



DEFENSE HEALTH AGENCY
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FALLS CHURCH, VIRGINIA 22042-5101

DHA-IPM 17-003
June 20, 2018

MEMORANDUM FOR ASSISTANT SECRETARY OF THE ARMY (MANPOWER AND RESERVE AFFAIRS)
ASSISTANT SECRETARY OF THE NAVY (MANPOWER AND RESERVE AFFAIRS)
ASSISTANT SECRETARY OF THE AIR FORCE (MANPOWER AND RESERVE AFFAIRS)
DIRECTOR OF THE JOINT STAFF
DEPUTY ASSISTANT SECRETARY OF DEFENSE (HEALTH READINESS POLICY AND OVERSIGHT)
DEPUTY ASSISTANT SECRETARY OF DEFENSE (HEALTH SERVICES POLICY AND OVERSIGHT)

SUBJECT: Interim Procedures Memorandum 17-003, Accounting for Defense Health Program (DHP) Primary Care Managers (PCMs)

References: See Attachment 1.

Purpose. This Defense Health Agency-Interim Procedures Memorandum (DHA-IPM), based on the authority of References (a), (h), and (i), and in accordance with the guidance of References (b) through (g):

- Provides guidance on the establishment of use of uniform accountability and business rules for accounting of PCMs in Defense Medical Human Resource System-internet (DMHRSi).
- Is effective immediately and will expire effective 12 months from the date of issue.

Applicability. This DHA-IPM applies to OSD, the Military Departments (excluding the Coast Guard), the Office of the Chairman of the Joint Chiefs of Staff and the Joint Staff, the Combatant Commands, the Office of the Inspector General of the DoD, the Defense Agencies, the DoD Field Activities, and all other organizational entities within DoD (referred to collectively in this DHA-IPM as the “DoD Components”).

Policy Implementation. In accordance with Reference (e), and in support of high reliability organization principles to reduce variance through standard processes across the direct care system, uniform business rules will be used to calculate the number of Medical Treatment Facility (MTF) PCMs. The number of MTF PCMs will allow standard measurement of MTF enrollment capacity. This DHA-IPM identifies the required procedures to ensure accurate data retrieval from central systems that will allow for standard reporting of PCMs and enrollment. Operations Forces (line-funded providers) and their associated empanelment are captured in the

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methodology but will be excluded from the calculations of PCMs. Embedded specialist providers, such as behavioral health, physical therapy, and clinical pharmacists, assigned to Patient-Centered Medical Home (PCMH) clinics are also captured but will also be excluded in the calculations.

Responsibilities. See Attachment 2.

Procedures. See Attachment 3.

Releasability. **Cleared for public release.** This DHA-IPM is available on the Internet from the Defense Health Agency (DHA) SharePoint site at:

<http://www.health.mil/dhapublications>.



R.C. BONO
VADM, MC, USN
Director

Attachments:

As stated

cc:

Under Secretary of Defense for Personnel and Readiness

Assistant Secretary of Defense for Health Affairs

Surgeon General of the Army

Surgeon General of the Navy

Surgeon General of the Air Force

Medical Officer of the Marine Corps

Joint Staff Surgeon

Surgeon General of the National Guard Bureau

Director, National Capital Region Medical Directorate

ATTACHMENT 1

REFERENCES

- (a) DHA Procedural Instruction 5025.01, "Publication System," August 21, 2015
- (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) Title 32, Code of Federal Regulations, 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
- (g) TRICARE Policy Manual, April 1, 2015
- (h) DoD Directive 5136.01, "Assistant Secretary of Defense for Health Affairs (ASD(HA)),", September 30, 2013
- (i) DoD Directive 5136.13, "Defense Health Agency (DHA)," September 30, 2013

ATTACHMENT 2

RESPONSIBILITIES

1. DIRECTOR, DHA. The Director, DHA, will:

a. Assign responsibility for tracking the PCM empanelment measure, in collaboration with the Services, to the Director, Operations Directorate/J-3;

b. Support the Military Medical Departments by ensuring standard systems are in place to collect data and accurately measure the number of PCMs based on the approved definition; and

c. Ensure the DHA Medical Expense and Performance Reporting System (MEPRS) Office collaborates with the Services to resolve Service variance identified in paragraph 4 below.

2. DIRECTOR, OPERATIONS DIRECTORATE/J-3. The Director, Operations Directorate/J-3, will:

a. Monitor PCM empanelment results through the Tri-Service PCMH Advisory Board and Tri-Service Patient-Centered Care Integration Board (TSPCCIB);

b. Identify any required PCM definition modifications; and

c. Ensure PCM empanelment and capacity data retrieved from centralized systems are accurately updated on the Military Health System (MHS) Performance Dashboard.

