist in attachment F to include a current and 12-month projected staffing assessment. The MTF will show evidence the MTF explored or implemented strategies in Paragraph 13.a.

(2) The Market or DHR will conduct a business case analysis using quantitative data based on criteria in Paragraph 11 of this document and will provide a quantitative assessment via an in-person team visit to consult, train and coach the staff based on the MTF's completed checklist and on-site assessment.

(3) If business case analysis validates that staffing assistance is required, the Market or DHR will coordinate implementation from DHA CBO for longer-term strategies including:

(a) Staff on temporary duty from other MTFs with available personnel.

(b) Locum tenens staff.

(c) Additional reserve and IMA support

(d) MQS contracts

(e) Temporary Disengagement of Empaneled Beneficiaries. MTFs may disengage empaneled beneficiaries to obtain primary care in the network. MTFs must notify beneficiaries

in writing via direct mail of temporary disengagement and how to find primary care in the network via the TRICARE Regional Contractor provider directory.

(f) Voluntary Dis-empanelment. MTFs may offer voluntary dis-empanelment to beneficiaries after all other short and long-term strategies have been explored and/or implemented. MTFs may offer voluntary dis-empanelment to the following beneficiaries:

1. Beneficiaries empaneled to the MTF and who live beyond the drive-time standards in Reference (c).

2. Beneficiaries identified by Utilization Management (UM) as non-users who have not been seen in-person or virtually within three years.

3. Beneficiaries identified by UM as users of more UC care the network than PCMH care in the MTF.

4. Beneficiaries with Risk Utilization Bands 4 and 5 and if the MTF is a clinic not located in a Market with MTF specialty care.

14. BENEFICIARY DIS-EMPANELMENT PROCESSES

a. MTFs must submit requests to involuntarily dis-empanel beneficiaries to network PCMs through the Market or DHR to the Director DHA through the DAD, HCO. MTFs are not required to submit requests to dis-empanel beneficiaries who are being dis-empaneled for disruptive behavior or who want to be dis-empaneled from the MTF for personal reasons. Requests to involuntarily dis-empanel beneficiaries will be made through the Market or DHR to DHA including submission of the following documentation:

(1) A business case analysis based on the MTF self-assessment checklist in Appendix F.

(2) A Health System Area Assessment from the MCSC and TRO to evaluate the availability and capacity of local civilian or other federal healthcare providers in the community within the 30-minute drive time standard in Reference (c).

(3) Written coordination with the TRO.

b. The DHA CBO may coordinate with the Market or DHR electronically. If additional assessment is required, the DHA CBO may coordinate an in-person visit to the MTF to be accompanied by the Market or DHR staff.

c. If DHA approves involuntary beneficiary dis-empanelment, the MTF will implement the following minimum processes to provide a supportive and customer-focused patient experience:

(1) The MTF will coordinate stakeholder information content with the TRO and with beneficiaries to ensure beneficiaries are informed of network options for care and how to obtain a network PCM.

(2) The MTF will provide involuntarily dis-empaneled beneficiaries with paper or electronic copies of their relevant medical history.

(3) The MTF will coordinate with the TRO to assist beneficiaries who are in TRICARE Plus or in Resource Utilization Band (RUB) 4 and 5 in finding a network PCMs.

(4) MTF PCMs will coordinate a warm hand-off with the new network PCM of TRICARE Plus or RUB 4/5 beneficiaries who were involuntarily dis-empaneled to discuss relevant medical history and the beneficiary's current care plan.

15. PERMANENT REALLOCATION OF PCM RESOURCES TO MAXIMIZE DIRECT CARE SYSTEM EMPANELMENT CAPACITY

a. Annual Evaluation. DHA CBO will evaluate current allocation of PCM resources and whether there is excess capacity or unmet demand in a MTF's market area at least annually in coordination with the Market or DHR annual assessment in order to optimize MHS resources and maximize direct care system empanelment capacity.

b. MTF Excess Capacity. The MTF has excess capacity if the average empanelment per PCM by specialty has not achieved the minimum expected empanelment or has not met the criteria in Reference (j) and in Paragraph 11 of this DHA-PI. MTFs will be assessed as having excess empanelment capacity if one of the two following situations:

(1) If empanelment demand exists in the MTF's Market, the MTF will open empanelment using first voluntary and then involuntary empanelment until the standard is achieved. MTF requests to involuntarily empanel beneficiaries from network PCMs to MTF PCMs must be approved by the Director, DHA. If neither voluntary nor mandatory empanelment results in the MTF achieving standard empanelment per PCM, the MTF will be considered to have insufficient demand relative to the PCM resources.

