

REPORT DOCUMENTATION PAGE			Form Approved OMB No. 0704-0188	
Public reporting burden for this collection of information is estimated to average 1 hour per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to Washington Headquarters Services, Directorate for Information Operations and Reports, 1215 Jefferson Davis Highway, Suite 1204, Arlington, VA 22202-4302, and to the Office of Management and Budget, Paperwork Reduction Project (0704-0188), Washington, DC 20503.				
1. AGENCY USE ONLY (Leave blank)		2. REPORT DATE 17.May.99		3. REPORT TYPE AND DATES COVERED MAJOR REPORT
4. TITLE AND SUBTITLE TRICARE MARKETING ANALYSIS FOR THE 3 MEDICAL GROUP ELMENDORF AFB AK			5. FUNDING NUMBERS	
6. AUTHOR(S) CAPT BARNES WENDY L				
7. PERFORMING ORGANIZATION NAME(S) AND ADDRESS(ES) UNIVERSITY OF ALASKA ANCHORAGE			8. PERFORMING ORGANIZATION REPORT NUMBER	
9. SPONSORING/MONITORING AGENCY NAME(S) AND ADDRESS(ES) THE DEPARTMENT OF THE AIR FORCE AFIT/CIA, BLDG 125 2950 P STREET WPAFB OH 45433			10. SPONSORING/MONITORING AGENCY REPORT NUMBER FY99-108	
11. SUPPLEMENTARY NOTES				
12a. DISTRIBUTION AVAILABILITY STATEMENT Unlimited distribution In Accordance With AFI 35-205/AFIT Sup 1			12b. DISTRIBUTION CODE	
13. ABSTRACT (Maximum 200 words)				
14. SUBJECT TERMS			15. NUMBER OF PAGES 100	
			16. PRICE CODE	
17. SECURITY CLASSIFICATION OF REPORT	18. SECURITY CLASSIFICATION OF THIS PAGE	19. SECURITY CLASSIFICATION OF ABSTRACT	20. LIMITATION OF ABSTRACT	

Major Project Wendy Brown Dec/1998

I. Executive Summary

The 3rd Medical Group (3MDG) operates in a unique environment. The state of Alaska is geographically isolated, medically under-served throughout the state, devoid of health maintenance organizations (HMOs), and monopolistically aligned for specialty healthcare services. In addition to these factors, healthcare costs continue to rise while the Department of Defense (DOD) faces even slimmer budgetary authorizations. Given these challenges, the 3MDG must continue to provide quality care to approximately 40,200 beneficiaries who depend on them for their healthcare needs.

TRICARE is the DOD's response to this challenge. TRICARE is a healthcare program for members of the uniformed services and their families, survivors, and retired members and their families. TRICARE brings together the healthcare resources of each of the military services and supplements them with networks of civilian healthcare professionals to provide better access and higher quality service while maintaining the capability to support military operations.

TRICARE was implemented in Alaska on 1 November 1997. Since that time, the 3MDG has enrolled over 30,784 beneficiaries into the program with capacity left to spare. They have developed a civilian provider network in addition to teaming up with other Federal caregivers to form the Alaska Federal Healthcare Partnership (AFHCP). The implementation of TRICARE, thus far, has gone relatively smoothly for the 3MDG. Yet, the TRICARE program is far from being fully developed and exploited.

A thorough marketing analysis of TRICARE in the 3MDG setting can reveal opportunities and weaknesses upon which the program can be expanded and improved. This marketing analysis includes a scan of the 3MDG environment, TRICARE background as it applies to the 3MDG, population demographics, analysis of opportunity, competitive analysis, and finally, application of the aforementioned areas to grow into the next millennium.

This document will provide the 3MDG Executive Staff with a thorough analysis of TRICARE as it applies to their beneficiary population. It will also juxtapose the 3MDG with their surrounding competitors so that they can better understand the local healthcare environment.

19990610 058

**TRICARE MARKETING ANALYSIS
FOR THE
3 MEDICAL GROUP
ELMENDORF AIR FORCE BASE, AK**



**T R I C A R E
Alaska**

**WENDY L. BARNES
BA 656**

TABLE OF CONTENTS

I.	.....	Executive Summary
II.	.....	3MDG Environmental Scan
III.	.....	TRICARE Background
IV.	.....	3MDG TRICARE Assessment
V.	.....	Population Demographics
VI.	.....	Analysis of Opportunity
VII.	.....	Competitive Analysis
VIII.	.....	Bridge to 2000
IX.	.....	Glossary
X.	.....	Works Consulted
XI.	.....	Appendix

I. Executive Summary

The 3rd Medical Group (3MDG) operates in a unique environment. The state of Alaska is geographically isolated, medically under-served throughout the state, devoid of health maintenance organizations (HMOs), and monopolistically aligned for specialty healthcare services. In addition to these factors, healthcare costs continue to rise while the Department of Defense (DOD) faces even slimmer budgetary authorizations. Given these challenges, the 3MDG must continue to provide quality care to approximately 40,200 beneficiaries who depend on them for their healthcare needs.

TRICARE is the DOD's response to this challenge. TRICARE is a healthcare program for members of the uniformed services and their families, survivors, and retired members and their families. TRICARE brings together the healthcare resources of each of the military services and supplements them with networks of civilian healthcare professionals to provide better access and higher quality service while maintaining the capability to support military operations.

TRICARE was implemented in Alaska on 1 November 1997. Since that time, the 3MDG has enrolled over 30,784 beneficiaries into the program with capacity left to spare. They have developed a civilian provider network in addition to teaming up with other Federal caregivers to form the Alaska Federal Healthcare Partnership (AFHCP). The implementation of TRICARE, thus far, has gone relatively smoothly for the 3MDG. Yet, the TRICARE program is far from being fully developed and exploited.

A thorough marketing analysis of TRICARE in the 3MDG setting can reveal opportunities and weaknesses upon which the program can be expanded and improved. This marketing analysis includes a scan of the 3MDG environment, TRICARE background as it applies to the 3MDG, population demographics, analysis of opportunity, competitive analysis, and finally, application of the aforementioned areas to grow into the next millennium.

This document will provide the 3MDG Executive Staff with a thorough analysis of TRICARE as it applies to their beneficiary population. It will also juxtapose the 3MDG with their surrounding competitors so that they can better understand the local healthcare environment.

II. 3MDG Environmental Scan

Unlike most regions within the contiguous United States and Hawaii, Alaska is geographically isolated, medically under-served throughout the state, devoid of health maintenance organizations (HMOs), and monopolistically aligned for specialty healthcare services. As of one year ago, most community providers refused to accept the Civilian Health and Medical Program for the Uniformed Services (CHAMPUS) form of payment (now called TRICARE Standard), and instead balance billed. These circumstances make Alaska an interesting and fiscally challenging environment in which medical costs range from approximately 50-70% higher than continental U.S. prices. Please see the Appendix, Alaska Health Indicators, for a complete look at Alaska's healthcare environment.

Many Federal-sector health care providers, however, are influencing Alaska's medical environment. Forty percent of the state's population of 625,000 receives their medical care primarily through the federal government via Indian Health Services (IHS), Veterans Affairs (VA), U.S. Coast Guard (USCG), and all three branches of the military services (Army, Navy, and Air Force). Working together, these federal agencies established the Alaska Federal Health Care Partnership (AFHCP). Considering their collective opportunities, the Federal Partners believe their individual strengths can be coordinated to overcome many of the challenges presented by Alaska's unique healthcare environment.

The 3MDG recently completed a Joint Commission for the Accreditation of Healthcare Organizations (JCAHO) inspection and received an overall rating of 96% that extended accreditation for three years (through 2001). The accreditation will also apply to the new facility into which the 3MDG will be moving during February of 1999. A Health Services Inspection (HSI) was conducted in conjunction with the JCAHO visit by an Air Force Inspection team. The 3MDG received an overall "Excellent" rating with a 90%.

The 3rd Medical Group's (3MDG) vision and mission statements reflect the essence of the Air Force Surgeon General (AFSG), Headquarters Pacific Air Forces (HQ PACAF), and the 3rd Wing's (3WG) quality programs. They capture the geographic and demographic features of Alaska's size, weather, and location, as well as the very unique medical infrastructure of this vast state. The 3MDG's goals are aligned with the AFSG's pillars of medical readiness, TRICARE, healthy communities, and personnel. They are also aligned with HQ PACAF's operational taskings (OT) and the goals of the 3WG at Elmendorf Air Force Base (EAFB).

Vision: Delivering Federal healthcare for Alaska and beyond

Mission: Support the warrior mission--caring for people

Core Values: Integrity
Compassion
Patriotism
Professionalism

Goal #1: Strengthen Our Readiness Capability

HQ AF/SG Pillar #1: Reengineer Medical Readiness

HQ PACAF/SG OT1: Readiness Operation Support

3rd Wing Goal: Improve Air Sovereignty, Force Projection & Contingency Capability

Goal #2: Take Care of Our People

HQ AF/SG Pillar #2: Reengineer Medical Readiness

HQ AF/SG Pillar #3: Build Healthy Communities

HQ PACAF/SG OT3: Build Healthier Communities By Improving Population Health

3rd Wing Goal: Value, Respect and Take Care of People

3rd Wing Goal: Build a Continuous Improvement Culture

Goal #3: Implement and Maintain TRICARE Alaska

HQ AF/SG Pillar #2: Deploy TRICARE

HQ AF/SG Pillar #3: Rightsize

HQ PACAF/SG OT2: Build A Managed Care System That Integrates Quality, Cost, Access

3rd Wing Goal: Value, Respect and Take Care of People

Goal #4: Provide And Support Excellent Health Care And Promote Healthy Lifestyles

HQ AF/SG Pillar #4: Build Healthy Communities

HQ AF/SG Pillar #2: Deploy TRICARE

HQ AF/SG Pillar #3: Rightsize

HQ PACAF/SG OT3: Build Healthier Communities By Improving Population Health

HQ PACAF/SG OT4: Environmental Safety And Occupational Health/Flight Medicine

HQ PACAF/SG OT5: Provide A Sensitive & Responsive Health Care Atmosphere

3rd Wing Goal: Build Continuous Improvement Culture

3rd Wing Goal: Value, Respect and Take Care of People

Goal #5: Increase Scope And Effectiveness of Federal Health Care Cooperation In Alaska

HQ AF/SG Pillar #3: Rightsize

HQ AF/SG Pillar #2: Deploy TRICARE (Managed Care - Federal Agencies in Alaska)

HQ PACAF/SG OT2: Build A Managed Care System That Integrates, Quality, Cost, Access

3rd Wing Goal: Improve Safety In All Areas

Primarily, the medical group cares for approximately 6,500 active duty Air Force (ADAF) personnel on Elmendorf AFB and 2,100 active duty Army personnel on Fort Richardson, an adjacent Army post. Additionally, the 3MDG provides care for assigned dependents and retirees in the area bringing the total to 40,100. The hospital also functions as the VA hospital for the state, opening as a joint Department of Defense (DOD)/VA hospital in 1954.

Product lines provide approximately 92% of the care sought by beneficiaries in the area. A comprehensive array of medical and surgical care, primary care, and aerospace medicine care is available. For a complete list of services provided by the 3MDG, please see the Appendix under 3MDG Services.

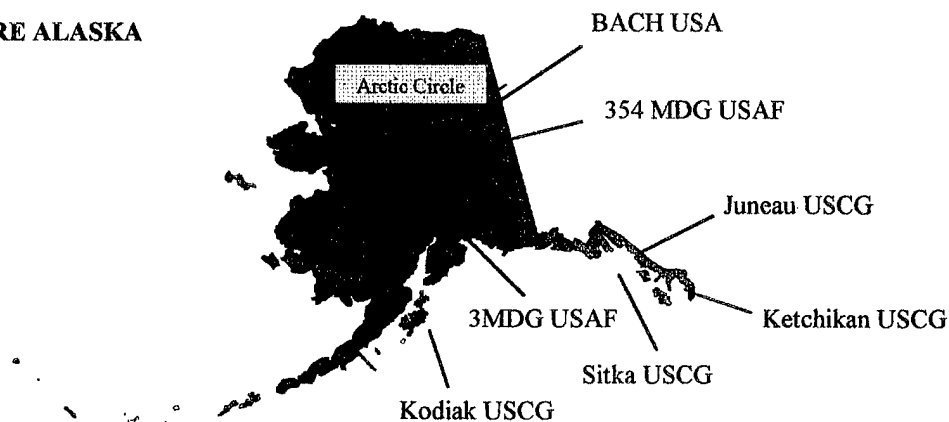
III. TRICARE Background

Rapidly rising healthcare costs and the closure of military bases, along with their hospitals, required the military to find new ways to provide healthcare. TRICARE is the Department of Defense's response to this challenge.

TRICARE is a health care program for members of the uniformed services and their families, survivors, and retired members and their families. TRICARE brings together the healthcare resources of each of the military services and supplements them with networks of civilian health care professionals to provide better access and high quality service while maintaining the capability to support military operations.

There are 11 TRICARE Regions in the U.S. plus TRICARE Europe, TRICARE Latin America and TRICARE Pacific. Each region has an assigned Lead Agent staff who is responsible for the military health system in that region. TRICARE Pacific (under which Elmendorf Air Force Base and the 3MDG fall) is managed administratively by the Region 12 Lead Agent Staff.

TRICARE ALASKA



TRICARE Alaska is composed of the above diagrammed units. Hawaii accounts for the remaining units within the Pacific Region 12. A complete list of TRICARE regions can be viewed in the Appendix, under TRICARE Summary.

TRICARE offers beneficiaries three choices for their health care: TRICARE Standard, a fee-for-service option that is the same as CHAMPUS; TRICARE Extra, a preferred provider option that saves money over Standard; and TRICARE Prime, where Military Treatment Facilities (MTFs) are the principal source of health care. More specifically:

TRICARE Prime is the managed care option offered by the Department of Defense. It integrates military and civilian health care into a single delivery system. Beneficiaries who choose this option agree to a one-year enrollment. Enrollees selecting this option choose a Primary Care Manager (PCM) to provide

or arrange for their healthcare needs. The TRICARE Prime option offers additional wellness and preventive care services.

TRICARE Extra is similar to TRICARE Standard but offers discounts to patients when they use TRICARE network providers (similar to a Preferred Provider Organization or PPO). This option allows beneficiaries to receive their care from civilian network providers at a reduced cost compared to TRICARE Standard. There are no claim forms to file—just a reduced copayment after satisfying the deductible. Beneficiaries may use a combination of the TRICARE Extra and Standard programs at any time, depending upon whether they choose physicians inside or outside of the network. There is no enrollment requirement for this program.

TRICARE Standard is a fee-for-service option that is the same as the standard CHAMPUS benefit offered to military personnel in the past. Beneficiaries using this option have the greatest choice of civilian physicians, but at a higher cost. The cost of having this choice includes a deductible, plus a percentage of subsequent charges, called copayment or copays. Enrollment is not a requirement to participate.

A detailed comparative chart outlining TRICARE's three options, a comprehensive list of frequently asked questions and answers, and a TRICARE brochure can be viewed in the Appendix, under TRICARE Summary.

IV. 3MDG TRICARE Assessment

At the very onset, Alaska was its own separate entity with no plans of implementing the TRICARE program. In 1996, however, military healthcare professionals laid out a vision for TRICARE in Alaska. They recognized the uniqueness of the Alaskan environment and made allowances for a plan. First and foremost, the Alaskan region would not receive a full at-risk managed care support contractor (like other TRICARE regions)--the only service to be provided was a Fiscal Intermediary to pay CHAMPUS claims. Thus, the first involvement of Foundation Health Federal Service (FHFS) came about to subcontract TRICARE Alaska's claims processing to Palmetto Government Beneficiaries Administrator (PGBA) out of Florence, SC.

Early Spring of April 1997 witnessed a shift in direction--FHFS became a *limited* partner in delivering the TRICARE Program. The Managed Care Support Contract for Regions 10 and 12 was amended to include Alaska. Foundation Health Federal Services major functions beginning 1 Oct 97 included:

- Enroll all CHAMPUS eligible beneficiaries who elect Prime
- Utilize Health Care Finders (HCF) to provide referral services outside of the Medical Treatment Facility (MTF) and authorize out of catchment area care
- Employ one Concurrent Review Registered Nurse (RN) and one Case Manager to serve all beneficiaries referred outside of the MTF with the exception of active duty personnel
- Provide a thorough credentials review of all network providers

Enrollment in TRICARE Prime received new emphasis in light of the impending implementation of enrollment-based capitation (EBC) budgeting and the enrollment based staffing model (EBSM) introduced by the Air Force Surgeon General at the 1998 Leesburg conference (an annual planning meeting for Air Force healthcare). These enrollment based models imply that future budgets and manpower will, for the most part, be based on the number of beneficiaries enrolled in TRICARE Prime. Each enrollee is "worth" a designated amount of money (derived from average healthcare expenditures). This standardized amount is then multiplied by the number of TRICARE Prime enrollees to determine the total budget received from the DOD. This revolutionary change in the Military Health Services resource allocation focuses 3MDG staff and leadership on Prime enrollment.

Managed Care TRICARE Transition Strategy at the 3MDG

The 3MDG established the TRICARE Implementation Team as an objective cross-functional body to develop the basic framework of healthcare delivery under TRICARE. Team members represent areas of clinical, administrative, finance and information systems to ensure all recommendations are tested and proven. The team will be dissolved

approximately one year after the implementation of TRICARE in Alaska (November 1998). The TRICARE Flight, within the 3MDG, monitors the performance measures and contractual requirements for the program.

Some of the goals, established by the team, for educating and marketing the TRICARE program to beneficiaries and providers are as follows:

- **Positive Awareness** - To be accomplished through newcomers orientation briefings, articles in the base paper and videos presented in patient waiting areas.
- **Educate Beneficiaries** - Teach patients the most effective way to receive their health care within the Alaska Region.
- **Educate Staff** - Teach 3MDG staff the best means of providing comprehensive, efficient, quality care to beneficiaries.

Two tools instrumental in educating both beneficiaries and staff are the TRICARE web site and TRICARE Learning Center (TLC). The TLC is a user-friendly department within the hospital that provides access to a plethora of information from CD-ROM based medical dictionaries to specific discussion groups via internet access. Both beneficiaries and medical staff are allowed to access Computer Based Instruction (CBI). This allows the beneficiary to move from a passive participant to an interactive participant; fostering ownership of their healthcare. Beneficiaries who are identified as "high risk" from the Health Enrollment Assessment Review Survey (initial survey given to all TRICARE enrollees) will be able to access specific CBI on such areas as smoking, obesity, cholesterol, and breast cancer prevention. Furthermore, staff education is enhanced by the TRICARE Ambassador Program that involves one member from every duty section within the 3MDG (for a total of 55 members). This group meets quarterly to discuss current TRICARE issues, which can then be passed onto other staff members or to patients.

Additional methods of education are covered via a comprehensive marketing effort. To date, these efforts include: weekly articles in the EAFB paper, strategically placed TRICARE flyers throughout the base, brochures given to each enrollee, community TRICARE briefing held each Friday for interested participants, comprehensive enrollment briefings for all Active Duty and retired members, mass mailings to *every* TRICARE eligible member in the area, quarterly newsletters, and target marketing to high expending CHAMPUS members enrolled in TRICARE Standard to show the merits of switching to Prime.

With the start of TRICARE on 1 November 1997, the 3MDG assigned four multi-specialty teams for beneficiary empanelment. Each multi-specialty team includes providers from Internal Medicine, Pediatrics, Obstetrics/Gynecology, and Family Practice. This provides beneficiaries with a full range of services.

The clinical and administrative staff is continually investigating innovative ways to maximize each Primary Care Managers (PCM) enrollment capacity without sacrificing quality care. Examples include:

Health Care Information Line and Self Care Manual: Offering the Health Care Information Line and Self Care Manual is a direct response to meeting customer needs for convenience and information. The Taking Care of Yourself book is thoroughly explained to each enrollee. If the patient calls for information, an RN, in conjunction with the patient's self care manual, can be used to answer questions. The caller can be forwarded to his or her PCM at any time during the conversation if they are not satisfied with the level of care rendered.

Prime Care Program: Prime Care is a health care advisor program within the 3MDG. It is staffed by RNs. The duties of Prime Care are to educate patients regarding minor illnesses and injuries, as well as triaging and booking all same-day (urgent) appointments for each of the four Primary Care Teams. Research from other Military Treatment Facilities indicates that this program scores high in customer satisfaction ratings. It is also a cost effective program.

New Medical Facility: A new 110-bed multistory Medical Treatment Facility will be completed the spring of 1999. In the present building, providers are limited to one exam room that also serves as the provider's office. In the new facility each provider will have their own office in addition to two exam rooms. According to previous studies conducted by the 3MDG, this should increase individual provider efficiency by 28 percent.

Total PCM capacities will be continually monitored and adjusted depending upon patient mix, number of providers assigned to the 3MDG, and facility limitations.

Civilian provider networks will play a crucial role in absorbing any overflow of Prime enrollees and for providing some specialty care. Currently, 207 civilian providers have signed Memorandums of Understanding (MOUs) with the 3MDG to supplement TRICARE. All of these providers are given a thorough briefing and policy packet on the specifics of the TRICARE Program. This network still is not complete, however. Areas for improvement include: ambulatory care, ophthalmology, nephrology, orthopedic surgery, pediatrics, cardiothoracic surgery, oral surgery, and durable medical equipment vendors. Beneficiary population demographics (discussed in Part IV of this report) will be frequently reviewed to ensure the civilian provider network has an adequate provider mix and capacity to meet the needs of 3MDG beneficiaries. The Alaska Federal Health Care Partnership (AFHCP, discussed in detail in Part VI) will play a crucial role in filling the primary and specialty care shortfalls of the 3MDG, as well.

As mentioned previously, with capitation based budgeting on the horizon, the goal of the 3MDG over the next ten years will be to enroll most CHAMPUS eligible beneficiaries into TRICARE. Without high enrollment numbers, the budget could be considerably smaller than current annual appropriations from DOD. Please see the Appendix, under Capitation Budgeting, for a breakdown of the 3MDGs annual budget.

BUILDING HEALTHIER COMMUNITIES BY EMPLOYING PREVENTIVE STRATEGIES

There are no regional health plans operating in the state of Alaska. TRICARE Alaska is the only such plan anticipated for the foreseeable future. Columbia Health Systems is attempting to form loose associations with the health care workers and clinics in some of the outlying communities, and has formed an Independent Practitioner Association (IPA) for the physicians with whom it has affiliations. Providence Health Systems has taken a different attack by providing management and financial support to several smaller community hospitals and local specialty clinics and hospitals. A rudimentary network has begun. (Further analysis of the local healthcare network can be referenced in Part VII of this report). Both of these efforts are likely to expand in the future. With the large number of TRICARE beneficiaries in the Anchorage area, however, TRICARE Alaska will be the dominant health plan in the state for at least five years. Consequently, TRICARE must take the lead in developing and implementing programs for healthier communities common to network health plans promoting wellness. Preventative programs will become a large "selling point" for the TRICARE program.

The ultimate goal with preventative programs is to reduce the demand for episodic care, shift from disease to health management, and reduce the load on the current system. A secondary, but important effect of any successful prevention practice is a reduction in lost personnel days due to preventable disease or illness. Such reductions result in corresponding improvements to the readiness posture of the 3WG and Elmendorf AFB as a whole.

A concentrated effort of both manpower and money will be required to make preventative services work to the 3MDG's benefit. By using health risk assessments (HEARS, given to each enrollee, see the Appendix for a complete HEARS Survey), personal interviews, chart reviews, patient questionnaires, and aggregate data coding summaries, the 3MDG can determine which areas preventative efforts should first be directed. Early efforts should be directed toward those processes that can be affected quickly such as occupational and recreational injuries. Second in priority should be those diseases and injuries which are preventable, and are causing significant morbidity and mortality. Lastly, concentration should be focused on high cost conditions among the patient population.

The 3rd Medical Group's plan for integrating preventative practices into the healthcare delivery system over the next ten years must begin right away, and progress logically and systematically. A foundation already exists for preventative medicine through the Health Promotions Department and the Put Prevention Into Practice (PPIP) reviews. A preventative medicine practices action group was formed to assess and continually monitor the 3MDG's status.

As it will not be feasible to initiate at once all of the preventative health services the beneficiary population will need over the next ten years, a prioritized list will be necessary. As returns are realized, additional programs can be instituted. The use of an

all inclusive health risk data form on the patient's medical record will Primary Care Management teams to identify and intervene with those individuals and families which might carry more immediate need for one-on-one intervention. It will be the responsibility of the preventative practices monitor on each TRICARE Primary Care Management Team to continuously evaluate the needs of the enrolled population, and alert the members of the team and the Preventative Services Coordinator of changing needs or newly identified areas in which to concentrate their efforts. Wherever possible, community resources should be used or shared. Outreach programs such as mobile work site evaluations and education should be used. If the population will not come to the service, take the service to the place it is needed.

Recurrent patient education in the form of posters, handouts, personal and group interviews will serve to involve the patient in the process. Patients must be actively involved in their own health and in the reduction of injuries and diseases. Self-help and awareness are two key elements that must be present if a return is to be anticipated from an investment in preventative services. Patients must have a mechanism where they can request and receive specific information and education on a particular disease process with an emphasis on preventing either the disease/ injury, or on preventing comorbidity or further complication.

Prevention cannot be thought of as a group of individual programs, or a place one sends the patient to get educated or preached to about an ailment. The Executive leadership of the 3rd Medical Group must understand the necessity of investing in a culture of prevention. Fostering such a culture enhances the benefits of TRICARE to the beneficiary. A healthy community has less need for expensive medical intervention.

V. Population Demographics

Current customers of the 3rd Medical Group amount to 40,200 active duty, dependents, and retirees and their dependents. A potential customer base includes additional beneficiaries from the U.S. Coast Guard who reside outside of the catchment area, but for whom the 3MDG is the closest and potentially the least expensive option for specialty care. The majority of the patient populations needs revolve around having a fit and ready force, and sufficient medical services to deploy in support of either a war time contingency or operations other than war. The latter is clearly on the increase and is predicted to continue to make demands upon the medical delivery system. The Alaska Federal Health care Partnership has the potential of purchasing excess capacity from the 3rd Medical Group for some of its member beneficiaries, but there may be very little available to sell if enrollment in TRICARE Prime goes as planned. A summary of current and potential customers includes:

CURRENT CUSTOMERS

Commanders
3WG Personnel
Various PACAF Personnel
3MDG Staff
Public Officials
Veterans Affairs
Civilian Providers/Facilities
Department of Defense Beneficiaries
DOD Facilities Outside the 3MDG Catchment Area

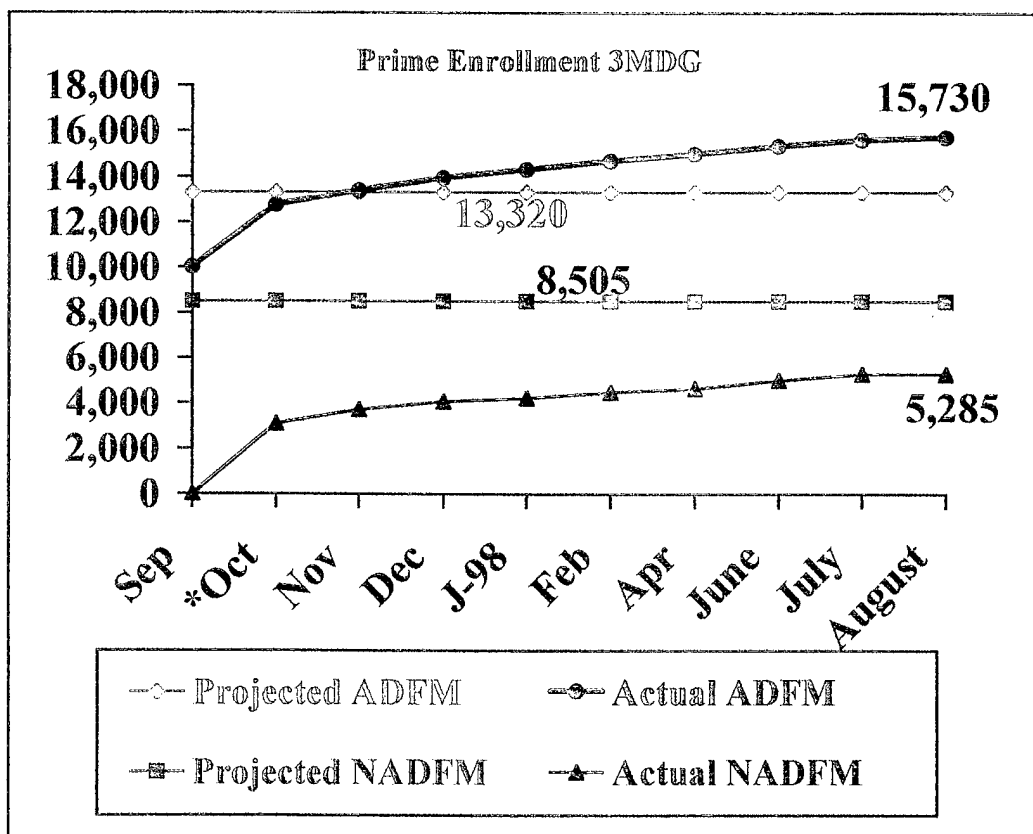
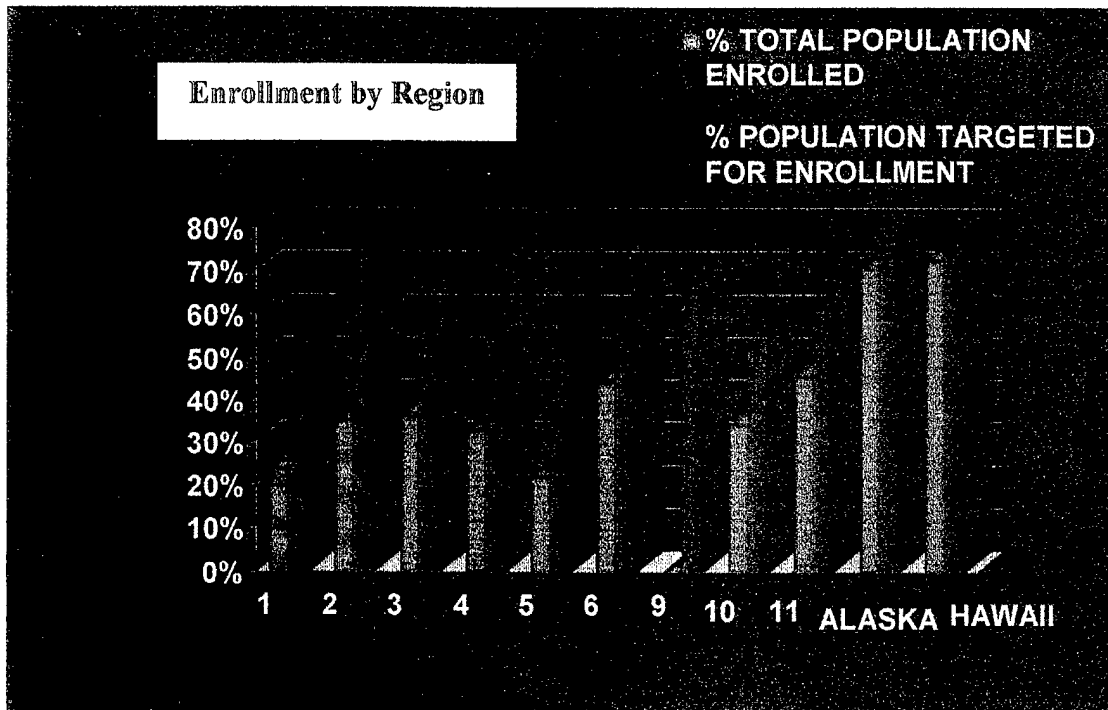
POTENTIAL CUSTOMERS

Other State and Federal Employees
Beneficiaries of Federal State Prisons
Native Americans (as part of Alaska Federal Health Care Partnership)

Beneficiary demographics drive the TRICARE program. A Defense Management Information System report published in March of 1998 provided the following breakdown of the 3MDG's population by age and beneficiary category. For a historical breakdown, please see the Appendix under Demographic Trends.

Age	Active Duty	AD Spouse	AD Child	AD/Dep Other	Retired	Ret Spouse	Ret Child	Other	Total
0-6	0	0	3,653	0	0	0	220	0	3,873
6-17	0	14	6,223	0	0	0	2,261	0	8,498
18-19	244	114	364	0	0	1	689	0	1,412
20-22	1,471	538	233	0	1	3	545	0	2,791
23-44	7,746	5,169	6	2	983	1281	63	0	15,250
45-64	329	272	0	38	3,212	2,889	1	1	6,742
>65	0	0	0	24	822	749	11	24	1,630
TOTAL	9,790	6,107	10,479	64	5,018	4,923	3,790	25	40,196

An exceptional market penetration of active duty and CHAMPUS eligible beneficiaries resulted in an unprecedented 96 percent enrollment in TRICARE based upon the established projection of 13,320. This exceeded the 3MDG's two-year goal within 8 months, while outpacing other TRICARE Regions as depicted below!



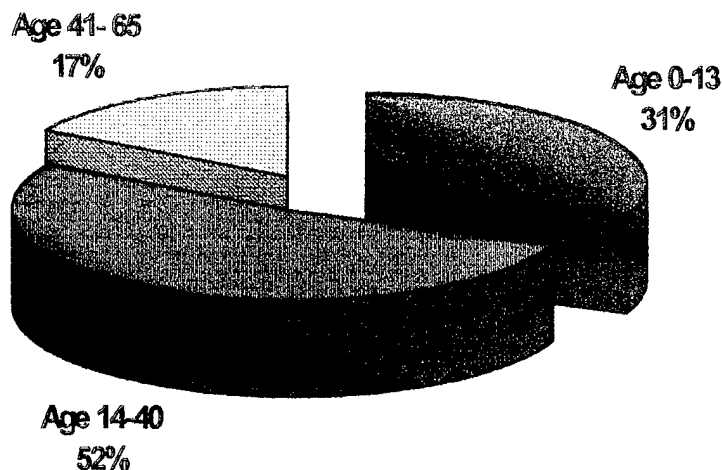
Prime enrollment continue to be strong with total enrollment as of August 1998 reaching 30,784 (see bottom graph on previous page).

With 100% of active duty personnel enrolled and 99.9% of active duty family members enrolled, the CHAMPUS eligible retiree population is the only beneficiary category with opportunity for improved enrollment. The previous graphs depict the great success the 3MDG has reaped from their TRICARE marketing efforts. Please see the Appendix (Enrollment Figures) for additional enrollment figures by clinic and empanelment team. The projected enrollment for CHAMPUS eligible retirees and their family members was based upon enrollment response in other TRICARE Regions. Based upon feedback during marketing sessions conducted by the 3MDG with future enrollees, however, they concluded that Alaska's retiree population is somewhat different than the norm.

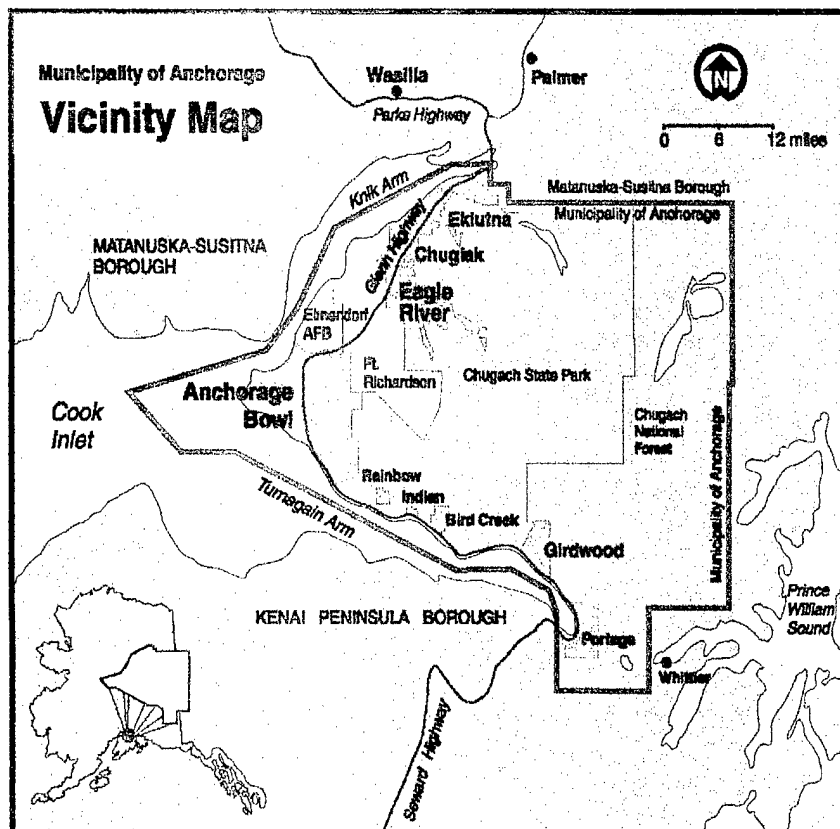
Many CHAMPUS eligible retirees who remain in Alaska are offered and often elect to use other health insurance provided by their new employers. Therefore, there is little incentive to enroll in Prime because the coverage is often overlapping. It is not the 3MDGs intent to lure this ghost population back into the TRICARE program. The goal is to identify and enroll those who are using TRICARE Standard (previously called CHAMPUS) and better manage their health care.

To make sound business decisions the 3MDG must have a comprehensive understanding of the ages, gender, location, and acuity of those enrolled in Prime. A study conducted in January 1998 revealed no statistically significant difference from clinic to clinic status when reviewing gender. Seventeen percent of the Prime population is 41 to 65 years in age, 52 percent are 14 to 40 and 31 percent are 0 to 13.

**Prime Population Age
Breakdown**



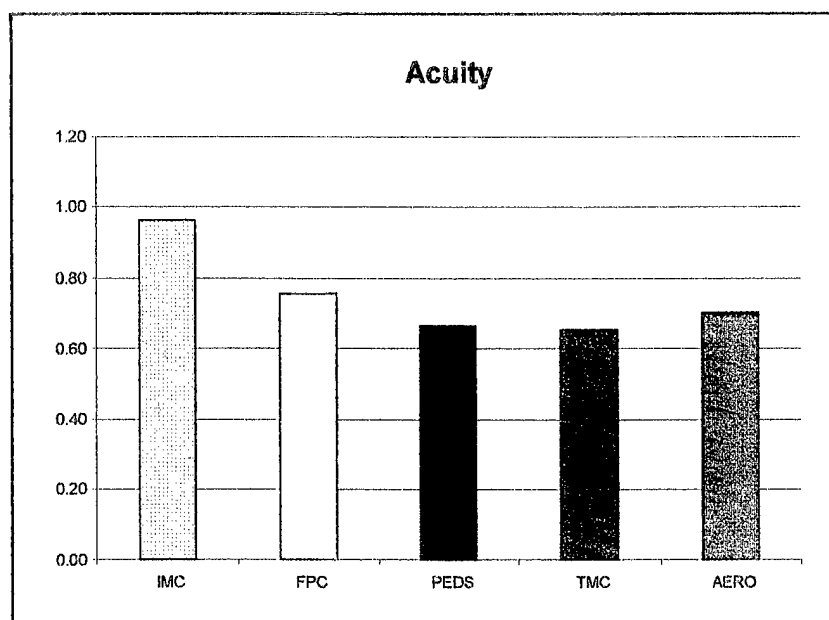
Over 42 percent of the Prime enrollees live on Elmendorf AFB and Ft Richardson. Another 40 percent live within the Anchorage and Eagle River city limits. The remaining 18 percent live within a one-hour drive from the 3MDG. More specifically, beneficiary population disbursement can be viewed by zip code. This can be extremely helpful in locating temporary preventive outreach programs and in developing a primary care network in the civilian community allowing the 3MDG to provide convenience of location for customers.



As mentioned previously, a large percentage of future budgets will be based on the capitated funds associated with the Prime enrollees. More specifically, the per member per month funding will be based on enrollee equivalent lives - which is enrolled prime beneficiaries adjusted for demographic factors to account for differences in health care requirements. The equivalent lives factors were developed from the FY 96 Annual Beneficiary Survey. These factors reflect the overall *eligible* population and are not specific for *actual* enrollees. The equivalent lives factors include demographic attributes such as age, sex, marital status, beneficiary category, and military department

Usage Expressed as Equivalent Lives (Source: FY96 Annual Beneficiary Survey)									
FEMALE									
Age/Status	0-1	2-11	12-17	18-44 Sing	18-44 Mar	45-54	55-64	65-74	75 up
Ben Group									
AD- Navy				1.04	0.85				
AD- AF				0.94	0.79		1.20		
AD- Army				1.29	1.11			1.35	2.07
AD Dependent	1.63	0.47	0.74	0.78	1.04	1.11	1.81		
Ret Dependent				0.72	0.81	0.98	1.04		
Retired Navy									
Retired AF				1.23	1.29	1.34	1.41	2.09	2.46
Retired Army									
MALE									
Age/Status	0-1	2-11	12-17	18-37 Sing	18-37 Mar	38-54	55-64	65-74	75 up
Ben Group									
AD- Navy				0.56	0.45	0.62			
AD- AF				0.46	0.42	0.55	0.66		
AD- Army				0.57	0.53	0.68		1.39	
AD Dependent	1.71	0.60	0.64	0.32	0.60	0.80	0.87		
Ret Dependent				0.42	0.30				
Retired Navy						0.91	0.94	1.41	2.04
Retired AF				1.61	1.25	0.81	1.03	1.60	1.99
Retired Army						1.09	1.09	1.65	2.34

affiliation. This chart (previous page) represents the equivalent lives factors used for the FY 98 Enrollment Based Capitation (EBC) model. These factors were calculated by identifying the average adult as having a utilization factor of one. Using a locally built model, the 3 MDG's March 1998 Prime enrollment data was applied to determine the total enrollee equivalent lives for their patient population. The results indicated an average acuity for a Prime enrollee of 0.7, far below the Military Health Services average of one. The graph below depicts the average acuity as calculated for individual clinics within the 3MDG (Internal Medicine, Family Practice, Pediatrics, Therapy, and Aerospace Medicine).



The March study coincides with collected demographic data that indicates a young and healthy patient population. This data can then be applied to calculate the capitated budget. As an example, the Prime population in March of 1998 was 27,828. The total enrollee equivalent lives for the same month equated to 20,479--multiplying this number against the 3MDG's per member per month rate would result in an Enrollment Budget under EBC for both operations and staffing. The EBC and EBS models will be implemented by FY 2000 (directed by the AF Surgeon General's Office) which will directly impact future staffing and budget decisions. To date, there is insufficient detail from the HQ PACAF Surgeon General on how the particulars of Category 3 monies (money for capital projects) will be calculated under EBC for the 3MDG.

VI. Analysis of Opportunity

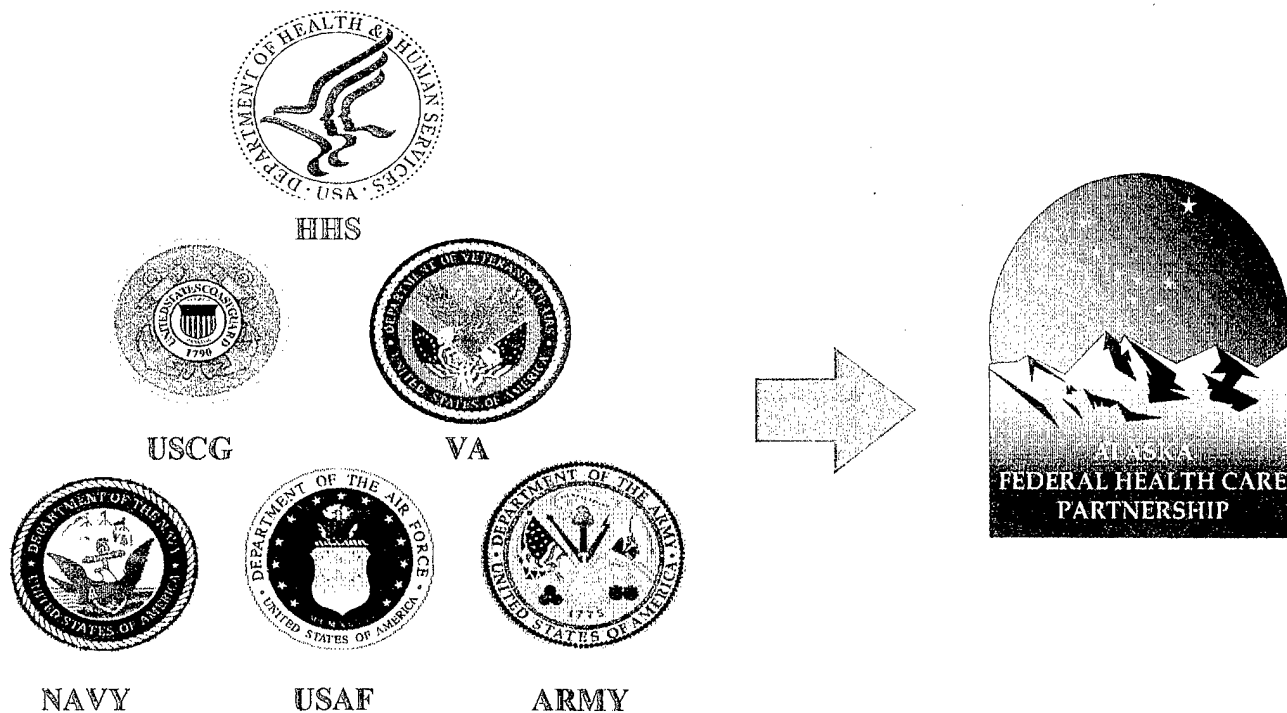
The geographic and limited medical environment of Alaska makes it difficult to provide low cost healthcare. However, the talent and proactive nature of the 3MDG staff coupled with the Alaska Federal Health Care Partnership provide the winning solution to overcoming these formidable challenges. The following diagram provides a brief review of the Strengths, Weakness, Opportunities, and Threats (SWOT) which have the greatest potential to impact the delivery of healthcare to 3MDG beneficiaries.

STRENGTHS 1. Young, healthy enrolled population 2. Strong primary care base 3. Low retiree/Medicare population 4. Strong leadership and excellent staff 5. Marketing and educational programs 6. Alaska Federal Health Care Partnership 7. Managed care leaders in Anchorage area 8. Third Party Collection Program 9. Excellent community relations	WEAKNESSES 1. Very expensive civilian care 2. Overseas Clearance Program 3. Limited civilian medical support 4. Some specialties/subspecialties completely unavailable within the state 5. Lack some specialties within the civilian network 6. Stress of extreme cold and darkness during winter months 7. High staff/beneficiary turnover 8. CHAMPUS Reimbursement
OPPORTUNITIES 1. Alaska Federal Health Care Partnership 2. Telemedicine/Teleradiology 3. VA/ANMC CHAMPUS certification 4. New facility 5. Resource Sharing 6. Aeromedical Evacuation 7. Put Prevention Into Practice 8. Information Systems 9. Medicare Subvention 10. Utilization Management	THREATS 1. Personnel drawdown 2. Budget constraints 3. Deployments 4. Policies developed and implemented by the TRICARE Management Activity which do not apply or take into consideration the uniqueness of Alaska

Key Strengths

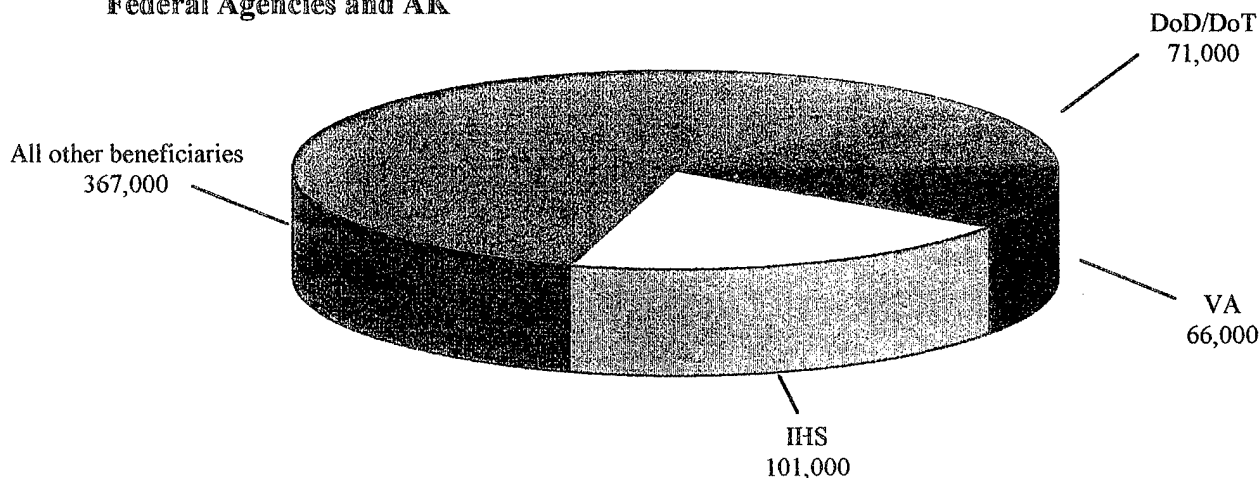
1. Alaska Federal Health Care Partnership (AFHCP) – smart way of doing business:

The medical activities of the Department of Transportation, Department of Defense, Veteran's Administration, and the Indian Health Service have enjoyed a mutually supportive relationship in Alaska since World War II. Alaska's tremendous geographic size, few providers, deficient lines of communication, and travel constraints create an environment conducive to interagency beneficiary support.

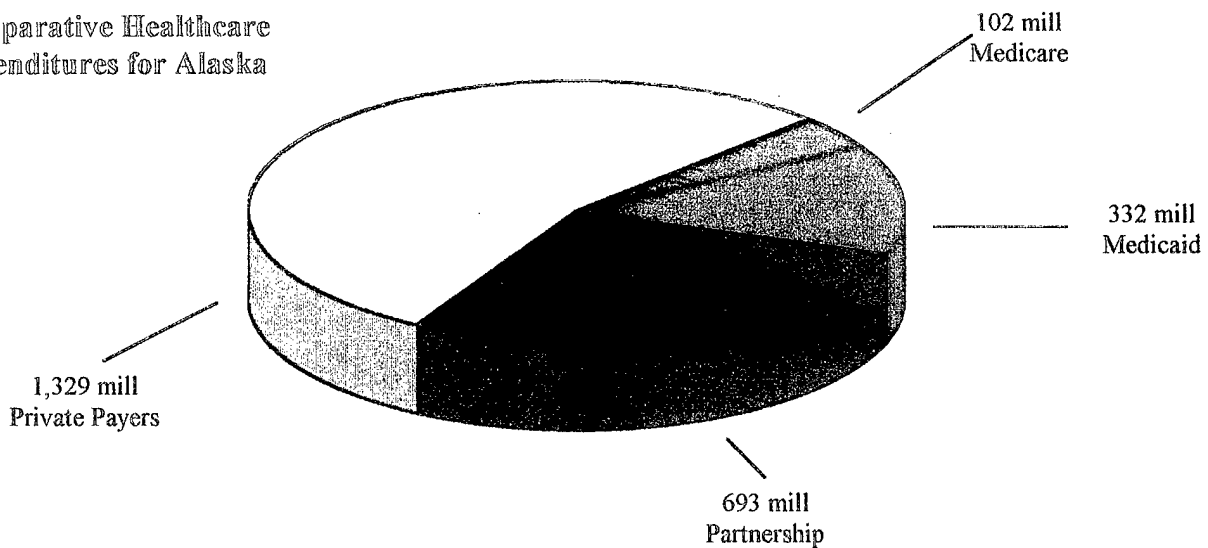


Individually, each facility represents a small beneficiary population lacking the power to obtain discounted prices for healthcare from civilian sources. When combining resources, the beneficiary population accounts for 40 percent of the state's population (at 238,000 federal beneficiaries and AK State population of 615,000—see below graph), 490 total beds, \$693 million in combined expenditures (see graph on top of page 19), and 12 medical facilities. This combined network provides an added source of care into which TRICARE can send referrals. This gives federal agencies leverage to be major players in the state's healthcare environment, and also allows them to share talents and experience to improve patient care.

**Beneficiary Breakdown for
Federal Agencies and AK**



Comparative Healthcare Expenditures for Alaska



The Partnership continues to capitalize upon its strong interagency relationships. The military, IHS, and VA facilities have formalized many previously informal agreements. By working together, the Partnership has markedly lowered the cost of care. For details on healthcare savings and cost avoidance, please refer to the Partnership's Annual Report and savings graphs under AFHCP in the Appendix. The goals of the Partnership include:

- Integrate Federal healthcare throughout Alaska
- Cut bureaucracy that prevents serving patients effectively
- Ensure patients have access to the right kind of care, at the right time, in the right place

The Partnership plans to meet these goals by lowering costs and increasing access to services in three ways:

- Joint procurement to allow leveraged purchasing
- Sharing of medical equipment
- Sharing of staff and providers

The combined efforts of the Alaska Federal Health Care Partners have saved an estimated **6.9 million** taxpayer dollars over the past three years. Approximately **4.3 million dollars** in expenditures were avoided in 1997 alone. The most significant outcome, however, is that as the Partnership matures and gains experience, the savings will continue to mount through resource sharing and joint procurement activities.

The AFHCP has received numerous accolades to include: recognized as the Federal Employee Team of the Year for 1997, recipient of the Dr. Kizer Alliance Award, recipient of Vice President Gore's Hammer Award for reinvesting government in 1997, and cited twice for excellence in healthcare delivery by *U.S. Medicine*.

2. Managed Care Leaders in the Anchorage Area:

The implementation of the TRICARE program empowered the 3MDG to introduce the first Health Maintenance Organization (HMO) in the Anchorage area. Before the 3MDG opened the doors, they realized the importance of provider continuity and timely access to quality medical care.

Leaders in provider continuity: Assigning Prime enrollees to a "team" of healthcare providers allowed 3MDG providers to establish relationships with their beneficiaries. The Central Appointments staff makes every effort to schedule appointments with the same provider each time a beneficiary needs to be seen. In fact, a March 1998 study revealed that Prime enrollees saw the same Primary Care Manager 70% of the time and they saw a provider from their team 90% of the time.

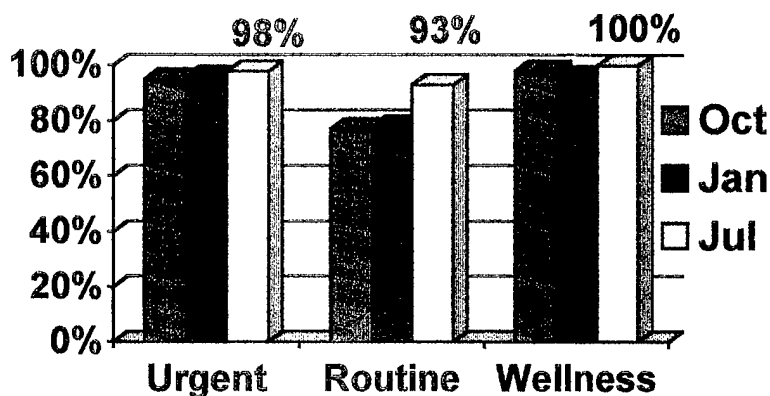
Access to Timely Care: Before the implementation of TRICARE Prime, access to timely healthcare was a prominent issue. As a new HMO, the 3MDG's guarantee is Urgent care within 24 hours; Routine care within 7 days; and Wellness and Specialty care within 30 days. Has the 3MDG delivered on this promise? Three months were selected in 1998 to demonstrate the continued improvements the 3MDG has made in access since the implementation of TRICARE. The following graph illustrates the percentage of appointments that met the access standards for each category of care.