3. SURGEONS GENERAL OF THE MILITARY MEDICAL DEPARTMENTS. The Surgeons General of the Military Medical Departments will:

a. Implement the standard business rules outlined in this DHA-IPM;

b. Ensure MTF Commanders and/or Senior Market Managers assign personnel appropriately using standard information systems;

c. Monitor performance data on the PCM empanelment measure;

d. Ensure providers are assigned with the correct Service Unique Occupation Code;

e. Minimize variation and seek standardization of the utilization of the DoD Occupation Codes; and

f. Provide the Medical Personnel Operations Group (MPOG) with a listing of inpatient facility Defense Medical Information System Identifiers (DMIS IDs) and their status with respect

to “small bedded facility, residency, or medical center” status at least annually. The MPOG is responsible for providing a collaborative and transparent forum for providing input to the Surgeons General-level governance body and the Medical Deputies Action Group on activities associated with military, civilian, contract manpower, and personnel requirements; sharing agreements; and business rules across the Services and DHA.

4. THE DHA MEPRS PROGRAM OFFICE. The DHA MEPRS Program Office will:

a. Ensure the Expense Assignment system Version IV Service Unique Occupation Codes for DoD Occupation Code Mapping Tables are sent to the Medical Data Repository (MDR); and

b. Collaborate with the Services through the MEPRS Sub-Working Group to resolve Service variance in the Service Unique Occupation Codes mapping to the standardized DoD Occupation Codes.

ATTACHMENT 3

PROCEDURES

1. OVERVIEW. This guidance supplements Reference (b) and establishes uniform accountability and business rules for capturing data in standard MHS information systems. The overarching objective of this guidance is to automate the capture and presentation of data related to PCMs and empanelment to allow standard measurement of MTF capacity. To the extent practicable, this guidance applies to all DHP-funded operations.

2. TIMELINE

a. Full compliance with this guidance is required within 12 months from signature for MTFs in multi-Service markets.

b. Full compliance with this guidance is required within 6 months from signature for all other MTFs.

3. GOVERNANCE

a. The direct care system's enrollment capacity and empanelment to each PCM will be monitored by the Tri-Service PCMH Advisory Board and the TSPCCIB.

b. The TSPCCIB will report to the Medical Operations Group.

4. DEFINING A PCM AND COUNTING METHOD

a. PCMs are those DHP-funded providers assigned to a MEPRS Code whose 3rd level identifier indicates a primary care product line (Family Medicine, Internal Medicine, Pediatrics, and Flight/Operational Medicine) that are not line-funded. Individuals working in subspecialties of internal medicine and pediatrics are not PCMs.

b. PCMs may be active duty, contractor, or General Schedule (GS) civilian.

(1) For active duty and GS civilian, assigned individuals will be counted; and

(2) For contract PCMs, individuals will be counted based on DMHRSi "available" reporting.

(3) PCMs are physicians, nurse practitioners, and physician assistants with an empanelment of one or greater.

(4) Residents/students will be captured in the methodology but not included in the number of PCMs.

c. Borrowed labor will not be included, but part-time labor will be.

d. Only empanelment to PCMs and appropriately identified residents/students will accrue to the MTF identified by the DMIS ID of the provider's assignment.

e. The PCM total for an MTF will be adjusted based upon facility scope and size and will be maintained by DMIS ID in a "deduction list." Deductions are mutually exclusive, that is to say each DMIS ID is only eligible for one category of deduction, so a medical center with Graduate Medical Education would only get -10.0:

(1) Minus 2.5 full-time equivalent (FTE) (-2.5) for a small-bedded MTF;

(2) Minus 5.0 FTE (-5.0) for an MTF with a residency program; and

(3) Minus 10.0 FTE (-10.0) for a medical center. DHP-funded operational providers (i.e., flight surgeons and undersea medicine) should be a minus 0.5 FTE for the MTF.

(4) All DHP-funded operational providers (i.e., flight surgeons, undersea medicine) will be counted as 0.50 FTE for the MTF; while counted as a 0.50 FTE, the DHA-funded operational providers will be empaneled to see the number of beneficiaries in the assigned unit.

(5) Non-enrolled visits will translate to an FTE deduction for each MTF by dividing the number of non-enrolled visits to primary care in the last rolling 12 months by the MHS average utilization rate, which will be furnished yearly by DHA. This will generate a number of "pseudo-enrollees" that is converted to an FTE equivalent (by dividing by 1,100), and then subtracted from the MTF's FTE denominator.

5. PROCEDURES FOR USE OF STANDARD SYSTEMS TO CALCULATE PCMs

a. 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) Flight and Operational Medicine PCMs 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.

6. COMPUTING EMPANELMENT PER PCM

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

(1) Those who exist within DMHRSi manpower file (to include those who do and do not report time).

(2) Those who completed at least one encounter in the month of measurement.

(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 EDIPN of the provider.

c. The providers and associated empanelment will be filtered using the criteria and deductions outlined above to resolve an empanelment per PCM by parent DMIS ID.

GLOSSARY

ABBREVIATIONS AND ACRONYMS

DHA	Defense Health Agency
DHA-IPM	Defense Health Agency-Interim Procedures Memorandum
DHP	Defense Health Program
DMHRSi	Defense Medical Human Resource System-internet
DMIS ID	Defense Medical Information System Identifier
FTE	full-time equivalent
MEPRS	Medical Expense and Performance Reporting System
MHS	Military Health System
MTF	Medical Treatment Facility
PCM	Primary Care Manager
PCMH	Patient-Centered Medical Home
TSPCCIB	Tri-Service Patient-Centered Care Integration Board