(2) If insufficient empanelment demand exists in the MTF's Market, DHA will reallocate the number of excess PCMs and associated support staff authorizations required to increase the MTF's average empanelment PCM to the standards in Paragraph. PCMs will be reallocated to MTFs with excess demand in the Market or to MTFs with higher empanelment per PCM and which are not able to meet access to care standards in Reference (c).

c. Unmet Empanelment Demand. If there is unmet empanelment demand in a MTF's Market and if the MTF is meeting the criteria in Reference (j), the DHA will resource the MTF with additional PCM resources and associated support staff through the following means:

(1) Reallocation of PCM and associated support staff positions from MTFs with insufficient demand, as described above.

(2) By funding new contract or GS positions and associated support staff positions.

d. Processes for Reallocating PCM Positions. Contract PCM and support staff position funding will be reallocated prior to reallocating GS and active duty positions.

(1) Excess contract PCM positions will be eliminated at the first contractual opportunity but will not be continued beyond the current contract option year. DHA will reallocate the funding available through terminating excess contract PCM positions to new contracts at MTFs with higher demand to allow the gaining MTF capacity either to increase to a minimum of 1,100 or higher, if additional demand exists in the gaining MTF Market area and if there are enough available exam rooms to accommodate additional PCMs or if operating hours can be expanded in accordance with Reference (k).

(a) The Market or DHR will coordinate recommendations for terminating excess contract PCM positions with DHA CBO.

(b) The Director, DHA through the DAD, HCO will make the final decision on reallocating funding to MTFs with higher demand.

(2) Processes for Reallocating active duty or GS PCM positions.

(a) Active duty or GS PCM and associated support staff positions will be reallocated to MTFs with higher demand if additional demand exists in the gaining MTF Market and if there are enough available exam rooms to accommodate additional PCMs or if operating hours can be expanded in accordance with Reference (k).

(b) The Market or DHR will coordinate reallocation recommendations to DHA. The Market and DHR also will coordinate reallocation recommendations of GS PCM positions with the applicable union.

(c) The Director, DHA through the DAD, HCO will make the final decision on GS PCM positions and will coordinate with the applicable Uniformed Service on active duty PCM positions.

16. PROCEDURES FOR USE OF STANDARD SYSTEMS TO CALCULATE PCMS

a. Pediatric Subspecialty Clinics. A Pediatric Subspecialty Clinic MEPRS three-letter Code BDB shall only be established when it meets the criteria of a physical work center.

b. Within DMHRSi:

(1) Pediatric subspecialists should be assigned to MEPRS Code BDB*.

(2) Family Medicine PCMs should be assigned to MEPRS Codes BGA*/BGZ* or BHA*/BHZ*.

(3) Pediatric PCMs should be assigned to MEPRS Code BDA*/BDZ*.

(4) Internal Medicine PCMs will be assigned to MEPRS Codes BAA*/BAZ*.

(5) DHP-funded Flight and Operational Medicine PCMs attached to separate flight or operational medicine clinics will be assigned to MEPRS Codes BJA*/BKA*.

(6) Full time-hospitalists are to be assigned to "B" MEPRS Codes to ensure they are not double discounted. If full-time hospitalists are assigned to "A" MEPRS Codes, the standard inpatient deduction will be decreased for each hospitalist assigned to an "A" MEPRS Code.

17. COMPUTING EMPANELMENT PER PCM

a. To calculate empanelment per PCM, all provider Electronic Data Interchange Person Numbers will be gathered from source tables within the Medical Data Repository as follows:

(1) Those who exist within DMHRSi manpower file, not including borrowed labor but including part-time labor; and

(2) Those who have empaneled at least one patient and completed at least one encounter in the month of measurement; and

(3) Those who exist in Defense Enrollment Eligibility Reporting System (DEERS) as a provider.

b. All the patients in DEERS will be matched to their PCM using the PCM Identifier that matches the Electronic Data Interchange Person Number of the provider.

c. The providers and associated empanelment will be filtered using the criteria and adjustments outlined above to resolve an empanelment per PCM by parent Defense Medical Information System Identifier.