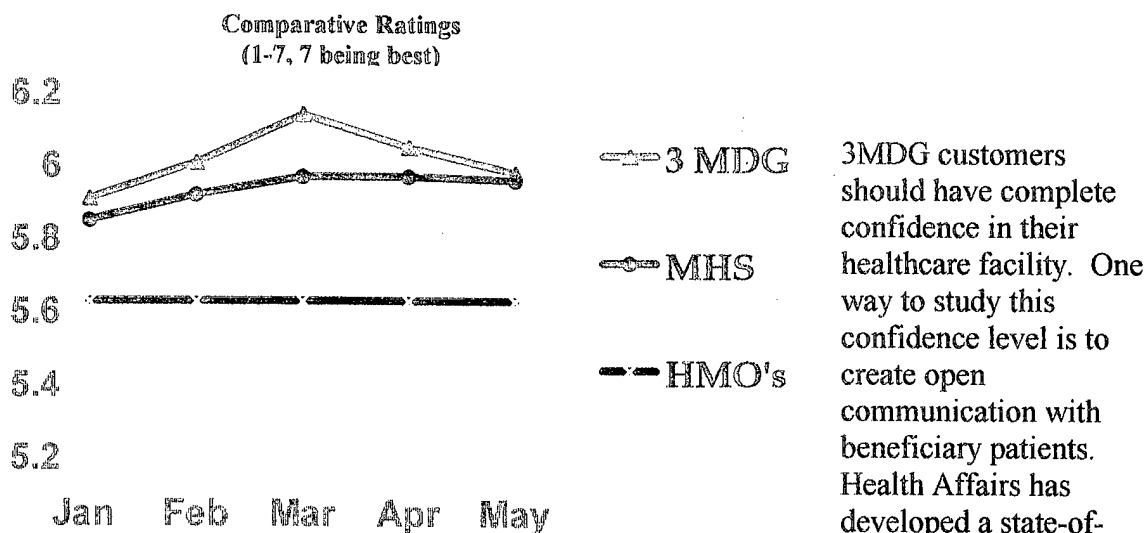
Months which reveal less than 100% indicate that the 3MDG was unable to offer an appointment with the team in

which the beneficiary was enrolled while complying with established access standards.

Appointments were available, however, but they were made with other teams. The 3 MDG provides 97% of all specialty care required by its Prime enrollees. The small number of specialties not provided is offered by the civilian provider network or other Military Treatment Facilities through

the Air Evacuation process. While tools for measurement of specialty care are still in the "developmental phase", this study indicates that the 3MDG is meeting beneficiary needs in a timely manner through the use of TRICARE.





performance monitoring system. Each month a random sample of patients who were seen at the 3MDG is sent Customer Satisfaction Surveys. (Please see the Appendix under 3MDG Survey to view the survey). The feedback provided by patients helps the 3MDG to make changes in processes and policy to better serve enrollees. The survey results also allow comparison to other Military Treatment Facilities in the Military Health System as well as to civilian Health Maintenance Organizations. Timely completion of these surveys is important. Even more critical, however, is the specific information the patients provide. Detailed information allows the 3MDG to be more precise in addressing or correcting processes and policy. According to these survey results, when considering accessibility, cost, continuity of care, and the preventive services offered, the 3MDG demonstrates leadership not only in the Military Health Services but in the civilian sector as well (as illustrated by the above graph).

Prominent Weaknesses

Some problems and weaknesses faced by the 3MDG are shared by most MTF's. Issues such as infrastructure and outdated computer hardware will be resolved with the occupancy of the new MTF. However, another area of concern pertains to staff turnover rate. Part of "keeping the promise" to our enrollees is initiating and maintaining provider continuity. Continuity of care is crucial for maintaining patient satisfaction under TRICARE Prime. Understandably, when MTFs are compared to the civilian sector they do not typically fair as well due to approximately one third of the Primary Care Managers turning over every year with military moves.

Alaska's distance from the Continental U.S. (CONUS) and weak specialty to population ratio presents other problems. Travel time to CONUS for referrals to larger facilities is at least three to four hours by air to Madigan Army Medical Center or David Grant Medical Center. Other MTFs would require an additional days-flying time. Aeromedical Evacuation support continues to be strong by providing an alternative means for acquiring timely specialty care for our beneficiaries. However, the overseas theater may soon face the same draw-down of services experienced by CONUS military bases, thus reducing the frequency of missions. A cost analysis is performed for each air evacuation mission taking into consideration access, cost, and quality. Under EBC, it is still unclear if and when a transfer of payment would be made from the referring hospital to the destination hospital within the direct care system. When more precise data becomes available, the added cost to the 3MDG will be considered in determining if care should be purchased in the local civilian community or by paying for a DOD provider to bring their respective services to the 3MDG.

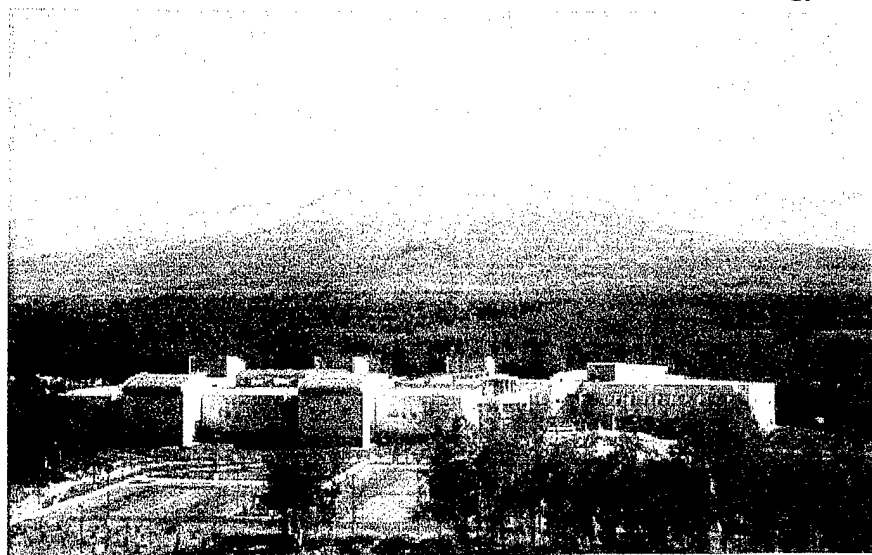
Overseas medical clearances are another concern. Alaska's harsh and extremely long, dark winters, and its distance from CONUS, present many stresses that can create or exacerbate emotional problems. Mental Health is one of the 3MDGs largest TRICARE referral expenses. Family members who arrive in Alaska with emotional/depressive disorders may end up requiring lengthy inpatient stays in CONUS facilities.

Alaska has fewer healthcare providers per capita than any other state except Mississippi. This scarcity provides for a largely non-competitive environment. The prevailing rates for many healthcare services may run up to 70 percent higher than the national average, yet CHAMPUS reimbursement rates do not accurately reflect this higher cost. As mentioned previously, Anchorage Health Indicators can be viewed in the Appendix. Despite recent legislative action which aligned CHAMPUS Maximum Allowable Charge (CMAC) rates with Medicare (out of 250 codes below Medicare, all have gone up to match Medicare except 6) many providers in this area are still reluctant to accept CMAC as payment in full. Low levels of managed care activity allow local physicians to demand higher reimbursements on a fee-for-service basis.

Key Opportunities

1. **New Facility:** The DOD/VA joint medical hospital is expected to open in March of 1999. This new 110-bed facility will be a showcase of the latest in modern medical technology.

In the 3MDG's present building, providers are limited to one exam room, which also serves as the provider's office. In the new facility, each provider will have an individual office in addition to two exam rooms. According to previous studies, this should increase provider efficiency by 28 percent.



Increased efficiency will be crucial in meeting future demands projected by the Enrollment Based Staffing (EBS) model.

2. **Implementation of Put Prevention into Practice (PPIP):** The PPIP program offers great opportunity for primary care managers to proactively manage their beneficiaries health care. Prevention is the tool TRICARE uses to create a climate of wellness and disease or injury avoidance. Visits to a Primary Care Manager will have a greater emphasis placed on health education and personal responsibility in attaining and maintaining a healthy lifestyle. Counseling, education, and referrals will be made for behavior based risk factors such as tobacco use, neglecting immunizations, sedentary life style, poor nutrition habits, poor coping skills, and alcohol abuse. Prevention involves early detection of disease utilizing health screens such as specific lab tests, cholesterol checks, and mammograms.

Prominent Threats

The 3MDG's primary threat is undoubtedly the possibility of continuing budget and personnel reductions. The true effects of the EBC and EBS models will be realized in the very near future. Current projections under the EBS for future staffing of Primary Care Managers look bleak. The 3MDG currently has 36 Primary Care Managers. If the 3MDG is unable to meet the "upper enrollment level" of 39,000 (as submitted to HQ PACAF SG) they will lose approximately ten Primary Care Managers. Due to the many CHAMPUS eligible retirees and their family members who are electing to use their "Other Health Insurance", this value of 39,000 may be overstated. A more accurate "upper enrollment limit" may be 32,000, which would bring the total Primary Care base from 36 down to approximately 21. It is too soon to predict the impact the EBS model will have on 3MDG specialty clinics and ancillary services.

The 3MDG also possesses the Region's largest mobility mission. Any significant or lengthy deployment of 3MDG assets would dramatically increase expenditures of CHAMPUS and Supplemental Care Funds (funds expended for referral care outside of the MTF). Over the past five years, the medical group has seen a major increase in its Readiness Mission. This mission includes two Air Transportable Hospitals and numerous Unit Training Codes. A major deployment and delay in back-fill support could have a dramatic impact on how the medical group delivers care to those patients enrolled in Prime. As the DOD strives to reach its goal of robust Air Expeditionary Forces, Readiness may be the sole driving force for determining timely access and outsourcing health care initiatives.

Weather and natural disasters also merit attention. Extremely cold or blizzard-like conditions regularly delay patient access into the direct care system for days and sometimes weeks at a time. A volcanic eruption dumped ash throughout the state's southern region in 1992 that delayed patient access to direct care for a significant amount of time. In 1964, the largest earthquake recorded in North America ripped through southern Alaska damaging the 3MDG (damage and associated repairs are still visible to this day) and pulling medical group personnel to respond to the community's needs. Therefore, although weather, volcanoes, and earthquakes might seem like remote factors affecting the Region's ability to deliver healthcare, they are significant factors that must not be overlooked.

VII. COMPETITIVE ANALYSIS

It is difficult to distinguish between facilities and providers who are the competition and those who are partners in providing care. Because the 3MDG doesn't offer all the specialties and subspecialties its customers need, it relies upon the civilian network, established through TRICARE, as a necessary part of delivering care to beneficiaries. In Fiscal Year 1997, \$7 million was expended in CHAMPUS Funds for services provided by local civilian facilities and providers. However, thus far in Fiscal Year 1998 reveals a significant decline in CHAMPUS expenditures. The 3MDG believes the year-to-date savings of \$1.7 million is directly attributable to the high enrollment rate in Prime which enabled greater involvement in managing and coordinating beneficiary care (See Appendix under CHAMPUS Expenditures for more information).

The 3MDG is capable of caring for almost all of its enrollees primary care/family practice needs. They can also care for most specialty care needs such as internal medicine, neurology, and mental health. However, subspecialty care such as certain rheumatology, thoracic surgery, and pulmonology is dominated by the competition. Fortunately, such services are not in high demand within the beneficiary population. The competition provides services to 3MDG beneficiaries which they cannot--child/adolescent mental health, residential treatment centers, full neonatology services for premature newborns, and most subspecialty care--and they can do so quickly.

Ironically, were it not for the 3MDG's "competitors," they could not care for the beneficiaries in Alaska. The 3MDG's two largest competitor/partners are Sisters of Providence Health System and Alaska Regional Hospital. These facilities are the primary sources for healthcare plans in competition with the Military Health Services System. The 3MDG is closely watching a new arrival HealthSouth -- this corporation has enormous potential to initiate change. A comparison of the different competitors follows with a more detailed look at individual strengths and weaknesses.

In 1980, the **Graduate Medical Education National Advisory Committee (GMENAC)** formulated a series of physician-to-population ratios (**GMENAC Physician Population Ratios**). **GMENAC** is one of the few groups to suggest that the ratio of physicians to population should be determined by specialty for a given population. Using the **GMENAC** standard, the 3MDG developed a "living" metric that identifies the deficiencies they have after combining their resources and those of the civilian provider network. Obviously greater emphasis is placed on the higher cost and higher utilized services. Inadequate specialties highlight areas for improvement, which can be viewed on the following page.

GMENAC Standards

Specialty	Specialty Status	GMENAC Standards for Specialists (Per 1000 Enrollees)	Elmendorf AFB Providers Required to Meet Standards for Specialists	Network FTEs	Direct Care FTEs	Total
Allergy	ADEQUATE	0.01	0.3	0	1	1
Anesthesiology	ADEQUATE	0.08	2.5	0	3	3
Cardiology	ADEQUATE	0.03	0.9	7	1	8
Dermatology	ADEQUATE	0.03	0.9	0	1	1
Emergency Medicine	ADEQUATE	0.06	1.1	0	5	5
Endocrinology	ADEQUATE	0.01	0.3	2	0	2
Gastroenterology	ADEQUATE	0.03	0.9	0	1	1
General/Family Practice	ADEQUATE	0.25	7.75	42	12	54
Hematology/Oncology	INADEQUATE	0.04	1.2	1	0	1
Infectious Disease	ADEQUATE	0.01	0.3	1	0	1
Internal Medicine	INADEQUATE	0.29	9	2	4	6
Neonatology	INADEQUATE	0.01	0.3	0	0	0
Nephrology	INADEQUATE	0.01	0.3	0	0	0
Neurology	ADEQUATE	0.02	0.6	0	2	2
Nuclear Medicine	ADEQUATE	0.02	0.6	0	1	1
Obstetrics/GYN	ADEQUATE	0.5	15.5	12	10	22
Ophthalmology	ADEQUATE	0.05	1.6	0	2	2
Otolaryngology	ADEQUATE	0.03	0.3	0	2	2
Pathology	ADEQUATE	0.06	1.9	0	3	3
Pediatrics	ADEQUATE	0.13	4	2	8	10
Physical Medicine	ADEQUATE	0.01	0.3	18	5	23
Preventive Medicine	INADEQUATE	0.03	0.9	0	0	0
Psychiatry	ADEQUATE	0.02	0.6	81	3	84
Pulmonary Medicine	INADEQUATE	0.01	0.3	0	0	0
Radiology, Diagnostic	ADEQUATE	0.07	2.2	0	5	5
Radiology, Therapeutic	ADEQUATE	0.01	0.3	2	0	2
Rheumatology	INADEQUATE	0.01	0.3	0	0	0
Surgery, Colon, Rectal	ADEQUATE	0.01	0.3	0	1	1
Surgery, General	INADEQUATE	0.11	3.4	0	3	3
Surgery, Neurosurgical	ADEQUATE	0.01	0.3	3	0	3
Surgery, Orthopedic	ADEQUATE	0.06	1.1	0	3	3
Surgery, Plastic	INADEQUATE	0.01	0.3	0	0	0
Surgery, Thoracic/Cardiovascular	INADEQUATE	0.01	0.3	0	0	0
Urology	ADEQUATE	0.03	0.9	8	2	10

The following table compares the services and capacities of Providence, Alaska Regional, 3MDG, and the 3MDG's federal partner Alaska Native Medical Center.

Type of Service	Providence Medical Center	Alaska Regional Medical Center	Alaska Native Medical Center	3rd Medical Group
Wellness Education	Yes	Yes	Yes	Yes
Case Management	Yes	Yes	Yes	Yes
Primary Care	Yes	Yes	Yes	Yes
Home Health Care	Yes	Yes	Yes	No
Same Day Surgery	6,200	4,500	3,850	3,876
Beds	340	240	143	103
Yearly Admissions	11,230	5,500	5,000	4,654
ADC	188	45	99	53
Outpatient Visits	211,000	205,000	186,000	286,000
Subacute	56 beds	35 beds	No	No
Hospice	Yes	Yes	No	No
Adult Care	Yes	No	No	No
Long Term Care	314	No	No	No
Physical Rehabilitation	Yes	Yes	Limited	Limited
Substance Abuse	Yes	No	No	No

This chart clearly shows the 3MDG's reliance upon the civilian network for specialty services.

Sisters of Providence Health System in Alaska

Sisters of Providence Health	
Strengths	Weaknesses
Brand identity (strong name recognition in state)	Expensive
Long history and strong reputation	Risk-averse culture
Established in community	Limited primary care base
Community involvement	Deficient information systems
Financially stable	Staff unfamiliar with managed care
Beautiful facility	
Dedicated staff	
Not-for-profit	
Fast access	
Large	

This 340-bed hospital has traditionally been considered the area's premier hospital. As a not-for-profit Catholic Hospital, it enjoys an honest and high quality reputation. As Anchorage grew from 120,000 in the 1970's to a 260,000 person metropolitan community in the 1990's, Providence grew too, and it is now the largest medical facility in the state. Providence serves more than just the surrounding community. Providence receives referrals from as far away as Barrow, 700 miles north, and Attu, 1500 miles to the west.

Providence has had a presence in Alaska since 1902, 57 years before Alaska became a state. Their Anchorage Medical Center has maintained the same owner, same name, same financial stability, and same quality reputation since its completion 50 years ago. Providence has enjoyed and profited from its reputation and aggressively seeks to maintain its strong brand identification within the community.

In the past, federal agencies have tended to refer more patients to Providence due to their reputation. Historically, Providence has received more Alternative Care, CHAMPUS inpatient, and CHAMPUS outpatient claims than any other facility in Alaska. However, Columbia Alaska Regional is proving to be the key competitor for Providence. In fact, due to the combined purchasing power of the AFHCP, Alaska Regional has negotiated health contracts offering significant cost savings to the federal government thus providing an incentive to shift referrals from Sisters of Providence to Regional.

Columbia Alaska Regional Medical Center

Alaska Regional Hospital

Strengths

Owner is (Columbia/HCA) strong in industry
State-of-the-art radiology & support services
Located next to VA and other medical clinics
Gaining market share from Providence
Steadily growing positive reputation
Very aggressive risk taker
Attractive facility
"Deep pockets"
Fast access

Weaknesses

Is a for-profit hospital
High administrative turnover
Lacks strong community-image
Owned by "outsiders" (unAlaskan)
Seen as *big corporation* hospital

Constructed in 1976, Alaska Regional is a high quality, 240-bed facility. Alaska Regional offers the patient the same availability to most clinics. Alaska Regional enjoys a close relationship with the Veterans Administration (VA), both in business and in vicinity. The VA Clinic and Alaska Regional are connected by a covered walkway and share the same parking lot. Next to the VA and Alaska Regional stands one of the city's largest medical clinic buildings and a well-known radiology group office. Together, the facilities make a convenient and attractive medical mall. The close relationship between Alaska Regional and the VA fostered the development and implementation of a contract with the AFHCP allowing all federal partners to take 50% off of billed facility charges.

Health South

Health South, a Managed Care Corporation based out of Birmingham AL, has caught the attention of the medical community in the Anchorage area. Other than the TRICARE Prime option offered by the military to CHAMPUS eligible and active duty members, Alaska has no civilian HMO or significant managed care activity. However, Health South may in fact push the Anchorage area and perhaps Fairbanks into a much more competitive environment. Health South has purchased over a dozen health practices in the last two years, including, seven physical therapy offices, four clinics and one outpatient surgery center. Most recently, in June of 1998, Health South bought Primary Care Associates – one of the city's largest family practices which caught the attention of Providence and Alaska Regional.

Health South has almost doubled the number of its employees nationwide in the last few years. In 1997, the company earned \$3 billion in revenue keeping \$331 million in profit. Health South has a reputation for entering into markets by acquiring individual practices and clinics. Their historical strategy has been to acquire practices and clinics and then bring them together under one roof to offer patients an "integrated approach" to healthcare. There is a strong possibility that Health South will soon build a medical plaza in Anchorage which would house certain specialty and ancillary services for one-stop-shopping.

VIII. Bridge to 2000

The future for the 3MDG lies in meeting and exceeding enrollee's expectations. Efforts to decrease costs, and to increase access and patient satisfaction through TRICARE will be key for the medical group in providing quality patient care. As the healthcare industry struggles to operate within an environment of reduced resources and budget cutbacks, the 3MDG must constantly come up with innovative ways to provide services for the beneficiary population. Part of this effort includes assuming greater fiscal responsibility over the funds still available to them.

Seeking resources through the Alaska Federal Health Care Partnership has and will continue to have a dramatic impact on how the 3MDG delivers healthcare. Eventually, MTFs will be expected to receive budgets (manpower and dollars) based on the number of TRICARE Prime enrollees and other factors such as medical readiness missions. If the 3MDG is reimbursed in part for those who are enrolled in TRICARE Prime, they will naturally "rightsize" to meet the needs of their enrolled Prime population.

As the 3MDG "rightsizes" they will depend more heavily on the AFHCP to supplement their services. Doing so will allow them to continue to provide quality, accessible and cost effective healthcare to enrolled beneficiaries. A key initiative recently undertaken by the AFHCP is obtaining authority to allow the Alaska Native Medical Center and the Veterans Affairs to become CHAMPUS certified. This would add the two respective facilities to the provider network and supplement the direct care system. Excess capacity would be offered first to TRICARE Prime enrollees and secondly to those beneficiaries who remain in Standard. This will become more important as the Enrollment Based Staffing model is applied to the 3MDG. With the AFHCP, the 3MDG can work toward jointly contracted PCMs, appointments systems, support services, credentialing processes, telemedicine linkages, and shared health promotion programs.

The one element that can be counted on in the Alaska healthcare environment is change. One element of this change is Managed Care. Managed Care is slowly emerging in the Anchorage bowl. Corporations like Health South view the Anchorage community as a major market with tremendous opportunity. They are acutely aware of the changing demographics as depicted in the Appendix under Anchorage Health Indicators. The significant increase over the past few years in Primary Care Physicians coupled with an unchecked rise in the cost of medical care in comparison with other goods and services, turns this once undesirable market local into a "hotzone" for managed care opportunity.

The staff of the 3MDG cannot afford to be complacent in this environment! To remain competitive, two major initiatives must be undertaken by each member of the staff. First, everyone must be familiar with the particulars of TRICARE, from the airmen to the field grade officers; all need to understand the TRICARE Program. The TRICARE marketing staff is a very small part of the 3MDG team. Each member of the 3MDG has a marketing role--every encounter, or interaction that by MTF staff either confirms or undermines a beneficiary's decision to enroll in Prime. Inconsiderate responses and/or misinformation to beneficiaries will deflate thousands of dollars spent in marketing efforts within minutes. Secondly, 3MDG staff must examine the many processes which constitute the services the organization provides. They must reengineer the way they do business now to survive the

fiscal restraints of tomorrow. As Dr. Stephen C. Joseph stated in his opening remarks at the 97 TRICARE Conference, "The reengineering effort will not happen automatically or even easily. We must be mindful of how our competition is delivering healthcare and adapt those processes that are successful means of achieving healthy and satisfied beneficiary populations. And, we must avoid the very real shortcomings that are focusing legitimate criticism on civilian managed care. Place yourselves in the shoes of your customers...both beneficiary and line commander". If the 3MDG heeds such advice, TRICARE is sure to succeed in the future.

TRICARE has catapulted the staff of the 3rd Medical Group into a new paradigm. They must realize the number of eligible beneficiaries who choose to enroll in TRICARE Prime will drastically affect future budgets and manpower. They must be ever mindful that this is their beneficiaries health care system – it is the customer's choice to enroll in Prime which keeps the 3MDG in business!

IX. GLOSSARY

3 Medical Group (3MDG)

Medical community of Elmendorf Air Force Base.

3 Wing (3WG)

Numbered wing of Elmendorf Air Force Base.

Accept TRICARE Standard Assignment

See "Participate in TRICARE".

Active Duty (AD)

Status of currently active military members.

Alaska Federal Healthcare Partnership (AFHCP)

Joint alliance of all federal agencies in Alaska to share healthcare resources, lower the cost of care, and improve patient access to care.

Air Force Surgeon General (AFSG)

General who oversees healthcare activities for the Air Force.

Allowable Charge

The amount on which TRICARE Standard figures the cost-share for covered care. TRICARE Standard figures the allowable charge from all professional providers' bills nationwide, with adjustments for specific localities over the last year. The claims processor can tell a provider the allowable charge amount for specific services or procedures. Also known as the "CHAMPUS Maximum Allowable Charge" (CMAC).

Authorized Provider

A doctor or other individual authorized provider of care, hospital or supplier who has applied to, and been approved by, TRICARE to provide medical care and supplies. Generally, that means the provider is licensed by the state, accredited by a national organization, or meets other standards of the medical community. If a provider is not authorized, TRICARE will not cover payment.

Balance Billing

This is when a provider bills the patient for the rest of his or her charges (the "balance" of the charges), after the civilian health insurance plan or TRICARE has paid everything it's going to pay. Federal law exempts payment for amounts in excess of 15% above the TRICARE allowable charge.

Capitation

A fixed amount of money that a managed care plan gives to a doctor or hospital to care for a patient, no matter what the patient's care actually costs.

Catastrophic cap

A cost "cap" or upper limit has been placed on TRICARE Standard-covered medical bills in any fiscal year. The limit that an active-duty family will have to pay is \$1,000; the limit for all other TRICARE Standard-eligible families is \$7,500.

Civilian Health and Medical Program for the Uniformed Services (CHAMPUS)

Old military health system replaced by TRICARE Standard.

CHAMPUS Maximum Allowable Charge (CMAC)

See "Allowable Charge".

Claims processor

The contractor who handles the TRICARE claims for care received within a particular state or region. They're also called TRICARE contractors and "fiscal intermediaries" or FIs. They have toll-free phone numbers to answer questions.

Computer Based Information (CBI)

Information for patient use accessible by computer.

Continental United States (CONUS)

Contiguous 48 states. All states except Hawaii and Alaska.

Co-payment

Fixed amount paid when enrolled in TRICARE or for a doctor visit. Sometimes, the terms "co-payment" and "cost-share" are used interchangeably.

Cost-share

The percentage paid by the patient and by TRICARE based on allowable charges for care for each claim. The amount depends upon the sponsor's status (retired or active duty). It is paid in addition to the annual deductible for outpatient care and anything a non-participating provider charges above the allowable charge.

Deductible

The amount to be paid by the patient each year toward outpatient medical care, before TRICARE begins sharing the cost of medical care. It is separate from, and in addition to, the cost-share.

Enrollment Based Capitation (EBC)

See "Capitation". Capitation applied to annual budgets.

Enrollment Based Staffing Model (EBSM)

See "Capitation". Capitation applied to staffing authorizations.

Defense Enrollment Eligibility Reporting System (DEERS)

Computerized data bank which lists all active duty and retired military members plus dependents.

Department of Defense (DOD)

Department of U.S. government under which the military services exist.

Diagnosis-Related Groups (DRGs)

A method of paying civilian hospitals for inpatient care under TRICARE Standard. They represent standardized prices for inpatient procedures.

Elmendorf Air Force Base (EAFB)

Air Force Base located in Anchorage, AK.

Explanation of Benefits (EOB)

A statement from a TRICARE contractor explaining who participates in TRICARE, who provided the care, the kind of covered service or supply received, the allowable charge and amount billed, the amount TRICARE paid, how much of the deductible that has been paid, and the cost-share. It also gives a reason for denying any claim. Sometimes called the TRICARE Explanation of Benefits (TEOB).

Extra

See "TRICARE Extra".

Fiscal Intermediary (FI)

See "claims processor".

Graduate Medical Education National Advisory Committee (GMENAC)

Group of physicians who study and publish information in the healthcare community.

Health Benefits Advisor (HBA)

Persons at military hospitals or clinics who advise beneficiaries on getting healthcare through TRICARE and the referral network. They cannot guarantee coverage under TRICARE. The TRICARE contractor must review each claim and make payment determinations in accordance with uniformed services eligibility rules and the TRICARE regulation.

Health Care Finder (HCF)

Healthcare professionals, generally registered nurses, who help find needed care for beneficiaries. The work with the Primary Care Manager (PCM) to locate required specialty care. They are located at TRICARE Service Centers.

Health Enrollment Assessment Review (HEARS)

Survey given to all new enrollees in TRICARE.

Health Maintenance Organization (HMO)

A health plan using a fixed premium (often for smaller user fees) for an assortment of medical services, usually including primary and preventive care.

Health Services Inspection (HSI)

Inspection conducted by Air Force teams of healthcare professionals to assess military hospital standards.

Indian Health Services (IHS)

Federal healthcare division in Alaska representing Native Alaskans.

Joint Commission for the Accreditation of Healthcare Organizations (JCAHO)

Civilian group who performs healthcare inspections, for both military and civilian healthcare organizations, and provides accreditation to such organizations.

Managed Care

A concept under which an organization (like an HMO) delivers healthcare to enrolled members and controls costs by closely supervising and reviewing the delivery of care.

Medically (or psychologically) necessary

Medical (or psychological) services or supplies which are considered to be appropriate care and are generally accepted by qualified professionals to be reasonable and adequate for the diagnosis and treatment of illness, injury, mental disorder, or well-child care.

Military hospitals

Shorthand for all uniformed service hospitals including the ten former Public Health Service hospitals. Also known as "MTF" or military treatment facility.

Memorandum of Understanding (MOU)

Agreement on paper signed by involved parties (not legally binding like a contract).

Nonavailability statement (NAS)

Certification from a uniformed service hospital explaining their inability to provide a certain form of care.

Operational tasking (OT)

Readiness missions assigned to military members.

Other health insurance

Other insurance in addition to TRICARE. Also called double coverage or coordination of benefits.

Participate in TRICARE

Healthcare providers who "participate" in TRICARE, also called "accepting assignment" agree to accept the TRICARE allowable charge as the full fee for care. Individuals providers can participate on a case-by-case basis.

Participating provider

See "Participate in TRICARE".

Preferred Provider Organization (PPO)

A network of healthcare providers who provide services to patients at discounted rates or cost-shares for seeking care within their network.

Primary Care Manager (PCM)

Provider assigned as the primary caregiver for a TRICARE enrollee.

Prime

See "TRICARE Prime".

Provider

A doctor, hospital, or other person or place that delivers medical services and/or supplies.

Put Prevention Into Practice (PPIP)

Military program emphasizing proactive, wellness oriented healthcare.

Registered Nurse (RN)

A graduate trained nurse who has been licensed by a state authority after qualifying for registration.

Sponsor

The service person; either active duty, retired or deceased, whose relationship to the beneficiary makes them eligible for TRICARE.

Strengths, Weaknesses, Opportunities, and Threats (SWOT)

Method of analysis useful when looking at an organization.

TRICARE Prime

One of three healthcare options under DOD's TRICARE managed healthcare program for military families. TRICARE Prime is the HMO-type option, under which beneficiaries enroll for one year, agreeing to seek healthcare from the network of providers and institutions set up by the TRICARE contractor in that region.

TRICARE Extra

The second option under DOD's TRICARE managed healthcare program. It does not require enrollment; it can be used on a case-by-case basis. A provider can be seen, as part of the network, for a reduced cost-share.

TRICARE Standard supplemental insurance

Health benefit plans specifically designed to supplement TRICARE Standard benefits. They usually cover the remainder of TRICARE Standard costs.

Uniformed services hospitals

This includes all military hospitals and former Public Health Service hospitals that are now called "uniformed services treatment facilities" (USTFs) in Baltimore, Boston, Seattle, Portland, Cleveland, Houston, Galveston, Port Arthur, Nassau Bay, and Staten Island.

United States Coast Guard (USCG)

Branch of the military service responsible for coastal defense and some drug enforcement.

Veteran's Affairs (VA)

Division of the Department of Defense accountable to retired military members, to include members who fought in wars.

X. WORKS CONSULTED

"Alaska Federal Healthcare Partnership Annual Report 1997". Anchorage: AFHCP, 1997.

"Alaska Federal Healthcare Partnership Annual Report 1998". Anchorage: AFHCP, 1996.

"Anchorage Health Indicators". Online. Internet. September 10, 1998. Available <http://www.ci.anchorage.ak.us>.

Arnold, Marilyn, Major USAF. Personal interview. TRICARE Alaska Regional Office. April 1, May 9, and June 7 1998.

Composite Healthcare System Database. 3rd Medical Group. Elmendorf Air Force Base, AK. August 15, 1998.

Defense Management Information System. 3rd Medical Group. Elmendorf Air Force Base, AK. August 15, 1998.

Hinger, Ward, Captain USAF. Personal interview. 3rd Medical Group. Elmendorf Air Force Base, AK. September 9 and September 15, 1998.

"Mission Support Plan". 3rd Medical Group. Elmendorf Air Force Base, AK. Fiscal Year 1997.

"Mission Support Plan". 3rd Medical Group. Elmendorf Air Force Base, AK. Fiscal Year 1998.

"TRICARE". Online. Internet. August 10, 1998. Available <http://www.ochampus.mil>.

APPENDIX
TABLE OF CONTENTS

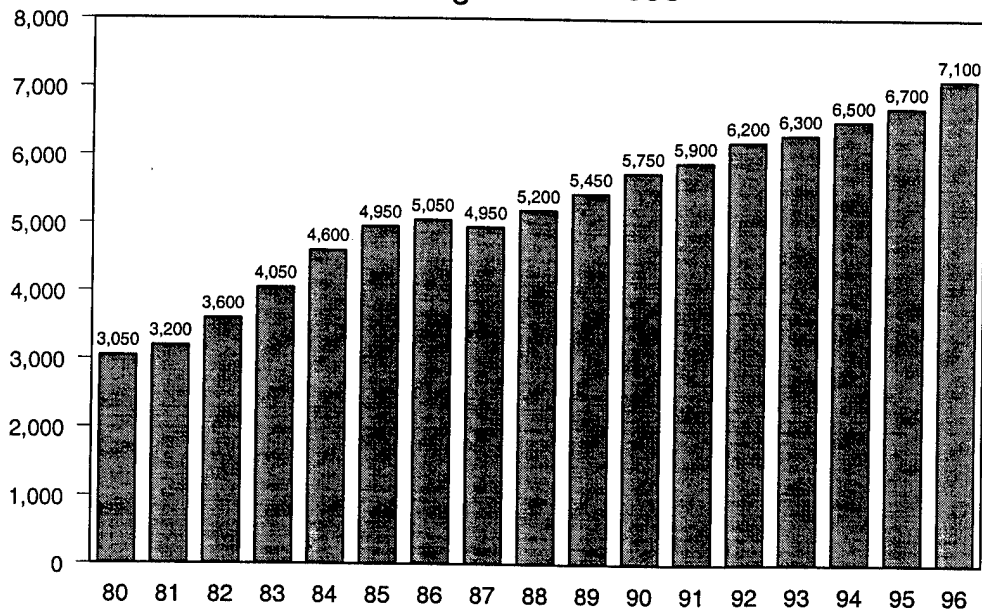
A.		Alaska Health Indicators
B.	.....	3MDG Services
C.	.....	TRICARE Summary
D.	.....	Capitation Budgeting
E.	.....	HEARS Survey
F.	.....	Demographic Trends
G.	.....	Enrollment Figures
H.	.....	AFHCP
I.	.....	3MDG Survey
J.	.....	CHAMPUS Expenditures

100

A

Health Care Employment

Anchorage 1980 - 1996

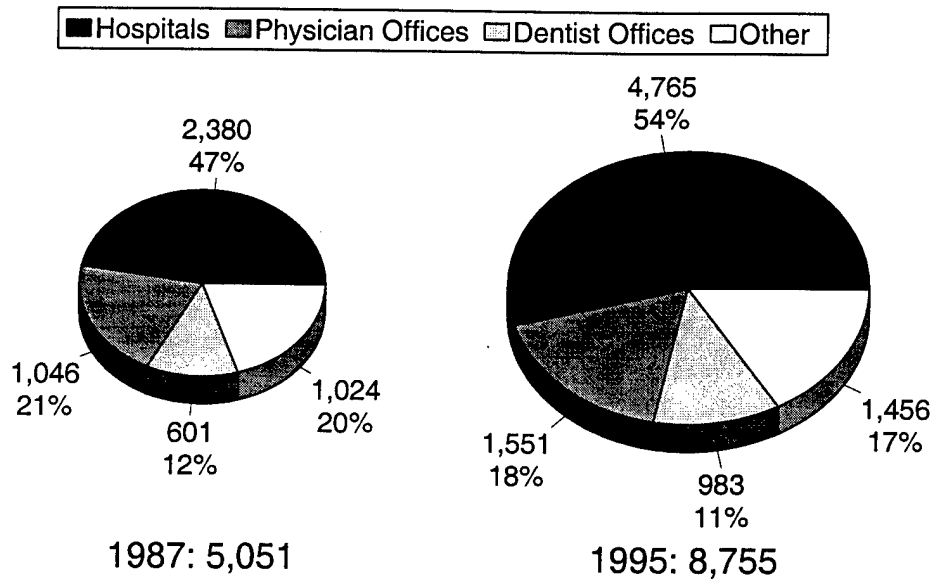


Source: Alaska Department of Labor. (Revised 7/8/97)

97health #1

Health Care Employment

Anchorage - 1987 & 1995

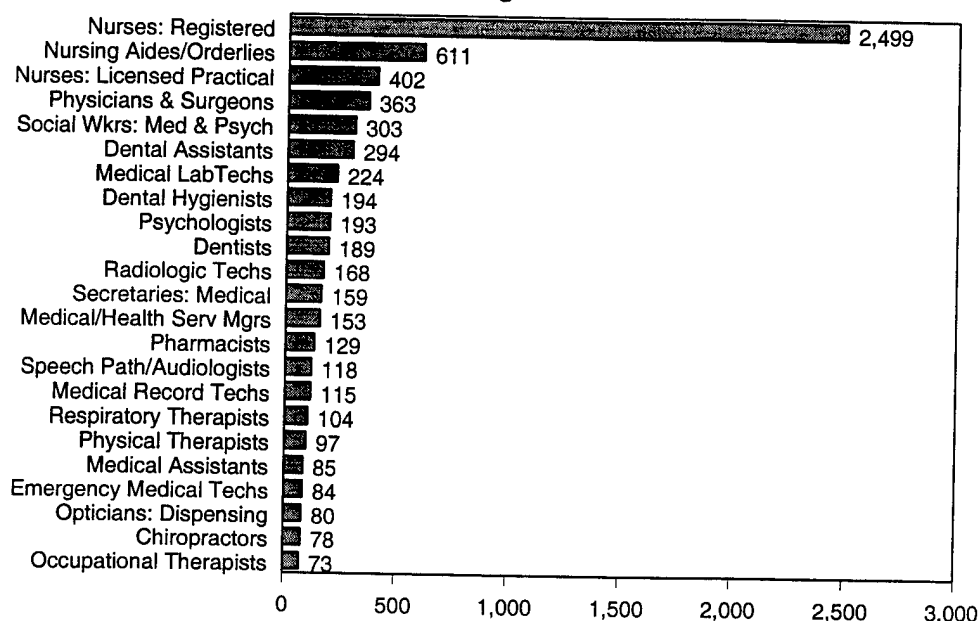


Source: "County Business Patterns - Alaska," U.S. Department of Commerce, Bureau of the Census. (Revised 12/4/97)

97health #127

Employment for Selected Health Occupations

Anchorage - 1995

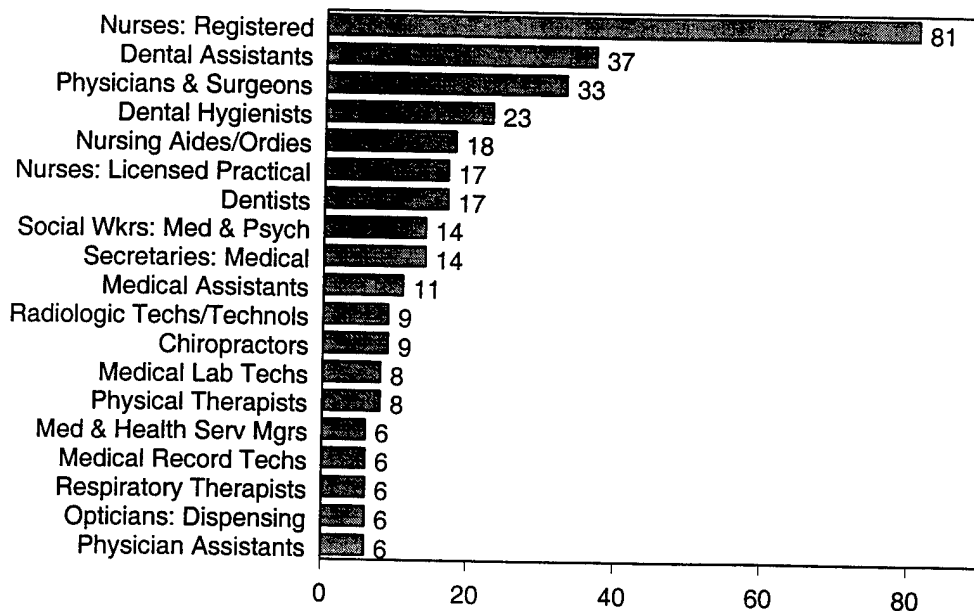


Source: Alaska Department of Labor, Research & Analysis. (Revised 7/8/97)

97health #14

Annual Job Openings

Anchorage - Selected Health Occupations - 1995-2000



Source: Alaska Department of Labor, Research & Analysis. (Revised 7/8/97)

97health #15

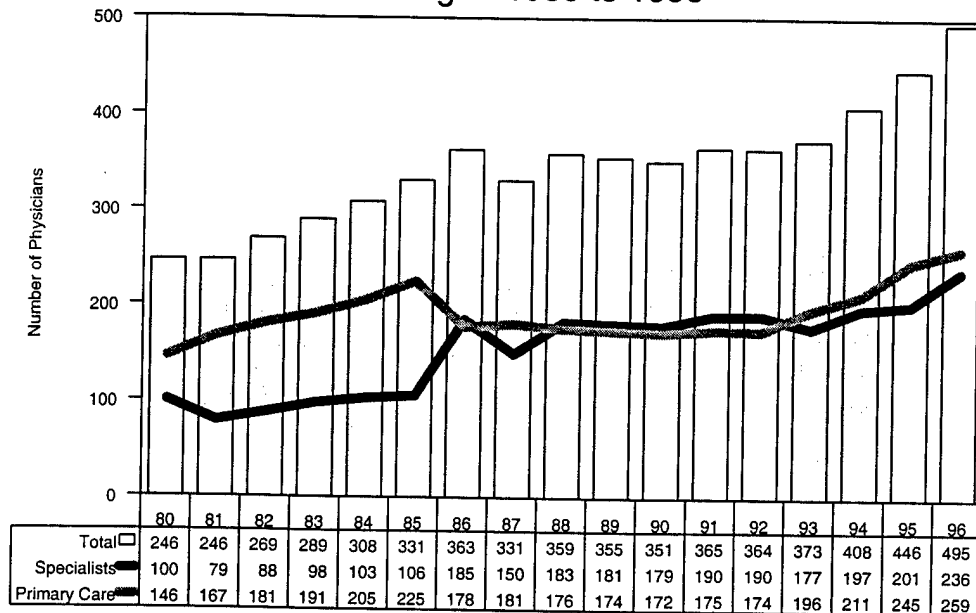
Anchorage/Mat Su Occupational Outlook - Health Care 1995-2000

Occupational Title	Employment		Annual Openings
	1995	2000	
Executives, Administrators, And Managers			
Medicine & Health Services Managers	153	166	6
Professional Specialty Workers			
Chiropractors	78	114	9
Dentists	189	251	17
Dieticians & Nutritionists	63	71	4
Nurses: Registered	2,499	2,749	81
Occupational Therapists	73	88	4
Pharmacists	129	146	5
Physical Therapists	97	132	8
Physician Assistants	68	95	6
Physicians & Surgeons	363	496	33
Psychologists	193	207	4
Residential Counselors	421	437	11
Respiratory Therapists	104	126	6
Social Wkrs, Ex Medical/Psychiatric	592	605	13
Social Wkrs: Medical & Psychiatric	303	349	14
Speech Pathologists & Audiologists	118	128	4
All Oth Therapists	38	44	2
Technicians And Related Support Workers			
Dental Hygienists	194	292	23
Emergency Medical Techs	84	99	4
Medical Laboratory Techs/Technols	224	246	8
Medical Record Techs	115	137	6
Nurses: Licensed Practical	402	453	17
Opticians: Dispensing & Measuring	80	100	6
Pharmacy Techs	25	26	0
Radiologic Techs/Technols	168	193	9
All Oth Health Diagnos/Treat Practices	27	33	1
All Oth Health Professional/Tech/Paraprof	350	390	13
Clerical Workers			
Secretaries: Medical	159	213	14
Service Workers			
Dental Assistants	294	434	37
Home Health Aides	44	62	5
Medical Assistants	85	136	11
Nursing Aides/Orderlies/Attendants	611	659	18
Personal & Home Care Aides	72	76	3
Physical/Corrective Therapy Assist/Aides	34	56	5
All Oth Health Service Wkrs	248	297	16
Precision Production, Craft, & Repair			
Dental Laboratory Techs	34	43	3
Electromedical/Biomedical Equip Repairs	29	32	2

Source: Alaska Department of Labor, Research & Analysis Section.

Primary Care & Specialist Physicians

Anchorage - 1980 to 1996

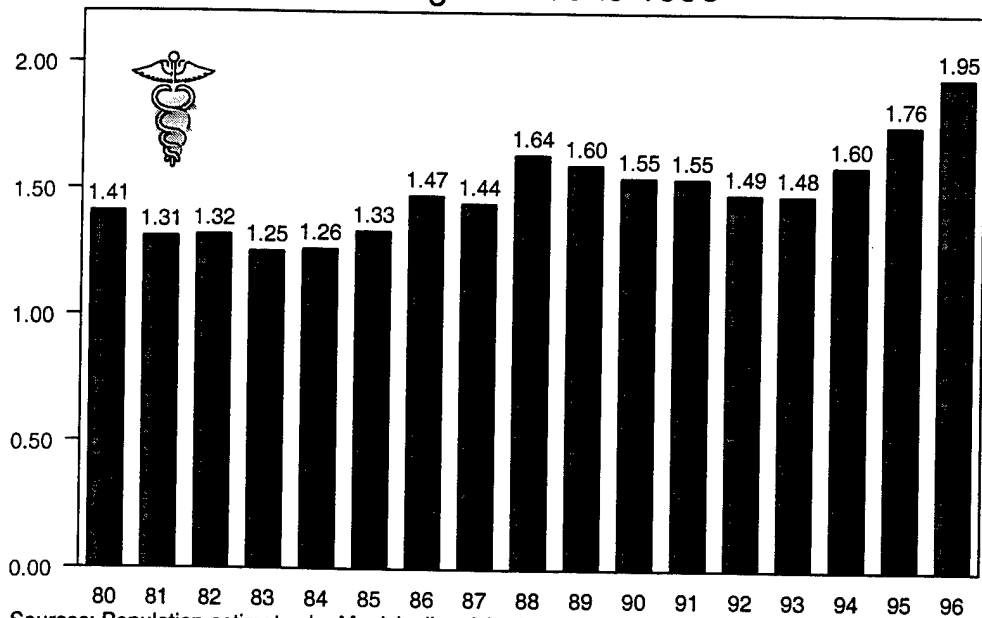


Source: Alaska State Medical Association. (Revised 5/21/97)

97health #3

Private Physicians Per 1,000 Population

Anchorage - 1980 to 1996

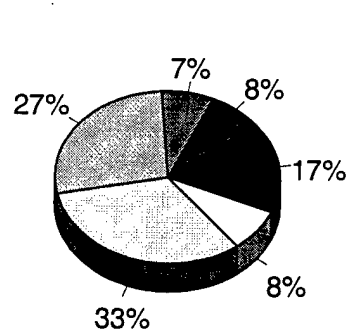
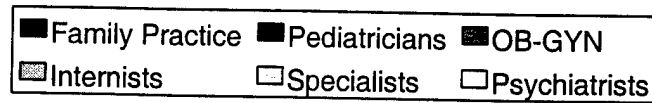


Sources: Population estimates by Municipality of Anchorage Community Planning & Development Department; number of physicians in private practice provided by the Alaska State Medical Association. (Revised 7/8/97)

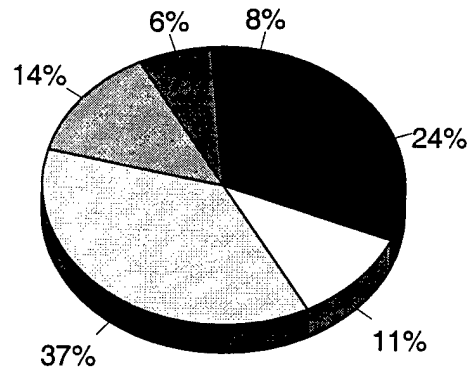
97health #4

Physicians by Specialty

Anchorage 1980 & 1996



1980: 246 Physicians



1996: 495 Physicians

Source: Alaska State Medical Association. (Revised 7/8/97)

97health #8

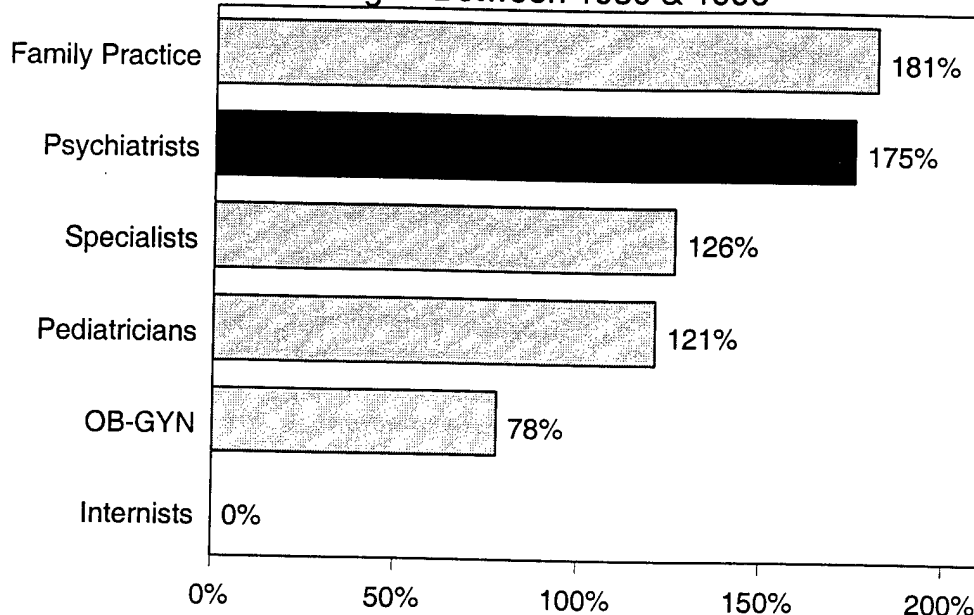
Anchorage & Alaska Physicians in Private Practice - 1980 to 1996

Year	Anchorage										Alaska
	Primary Care Physicians						Non-Primary Care	Total Physicians	Total Population	Physicians Per 1,000 Residents	Total Physicians
	Family Practice	Pedia- tricians	Obstet/ Gynec.	Internal Medicine	Total						
					#	%					
1980	42	19	18	67	146	59%	100	246	174,431	1.41	412
1981	46	25	16	80	167	68%	79	246	187,761	1.31	412
1982	50	29	17	85	181	67%	88	269	204,226	1.32	458
1983	58	30	16	87	191	66%	98	289	230,847	1.25	502
1984	59	33	20	93	205	67%	103	308	244,030	1.26	534
1985	67	41	20	97	225	68%	106	331	248,263	1.33	567
1986	76	26	23	53	178	49%	185	363	246,139	1.47	625
1987	74	26	28	53	181	55%	150	331	229,117	1.44	567
1988	71	23	29	53	176	49%	183	359	218,979	1.64	618
1989	65	31	28	50	174	49%	181	355	221,870	1.60	614
1990	72	29	24	47	172	49%	179	351	226,338	1.55	603
1991	72	29	23	51	175	48%	190	365	235,893	1.55	614
1992	74	29	23	48	174	48%	190	364	245,095	1.49	625
1993	68	38	26	64	196	53%	177	373	251,805	1.48	731
1994	75	40	31	65	211	52%	197	408	255,422	1.60	780
1995	99	44	32	70	245	55%	201	446	253,614	1.76	824
1996	118	42	32	67	259	52%	236	495	254,269	1.95	909

Source: Alaska State Medical Association.

% Change in Physicians by Specialty

Anchorage - Between 1980 & 1996

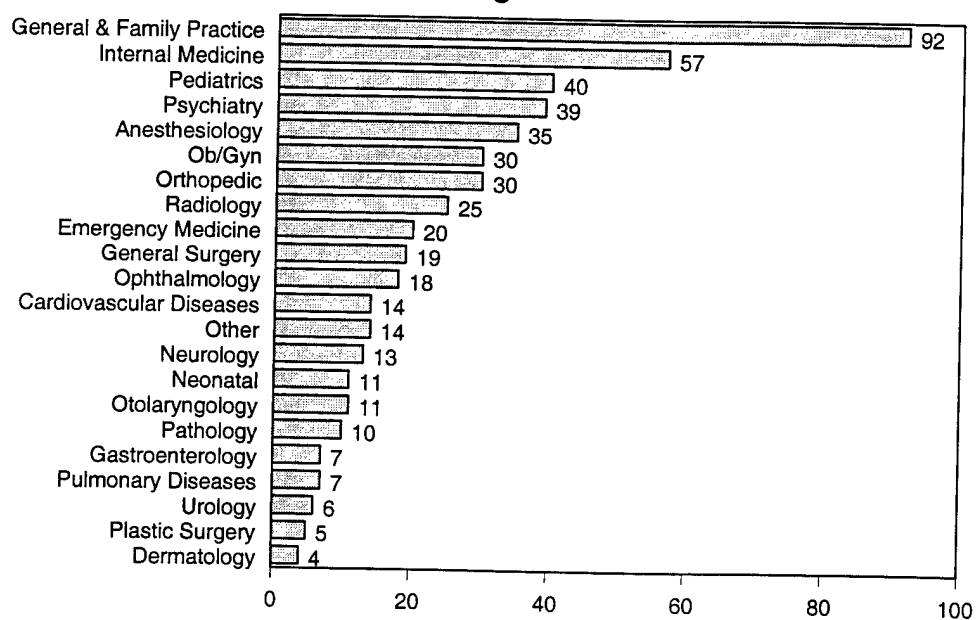


Source: Alaska State Medical Association. (Revised 7/8/97)

97health #6

Private Physicians by Specialty

Anchorage - 1997

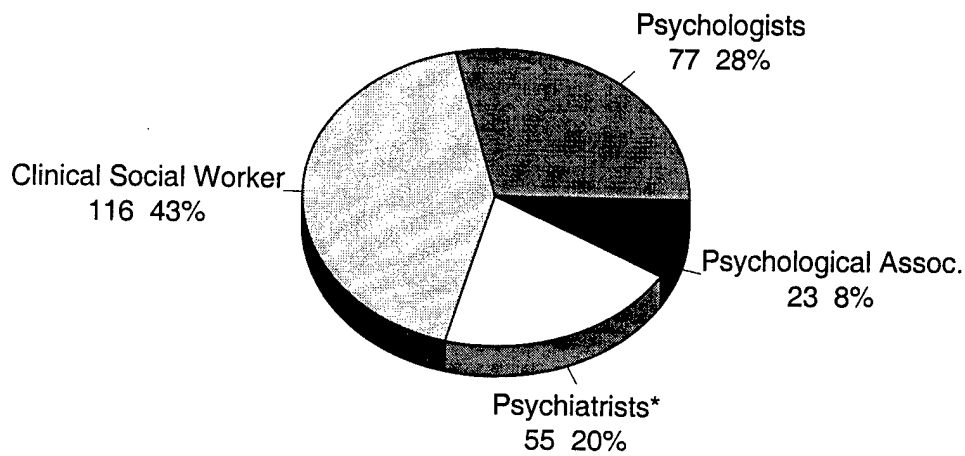


Source: Alaska State Medical Association. (Revised 7/24/97)

97health #112

Mental Health Professionals

Anchorage - 1996



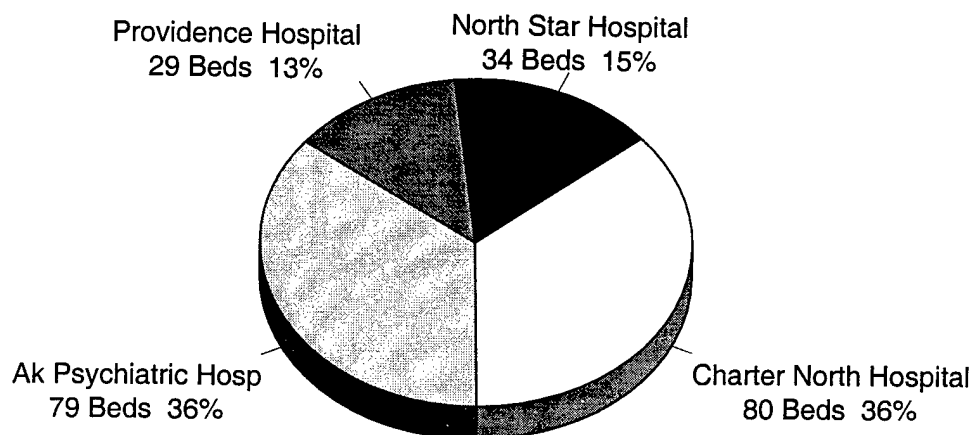
Total: 271

Sources: Alaska State Medical Association and Alaska Division of Occupational Licensing. *Does not include psychiatrists employed by military or public hospitals. (Revised 7/8/97)

97health #8

Psychiatric Hospital Beds

Anchorage - 1997



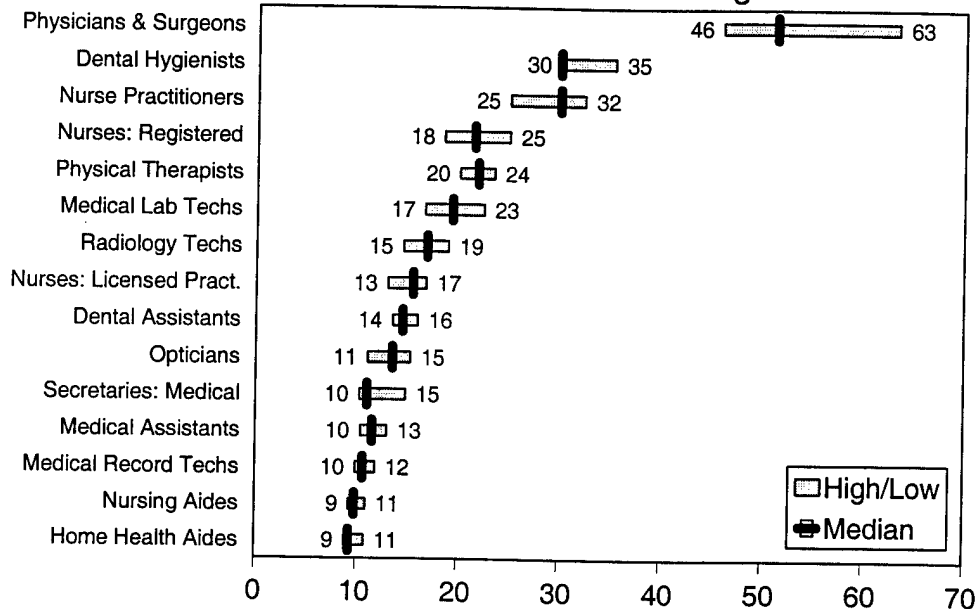
Total Beds: 222

Source: MOA Community Planning & Development Department survey of facilities.

97health #7

Health Care Personnel Hourly Wages

Anchorage & Mat-Su Census Areas - August 1996



Source: Alaska Department of Labor, Research & Analysis. (Revised 5/21/97)

97health #19

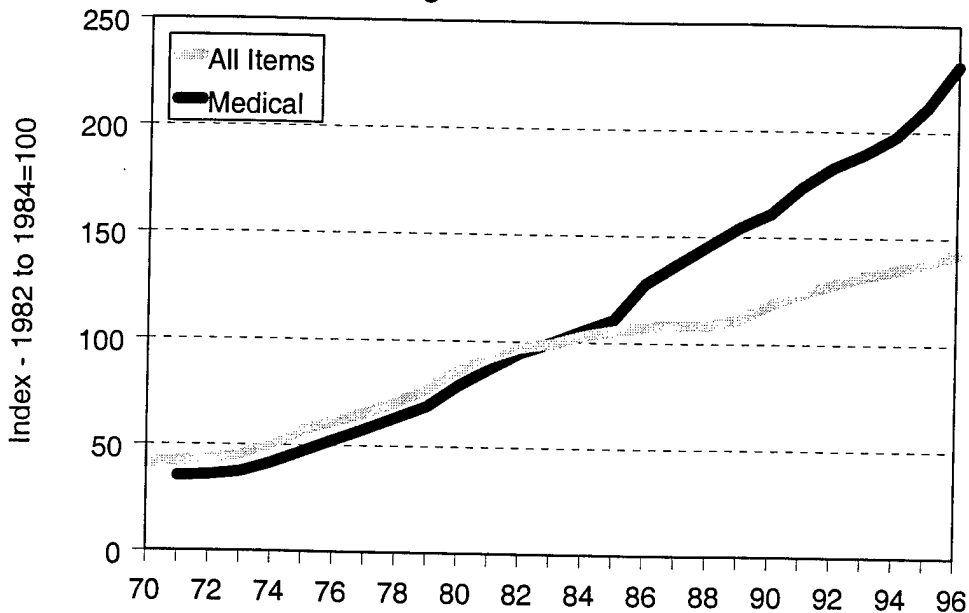
Private Sector Wage Data for Medical Occupations Anchorage and MatSu Boroughs - August 1996

Occupation	Median (\$)	Middle Range		Average (\$)	Businesses Responding	Employees Represented
		Low(\$)	High(\$)			
Dental Assistants	14.50	13.50	16.00	14.48	20	43
Dental Hygienists	30.00	30.00	35.41	31.60	14	33
Home Health Aides	9.30	8.87	10.82	9.99	7	38
Medical Assistants	11.55	10.39	13.00	11.75	10	19
Medical Laboratory Techs	19.37	16.63	22.50	18.99	7	78
Medical Record Technicians	10.64	9.92	11.87	11.00	8	24
Nurse Practitioners	30.00	25.00	32.40	29.19	13	41
Nurses: Licensed Practical	15.50	13.00	16.81	15.17	17	82
Nurses: Registered	21.52	18.48	25.02	21.45	33	653
Nursing Aides, Orderlies & Atten.	9.83	9.27	10.94	10.20	7	218
Opticians: Dispensing & Measuring	13.50	11.06	15.28	13.24	9	20
Physical Therapists	21.88	20.05	23.50	22.43	7	39
Physicians & Surgeons	51.32	46.00	63.41	57.37	18	53
Radiologic Technicians	16.87	14.50	19.00	16.84	11	71
Secretaries: Medical	11.00	10.25	14.82	12.51	10	22

Source: Alaska Department of Labor, Research and Analysis Section. Middle Range=The middle 50% of hourly wages. One-quarter of the workers in an occupation earn less than the low end of the range and one-quarter earn more than the high end of the range. (Revised 5/21/97)

CPI - All Items vs. Medical

Anchorage - 1970 to 1996

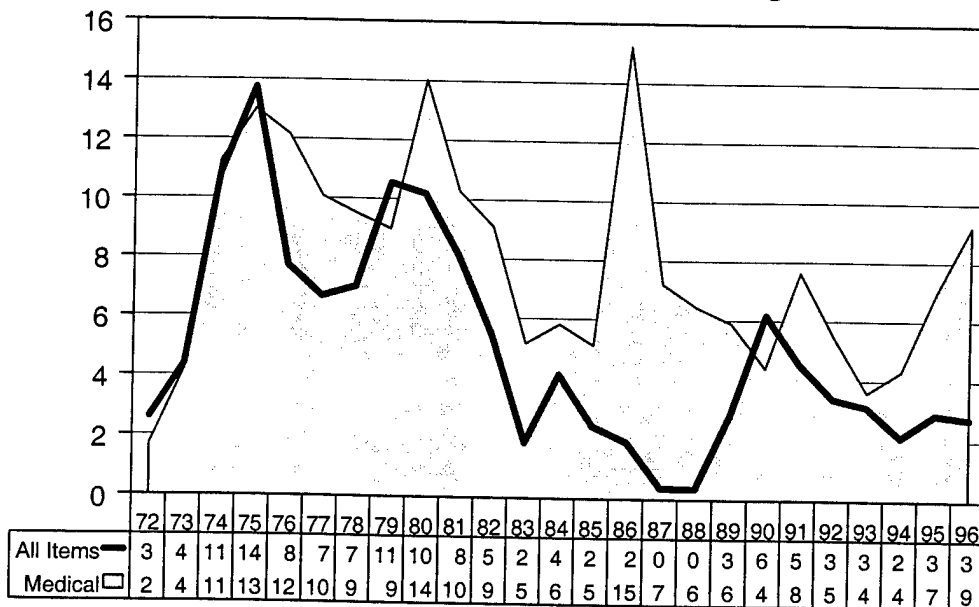


Source: Consumer Price Index for All Urban Consumers, U.S. Department of Labor, Bureau of Labor Statistics. (Revised 7/8/97)

97health #10

Annual % Increase in Medical Costs

Comparison of All Items & Medical - Anchorage 1972-96

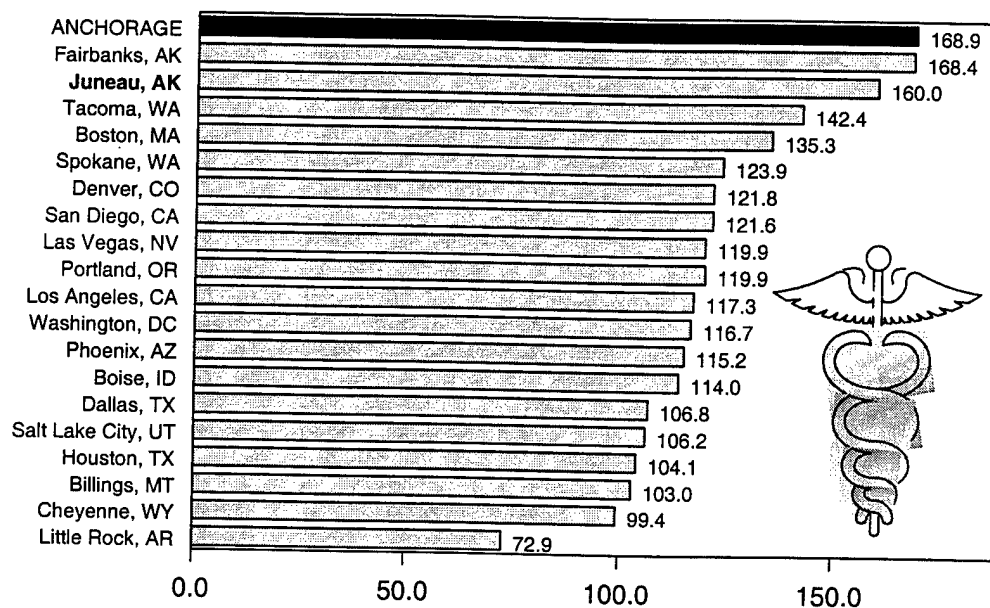


Source: Consumer Price Index for All Urban Consumers, U.S. Department of Labor, Bureau of Labor Statistics. (Revised 5/21/97)

97health #9

ACCRA Cost of Living Index - Medical

Anchorage & Selected U.S. Cities - 2nd Quarter - 1996

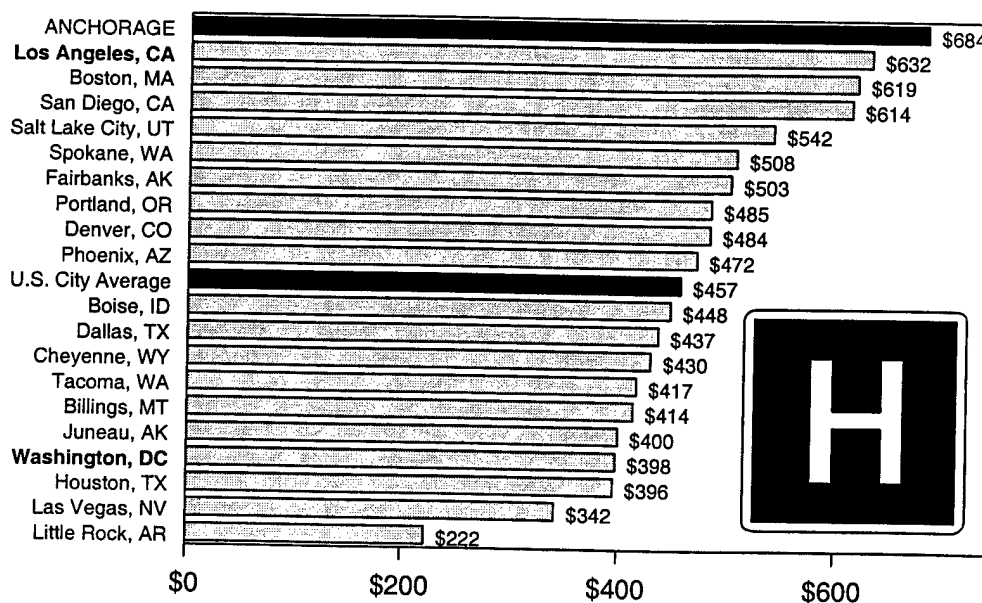


Source: ACCRA Cost of Living Index, Louisville, Kentucky. (Revised 7/8/97)

97health #11

Hospital Room Daily Rate

Anchorage & Selected U.S. Cities - 2nd Quarter - 1996

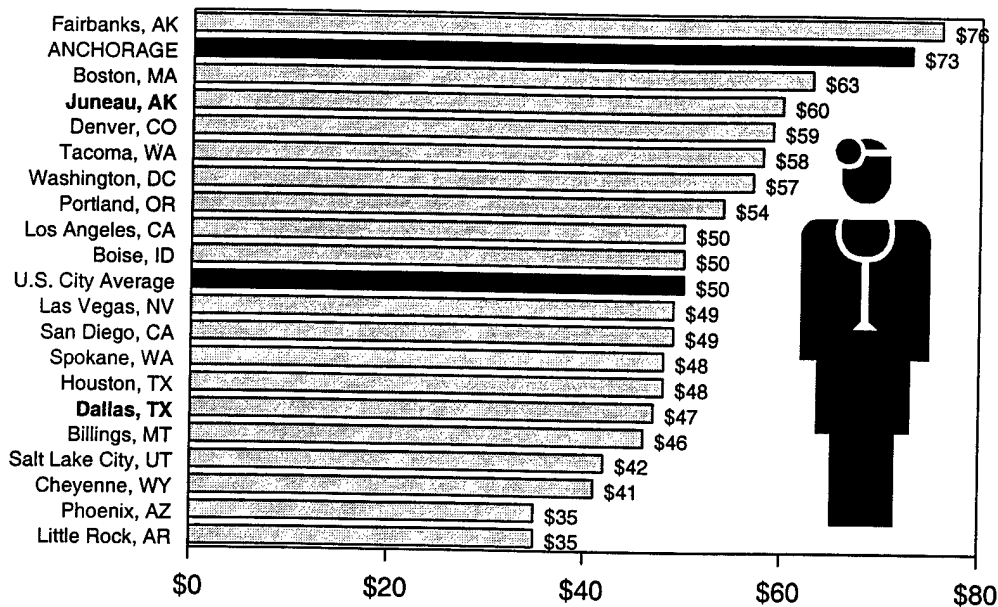


Source: ACCRA Cost of Living Index, Louisville, Kentucky. (Revised 7/8/97)

97health #12

Cost of Brief Doctor Visit

Anchorage & Selected U.S. Cities - 2nd Quarter - 1996

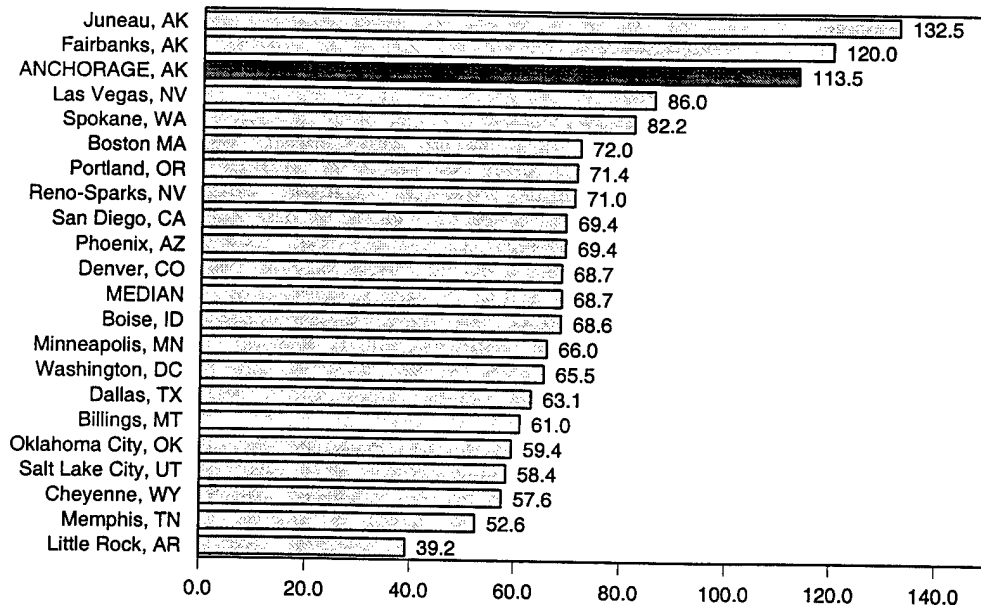


Source: ACCRA Cost of Living Index, Louisville, Kentucky. (Revised 7/8/97)

97health #13

ACCRA Cost of Living Index - Dental Procedure*

Anchorage & Selected U.S. Cities - 2nd Quarter - 1996

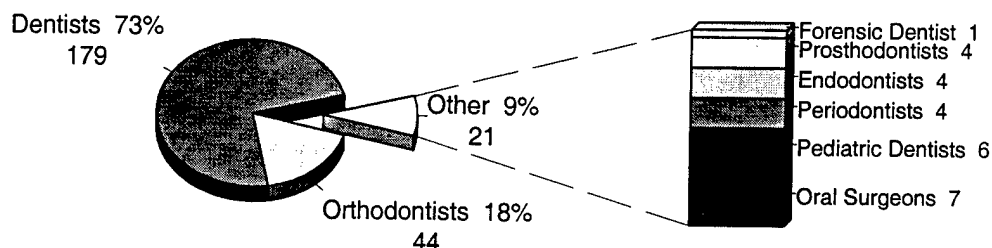


Source: ACCRA Cost of Living Index, Louisville, Kentucky. Adult dental cleaning and exam without x-rays. (Revised 3/26/97)

97 ACCRA #39

Dentists by Specialty

Anchorage - 1997



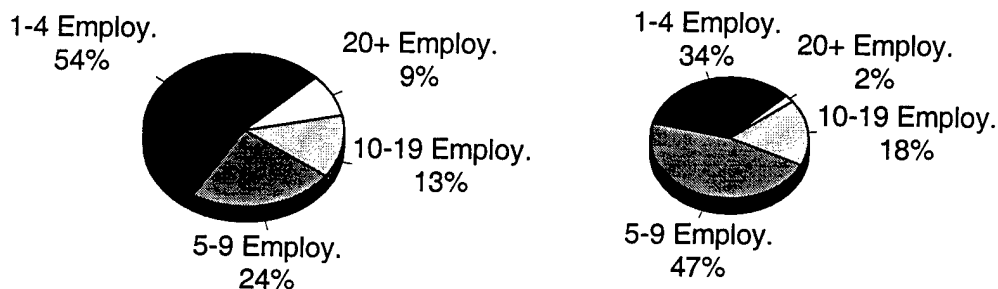
Total Dentists: 216

Source: Anchorage Dental Society. (Revised 7/22/97)

97health #2

Size of Medical & Dental Practices

Anchorage - 1995



Total Medical Clinics: 212

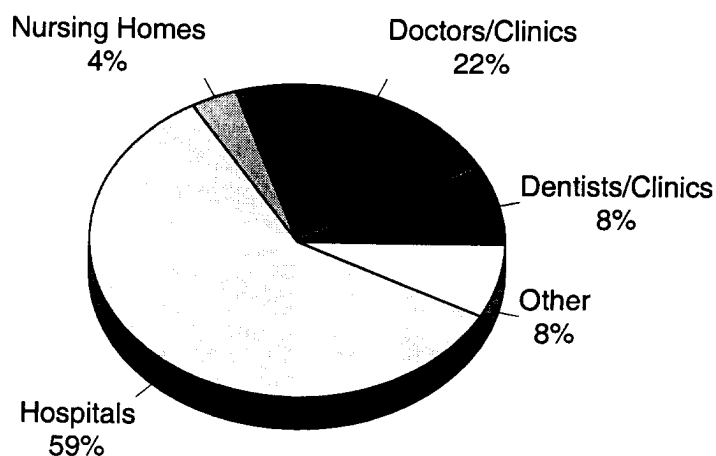
Total Dental Clinics: 154

Source: "County Business Patterns 1995 - Alaska," U.S. Department of Commerce, Bureau of the Census. (Revised 12/4/97)

97health #128

Annual Payroll for Health Services

(In Millions of \$) - 1995



1995 Total: \$388 Million

Source: "County Business Patterns 1995 - Alaska," U.S. Department of Commerce, Bureau of the Census.

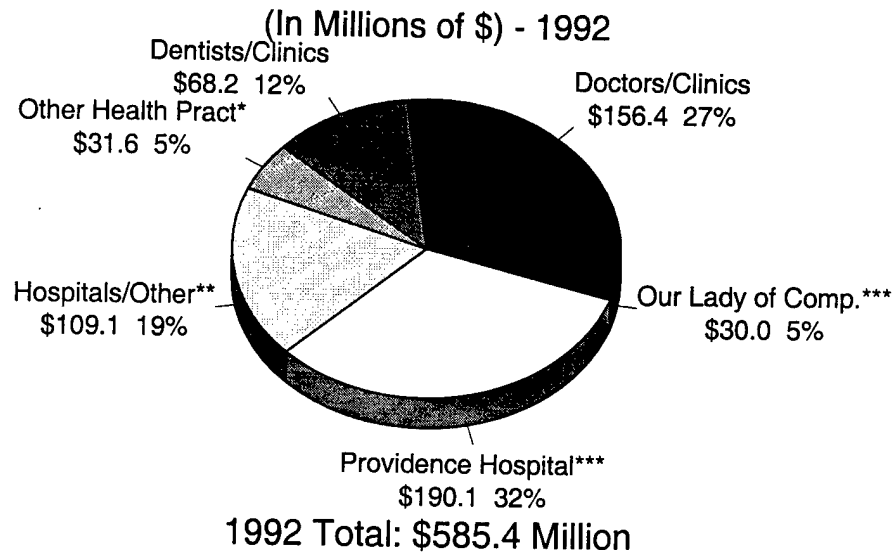
97health #126

Anchorage Health Service Businesses Employees, Payroll, and Size of Establishments Anchorage - 1995

SIC	Industry	Employees March 1995	Annual Payroll (\$1,000)	Establishments by Number of Employees				
				Total	1-19	20-99	100-499	> 499
8000	Health services	8,755	388,083	551	510	33	5	3
8010	Offices and clinics of medical doctors	1,551	85,262	212	193	19	0	0
8020	Offices and clinics of dentists	983	30,651	154	151	3	0	0
8030	Offices of osteopathic physicians	46	1,697	9	9	0	0	0
8040	Offices of other health practitioners	342	10,826	105	104	1	0	0
8041	Offices and clinics of chiropractors	155	5,395	38	38	0	0	0
8042	Offices and clinics of optometrists	(B)	0	19	18	1	0	0
8043	Offices and clinics of podiatrists	(A)	0	4	4	0	0	0
8049	Offices of health practitioners, n.e.c.	106	2,555	44	44	0	0	0
8050	Nursing and personal care facilities	511	14,174	9	7	0	2	0
8060	Hospitals	4,765	228,834	7	0	2	2	3
8070	Medical and dental laboratories	158	4,048	22	20	2	0	0
8071	Medical laboratories	(C)	0	12	10	2	0	0
8072	Dental laboratories	(B)	0	10	10	0	0	0
8080	Home health care services	(B)	0	3	2	1	0	0
8090	Health and allied services, n.e.c.	274	8,588	17	11	5	1	0

Source: "County Business Patterns 1995, Alaska," U.S. Department of Commerce, Bureau of the Census.
 Note: SIC=Standard Industrial Classification; n.e.c.=Not elsewhere classified. Employment-size classes are as follows: A--0 to 19; B--20 to 99; C--100 to 249; E--250 to 499.

Anchorage Health Care Receipts

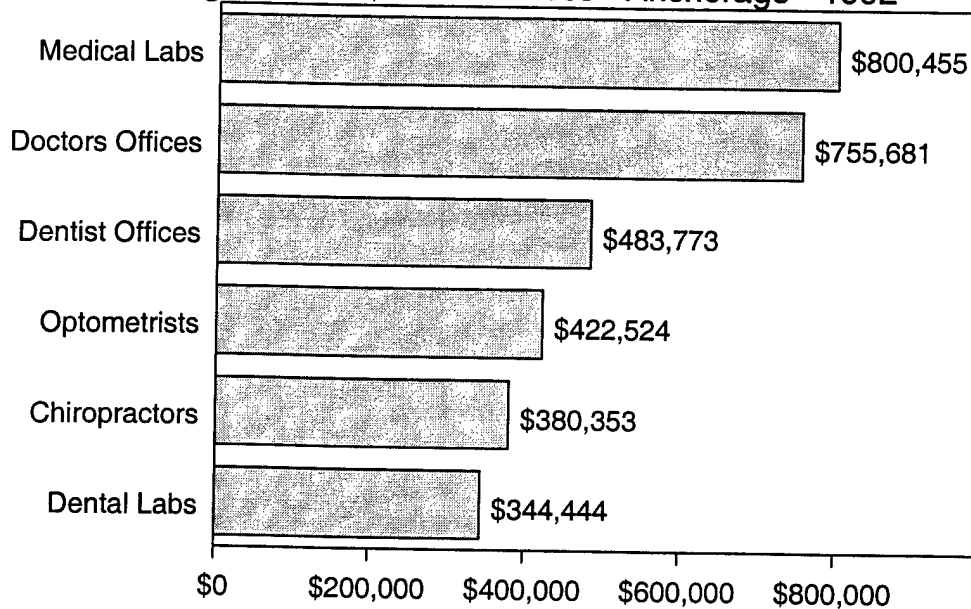


Source: Census of Service Industries, Alaska, 1992, U.S. Bureau of the Census. *Chiropractors, optometrists, podiatrists etc. **Includes private hospitals, nursing homes, medical & dental labs, homes health care services and miscellaneous health services. ***There are non-profit facilities which were not included in the census. Information was obtained from the facilities directly.

97health #44

Receipts For Selected Medical Services

Average Annual \$ Per Business - Anchorage - 1992



Source: Census of Service Industries, Alaska, 1992, U.S. Bureau of the Census.

97health #27

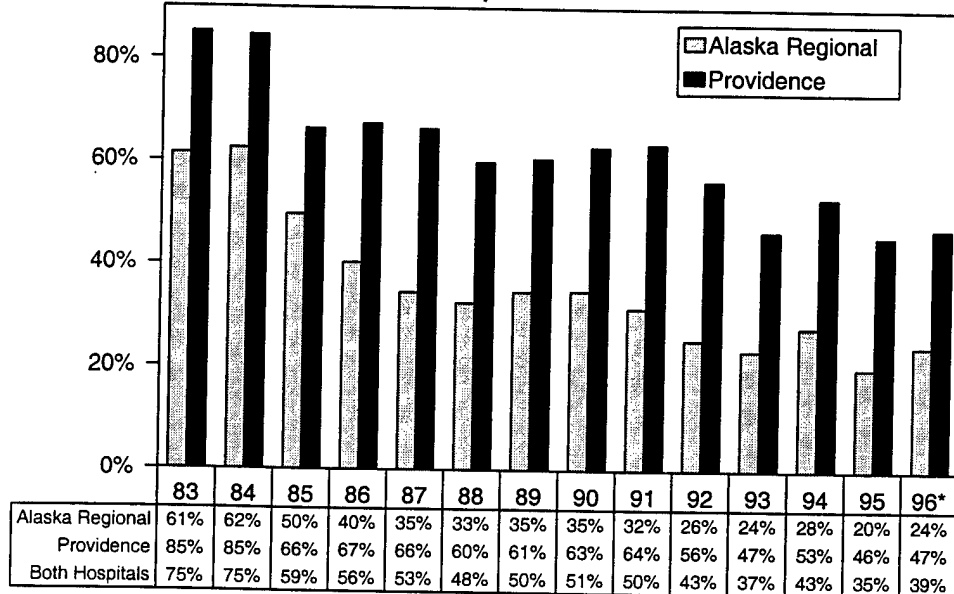
Anchorage Private Hospital Statistics - 1983 to 1996

	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996
Total Beds	512	516	620	627	634	638	638	638	638	638	638	620	638	585
AK Regional*	226	226	266	266	273	273	273	273	273	273	273	255	273	220
Acute	199	199	238	238	238	238	238	238	238	238	238	220	238	179
Nursery	27	27	28	28	35	35	35	35	35	35	35	35	35	25
NICU														16
Providence	286	290	354	361	361	365	365	365	365	365	365	365	365	365
Acute	244	246	280	299	299	303	303	303	303	303	303	303	303	303
Nursery	24	24	36	24	24	24	24	24	24	24	24	24	24	24
NICU*	18	20	38	38	38	38	38	38	38	38	38	38	38	38
Total Admits	25,537	26,164	24,489	24,499	23,236	21,662	21,905	22,628	22,407	21,080	20,594	20,939	18,362	18,389
AK Regional*	10,061	9,858	10,474	8,533	7,428	7,332	7,534	7,877	7,326	6,478	6,163	6,308	4,980	5,258
Acute	8,296	8,249	8,510	6,972	6,200	5,973	6,210	6,432	5,943	5,296	5,129	5,273	4,028	4,519
Nursery	1,765	1,609	1,964	1,561	1,228	1,359	1,324	1,445	1,383	1,182	1,034	1,035	952	739
Providence	15,476	16,306	14,015	15,966	15,808	14,330	14,371	14,751	15,081	14,602	14,431	14,631	13,382	13,131
Acute	12,957	13,673	11,621	13,238	13,182	11,915	11,961	12,246	12,522	11,865	11,747	11,836	10,752	10,658
Nursery	2,148	2,205	2,065	2,276	2,188	1,997	2,033	2,150	2,218	2,330	2,321	2,394	2,271	2,083
NICU**	371	428	329	452	438	418	377	355	341	407	363	401	359	390
Tot. Patient Days	139,478	141,294	133,901	127,773	121,910	112,486	115,254	118,488	116,050	100,468	85,740	96,603	80,801	82,497
AK Regional*	50,673	51,620	48,160	39,028	34,405	32,450	34,582	34,734	31,504	25,417	23,711	26,058	20,050	19,560
Acute	46,573	47,759	43,527	35,388	30,908	27,849	29,596	29,927	27,156	21,658	21,938	24,507	18,649	17,200
Nursery	4,100	3,861	4,633	3,640	3,497	3,133	2,968	3,061	2,734	2,202	1,773	1,551	1,401	1,267
NICU**						1,468	2,018	1,746	1,614	1,557	0	0	0	1,093
Providence	88,805	89,674	85,741	88,745	87,505	80,036	80,672	83,754	84,546	75,051	62,029	70,545	60,751	62,937
Acute	77,360	77,490	72,749	74,733	73,219	66,452	68,117	70,576	72,493	62,050	50,668	58,450	49,631	49,859
Nursery	4,919	5,086	4,797	5,098	4,902	4,417	4,599	4,610	4,418	4,365	3,735	3,610	3,369	3,238
NICU**	6,526	7,098	8,195	8,914	9,384	9,167	7,956	8,568	7,635	8,636	7,626	8,485	7,751	9,840
Occupancy Rates	74.6%	75.0%	59.2%	55.8%	52.7%	48.3%	49.5%	50.9%	49.8%	43.1%	36.8%	42.7%	34.7%	38.6%
AK Regional*	61.4%	62.4%	49.6%	40.2%	34.5%	32.5%	34.7%	34.9%	31.6%	25.5%	23.8%	28.0%	20.1%	24.4%
Providence	85.1%	84.5%	66.4%	67.4%	66.4%	59.9%	60.6%	62.9%	63.5%	56.3%	46.6%	53.0%	45.6%	47.2%
Avg. Stay (Days)	5.5	5.4	5.5	5.2	5.2	5.2	5.3	5.2	5.2	4.8	4.2	4.6	4.4	4.5
AK Regional*	5.0	5.2	4.6	4.6	4.6	4.4	4.6	4.4	4.3	3.9	3.8	4.1	4.0	3.7
Providence	5.7	5.5	6.1	5.6	5.5	5.6	5.6	5.7	5.6	5.1	4.3	4.8	4.5	4.8
Revenues (\$Mil.)	121.4	132.4	155.6	162.1	181.3	192.8	219.0	253.4	271.1	282.5	305.8	346.5	379.0	420.3
AK Regional	44.0	44.8	61.4	58.9	63.5	66.3	74.9	81.0	87.8	92.4	105.8	144.1	154.5	155.0
Inpatient	36.9	36.1	52.0	48.5	51.5	53.0	60.2	63.9	68.4	66.8	72.9	98.7	107.3	104.9
Outpatient	7.0	8.7	9.4	10.4	12.0	13.3	14.7	17.1	19.4	25.6	32.9	45.5	47.1	50.2
Providence	77.4	87.6	94.2	103.2	117.8	126.6	144.0	172.5	183.3	190.1	200.0	202.3	224.5	265.2
Inpatient	65.0	72.7	79.8	87.2	97.1	103.1	116.1	135.6	141.5	149.8	155.0	155.6	170.3	206.0
Outpatient	12.5	14.9	14.4	16.0	20.6	23.5	27.9	36.8	41.8	40.3	45.0	46.7	54.2	59.3
Inpatient Charges														
Per Admit-Both	3,990	4,159	5,381	5,538	6,399	7,088	8,051	8,818	9,371	10,276	11,066	12,143	15,006	17,128
Alaska Regional	3,669	3,663	4,962	5,680	6,940	7,225	7,995	8,114	9,341	10,310	11,830	15,640	21,552	21,130
Providence	4,198	5,157	5,695	5,462	6,145	7,020	8,080	9,195	9,385	10,261	10,741	10,636	12,725	15,683
Per Day - Both	730	769	984	1,062	1,220	1,406	1,530	1,790	1,907	2,156	2,658	2,632	3,410	3,818
Alaska Regional	728	700	1,079	1,242	1,498	1,710	1,742	1,840	1,907	2,156	2,658	2,632	3,410	3,818
Providence	732	811	931	983	1,110	1,288	1,439	1,619	1,674	1,886	2,499	2,206	2,803	3,272

The full name is Columbia Alaska Regional Hospital; it was formerly called Humana Hospital Alaska. ** NICU = Neonatal Intensive Care Unit.
Source: Alaska Department of Health and Social Services, Medicaid Rate Advisory Commission. (Revised 12/4/97)

Anchorage Hospital Occupancy

Percent Beds Occupied - 1983 to 1996

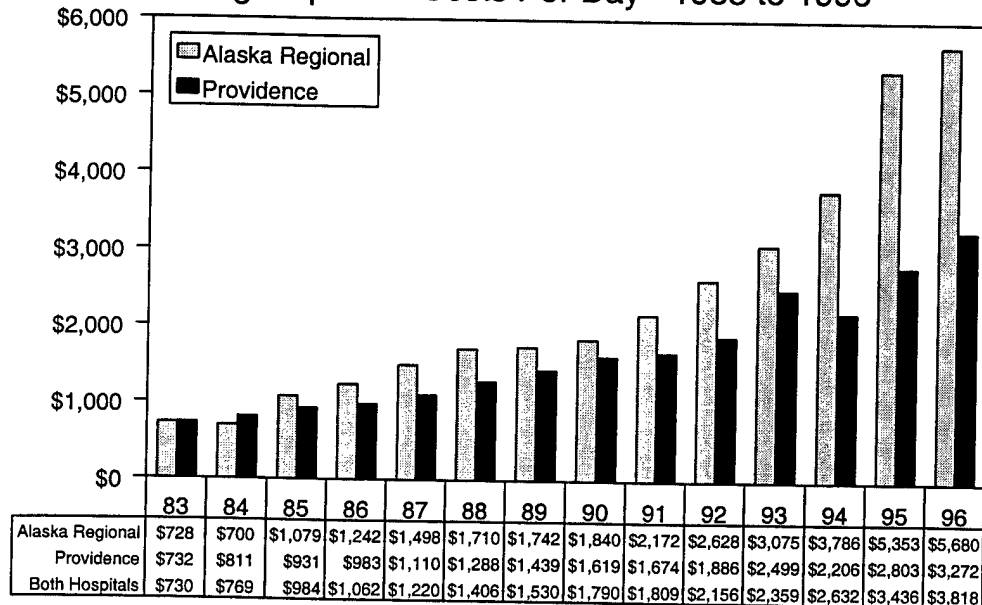


Source: Alaska Department of Health & Social Services, Medicaid Rate Advisory Commission.
(Revised 12/4/97)

97health #25

Anchorage Hospital Costs

Average Inpatient Costs Per Day - 1983 to 1996



Source: Alaska Department of Health & Social Services, Medicaid Rate Advisory Commission. (Revised 7/22/97)

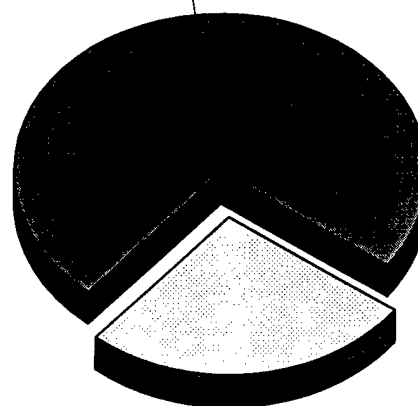
97health #26

Inpatient & Outpatient Revenues

Anchorage Hospitals - 1983 & 1996
 Inpatient 74%
 \$310.8 Million



1983: \$121.4 Million



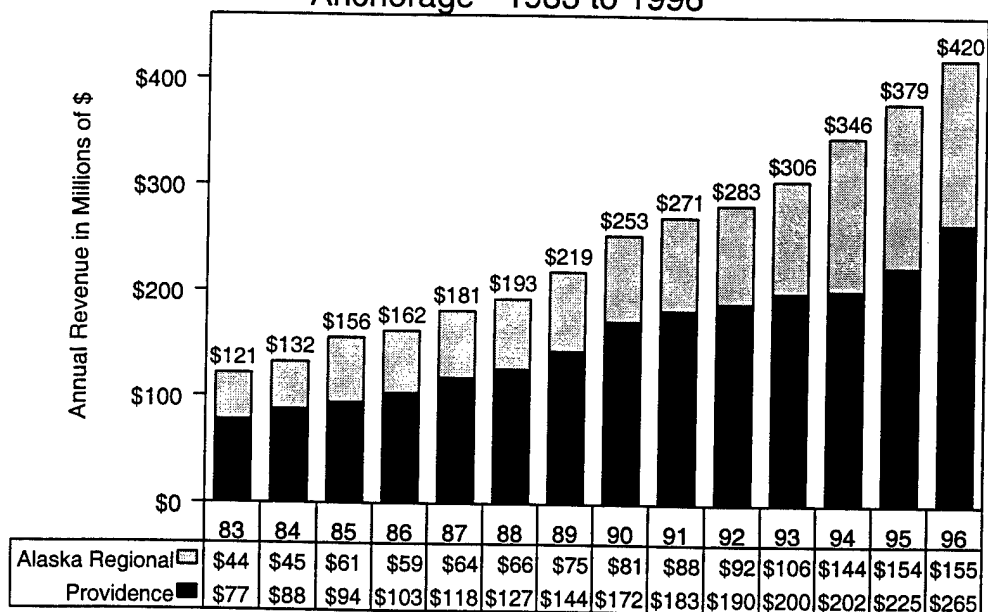
1996: \$320.3 Million

Source: Alaska Department of Health & Social Services, Medicaid Rate Advisory Commission. (Revised 7/22/97)

97health #29

Hospital Revenues (Millions of \$)

Anchorage - 1983 to 1996

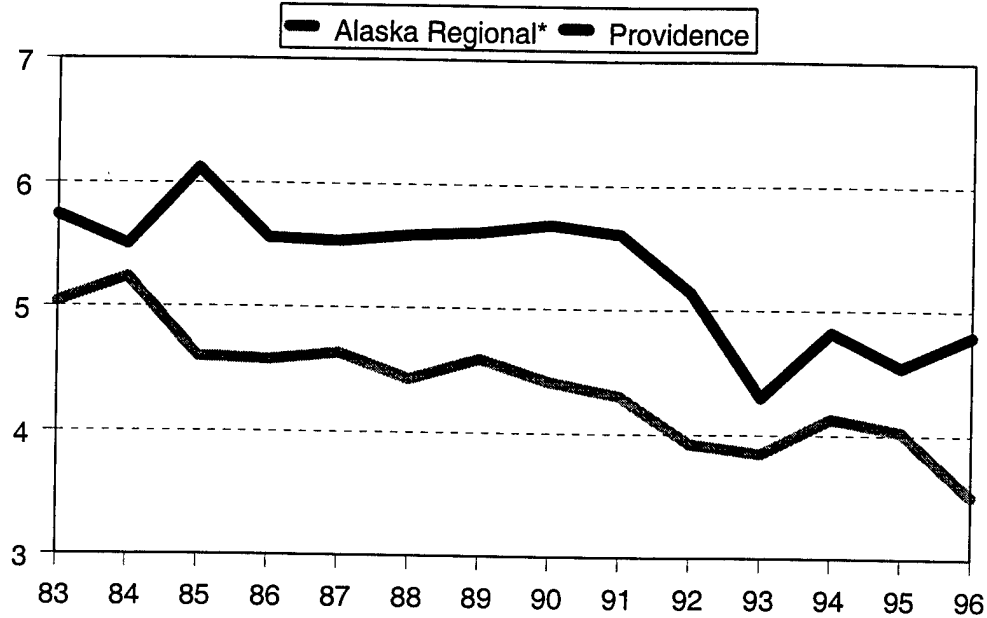


Source: Alaska Department of Health & Social Services, Medicaid Rate Advisory Commission. (Revised 7/22/97)

97health #27

Average Days of Hospital Stay

Anchorage - 1983-96

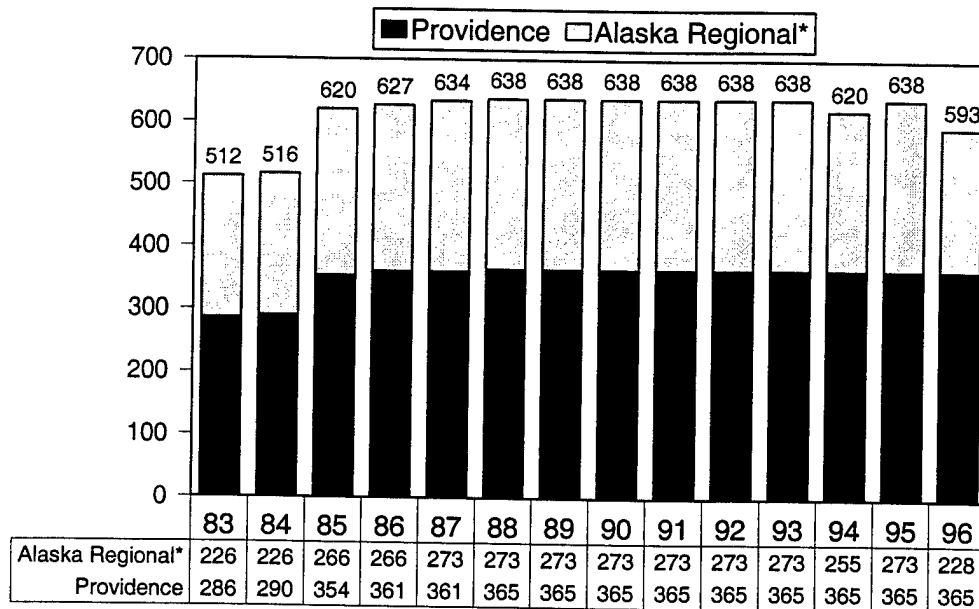


Source: Alaska Department of Health & Social Services, Medicaid Rate Advisory Commission.
(Revised 7/22/97)

97health #3

Private Hospital Beds

Anchorage - 1983-1996

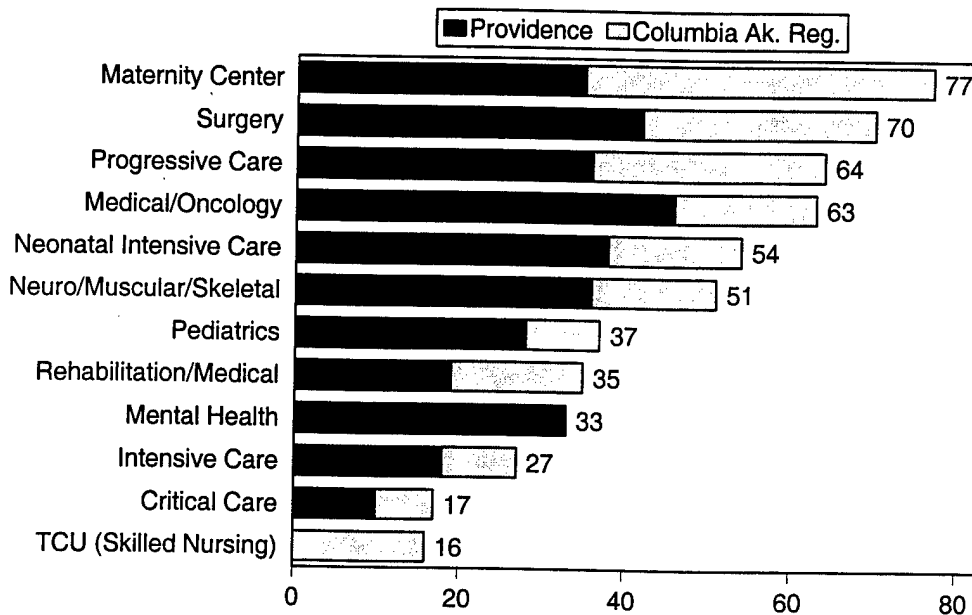


Source: Alaska Department of Health & Social Services, Medicaid Rate Advisory Commission.
(Revised 12/4/97)

97health #5

Private Hospital Acute Care Beds by Service

Anchorage - 1997



Sources: Providence Alaska Medical Center and Alaska Regional Hospital. (Revised 11/24/97)

97health #124

Private Hospital Acute Care Beds by Service

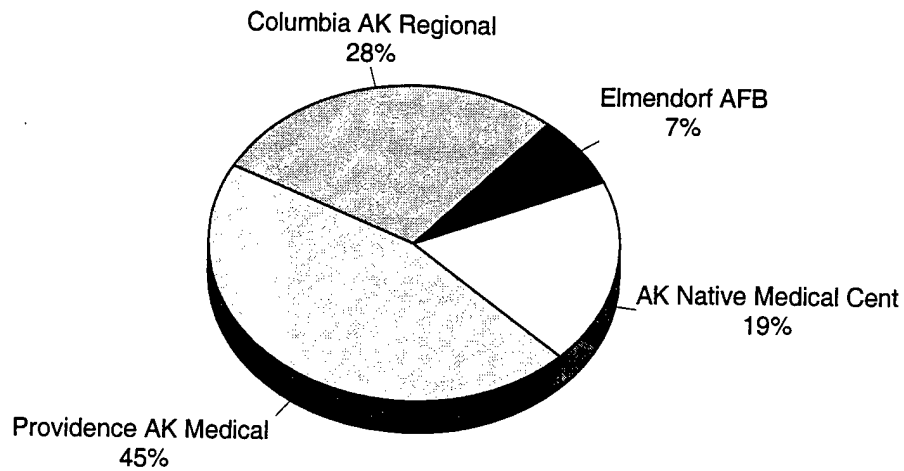
Anchorage - 1997

Type of Care	Providence	Col. Ak. Reg.	Total
Critical Care	10	7	17
Intensive Care	18	9	27
Maternity Center	35	42	77
Medical/Oncology	46	17	63
Mental Health	33	0	33
Neuro/Muscular/Skeletal	36	15	51
Pediatrics	28	9	37
Progressive Care	36	28	64
Rehabilitation/Medical	19	16	35
Surgery	42	28	70
TCU (Skilled Nursing)	0	16	16
Sub-total Adult & Pediatric Beds	303	187	490
Neonatal Intensive Care	38	16	54
TOTAL	341	203	544

Sources: Providence Alaska Medical Center and Columbia Alaska Regional Hospital.
(Revised 11/24/97)

Acute Care Hospital Beds

Anchorage - 1997



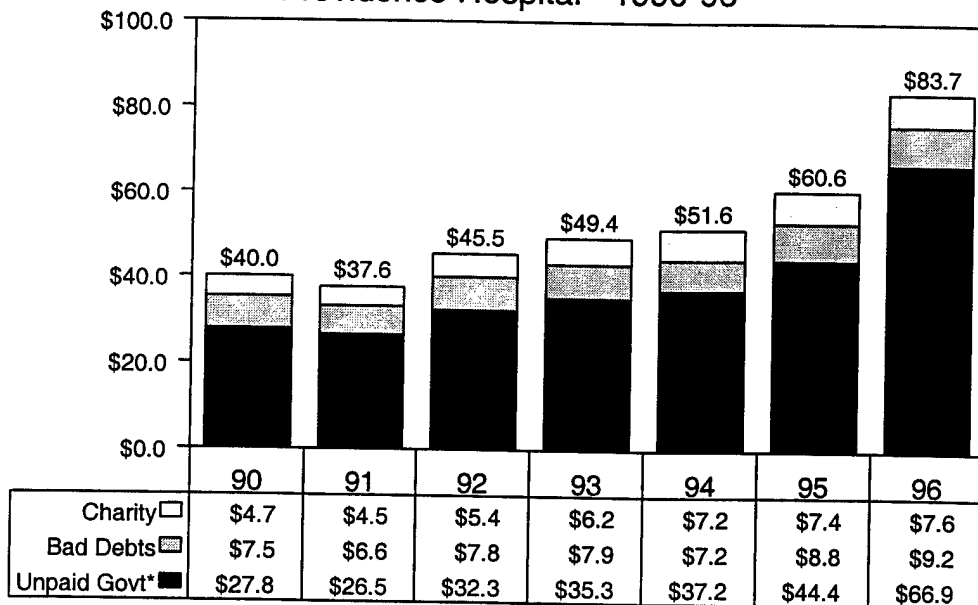
Total Beds: 803

Source: MOA Community Planning and Development telephone survey of hospitals. (Revised 12/5/97)

97health #71

\$ Value (Millions) of Uncompensated Care

Providence Hospital - 1990-96

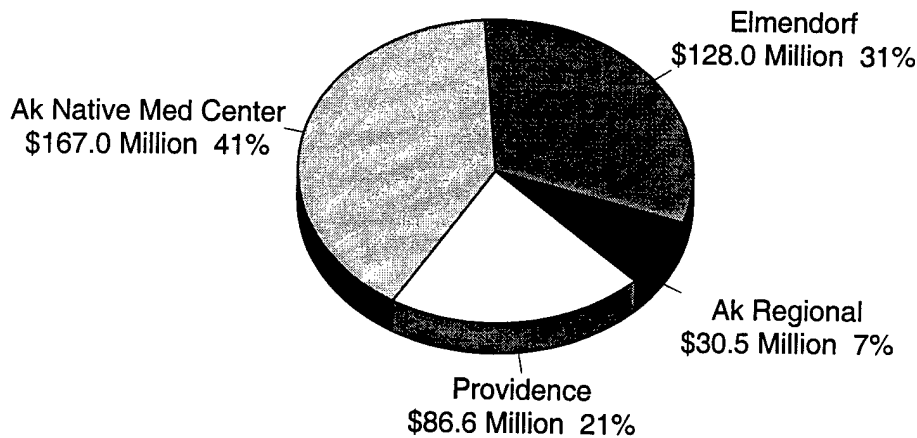


Source: Providence Hospital. *The difference between the price of a procedure and the government reimbursement paid by programs such as Medicare and Medicaid. (Revised 7/8/97)

97health #26

\$ Value of Hospital Construction

Anchorage - 1991-98



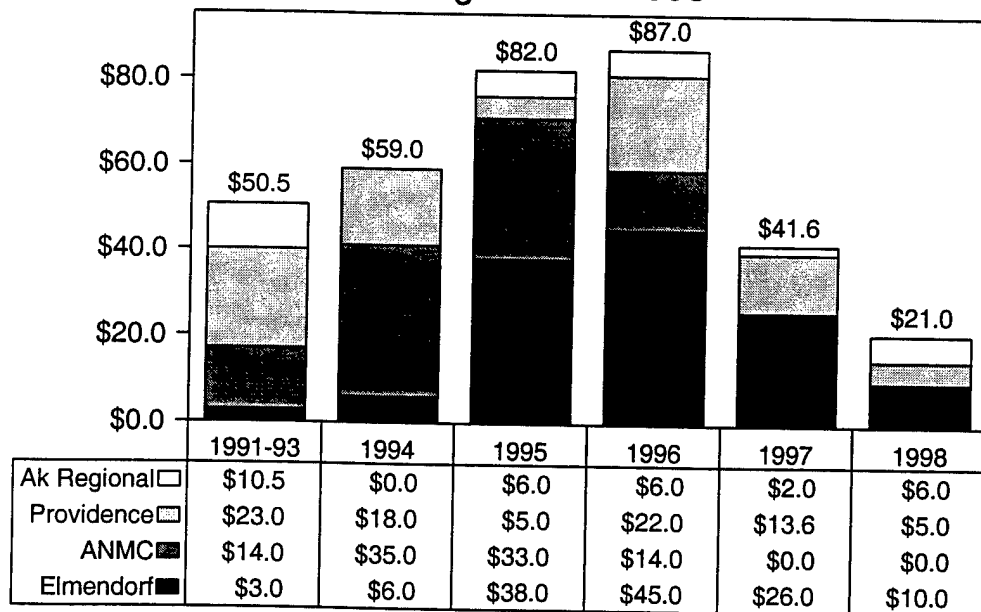
Total Value: \$412.1 Million

Source: Data from "Anchorage Medical Facility Expansion, A Market Analysis," by the Anchorage Economic Development Corporation, March 1995 was supplemented with additional information provided to the MOA Community Planning Department by each of these hospitals. (Revised 12/4/97)

97health #30

\$ Value of Hospital Construction

Anchorage - 1991-1998

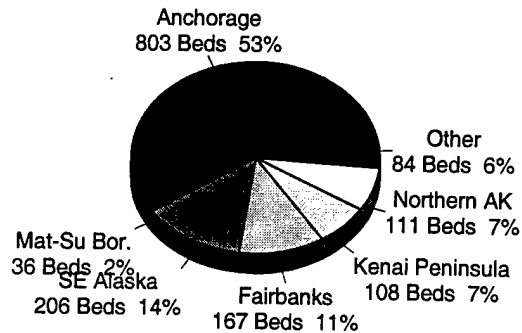


Source: Data from "Anchorage Medical Facility Expansion, A Market Analysis," by the Anchorage Economic Development Corporation, March 1995 was supplemented with additional information provided to the MOA Community Planning Department by each of these hospitals. (Revised 12/4/97)