18. MONITORING, REPORTING, AND EVALUATION

a. Monitoring. The DHA CBO will monitor compliance with the standards identified in this DHA-PI by MTF using data available on the MHS Dashboard, the TOC and in the DART and MHSPHP Carepoint quarterly.

b. Reporting and Measurement. The DHA CBO will coordinate with the PCCOB and will report at least quarterly to the DAD, HCO and the ESB at minimum on the following measures.

(1) Average empanelment per PCM by MTF. Average empanelment per PCM by MTF is an approved MHS Core Measure. The measure results and methodology documents will be included on the MHS Dashboard on Carepoint.[12]

(2) MTFs not complying with the standards and processes identified in this DHA-PI based on data and/or as assessed by DHA CBO Market or DHR counterparts.

c. Evaluation. The DHA CBO will evaluate empanelment performance at least annually and make recommendations for PCM and associated support staff allocation across the direct care system to the ESB and to the DAD, HCO.

[12] https://carepoint.health.mil/_login/default.aspx?ReturnUrl=%2fsites%2fMHSP4I%2f_layouts%2f15%2fAuthenticate.aspx%3fSource%3d%252Fsites%252FMHSP4I%252FSitePages%252FHome%252Easpx%253Ffiltertype%253Dexec&Source=%2Fsites%2FMHSP4I%2FSitePages%2FHome%2Easpx%3Ffiltertype%3Dexec

GLOSSARY

PART I. ABBREVIATIONS AND ACRONYMS

ACGME	Accreditation Council for Graduate Medical Education
ADSM	Active Duty Service Member
ARC-PA	Accreditation Review Commission on Education for the Physician Assistant
CBO	Clinical Business Operations
CSSP	Clinical Support Staff Protocols
DAD	Deputy Assistant Director
DART	Direct Access Reporting Tool
DEERS	Defense Enrollment Eligibility Reporting System
DHA	Defense Health Agency
DHA-IPM	Defense Health Agency-Interim Procedures Memorandum
DHA-PI	Defense Health Agency-Procedural Instruction
DHP	Defense Health Program
DHR	Defense Health Region
DMHRSi	Defense Medical Human Resource System-internet
ER	Emergency Room
ESB	Enterprise Solutions Board
FTE	Full-Time Equivalent
GME	Graduate Medical Education
GS	General Schedule
HCO	Healthcare Operations
IBI	Illness Burden Index
IMA	Individual Mobilization Augmentee
MCSC	Managed Care Support Contractor
MEPRS	Medical Expense and Performance Reporting System
MHS	Military Health System
MHSPHP	Military Health System Population Health Portal
MTF	Medical Treatment Facility
NAL	Nurse Advice Line
NCR	National Capital Region
NEMO	Non-Empaneled Medical Officer

PCC	Primary Care Clinician
PCCOB	Patient Centered Care Operations Board
PCM	Primary Care Manager
PCMH	Patient Centered Medical Home
PGY	Program Year
PI	Procedural Instruction
RUB	Resource Utilization Band
TFL	TRICARE For Life
TOC	TRICARE Operations Center
TRO	TRICARE Regional Office
TOL	TRICARE On-Line
UC	Urgent Care
UM	Utilization Management

PART II. DEFINITIONS

ACGME. The ACGME is the national organization, which sets and monitors the professional educational standards essential in preparing physicians to deliver safe, high-quality medical care.

ARC-PA. The ARC-PA is the national organization, which defines the standards for physician assistant education.

ADSMs: ADSMs are members of both the active and reserve components who are on active duty.

Borrowed labor. When a primary care provider is assigned to a full-time job outside the MTF but who provides care on an ad hoc basis to beneficiaries empaneled to a MTF. It includes but it not limited to NEMOs and IMAs. Borrowed labor, in some instances, can be classified as PCMs; however, PCMs who are borrowed labor will not be included in the MTF average empanelment calculation. This includes operational providers regardless of funding who provide care to their empaneled beneficiaries within the MTF purview/footprint.

Direct Care. Direct care refers to healthcare delivered in MTFs.

Empanelment. TRICARE Prime or Plus beneficiaries are empaneled to a MTF PCM.

Empanelment Capacity. Empanelment capacity is the total MTF capacity to empanel TRICARE beneficiaries to MTF PCMs.

Enrollment. Enrollment is the term the MHS uses to describe the TRICARE Plan (Prime or Select) to which a TRICARE beneficiary is enrolled.