97health #75

Acute Care Hospital Beds

Alaska 1997



Location



Funding Source

Sources: Alaska Department of Health & Social Services, Medicaid Rate Advisory Commission; Alaska Native Medical Center; personal communications with hospitals. (Revised 12/5/97)

97health #70

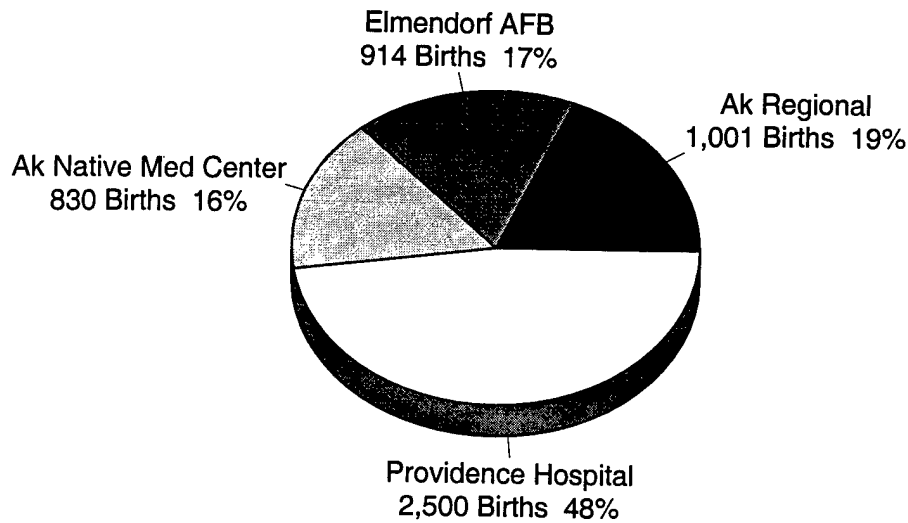
Alaska Hospital Bed Summary - 1997

Location/Hospital	Owner	Beds	Location/Hospital	Owner	Beds
Anchorage			Southeast Alaska		
Alaska Native Medical Center	IHS	150	Bartlett Memorial (Juneau)	Private	63
Columbia Alaska Regional Hospital	Private	228	Ketchikan General Hospital	Private	40
Elmendorf Air Force Base Hospital	Military	60	Mt. Edgecumb Hospital (Sitka)	IHS	60
Providence Alaska Medical Center	Private	365	Petersburg General Hospital	Private	11
Fairbanks			Sitka Community Hospital	Private	23
Bassett Army Community Hosp. (Ft. Wainwright)	Military	43	Wrangell General Hospital	Private	9
Fairbanks Memorial Hospital	Private	124	Northern Alaska		
Southwest Alaska			Manilaq Health Center (Kotzebue)	IHS	17
Kanakanak Hospital (Dillingham)	IHS	17	Norton Sound Regional Hospital (Nome)	Private	20
Kodiak Island Hospital	Private	30	Samuel Simmonds Memorial Hosp. (Barrow)	IHS	14
Kenai Peninsula			Yukon-Kuskokwim Delta Reg. Hosp. (Bethel)	IHS	60
Central Peninsula General Hospital (Soldotna)	Private	78	Valdez/Cordova		
Seward General Hospital	Private	10	Cordova Community Hospital	Private	17
South Peninsula Hospital (Homer)	Private	20	Valdez Community Hospital	Private	20
Mat-Su Borough			Total Beds		
Valley Hospital (Palmer)	Private	36	1,515		

Sources: Alaska Department of Health & Social Services, Medicaid Rate Advisory Commission; Alaska Native Medical Center; personal communications with hospitals. (Revised 12/4/97)

Live Births by Hospital

Anchorage - 1995



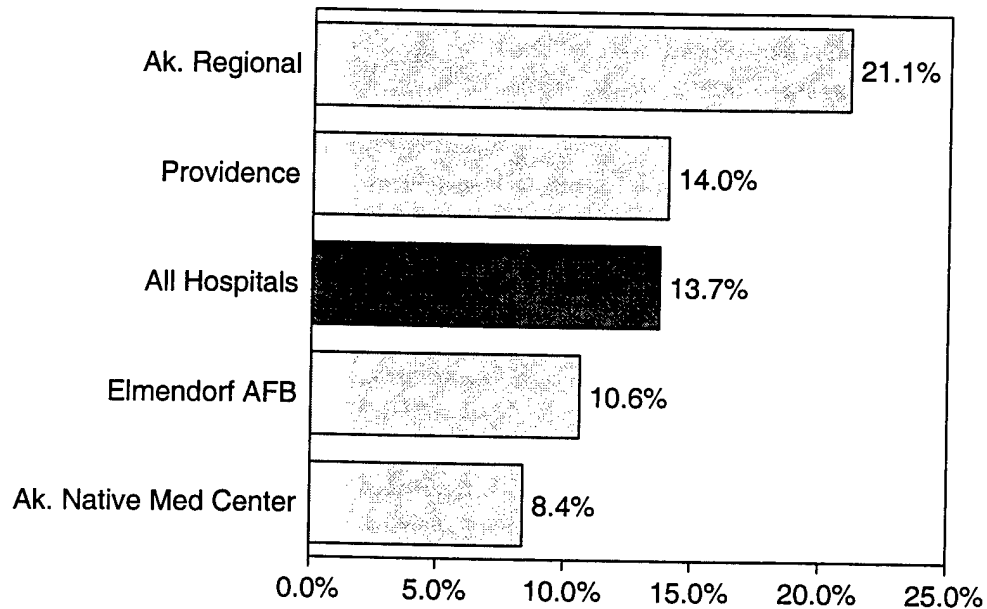
Total Births: 5,245

Source: Alaska Department of Health & Social Services, Division of Public Health, Alaska Bureau of Vital Statistics. (Revised 12/4/97)

97health #129

% C-Section Deliveries

Anchorage Hospitals - 1995

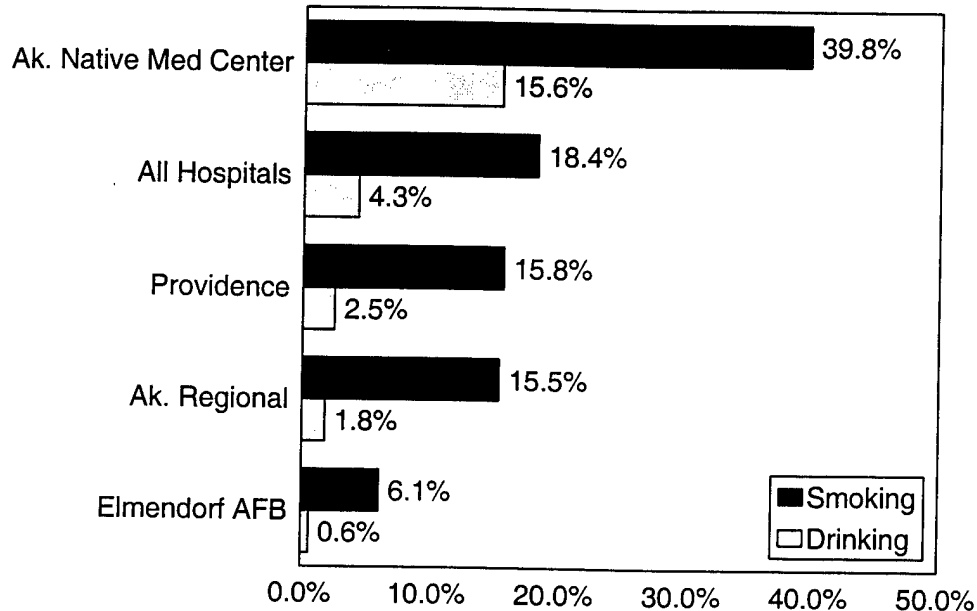


Source: Alaska Department of Health & Social Services, Division of Public Health, Alaska Bureau of Vital Statistics. (Revised 12/4/97)

97health #131

% Births by Smoking & Drinking Mothers*

Anchorage Hospitals - 1995

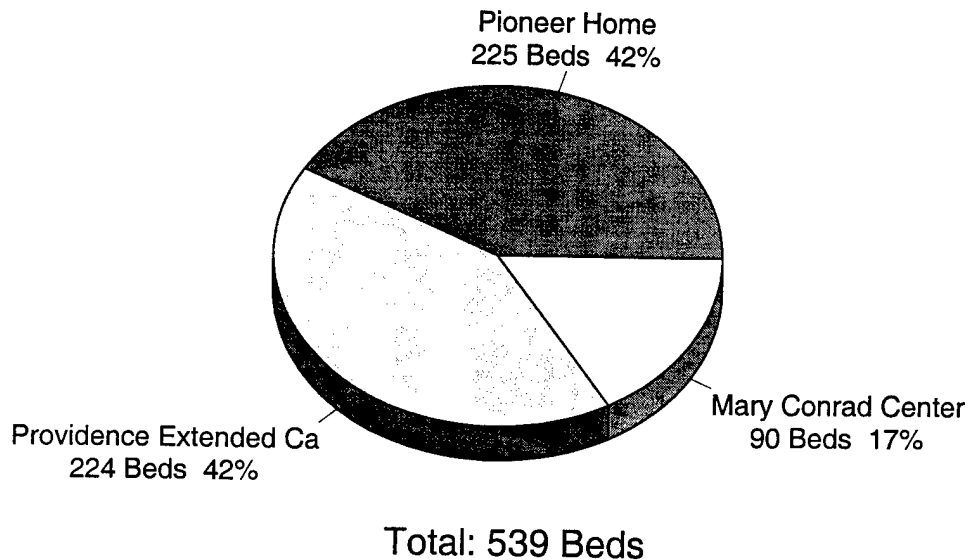


Source: Alaska Department of Health & Social Services, Division of Public Health, Alaska Bureau of Vital Statistics. *Mothers who reporting drinking alcohol or smoking during pregnancy. (Revised 12/4/97)

97health #130

Nursing Home Beds

Anchorage - December 1997

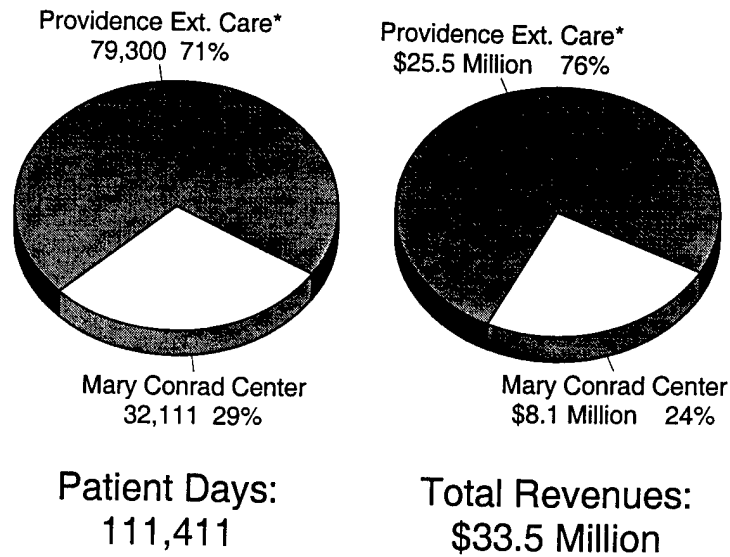


Source: MOA Community Planning & Development Dept. survey of facilities. *Note: this facility is only for senior citizens and offers a combination of nursing home care and assisted living. (Revised 12/5/97)

97health #78

Nursing Home Patient Days & Revenues

Anchorage - FY 1995

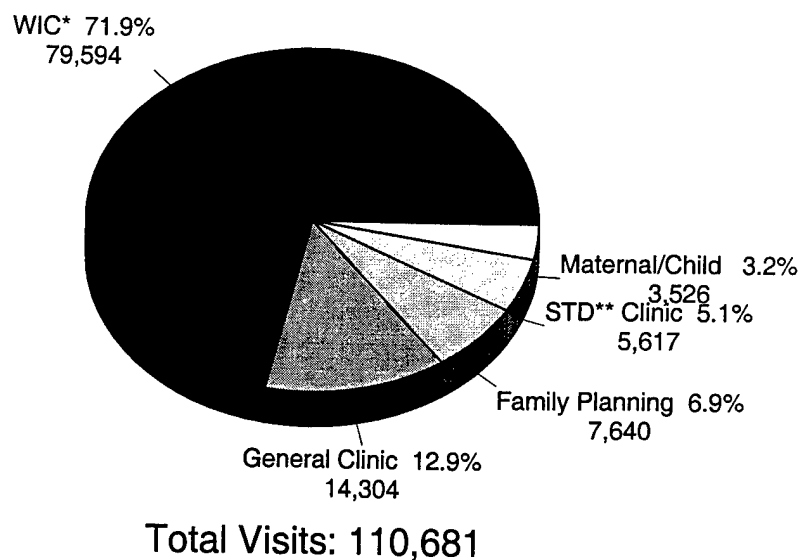


*Providence Extended Care (formerly called Our Lady of Compassion Care Center).
 Source: Alaska Department of Health & Social Services, Medicaid Rate Advisory Commission. Note:
 This information does not include patient days or revenues of the nursing home beds at the
 Anchorage Pioneers' Home which is operated by the state. (Revised 7/28/97)

97health #76

Visits by Program

Municipality of Anchorage Health Programs - 1996

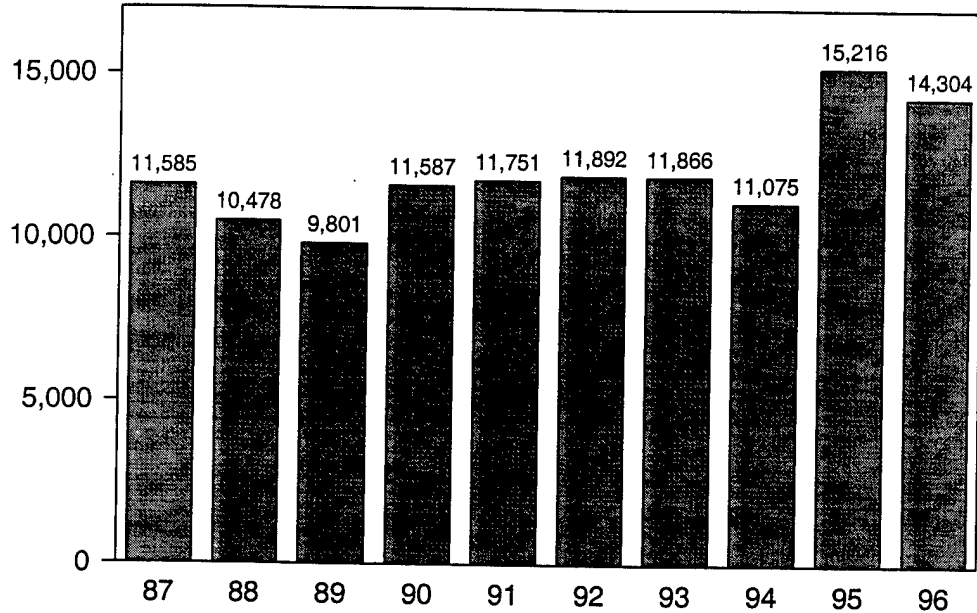


Source: Municipality of Anchorage, Health & Human Services Department. *Women, Infants and Children's Program. **Sexually Transmitted Diseases.

97health #62

MOA General Health Clinic Visits

Municipality of Anchorage Clinic - 1987-96

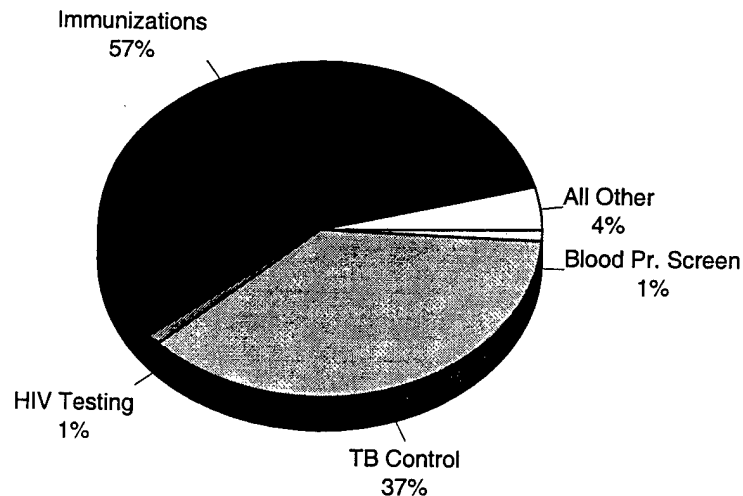


Source: Municipality of Anchorage, Health & Human Services Department, Disease Prevention & Control Program. (Revised 5/21/97)

97health #55

Reason for Visit to General Health Clinic

Anchorage - 1996



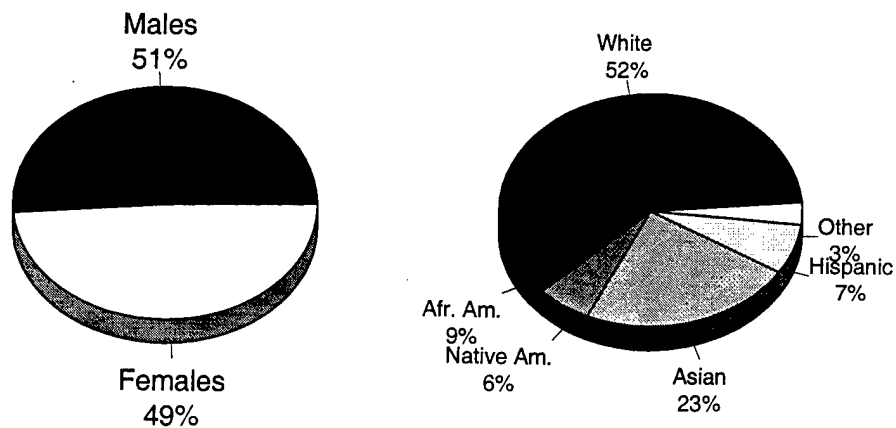
Total Services*: 17,584

Source: Municipality of Anchorage, Health & Human Services Department, Community Health Services Division. *Patients may have more than one service per visit. (Revised 5/21/97)

97health #73

MOA General Health Clinic Visits

Anchorage - 1996



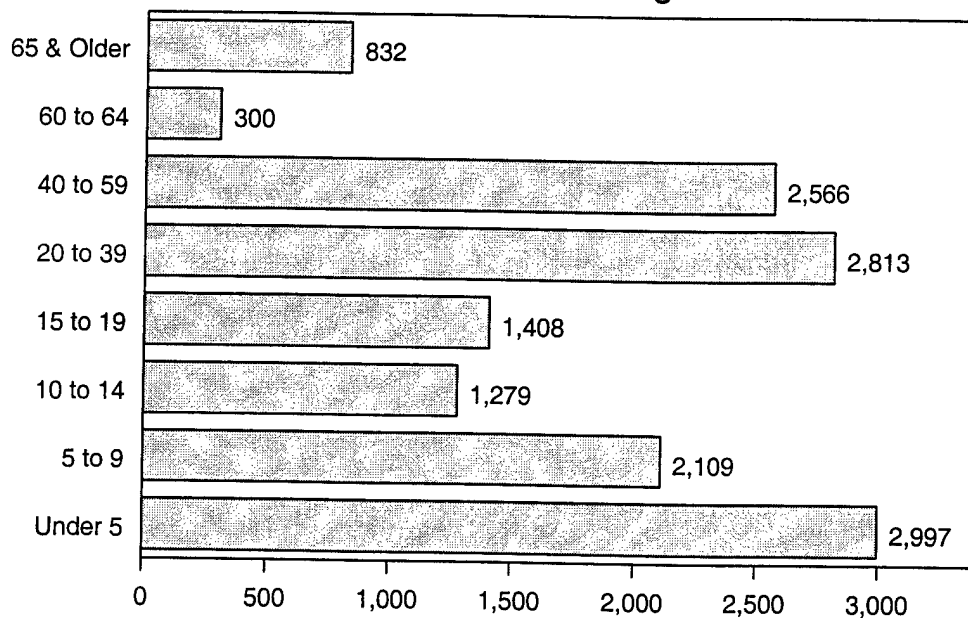
Total Visits: 14,304

Source: Municipality of Anchorage, Health & Human Services Department, Community Health Services Division, Disease Prevention & Control Program. (Revised 5/21/97)

97health #77

MOA General Health Clinic Visits

By Age of Patient - Anchorage - 1996

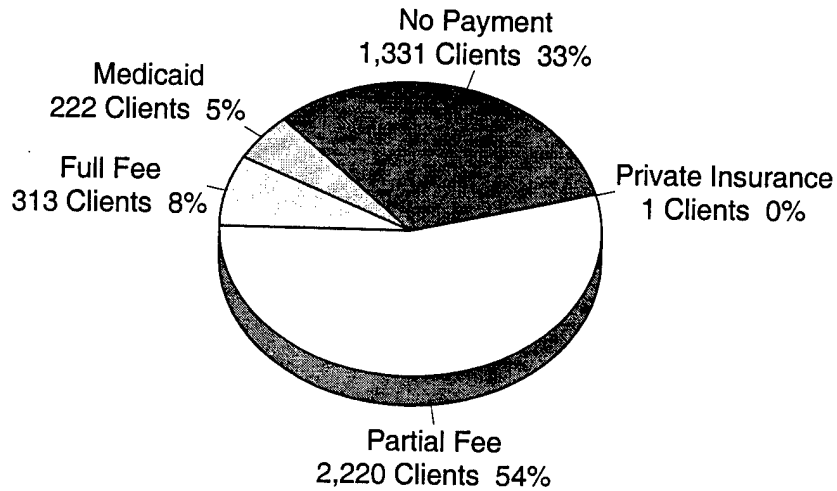


Source: Municipality of Anchorage, Health & Human Services Department, Community Health Services Division. (Revised 5/21/97)

97health #72

MOA Family Planning Client Payer Status

Anchorage - 1996



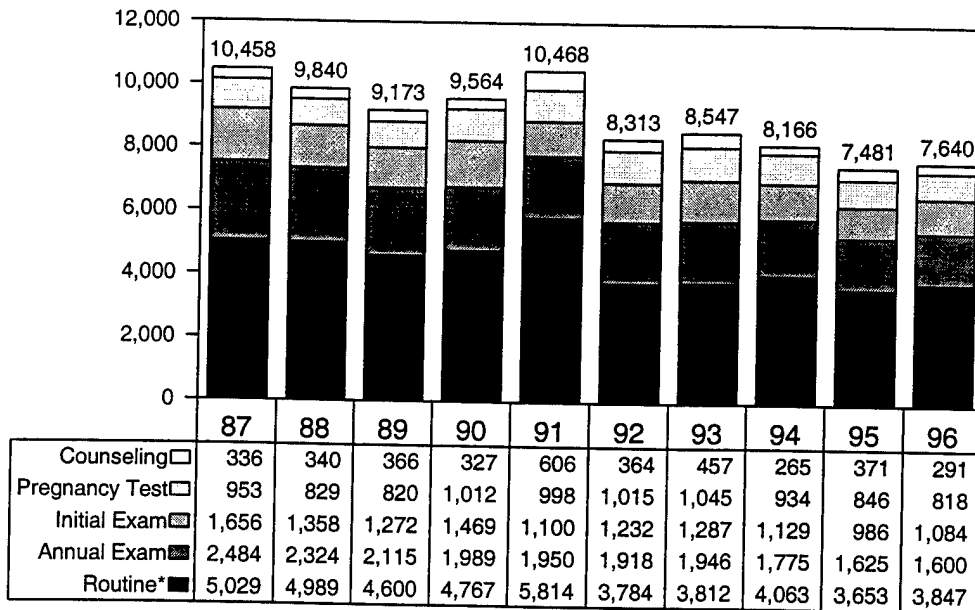
Total Clients: 4,087

Source: Municipality of Anchorage, Health & Human Services Department, Community Health Services Division, Family Planning Program. (Revised 8/1/97)

97health #45

MOA Family Planning Clinic Visits

Anchorage - 1987-96

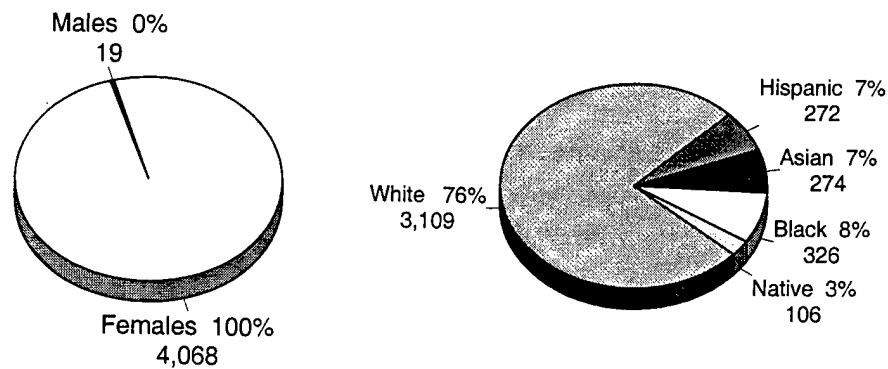


Source: Municipality of Anchorage, Health & Human Services Department, Community Health Services Division. *Includes 200 to 400 annual visits for medical problems.

97health #44

Sex & Ethnicity of MOA Family Planning Clients

Anchorage - 1996



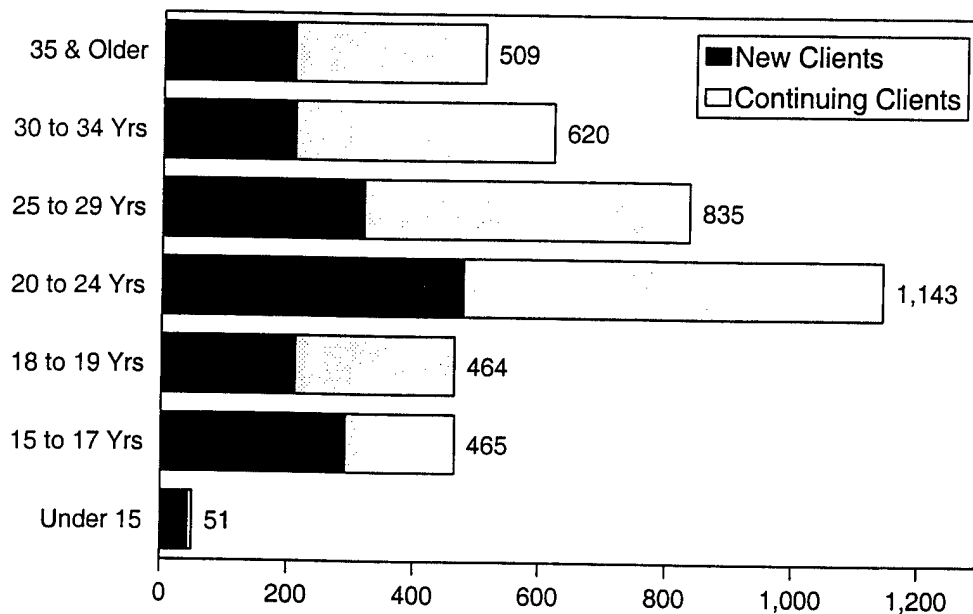
Total Clients: 4,087

Source: Municipality of Anchorage, Health & Human Services Department, Community Health Services Division, Family Planning Program.

97health #47

Age of MOA Family Planning Clinic Clients

Anchorage - 1996

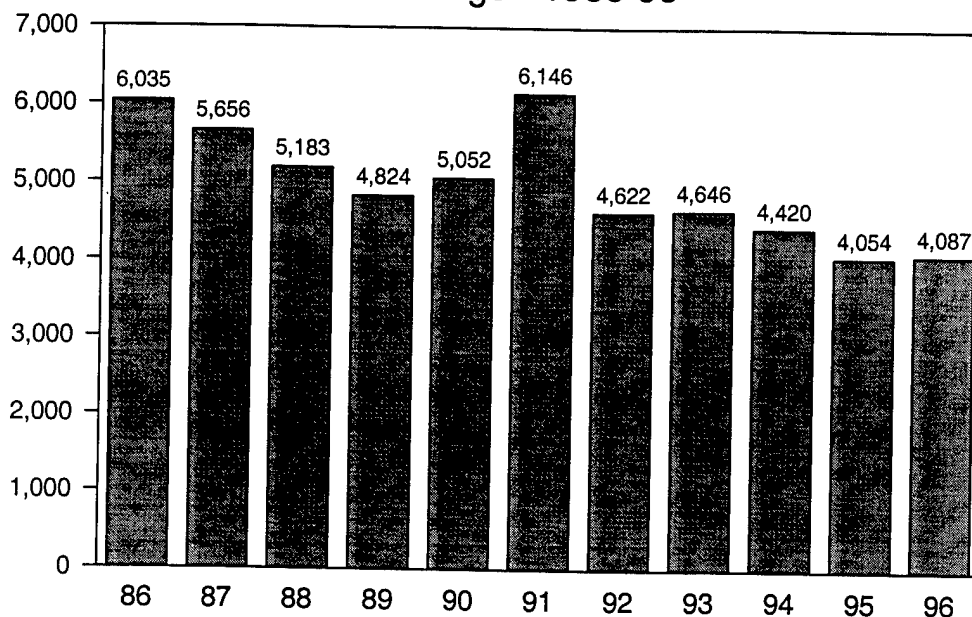


Source: Municipality of Anchorage, Health & Human Services Department, Community Health Services Division. (Revised 8/1/97)

97health #46

MOA Family Planning Clinic Clients*

Anchorage - 1986-96



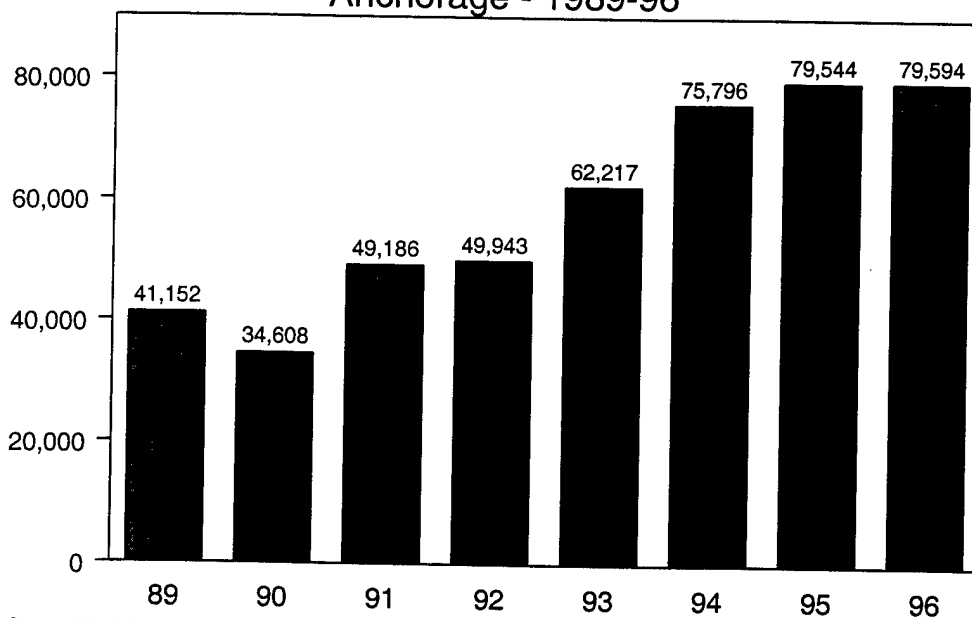
*Unduplicated.

Source: Municipality of Anchorage, Health & Human Services Department, Family Planning Program.

97health #58

WIC Program* Visits

Anchorage - 1989-96

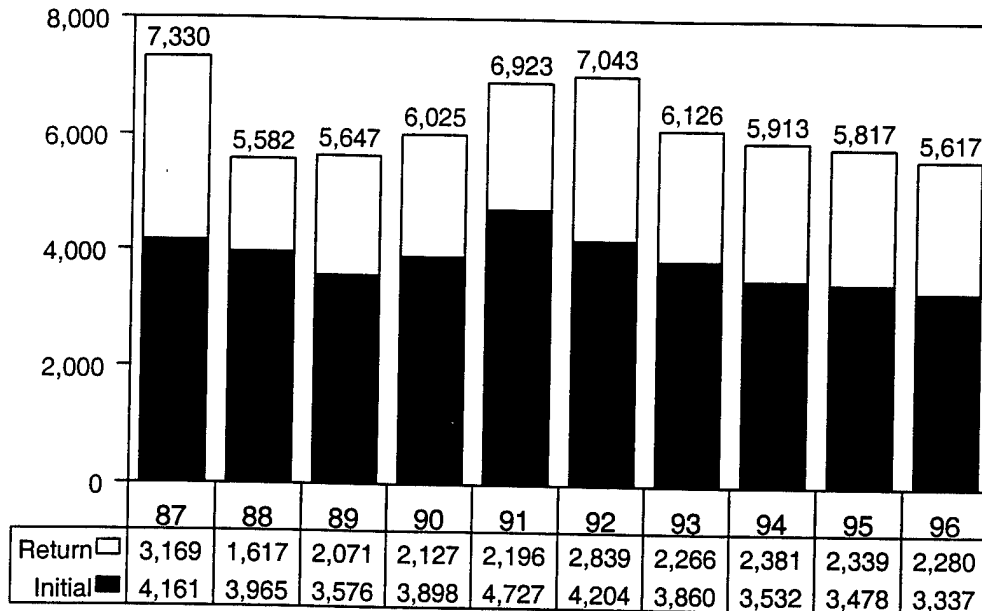


Source: Municipality of Anchorage, Health & Human Services Department, Community Health Services Division, Women's, Infants & Children (WIC) Supplemental Food Program serves provides food vouchers, nutrition assessments, counseling & referrals to pregnant or breast feeding women and children under five years of age. (Revised 5/21/97)

97health #89

MOA STD Clinic Visits

Anchorage - 1987-96

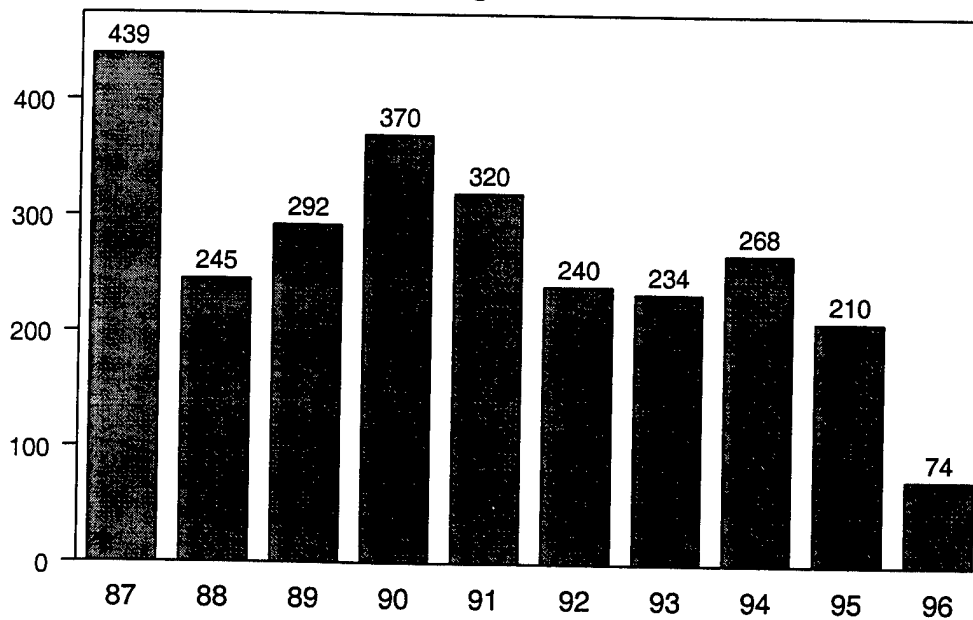


Source: Municipality of Anchorage, Health & Human Services Department, Community Health Services Division, Sexually Transmitted Disease (STD) Program. (Revised 5/21/97)

97health #82

Gonorrhea Cases - MOA STD Clinic

Anchorage - 1987-96

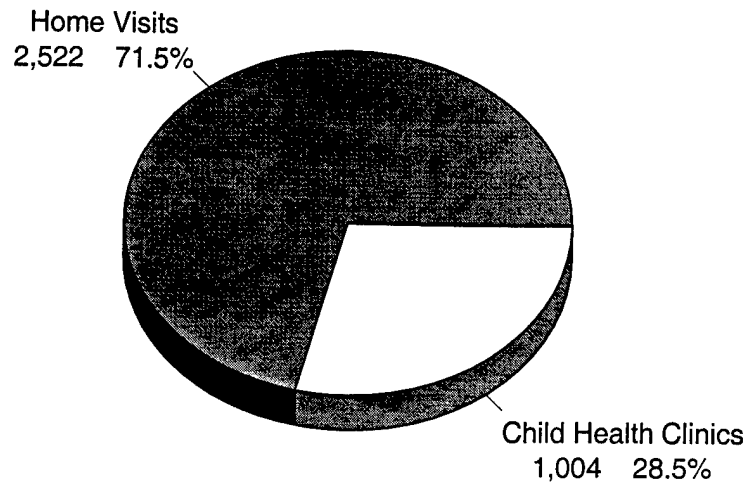


Source: Municipality of Anchorage, Health & Human Services Department, Sexually Transmitted Disease (STD) Program. (Revised 5/21/97)

97health #93

MOA Maternal Child Health Visits

Anchorage - 1996



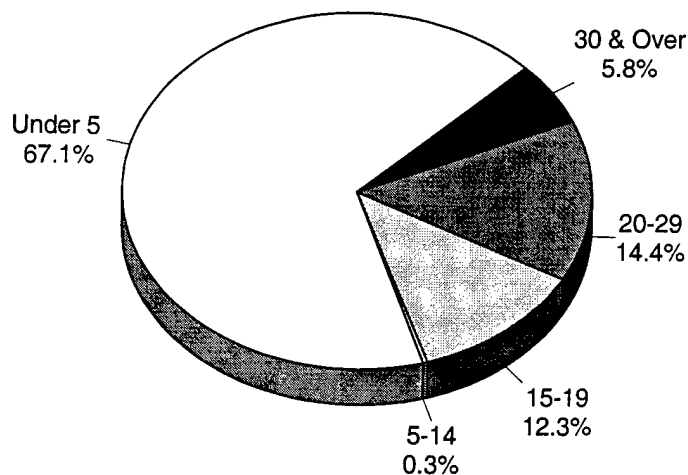
Total Visits: 3,526

Source: Municipality of Anchorage, Health & Human Services Department, Community Health Services Division, Maternal Child Health Program. (Revised 7/11/97)

97health #86

MOA Maternal Child Health* Visits

By Patient Age - Anchorage - 1996



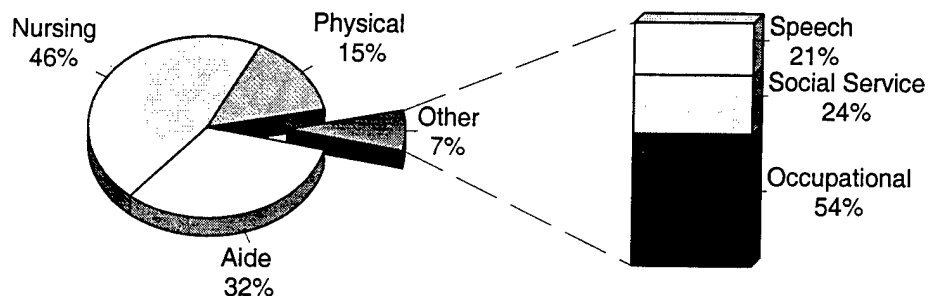
Total Visits: 3,526

Source: Municipality of Anchorage, Health & Human Services Department, Community Health Services Division. *Includes clients served by home visits, well child clinics and immunization clinics. (Revised 12/5/97)

97health #49

Home Health Care Visits by Type

Anchorage - FY 1996



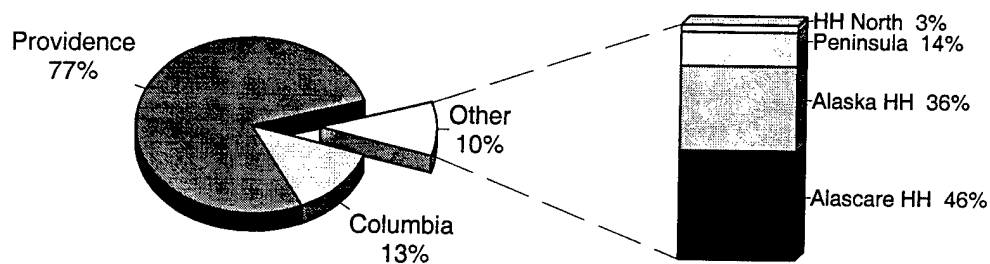
Total Visits: 38,713

Source: Alaska Department of Health & Social Services, Medicaid Rate Advisory Commission.
 Notes: Physical = Physical Therapy; Occup. = Occupational Therapy; Speech = Speech Therapy;
 Nursing = Skilled Nursing; Aide = Aide/Home Health/Visit; Social Service = Medical Social Service.
 (Revised 7/28/97)

97health #72

Home Health Care Visits by Provider

Anchorage - FY 1996



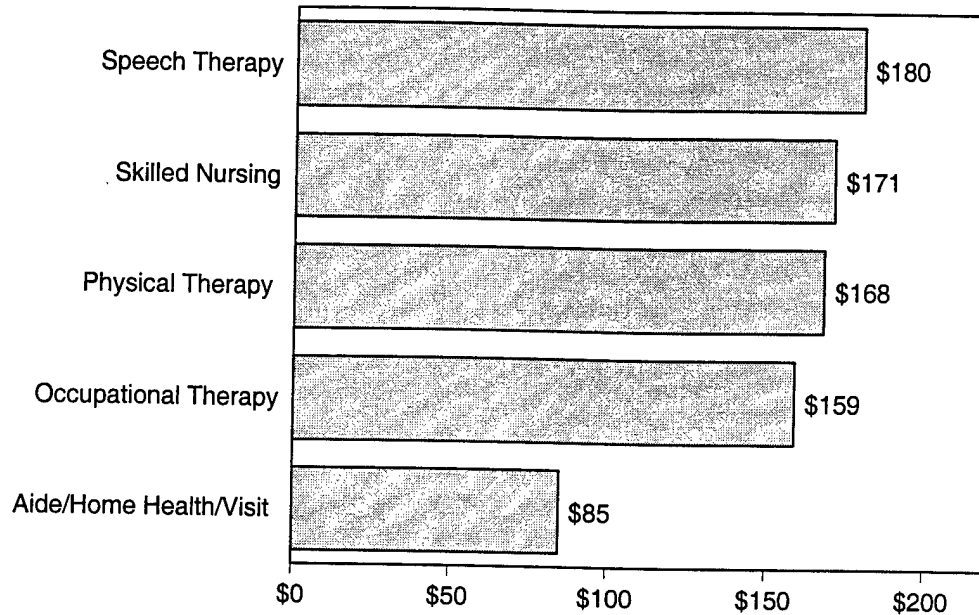
Total Visits: 38,713

Source: Alaska Department of Health & Social Services, Medicaid Rate Advisory Commission.
 Notes: Providence = Providence Home Health Care; HH North = Home Health North, Inc.; Alascare
 HH = Alascare Home Health; Columbia = Columbia Alaska Regional Home Health; Alaska HH =
 Alaska Home Health Care Agency; Peninsula = Peninsula Home Health Care-Anchorage. (Revised
 7/28/97)

97health #73

Home Health Care Average Cost* Per Visit

Anchorage - FY 1996

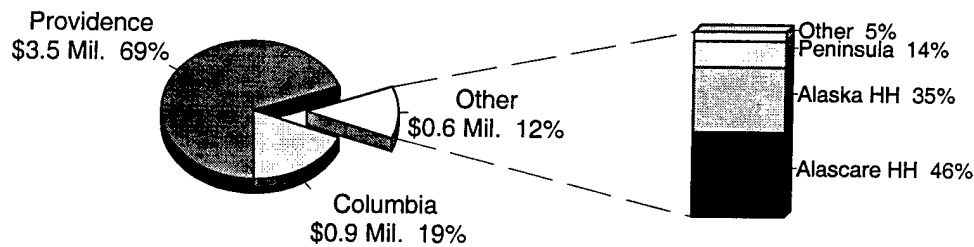


Source: Alaska Department of Health & Social Services, Medicaid Rate Advisory Commission.
 *Based on average billed costs. (Revised 7/28/97)

97health #75

Home Health Care Revenue by Provider

Anchorage - FY 1996



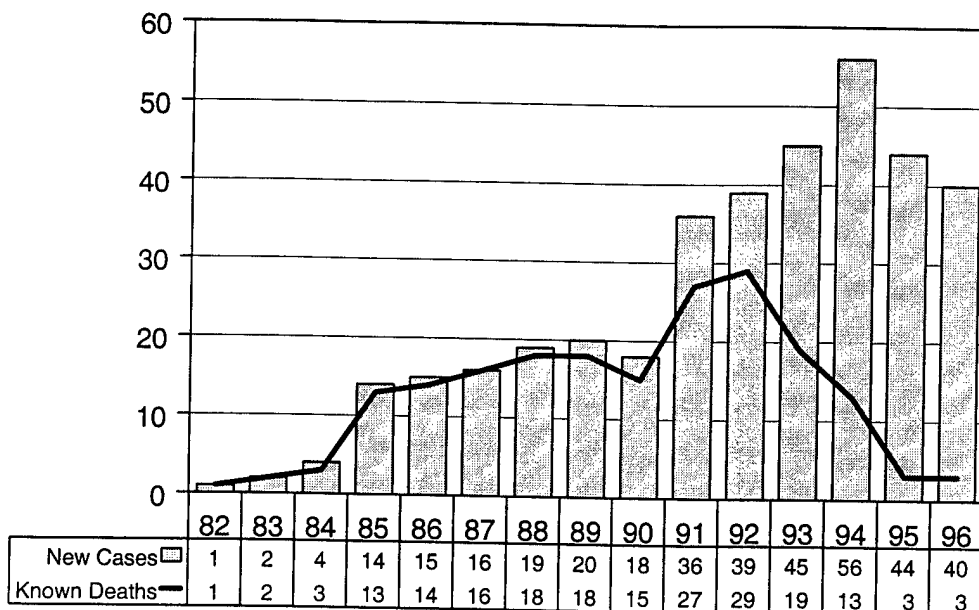
Total Revenue: \$5 Million

Source: Alaska Department of Health & Social Services, Medicaid Rate Advisory Commission.
 Notes: Providence = Providence Home Health Care; Alascare HH = Alascare Home Health;
 Columbia = Columbia Alaska Regional Home Health; Alaska HH = Alaska Home Health Care
 Agency; Peninsula = Peninsula Home Health Care-Anchorage; Other = Home Health North Inc. and
 Tokos Clinical Services. (Revised 7/28/97)

97health #74

AIDS Cases & Deaths

Alaska - 1982-96

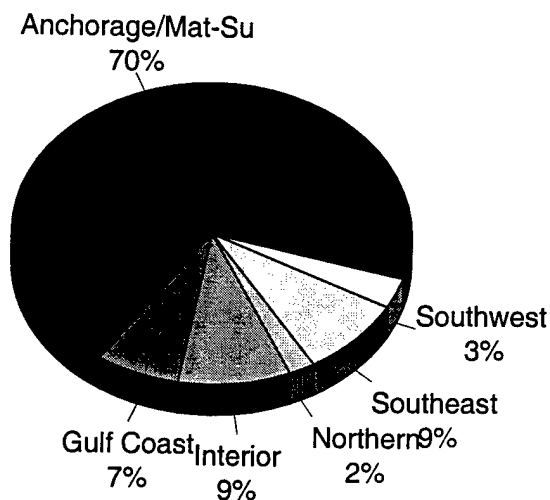


Source: Alaska Department of Health & Social Services, Division of Public Health, Section of Epidemiology.

97health #58

Total AIDS Cases By Region

Alaska 1982-96

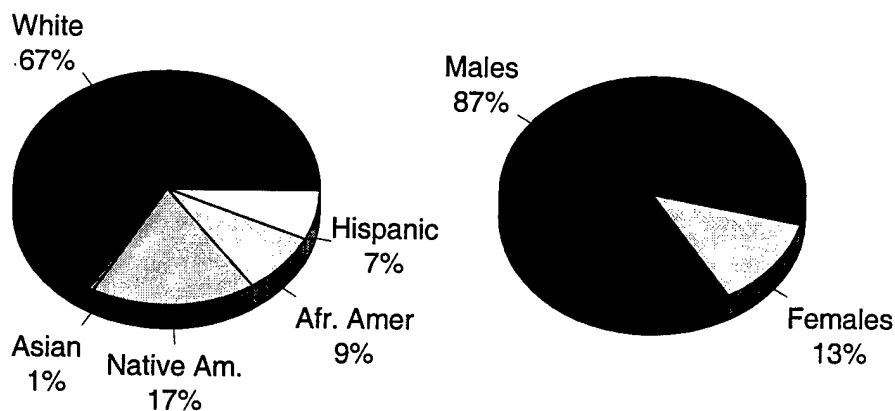


Total Cases: 369

Source: Alaska Department of Health & Social Services, Division of Public Health, Section of Epidemiology.

97health #60

Total AIDS Cases by Race & Sex Alaska 1982-96

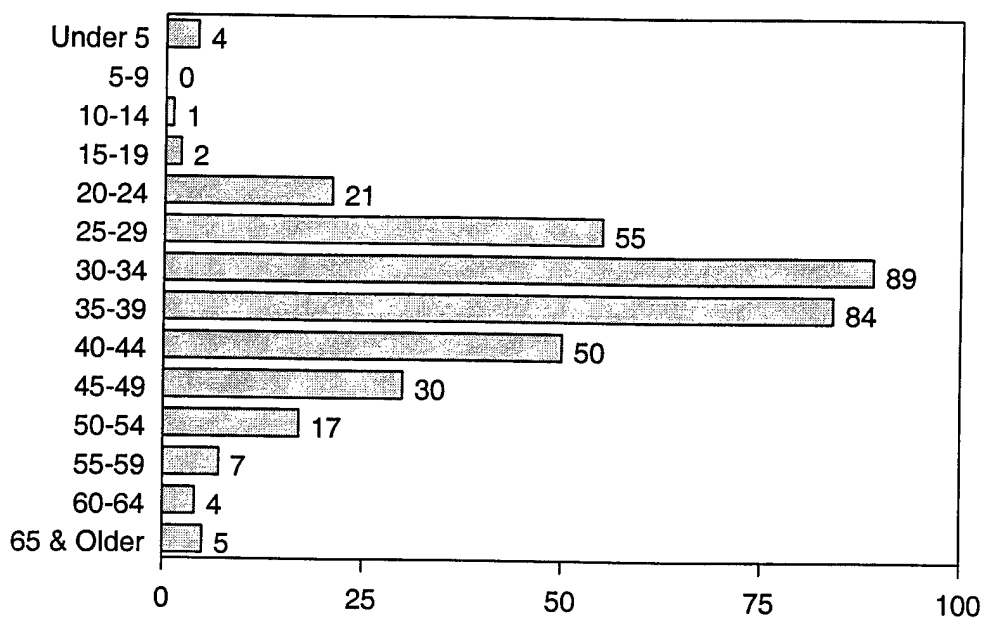


Total Cases: 369

Source: Alaska Department of Health & Social Services, Division of Public Health, Section of Epidemiology.

97health #61

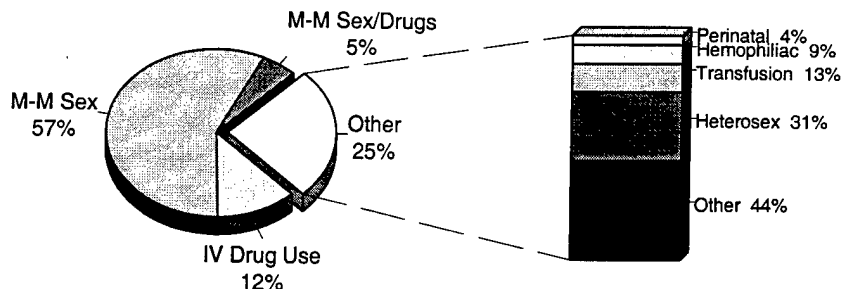
Age at Time of AIDS Diagnosis Alaska AIDS Cases - 1982-96



Source: Alaska Department of Health & Social Services, Division of Public Health, Section of Epidemiology. (Revised 7/18/97)

97health #59

Total AIDS Cases By Risk Category Alaska 1982-96

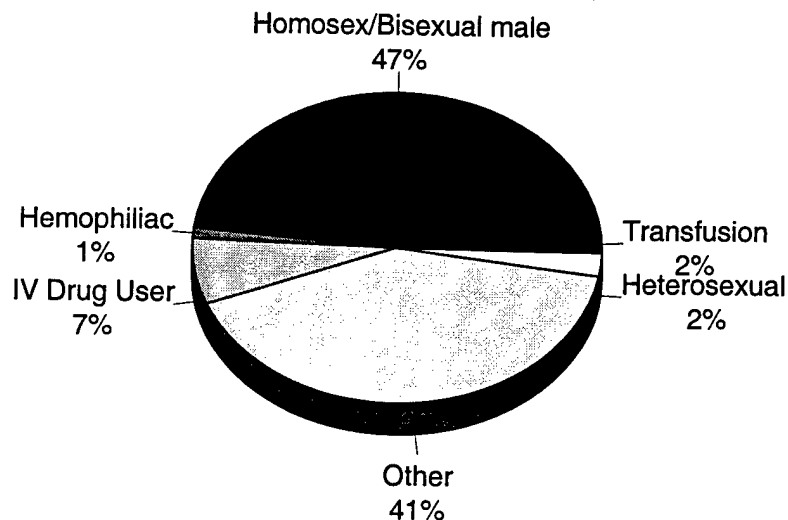


Total Cases: 369

Source: Alaska Department of Health & Social Services, Division of Public Health, Section of Epidemiology. M-M Sex = Male-Male Sex

97health #62

Positive HIV Test by Risk Category Alaska - May 1, 1985-Dec. 31, 1996



Total Cases: 640

Source: Alaska Department of Health & Social Services, Division of Public Health, Section of Epidemiology. (Revised 7/18/97)

97health #63

100

100

100

100

100

100

100

100

100

100

B

100

100

MEDICAL SERVICES

3RD MEDICAL GROUP

Aeromedical Services	Nursing
Allergy/Immunization	Obstetrics/Gynecology
Ambulatory Surgery	Ophthalmology
Audiology	Optometry
Anesthesiology	Orthopedic Surgery
Cardiology	Otorhinolaryngology
Dermatology	Pathology
Emergency Medicine	Pediatrics
Family Practice	Psychiatry
Gastroenterology	Psychology
General Surgery	Social Work Services
Internal Medicine	Substance Abuse Recovery
Medical Imaging	Urology
Neurology	

ANCILLARY SERVICES 3RD MEDICAL GROUP

Anatomical
Laboratory

Bio-Env Engineering

Blood Bank

Clinical Laboratory

Dental Laboratory

Health Promotions

Military Public
Health

Nuclear Medicine

Nutritional
Medicine

Occupational
Therapy

Pharmacy

Physical Therapy

DENTAL SERVICES

3RD MEDICAL

GROUP

General Dentistry

Endodontics

Oral Surgery

Orthodontics

Periodontics

Prosthodontics

C

TRICARE Information**THE HISTORY OF CHAMPUS AND ITS EVOLVING ROLE IN TRICARE**

CHAMPUS--now called TRICARE Standard in most of the country--marked its 30th anniversary in 1997. It has evolved into a key component of the new TRICARE health benefits program of the Department of Defense.

Today's TRICARE program has been nearly 200 years in development. The idea of military medical care for the families of active-duty members of the uniformed services dates back to the late 1700s. In 1884, Congress directed that the "medical officers of the Army and contract surgeons shall whenever possible attend the families of the officers and soldiers free of charge."

There was very little change until World War II. Most draftees in that war were young men who had wives of child-bearing age. The military medical care system, which was on a wartime footing, couldn't handle the large number of births, nor the care of very young children. In 1943, Congress authorized the Emergency Maternal and Infant Care Program (EMIC). EMIC provided for maternity care and the care of infants up to one year of age for wives and children of service members in the lower four pay grades. It was administered by the "Children's Bureau," through state health departments.

The Korean conflict again strained the capabilities of the military health care system. On Dec. 7, 1956, the Dependents Medical Care Act was signed into law. The 1966 amendments to this act created what would be called CHAMPUS beginning in 1967. The law authorized ambulatory and psychiatric care for active-duty family members, effective Oct. 1, 1966. Retirees, their family members, and certain surviving family members of deceased military sponsors were brought into the program on Jan. 1, 1967.

The CHAMPUS budget for Fiscal Year 1967 was \$106 million. Records don't indicate how many claims were filed in FY 1967, but the total probably wasn't more than a few thousand. In FY 1996, the TRICARE/CHAMPUS budget was more than \$3.5 billion, and more than 20 million claims were received. Today, nearly 5.5 million people are eligible for TRICARE benefits.

Over the past three decades, many new benefits--such as liver, heart, lung and heart-lung transplants, and hospice care--have been added to the program. Many procedures that once required admission to a hospital are now done on an outpatient basis. Non-hospital facilities, such as ambulatory surgical centers and free-standing birthing centers, have been added as authorized providers of care.

In the 1980s, the search for ways to improve access to top-quality medical care, while keeping costs under control, led to several CHAMPUS "demonstration" projects in various parts of the U.S. Foremost among these was the "CHAMPUS Reform Initiative" (CRI), in California and Hawaii. Beginning in 1988, CRI offered service families a choice of ways in which they might use their military health care benefits. Five years of successful operation and high levels of patient satisfaction convinced Defense Department officials that they should extend and improve the concepts of CRI, as a uniform program nationwide. The new program, known as TRICARE, is expected to be fully phased in nationwide by mid-1998, with concurrent expansion overseas.

TRICARE offers families three choices:

1. Enrollment in TRICARE Prime, a health maintenance organization (HMO)-type source of care which has very low costs;
2. TRICARE Extra, an expanded network of providers that offers reduced cost-sharing, doesn't require enrollment, and can be used on a case-by-case basis;
3. TRICARE Standard, which is the same as CHAMPUS, with the same benefits and cost-

sharing structure.

For more information about any of the three TRICARE options, contact your regional contractor's nearest TRICARE service center; or call the health benefits adviser at the nearest military medical facility.



[Back](#) [Home](#) [Top](#)

TRICARE REGIONS

Region 1 Maine, New Hampshire, Vermont, Massachusetts, Connecticut, Rhode Island, Pennsylvania, the District of Columbia, Northern Virginia, and the NE corner of W. Virginia Operational June 1, 1998 1-888-999-5195	Region 6 Oklahoma, Arkansas, western 2/3 of Louisiana, Texas (excluding SW corner) Operational November 1, 1995 1-800-406-2832	Region 12 (Pacific) Hawaii and Alaska Operational April 1, 1996 Pacific and WESTPAC 1-888-777-8343
Region 2 North Carolina and most of Virginia Operational May 1, 1998 1-800-931-9501	Central (Region 7/8) New Mexico, Arizona (not Yuma), Nevada and SW corner of Texas, Colorado, Utah, Wyoming, Montana, Idaho (not Northern), North Dakota, South Dakota, Nebraska, Kansas, Minnesota, Iowa and Missouri Operational April 1997 1-888-TRIWEST (874-9378)	Latin America, Panama, Central America, South America 1-888-777-8343
Region 3 South Carolina, Georgia, and Florida excluding panhandle Operational July 1, 1996 1-800-444-5445	Region 9 Southern California and Yuma, Arizona Operational April 1, 1996 1-800-242-6788	Europe Europe, Africa, Middle East, Azores and Iceland Operational October 1996 1-888-777-8343
Region 4 Florida panhandle, Alabama, Mississippi, Tennessee and eastern 1/3 of Louisiana Operational July 1, 1996 1-800-444-5445	Region 10 Northern California Operational April 1, 1996 1-800-242-6788	
Region 5 Michigan, Wisconsin, Illinois, Indiana, Ohio, Kentucky, and W Virginia (excluding NE corner) Operational May 1, 1998 1-800-941-4501	Region 11 Washington, Oregon, and N Idaho Operational March 1, 1995 1-800-404-0110	

TRICARE Information**TRICARE: The Basics**

TRICARE is the Defense Department's regional managed health care program for service families. It consists of three options: TRICARE Prime, TRICARE Extra, and TRICARE Standard. It is being implemented region-by-region throughout the country, and is expected to be in place nationwide by mid-1998. Here's a brief description of each option:

TRICARE Prime

This is a voluntary enrollment option that's much like a civilian health maintenance organization (HMO). If you live in an area where TRICARE Prime is offered, and you decide to get your care through TRICARE Prime, you'll enroll for a year at a time. You'll normally receive your care from within the Prime network of civilian and military providers. Active-duty service members themselves will have automatic enrollment and will choose, or be assigned to, a primary care manager. Their families--and all others who are eligible--must take action if they want to enroll. Enrollment of newborns and newly adopted children in TRICARE Prime is automatic if another family member is enrolled (unless the sponsor specifies otherwise)--but the children must be registered in DEERS (the Defense Enrollment Eligibility Reporting System) before their enrollment in TRICARE Prime becomes effective.

Active-duty families won't have to pay an annual enrollment fee. All others will, but there'll be no annual deductibles, and the patient's share of the costs for services under Prime will be reduced. You won't have to file claims when using TRICARE Prime network providers.

Covered services will be like those of TRICARE Standard (formerly called CHAMPUS), plus additional preventive and primary care services. For example, physical screenings are covered at no charge under TRICARE Prime, but are not covered under the other two health care options, TRICARE Extra and TRICARE Standard.

You'll choose, or will be assigned, a "primary care manager" (PCM), from whom you'll get most of your routine health care. Your PCM will manage all aspects of your care, including referrals to specialists, with the help of the local health care finder (HCF). Remember: Your PCM and HCF must arrange for a referral when required, before you get specialized care.

As a TRICARE Prime enrollee, you also have what's called a "point-of-service" (POS) option. This means that you can choose to get non-emergency services without a referral from your primary care physician. However, if you decide to get care under the POS option, there's an annual deductible of \$300 for an individual or \$600 for a family. After the deductible is satisfied, your cost-share for POS care will be 50 percent of the TRICARE allowable charge. You may also have to pay any additional charges by non-network providers--up to 15 percent above the allowable charge. And, you may have to pay the entire bill when you receive the services, then--after a claim is filed-- wait for reimbursement of the government's share of the costs.

TRICARE Extra

Under this option, you don't have to enroll, or pay an annual fee. You can seek care from a provider who's part of the TRICARE network, and get a discount on services, and pay reduced cost-shares (five percent below those of TRICARE Standard) in most cases. You won't have to file any claims when using network providers. You will have to meet the normal annual outpatient deductible (\$50 for one person or \$100 for a family, for active-duty pay grades E-4 and below; or \$150 for one person, and \$300 for a family, for all other eligible persons), as you would under TRICARE Standard. Call your contractor's local health care finder for help in locating a provider who's part of the TRICARE Extra network. Or, use the contractor's directory of providers (available at TRICARE service centers). You can still use a military medical facility when space is available.

TRICARE Standard

This option is what you've come to know as CHAMPUS. The name change doesn't change the benefits or how you use them. TRICARE Standard pays a share of the cost of covered health services that you obtain from a non-network civilian health care provider. There's no enrollment in TRICARE Standard. The annual deductibles, cost-shares and benefits are the same as they were for CHAMPUS. Under this option, you have the most freedom to choose your provider of care--but your costs will be higher than with the other two TRICARE options. Also, you may have to file your own claim forms--and perhaps pay a little more for the care (up to 15 percent more than the allowable charge), if the provider you choose doesn't participate in TRICARE Standard. If the provider does participate, he or she agrees to accept the TRICARE Standard allowable charge as the full fee for the care you receive, and will file the claims for you.

To use TRICARE Standard, just pick a physician or other TRICARE-authorized provider of care. Ask the provider if he or she participates in TRICARE Standard. Of course, you can still use your nearby military hospital or clinic, if they have the capacity to provide services to you.

No matter which of the three TRICARE options you decide to use, be sure you understand the rules under which they operate. Get copies of any brochures, fact sheets or handbooks that pertain to the option you select. You can usually obtain informational materials from the health benefits adviser at the nearest military medical facility, or from the regional TRICARE contractor's local TRICARE service center.



TRICARE OPTIONS

	TRICARE Prime	TRICARE Extra	TRICARE Standard (CHAMPUS)
Choice of civilian doctors, hospitals, clinics	Must Choose from government-approved network	Must choose from preferred provider network	Unlimited
Annual enrollment fees			
Active duty & Family members	None	None	None
Annual outpatient deductibles			
E-4 and Below	None	Individual: \$50 Family: \$100	Individual: \$50 Family: \$100
E-5 and Above	None	Individual: \$150 Family: \$300	Individual: \$150 Family: \$300
Copayments for visit to civilian doctor			
E-4 and Below family members	\$ 6	15 percent	20 percent
E-5 and Above family members	\$12	15 percent	20 percent
Copayments at Civilian hospitals for inpatient care			
Active Duty family members	\$11 per day \$20 per day, Mental Health	\$9.50 per day (\$25 minimum)	\$9.50 per day (\$25 minimum)

Frequently Asked Questions

January 1998, Revision 5



General Information

1. What is TRICARE?
2. What will happen if I don't take any action to change my current health care plan?
3. How does TRICARE improve military readiness?
4. Will the quality of care that I am currently receiving through the Military Treatment Facility (MTF) improve with the TRICARE program?
5. How can I find the location of my nearest TRICARE Service Center?
6. Who is eligible to participate in TRICARE?
7. I am currently enrolled in the Uniformed Services Family Health Plan (USFHP). How does that program fit into TRICARE?
8. What are my health plan options available under TRICARE?
9. Which option is the best choice for me if I don't live close to an MTF?
10. Which is the best of the three TRICARE options for a retiree who lives in two different parts of the country?
11. How do TRICARE Service Centers assist beneficiaries?
12. How can I find out more information about the TRICARE programs?
13. What is my priority for care in the MTF?
14. If I have a grievance for services rendered under the TRICARE program, who can I contact?
15. Is there a maximum that I may have to pay under the three TRICARE options?

TRICARE Prime

16. Should a family member covered by other comprehensive health insurance enroll in Prime?
17. What guarantees do I have that, as a TRICARE Prime enrollee, I won't just end up on the phone, waiting to make an appointment at the hospital or clinic?
18. What should I do if I'm a Prime enrollee and get sick while traveling outside my region? What if the 800 number is busy and I can't make contact?

Active Duty

19. I'm on active duty and stationed away from a military installation. What do I do for medical care, and do I have to pay?

Enrollment

20. Does the enrollment fee for TRICARE Prime have to be paid all at once, or can it be paid in installments?
21. How can I enroll in TRICARE Prime?
22. What is my priority for being offered enrollment in TRICARE Prime?
23. If I enroll in TRICARE Prime does that mean that my whole family has to enroll?
24. Is there a minimum enrollment period requirement for TRICARE Prime?
25. If I choose to disenroll after I have enrolled in TRICARE Prime, what penalty is incurred? Can I get back into TRICARE Prime if I don't like the other options?

26. Are there any deadlines or restrictions for enrolling in TRICARE Prime?
27. Can my son or daughter, who is away from home at college, enroll in TRICARE Prime at his college if the option is available there?
28. In the near future, I might want my children, who will be leaving for college, to switch from Prime to Standard. What is the process for this?

Portability (Moving)

29. As a retiree enrolled in TRICARE Prime, does my enrollment transfer to the new region if I move?
30. If my family moves to a different region, are we (active duty) automatically assigned a new Primary Care Manager, or do we have to re-enroll?
31. If I'm a Prime enrollee and move to a region where TRICARE isn't implemented, what happens? What happens to the balance of my enrollment fee?

Primary Care Providers

32. What is a Primary Care Manager (PCM)?
33. How can I get a listing of PCMs and other network providers?
34. If I select a civilian network PCM, can I still use a MTF for routine health care services?
35. If I am already confident that I need to see a specialist, do I need to contact my PCM before I go? What will happen if I don't?
36. My PCM refuses to provide a referral for services I believe I need. What do I do?

Special Benefits

37. How do we obtain emergency care under TRICARE?
38. Does the copayment increase for the emergency room?
39. What is a Health Evaluation and Risk Assessment?
40. Is mental health and substance abuse recovery covered under TRICARE Prime?
41. What is the function of the Nurse Advisor?
42. Does TRICARE Prime cover long-term care?
43. Will a pre-existing condition be a factor before being accepted into Prime?

TRICARE Extra & TRICARE Standard

44. Is preventive care covered under Standard or Extra?
45. How do I switch from TRICARE Standard to Extra and vice-versa? Can I do this at any time?
46. If I am participating in TRICARE Standard, do I have to pay for medical care at a MTF?
47. I am participating in TRICARE Standard. Do I need to pay for my medical expenses up front, or will the doctor bill TRICARE directly?

Program for Persons with Disabilities

48. I have an eligible family member with special needs. How does TRICARE fit in with the Program for Persons with Disabilities (PFPWD), previously known as the Program for the Handicapped?

National Mail Order Pharmacy

49. What is the National Mail Order Pharmacy Program (NMOP)?
50. Who is eligible for the NMOP?
51. I currently have access to a mail order program under TRICARE Prime. Is the NMOP the same program?
52. What medications are available through the NMOP?
53. What if I have other health insurance with a prescription benefit?
54. How can I get more information about the NMOP?

Medicare

55. I am disabled, under age 65. Can I enroll in TRICARE Prime?
56. I am under age 65 and have Medicare Part A and B due to end-stage renal disease. I am responsible for and pay the monthly Medicare Part B premium. If I enroll in TRICARE Prime, will I also be responsible for the enrollment fee or will it be waived?
57. Can Medicare eligibles, over 65, enroll in Prime?
58. How will TRICARE Senior Prime work?
59. How can I be part of the TRICARE Senior Prime demonstration program?
60. How can I obtain more information about the TRICARE Senior Prime demonstration program?

Reserve and National Guard Components

61. As a reservist when are my family members and I eligible for TRICARE?
62. As an activated reservist how will I receive my health care?
63. Will my family members need to choose between the three TRICARE options?
64. Am I eligible for health care in the MHS when I retire from the reserves/guard?

Dental

65. What is the TRICARE Selected Reserve Dental Program (TSRDP)?
66. What sort of coverage do I get with the TSRDP?
67. Will the TSRDP cost me anything?
68. Who is eligible for the TSRDP?
69. How can I get more information about the TSRDP?

GENERAL INFORMATION

1. What is TRICARE?

TRICARE is a health care program for members of the uniformed services and their families, and survivors and retired members and their families. TRICARE brings together the health care resources of each of the military services and supplements them with networks of civilian health care professionals to provide better access and high quality service while maintaining the capability to support military operations. There are 11 TRICARE Regions in the U.S. plus TRICARE Europe, TRICARE Latin America and TRICARE Pacific. Each region has an assigned Lead Agent staff who are responsible for the military health system in that region. TRICARE Pacific is managed administratively by the Region 12 Lead Agent staff.

2. What will happen if I don't take any action to change my current health care plan?

If you are on active duty, you will be enrolled in the TRICARE Prime benefit. All other eligible persons deciding not to enroll in TRICARE Prime may still be eligible for care in military medical facilities on a space available basis and maintain TRICARE Standard eligibility (formally CHAMPUS). You may also participate in a new money-saving option called TRICARE Extra by choosing a physician in the Extra network.

3. How does TRICARE improve military readiness?

TRICARE increases flexibility of the Military Health System (MHS), which affords our military medical personnel the ability to maintain their personal readiness while assigned to a base hospital or clinic. This flexibility is demonstrated in the unprecedented collaboration among the military medical departments and in the partnerships we are building with civilian health care companies. These initiatives which include joint service sharing and strong public-private partnerships, contribute to the durability of the MHS.

4. Will the quality of care that I am currently receiving through the Military Treatment Facility (MTFs) improve with the TRICARE program?

The same high quality of care that you are receiving will continue and be enhanced because of improved access and continuity of care for enrolled members. TRICARE Prime also offers the additional benefit of wellness and prevention programs.

5. How can I find the location of my nearest TRICARE Service Center?

If your region has initiated TRICARE, you may inquire using your phone system's directory assistance operator, or call the nearest military hospital or clinic. Additionally, below are telephone numbers for each region, where you can call and get information about TRICARE and your health care benefits.

Region 1 Maine, New Hampshire, Vermont, Massachusetts, Connecticut, Rhode Island, Delaware, Maryland, New Jersey, New York, Pennsylvania, the District of Columbia, Northern Virginia, and the northeast corner of West Virginia Operational June 1, 1998 1-888-999-5195	Region 6 Oklahoma, Arkansas, western two thirds of Louisiana, Texas, excluding southwest corner. Operational November 1, 1995 1-800-406-2832	Region 12 (Pacific) Hawaii and Alaska Operational April 1, 1996 1-800-242-6788 Pacific and WESTPAC 1-888-777-8343
Region 2 North Carolina and most of Virginia. Operational May 1, 1998 1-800-931-9501	Central (Region 7/8) New Mexico, Arizona excluding Yuma, Nevada and southwest corner of Texas, including El Paso, Colorado, Utah, Wyoming, Montana, Idaho excluding northern Idaho, North Dakota, South Dakota, Nebraska, Kansas.	Latin America Panama, Central America, South America 1-888-777-8343

	Minnesota, Iowa and Missouri Operational April 1997 1-888-TRIWEST (874-9378)	
Region 3 South Carolina, Georgia, and Florida excluding panhandle Operational July 1, 1996 1-800-444-5445	Region 9 Southern California and Yuma, Arizona Operational April 1, 1996 1-800-242-6788	Europe Europe, Africa, Middle East, Azores and Iceland Operational October 1996 1-888-777-8343
Region 4 Florida panhandle, Alabama, Mississippi, Tennessee and eastern third of Louisiana Operational July 1, 1996 1-800-444-5445	Region 10 Northern California Operational April 1, 1996 1-800-242-6788	
Region 5 Michigan, Wisconsin, Illinois, Indiana, Ohio, Kentucky, and West Virginia excluding the northeast corner. Operational May 1, 1998 1-800-941-4501	Region 11 Washington, Oregon, and northern Idaho Operational March 1, 1995 1-800-404-0110	

6. Who is eligible to participate in TRICARE?

All active duty members in the seven uniformed services: Army, Navy, Air Force, Marines, Coast Guard, National Oceanic and Atmospheric Administration (NOAA) and Public Health Service (PHS), as well as their CHAMPUS-eligible family members, CHAMPUS-eligible retired military, their family members and survivors as well as active duty family members and retirees and their family members who are under age 65, Medicare eligible because of a disability, and enrolled in Medicare Part B.

7. I am currently enrolled in the Uniformed Services Family Health Plan (USFHP). How does that program fit into TRICARE?

If you are enrolled in the USFHP, you cannot participate in TRICARE, and vice-versa, until your enrollment expires. The USFHP is responsible for the total health care needs of its member patients. With a referral from a Uniformed Services Treatment Facility, you may use the local MTF. *(Note: The USFHP is a managed care program for nonactive duty Uniformed Services beneficiaries, CHAMPUS and Medicare eligibles, delivered by Uniformed Services Treatment Facilities, under contract to DoD to provide care for Title 10 beneficiaries.)*

8. What are my health plan options available under TRICARE?

For eligible beneficiaries, the TRICARE program offers a triple-option health care plan.

TRICARE Prime is the managed care option offered by the Department of Defense. It integrates military and civilian health care into a single delivery system. Beneficiaries who choose this option agree to a one-year enrollment. Enrollees selecting this option choose a Primary Care Manager (PCM) (see question 32 for definition) to provide or arrange for their health care needs. The TRICARE Prime option offers additional wellness and preventive care services.

TRICARE Extra is similar to TRICARE Standard but offers discounts to patients when they

use TRICARE network providers. This option allows beneficiaries to receive their care from civilian network providers at a reduced cost compared to TRICARE Standard. There are no claim forms to file -- just pay your reduced copay after satisfying the deductible. You may use a combination of the TRICARE Extra and Standard programs at any time, depending on whether you choose physicians inside or outside the network. There is no enrollment requirement for this program.

TRICARE Standard is a fee-for-service option that is the same as the standard CHAMPUS benefit. Beneficiaries using this option have the greatest choice of civilian physicians, but at a higher cost. The cost of having this choice includes a deductible, plus a percentage of subsequent charges, called copayments or copays. Enrollment is not a requirement to participate.

9. Which option is the best choice for me if I don't live close to an MTF?

If you are able to enroll in the TRICARE Prime program, this would be the most cost-efficient option for you. If there is not a Prime program serving your area, you can still save money by participating in the TRICARE Extra program by using a civilian network provider. TRICARE Service Centers (TSC) have lists of TRICARE Extra network physicians. If TRICARE Extra is not available in your area, you will have to utilize TRICARE Standard.

10. Which is the best of the three TRICARE options for a retiree who lives in two different parts of the country?

For a retiree with two residences, because of the new "Portability Rules" they will still have the triple option available and can choose the best option for themselves. The only change is that if they choose Prime they will be able to disenroll and reenroll twice in the same year as long as their second re-enrollment is in the original region. For those individuals desiring more flexibility they may want to elect to utilize either TRICARE Extra or Standard.

11. How do TRICARE Service Centers assist beneficiaries?

TRICARE Service Centers are staffed by health care professionals who are there to help beneficiaries get the service that they need. Such as:

- Health Care Finders, who will make appointments and help find specialists when you need them. They also provide names of doctors participating in the TRICARE Extra network, and will help locate doctors who accept Medicare payments for services provided Medicare eligible beneficiaries age 65 and over.
- Beneficiary Services Representatives, who will help explain the options available to you and assist in your choice of the program that suits you best. They can enroll you in TRICARE Prime, assist with the selection of a Primary Care Manager, and help resolve any billing problems.

TRICARE Service Centers also send beneficiaries TRICARE information packages describing the features of each of the TRICARE options and what alternatives are available for each beneficiary category.

12. How can I find out more information about the TRICARE program?

By visiting or calling your local TRICARE Service Center which is usually located near or within a MTF, or, the Health Benefits Advisor (HBA) at any MTF.

13. What is my priority for care in the MTF?

By law, priority for care at the MTF will be based on the following criteria:

- Active duty personnel
- Active duty family members enrolled in TRICARE Prime
- Retirees, Survivors and their family members enrolled in Prime
- Active duty family members not enrolled in Prime
- Retirees, Survivors and their family members not enrolled in Prime

Non-enrolled persons eligible for military health care will be seen at military hospitals and clinics on a space-available basis.

14. If I have a grievance for services rendered under the TRICARE program, who can I contact?

Any grievance should be reported to the MTF Commander or Lead Agent. Generally, the regional Managed Care Support contractor will be responsible for grievances for services rendered by civilian network providers under the TRICARE program. Contact the nearest TRICARE Service Center for more information.

15. Is there a maximum that I may have to pay under the three TRICARE options?

Under TRICARE Standard and Extra, active duty family members can be responsible for up to \$1,000 and retirees for up to \$7,500 per year in total out-of-pocket costs for covered medical services. Under Prime, the maximum out-of-pocket expenditure per year for covered medical services is \$1,000 for active duty family members and \$3,000 for retirees and their families per enrollment year. Effective March 26, 1998 the catastrophic cap for the Prime Point-of-Service option will be lifted. Under the Point-of-Service option you pay 50 percent of the cost after a separate, somewhat higher deductible is met (\$300 for single enrollment and \$600 for family enrollment).

TRICARE PRIME

16. Should a family member covered by other comprehensive health insurance enroll in Prime?

If a family member has other comprehensive health care insurance, we do not encourage enrollment in TRICARE Prime. When other comprehensive health coverage is involved, TRICARE is automatically the secondary payer. It may be easier to coordinate benefits with other health insurance under TRICARE Extra and TRICARE Standard. Please check with your TRICARE Service Center for further guidance.

17. What guarantees do I have that, as a TRICARE Prime enrollee, I won't just end up on the phone, waiting to make an appointment at the hospital or clinic?

Like many aspects of TRICARE Prime, performance standards have been applied to the central appointments system, which is available at most locations. We have arranged for enough phone lines and people to answer them to avoid patients waiting for unreasonable periods of time. If additional capability is still required, we will provide it. However, you will likely find busy signals and long waits a thing of the past.

18. What should I do if I'm a Prime enrollee and get sick while traveling outside my region? What if the 800 number is busy and I can't make contact?

You should contact your Primary Care Manager for instructions in a non-emergency situation. Authorization for care can also be obtained from the Health Care Finders. For non-urgent or non-emergency care you must first obtain authorization. If you see a physician without authorization for a non-emergency problem, you will still be covered for some of the costs incurred under the Point-of-Service option. That option pays 50 percent of the cost after a separate, somewhat higher deductible is met (\$300 for single enrollment and \$600 for family enrollment).

Active Duty

19. I'm on active duty and stationed away from a military installation. What do I do for medical care, and do I have to pay?

Currently, as an active duty member, you are covered for your health care needs through supplemental care funds; under no circumstance will you be required to pay for any health care you may need. While not available currently, policy changes are being worked to provide TRICARE Prime from civilian PCM in the local area for Geographically Separated Units (GSU).

Enrollment

20. Does the enrollment fee for TRICARE Prime have to be paid all at once, or can it be paid in installments?

It is permissible to pay the Prime enrollment fee in quarterly installments. There is no additional administrative fee for quarterly payments.

21. How can I enroll in TRICARE Prime?

If you are on active duty you will be enrolled in TRICARE Prime automatically and assigned a Primary Care Manager. When Prime is fully implemented in your area, other categories of beneficiaries can enroll on a voluntary basis either by visiting or calling the local TRICARE Service Center and completing an enrollment application.

22. What is my priority for being offered enrollment in TRICARE Prime?

Priority for enrollment is: 1) active duty will be automatically enrolled and receive most of their care in the MTF; 2) active duty family members may voluntarily enroll and will be primarily accommodated within the MTF; 3) retirees and their family members and survivors may voluntarily enroll. If the MTF has reached capacity, everyone wishing to enroll in Prime will be referred to the network providers.

23. If I enroll in TRICARE Prime does that mean that my whole family has to enroll?

Not all family members are required to enroll in TRICARE Prime. Depending on your specific situation and needs, it may be best, for example, for a spouse to be in TRICARE Prime, and a student son or daughter, to use Extra or Standard. Contact your TRICARE Service Center for advice.

24. Is there a minimum enrollment period requirement for TRICARE Prime?

Enrollment is for a 12-month period under TRICARE Prime. At the end of this initial

consecutive 12-month enrollment period, you must choose to continue your enrollment in Prime or choose another option that best suits your situation. If you disenroll early for nonpayment of fees, or you request disenrollment without a move, you will be eligible to re-enroll in 12 months.

25. If I choose to disenroll after I have enrolled in TRICARE Prime, what penalty is incurred? Can I get back into TRICARE Prime if I don't like the other options?

If the enrollment fee was paid in one payment, you will not receive a refund. Enrollment is for 12 months, unless you move from the area or lose eligibility; if you disenroll early you are eligible to re-enroll in 12 months.

26. Are there any deadlines or restrictions for enrolling in TRICARE Prime?

If implemented in your area, you may enroll in TRICARE Prime at any time. Please note that while enrollment for Prime is on a continuous basis, assignment to a Primary Care Manager in a military clinic, where treatment is free, is based on a first come, first served basis. However, Military Treatment Facility Commanders can determine whether your enrollment will be to a civilian Primary Care Manager or an MTF Primary Care Manager. Those enrolled to an MTF may be required to select a civilian Primary Care Manager at the time of re-enrollment because of changes in MTF capacity.

27. Can my son or daughter, who is away from home at college, enroll in TRICARE Prime at his college if the option is available there?

For active duty families your son or daughter may enroll in TRICARE Prime as an individual if the option is offered in his or her geographic area. Retiree's and their family members will have the option of split enrollments (enroll as a family in one region and pay one fee but be able to receive care for children in school in a different region) once all regions are up and fully functional.

28. In the near future, I might want my children, who will be leaving for college, to switch from Prime to Standard. What is the process for this?

Currently, when you enroll yourself or your family in Prime, there is a one-year commitment. If you know in advance that you will want to change programs, you will have the option not to re-enroll those persons at the end of the year. However, disenrollment is permissible for a move.

By not enrolling you will automatically be participating in TRICARE Standard.

Portability (Moving)

29. As a retiree enrolled in TRICARE Prime, does my enrollment transfer to the new region if I move?

As a retiree you will be allowed to disenroll and re-enroll twice during the same year. The caveat is that you re-enroll to the original region (i.e. disenroll in region 1 and enroll to region 3 then disenroll in 3 and re-enroll back to region 1). You will be covered for emergency care under Prime from your original region while in route to the next region.

30. If my family moves to a different region, are we (active duty) automatically assigned a new Primary Care Manager, or do we have to re-enroll?

Enrollment in TRICARE Prime entails the assignment of a Primary Care Manager, enrollment in DEERS, and communication with the member on what enrollment in the TRICARE

program means. For active duty members, enrollment is automatic. For active duty family members, enrollment in TRICARE Prime is on a voluntary basis.

Currently, if you move to a different region, you will have up to 30 days at the new site to enroll. Your old region will cover you for care until you enroll at the new region. Enrolled members will start a new 12-month enrollment period.

31. If I'm a Prime enrollee and move to a region where TRICARE isn't implemented, what happens? What happens to the balance of my enrollment fee?

TRICARE should be implemented across the U.S. by mid 1998. However, if Prime is not available in the new region, you must disenroll from your old region after 30 days. You may seek care in a MTF, or use TRICARE Standard (CHAMPUS) for civilian health care and file a claim for reimbursement. For retirees, enrollment fees are not refundable. If you believe you will be transferred before your enrollment year is up, pay the fee in quarterly installments and stop paying when you leave.

Primary Care Providers

32. What is a Primary Care Manager (PCM)?

A PCM is a medical professional, or a team of providers, in a military hospital or clinic, or in a civilian network, who will assume primary responsibility for providing, arranging and coordinating an enrollee's total health care. A physician designated as a PCM could be one who practices in General or Family Practice, Internal Medicine, Pediatrics and OB/GYN. Nurse Practitioners and Physician's Assistants who are privileged to provide primary care services may be organized as part of the PCM team.

33. How can I get a listing of PCMs and other network providers?

A listing of network providers (Provider Directory) in your area is available at your local TRICARE Service Center.

34. If I select a civilian network PCM, can I still use a MTF for routine health care services?

No, enrollees choosing a civilian Primary Care Manager must be referred to the military treatment facility for specialty and inpatient care by that Primary Care Manager. An enrollee who has chosen a civilian Primary Care Manager may, however, return for pharmacy, laboratory, radiology and other ancillary care they may require.

35. If I am already confident that I need to see a specialist, do I need to contact my PCM before I go? What will happen if I don't?

For those enrolled in TRICARE Prime, it is always necessary to first consult your Primary Care Manager for specialty care. If it is necessary for you to see a specialist, your PCM will help make an appointment for you. If you see a specialist on your own, without prior approval from your PCM you will be participating in Prime's Point-of-Service option and will be responsible for 50 percent of the cost after the deductible (\$300 for single enrollment and \$600 for family enrollment) is met.

36. My PCM refuses to provide a referral for services I believe I need. What do I do?

The TRICARE Prime program has provisions for second opinions. If you feel that the diagnosis or treatment plan may not be correct, you can request that your Primary Care

Manager refer you out for a second opinion. Additionally, if you are dissatisfied with your Primary Care Manager (PCM), you can request assignment to another PCM. If you are still not satisfied, you can file a complaint or grievance regarding the non-availability of service decision to the MTF Commander or Regional Lead Agent. Finally, you have the option of using the Point-of-Service option under Prime. A retroactive reimbursement may be an option through a successful appeal process.

Special Benefits

37. How do we obtain emergency care under TRICARE?

Any eligible beneficiary should access the nearest emergency room of any military or civilian hospital for true emergencies, regardless of which TRICARE option you use.

38. Does the copayment increase for the emergency room?

There are no out-of-pocket costs for any care received at a military hospital, including emergency room care. The out-of-pocket costs for care received at a civilian emergency room for families of E-4 and below enrolled in Prime is \$10. For families of E-5 and above and retirees and their families, the copay for an emergency room visit is \$30. This single payment, \$10 or \$30, includes all emergency room services provided in conjunction with the visit. For those who have chosen to remain in TRICARE Standard, or use the TRICARE Extra program, their regular deductibles and copayments apply.

39. What is a Health Evaluation and Risk Assessment?

It is a self-initiated questionnaire surveying many lifestyles and diet factors which will be reviewed and discussed with you by your primary care provider.

40. Is mental health and substance abuse recovery covered under TRICARE Prime?

Mental health and substance abuse treatments are covered under TRICARE Prime with a minimal copayment. The cost for outpatient visits will be \$10 for E-4 and below and \$20 for E-5 and above. Retirees will pay \$25 per visit. The copayments are reduced for group visits. For inpatient care the costs are \$20 per day for all active duty family members and \$40 per day for retirees.

41. What is the function of the Nurse Advisor?

Nurse advisors are available in most regions, by phone, to provide advice and assistance that will enhance patient decision making about their health care. They are available 24 hours a day, 7 days a week, and can discuss treatment alternatives, symptoms, and illness prevention or can advise whether a situation warrants immediate medical attention. Any TRICARE-eligible person can use the service of the nurse advisor.

42. Does TRICARE Prime cover long-term care?

Prime will cover long-term health care to the extent that CHAMPUS does today, that is, noncustodial, skilled care. Please discuss specific care requirements with your local Health Benefits Advisor.

43. Will a pre-existing condition be a factor before being accepted into Prime?

No. Pre-existing conditions will not disqualify you from enrolling in Prime.

TRICARE EXTRA & TRICARE STANDARD

44. Is preventive care covered under Standard or Extra?

Preventive care is an added benefit under Prime. If the particular preventive service is a benefit included under the TRICARE Standard (CHAMPUS) benefits, you will be responsible for the deductible and copayment under Extra and Standard. See your Health Benefits Representative about specific preventive care under TRICARE Standard.

45. How do I switch from TRICARE Standard to Extra and vice-versa? Can I do this at any time?

As long as you are not enrolled in TRICARE Prime, you may switch between Standard and Extra at any time. You can switch by making the choice between any civilian doctor and a doctor within the Extra network.

46. If I am participating in TRICARE Standard, do I have to pay for medical care at a MTF?

There aren't any out-of-pocket costs for outpatient care received at an MTF. However, it is important to remember that TRICARE Prime enrollees will receive priority for care at that MTF before non-enrolled beneficiaries. You will be seen on a space-available-basis only.

47. I am participating in TRICARE Standard. Do I need to pay for my medical expenses up front, or will the doctor bill TRICARE directly?

Under TRICARE Standard, depending upon your provider, you may be required to pay for your share of the medical treatment up front. If you go to a doctor who participates in the Extra network, your out-of-pocket costs will be less than with Standard and you will not have to file claims.

PROGRAM FOR PERSONS WITH DISABILITIES

48. I have an eligible family member with special needs. How does TRICARE fit in with the Program for Persons with Disabilities (PFPWD), previously known as the Program for the Handicapped?

The PFPWD is a financial assistance program for active duty dependents with severe physical disabilities or with moderate to severe mental retardation who cannot get specialized training or care through public resources. Active duty family members can take advantage of both TRICARE and the PFPWD programs concurrently. The exception is that authorized services provided in conjunction with the PFPWD qualifying condition cannot be furnished under the basic program as long as the qualifying condition exists and there is a PFPWD benefit authorization outstanding.

The PFPWD is used concurrently with TRICARE Prime, Extra or Standard. Authorization for benefits under PFPWD does not affect your enrollment in TRICARE Prime. It does provide an additional financial option to explore when utilizing medical resources. When you are enrolled in TRICARE Prime, you are assigned a Primary Care Manager, who has the responsibility to authorize specialty care under the Prime program. Benefits not normally covered may be cost shared under the PFPWD.

Because of the cost associated with care for family members with special needs, most families will be encouraged to review all of the TRICARE options. Recognizing that the catastrophic cap under Extra and Standard is only \$1,000, and all further cost are covered at 100% by the government, TRICARE Prime may not be your best option. Further, most State and Federal Agencies cover some of these specialty services at little or no additional cost. Check with your regional TRICARE Service Center to see which TRICARE option is the best for your particular family member. For personnel who are Medicare eligible due to a disability and are under the age of 65, they still retain their TRICARE eligibility (see questions 55 and 56 for more information).

NATIONAL MAIL ORDER PHARMACY

49. What is the National Mail Order Pharmacy Program (NMOP)?

The NMOP is DoD's new timesaving and inexpensive mail order service for maintenance prescriptions. Beneficiaries can receive free delivery to a home, temporary stateside address, or APO/FPO addresses.

50. Who is eligible for the NMOP?

At this time:

Active duty worldwide

CHAMPUS beneficiaries living in Alaska and Puerto Rico

All beneficiaries in the TRICARE Prime, Extra and Standard program except those in regions 1,2 and 5.

Uniformed services treatment facility enrollees

Overseas CHAMPUS beneficiaries with APO or FPO addresses

Base realignment and closure Medicare eligibles in TRICARE regions 1, 2, and 5.

Base realignment and closure Medicare eligibles at: Naval Air Station, Adak, AK; Naval Air Station, Alameda, CA; Naval Air Station, Treasure Island, CA; Sierra Army Depot, CA and Ft. Chaffee, AR

51. I currently have access to a mail order program under TRICARE Prime. Is the NMOP the same program?

No. It is an entirely different program that is not only region-wide, but also worldwide, under one contract with Merck-Medco Rx Services. Regarding current enrollees, the NMOP is only available to those enrolled in TRICARE Prime at an MTF. So, if you are enrolled at a MTF, and not through a Prime network, you are eligible to use the NMOP. Effective April 1, 1998 the NMOP will be available to all beneficiaries now covered by Managed Care Support contractors (both enrolled and non-enrolled beneficiaries). These beneficiaries will be phased in upon completion of negotiations with the MCS contractor currently responsible for their regional mail order benefit.

52. What medications are available through the NMOP?

The NMOP is for prescriptions that you take on a regular basis, such as medication to reduce blood pressure or treat asthma, diabetes, or any long-term health condition. It is not intended to be used for acute medications like antibiotics.

53. What if I have other health insurance with a prescription benefit?

Any beneficiary who is in one of the eligible groups for the NMOP, but has other health insurance with a pharmacy benefit will be required to use the other available pharmacy benefit coverage first.

54. How can I get more information about the NMOP?

If you are in one of the eligible beneficiary groups, see your local military treatment facility pharmacy for details, or call the Merck-Medco Member Services line at 1-800-903-4680. Outside the U.S., contact your long distance carrier for access. The TDD number for the hearing impaired is 1-800-759-1089. Both a short Program Registration Form and a Confidential Patient Profile Registration Form will need to be completed.

MEDICARE

55. I am disabled, under age 65. Can I enroll in TRICARE Prime?

Yes. Beneficiaries eligible for Medicare on the basis of disability or end stage renal disease that are: (1) under age 65, and (2) enrolled in Medicare Part B, are eligible to enroll in Prime and have the enrollment fee waived. However, when these beneficiaries reach age 65, they must receive their health care through Medicare.

56. I am under age 65 and have Medicare Part A and B due to end-stage renal disease. I am responsible for and pay the monthly Medicare Part B premium. If I enroll in TRICARE Prime, will I also be responsible for the enrollment fee or will it be waived?

DoD has instituted a new rule that allows them to waive the enrollment fee for all persons who fall into this very category.

57. Can Medicare eligibles, over 65, enroll in Prime?

In an effort to better serve the medical needs of all of our over 65 retirees, DoD has long supported a program that would allow dual-eligible beneficiaries to use their Medicare benefit at Military Treatment Facilities (MTFs). This program was previously referred to as Medicare Subvention. Congress recently passed legislation that allows DoD and the Health Care Financing Administration (HCFA-the government agency responsible for Medicare) to conduct a Medicare Subvention demonstration, called TRICARE Senior Prime, in selected areas.

Six project sites have been selected and enrollment may be an option for you if you reside in these areas. If you do not live near one of these demonstration sites, you can continue to seek care in an MTF on a space-available basis; acquire prescriptions through military pharmacies, as well as a retail and mail order pharmacy program if you reside in a Base Realignment and Closure (BRAC) area; and use the Health Care Finders to assist in finding physicians in the TRICARE Extra network who will accept Medicare.

58. How will TRICARE Senior Prime work?

TRICARE Senior Prime, DoD's Medicare Subvention program, will operate similar to a Medicare at-risk health maintenance organization (HMO), with the goal of becoming a fully participating Medicare HMO in the future. All care must be obtained either by or through your Primary Care Manager at the MTF.

59. How can I be part of the TRICARE Senior Prime demonstration program?

To be eligible to enroll in TRICARE Senior Prime, you must meet all of the following requirements:

- Be age 65, or attain age 65 on or prior to the first day of health care delivery, dates to be announced.
- Live in the geographic area covered by the demonstration program
- Be eligible for Medicare and care in the MTF.
- Received medical care in an MTF prior to July 1, 1997, or became eligible for Medicare after July 1, 1997
- Be enrolled in Medicare Part B
- Agree to access covered services only through the TRICARE Senior Prime program.

Even if you meet all of the eligibility requirements listed, you may not be enrolled in the demonstration if you:

- - Have elected Medicare hospice coverage or have end-stage renal disease*
- - Are under age 65 and eligible for Medicare because of a disability

* **Exception:** A beneficiary who is diagnosed with end-stage renal disease or who elects the Medicare Hospice benefit after enrollment in the project is eligible to remain in the program.

60. How can I obtain more information about the TRICARE Senior Prime demonstration Project?

If you live in one of the six geographic areas covered by the demonstration project, you will receive, in the mail, an information packet with more specific details about the project in your particular area, or call your local TRICARE Service Center.

RESERVE AND NATIONAL GUARD COMPONENTS

61. As a reservist when are my family members and I eligible for TRICARE?

As a reservist, you and your family members are eligible for TRICARE when you become activated and are issued orders sending you to active duty for a period of more than 30 consecutive days and when you retire from reserve status and are age 60.

62. As an activated reservist how will I receive my health care?

All activated reserve/guard members will be enrolled in TRICARE Prime and will receive all of their care in MTFs. If you are stationed in an area where there are no MTFs, you will receive your care from a civilian provider. Under no circumstance will you be responsible for any out-of-pocket costs.

63. Will my family members need to choose between the three TRICARE options?

This depends on the length of time for which your active duty orders have been issued. If you, the sponsor, have been issued orders for a period of more than 30 consecutive days, your eligible family members may choose to receive health care through the Military Health System (MHS). In the MHS your family member will have access to the benefits included in two TRICARE health plan options, TRICARE Standard (CHAMPUS), and, if available, TRICARE Extra. To help in the decision, an assessment of your family's health care needs and the health care delivery options for which they qualify will assist in them in choosing an option that best meets their health care and cost needs.

If you have been issued orders for 179 days or more, your family members have the option to enroll in a third TRICARE option, TRICARE Prime, if available in your area.

64. Am I eligible for health care in the MHS when I retire from the reserves/guard?

Upon becoming age 60 and completing the required service time, you and your eligible family members have the option to use TRICARE. Retired military personnel and their family members, aged 65 and older, are eligible to receive health care benefits under the Medicare system, and are not, at this time eligible for TRICARE. However, you are eligible for space-available-care at an MTF or clinic.

DENTAL

65. What is the TRICARE Selected Reserve Dental Program (TSRDP)?

In order to maintain dental readiness, the 1996 National Defense Authorization Act directed the establishment of the TSRDP for members of the Selected Reserve.

66. What sort of coverage do I get with the TSRDP?

Covered services include diagnostic, preventive, basic restorative, oral surgery and emergency services; items such as crowns, root canals, bridges and orthodontia are not covered.

67. Will the TSRDP cost me anything?

The monthly premium is \$4.36. Enrollees must submit a prepayment of 4 months of premiums ($\$4.36 \times 4 = \$17.44$) with their enrollment form. There are no copayments for diagnostic, preventive or emergency care services. Copayment responsibilities for restorative services for E1 through E-4 are 10%, for E-5s and above it is 20%. Copayment responsibilities for oral surgery services for E-1 through E4 is 30%, for E-5s and above it is 40%. The maximum annual benefit for all services is \$1,000 of paid allowable charges per contract year. Modest annual changes to the premium levels are anticipated.

68. Who is eligible for the TSRDP?

Eligible Selected Reserve members who have at least one year of Selected Reserve service remaining who are located in the 50 United States, the District of Columbia, Puerto Rico, Guam and the US Virgin Islands. TSRDP is not available to reservists living in Europe, Asia, or areas outside those mentioned.

Unit Members. A member who is assigned to a national Guard or Reserve unit that is organized to perform Inactive Duty Training (drills/UTAs) and annual training as a minimum.

Individual Mobilization Augmentees (IMAs). IMAs are Reserve personnel assigned to Active component organizations. They also perform drills and annual training.

Training Pipeline Personnel. Selected Reserve enlisted members who have not yet completed initial active duty for training (IADT) and officers who are in training for professional categories or in undergraduate flying training.

Excluded: Active Guard/Reserve (AGR), and Selected Reserve members on extended active duty are not eligible to sign up for this program. Others not eligible: Reserve/ Guard family members, members of the Standby Reserve,

Retired Reserve and Individual Ready Reserve.

69. How can I get more information about the TSRDP?

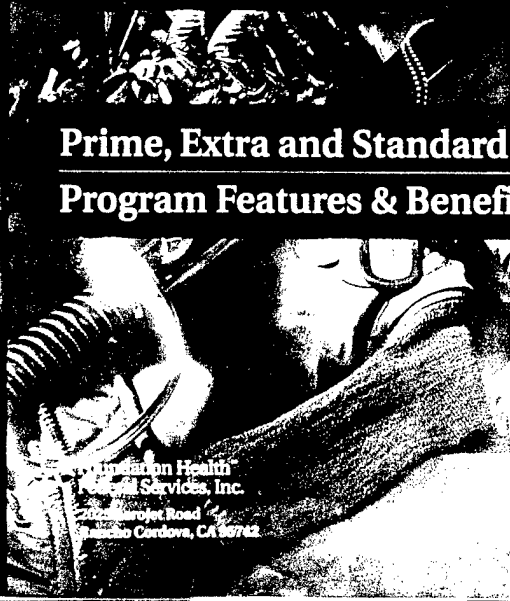
The contractor for the TSRDP, Humana Military Health Care Services has a toll free telephone number, 1-800-211-3614, which will be staffed Monday through Friday 0800-1800 E.S.T., to answer your questions.

[\[Top\]](#)

Last update: 9/2/1998



**Prime, Extra and Standard
Program Features & Benefits**



**Union Health
Medical Services, Inc.**
2100 Highway Road
San Jose, CA 95128

Your Military Health Plan



Welcome **Welcome to TRICARE**

What is TRICARE?

You're concerned about your health care needs. You want the highest quality health care possible. You also want the peace of mind that comes from knowing that whenever medical care is needed, it will be affordable, convenient and easy to use.

TRICARE is the Department of Defense's (DoD) Health Care Program for CHAMPUS-eligible beneficiaries worldwide. Beneficiaries can choose from three options-- TRICARE Prime, TRICARE Extra or TRICARE Standard.

Foundation Health Federal Services (FHFS), Inc. administers the TRICARE program in California, Hawaii, Alaska and Yuma, AZ., under a contract awarded by the DoD.

You may reach us on the world wide web at **www.FHFS.com**.

The information contained in this booklet is current as of the date of this printing. However, due to future changes that may affect the TRICARE program, please contact or visit your local TRICARE Service Center (TSC) or Beneficiary Service Office (BSO) for updated information.

WHO IS ELIGIBLE FOR TRICARE BENEFITS?

To be eligible for TRICARE benefits, you must be:

- CHAMPUS eligible beneficiaries
- Enrolled in the Defense Enrollment Eligibility Reporting System (DEERS)

The TRICARE program is a nondiscriminatory program for CHAMPUS eligibles offered without regard to beneficiary age, race, sex, rank, sponsor status, family size, personal income or medical history condition.

HOW DOES TRICARE STANDARD WORK?

- No enrollment fee
- Deductibles of \$50-\$300 per fiscal year
- Doctor's office visits of 20-25% cost-share (after your deductible is met)
- Best option for those who frequently travel for extended periods out of the region
- Offers the greatest choice of doctors
- Inpatient care may have further restrictions
- Best option for those who are also covered by another health insurance that is the primary payer to TRICARE

Under the TRICARE program, standard CHAMPUS has become TRICARE Standard. To use this option, all you need to do is visit any CHAMPUS-certified provider in the civilian community and pay an annual deductible and cost-share. Your cost-share will be 5% higher than TRICARE Extra. However, you will have a greater selection of doctors to choose from. You may also continue to seek care at the MTF on a space-available basis.

IS TRICARE EXTRA FOR YOU?

- No enrollment fees
- Deductibles of \$50-\$300 per fiscal year
- Out-of-pocket expense is 5% less than TRICARE Standard (after your deductible is met)
- Doctor's office visits of 15-20% cost-share (after your deductible is met)
- Inpatient care may have further restrictions

TRICARE Extra is easy to use just like TRICARE Standard, but you save 5% when you use a network

doctor or hospital. You do not need to enroll in TRICARE Extra. You simply go to any network doctor, hospital or other medical provider and show them your military ID card. You may also continue to seek care at the MTF on a space-available basis. TRICARE Extra Providers are listed in the Provider Directory.

TRICARE PRIME AT A GLANCE

- No enrollment fee for active duty service members or active duty family members (active duty service members are automatically enrolled in TRICARE Prime)
- Annual enrollment fee for retirees and their family members: \$230/yr. for individuals; \$460/yr. for 2 or more family members
- Primary Care Manager coordinates all care
- Lower out-of-pocket expenses than that of TRICARE Extra and TRICARE Standard
- No deductibles (unless using Point-of-Service)
- Point-of-Service - TRICARE Prime enrollees have the option to obtain services from any CHAMPUS-certified civilian provider (see page 27)
- Priority access to care at the MTFs
- Not recommended for those who frequently travel for extended periods outside of their TRICARE region
- Not recommended for those who have Other Health Insurance coverage that is a primary payer to TRICARE

If you or your family need medical care often, TRICARE Prime may be the right choice for you. TRICARE Prime features no deductibles and reduced out-of-pocket costs. Enrollment in TRICARE Prime is voluntary and easy to use, but does require enrollment for one year (12 consecutive months).

Whether you have a Military Treatment Facility (MTF) clinic site as your PCM or are enrolled with a PCM in the civilian network, TRICARE Prime members may be referred to the MTF for specialty and inpatient hospital care when such care is available at the MTF

Note: If you are enrolling in Prime, please refer to your Prime Member Handbook for additional information about TRICARE Prime Benefits.

TRICARE PRIME ENROLLMENT PORTABILITY

Portability means that TRICARE Prime beneficiaries can transfer their Prime coverage during a permanent or temporary move to another TRICARE Prime region.

In 1998, the split enrollment benefit will allow members of the same family to enroll in separate regions, with a maximum of one family enrollment fee.

Beneficiaries utilizing the enrollment portability benefit should remain enrolled in Prime while they are traveling to their new TRICARE Prime region, remembering to follow existing guidelines regarding non-emergency care authorizations. To transfer enrollment, beneficiaries must contact the TRICARE contractor in the new region through the local TRICARE Service Center (TSC) or Beneficiary Service Office (BSO), or call the region's toll-free information line.

Note: If enrolling in TRICARE Prime, please contact your local TSC/BSO for more detailed information about this benefit.

HOW TO ENROLL IN TRICARE PRIME

1. Call the toll free 800 line or visit your local TRICARE Service Center (TSC) or Beneficiary Service Office (BSO) and request a TRICARE Prime enrollment application.
2. Complete the enrollment application and mail it to the address on the front of the application or you may take the completed application into your local TSC/BSO. Remember to select a Primary Care Manager. Your application will not be processed without this information.
3. You may enroll at anytime.

Your TRICARE Prime benefits will be effective once your application fee is paid (if needed) and your application has been processed. If your application is received by the 20th of the month, your membership will become effective the first day of the following month. However, if your application is received after the 20th of the month, your membership will not become effective the first of the following month, but the first of the month after that. For example, if your application is received by June 25th, your membership will become effective August 1st.

INFORMATION AND HEALTH CARE FINDER (800) 242-6788

The toll free telephone number listed above, is available to you when you need information about TRICARE or have a question about your coverage. When you call (800) 242-6788, you will have several options to choose from. You will have the option of speaking with: a Health Care Finder for assistance obtaining a referral; a claims processor if you have a question or need help with your claim or bill; a telemarketing representative to request program materials; or a Beneficiary Services Representative if you have a specific question about your benefits. After you have made your selection, listen carefully as you may be given other options to choose from to make sure you reach the correct person.

HEALTH CARE INFORMATION LINE (HCIL)

The Health Care Information Line is a 24-hour toll-free telephone service that can help you with most health care questions. You may either speak with a nurse or listen to over 500 recorded health care topics in the Audio Health Library. You can access the HCIL by calling (800) 822-2878. For a listing of health care topics available in the Audio Health Library, visit your local TRICARE Service center and pick up a brochure.

PHARMACY BENEFITS FOR PRIME, EXTRA & STANDARD BENEFICIARIES

TRICARE offers you three options for getting prescriptions filled:

- Military network pharmacies at no cost
- TRICARE pharmacies for a low copayment
- Mail-order prescriptions at reduced cost

Those eligible for pharmacy benefits include:

- TRICARE beneficiaries
- DoD-Medicare eligible beneficiaries who have a primary residence in Base Realignment and Closure (BRAC) sites, or who can demonstrate reliance for prescriptions on a Military Treatment Facility in the last 12 months prior to termination of services at that facility.

See the benefits and coverage chart on pages 12 & 13 for copayments and cost-share amounts.

HOW TO FILE AN APPEAL OR GRIEVANCE

APPEALS:

For your protection, we have a formal appeals process. At some point, you may feel your claim was denied in error, or that you were improperly denied an authorization for care. In cases like these, you can file an appeal. The initial claim or authorization denial notification will provide instructions regarding how to file an appeal. Once your appeal has been processed, you will receive a decision within 60 days from the date your appeal was received. If the decision does not meet your satisfaction, you may request a reconsideration, also known as a second-level review. Instructions for filing a request for a second-level review will be included in the appeal determination letter you receive.

GRIEVANCES:

If you are dissatisfied with the quality, timeliness or availability of the care you have received, you may file a written complaint with Foundation Health Federal Services. Grievances may include, but are not limited to the following issues:

- *Quality of care*
- *Quality of customer service*
- *Performance of any part of the health care delivery system*

You will be notified when we have received your complaint. Most grievances are resolved within 60 days, then you will be notified again when a determination of your complaint is complete.

For additional information on filing an appeal or grievance, you can contact your local TRICARE Service Center, Beneficiary Service Office, or you can call our toll-free information line at (800) 242-6788.

**YOUR TRICARE SERVICE CENTERS AND
BENEFICIARY SERVICE OFFICES**

TRICARE Service Centers (TSC) and Beneficiary Service Offices (BSO) are conveniently located at or near your Military Treatment Facility (MTF). The TSCs and BSOs are staffed by Beneficiary Services Representatives to assist you with your health care needs. Please see individual times and days below for hours of operation for TSCs and BSOs near you, or call (800) 242-6788.