ESB. A flag-level governance group with voting members from DHA and the Services with oversight for healthcare clinical and business operations and clinical communities.

NEMO. A NEMO is a primary care clinician who is not empaneled but who sees patients in an MTF. NEMOs may be permanently assigned to the MTF or to another organization.

Non-Enrolled Beneficiaries. Non-enrolled TRICARE beneficiaries have not elected to enroll in either PRIME or Select. They may receive care in the direct care system on a space-available basis, only.

Part-time labor. Providers who are hired to work less than full-time.

PCC. PCCs are physicians, nurse practitioners and physician assistants trained in primary care specialties. The civilian healthcare industry uses the term PCC to describe PCMs.

PCCOB. A DHA-led board with Service lead voting representatives for primary and specialty care. The PCCOB is supported by Service representatives from access, medical management/population health, telehealth, referral management, coding/medical records, a DHA representative for the TRICARE Health Plan Enterprise Support Activity Work Group (when private sector care issues are discussed) and other key working groups. The PCCOB reports to the ESB.

PCM. PCMs is the MHS term for physicians, nurse practitioners and physician assistants trained in primary care specialties and to whom TRICARE Prime beneficiaries are empaneled.

PCMH. The MHS's model of primary care, which includes family medicine, pediatrics, internal medicine, operational medicine, and multi-disciplinary primary care clinics. PCMHs' operations are guided by Tri-Service standard processes and procedures with warranted variance in the type of additional care available based on the needs of the patient population.

Private Sector Care. Healthcare delivered in the civilian private sector care system through TRICARE contracts.

APPENDIX A

EMPANELMENT STANDARDS PER PRIMARY CARE MANAGER BY SPECIALTY

Primary Care Specialty	Minimum Empanelment	Upper Range Empanelment	Additional Empanelment Beyond Upper Range
Family Medicine and Pediatrics	1,100	1,300	Higher empanelment beyond the upper range identified here is authorized based on the criteria in Paragraph 11 of this DHA-PI to optimize MHS resources and maximize direct care system primary care capacity if access to care and other standards are met.
Internal Medicine IBI > 3.0	850	927	
Internal Medicine IBI > 2.5 and ≤ 3.0	900	982	
Internal Medicine IBI > 2.0 and ≤ 2.5	950	1,036	
Internal Medicine IBI ≤ 2.0	1,100	1,200	
Operational Medicine (ADSM Clinics)	550	650	
Executive Medicine Clinics	500	700	

APPENDIX B

ARMY STANDARD ADJUSTMENTS FOR LEADERSHIP ROLES

Specialty and Role	FTE Adjustment
Family Medicine, Pediatrics, and Internal Medicine	
Full Time PCM (Active Duty or GS)	0
Full Time PCM (Contract)	0.08
Department Chief (>30K-40K enrolled)	0.7
Department Chief (>20K-30K enrolled)	0.5
Medical Director, AMH/SCMH Practice (10-20K enrolled)*	0.3
Clinic Officer in Charge*	0.1
Residency Director**	0.82 (may adjust per ACGME Guidelines)
Assistant Residency Director**	0.78 (may adjust per ACGME Guidelines)
Core Faculty**	0.73
Chief Resident**	0.9
R1 – Family Medicine**	0.93
R2 – Family Medicine**	0.87
R3 – Family Medicine**	0.75
R1 – Pediatrics**	0.92
R2 – Pediatrics**	0.91
R3 – Pediatrics**	0.9
R1 – Internal Medicine**	0.96
R2 – Internal Medicine**	0.93
R3 – Internal Medicine**	0.92
Full Time PCM ("Must See" beneficiaries)	0
Line Unit PCM (DHP funded provider)	0.50 (or size of unit)
Line Unit Primary Care Clinician (Non-DHP funded provider)***	0.50 (or size of unit)
Additional Duty Adjustments	
Flight Medicine (who is not a line unit PCM)[1]	0.2
Pain Champion >15,000 Empaneled[2]	0.2
Pain Champion</= 15,000 Empaneled[2]	0.1
Family Advocacy Program Representative[3]	Varies (0.05-0.10)
Medical Review Officer[4]	Varies ( )
Exceptional Family Member Program[5]	Varies ( )
Committee Member[6]	Varies (0.0125-0.05)
Readiness[7]	0.1
Champion TBD[8]	0.05-0.10