TRICARE Service Centers are located at:

Elmendorf AFB

TRICARE Service Center
3rd Medical Group
24-800 Hospital Drive
Elmendorf AFB, AK 99506
7 a.m. - 5 p.m., M-F

Ft. Wainwright

TRICARE Service Center
Bassett Army Community Hospital
1060 Gaffney Road
Fort Wainwright, AK 99703
7 a.m. - 5 p.m., M-F

Beneficiary Service Office is located at:

Eielson AFB

Beneficiary Service Office
354th MDSS/SGSB
3349 Central Ave., Ste. 1
Eielson AFB, AK 99702
7:30 a.m. - 4:30 p.m., M-F



**Prime, Extra and Standard
Benefits and Coverage Chart**

See pages 8-17

**Clinical Preventive Services
Benefits and Coverage Chart**

See pages 18-23

The information contained in the following charts are current as of the date of this printing. However, due to future changes that may affect the TRICARE program, please contact or visit your local TRICARE Service Center (TSC) or Beneficiary Service Office (BSO) for updated information.

BENEFITS & COVERAGE CHART

Outpatient Services

Beneficiary Cost

SERVICES	TRICARE PRIME
ANNUAL ENROLLMENT FEE	Active Duty Family Members: None Retirees & Others: \$230/ person, \$460/2 or more
ANNUAL DEDUCTIBLE ⁽¹⁾ *There is a deductible if the TRICARE Prime enrollee exercises the Point-of-Service option. If enrolling in TRICARE Prime, please see the Prime Member Handbook.	None
AMBULANCE SERVICES When medically necessary and when needed for a medical condition that is covered by CHAMPUS. Subject to balance billing (see page 24 and reference the definition of balance billing).	Per ambulance ride: Active Duty Family Member E-4 and below: \$10 copayment. E-5 and above: \$15 copayment Retirees & Others: \$20 copayment
AMBULATORY (SAME DAY) SURGERY ⁽¹⁾⁽²⁾ Authorized hospital-based or freestanding ambulatory surgical center that is CHAMPUS certified.	Active Duty Family Members: \$25 copayment. Retirees & Others: \$25 copayment
DURABLE MEDICAL EQUIPMENT, PROSTHETIC DEVICES AND MEDICAL SUPPLIES PRESCRIBED BY YOUR PHYSICIAN ⁽²⁾ (If dispensed for use outside of the office or after the home visit.) Subject to balance billing (see page 24 and reference the definition of balance billing).	Percentage of contracted fee: Active Duty Family Members E-4 and below: 10% E-5 and above: 15% Retirees & Others: 20%
EMERGENCY SERVICES ⁽¹⁾ Emergency care obtained on an outpatient basis, both network and non-network, in or out of the area. Some emergency services are subject to balance billing (see page 24 and reference the definition on balance billing).	Per visit: Active Duty Family Members E-4 and below: \$10 copayment E-5 and above: \$30 copayment Retirees & Others: \$30 copayment
EYE EXAMINATIONS ⁽¹⁾⁽³⁾ One routine examination per year for Active Duty Family Members.	Active Duty Family Members, E-4 and below: \$6 copayment. E-5 and above: \$12 copayment. Retirees & Others: Not covered:

continued

Beneficiary Cost

Beneficiary Cost

TRICARE EXTRA	TRICARE STANDARD
None	None
Active Duty Family Members E-4 and below: \$50/person or \$100/family per fiscal year. All retirees and Active Duty Family Members, E-5 and above: \$150/person or \$300/family per year.	Active Duty Family Members E-4 and below: \$50/person or \$100/family per fiscal year. All retirees and Active Duty Family Members, E-5 and above: \$150/person or \$300 /family per year.
Cost-share after deductible has been met: Active Duty Family Members: 15% of contracted fee. Retirees & Others: 20% of contracted fee.	Cost-share after deductible has been met: Active Duty Family Members: 20% of CHAMPUS Allowable Charge. Retirees & Others: 25% of CHAMPUS Allowable Charge.
Active Duty Family Members: \$25 copayment for hospital charges. Retirees & Others: 20% of contracted fee.	Active Duty Family Members: \$25 copayment for hospital charges. Retirees & Others: 25% cost-share of the CHAMPUS Allowable Charge.
Cost-share after deductible has been met: Active Duty Family Members: 15% of contracted fee. Retirees & Others: 20% of contracted fee.	Cost-share after deductible has been met: Active Duty Family Members: 20% of CHAMPUS Allowable Charge. Retirees & Others: 25% of CHAMPUS Allowable Charge.
Cost-share after deductible has been met: Active Duty Family Members: 15% of contracted fee. Retirees & Others: 20% of contracted fee.	Cost-share after deductible has been met: Active Duty Family Members: 20% of CHAMPUS Allowable Charge. Retirees & Others: 25% of CHAMPUS Allowable Charge.
Cost-share after deductible has been met: Active Duty Family Members: 15% of contracted fee. Retirees & Others: Not covered.	Cost-share after deductible has been met: Active Duty Family Members: 20% of CHAMPUS Allowable Charge. Retirees & Others: Not covered.

BENEFITS & COVERAGE CHART

Outpatient Services Beneficiary Cost

SERVICES	TRICARE PRIME
FAMILY HEALTH SERVICES⁽¹⁾⁽⁴⁾ Family planning and well baby care (up to 24 months of age). Certain exclusions apply as currently defined by CHAMPUS.	Per visit: Active Duty Family Member E-4 and below: \$6 copayment E-5 and above: \$12 copayment Retirees & Others: \$12 copayment
HOME HEALTH CARE⁽²⁾⁽⁴⁾ Part-time skilled nursing care, physical, speech and occupational therapy, as currently defined by CHAMPUS (when medically necessary and a covered benefit). Care may be subject to visit limitations based on CHAMPUS policy.	Per visit: Active Duty Family Members: E-4 and below: \$6 copayment. E-5 and above: \$12 copayment Retirees & Others: \$12 copayment
IMMUNIZATIONS FOR REQUIRED OVERSEAS TRAVEL Immunizations required for Active Duty Family Members whose sponsors have permanent change of station orders to overseas locations. No copayment if provided as part of an office visit and a copayment is collected.	Per visit: Active Duty Family Members: E-4 and below: \$6 copayment. E-5 and above: \$12 copayment. Retirees & Others: Not covered.
IMMUNIZATIONS - CHILDHOOD No copayment if provided as part of an office visit and a copayment is collected for the office visit. DPT: 2 mos.; 4 mos.; 6 mos. DTaP: (acellular): 15-18 mos. OPV: 2 mos.; 4 mos.; 15-18 mos.; MMR: 15 mos.; HIB: 2, 4, 6, & 15 mos.; Hepatitis B: infants: Varicella as recommended by the American Association of Pediatrics.	Per visit: Active Duty Family Members E-4 and below: \$6 copayment E-5 and above \$12 copayment. Retirees & Others: Not covered.
INDIVIDUAL PROVIDER SERVICES⁽¹⁾ Office visits; outpatient office-based medical and surgical care; consultation, diagnosis and treatment by a specialist; allergy tests and treatment; osteopathic manipulation; medical supplies used within the office including casts, dressings, and splints.	Per visit: Active Duty Family Members E-4 and below: \$6 copayment. E-5 and above: \$12 copayment. Retirees & Others: \$12 copayment.

continued

Beneficiary Cost

Beneficiary Cost

TRICARE EXTRA	TRICARE STANDARD
Cost-share after deductible has been met: Active Duty Family Members: 15% of contracted fee. Retirees & Others: 20% of contracted fee.	Cost-share after deductible has been met: Active Duty Family Members: 20% of CHAMPUS Maximum Allowable Charge. Retirees & Others: 25% of CHAMPUS Allowable Charge.
Cost-share after deductible has been met: Active Duty Family Members: 15% of contracted fee. Retirees & Others: 20% of contracted fee.	Cost-share after deductible has been met: Active Duty Family Members: 20% of CHAMPUS Allowable Charge. Retirees & Others: 25% of CHAMPUS Allowable Charge
Cost-share after deductible has been met: Active Duty Family Members: 15% of contracted fee. Retirees & Others: Not covered.	Cost-share after deductible has been met: Active Duty Family Members: 20% of CHAMPUS Allowable Charge. Retirees & Others: Not covered.
Cost-share after deductible has been met: Active Duty Family Members: 15% of contracted fee. Retirees & Others: Not covered.	Cost-share after deductible has been met: Active Duty Family Members: 20% of CHAMPUS Allowable Charge Retirees & Others: Not covered.
Cost-share after deductible has been met: Active Duty Family Members: 15% of contracted fee. Retirees & Others: 20% of contracted fee.	Cost-share after deductible has been met: Active Duty Family Members: 20% of CHAMPUS Allowable Charge. Retirees & Others: 25% of CHAMPUS Allowable Charge.

BENEFITS & COVERAGE CHART

Outpatient Services

Beneficiary Cost

SERVICES	TRICARE PRIME
LABORATORY & X-RAY SERVICES (INCLUDING MAMMOGRAMS)⁽¹⁾⁽³⁾	Per visit: Active Duty Family Members: E-4 and below: \$6 copayment E-5 and above, and Retirees & Others: \$12 copayment.
MAIL ORDER PHARMACY BENEFIT The mail order pharmacy service is available to all eligible beneficiaries. The benefit enables the beneficiary to obtain a 90-day supply of medication by mail. Note: This benefit will be available through Merck-Medco. Please contact Merck at (800) 903-4680.	PER 30-DAY PRESCRIPTION: Active Duty Family Members: \$4 copayment Retirees & Others: \$8 copayment
OUTPATIENT BEHAVIORAL HEALTH⁽⁴⁾ One hour of therapy, no more than two times each week when medically necessary.	Individual visits: Active Duty Family Members E-4 & below: \$10 copayment E-5 & above: \$20 copayment Retirees & Others: \$25 copayment For group visits: E-4 and below: \$6 copayment. E-5 and above: \$12 copayment Retirees & Others: \$17 copayment
PAP SMEARS - ROUTINE⁽¹⁾ Frequency depends on physician recommendations based on the published guidelines of the American Academy of Obstetrics and Gynecology.	No copayment
PRESCRIPTION DRUGS⁽¹⁾ No charge for prescriptions at the MTF. Copayments at network pharmacies are per 30-day prescription, up to a 90-day supply (prescriptions at the MTF are limited to a 30-day supply). Copayments for a 90-day supply will be three (3) times the copayment for a 30-day supply. NOTE: No deductible for prescription drugs provided by a TRICARE Extra participating pharmacy.	Active Duty Family Members: \$5 copayment Retirees & Others: \$9 copayment

continued

Beneficiary Cost

Beneficiary Cost

TRICARE EXTRA	TRICARE STANDARD
Cost-share after deductible has been met: Active Duty Family Members: 15% of contracted fee. Retirees & Others: 20% of contracted fee.	Cost-share after deductible has been met: Active Duty Family Members: 20% of CHAMPUS Allowable Charge. Retirees & Others: 25% of CHAMPUS Allowable Charge.
PER 30-DAY PRESCRIPTION: Active Duty Family Members: \$4 copayment Retirees & Others: \$8 copayment	PER 30-DAY PRESCRIPTION: Active Duty Family Members: \$4 copayment Retirees & Others: \$8 copayment
Cost-share after deductible has been met: Active Duty Family Members: 15% of contracted fee. Retirees & Others: 20% of contracted fee.	Cost-share after deductible has been met: Active Duty Family Members: 20% of CHAMPUS Allowable Charge. Retirees & Others: 25% of CHAMPUS Allowable Charge.
Cost-share after deductible has been met: Active Duty Family Members: 15% of contracted fee. Retirees & Others: 20% of contracted fee.	Cost-share after deductible has been met: Active Duty Family Members: 20% of CHAMPUS Allowable Charge. Retirees & Others: 25% of CHAMPUS Allowable Charge.
Cost-share after deductible has been met: Active Duty Family Members: 15% of contracted fee. Retirees & Others: 20% of contracted fee.	Cost-share after deductible has been met: Active Duty Family Members: 20% of CHAMPUS Allowable Charge. Retirees & Others: 25% of CHAMPUS Allowable Charge.

BENEFITS & COVERAGE CHART

Inpatient Services

Beneficiary Cost

SERVICES	TRICARE PRIME
HOSPITALIZATION⁽¹⁾⁽²⁾⁽³⁾⁽⁶⁾⁽⁷⁾ Semiprivate room (and when medically necessary, special care units), general nursing and hospital service. Includes inpatient physician and their surgical services, meals (including special diets), drugs and medications while an inpatient, operating and recovery room, anesthesia, laboratory tests, X-rays and other radiology services, necessary medical supplies and appliances, blood and blood products. Unlimited services with authorization, as medically necessary.	Active Duty Family Members, MTF care: \$10.20 per day. Civilian care: \$11.00 per day or \$25 minimum charge per admission, whichever is greater. Retirees & Others, MTF care: \$10.20 per day. Civilian care: \$11.00 per day or \$25 minimum charge per admission, whichever is greater. No separate copayment or cost-share for separately billed professional charges. Catastrophic loss protection limits do apply.
MATERNITY⁽¹⁾⁽²⁾⁽³⁾⁽⁶⁾ Hospital and professional services (prenatal, postnatal). Unlimited services with authorization, as medically necessary.	
SKILLED NURSING FACILITY CARE⁽¹⁾⁽²⁾⁽⁶⁾ Semiprivate room, regular nursing services, meals including special diets, physical, occupational and speech therapy, drugs furnished by the facility, necessary medical supplies and appliances. Unlimited services with authorization, as medically necessary.	
HOSPITALIZATION FOR MENTAL ILLNESS⁽¹⁾⁽²⁾⁽³⁾⁽⁶⁾⁽⁷⁾ Up to 30 days per fiscal year for ages 19+, up to 45 days per fiscal year for ages under 19, and up to 150 days per fiscal year for Residential Treatment Centers (as medically/psychologically necessary).	Active Duty Family Members: \$20 per day for each day of the inpatient admission. Retirees & Others: \$40 per day copayment, or \$25 minimum charge per admission, whichever is greater. No copayment or cost-share for separately billed professional charges.

continued

Beneficiary Cost

Beneficiary Cost

TRICARE EXTRA	TRICARE STANDARD
Active Duty Family Members, MTF care: \$10.20 per day. Civilian care: \$10.20 per day or \$25 minimum charge per admission, whichever is greater. Retirees & Others, MTF care: \$10.20 per day. Civilian care: \$250 per day or 25% cost-share of the total contracted rate charges for institutional services, whichever is less, plus 20% cost-share of separately billed professional charges based on contracted rate.	Active Duty Family Members, MTF care: \$10.20 per day. Civilian care: \$10.20 per day or \$25 minimum charge per admission, whichever is greater. Retirees & Others: MTF: \$10.20 per day. Civilian care: \$360 per day or 25% cost-share of billed charges, whichever is less, plus 25% cost-share of CHAMPUS Allowable Charge for separately billed professional charges.
↓	Active Duty Family Members: \$25 per admission or \$9.90 per day, whichever is greater. Retirees & Others: 25% cost-share of allowed charges, plus 25% cost-share of CHAMPUS Allowable Charge for separately billed professional charges.
Active Duty Family Members: \$20 per day for each day of the inpatient admission. Retirees & Others: 20% cost-share of allowed rate for institutional services, plus 20% cost-share of separately billed professional charges, based on contracted fee.	Active Duty Family Members: \$20 per day for each day of the inpatient admission. Retirees & Others: 25% cost-share of allowed amount, plus 25% of CHAMPUS Allowable Charge for separately billed professional charges. PREAUTHORIZATION REQUIRED.

BENEFITS & COVERAGE CHART

Inpatient Services

Beneficiary Cost

SERVICES	TRICARE PRIME
ALCOHOLISM (1)(2)(4)(7) 7 days for detoxification and 21 days for rehabilitation per 365 days. Maximum of one rehabilitation program per year and three per lifetime. Detoxification and rehabilitation days count toward TRICARE limit for behavioral health benefits.	Active Duty Family Members: \$20 per day copayment. Retirees & Others: \$40 per day copayment or \$25 minimum charge per admission, whichever is greater. No separate copayment or cost-share for separately billed professional charges. Cat cap limits do apply.
PARTIAL HOSPITALIZATION - MENTAL HEALTH (1)(2)(4)(7) Up to 60 days per fiscal year (minimum of 3 hours per day of therapeutic services.)	Active Duty Family Members: \$20 per day copayment. Retirees & Others: \$40 per day copayment or \$25 minimum charge per admission, whichever is greater. No copayment or cost-share for separately billed professional charges.

For Active Duty Family Members, the maximum family liability (Catastrophic Cap Benefit) is \$1,000 for deductibles and cost-shares based on allowable charges for the basic Program Services and supplies received in a fiscal year. TRICARE Prime enrollees who are non-active duty beneficiaries (retirees, retiree family members, survivors, former spouses) have a catastrophic cap of \$3,000 per enrollment period and \$7,500 per fiscal year. After the maximum dollar limit is reached, TRICARE beneficiaries will not pay any additional cost-share or deductible for allowable health care services received during the remainder of the enrollment or fiscal year. An exception is Point-of-Service (POS) cost-shares. POS cost-shares mean a TRICARE Prime member chooses to obtain services from a provider without a referral from their PCM or Health Care Finder and all requirements applicable to TRICARE Standard apply. All care paid under the POS option must be cost-shared at 50% of the allowable charge (after meeting the POS deductible), even if the enrollment and fiscal year catastrophic caps are met. In order to get credit for all family expenditures allowed toward the Catastrophic Cap Benefit, the beneficiary may be required to submit appropriate documentation (e.g., CHAMPUS Explanation of Benefits).

This is only a summary description of your coverage. Please see the TRICARE Standard Handbook and if you enroll in TRICARE Prime, refer to your TRICARE Prime Member Handbook for a more complete description of all terms and conditions. In addition, the CHAMPUS regulation and the implementations under that regulation are the final authority on covered services.

continued

Beneficiary Cost

Beneficiary Cost

TRICARE EXTRA	TRICARE STANDARD
Active Duty Family Members: \$20 per day or \$25 minimum charge per admission, whichever is greater. Retirees & Others: 20% cost-share of allowed rate for institutional services, plus 20% cost-share of separately billed professional charges, based on contracted fee.	Active Duty Family Members: \$20 per day or \$25 minimum charge per admission, whichever is greater. Retirees & Others: 25% cost-share of allowed amount, plus 25% of CHAMPUS Allowable Charge for separately billed professional charges. PREAUTHORIZATION REQUIRED.
Active Duty Family Members: \$20 per day copayment. Retirees & Others: 20% cost-share of total charges based on contracted rates for institutional services, plus 20% cost-share of separately billed professional charges based on contracted fee.	Active Duty Family Members: \$20 per day copayment or \$25 per admission, whichever is greater. Retirees & Others: 25% cost-share of allowed charges, plus 25% of CHAMPUS Allowable Charge for separately billed professional charges. PREAUTHORIZATION REQUIRED.

Footnotes:

1. Balance billing: TRICARE beneficiaries may have to pay charges up to 15% over the CHAMPUS Maximum Allowable Charge when a non-network provider does not accept assignment.
2. With preauthorization for TRICARE Prime & Extra.
3. If provided as part of an office visit and a copayment is collected for the visit under TRICARE Prime, no additional copayment will be collected for these services.
4. Applied to outpatient services. TRICARE Extra and Standard deductibles and cost-shares are subject to change.
5. Cost-shares are subject to change at the beginning of each fiscal year (Oct. 1).
6. TRICARE Standard cost-share for retirees may vary depending on the type of treatment or type of hospital.

BENEFITS & COVERAGE CHART

CLINICAL PREVENTIVE SERVICES

For TRICARE Extra and Standard users, clinical preventive services can only be provided at the same time an immunization or cancer screening service is provided, in order to be covered. For example, if a TRICARE-eligible female goes in for a routine pap smear or a tetanus shot, she is also eligible to receive other preventive services such as tuberculosis

continued on next page

Beneficiary Cost

SERVICES	TRICARE PRIME
EYE EXAMS/REFRACTIONS: General Screening: One routine eye examination per calendar year per person for dependents of active duty members. Well-Child Care: Eye and vision screening by primary care provider during routine examination at birth, approximately 6 months, 3 years and 5 years of age. Additionally, age 3-6 comprehensive eye examination for amblyopia and strabismus. For Adults: Comprehensive eye examination, including screening for visual acuity and glaucoma, every 3 to 5 years in African Americans aged 20-39 years; and regardless of race, every 2 to 4 years in individuals aged 40-64 years. Diabetic patients, at any age, should have comprehensive eye examinations at least yearly.	No copayment No copayment No copayment
PERIODIC SCREENING EXAMINATIONS Beneficiaries will be offered age and gender appropriate screening tests for the early detection of disease and/or disease risk factors, including: Cancer Screening: Mammography, Pap smears/pelvic exams, proctosigmoidoscopy or sigmoidoscopy, colonoscopy, fecal occult blood testing, prostate-specific antigen testing, and genetic testing and counseling. Cardiovascular: Cholesterol and blood pressure. Other: Hearing screening and pediatric blood lead.	No copayment

continued

screening, blood pressure screening and cholesterol screening. However, if she visits her physician because she has the flu, she is only eligible for immunization or cancer screening preventive services. Other preventive services like tuberculosis would not be covered. TRICARE Prime members can still obtain Clinical Preventive Services individually.

Beneficiary Cost	Beneficiary Cost
TRICARE EXTRA	TRICARE STANDARD
No copayment	No copayment
No copayment	No copayment
Not Covered	Not Covered
Applicable cost-share and deductible applies when service is included as part of a cancer screening visit. Preventive hearing screenings only allowed under Well-Child benefit.	Applicable cost-share and deductible applies when service is included as part of a cancer screening visit. Preventive hearing screenings only allowed under Well-Child benefit.

CLINICAL PREVENTIVE SERVICES

Beneficiary Cost

SERVICES	TRICARE PRIME
IMMUNIZATIONS Beneficiaries will be offered age appropriate immunizations against vaccine preventable diseases according to current Centers for Disease Control (CDC) recommendations: Tetanus, Diphtheria, Pertussis, Poliomyelitis, Mumps, Measles, Rubella, Influenza, Pneumococcal Disease, Haemophilus Influenza Type B, Hepatitis A, Hepatitis B and Varicella (Chicken Pox). Hepatitis B: Infants (<i>see specific benefit below</i>).	No copayment
CLINICAL EXAMINATIONS Periodic health promotion exams and periodic disease prevention exams, including the following cancer screenings: Clinical breast exams; testicular cancer; digital rectal; skin cancer; oral cavity & pharyngeal cancer; thyroid. Other clinical exams: Blood pressure and body measurement (adults and children).	No copayment
PATIENT & PARENT EDUCATION/COUNSELING SERVICES The following education services are covered when part of an office visit with your PCM: Dietary assessment & nutrition; physical activity & exercise; cancer surveillance; safe sexual practices; tobacco, alcohol & substance abuse; accident & injury prevention; promoting dental health; stress, bereavement and suicide risk assessment.	No copayment

continued

Beneficiary Cost

Beneficiary Cost

TRICARE EXTRA	TRICARE STANDARD
Applicable cost-share and deductible applies when service is included as part of a cancer screening visit.	Applicable cost-share and deductible applies when service is included as part of a cancer screening visit.
Applicable cost-share and deductible applies when service is included as part of a cancer screening visit.	Applicable cost-share and deductible applies when service is included as part of a cancer screening visit.
Applicable cost-share and deductible applies when service is included as part of a cancer screening visit.	Applicable cost-share and deductible applies when service is included as part of a cancer screening visit.

CLINICAL PREVENTIVE SERVICES

Beneficiary Cost

SERVICES	TRICARE PRIME
HEPATITIS B VACCINE For Hepatitis B surface Antigen (HBsAg). Infants born to HBsAg-negative mothers receive HBG vaccine before discharge; second dose at 1-2 months of age; third dose at 6 - 18 months of age. Infants born to HBsAg-positive mothers; immunize with single dose of HBIG within 12 hours of birth to provide immediate passive protection, and a complete series of 3 doses of vaccine should be initiated as soon as birth as possible. The first dose should be given concurrently with the HBIG at birth but at a separate site. Second and third doses at one and six months of age. Serilogic status should be checked at nine months and fourth dose administered to infants who are HBsAg-negative with titers of anti-HBs < 10 mIU/mL. Re-test one month later for anti-HBs. Up to two additional doses may be considered for those who fail to respond.	No copayment
INFECTIOUS DISEASES • Hepatitis B Screening (HBsAg screening for pregnant women; See Hepatitis B Vaccine section). • Human immunodeficiency virus (HIV) testing. • Prophylaxis (Preventive therapy for those at risk of developing the following active disease): - Tetanus immune globulin and tetanus toxoid (following an injury) - Anti-rabies serum or human rabies immune globulin and rabies vaccine (following an animal bite) - Rh immune globulin (pregnancy testing) - Isoniazid therapy (tuberculosis) - Rubella anti-bodies (females, once during age 12-18 unless documented history of previous rubella vaccination)	No copayment

continued

Beneficiary Cost

Beneficiary Cost

TRICARE EXTRA	TRICARE STANDARD
Applicable cost-share and deductible applies when service is included as part of a cancer screening visit.	Applicable cost-share and deductible applies when service is included as part of a cancer screening visit.
Applicable cost-share and deductible applies when service is included as part of a cancer screening visit.	Applicable cost-share and deductible applies when service is included as part of a cancer screening visit.

COMMONLY USED TRICARE TERMS

ACCEPTING ASSIGNMENT:

A provider's agreement to accept the CHAMPUS Maximum Allowable Charge (CMAC) as the full fee. The provider agrees not to charge the patient the difference between the provider's charge and the CHAMPUS Maximum Allowable Charge.

BALANCE BILLING:

Is the amount of billed charges that exceed the CHAMPUS Maximum Allowed Charge (CMAC) and, in turn, charged to the patient.

- Network providers and participating CHAMPUS providers that accept assignment are not allowed to balance bill their patients.
- Non-participating providers may charge that patient up to 115% of the CMAC. There are some non-participating providers who are exempt from this rule such as: pharmacies, ambulance services; independent labs; mobile X-ray companies, screening mammography centers; durable medical equipment and medical supply companies.

BENEFICIARY SERVICES REPRESENTATIVE:

A Foundation Health Federal Services (FHFS) employee who can provide information and assistance to all beneficiaries about the TRICARE program and other benefits. This includes assisting beneficiaries with TRICARE claim problems. Benefits information and assistance will be provided to active-duty personnel and their families, retirees and their families, survivors, Medicare-eligible beneficiaries, and all other categories of individuals eligible to receive services through the Military Health Services System (MHSS).

BILLED CHARGES:

The amount submitted by providers of service as their fee for services or supplies rendered to the patient.

CATCHMENT AREA:

ZIP codes within approximately a 40-mile radius of a Military Treatment Facility.

CATASTROPHIC CAP:

A cost "cap" or upper limit on out-of-pocket expenses has been placed on CHAMPUS-covered medical bills. The fiscal year limit for an active-duty family is \$1,000. TRICARE Prime enrollees who are non-active duty beneficiaries (retirees, retiree family members, survivors, former spouses) have a catastrophic loss protection limit (cat cap) of \$3,000 per enrollment period; and \$7,500 catastrophic cap per fiscal year. Charges or health care in excess of the CHAMPUS Maximum Allowable Charge do not count towards these caps. TRICARE Prime families who use the Point-of-Service (POS) option will have POS deductible and cost-share amounts applied to the fiscal year catastrophic cap. *Note regarding Point of Service:* Point-of-Service claims do not have a catastrophic cap

even though Point-of-Service deductibles and cost-share amounts are applied to the fiscal year catastrophic cap. All care paid under the Point-of-Service option must be cost-shared at 50% of the allowable charge (after meeting the Point-of-Service deductible) even if the enrollment and fiscal year cat caps are met.

CHAMPUS ALLOWABLE:

The maximum that will be paid to a participating provider. The allowable is based upon a CHAMPUS-approved reimbursement method.

CHAMPUS-CERTIFIED PROVIDER:

A hospital, institution, physician or another health care professional who meets the licensing and certification requirements of the CHAMPUS regulations and practices within the scope of that license.

CHAMPUS EXPLANATION OF BENEFITS (CEOB):

A statement that shows exactly how your claim was processed and what payments were made to the provider. If your claim was denied, it will explain the reason(s) for denial. A CEOB is not a bill or invoice for services received.

COPAYMENT:

A TRICARE Prime patient's fixed fee for covered services usually paid to the physician or provider at the time of service. Your Prime copayment depends on your sponsor's military status and pay grade.

COST-SHARE:

A patient's share of costs for covered services. Your cost-shares are based on your sponsor's military status and pay grade. In the TRICARE Prime Point-of-Service option, the deductible has to be met before cost-sharing begins.

DEDUCTIBLE:

The amount that TRICARE Standard and Extra beneficiaries must pay for covered outpatient services or supplies provided in any one fiscal year (October 1 through September 30). Currently, the fiscal year deductible is \$150 per person or \$300 per family (E-4 and below, \$50 and \$100 respectively). TRICARE Prime members are not required to pay a deductible unless they exercise the Point-of-Service option. Currently, the fiscal year deductible when using the Point-of-Service option is \$300 per person and \$600 per family.

EMERGENCY:

An emergency is a sudden and unexpected medical condition or the worsening of a condition that threatens your life, limb or sight and requires immediate treatment, or requires treatment to relieve suffering from painful symptoms. Emergency care is normally provided at a hospital emergency room. Some examples of conditions that require emergency care include loss of consciousness, shortness of breath, chest pain, uncontrolled bleeding, sudden or unexpected weakness or paralysis, fractures, poisoning, suicide attempts, drug overdose, acute psychosis and major depression.

HEALTH BENEFITS ADVISOR (HBA):

A federal government employee who helps you to understand CHAMPUS and explains your TRICARE health care benefits. In addition, the HBA can help you learn about the care you may receive at the Military Treatment Facility (MTF).

HEALTH CARE FINDER (HCF):

Generally a registered nurse employed by Foundation Health Federal Services who will help you find proper care in the military or civilian health care system. Your PCM works with the HCF to help refer you to inpatient or outpatient specialty care. This service is available at the TRICARE Service Center on a walk-in basis during normal business hours, or by phone on a 24-hour basis, seven days a week, by calling (800)242-6788.

HOSPITAL:

An institution which is licensed under state and local laws and regulations to provide services for the medical diagnosis and treatment of persons in need of acute inpatient care.

INPATIENT:

An individual admitted and assigned as a bed patient in a hospital or skilled nursing facility, who requires routine or specialized hospital or skilled nursing facility care, with the intent to keep the patient overnight.

MEDICALLY/PSYCHOLOGICALLY NECESSARY:

The appropriate and necessary treatment of the patient's illness or injury according to accepted standards of medical practice and CHAMPUS policy.

MILITARY TREATMENT FACILITY (MTF):

A military hospital or clinic.

NETWORK PROVIDER:

A CHAMPUS-certified provider contracted by Foundation Health Federal Services to provide services to individuals enrolled in TRICARE Prime.

NONAVAILABILITY STATEMENT:

A certification from the uniformed services hospital that says it can't provide the care you need. For all *outpatient* services from civilian sources beneficiaries do not need an NAS. For civilian hospital admissions an *inpatient* NAS is not required for persons who are enrolled in TRICARE Prime and who live within the service area of a uniformed services hospital.

NON-NETWORK PROVIDER:

A health care provider or a health care facility who does not have a written agreement to provide care to a member. For referral purposes, a non-network provider must be a CHAMPUS-certified provider.

NON-PARTICIPATING PROVIDER:

A CHAMPUS-certified provider who does not accept the CHAMPUS-determined allowable charge as full fee for

care. Payment goes directly to the patient in this case, and the patient is responsible for costs that exceed the CHAMPUS allowable amount up to 115 percent. (There are exceptions to this limitation as noted under "Balance Billing"). The patient is also responsible for all charges that are disallowed by CHAMPUS.

OTHER COMPREHENSIVE HEALTH CARE INSURANCE (OHI):

Any non-CHAMPUS health insurance available to you or other members of your family through other entitlement programs, employment, or insurance coverage. Federal law requires that all TRICARE programs pay for services only after the other comprehensive health care insurance is used. The exception is when the other insurance is Medicaid.

OUTPATIENT:

An individual who requires medical treatment but is not confined as a bed patient in a hospital.

PARTICIPATING PROVIDER:

A CHAMPUS-certified provider who agrees to accept the CHAMPUS Maximum Allowable Charge (CMAC) as full payment for the care provided. Payment goes directly to the provider. The beneficiary must still pay the copayment, cost-share or deductible as applicable.

POINT-OF-SERVICE (POS) OPTION:

When a TRICARE Prime member chooses to obtain services from a provider without a referral from their PCM or Health Care Finder, the following POS rules apply: 1) Annual deductible of \$300 per individual or \$600 per family; 2) 50 percent of the CHAMPUS maximum allowable charge (CMAC). This includes pharmacy prescriptions. If a Prime member takes a prescription into a non-network pharmacy, the prescription will be cost-shared as point-of-service.

PREAUTHORIZATION:

Formal approval by Foundation Health Federal Services before obtaining a TRICARE covered service. Certain specialty services and inpatient care require preauthorization under TRICARE Prime. If using the Point-of-Service option under TRICARE Prime, no referral is necessary; however, some procedures do require preauthorization.

PRIMARY CARE MANAGER (PCM):

A Primary Care Manager (PCM) is a clinic site at your Military Treatment Facility (MTF), a TRICARE Prime civilian network provider or network clinic site. You may have the option of either the military provider or a civilian network provider as your PCM. Your PCM assumes primary responsibility for arranging and coordinating your total health care needs. PCMs are listed in the TRICARE provider directory.

IMPORTANT PHONE NUMBERS

TRICARE PROGRAM INFORMATION:

(800) 242-6788

BENEFICIARY SERVICES REPRESENTATIVE:

(800) 242-6788

HEALTH CARE FINDER (HCF):

(800) 242-6788

DEERS: (800) 334-4162 (CA)

(800) 538-9552 (YUMA, AZ)

(800) 527-5602 (HI, AK)

HEALTH CARE INFORMATION LINE (HCIL):

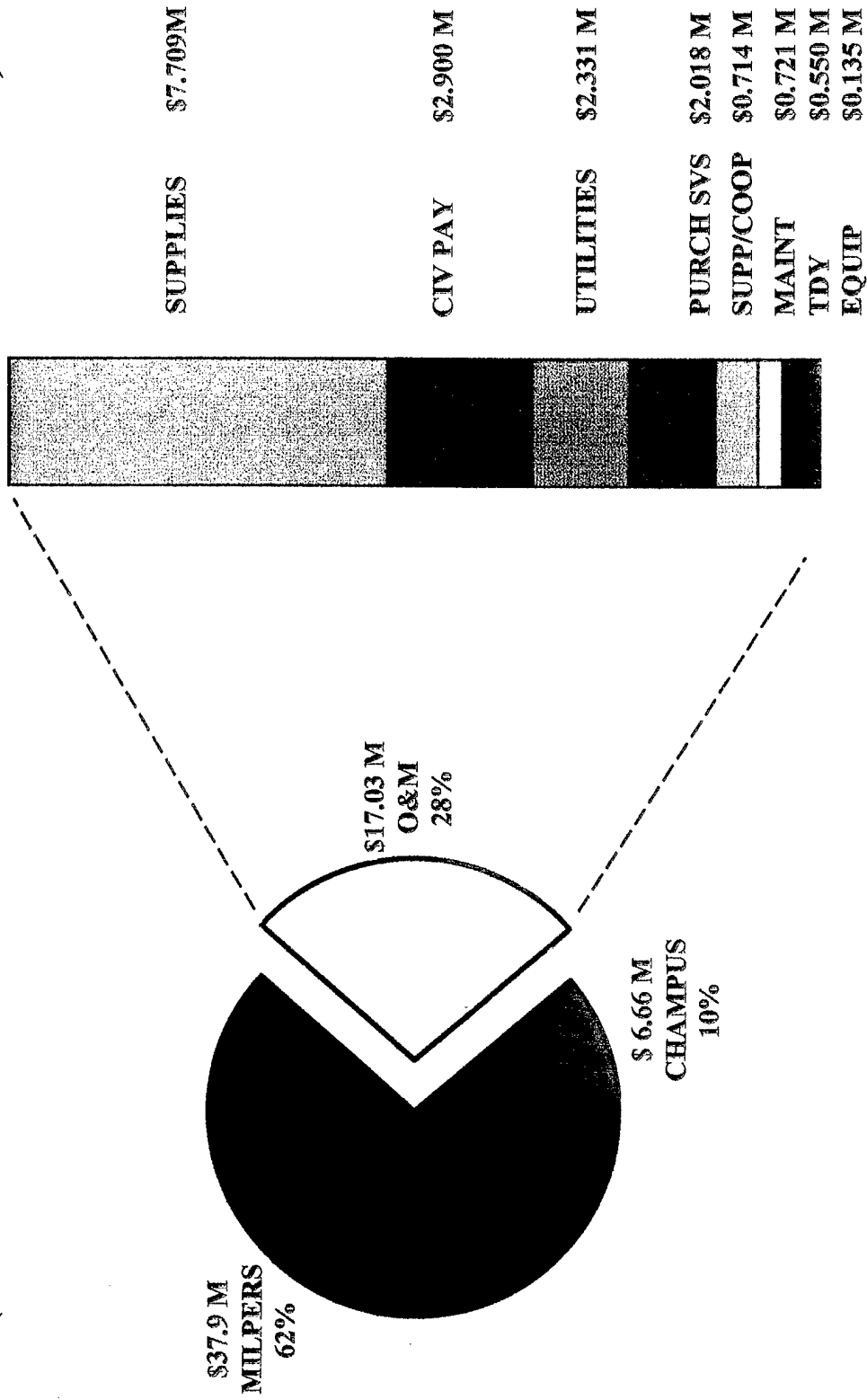
(800) 822-2878 (www.PHA-ONLINE.com/HCIL)

TRICARE CLAIMS: (800) 378-7568

D

FY 97 CAPITATED BUDGET

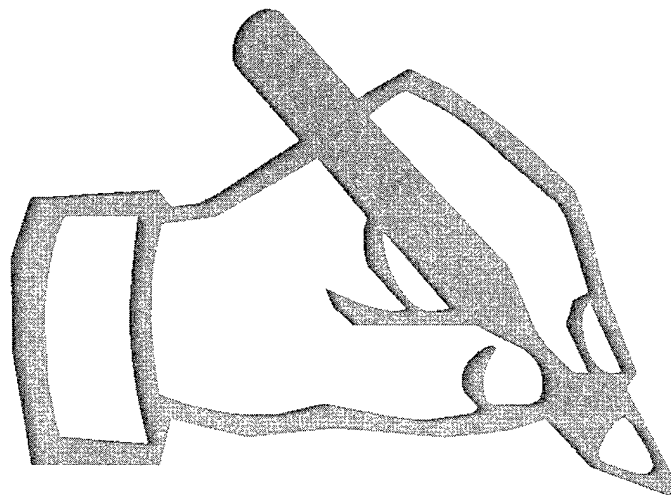
(\$61.6 M - INCLUDES \$2.6 M REIMBURSEMENTS)



E



Health Enrollment Assessment Review



This questionnaire was developed by the Office for Prevention and Health Services Assessment (OPHSA), the National Center for Environmental Health (NCEH), and the Battelle Memorial Institute for TRICARE Region VI and IV through a Memorandum of Agreement between Armstrong Laboratory Human Services Command, U.S. Air Force Materiel Command, and the Centers for Disease Control and Prevention (CDC).

Health Enrollment Assessment Review (HEAR)

INSTRUCTIONS

General Instructions:

Please use a pencil to complete the survey. Please fill in the circle with a complete dark mark. If you make a mistake, erase the incorrect mark and fill in the correct circle.

Example:

Correct



Incorrect



Here is an example of how someone born on June 23, 1971 would answer question A1.

A1. DATE OF BIRTH

(YEAR / MONTH / DAY)

19	7	1	/	0	6	/	2	3
1	☐	☒		☐	☐		☐	☐
2	☐	☐		☒	☐		☒	☐
3	☐	☐		☐			☐	☒
4	☐	☐		☐			☐	☐
5	☐	☐		☐			☐	☐
6	☐	☐		☒			☐	☐
7	☒	☐		☐			☐	☐
8	☐	☐		☐			☐	☐
9	☐	☐		☐			☐	☐
0		☐		☐			☐	☐

Here is an example of how someone 6 feet 2 inches tall would answer question A3.

A3. Without shoes, about how tall are you?

	6	feet		0	2	inches
3	☐		1	☐	☐	
4	☐		2	☐	☒	
5	☐		3	☐	☐	
6	☒		4	☐	☐	
7	☐		5	☐	☐	
			6	☐	☐	
			7	☐	☐	
			8	☐	☐	
			9	☐	☐	
			0	☒	☐	

Health Enrollment Assessment Review (HEAR)

INSTRUCTIONS *(Continued)*

Please **answer all appropriate questions** and complete the entire survey. However, you should skip questions where the survey says to do so. For example, males should not answer the female questions, and non-smokers should not answer the smoking questions.

Example: In the illustration below, we have answer "not at all" to question **G2**. Therefore we will skip the rest of the **G** section questions and go directly to question **H1**.

G2. Do you NOW smoke cigarettes every day, some days, or not at all?

- ☐ Every day ☐ Some days ☒ Not at all (go to H1)

Do not fold or staple the survey pages. Please complete the survey and **return it by mail within 5 days**, using the pre-addressed envelope provided.

Privacy Act Statements:

AUTHORITY: 10 U.S.C., 8013

PURPOSE: The health enrollment assessment review (HEAR) survey is designed to collect personal information from military health services system beneficiaries.

ROUTINE USES: This information is used primarily by health care personnel to plan health care delivery needs. Information used in this survey will be sent only to you and your Primary Care Manager (PCM) and kept in your medical record. Other results from this survey will be provided only in combination with results from other enrollees and cannot be used to identify you.

DISCLOSURE: Completion of information in this survey is highly desirable, but not mandatory. Completion of the survey information will help your PCM design a plan of care. Preexisting medical conditions and other risk factors will in no way affect enrollment eligibility.

Thank you for completing the survey.



TRICARE HEALTH ENROLLMENT ASSESSMENT REVIEW QUESTIONNAIRE



FIRST NAME (Formal)

12094

5 9 8 2 2 0 0 A

12094

5 9 8 2 2 0 0 A

MI

12094

5 9 8 2 2 0 0 A

12094

5 9 8 2 2 0 0 A

LAST NAME (include space before JR or III)

12094

5 9 8 2 2 0 0 A

12094

5 9 8 2 2 0 0 A

Your Social Security #:

12094

5 9 8 2 2 0 0 A

12094

5 9 8 2 2 0 0 A

Sponsor's Social Security #:

12094

5 9 8 2 2 0 0 A

12094

5 9 8 2 2 0 0 A

FOR OFFICE USE ONLY

Please do not write or mark in this area.

PCMID CODE

12094

5 9 8 2 2 0 0 A

12094

5 9 8 2 2 0 0 A

TRICARE HEALTH ENROLLMENT ASSESSMENT REVIEW QUESTIONNAIRE

STREET ADDRESS (include apartment #)

Example: 1234(space)54TH(space)AVE(space)Apt(space)2A

CITY

Example: Puget(space)Sound

STATE



A
0
0
0
2
2
2
B
9
5

Grid for Street Address (26 columns, 1 row)

Grid for City (26 columns, 1 row)

Grid for State (2 columns, 1 row)

Grid for Street Address (26 columns, 26 rows, A-Z)

Grid for City (26 columns, 26 rows, A-Z)

Grid for State (26 columns, 1 row, A-Z)

ZIP CODE

Grid for ZIP Code (5 columns, 1 row)

FOR OFFICE USE ONLY

Grid for ZIP Code (5 columns, 1 row)

Please do not write or mark in this area.



TRICARE HEALTH ENROLLMENT ASSESSMENT REVIEW QUESTIONNAIRE

A1. DATE OF BIRTH:
(YEAR /MONTH /DAY)

1 9 / /

1	☐	☐	☐	☐
2	☐	☐	☐	☐
3	☐	☐	☐	☐
4	☐	☐	☐	☐
5	☐	☐	☐	☐
6	☐	☐	☐	☐
7	☐	☐	☐	☐
8	☐	☐	☐	☐
9	☐	☐	☐	☐
0	☐	☐	☐	☐

A4. Racial/Ethnic Background:

- ☐ Amer. Indian or Alaska Native
- ☐ Asian/Oriental
- ☐ Black, Hispanic
- ☐ Black, Non-Hispanic
- ☐ Pacific Islander
- ☐ White, Hispanic
- ☐ White, Non-Hispanic
- ☐ Other

A6. About how tall are you, without shoes?

feet inches

3	☐	1	☐	☐
4	☐	2	☐	☐
5	☐	3	☐	☐
6	☐	4	☐	☐
7	☐	5	☐	☐
		6	☐	☐
		7	☐	☐
		8	☐	☐
		9	☐	☐
		0	☐	☐

A8. Would you say that your health in general is...

- ☐ Excellent ☐ Fair
- ☐ Very good ☐ Poor
- ☐ Good

B1. About how long has it been since you last had your blood pressure taken by a doctor, nurse, or other health professional?

- ☐ Less than 1 year ago ☐ 3 or more years ago
- ☐ 1 year ago ☐ Never
- ☐ 2 years ago ☐ Don't know

B2. Have you ever been told by a doctor or other health professional that you had hypertension, sometimes called high blood pressure?

- ☐ Yes (go to B3) ☐ Only during pregnancy (go to C1)
- ☐ No (go to C1)

A2. GENDER:

- ☐ Male
- ☐ Female

A3. MARITAL STATUS:

- ☐ Never married
- ☐ Married
- ☐ Separated
- ☐ Divorced
- ☐ Widowed

A5. Are you:

- ☐ Active duty service member
- ☐ Retired service member

OR Family Member of:

- ☐ Active duty service member
- ☐ Retired/deceased service member
- OR**
- ☐ Other

A7. About how much do you weigh, without shoes?

pounds

1	☐	☐	☐
2	☐	☐	☐
3	☐	☐	☐
4	☐	☐	☐
5	☐	☐	☐
6	☐	☐	☐
7	☐	☐	☐
8	☐	☐	☐
9	☐	☐	☐
0	☐	☐	☐

B3. Have you been told two or more different times that you had hypertension or high blood pressure?

- ☐ Yes ☐ No ☐ Don't know

B4. Has any medicine ever been prescribed by a doctor for your hypertension or high blood pressure?

- ☐ Yes ☐ No (go to C1) ☐ Don't know (go to C1)

B5. Are you now taking any medicine prescribed by a doctor for your hypertension or high blood pressure?

- ☐ Yes ☐ No (go to C1) ☐ Don't know (go to C1)

B6. How regularly do you take your high blood pressure medicine?

- ☐ Always ☐ Less than half the time
- ☐ Most of the time ☐ Never
- ☐ About half the time

C1. Blood cholesterol is a fatty substance found in blood. Have you ever had your blood cholesterol checked?

- ☐ Yes (go to C2) ☐ No (go to C4) ☐ Don't know (go to C4)

C2. About how long has it been since you last had your blood cholesterol checked?

- ☐ Less than 1 year ago ☐ 5 years ago
- ☐ 1-2 years ago ☐ More than 5 years ago
- ☐ 3-4 years ago ☐ Don't know

C3. Have you ever been told by a doctor or other health professional that your blood cholesterol is high?

- ☐ Yes ☐ No ☐ Don't know

C4. About how long has it been since you had a rectal exam?

- ☐ Less than 1 year ago ☐ 3 or more years ago
- ☐ 1 year ago ☐ Never
- ☐ 2 years ago ☐ Don't know

C5. During the past ten years, have you had a tetanus shot?

- ☐ Yes ☐ No ☐ Don't know

D1. In an average week, how many times do you engage in physical activity (exercise or work which lasts at least 20 minutes without stopping and which is hard enough to make you breathe heavier and your heart beat faster)?

- ☐ Less than 1 time per week ☐ At least 3 times per week
- ☐ 1-2 times per week

D2. How much hard physical work is required on your job? Would you say...

- ☐ A great deal ☐ None
- ☐ A moderate amount ☐ Not currently working
- ☐ A little

D3. How much hard physical work is required in your main daily activity (household or other non-job activities)? Would you say...

- ☐ A great deal ☐ A moderate amount ☐ A little ☐ None

Office Use Only

13665



A 0 0 0 2 2 2 8 6 5

Please do not write or mark in this area.



TRICARE HEALTH ENROLLMENT ASSESSMENT REVIEW QUESTIONNAIRE

E. Women's Health (men go to F1)

E1. About how long has it been since you had a breast examination by a doctor or other health professional?

- ☐ Less than 1 year ago ☐ 3 or more years ago
☐ 1 year ago ☐ Never
☐ 2 years ago ☐ Don't know

E2. A mammogram is an x-ray of each breast to look for breast cancer. Have you ever had a mammogram?

- ☐ Yes ☐ No (go to E4) ☐ Don't know (go to E4)

E3. How long has it been since you had your last mammogram?

- ☐ Less than 1 year ago ☐ 3 or more years ago
☐ 1 year ago ☐ Don't know
☐ 2 years ago

E4. A Pap smear is a test for cancer of the cervix. Have you ever had a Pap test (or Pap smear)?

- ☐ Yes ☐ No (go to G1) ☐ Don't know (go to G1)

E5. How long has it been since you had your last Pap smear?

- ☐ Less than 1 year ago ☐ 3 or more years ago
☐ 1 year ago ☐ Don't know
☐ 2 years ago

F. Men's Health (women go to G1)

F1. How long has it been since you had a testicular examination by a doctor or other health care professional?

- ☐ Less than 1 year ago ☐ 3 or more years ago
☐ 1 year ago ☐ Never
☐ 2 years ago ☐ Don't know

G1. Have you smoked at least 100 cigarettes in your entire life? (Note: 1 pack = 20 cigarettes) ☐ Yes ☐ No (go to H1)

G2. Do you **NOW** smoke cigarettes every day, some days, or not at all?

- ☐ Every day ☐ Some days ☐ Not at all (go to H1)

G3. On the average, about how many cigarettes a day do you now smoke?

- ☐ Less than 1 per day ☐ 21-40 per day
☐ 1-10 per day ☐ 41 or more per day
☐ 11-20 per day ☐ Don't know

G4. Are you seriously intending to quit smoking in the next 6 months? ☐ Yes ☐ No

G5. Are you planning to quit smoking in the next month? ☐ Yes ☐ No

G6. Have you tried to quit smoking in the past 12 months? ☐ Yes ☐ No

H1. During the **past month**, have you had at least one drink of any alcoholic beverage such as beer, wine, wine cooler, or liquor?

- ☐ Yes ☐ No (go to I1) ☐ Don't know

H2. In the past two weeks, on how many days did you drink any alcoholic beverages, such as beer, wine, or liquor?

- ☐ None (go to H4) ☐ 5-6 days
☐ 1-2 days ☐ 7 or more days
☐ 3-4 days ☐ Don't know

H3. A drink is 1 can or bottle of beer, 1 glass of wine, 1 can or bottle of wine cooler, 1 cocktail, or 1 shot of liquor. During the past 2 weeks, on the days when you drank, how many drinks did you drink on average?

- ☐ 1-2 drinks ☐ 7 or more drinks
☐ 3-4 drinks ☐ Don't know
☐ 5-6 drinks

H4. During the past month, how many times have you driven when you've had perhaps too much to drink?

- ☐ None ☐ 7 or more times
☐ 1-2 times ☐ Don't drive
☐ 3-4 times ☐ Don't know
☐ 5-6 times

H5. During the past month, have you thought you should cut down on your drinking of alcohol? ☐ Yes ☐ No

H6. During the past month, has anyone complained about your drinking? ☐ Yes ☐ No

H7. During the past month, have you felt guilty or upset about your drinking? ☐ Yes ☐ No

H8. During the past month, was there at least one day on which you had five or more drinks of beer, wine, or liquor? ☐ Yes ☐ No

I1. How often do you feel that your present work or lifestyle is putting you under too much stress?

- ☐ Often ☐ Sometimes ☐ Seldom ☐ Never

I2. During the **past 2 weeks**, would you say that you experienced...

- ☐ A lot of stress
☐ A moderate amount of stress
☐ Relatively little stress
☐ Almost no stress at all

I3. In the past year, how much effect has stress had on your health?

- ☐ A lot ☐ Some ☐ Hardly any or none

J1. In general, how satisfied are you with your life (e.g., work situation, social activity, accomplishing what you set out to do)?

- ☐ Not satisfied ☐ Mostly satisfied
☐ Somewhat satisfied ☐ Totally satisfied

J2. How often do you have any serious problems dealing with your husband or wife, parents, friends, or with your children?

- ☐ Often ☐ Sometimes ☐ Seldom ☐ Never

J3. During the past year, have you been separated from your family for a block of at least 30 days?

- ☐ Yes ☐ No

Office Use Only

13665



A 0 0 0 2 2 2 8 6 5

Please do not write or mark in this area.



TRICARE HEALTH ENROLLMENT ASSESSMENT REVIEW QUESTIONNAIRE

In the past month, have you often been bothered by ...

- K1.** ...little interest or pleasure in doing things? ☐ Yes ☐ No
- K2.** ...feeling down, depressed, or hopeless? ☐ Yes ☐ No
- K3.** ..."nerves" or feeling anxious or on edge? ☐ Yes ☐ No
- K4.** ...worrying about a lot of different things? ☐ Yes ☐ No
- K5.** During the past month, have you had an anxiety attack (suddenly feeling fear or panic)? ☐ Yes ☐ No
- K6.** During the past 12 months, have you seen a mental health professional? ☐ Yes ☐ No ☐ Don't know

L1. During the past two weeks, how many days did you stay in bed for more than half of the day because of illness or injury?

- ☐ None ☐ 5-6 days
☐ 1-2 days ☐ 7 or more days
☐ 3-4 days ☐ Don't know

L2. During the past two weeks, how many days did you miss more than half of the day from your job or business because of illness or injury?

- ☐ None ☐ 5-6 days
☐ 1-2 days ☐ 7 or more days
☐ 3-4 days ☐ Don't know

L3. Do you have difficulty walking such as hobbling, shuffling, or not being able to walk a straight line? ☐ Yes ☐ No

M1. How many different prescription medications are you currently taking?

- ☐ None ☐ 6 or more medications
☐ 1-2 medications ☐ Don't know
☐ 3-5 medications

M2 & M3. Excluding visits for pregnancy, medication refills, and dental care, how many times did you see a doctor, nurse, or other health care professional for an office visit or clinic appointment?

(Include both civilian and military health care professionals. Only include visits for yourself.)

during the PAST MONTH

during the PAST 12 MONTHS

- ☐ None
☐ 1-2 visits
☐ 3-4 visits
☐ 5-6 visits
☐ 7 or more visits
☐ Don't know

- ☐ None
☐ 1-5 visits
☐ 6-10 visits
☐ 11-15 visits
☐ 16-20 visits
☐ 21 or more visits
☐ Don't know

M4. During the past 12 months, how many times have you gone to an emergency room or urgent care clinic?

- ☐ None ☐ 5-6 visits
☐ 1-2 visits ☐ 7 or more visits
☐ 3-4 visits ☐ Don't know

M5. During the past 12 months, have you spent one or more nights in the hospital? (Do not include hospitalizations for deliveries.) ☐ Yes ☐ No (go to N1)

M6. During the past 12 months, how many nights have you spent in the hospital? ☐ 1-2 nights ☐ 3-4 nights ☐ 5-6 nights ☐ 7 or more nights ☐ Don't know

M7. During the past 12 months, on how many different occasions have you entered the hospital and stayed for at least one night? ☐ 1 time ☐ 2-3 times ☐ 4 or more times ☐ Don't know

Have you ever been told by a health care provider that you have ...

N1. ...diabetes or sugar diabetes? ☐ Yes ☐ No ☐ Don't know

N2. ...had a stroke? ☐ Yes ☐ No ☐ Don't know

N3. ...had a heart attack? ☐ Yes ☐ No ☐ Don't know

N4. ...emphysema/chronic bronchitis? ☐ Yes ☐ No ☐ Don't know

N5. ...arthritis? ☐ Yes ☐ No ☐ Don't know

N6. ...Parkinson's disease or other neurologic disease? ☐ Yes ☐ No ☐ Don't know

N7. ...depression? ☐ Yes ☐ No ☐ Don't know

N8. ...HIV or AIDS? ☐ Yes ☐ No ☐ Don't know

N9. ...anxiety or personality disorder? ☐ Yes ☐ No ☐ Don't know

N10. ...cancer? ☐ Yes ☐ No ☐ Don't know

N11. ...heart disease or angina? ☐ Yes ☐ No ☐ Don't know

N12. ...liver disease? ☐ Yes ☐ No ☐ Don't know

N13. ...kidney disease? ☐ Yes ☐ No ☐ Don't know

N14. ...a stomach ulcer? ☐ Yes ☐ No ☐ Don't know

N15. ...asthma? ☐ Yes ☐ No ☐ Don't know

N16. During the past 12 months, have you seen a health care provider on 2 or more occasions for a bone, joint, back, or muscle problem? ☐ Yes ☐ No

N17. Do you have a dependent family member less than 18 years old with a serious medical condition? ☐ Yes ☐ No

N18. Do you have a close family member (parent, brother/sister, or child) who has or had angina, a heart attack, or other heart disease? ☐ Yes ☐ No ☐ Don't know

Office Use Only

13665

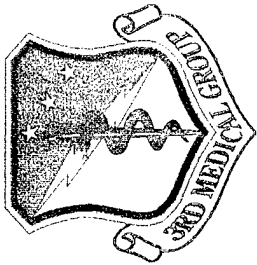
Please do not write or mark in this area.



A 0 0 0 2 2 2 8 6 5



F



CATCHMENT AREA POPULATION

FY 94 - FY 97

Historical Trends

42,097

39,772

39,415

39,960

10,569

5,475

15,922

10,131

FY 97

☐ All Other

8,968

4,605

16,115

10,084

FY 96

☒ Retiree

9,009

4,626

15,863

9,917

FY 95

☒ A/D Dep

9,075

4,664

16,134

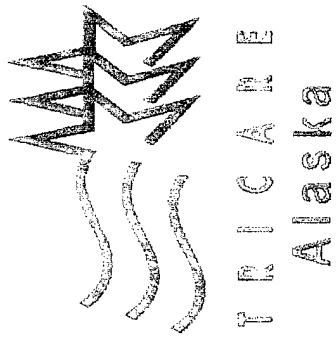
10,087

FY 94

☒ Active Duty

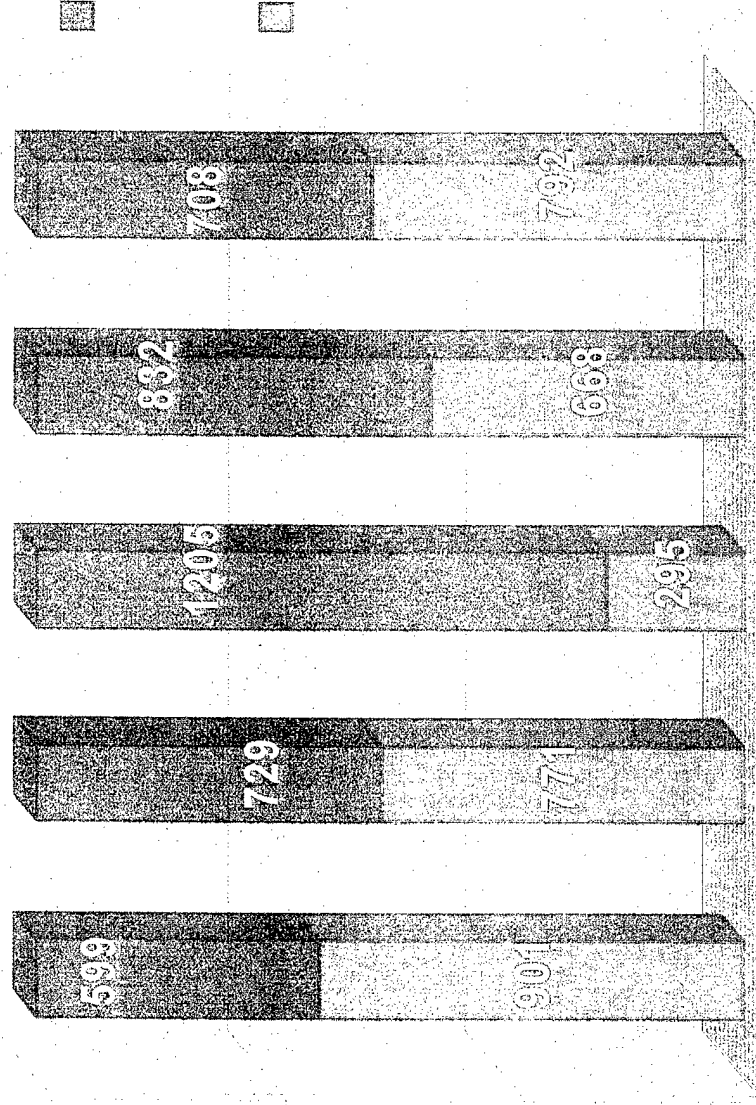
10-10-10

G



3 MIDG

ENROLLMENT BY PCMI



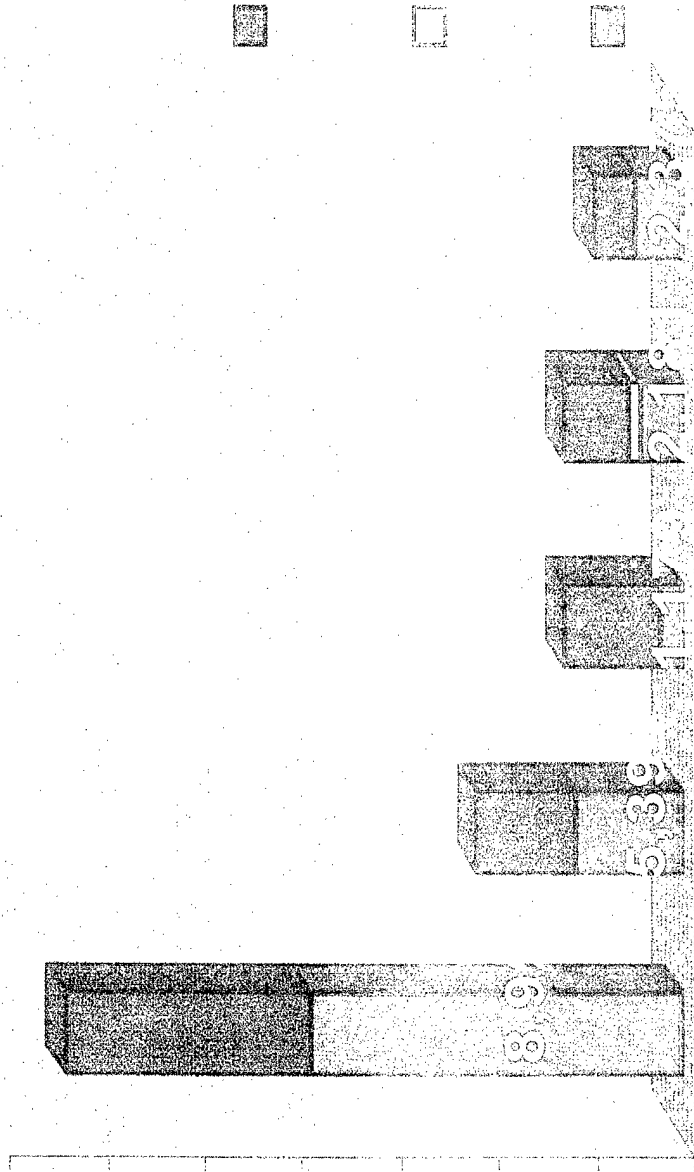
Source: FHFS CRIS July 98



TRICARE
Alaska

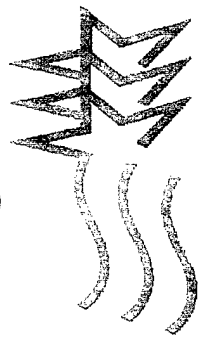
3 MIDG

ENROLLMENT BY TEAM



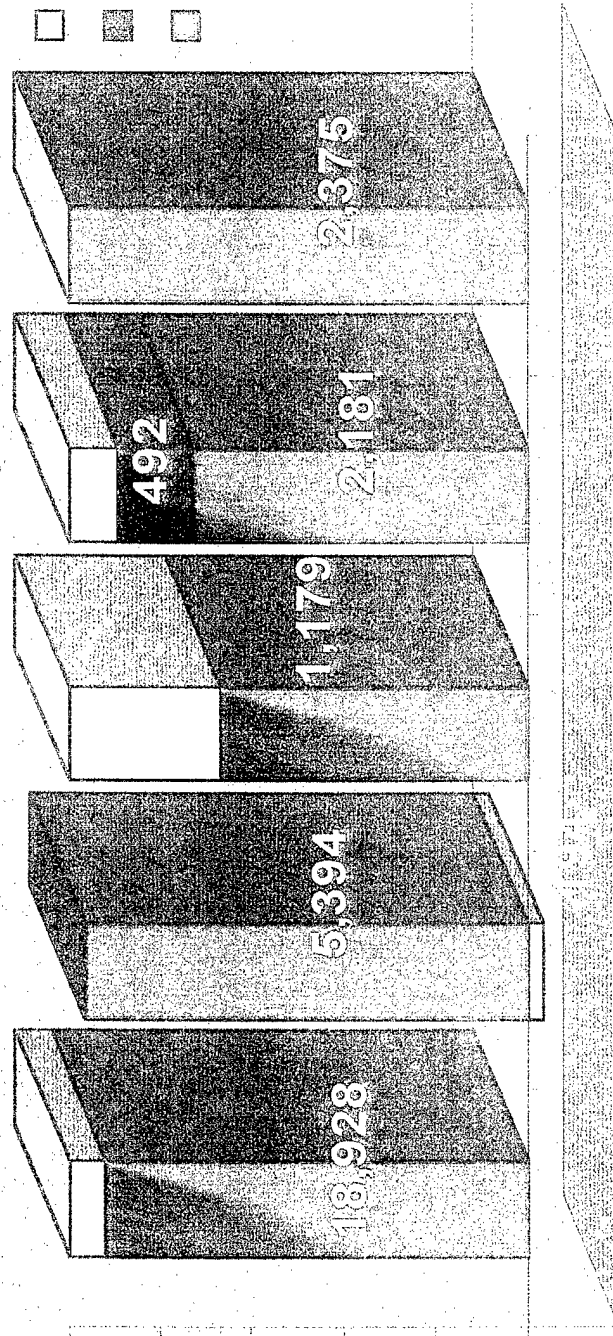
Source: FHFS CRIS Jul 98

Total enrolled as of 2 Jul 98 is 30,057/54,000 = 56% of present capacity.



TRICARE
Alaska

3 MDG PRIME ENROLLMENT STATUS



8,400	8,000	8,800	3,000	2,234

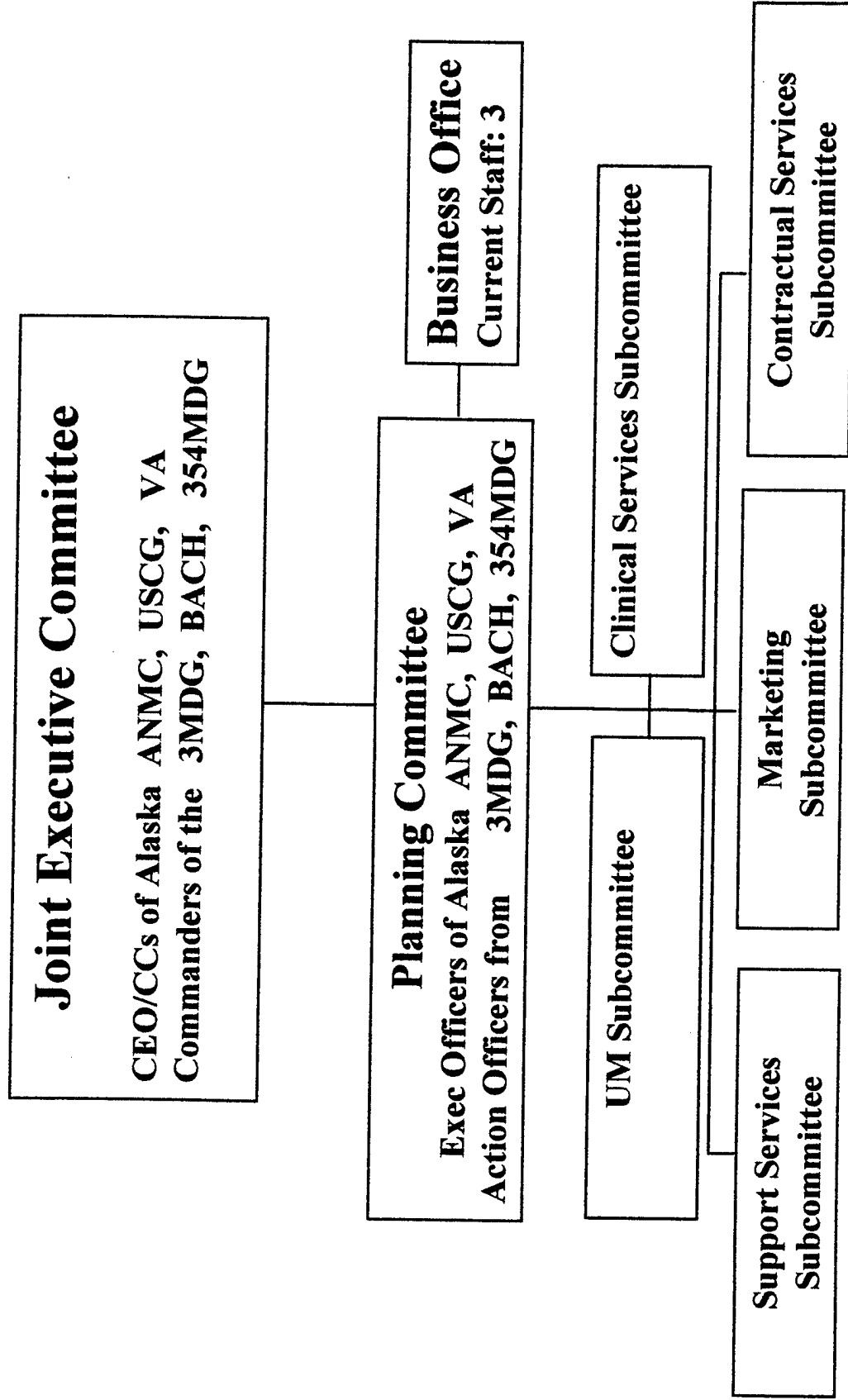
Total enrolled 30,057/30,423 = 99% of present capacity.

Source: 3 MDG CHCS Mar 98

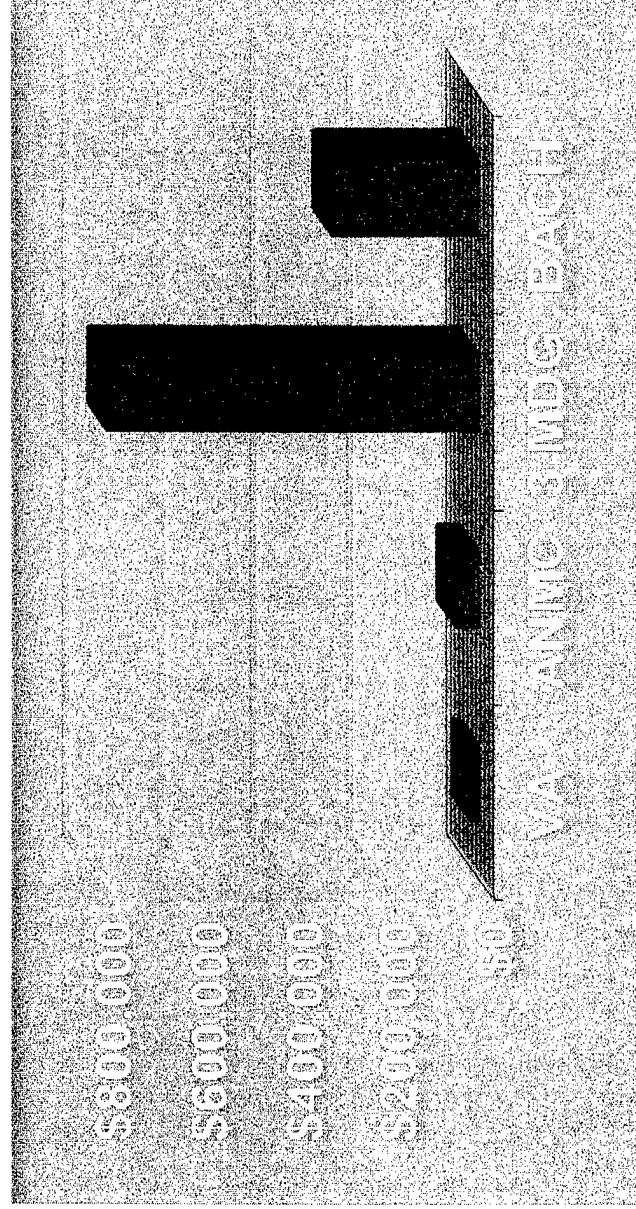
100-100000

H

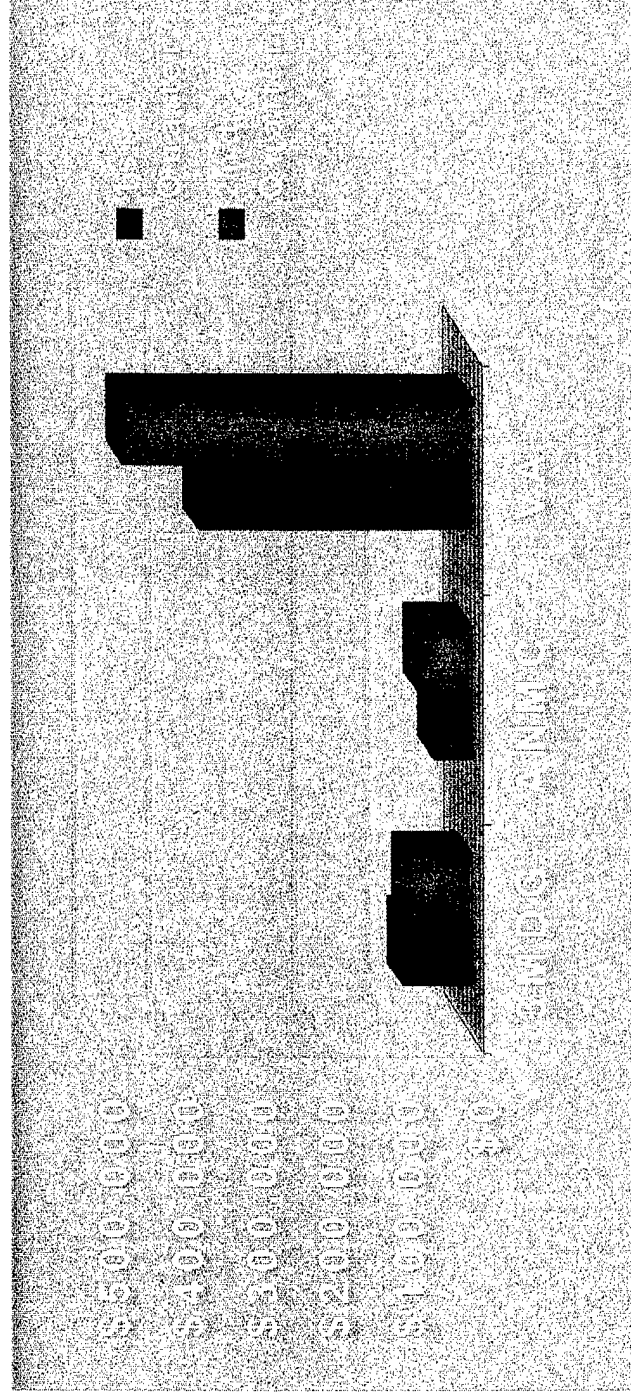
Partnership Organization



UNCAPTURED REVENUE



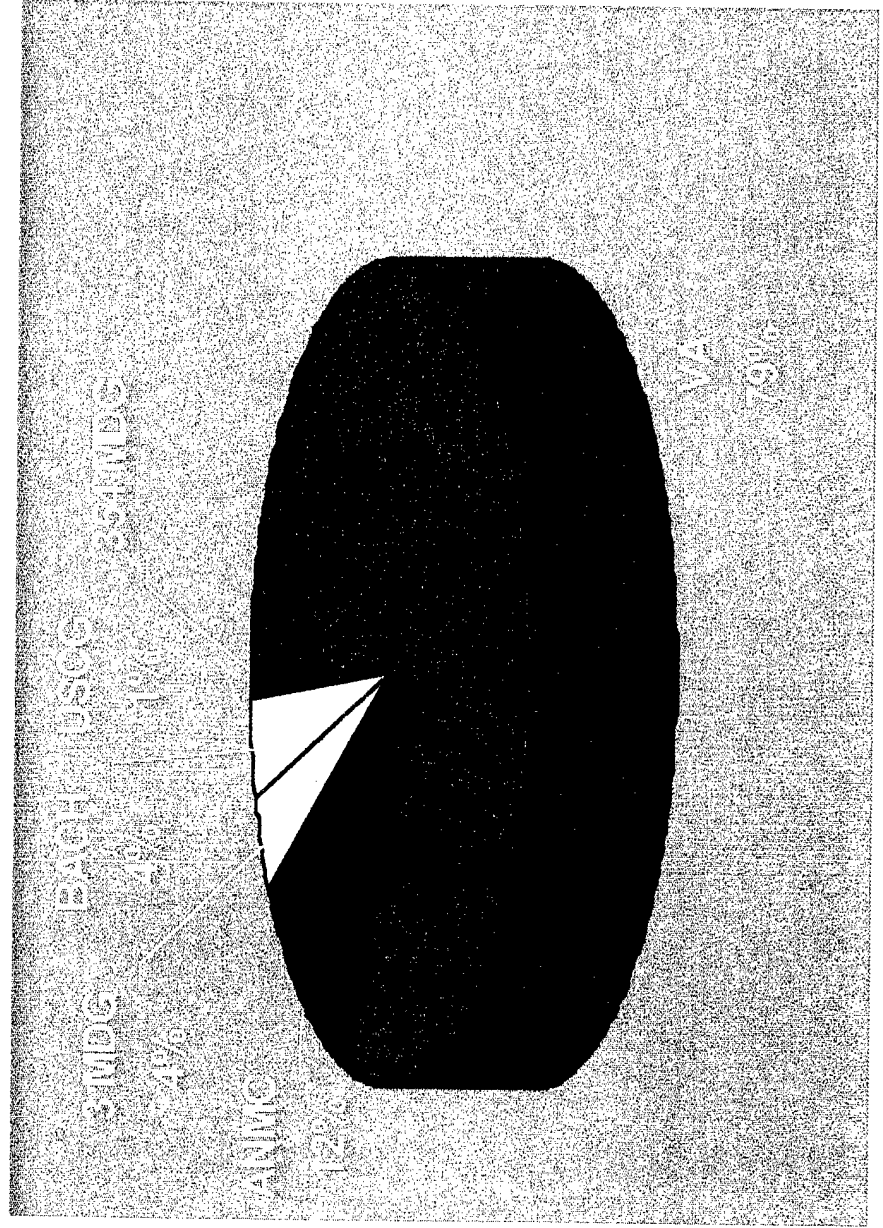
YTD FY98 COST AVOIDANCE



Cost avoidance through 2nd Qtr 98 = \$176,380

Jul 98

17007 POST AUDITANCE



VA - \$3,365,973
 ANMC - \$535,065
 3 MDG - \$192,241
 BACH - \$167,923
 USCG - \$26,562
 354 MDG - \$354

Jul 98



Alaska Federal Health Care Partnership
Annual Report
1996



Letter from the Executive Committee of the Alaska Federal Health Care Partnership

The Alaska Federal Health Care Partnership . . . what was once a grassroots initiative to help a few of our patients and save a couple dollars has blossomed into a successful program serving nearly a quarter million people and saving taxpayers more than a million dollars annually.

Two years ago we created the Alaska Federal Health Care Partnership with a goal of improving federal health care in Alaska. All of our goals are listed on the next page, but we can summarize them in one simple sentence: We work together to cut bureaucracy so we can serve our beneficiaries.

The "we" are 12 medical facilities belonging to the Alaska Native Medical Center, Department of Veterans Affairs, U.S. Coast Guard, Army, and the Air Force. Together, our facilities care for nearly 240,000 beneficiaries in Alaska; that's 40 percent of the state's entire population. The Partnership cares for these people through three simple methods:

1. We share our staff. This provides our beneficiaries greater access to specialists.
2. We share our medical equipment. This offers our providers greater access to technology to assist beneficiaries.
3. We share numerous contracts. By contracting jointly we have more purchasing power because together we have more money to spend. This attracts civilian providers and suppliers and acts as an incentive for them to lower their prices.

Through these three simple ideas the Partnership saved taxpayers \$2,200,000 in just under two years. That savings is reinvested into our Partnership; reinvested in staff, equipment, pharmaceuticals, laboratories, and other services to directly care for our beneficiaries.

This 1996 Annual Report describes Alaska's unique environment – both medical and geographical—and explains why the Partnership is so important to our state. It also describes many of the more than 100 current initiatives the Partnership is pursuing at the time of this report's publication.

We hope you enjoy reading about our accomplishments in this, our second year. We look forward to sharing with you many more successes in the years to come.

The Executive Board



Richard Mandsager
*Rear Admiral, Public
Health Service Director,
Alaska Native Medical
Center*



Tony Carter, Colonel
*U.S. Army Medical
Corps, Commander,
MEDDAC-AK*



Steve Tuller, U.S.
*Coast Guard Chief,
Health and Safety
MLC, Pacific*



Don A Lawrence,
*Colonel, U.S. Air
Force, Flight Surgeon
Commander, 354th
Medical Group*



Alonzo M. Poteet III
*Director, Veterans
Affairs Medical &
Regional Office Center*



William B. Tate,
*Colonel, U.S. Air
Force, Flight Surgeon
Commander, 3rd
Medical Group*

Mission of the Alaska Federal Health Care Partnership

We, the Alaska Federal Health Care Partnership, are dedicated to providing our beneficiaries ready access to quality, customer-oriented, compassionate, comprehensive, and cost-effective health care.

Vision of the Alaska Federal Health Care Partnership

The Alaska Federal Health Care Partnership provides a health care delivery system where the strengths and needs of individual agencies are combined to provide quality customer service.

Goals of the Alaska Federal Health Care Partnership

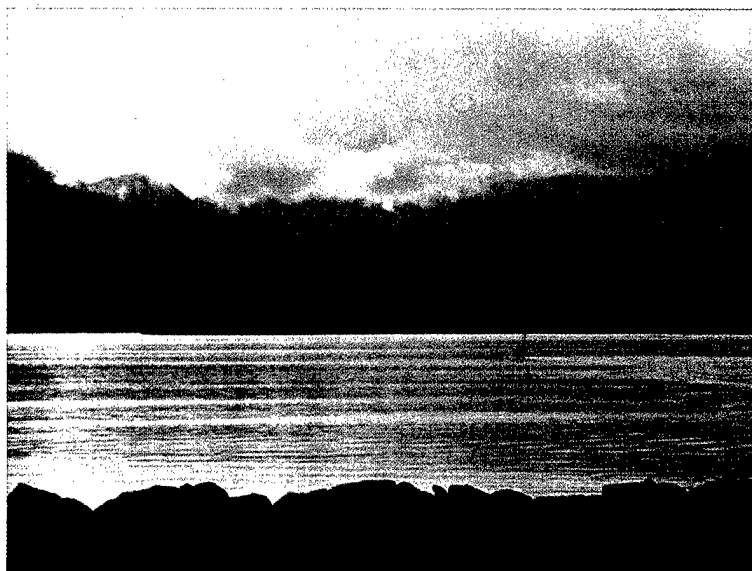
Ensure patients have access to the right care, at the right time, in the right place.

Create a better business environment.

Maintain medical preparedness.

Optimize use of technology.

Promote patient wellness.



REN MELTON

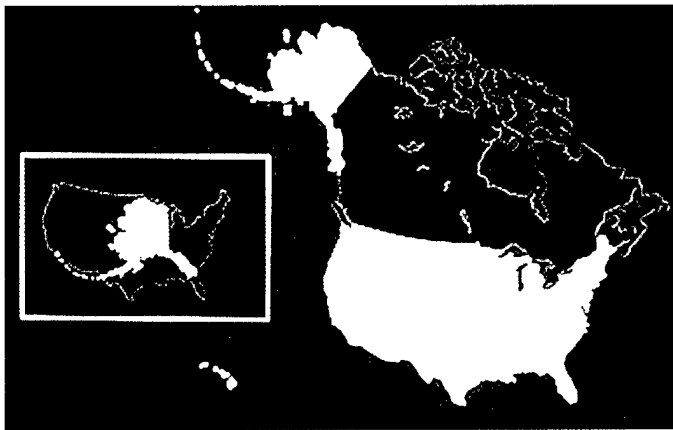


Alaska's Unique Environment

Alaska is unlike any other state in the nation; it offers unique challenges to the Federal Health Care Partnership unlike those found anywhere else in the United States. Consider these interesting obstacles the Partnership has successfully overcome to deliver care to its beneficiaries:

Everything Costs More in Alaska, Especially Health Care. Alaskans grin and bear their steep grocery bills; a gallon of milk costs \$4.25 in the state's largest city, Anchorage, but costs \$6.50 in Nome where it arrives frozen by oceanic barge. Alaskans, especially those in the state's interior, are used to paying over \$1.00 for a lemon, \$1.50 for a grapefruit, or nearly \$3.00 for a loaf of Wonderbread, but they find it hard to swallow the state's high cost for medical care.

Alaska is the second most expensive state in the nation for average cost per stay in a hospital: nearly \$7,500 (only Washington D.C. is higher at \$8,218). Alaska is the third most expensive state for cost-per-day per hospital visit: \$1,116 (the two most expensive are California and Washington D.C. at \$1,134 and \$1,124 respectively).



Alaska is the United State's largest state. It is 25% the size of the Continental United States.

The average cost for most health care services in Alaska can exceed 200 percent the cost for similar services in the rest of the United States. The federal government spends nearly \$700 million a year on health care in Alaska. That is nearly 30 percent of the \$2.4 billion spent by all payers.

Obviously, the cost-saving efforts of the Alaska Federal Health Care Partnership are sorely needed in such an expensive environment.

Alaska's Size Makes Patient Travel Difficult. Alaska's immense size and lack of roads make health care delivery in the state difficult. Few people realize how huge the state is. At 586,412 square miles if you split Alaska in half, making each half its own state, Texas would still be only the third largest state.

To demonstrate their state's vast size, Alaskans enjoy placing a map of the state over one of the Continental United States. Such a display shows Alaska stretching from Tallahassee, Florida in the East to San Diego, California in the West—2300 miles. It would stretch from Dallas, Texas in the south to nearly touching the Canadian border in the north 1,420 miles.

Alaska's Climate Extremes. Alaska has a 180 degree temperature range; it is capable of reaching both 100°F and -80°F. Because of its extreme northern latitude, much of the state experiences 24-hour daylight in summer and 24-hour darkness in winter.



Denali (Mt. McKinley) in the heart of Alaska, is north America's tallest mountain at 20,320 feet.

Earthquakes. Alaska has the dubious distinction of having experienced the largest earthquake in recorded history; a 9.2 on the Richter scale, on Good Friday, 1964. The state still experiences over 1000 quakes a year of 3.4 or greater on the Richter Scale. Many of the quakes begin in the rumblings of the state's many active volcanoes.

Volcanoes and earthquakes may have little affect on the delivery of health care in the state, but Alaska's bitter cold temperatures and seven-month winters create difficulties in getting beneficiaries from towns and villages to major population centers to receive care.

Beneficiaries brave these conditions to arrive at Partnership medical facilities by car, plane, snowmobile, and even dogsled.

Few Medical Providers. There are very few private physicians; just over 600. Only Mississippi has fewer providers per person. About 75 percent of all these providers practice in and around Anchorage, meaning just over 150 private physicians are sprinkled throughout the rest of the state's remaining half million square miles.

Alaska Trivia

Jeopardy buffs will appreciate knowing Alaska is the nation's northern-most, western-most, and eastern-most state – Alaska's Aleutian Island Chain stretches into the Eastern Hemisphere making it technically farther east than even Maine.



THOMAS PURSCHKE

Because Alaska has few roads and vast distances it has become the "flyingest" state. Many teenagers here learn to fly planes before they learn to drive cars.

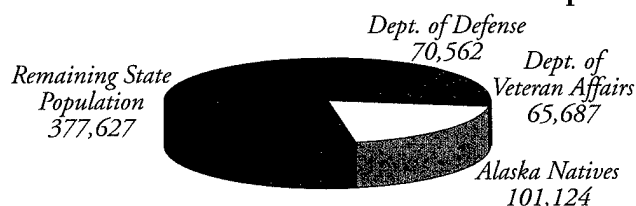
Alaska's Sparse Population. Alaska is big, but its population is small; 615,000, that's a little more than one person per square mile of land. If New York's bustling Manhattan Island had the same population density it would have only 16 people. Only Wyoming has a smaller population than Alaska. Because there are so few people spread out over such a wide area, it's no wonder Alaska is the "flyingest" state with an average of one out of every 13 households owning an airplane and one out of every 50 residents owning a private pilots license.



ALASKA STATE DIVISION OF TOURISM

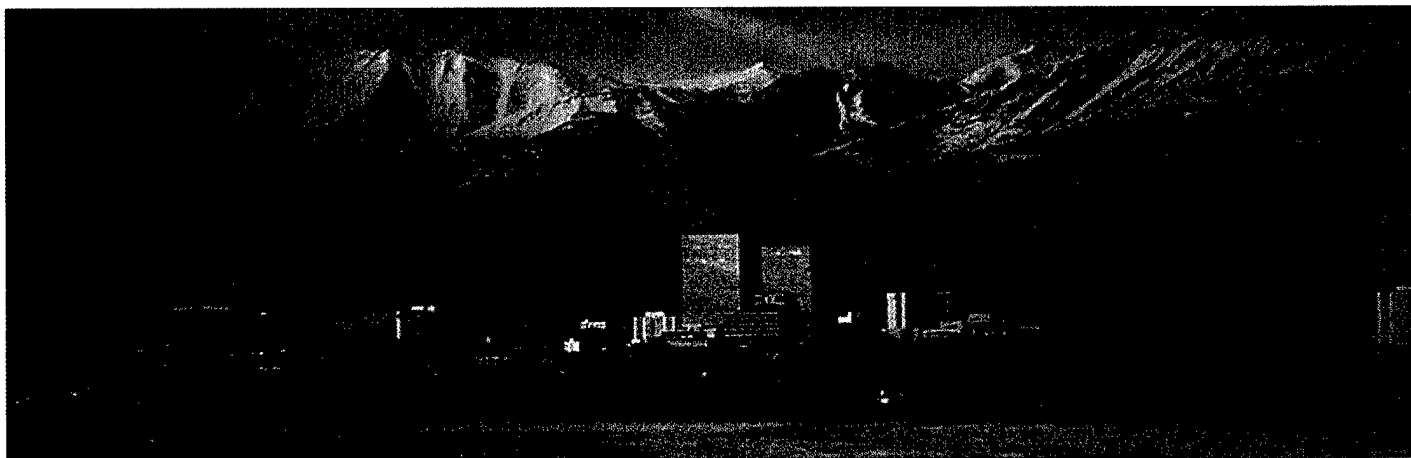
In Alaska, Partnership facilities welcome patients who arrive by boat, plane, car, snowshoe and even dogsled.

Beneficiary Population of the Alaska Federal Health Care Partnership



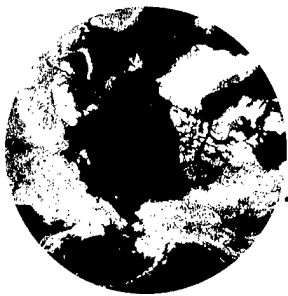
Total Partnership Population 237,373
Total Alaska Population 615,000

The Alaska Federal Health Care Partnership. The Partnership is the largest health care organization in the state. The combined efforts of the Alaska Native Medical Center, Department of Veterans Affairs, Army, Air Force, and U.S. Coast Guard work to overcome the state's high costs, extreme size and climate to provide care to over 237,000 people, nearly 40 percent of the state's population.



ALASKA STATE DIVISION OF TOURISM

Alaska's largest city, Anchorage is home to more than half of the state's 615,000 residents and four of the Partnership's member facilities.



Partnership Member Facilities

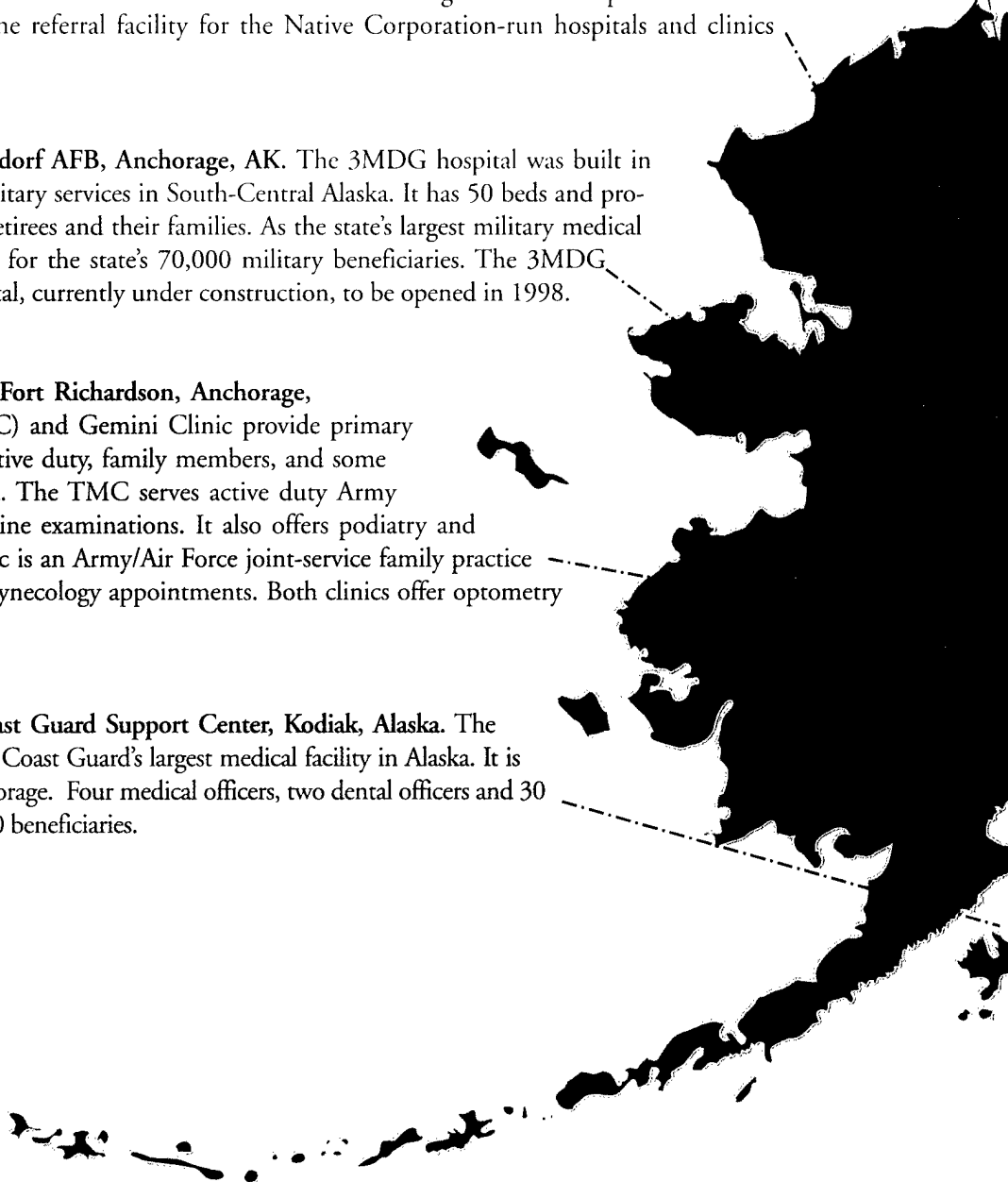
Bassett Army Community Hospital (BACH), Fort Wainwright, Fairbanks, Alaska. Located an hour's drive south of the Arctic Circle, BACH has the distinction of being the military's northern-most hospital. BACH has 55 beds and is the state's largest Army medical facility, and as such, directs medical activities of Alaska's other two Army facilities; Fort Greely Clinic, and Fort Richardson Troop Medical and Gemini Clinics.

Alaskan Native Medical Clinic (ANMC), Anchorage, Alaska. The new ANMC buildings will begin admitting patients in June, 1997. The facility replaces the antiquated structure originally built in 1953 as a tuberculosis (TB) sanitarium. The new ANMC complex will have five buildings with 370,000 square feet of clinical and administrative office space. The ANMC is currently an administrative unit of the Indian Health Service through the U.S. Department of Health and Human Services and serves as the referral facility for the Native Corporation-run hospitals and clinics throughout the state.

3rd Medical Group (3MDG), Elmendorf AFB, Anchorage, AK. The 3MDG hospital was built in 1954 to care for beneficiaries of all military services in South-Central Alaska. It has 50 beds and provides services for 41,000 active duty, retirees and their families. As the state's largest military medical facility, it serves as the referral facility for the state's 70,000 military beneficiaries. The 3MDG facility will be replaced by a new hospital, currently under construction, to be opened in 1998.

Troop Medical and Gemini Clinics, Fort Richardson, Anchorage, AK. The Troop Medical Clinic (TMC) and Gemini Clinic provide primary outpatient medical care to all army active duty, family members, and some retirees in the greater Anchorage area. The TMC serves active duty Army members providing sick-call and routine examinations. It also offers podiatry and orthopedic services. The Gemini Clinic is an Army/Air Force joint-service family practice clinic. It also provides Well Woman Gynecology appointments. Both clinics offer optometry and physical therapy.

Rockmore/King Memorial Clinic, Coast Guard Support Center, Kodiak, Alaska. The Rockmore/King Memorial Clinic is the Coast Guard's largest medical facility in Alaska. It is located 325 air miles southwest of Anchorage. Four medical officers, two dental officers and 30 support staff provide care to nearly 3,000 beneficiaries.



345th Medical Group, Eielson AFB, North Pole, Alaska. The 354th Medical Group provides outpatient medical care for all active duty military personnel, retirees, and their families living in the interior of Alaska. The clinic operates a family practice service, but also offers pediatrics, optometry, mental health, obstetrics, gynecology, immunizations and x-ray services. Services not provided by the 354th Medical Group can be obtained at the nearby Bassett Army Community Hospital which serves as their primary referral facility.

Fort Greely. Medical facilities at the Fort Greely U.S. Health Clinic, located in the vicinity of Delta Junction, consists of the Health Clinic Preventive Medicine and Mental Health Services. The clinic, located in building 663, is staffed by two doctors, one clinical nurse, and 25 medical technicians. The clinic provides outpatient treatment, laboratory, x-ray, emergency and other limited medical services. Pediatrics, adult medicine, OB-GYN, and surgery providers from Bassett Army Community Hospital, Fort Wainwright, visit the clinic on a periodic basis.

Department of Veteran's Affairs Medical & Regional Office Center (VAM&ROC), Anchorage, Alaska. The VAM&ROC serves 73,000 veterans in Alaska. Besides caring for vets through their beautiful Anchorage clinic built in 1992, they also purchase health care for their beneficiaries from the private sector. Besides primary care, the clinic also offers dental, prosthetics, audiology, radiology and ambulatory surgery. The VA also operates a 50-bed homeless domiciliary that opened in December of 1995.

Juneau Medical Clinic, 17th Coast Guard District, Juneau, Alaska. The Juneau Coast Guard Medical Clinic is located on the sixth floor of the Federal Building in downtown Juneau. It was renovated and expanded in 1992 to 1,750 square feet. The facility is 577 air miles southeast of Anchorage and provides primary and dental care to 530 active duty members, retirees, and their families.

Sitka Medical Clinic, Sitka Coast Guard Air Station, Sitka, Alaska. Located on the Island of Sitka, the clinic is 617 air miles southeast of Anchorage. One medical officer, one dental officer and 8 support staff provide primary and dental care to the island's 648 military and Coast Guard beneficiaries.

Ketchikan Clinic, Coast Guard Base Ketchikan, AK. The Ketchikan Clinic is located in a new 5,700 square foot facility in Ketchikan, Alaska. The facility is 890 air miles southeast of Anchorage. Its seven staff provide primary care to 730 active duty, retirees and their family members.



How the Partnership Works

Partnership Success. The Partnership saved taxpayers nearly \$2 million since its inception in August of 1995. It has done so through three simple actions: The Partnership;

- 1) shares staff,
- 2) shares equipment, and
- 3) shares contracts.

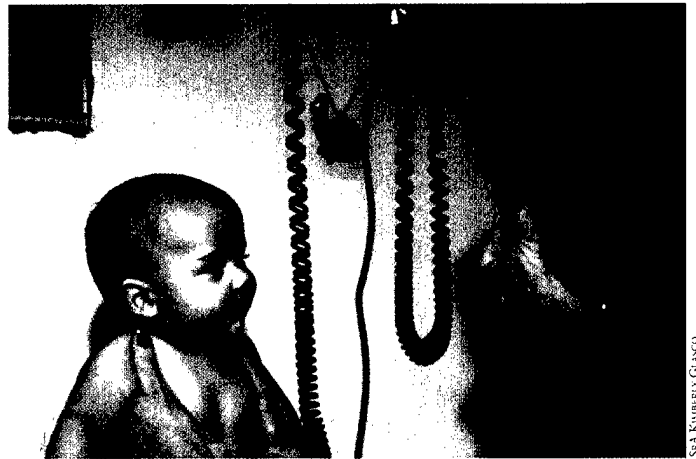
The following is a "short story" of how the Partnership came into being and a description of how it works so well.

The Old Way of Doing Business in Alaska. Before the Partnership, there was minimal interaction and sharing between the 12 member facilities. Anchorage, Alaska is home to the state's largest Indian Health Services, VA, and Air Force medical facilities and one of the Army medical clinics. They were less than three miles apart, yet rarely took advantage each other's assets.

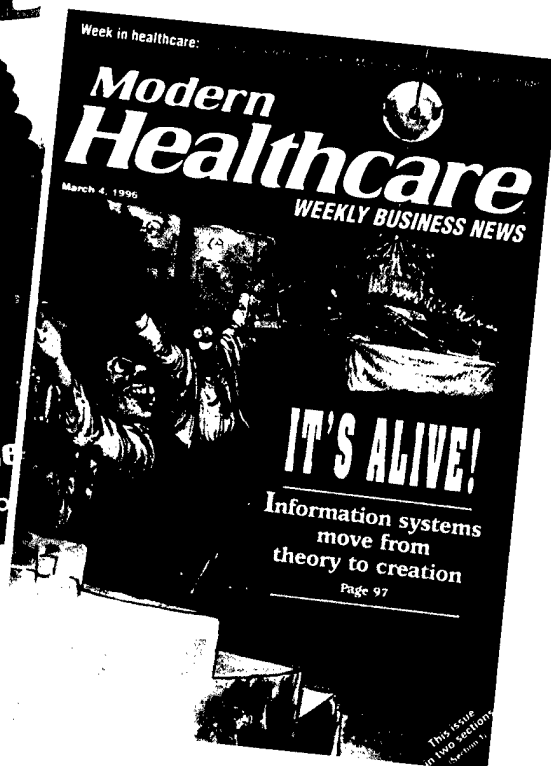
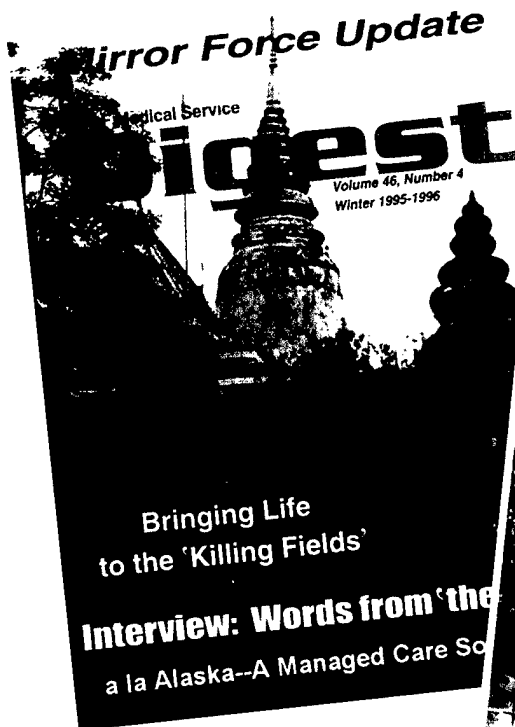
The New Way of Doing Business in Alaska. In the early 1990s the directors of the federal health care facilities realized they could help more patients and save taxpayers' money by working together and sharing resources, whether those resources were something simple like a sterilizer to clean medical instruments or as significant as sharing the work of doctors like their OB/GYN or Orthopedics providers.

After all, it costs significantly less, for example, if the Alaska Native Medical Center borrows an orthopedic doctor from the military. In doing so they avoid paying for the service from a local private physician or flying the patient to the Lower 48 states for care. Patients also benefit because they need not travel far from home to receive care. It was a win-win situation.

The "Alaska First" Policy. The directors also agreed to do everything possible to keep patients in Alaska, close to their families for treatment. If a patient needed medical care unavailable from any of the 12 federal medical facilities, the facilities would create contracts with local private providers



The Partnership's "Alaska First" policy ensures beneficiaries receive care in Alaska close to home and family.



The Partnership has received recognition from national publications and has been nominated for the Vice President's Hammer Award. The Partnership was awarded the VA Secretary's prestigious Strategic Alliance Award, 1996.

Partnership Success Case Study: VA Women's Health Care Program

In Spring of 1996 the Alaska VA opened its **Women's Health Care Program**. This program is an excellent example of how Partners contribute and share their staff, share medical equipment, and share contracts for the benefit of female VA beneficiaries.

In this unique program VA female beneficiaries are examined by **Alaska Native Medical Center Providers** in the VA medical facility. Patients are then sent to the **Air Force's Elmendorf AFB Hospital** where they receive **mammographies** in the facility's new **Mammography Suite**. Patients receive follow-up exams by any Partnership provider and **pharmaceuticals** from the VA or Air Force.

If the patient needs advanced subspecialty care not available in the Partnership facilities, she is cared for by local private providers at **reduced prices negotiated through the Partnership**. And any Partnership beneficiary, whether a VA beneficiary or not, may receive **emergency air transport** from the Partnership's **Providence Medical Systems Life Guard** emergency air service through a contract jointly held by all Partnership members.

to care for the patient. This agreement ensured patients are cared for close to home and that health care dollars were spent among the state's private providers as opposed to providers in the Lower 48 states.

The Partnership calls this their "Alaska First" policy - it is a policy that is good for patients, good for the Partnership, and good for Alaska's private physicians and economy.

The Birth of the Partnership. In 1995 the directors realized their small, grassroots resource sharing efforts had mushroomed into a large and mutually profitable program. They agreed to formalize the program by signing the Alaska Federal Health Care Partnership charter. This gave the program an official name and mission.

The Big Difference. Whereas five years ago there was little interaction between the different facilities, today it is not



W.F. BOOTHMAN

uncommon to see VA providers and military providers working side-by-side, or to see Indian Health Service (IHS) and VA representatives at a military contract management meeting. It is almost unthinkable today for the staff of one facility, for example the Bassett Army Community Hospital, to enter into negotiations with a private healthcare organization without having other military partners or the IHS or VA representatives sitting at their side.



SEA TIM WOOTEN

All Partners combine their resources to support Women's Health Care Programs.

The Partnership Today. The Partnership's philosophy of sharing staff, equipment, and contracts might sound simple, but those familiar with the federal bureaucracies know how difficult it is to coordinate actions within one facility, let alone throughout 12 facilities (belonging to six different federal agencies of the Indian Health Services, Department of VA, Department of Transportation, the Army, Navy, and Air Force!).

The example, or case study, on this page is one example of how the Partnership works to care for its beneficiaries. As you read it, look for examples of how each Partner contributes staff, equipment, or shares contracts.

The following pages describe some of the Partnership's over 100 current and future initiatives. As you read them, look for how Partners share staff, equipment, and contracts in each.



Sharing Staff to Help People

The Alaska Federal Health Care Partnership helps beneficiaries and saves taxpayer dollars by sharing its staff.

The Partnership's New Business Office. In 1995, the Partnership's first year, it saved over \$1 million. Amazingly, this feat was accomplished by an extremely small, but dedicated, group of staff from each facility who worked on Partnership programs during breakfast and lunch hour meetings as an additional duty to their regular jobs. Their efforts were truly "grass roots."



ARMY, JEFF RICHARDSON, PUBLIC AFFAIRS

When military doctors are away for long periods to support troops in the field, train, or provide humanitarian support in other countries, the ANMC and VA providers assist the military in caring for its beneficiaries.

Now, two years later, the Partnership is more established and has created a Business Office located at the Alaska Native Medical Center (ANMC). The office's small shared staff devote themselves full time to creating and monitoring the Partnership's hundred or so initiatives.

The following information describes ways in which the Partnership shares staff in order to provide better and less expensive care to its beneficiaries.

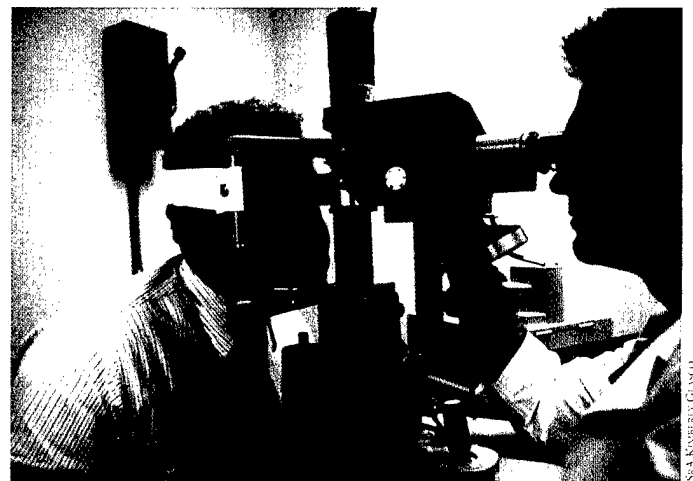
Joint Humanitarian Visits to Native Villages. In spring of 1996 the U.S. Coast Guard (USCG) spearheaded an effort to increase healthcare to remote native villages during a "goodwill" mission. Embarking the USCG Cutter STORIS, USCG staff, a U.S. Navy Chaplain, and an Air Force physician, dentist and optometrist cared for Indian Health Service beneficiaries in the village of Old Harbor on Kodiak Island.

USCG dentists and technicians also ship a Public Health Service mobile dental unit to such remote locations as St. Paul and St. George on the Pribilof Islands, Unalaska, Nikolski, and Atka on the Aleutian Islands. These missions provide care to hundreds of villagers.

Entitlement to health care is worth little unless there is also access to care. The USCG and its Partners in the Alaska Federal Health Care Partnership help Alaska Natives access the health care they need.