Source: Appendix 11 to Annex R to Army OPORD 16-02 (Army Medical Home)

APPENDIX C

NAVY STANDARD ADJUSTMENTS FOR LEADERSHIP ROLES

Role (Family Medicine, Pediatrics and Internal Medicine)	FTE Adjustment	Notes
Director of Medical Services or MTF equivalent (Director for Health Services or Director for Primary Care)	0.9	Medical Center
	0.6	Large Facility
	0.4	Small Facility
Director of Branch Clinics	0.9	10 or more branch clinics
	.1 per branch clinic	1 to 9 branch clinics
Medical Home Port (MHP) Clinic Department Head	Varies; 0.1+	Department Heads take 0.1 deduction for every MHP Team in their department
Chair or Co-Chair of Family Advocacy Program	Varies; Maximum 0.1	Deduction includes time to attend meetings and for reviewing cases only if required to maximum of 0.1.
Officer in Charge (OIC) of branch clinic (when NOT a separately billeted position)	Varies; 0.1+	Deduction consistent with actual time needed to fulfill duties. Billeted OICs do not generate enrollment expectation and may practice clinically at their own discretion.
Specialty Leader	0.6	300 or more billets
	0.4	100 - 299 billets
	0.2	Less than 100 billets
Chief Medical Informatics Officer or Chief Nurse Informatics Officer	0.3	Medical Center
	0.2	Large Facility
	0.1	Small Facility
Navy TSWF Representative	0.5	Voting member of the DHA TSWF working group; deduction dictated locally by workload fluctuation
Medical Executive Committee or Executive Committee of Nurse Staff (ECONS) - Chair	0.9	Medical Center
	0.6	Large Facility
	0.4	Small Facility
Chief Medical Officer	Billeted Position	Deduction should equate actual time required to perform job duties, and may vary throughout tenure based on project workload. Deduction only applies if position is not separately billeted.
MTF Secure Messaging Champion	0.1	Medical Center
	0.05	Other Facilities
DHP-Funded Undersea Medical Officer or Flight Surgeon	Per operational requirements to maintain qualifications and proficiency	When billeted to BSO-18 activities
Wounded Warrior PCC	-	Enroll to 400
Aviation Medical Examiner	0.2	
GME Program Director - FM, IM or PEDS Residency		Per ACGME guidelines
Assistant Program Director - FM, IM or PEDS Residency		Per ACGME guidelines
Core Faculty or Clinical Teaching	Varies	**Calculation**: Per RRC requirements, total number of hours needed for residency program/ Total number of Faculty clinicians
PEDS or IM Residency Liaison (Chief Resident	0.9	

Source: BUMED Instruction 6300.19A "Primary Care Services in Navy Medicine"

APPENDIX D

AIR FORCE STANDARD ADJUSTMENTS FOR LEADERSHIP ROLES

Specialty and Role	FTE Adjustment
Family Health and Pediatrics	
Full Time GS or Contractor PCM	No Adjustment
Full Time Active Duty PCM	No Adjustment
AD assigned to a Unit Type Code (UTC) position	Up to 0.1 based on CMRP requirements
Flight Commander * < 5,000 Empaneled Beneficiaries	0.1
Medical Director ** < 5,000 Empaneled Beneficiaries	0.1
Flight Commander * 5,000 to < 10,000 Empaneled Beneficiaries	0.2
Medical Director ** 5,000 to < 10,000 Empaneled Beneficiaries	0.2
Flight Commander * 10,000 to < 15,000 Empaneled Beneficiaries	0.3
Medical Director ** 10,000 to < 15,000 Empaneled Beneficiaries	0.3
Flight Commander * 15,000 to < 20,000 Empaneled Beneficiaries	0.4
Medical Director ** 15,000 to < 20,000 Empaneled Beneficiaries	0.4
Flight Commander * ≥ 20,000 Empaneled Beneficiaries	0.6
Medical Director ** > 20,000 Empaneled Beneficiaries	0.6
Internal Medicine	
Full Time GS or Contractor PCM	No Adjustment
Full Time Active Duty PCM	No Adjustment
AD assigned to a UTC positon	Up to 0.1 based on CMRP requirements
Flight Commander * < 2,500 Empaneled Beneficiaries	0.1
Medical Director ** < 2,500 Empaneled Beneficiaries	No Adjustment
Flight Commander * 2,500 to 5,000 Empaneled Beneficiaries	0.1
Medical Director ** 2,500 to 5,000 Empaneled Beneficiaries	0.1
Flight Commander * > 5,000 Empaneled Beneficiaries	0.2
Medical Director ** > 5,000 Empaneled Beneficiaries	0.2
Flight Medicine	
Full Time GS or Contractor PCM	No Adjustment
Full Time Active Duty PCM	No Adjustment
Flight Commander * < 1,500 Empaneled Beneficiaries	0.1
Medical Director ** < 1,500 Empaneled Beneficiaries	No Adjustment
Flight Commander * ≥ 1,500 Empaneled Beneficiaries	0.1
Medical Director ** ≥ 1,500 Empaneled Beneficiaries	0.1
Pain Champion * **	
Pain Champion ≤ 15,000 Empaneled Beneficiaries	0.1
Pain Champion > 15,000 Empaneled Beneficiaries	0.2
Residency Programs	
Family Medicine Residency: 850 patients per pod, where each pod represents one staff family medicine provider and three residents along with the commensurate support staff. There is no empanelment expectation for the Program Director or Associate Program Director.	
Pediatric Residency: 950 patients per pod, where each pod represents one staff pediatrician and three residents along with the commensurate support staff. There is no empanelment expectation for the Program Director or Associate Program Director.	
Internal Medicine Residency: 550 patients per pod, where each pod represents one staff internal medicine physician and three residents along with the commensurate support staff. There is no empanelment expectation for the Program Director or Associate Program Director.	
The above empanelment targets for GME platforms may be adjusted via collaboration between the Program Director, consultant/specialty leader and the MTF Commander in situations of inadequate staff or limitations due to ACGME requirements.	

* Flight commander responsibilities and decrements will supersede those outlined in AFI 44-171, Patient Centered Medical Home Operations.

** The Medical Director decrement is based on responsibilities including, but not limited to, credentialing and coordinating performance-based privilege data, governing the facility's provision of care, supervising the professional services rendered by staff and residents, leading the development and implementation of patient safety, quality control, and peer review, as well as the orientation and ramp-up of newly assigned members of the medical staff.

*** Only one Primary Care Pain Champion will receive a decrement per MTF, and the decrement will be applied based on the total empanelment of the facility. It is intended to facilitate execution of the responsibilities of the position. Those responsibilities include, but are not limited to, communicating lessons learned, best practices and pain management policies to primary care clinics, oversee the education and training of pain management programs to clinic staff, monitoring and adhering to pain management policies, providing consultative and clinical support to PCMs, and relaying feedback and relevant issues, questions, and concerns to pain management program leadership.

Source: HQ USAF/SG3/5 Memorandum, "Air Force Medical Home (AFMH) Primary Care Manager (PCM) Empanelment Capacity Policy and Standard Decrement Guidance", dated May 18, 2018

APPENDIX E

NATIONAL CAPITAL REGION STANDARD ADJUSTMENTS FOR LEADERSHIP ROLES

Family Medicine and Pediatrics	**FTE Adjustment**
Non-Academic GS Providers	0
Active Duty Personnel (not KCF, CF or in Leadership Roles below)	0
Academic Staff (not KCF or CF)	0.2
Specialty Leader/Consultant/NCR Product Line Chair (< 75 billets)	0.3
Key Clinical Faculty (KCF), Core Faculty (CF), or Committee Chair	0.3
Associate Program Director	0.4
Program Director (< 15 trainees)	0.5
Specialty Leader/Consultant/NCR Product Line Chair (≥ 75 billets)	0.4
Program Director (≥ 15 trainees)	0.6
Service Chief (< 50 personnel)	0.5
Deputy Director	0.6
Service Chief (> 50 personnel)	0.6
Department Chief	0.8
Director For	0.9
Internal Medicine	**FTE Adjustment**
Non-Academic GS Providers	0
Active Duty Personnel (not KCF, CF or in Leadership Roles below)	0
Academic Staff (not KCF or CF)	0.2
Specialty Leader/Consultant/NCR Product Line Chair (< 75 billets)	0.3
Key Clinical Faculty (KCF), Core Faculty (CF), or Committee Chair	0.3
Associate Program Director	0.4
Program Director (< 15 trainees)	0.5
Specialty Leader/Consultant/NCR Product Line Chair (≥ 75 billets)	0.4
Program Director (≥ 15 trainees)	0.6
Service Chief (< 50 personnel)	0.5
Deputy Director	0.6
Service Chief (> 50 personnel)	0.6
Department Chief	0.8
Director For	0.9
Pain Champion (1 per MTF)	
Pain Champion ≤ 15,000 Empaneled Beneficiaries	0.1
Pain Champion > 15,000 Empaneled Beneficiaries	0.2

KCF: Key Clinical Faculty
CF: Core Faculty

Source: Director, NCR/MD, "National Capital Region Medical Directorate Provider Clinical Full Time Equivalent Standards", dated September 20, 2016

APPENDIX F

CRITERIA FOR MTF EMPANELMENT ASSESSMENT

MTFs will be assessed based on compliance with the criteria in Paragraph 11 and the strategies in Paragraph 13. The MTF will provide supporting documentation for a self-assessment and the Market or DHR will evaluate the MTFs on criteria including but not limited to the following:

Performance and DHA-IPM 18-001 and DHA-PI 6025.03 Compliance	**Assessment**
Average Days to Third Next 24-Hour (24HR) and Future (FTR) Appointments	
Percent Primary Care Leakage and Leakage to MTF or IMO ER/UC	
Satisfaction with Getting Care When Needed	
Number of Scheduled Face-to-Face and Virtual Encounters in CHCS or MHS GENESIS	
Provider Availability	
MTF Operating Days	
MTF Operating Hours	
HEDIS Quality Standards	
PCM and Other Staff Assessment	**Assessment**
PCMs Adjustments for Leadership Roles by MEPRS3 Clinic	
Total Number of PCMs assigned versus positions currently and monthly for next 12 months	
Projected Outbound (and when expected)	
Projected Inbound (and when expected)	
Calculated average MTF empanelment per PCM currently and monthly for the next 12 months	
Calculated average empanelment per PCM by MEPRS3 clinic currently and for the next 12 months	
NEMOs, IMAs and other Borrowed Labor including average availability per month	
PCMH Support Staff by MEPRS3 Clinic (including assessment of staff performing non-PCMH duties	
PCMH Integrated Specialty Staff	
Medical Management Staff	
Strategy Assessment	**Assessment**
Does the MTF comply with DHA-IPM 18-001 And DHA-PI 6025.03?	
Did the MTF implement temporary surge operations (specify how)?	
Did the MTF implement additional appointment capacity using NEMOs, MTF command staff, IMAs, etc. if available?	
Did the MTF implement a temporary halt to new empanelment except for ADSMs?	
Did the MTF shift empanelment to other MTF PCMH clinics with capacity or realign beneficiaries to other PCMHs?	
Did the MTF maximize enhanced access capabilities (CSSPs, secure messaging, TOL, NAL, integrated PCMH specialists)?	
Did the MTF promote use of secure messaging and TOL for asynchronous communication with PCMHs?	
Did the MTF stop providing care to space-available beneficiaries?	
Did the MTF promote the use of network UC clinics for self-limiting or minor acute illness?	
Did the MTF permit limited cross-booking to other teams with open appointments?	
Did the MTF reach out to the Services, enhanced Multi-Service Market or other nearby MTFs for manning assistance?	
Did the MTF arrange short-term extended primary care network referrals through the TRO for routine care?	
Did the MTF explore temporary gap-fill contract opportunities?	
Did the MTF attempt to execute short-term locum tenens or MQS contracts?	
Did the MTF coordinate with the TRO and MCSC on a Clinical Support Agreement for PCM resources?	
beneficiaries?	
Did the MTF offer voluntary disempanelment to non-ADSMs?	
Did the MTF offer to disempanel beneficiaries who live beyond drive-time standards?	
Did the MTF offer to disempanel non-users (no in-person or virtual appointment within 3 years)	
Did the MTF maximize enhanced access efforts?	
Did the MTF extend Primary Care Referrals to the network (in coordination with the TRO)	
Did the MTF coordinate with the MCSC and TRO?	
providers	
Did the MTF request a Health System Area Assessment report from the MCSC/TRO to validate the availability and capacity of civilian or other federal healthcare providers in the community?	
Capacity/Demand Assessment	**Assessment**
If there additional capacity with current resources?	
Is there unmet empanelment demand in the community through voluntary or involuntary means?	
Are there excess PCM resources in areas of no unmet demand who can be reallocated elsewhere in the direct care system?	

APPENDIX G

EMPANELMENT CAPACITY EXAMPLE

Example: Navy small bedded MTF with four primary care clinics, including an Internal Medicine clinic with an IBI of 2.9, and 6,400 "must see" encounters.

Remarks: MTF capacity is calculated based on each specialty's upper limit empanelment. MTFs are authorized to exceed the upper limit by specialty during surge operations or permanently if the MTF is able to meet access to care and other standards.

Step 1: Calculate Upper Limit Total and Average MTF Empanelment

Key	Primary Care Specialty	Assigned PCMs	Upper Limit	Calculation	Example
A	Family Medicine	13	**1,300**	Key A + Upper Limit	16,900
B	Pediatrics	7	1,300	Key B + Upper Limit	9,100
C	Internal Medicine (IBI 2.9)	6	950	Key C + Upper Limit	5,700
D	Operational/Flight Medicine (Assigned Unit Strength)	3	550	Key D + Upper Limit	1,650
E 1 & 2	Total Upper Limit Empanelment	29			33,350
F	**Average MTF Empanelment (Key E2 / Key E 1)**	**1,150**			
G	Average Annual Utilization Rate	4			

Step 2: Calculate MTF Capacity adjusting for leadership and other standard adjustments (Enclosure 3, Paragraphs 7-8)

Key	Standard Adjustment Type	Adjustment	Average MTF Empanelment (Key F)	Empanelment Adjustment
G	Six Percent for Approved Leadership Roles	0.06	1,150	69
H	Inpatient/GME Deduction	2.50	1,150	2,875
I	"Must See" Deduction; Credit = ((Visits/Avg Util Rate)/Avg MTF Empanelment)	1.39	1,150	1,600
J	MTF Total Capacity Adjustment			4,544
K	**MTF Upper Limit Capacity (Key E 2 - Key J)**			**28,806**

APPENDIX H

EMPANELMENT DISTRIBUTION

Example: AF MTF clinic with 8, 000 Empaneled Beneficiaries, 7 total PCMs (All Family Medicine) and no Inpatient/GME Mission

Remarks: 8,000 beneficiaries are empaneled to MTF X, based on the calculated capacity. The calculated capacity included an adjustment for approved leadership roles (see Appendix G). E The empanelment associated with leadership roles or any local MTF Commander or Director adjustments will be distributed to remaining PCMs.

Step 1:

Key	Variable	Number or Calculation	Example
A	Actual total clinic empanelment	Total # Prime and Plus Empaneled to MTF	**7,800**
B	Total Number of MTF PCMs assigned to the clinic	Number	7
C	Non-adjusted average empanelment per PCM	Row A/Row B	1,114
D	Number of MTF PCMs in leadership or local roles	Number (See Keys E-G below)	3

Step 2:

Key	Leadership Adjustments	Number or Calculation	Example	Non adjusted empanelment (from Key C)	Approved adjustment (From Key E, F or G)	OUTPUT Decremented Empanelment (Key C * From Key E, F or G)
E	Leadership Role 1 (Appendices B - E)	1 minus approved leadership adjustment	0.8	1,114	0.8	891
F	MTF Pain Champion (Appendices B - E)	1 minus approved leadership adjustment	0.9	1,114	0.9	1,003
G	Local MTF Commander adjustment	1 minus local adjustment	1.0	1,114	0.95	1,059
H	Total leadership adjusted empanelment	SUM (From Key E-H)	2,953			
I	Total patients to redistribute to remaining PCMs (From Lines E-G)	(Row C * Row D) - (Row H)	390			

Step 3:

Key	Empanelment to be Distributed to Remaining PCMs	Number or Calculation	Example
J	Number of remaining PCMs	Total less leaders (Rows B-D)	4
K	Number of remaining to be empaneled	From (Row I)	390
L	Number to empanel to each non-leader PCM	(Row K/Row J)	98

Step 4:

Key	Final Empanelment	Number or Calculation	Example
	PCM 1	SUM (Row C + Row L)	1,212
	PCM 2	SUM (Row C + Row L)	1,212
	PCM 3	SUM (Row C + Row L)	1,212
	PCM 4	SUM (Row C + Row L)	1,212
	PCM 5 (Leadership role 1)	Output from Row E	891
	PCM 7 (MTF Pain Champion)	Output from Row G	1,003
	PCM 8 (MTF Commander-approved role)	Output from Row H	1,059
	Total Empaneled	Match Row A	**7,800**