Sharing Medical Specialists. The Partners are usually able to care for many of their patient's primary care needs within their own facilities. However, sometimes a patient requires special care not available in the facility. When this happens the Partners turn to each other. For example, the military hospitals and clinics lack an **oncologist** (a physician specializing in caring for people with cancer). However, the ANMC does have an oncologist. Because of the Partnership's philosophy of sharing providers, a military beneficiary with cancer can receive compassionate and inexpensive care from the ANMC.

The military returns the favor, as it has six **orthopedists** (doctors who specialize in diagnosing and treating problems with bones). The military orthopedists not only care for their own patients, but those of the ANMC, VA, and the U.S. Coast Guard as well.



SNA KIMBERLY GLASS

The DoD shares its Ophthalmologists with other Partners.

The military providers are often times "deployed" (sent out of Alaska to care for troops or civilians in other parts of the world). When military providers are deployed for long periods, doctors from neighboring Partnership facilities can assist the military facility by sharing their staff.

In winter of 1996, Elmendorf and Eielson Air Force Bases sent medical staff to the Island of Guam to care for Kurdish refugees who were staying on the island before relocating to the United States. In this and similar deployments, the military can count on their Federal Partners to assist them in providing specialty care to military beneficiaries.

As described earlier, this sharing goes two ways. The army sends a **pediatric endocrinologist** and **cardiologist** up from the Lower 48 states to care for both military and Alaska Native beneficiaries. By bringing the specialist to Alaska, the Partnership is able to prevent having to send numerous patients to the Lower 48. This not only saves taxpayers money, but keeps the children in Alaska with their families.

The Partnership also continues to share the valuable skills of other specialists such as **ultrasound technicians**, **OB/GYN staff**, **operating room nurses**, **vascular surgeon**, **ophthalmology**, **internal medicine specialist**, **physical therapy**, **radiology**, and **nuclear medicine staff**.

Partners share more than just medical staff, they also share **administrative technicians**, **marketing and education staff**, and **utilization management nurses**.

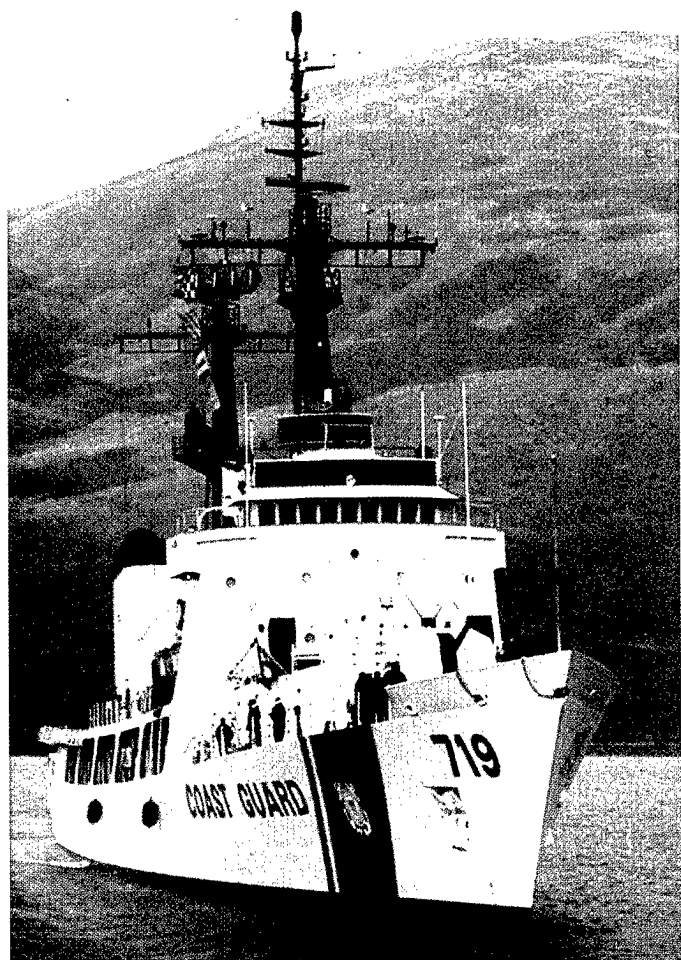
One particularly valuable example of sharing nonprovider staff is the Partnership's ability to swap **medical equipment repair technicians**. Many of the more complicated and expensive pieces of equipment belonging to the Partnership



By sharing medical equipment repair technicians, Partnership members nearly eliminate the need of flying costly repair technicians to Alaska from the lower 48 states.

facilities require a repair person to be flown up from the Lower 48 states to fix it if it breaks. Through the Partnership, this costly practice is nearly eliminated as Partners throughout the state now rely on the highly trained repair technicians of the military and Alaska Native Medical Center to travel the state maintaining important medical equipment.

The following pages describe how the Partnership also shares medical equipment and contracts to further care for beneficiaries.



ARMY, FORT RICHARDSON PUBLIC AFFAIRS

The U.S. Coast Guard and military members annually cruise to villages to provide health care.

Staff Shared Between Partnership Facilities

- UROLOGY
- OB/GYN
- PEDIATRICS
- OPTOMETRY
- ORTHOPEDICS
- OPHTHALMOLOGY
- STAFF EDUCATION
- NURSE CASE MANAGERS
- MEDICAL EQUIPMENT REPAIR TECHS
- MARKETING AND EDUCATION
- PEDIATRIC CARDIOLOGIST
- VASCULAR SURGEON
- PLASTIC SURGEON
- NEUROLOGIST
- PATHOLOGIST
- ULTRASOUND
- OR NURSES
- ALLERGY



Helping People by Sharing Medical Equipment

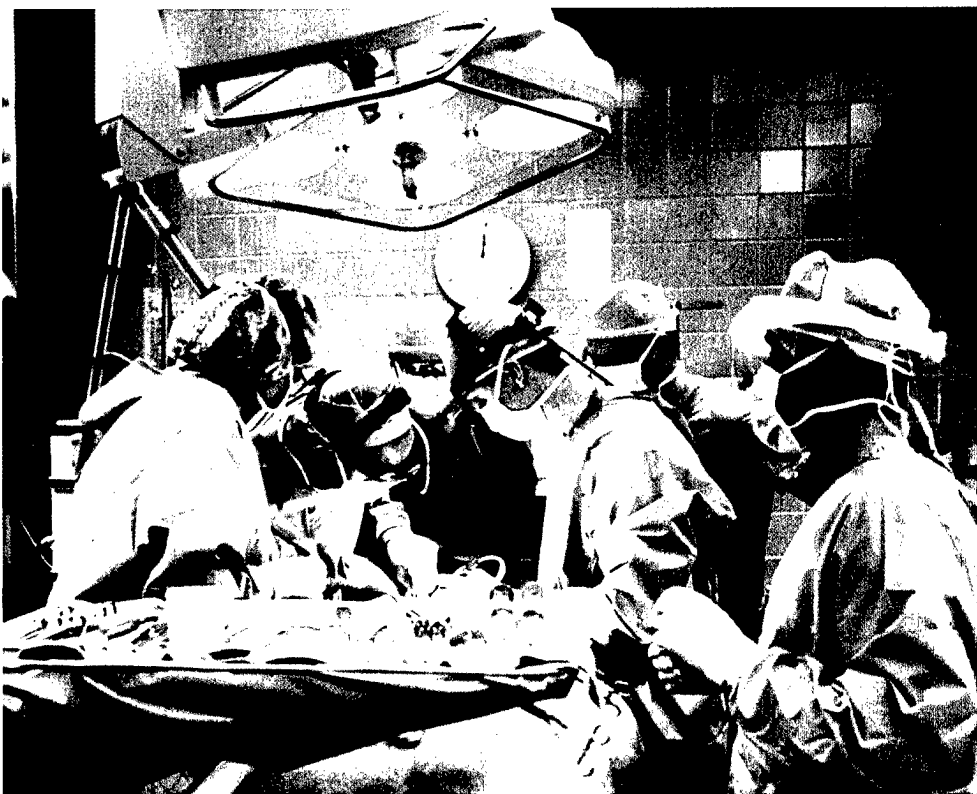
The Alaska Federal Health Care Partnership gives patients access to modern medical technology by sharing medical equipment.

By sharing equipment, Partners avoid having to buy duplicate systems or having to purchase the use of medical equipment from expensive private clinics.

By far the greatest example of the wisdom of sharing medical equipment among the Partnership's 12 medical facilities is its radiology and nuclear medicine sharing program. For instance, currently, the military owns the state's only federally operated **Magnetic Resonance Imager (MRI)**. MRIs are tremendously expensive, yet valuable, tools physicians use to view inside the human body without surgeries. They work even better than x-rays in allowing physicians to view such things as bones, the brain, stomach, and other organs. All Partners have access to the military's MRI, and financially contribute to its cost and maintenance. Because of this program, beneficiaries have much greater access to MRIs at a greatly reduced cost to the government.

The military also owns the latest "environmentally friendly" gas sterilizer which it shares with Partners. Sterilizers use heat or chemicals to clean medical and surgical equipment. Heat sterilizers can damage sensitive or plastic tools, while chemical sterilizers can be bad for the environment. But the Elmendorf AFB's new low temperature **ABTOX sterilizer** treats equipment without heat or harsh chemicals.

Partners share the hospital's sterilizer until they can acquire their own (Alaska Native Medical Center plans on placing their own such sterilizer in their new facility.)



Under the Alaska Federal Health Care Partnership Alaska Native Medical Center, VA, and military staff work side-by-side.



The military's MRI give doctors a high-tech and sometimes life-saving look at the human body.



Telemedicine uses the latest technology to connect doctors with patients hundreds of miles away.

The Partners continue to share **Telemedicine Technology**. Telemedicine allows providers to view and care for patients hundreds of miles away through the use of cameras and television. With just the flick of a switch a doctor in Anchorage can view and care for a patient hundreds of miles away in remote areas like Adak or Barrow. Partners also use telemedicine for training and teleconferencing.

Another example of sharing medical equipment is in **ophthalmology**. The military has providers trained to perform ophthalmic (eye) laser surgery but lacks the equipment. The Anchorage VA Clinic across town has the equipment, but lacks a provider to use it. The Partnership has brought together provider and equipment in order to perform ophthalmic surgeries for Partnership beneficiaries.

The above examples describe some of the numerous ways the Partnership shares equipment. The Partnership also serves patients by sharing contracts. The next page describes how federal health facilities share contracts to help patients and save taxpayer dollars.



Helping Patients by Sharing Contracts

Previous pages described how the Partnership shared staff and equipment. This page describes how it uses joint contracting to save the government money.

Individually, each Partnership facility cares for a rather small number of beneficiaries, but combined they care for nearly 240,000 people – nearly 40 percent of the state's entire 615,000 population.

Private medical facilities and suppliers enjoy the idea of contracting with such a large organization as it means they will increase their business. In order to attract the Partnership's business these private companies lower their prices giving Partners better deals.

It is through the practice of joint contracting that the Partnership has made its biggest impact. It's hard to put a price tag on how much money is saved through sharing staff or equipment, but it's easy to determine government savings in the contracting arena. In 1996 alone the Partnership saved nearly \$700,000 just through joint contracting.

The ongoing Providence Medical System's Life Guard contract is saving the Partnership hundreds of thousands of dollars annually while providing beneficiaries with a much-needed emergency air transport service. Patients in remote locations like the state's interior or the Aleutian Island Chain can rely on Providence Life Guard flights to transport them to the nearest medical facility at a moment's notice. Previously, this service cost anywhere from \$10,000-\$15,000 a flight, but through the Partnership's joint contract the price was cut dramatically. The Partnership has saved \$513,655 to date through this contract alone.

The contracts are not always for distinctly medical activities. The Partners joined together in a Medical



When patients need to travel far in a short time, the Partnership turns to Providence Hospital's Life Guard emergency air service.

Transcription Contract in which private transcribers assist Partners when they are understaffed in their transcription departments (\$25,000 savings) and Partners also share laundry and linen contracts (\$35,000 savings). Recently the Partnership signed an agreement with Columbia's Alaska Regional Hospital which currently gives Partners 30-50 percent off inpatient and outpatient services; an arrangement expected to save the Partnership hundreds of thousands of dollars.

Obviously, the Partnership has accomplished much in the last couple years, but it hopes to do even more in the years to come. The information on the next page describes activities the Partnership has planned for 1997 and beyond.



FRANK FLAVIN

The Partners recently signed an agreement with Columbia's Alaska Regional Hospital offering partners 30-50% discounts off medical services.



SEA KIMBERLY GLASCO

The Partnership joint reference lab contract saved the federal government nearly \$150,000 in 1996.

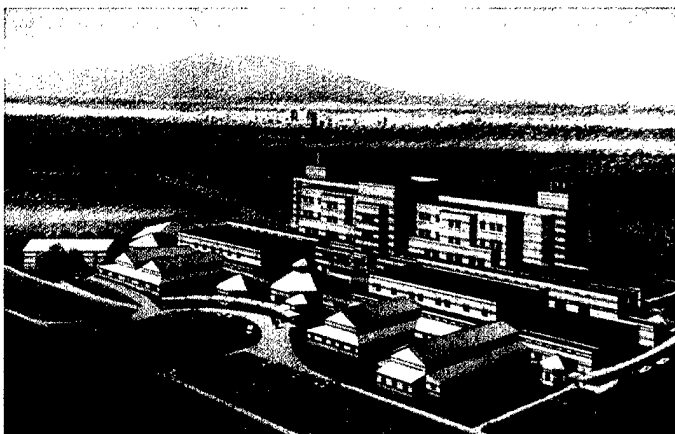


FRANK FLAVIN

By jointly acquiring contracts with local providers and hospitals the Partnership is able to reduce the cost of care to government and Alaskan families.



The Future of the Alaska Federal Health Care Partnership



The beautiful new Alaska Native Medical Center will begin seeing patients in summer of 1997.

The Partnership will benefit greatly from the addition of two new facilities. Both the Air Force's 3rd Medical Group and the Alaska Native Medical Center are building new hospitals in Anchorage. The Alaska Native Medical Center will move into its 370,000 square foot, 5-building health care complex in summer of 1997. The joint VA/3rd Medical Group Hospital at Elmendorf Air Force Base will open its doors to patients in early 1998.

Both buildings are built upon the "mall philosophy" of healthcare delivery in which the interiors are laid out in much the same way as a convenient shopping mall with a large, central common area surrounded by many clinics (much like a small mall's shops surround the mall's interior).

In the near future, the Partners will enjoy using their new agreement with **Columbia Alaska Regional Hospital**. In this agreement the Partners may take advantage of discounts of both inpatient and outpatient services.

The Partners are pursuing a joint **credentialing program** to allow any provider credentialed in one federal facility to see patients in any other Partnership facility. This eliminates the need to go through the laborious credentialing process at each facility. When completed, this program will be the *first in the United States* to combine Native, VA, and military credentialing. The Bassett Army Community Hospital recently signed a similar credentialing agreement in which its doctors are now credentialed to practice at Fairbanks Memorial Hospital.

In early 1997, the military will use the VA's **ambulatory surgery suite** to provide same-day surgeries to military beneficiaries. The military does not always have enough operating



Here's What It Takes To Build the New VA/3rd Medical Group Hospital. (pictured above)

10,923	windows	4.5	acres of vinyl wall covering
3,252	doors	3.5	miles of vinyl base
2,252	light switches	1,631	tons of reinforcing steel
9,256	fluorescent lights	30,170	cubic yards of concrete
372	exit lights	8,180	tons of structural steel
3,907	phone jacks	4	acres precast concrete panels
217	toilet paper holders	.5	miles chair rail in main mall
12	elevators	7.5	miles of copper pipe
18	acres of paint	9	miles of cast iron pipe
1.5	miles of steel pipe	10	miles of wet sprinkler system
101	miles of conduit	289	miles of wire
900	feet of fiber optic cable	162	miles of communication cable

When completed, the new VA/3MDG Hospital will be the largest single-purpose building in the state of Alaska.

rooms to accommodate all its patients. Instead of referring the patients to other providers or making them wait, the military will simply schedule patients into the VA surgery suite where military doctors will perform the operation.

In October of 1997 the military begins its new **TRICARE Prime** health care program. Under **TRICARE Prime** the military relies on assistance of other federal agencies and private providers to ensure beneficiaries have quick access to care. The military will rely heavily on the Partnership to supply access to providers and equipment to make **TRICARE Prime** a success.

The Partnership will pursue many new agreements and programs in areas such as **cardiology, urology, internal medicine, surgery, sterilizers and other equipment, sleep disorder studies, joint educational programs for staff and beneficiaries, state-wide mental health programs, Nurse Advice Lines, and other beneficial services.**

The staff of the Alaska Native Medical Center, VA Clinic, Army, Air Force, and Coast Guard hospitals and clinics are proud of their accomplishments and look forward to seeing their patients benefit from the Alaska Federal Health Care Partnership's continued success.



Alaska Federal Health Care Partnership Reference List

Alaska Federal Health Care Partnership Business Office, 255 Gambell, Anchorage, Alaska 99501-3700

After 1 June, 1997 the new address is 4315 Diplomacy Drive, Anchorage, Alaska 99508

Director	(907) 343-3993	Fax 393-3992
----------	----------------	--------------

Alaska Native Medical Center, 255 Gamble, Anchorage, Alaska 99501-3700

After 1 June, 1997 the new address is 4315 Diplomacy Drive, Anchorage, Alaska 99508

Director	(907) 257-1250	Fax 257-1037
Executive Officer	(907) 257-1421	Fax 257-1037
Public Affairs	(907) 257-1363	Fax 257-1168
Medical Director	(907) 257-1250	Fax 257-1037

Veterans Affairs Medical Clinic, 2925 DeBarr Road, Anchorage, Alaska 99508-2928

Director	(907) 257-5460	Fax 257-6774
Managed Care Coordinator	(907) 257-5476	Fax 257-6774
Chief, Nursing	(907) 257-5460	Fax 257-6774
Chief of Staff	(907) 257-5460	Fax 257-6774
Joint Venture Coordinator	(907) 552-4929	Fax 257-5495

Bassett Army Community Medical Hospital, Fort Wainwright, Alaska 99703

Commander	(907) 353-5108	
Director of Managed Care/TRICARE	(907) 353-5563	Fax 353-5700
Chief, Utilization Management	(907) 353-5602	Fax 353-5700
Health Systems Specialist	(907) 353-5610	Fax 353-5700

Medical Detachment, Fort Greely, APOAP 96508

Commander	(907) 873-4111	Fax 873-4704
-----------	----------------	--------------

3rd Medical Group, 24-800 Hospital Drive, Elmendorf Air Force Base, Alaska 99506

Commander	(907) 552-3500	Fax 552-7378
Director of Managed Care	(907) 552-8749	Fax 552-7802
Chief, Utilization Management	(907) 552-5379	Fax 552-7802
Chief, Plans and Communications	(907) 552-8749	Fax 552-7802
TRICARE/ Health Benefits Advisor Office	(907) 552-3430	Fax 552-8388

354th Medical Group, Eielson Air Force Base, Alaska 99702

Commander	(907) 377-5235 ext 282	Fax 377-4053
Director of Managed Care	(907) 377-5155 ext 384	Fax 377-4325
Resource Management	(907) 377-4108 ext 395	Fax 377 4325

Ketchikan Coast Guard Clinic, USCG Base Ketchikan, 1300 Stedman, Ketchikan, Alaska 99901

Administrator	(907) 228-0320	Fax 228-0255
---------------	----------------	--------------

Rockmore/King Memorial Clinic, USCG Support Center, P.O. Box 195002, Kodiak, Alaska 99619-0615

Administrator	(907) 487-5757 ext 107	Fax 487-5360
---------------	------------------------	--------------

Juneau Coast Guard Clinic, 17th Coast Guard District, P.O. Box 25517, Juneau, Alaska 99802-5517

Administrator	(907) 463-2146	Fax 463-2150
---------------	----------------	--------------

Sitka Coast Guard Clinic, USCG Air Station, 611 Airport Road, Sitka, Alaska 99835-6500

Administrator	(907) 966-5430	Fax 966-5428
---------------	----------------	--------------

Coast Guard Maintenance Logistics Command, Pacific Alameda, California 94501-5100

Asst Medical Admin Branch Chief	(510) 437-3964	Fax 437-5808
---------------------------------	----------------	--------------

Branch Medical Clinic, Adak, Rm 11 NAF, Adak Island, Alaska 99695

Administrator	(907) 572-8383	Fax 572-4287
---------------	----------------	--------------



For Information

Captain Jim Clapsaddle, Marketing and Communications

Alaska Federal Health Care Partnership

24-800 Hospital Drive, EAFB, AK 99506

(907) 552-8749 • Fax (907) 552-7802 • DSN 317-552-8749

Concept and copy by Jim Clapsaddle • Layout by Classic Design & Typography

Photography by Ann Kimberly Glasco, SrA Jeremy Cross, SrA Tim Wooten, Frank Flavin, SCPO W.F. Boatman, Alaska Division of Tourism

Cover Photo: Ernst Schneider • Back Cover Photo: Robert Angell

Alaska Federal Health Care Partnership

Annual Report 1997



Table of Contents

Letter from the Chairman of the Board.....	1
Goals and Accomplishments.....	2
Summary of Financial Figures.....	7
Management Discussion and Analysis.....	9
Subsidiaries and Addresses.....	10
History of the Partnership.....	12
Reference Telephone Listing.....	13

Letter from the Chairman of the Board:

In 1997, as we envisioned a health care delivery system where the strengths and needs of individual agencies are combined to provide customer service, we had one mission in mind: dedicate ourselves to provide our beneficiaries ready access to quality, customer-oriented, compassionate, comprehensive, and cost-effective health care.

To this end, we committed ourselves to seek out new and innovative ways to accomplish our goals. As you will soon see by reading this report, the Partnership has gained momentum in 1997 and continues to show unlimited potential.

The concept of sharing staff, equipment, and purchasing power is the staple of our existence. To date, this method has saved an estimated 4.3 million federal dollars. More importantly however, it has helped us achieve our goals.

- Ensure patients have access to the right care, at the right time, in the right place.
- Create a better business environment.
- Maintain medical preparedness.
- Optimize the use of technology.
- Promote patient wellness.

The next few pages illustrate just how this has been accomplished through some very personal stories. We thank you for your interest in our organization and hope this annual report reflects our enthusiasm and desire to succeed well into the future.

Sincerely,

Richard Mandsager

RADM Richard Mandsager
Chairman, Executive Board, AFHCP



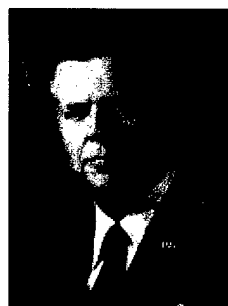
RADM Richard Mandsager
Public Health Service Director,
Alaska Native Medical Center



Colonel Tony Carter
U.S. Army Medical Corps,
Commander, USAMEDDAC-Alaska



Mr. Steve Tuller
U.S. Coast Guard
Chief, Health and Safety MLC Pacific



Colonel Robert L. Crane
U.S. Air Force,
Commander, 354th Medical Group



Mr. Alexander Spector
Director, Veterans Affairs Medical &
Regional Office Center



Colonel William B. Tate
U.S. Air Force,
Commander, 3rd Medical Group



Master Sergeant (MSGT) Chester Fritz, his wife Margaret and their two sons are grateful to the Alaska Native Medical Center and the Partnership for providing access to the right care, at the right time, in the right place. MSGT Fritz was the first active duty Air Force member transferred to the new native medical center after

suffering severe multi-lobar community acquired pneumonia and requiring intensive 24 hour pulmonary rehabilitation unavailable in any of the other local federal facilities.

base. Before this agreement, Veterans could purchase a short-term supply of needed medications at a local pharmacy, but the majority of their medication needs were met through the mail-out program offered through the Anchorage VA. Veterans can now access a local pharmacy directly by using the pharmacy at BACH. As a result of this agreement, Veterans living in the North Interior of Alaska have gained improved access – better, easier, and more timely, and in the *right place* — their home community.

Medical personnel from Fort Wainwright's Kamish Clinic were certainly in the *right place, at the right time* for the village of Quinhagak. During **Operation Arctic Care** physicians

Ensure patients have access to the right care, at the right time, in the right place.

The story of the Fritz family is just one example of how the Partnership shares facilities, personnel, and equipment in an effort to better serve our beneficiaries. For Chester Fritz, it may have saved his life by giving him access to the *right care* at the *right time*.

The VA maintains a medical center in Anchorage, but has traditionally not had any direct providers in other areas of the state. By utilizing the facilities and resources of Bassett Army Community Hospital (BACH) at Fort Wainwright in Fairbanks the VA has been able to strengthen the link between the Department of Veteran's Affairs and Veterans living outside the Anchorage metropolitan area.

Through the BACH/ VA sharing agreement, Veterans in Fairbanks can receive both inpatient and outpatient services on

were called upon to assist in the tiny village's most traumatic event of the year. One person lay dead, and another lay bleeding from gunshot wounds to the neck. The medical team was able to stabilize the patient and later transport him to a hospital in Bethel.

Operation Arctic Care has evolved into a joint training exercise in recent years. Participants include both active and reserve components of the Army, Air Force, Navy, and Marines. The exercise brings medical, dental, and veterinary care to remote villages throughout Alaska while providing training for soldiers.



Alaska Army National Guard



discounts than any single facility could have achieved on its own. In previous years, the Partnership negotiated better deals for reference lab services, medical evacuation transportation, and inpatient/outpatient hospital services in the private market.

The Federal Partnership also helps to foster a *better business environment* by coordinating some administrative functions. Under the auspices of the Partnership, a memorandum of understanding was

signed 20 June 97 to establish a standardized joint credentialing process. The purpose is to facilitate the sharing of federal health care licensed independent practitioners among AFHCP. Members currently share certified original copies of the credentialing verification information. ANMC and VA consolidated credentialing source verification through an interagency agreement where the VA performs the function for both themselves and ANMC providing a more cost effective and time efficient program.

With a phone in one hand and a mouse in the other Christine Swink, credentialing coordinator, is an invaluable member of the federal health care team. Christine is responsible for saving ANMC approximately \$12,750 and recapturing approximately \$11,750 for the VA.



Photo by Dede Strother

Create a better business environment.

In October of 1997, the Partnership was selected to receive the prestigious *Hammer Award*. This award is Vice President Gore's special recognition of teams making significant contributions in support of the President's National Performance Review principles. The award cited the Partnership for improvements in health care services to Alaska's federal beneficiaries.

One of the primary principles of contracting states that the greater volume of services you purchase, the greater the discount you'll receive for those services. The Federal Partnership takes advantage of this principle by pooling its beneficiaries together to achieve better discounts for care purchased in the private market.

In FY97, the Partnership negotiated a contract for professional Cardiology services. By contracting together, the Federal Partnership was able to achieve better



Blind in his left eye since 1977, 45 year old Veteran Anthony Mathews' eyes teared when Dr. Winkle (a U.S. Army Ophthalmologist) asked him, "Can you see anything out of your left eye?" In 1973, aboard the USCGC Madrona, Anthony's cornea was scratched by a piece of debris and by November 1977

he had lost his left eye vision and his new career as a professional truck driver.

Anthony works full time as a community service patrol member. He loves helping people and keeping them safe. Anthony says he feels grateful for every day he can see out of both eyes. Anthony and Linda, his wife of 13 years, spend their time raising their three children.

Maintain medical preparedness

Sharing professionals among the federal partners has a less obvious benefit as well. The Partnership plays an important role in maintaining the medical preparedness of our Armed Forces medical personnel. When U.S. Military physicians, like MAJ Kevin Winkle, are assigned to care for our active duty soldiers, they rarely have the opportunity to hone their skills with new and challenging cases. After all, our fighting forces are among the healthiest citizens in the country. By sharing our physician resources, we increase the patient pool and the exposure to a variety of pathology and

trauma. This exposure helps our physicians maintain a higher state of readiness and *medical preparedness*.

Our beneficiaries don't always come to us...sometimes the Partnership delivers care to them.

Continuing a decade long tradition, the U.S. Coast Guard (USCG) Cutter *Storis* transported a U.S. Public Health Service physician, dentist, and USCG health services technician to the remote Alaskan villages of Atka, St. Paul, and St. George. Dr. Stephen Kinsley, Dr. Susan Buck, and Petty Officer Ira Kessler, from the Rockmore-King Clinic at USCG Integrated Support Command Kodiak, volunteered for this mission in support of the Partnership. While these professionals provided basic and preventive medical and dental care, crew from the *Storis* helped native Alaskans with local construction projects such as bridges and handicapped access ramps.

Photo by USCG Storis



Photo by USCG Storis

Natives celebrate the construction of a Tsunami foot bridge that allows local children to walk to school.



Dr. Cathy Woomert, Radiologist sits at a work station and reads a cervical spine image from Dillingham. "After I

read the description of the technology I was excited about ANMC's commitment to filmless radiology and teleradiology". She moved from Pennsylvania in July 97. Dr. Midthun, Chief of Radiology, states "the doctors in Dillingham have immediate access to radiology consultations; dramatically improving the turnaround time for reports". Prior to teleradiology connection, Dillingham waited 9 to 21 days for interpretations and ANMC's goal is a turnaround time of 24 hours. Dr. Midthun adds, "another aspect of teleradiology is that Dillingham doctors have immediate access to clinical consultation with specialists in our facility... if technology advances do not help the patient then what good is it; no doubt teleradiology helps our beneficiaries".

Optimize the use of technology.

Medical technology is a crucial tool for providing both the diagnostic and therapeutic health care services necessary for improving the health of patients. Unfortunately, the purchase and maintenance of equipment in this fast-changing market can be costly and difficult to sustain. Sharing medical technology among federal partners helps all beneficiaries by allowing greater access to more high tech equipment for a lower

cost. The Federal Partnership has helped to achieve this kind of optimization through several initiatives, including the Elmendorf/ANMC sharing agreement for radiology/nuclear medicine services, and the Elmendorf/VA operating room agreement. As the result of the agreement between Elmendorf and ANMC, Alaska Native beneficiaries received 200 radiology and nuclear medicine services during FY97 that were unavailable to them at the ANMC facility. Almost all of these were for MRIs, bone scans and other expensive but valuable diagnostic tests.

Likewise, as a result of Elmendorf's agreement to rent the VA's excess capacity operating room space, Air Force doctors were able to perform 42 surgeries at the VA. The use of operating room technology was maximized to its fullest, DoD beneficiaries were able to receive services more quickly, and some Veterans were able to receive services which would have been otherwise unavailable at the VA from the visiting DoD specialists.



Telemedicine in action...health aides like Cheryl Booth, CHP in Noatak, capture images to be stored and then forwarded to physicians in hospitals hundreds of miles away.



Through the auspices of the Alaska Federal Health Care Partnership, the first Women Veterans Health Clinic was established in January 1996. The clinic is staffed by a full-time on-site VA Advanced Nurse Practitioner, with twice monthly clinics provided by consulting board-certified OB/

GYN physicians from the Alaska Native Medical Center. Shirley Henley, ANP, is proud to be a part of a clinic that has grown from 112 clients in FY96 to over 400 in FY97. She states, "both the growing number of women vets and word of mouth have been responsible for our expansion". "As a clinician this venture has been very rewarding because of the collaborative relationship formed with ANMC in both using their women's health software and interacting with their physicians."

Promote patient wellness.

Sometimes, it is in the best interest of the patient to receive the care they need at the medical facility they are most familiar with. This helps the patient feel comfortable and ensures that care is coordinated with all of the patient's medical providers. To achieve this, though, the facility must have access to the entire spectrum of care.

The Federal Partnership helps to promote this goal by building agreements that allow federal facilities to share the skills and expertise of their medical specialists. Often, these agreements provide for medical specialists from one federal facility to

set up clinics at another federal facility — bringing the specialist directly to the patient. During FY97, one of DoD's ophthalmologists provided 87 procedures to Veterans at the VA Medical Center over a 2-month period. In addition, ANMC physicians provided 132 OB/GYN services to female Veterans and 251 Urological services at the VA. Patients received more specialized care within their own facility as a result of these Partnership agreements.

Continuity of care goes a long way in promoting *patient wellness* for our beneficiaries and that is just what Bassett Army Community Hospital is doing in Fairbanks.

Recently, Bassett negotiated a local Resource Sharing Agreement with Fairbanks Memorial Hospital (FMH). The agreement allows military specialists to use FMH inpatient facilities and intensive care unit to treat military patients. Because of this initiative, our physicians are able to continue the care of seriously ill patients even if they require resources beyond the capability of the military hospital. When our physicians are allowed to provide care in local institutions, professional fees are eliminated. This has led to a reduction of inpatient costs by approximately 20% for Bassett Army Community Hospital.

Other benefits are derived from opening new lines of communication between local physicians and military providers. In working side-by-side and sharing their insights and concerns, all parties become involved in health care planning and the entire community benefits. This agreement is the result of negotiations spanning the last 12 months and the first major step toward a cooperative relationship with the civilian medical community in Fairbanks.

Summary of Financial Figures

As the health care industry struggles to operate within an environment of reduced resources and budget cutbacks, we must constantly come up with innovative ways of providing services to our beneficiary population. Part of this effort is to assume greater fiscal responsibility over the funds still available to us.

...Partners have saved an estimated 6.9 million , tax payer dollars over the past three years.

The combined efforts of the Alaska Federal Health Care Partners have saved an estimated **6.9 million**, taxpayer dollars over the past three years. Approximately **4.3 million dollars** in expenditures were avoided in 1997 alone. The most significant news, however, is the trend that is developing. As the Partnership matures and gains experience, the savings continue to mount.

Each facility has an opportunity to save money in two unique ways. By entering into joint contracting arrangements, the partners can take advantage of large volume discounts. In this way, historically higher costs avoided.

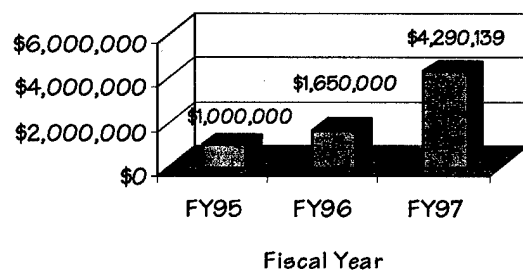
The second way in which facilities save money through the Partnership is by recapturing revenue that would historically be lost outside the federal system. When a partner can utilize excess capacity of another facility at a discounted rate, those

funds are retained within the federal system. In turn, facilities have the ability to enhance benefits with resources now available.

When Partnership saves federal tax payer dollars as we have just described , Alas-

kans benefit in another way. The Partnership operates under an ***Alaska First Policy***. This means when care is not

AFHCP Estimated Cost Avoidance FY95 - FY 97



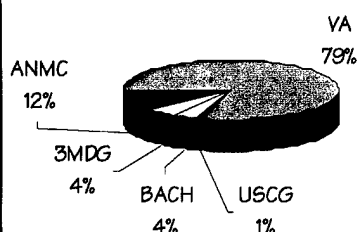
available within any of the federal facilities, contracts are created with *local private providers*. In this way, our patients are

...4.3 million dollars in expenditures were avoided in 1997 alone.

cared for close to home and health care dollars are reinvested in our own Alaskan community. This is a policy that is good for patients, good for the Partnership, and good for Alaska's private physicians and economy.

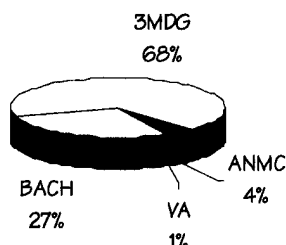
Total Cost Avoidance by Agency

\$4,290,139



Recaptured Revenue

\$1,162,287.01



Alaska Federal Health Care Partnership Business Office

Statement of Assets and Liabilities

October 1997

Assets:

Cash.....	0.00
Office equipment on-hand.....	19,380.00
Supplies on-hand.....	1,000.00
Total assets.....	\$20,380.00

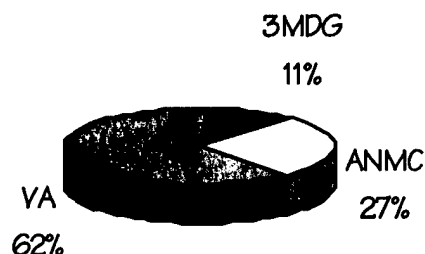
Liabilities & Equity:

Salaries ¹	180,229.00
Rent/ utilities (incl phone).....	8,880.00
Travel and training.....	3,576.00
Supplies/ Annual Report.....	16,300.00
Maintenance (office equipment).....	1,938.00
Moving expenses.....	2,500.00
Total liabilities and equity.....	\$213,423.00

Note: 1. includes benefits package

In 1997, the costs to operate the AFHCP Business Office were spread among the Partners as depicted in the diagram to the right. During this period the office was temporarily located on the roof of the old Alaska Native Medical Center, and then in an office building on Tudor Centre Drive. Since that time, the office has outgrown its' facility once again and relocated to Fort Richardson.

Liability by Facility - FY 97



Management Discussion and Analysis

The previous data shows the estimated utilization and cost savings from contracts and agreements established through the Alaska Federal Health Care Partnership (AFHCP). The analysis was completed to show the overall cost savings. All cost comparison numbers, therefore, are representative of what each facility was paying prior to and after the Partnership initiatives were implemented.

The resulting numbers were affected by several important factors, including:

- **Data Availability:** The infrastructures for capturing good data on services being provided through AFHCP initiatives are slowly improving, but they were not always available in FY97. Utilization and savings are based on the best data available but may not capture the entirety of services provided.
- **Initiative Start Dates:** It should be noted that some initiatives were implemented during the course of FY97. Data for these initiatives will only cover the partial year.
- **Pre-AFHCP Contracted Rates:** Because the cost savings are based on what facilities were paying prior to when AFHCP contracts were put into place, the resulting cost savings will be affected by the rates each facility was able to negotiate prior to AFHCP. Facilities and agencies with better contracted rates for services in the private sector prior to AFHCP may show lower cost savings than other facilities.
- **Contract Implementation Issues:** Increased cost savings could have

been achieved through better implementation of AFHCP contracts. As a result, savings for some agencies may not show the total savings that were possible. These problems have since been identified and will hopefully show improved savings in future years.

• **Alternate Resources:** ANMC is the payer of last resort. As a result, the cost savings may appear smaller than other agencies due to payments made by alternate resources.

AFHCP's capacity for data gathering and analysis vastly improved during FY97. Numbers for FY97 are as accurate as possible given the limitations of data availability and reliability. It is expected that data collection systems and methodologies will continue to improve to bring more precise data in the future.

Subsidiaries and Addresses

Bassett Army Community Hospital (BACH), Fort Wainwright, Fairbanks, Alaska. Located 170 miles south of the Arctic Circle, BACH has the distinction of being the military's northern most hospital. BACH has 55 beds and is the largest Army medical facility in Alaska. BACH directs medical activities of Alaska's other two Army facilities; Fort Greely Clinic, and Fort Richardson Troop Medical Clinic.

Alaskan Native Medical Center (ANMC), Anchorage, Alaska. The new ANMC was dedicated on May 18, 1997 and began admitting patients on June 2 of last year. The new hospital is twice the size of the old retrofitted TB sanitarium, has 150 inpatient beds and is a gatekeeper for specialty/medical services to the other 6 hospitals and 15 health centers in rural Alaska. ANMC is a Level III Trauma Center, currently the only hospital in Alaska with that status, serving over 105,000 Alaska Natives and American Indians. The new ANMC received a first place national award for design from Modern Healthcare, a national industry publication, in October 1997.

354th Medical Group, Eielson AFB, North Pole, Alaska. The 354th Medical Group provides outpatient medical and dental care for approximately 8,000 active duty Air Force personnel, retirees, and family members residing in the interior of Alaska. The clinic delivers primary care service as well as offering pediatrics, optometry, mental health, obstetrics, gynecology, flight medicine, immunizations and x-ray services. Services not provided by the 354th Medical Group can be obtained at the nearby Bassett Army Community Hospital which serves as the 354th's primary referral facility.

3rd Medical Group (3MDG), Elmendorf AFB, Anchorage, Alaska. The 3MDG hospital was built in 1954 to care for beneficiaries of all military services in South-Central Alaska. It has 50 beds and provides services for 41,000 active duty, retirees and their families. As the state's largest military medical facility it serves as the referral facility for Alaska's 70,000 military beneficiaries. The 3MDG facility will be replaced by a new hospital, currently under construction, to be operational in 1998.

Troop Medical Clinic, Fort Richardson, Anchorage, Alaska. The Troop Medical Clinic (TMC) provides outpatient medical care to army soldiers in the greater Anchorage Area. The TMC serves active duty members by providing sick-call, primary care, routine examinations, optometry and physical therapy.

Department of Veteran's Affairs Medical & Regional Office Center (VAM&ROC), Anchorage, Alaska. The VAM&ROC serves 73,000 veterans in Alaska. Besides caring for vets through the clinic built in 1992, they also purchase health care for their beneficiaries from the private sector. In addition to primary care, the VA clinic offers dental, prosthetics, audiology, radiology, mental health, orthopedics and ambulatory surgery. The VA also operates a 50-bed homeless domiciliary that opened in December 1995.

Coast Guard ISC Clinic Ketchikan, Alaska. The Ketchikan Clinic is located in a new 5,700 square foot facility in Ketchikan, Alaska. The facility is 890 air miles southeast of Anchorage. Its seven staff provide primary care to 730 active duty, retirees and their family members.

Fort Greely. Medical facilities at the Fort Greely U.S. Health Clinic, located in the vicinity of Delta Junction, consists of primary family health care, preventative medicine, and mental health services. The clinic, located in building 663, is staffed by two doctors, one clinical nurse, and 25 medical technicians and provides outpatient treatment, laboratory, x-ray, emergency and other limited medical services. Pediatrics, adult medicine, OB-GYN, and surgery providers from BACH visit the clinic on a periodic basis.

Coast Guard ISC Clinic Juneau, Alaska. The Juneau Coast Guard Medical Clinic is located on the sixth floor of the Federal Building in downtown Juneau. It was renovated and expanded in 1992 to 1,750 square feet. The facility is 577 air miles southeast of Anchorage and provides primary and dental care to 530 active duty members, retirees, and their families.

Coast Guard ISC Clinic Kodiak, Alaska. The Kodiak Clinic is the Coast Guard's largest medical facility in Alaska. It is located 325 air miles southwest of Anchorage. Four medical officers, two dental officers and 30 support staff provide care to nearly 3,000 beneficiaries.

History of the Partnership Program:

The medical activities of the Department of Transportation, Department of Defense, Department of Veteran's Affairs, and the Indian Health Service have enjoyed a mutually supportive relationship in Alaska since World War II. Alaska's tremendous geographical size, few providers, deficient lines of communication, and travel difficulties create an environment in which the four agencies have always assisted in supporting each other's beneficiaries.

In the 1980's, it was common to see DoD, VA, and IHS medical staff working together through resource sharing arrangements. This cooperative alliance was further increased when decisions were made not to pursue the construction of a new VA Hospital in Alaska. This decision led to a DoD/VA Joint Venture in which the VA would occupy part of Elmendorf AFB's new hospital to be completed in 1998.

In the 1990's, with TRICARE as the emerging system for DoD health care, Alaska took the initiative to create a plan adapting TRICARE principles for military health care facilities that formed the *Alaska Region Health Care Plan*.

Capitalizing upon already strong inter-agency relationships, the military, IHS, and VA facilities formalized many previously informal agreements. By working together they lowered the cost of care, but that was only the first step. The next step was to work together to acquire cost-effective health care from civilian sources.

Individually, each facility represented a small beneficiary population that lacked the power to obtain discounted prices for health care from civilian sources. When combined, the beneficiary populations accounted for 40 percent of the state's population. This gave federal agencies leverage to be a major player in the state's health care environment, and also allowed them to share each other's talents and experience to improve patient care.

An alliance was composed between the VA, IHS's Alaska Native Medical Center (ANMC), and the 3rd Medical Group. These three agencies formed the *Anchorage Federal Health Care Provider Network*. In the Fairbanks area, Bassett Army Community Hospital (BACH) at Fort Wainwright, the 354th Medical Group (354MDG) at Eielson AFB, the VA, and the Tanana Chief's Conference (IHS) formed a separate federal coalition to consolidate their bargaining power with local civilian medical facilities in their geographical area.

In 1994, Dr. Stephen Joseph, Assistant Secretary of Defense, Health Affairs (ASD/HA), visited the 3MDG, BACH, 354MDG, VA, and ANMC. He reviewed the *Alaska Regional Health Care Plan* and expressed enthusiasm for joint agency initiatives. In December, Dr. Joseph met with representatives from the VA, Department of Health and Human Services, and U.S. Coast Guard (USCG). They agreed to allow Alaskan agencies to continue developing successful grass-roots initiatives. They viewed the Alaskan plan as the best way to benefit patients, acquire cost effective care, increase access, and perhaps provide national health care reform initiatives with an effective model.

In January 1995, leaders from the USCG, DoD, VA, and IHS met to determine the best structure for further addressing Tri-Agency initiatives. They formalized a state-wide, inter-agency organization calling it the *Alaska Federal Health Care Partnership*.

Reference Telephone Listing

AFHCP Business Office, Bldg. 658, Suite 201, Ft. Richardson, Alaska 99505

Director	(907) 384-3600	Fax 384-3944
----------	----------------	--------------

Alaska Native Medical Center, 4315 Diplomacy Drive, Anchorage, Alaska 99508

Director	(907) 729-1994	Fax 729-1984
Executive Officer	(907) 729-1994	Fax 729-1984
Public Affairs	(907) 729-1967	Fax 729-1984
Medical Director	(907) 729-1996	Fax 729-1984

Veterans Affairs Medical Clinic, 2925 DeBarr Road, Anchorage, Alaska 99508-2928

Director	(907) 257-5460	Fax 257-6774
Managed Care Coordinator	(907) 257-5487	Fax 257-6774
Chief of Staff	(907) 257-5460	Fax 257-6774
Joint Venture Coordinator	(907) 552-4929	Fax 257-5495

Bassett Army Community Medical Hospital, Fort Wainwright, Alaska 99703

Commander	(907) 353-5108	
Director of Managed Care	(907) 353-5563	Fax 353-5700
Chief, Utilization Management	(907) 353-5602	Fax 353-5700

Medical Detachment, Fort Greely, APOAP 96508

Commander	(907) 873-4111	Fax 873-4704
-----------	----------------	--------------

3rd Medical Group, 24-800 Hospital Drive, Elmendorf Air Force Base, Alaska 99506

Commander	(907) 552-4033	Fax 552-7378
Director of Managed Care	(907) 552-7011	Fax 552-7802
Chief, Utilization Management	(907) 552-5379	Fax 552-7802

354th Medical Group, Eielson Air Force Base, Alaska 99702

Commander	(907) 377-5235 ext 282	Fax 377-4053
Director of Managed Care	(907) 377-5155 ext 384	Fax 377-4325
Resource Management	(907) 377-4108 ext 395	Fax 377 4325

Coast Guard ISC Clinic Ketchikan, 1300 Stedman, Ketchikan, Alaska 99901

Administrator	(907) 228-0320	Fax 228-0255
---------------	----------------	--------------

Coast Guard ISC Clinic Kodiak, P.O. Box 195002, Kodiak, Alaska 99619-0615

Administrator	(907) 487-5757	Fax 487-5360
---------------	----------------	--------------

Coast Guard ISC Clinic Juneau, P.O. Box 25517, Juneau, Alaska 99802-5517

Administrator	(907) 463-2146	Fax 463-2150
---------------	----------------	--------------

Coast Guard Maintenance Logistics Command, Pacific Alameda, California 94501-5100

Managed Care Office	(510) 437-3534	Fax 437-5805
---------------------	----------------	--------------



Alaska Federal Health Care Partnership 1997 Annual Report
printed in cooperation with the
Alaska Area Native Health Service
1998

For more information contact us by writing to:
Alaska Federal Health Care Partnership, Bldg 658, Fort Richardson, Alaska 99505

or visit us on the Internet at
<http://www.alaska.amedd.army.mil/afhcp/default.html>



THE ASSISTANT SECRETARY OF DEFENSE

WASHINGTON, D.C. 20301-1200

3rd Medical Group
Flight Medicine Care

Please use the enclosed envelope
and mail the completed survey to:
Department of Defense
c/o National Research Corporation
1033 O ST. STE 401
LINCOLN, NE 68508-9855
1-800-733-6714

HEALTH AFFAIRS

*** 8382595-A-B995 ***

SGT [REDACTED]

EAGLE RIVER AK

99577-7000

Dear SGT

The Department of Defense is seeking your help in gathering important information about your family's health care. This survey asks about your satisfaction with your appointment on 28 May 1998 in the Flight Medicine Care of 3rd Medical Group. I ask that you restrict your comments to that particular visit so we may focus on your satisfaction with that experience.

You were selected from a scientifically designed random sample of patients seen in that clinic. As in any sample survey, it is important that you respond so we may obtain a more accurate understanding of your satisfaction with your visit. Your feedback will offer the Commander of 3rd Medical Group and the entire leadership of the Military Health System valuable information for improving the services and health care we provide. Once you have answered all the questions, please detach this cover letter and return only the questionnaire (and any written comments you care to make) in the enclosed postage-paid envelope at your earliest possible convenience.

Your answers to this survey will be held in strictest confidence, and you will not be personally identified in any reports or release of survey data. However, any written comments you provide will be forwarded directly to the Commander of the facility you visited, so please do not identify yourself in your comments. If your comments are of an urgent or personal nature, please contact the Commander or Patient Representative directly. Only authorized personnel will have access to your name and address, and only for mailing purposes. Information which might be used to identify specific individuals will be removed from the files, and only group statistics will be reported.

I urge you to invest the 5 - 10 minutes which this survey will require to help us improve military medicine. Thank you for your help.

Gary A. Christopherson
Principal Deputy Assistant Secretary
Health Affairs

Charles H. Roadman II, M.D.
Lieutenant General, USAF, MC
Surgeon General

Survey Guidelines

The survey is being conducted to help policy makers learn more about beneficiary satisfaction with the Military Health System. Information from the survey will be used to help develop policies that may be needed to improve the system. In addition, survey information will be used by military medical treatment facility commanders to evaluate services provided. The survey will be conducted monthly.

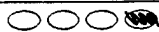
Providing information in this questionnaire is voluntary. There is no penalty if you choose not to respond. However, maximum participation is essential to ensure that the data are complete and accurately reflect the opinions of our beneficiaries as a whole. Your responses will be treated as confidential. Personal identifying information will only be used to prepare the questionnaire and send a follow up postcard. After that postcard is mailed, your name and street address will be purged from all databases. Only group statistics will be reported in findings from this survey. Any written comments you choose to send will be forwarded directly and exclusively to the commander of the facility which provided the health care.

Reports from this survey will be provided to the facility commander and intermediate levels of command up to the Office of the Assistant Secretary of Defense (Health Affairs). Some findings may be reported in manuscripts presented at conferences, symposia, scientific meetings and professional journals.

**PLEASE COMPLETE THE FOLLOWING SURVEY
ACCORDING TO THE MARKING INSTRUCTIONS BELOW**

MARKING INSTRUCTIONS

INCORRECT MARKS



• Please use a blue or black pen

• Fill the oval completely

CORRECT MARK



• Do not make any stray marks



3rd Medical Group
Elmendorf Air Force Base
Flight Medicine Care

RCS DD-HA(M)2016
Expires 7 March 2000

Please use the enclosed envelope
and mail the completed survey to:
Department of Defense
c/o National Research Corporation
1033 O ST. STE 401
LINCOLN, NE 68508-9855
1-800-733-6714

1. What was the main purpose of your visit on 28 May 1998 to the Flight Medicine Care?
- ☐ Care for illness or injury where you felt you needed to see a doctor right away (urgent care)
- ☐ Routine care for a non-urgent condition
- ☐ Well patient visit for preventive care (check-up)
- ☐ Specialty care, referral visit
2. Did DR. PRICE or another provider treat you?
- ☐ DR. PRICE
- ☐ Other Provider (please keep that person in mind as you complete this questionnaire)
3. Thinking about your visit on 28 May 1998, how would you rate DR. PRICE and the staff of the Flight Medicine Care on:
- | | Poor | Fair | Good | Very Good | Excellent |
|--|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| a. Friendliness and courtesy shown to you by the clinic's staff | ☐ | ☐ | ☐ | ☐ | ☐ |
| b. Attention given to what you had to say | ☐ | ☐ | ☐ | ☐ | ☐ |
| c. Thoroughness of treatment you received | ☐ | ☐ | ☐ | ☐ | ☐ |
| d. Explanations of medical procedures and tests | ☐ | ☐ | ☐ | ☐ | ☐ |
| e. Personal interest in you and your medical problems | ☐ | ☐ | ☐ | ☐ | ☐ |
| f. Advice you received about ways to avoid illness and stay healthy | ☐ | ☐ | ☐ | ☐ | ☐ |
| g. Amount of time you had with DR. PRICE and staff during your visit | ☐ | ☐ | ☐ | ☐ | ☐ |
| h. How much you were helped by the care you received | ☐ | ☐ | ☐ | ☐ | ☐ |
| i. How well the care met your needs | ☐ | ☐ | ☐ | ☐ | ☐ |
| j. Overall quality of the care and service you received | ☐ | ☐ | ☐ | ☐ | ☐ |
4. Would you recommend DR. PRICE to your family or friends?
- Definitely Not ☐ Probably Not ☐ Probably Yes ☐ Definitely Yes ☐
5. All things considered, how satisfied are you with the medical care you received at the Flight Medicine Care during this visit?
- | Completely dissatisfied | Very dissatisfied | Somewhat dissatisfied | Neither satisfied nor dissatisfied | Somewhat satisfied | Very satisfied | Completely satisfied |
|-------------------------|-----------------------|-----------------------|------------------------------------|-----------------------|-----------------------|-----------------------|
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
6. How many days were there between the day your appointment was made and the day you saw DR. PRICE?
- ☐ Same day ☐ 8 - 14 days
- ☐ 1 day ☐ 15 - 30 days
- ☐ 2 - 3 days ☐ More than 30 days
- ☐ 4 - 7 days ☐ I did not have an appointment time; I "walked in" to the clinic. (GO TO Q8)
7. How would you rate the number of days between the day your appointment was made and the day you saw DR. PRICE?
- | Poor | Fair | Good | Very Good | Excellent |
|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| ☐ | ☐ | ☐ | ☐ | ☐ |

4Z01VA0BB+

(8382595)

PLEASE DO NOT WRITE IN THIS AREA - FOR OFFICE USE ONLY



How long did you wait for DR. PRICE past your appointment time (or past the time you walked in if you did not have a specific appointment)?

- ☐ Did not wait ☐ 31 - 45 minutes
☐ 1 - 15 minutes ☐ 46 - 60 minutes
☐ 16 - 30 minutes ☐ More than 60 minutes

How would you rate the number of minutes you spent waiting for DR. PRICE?

- Poor Fair Good Very Good Excellent
☐ ☐ ☐ ☐ ☐

How would you rate the Flight Medicine Care on:

- a. Ease of making this appointment by phone
b. Access to medical care whenever you need it
c. The process of obtaining a referral for specialty care

- Poor Fair Good Very Good Excellent N/A
☐ ☐ ☐ ☐ ☐ ☐
☐ ☐ ☐ ☐ ☐ ☐
☐ ☐ ☐ ☐ ☐ ☐

Thinking about times when you have called the Flight Medicine Care for medical information or advice, how would you rate the length of time it took clinic personnel to return your call?

- Poor Fair Good Very Good Excellent N/A
☐ ☐ ☐ ☐ ☐ ☐

All things considered, how satisfied were you with the Flight Medicine Care during this visit?

- Completely dissatisfied Very dissatisfied Somewhat dissatisfied Neither satisfied nor dissatisfied Somewhat satisfied Very satisfied Completely satisfied
☐ ☐ ☐ ☐ ☐ ☐ ☐

Previously we asked you about your specific appointment with DR. PRICE and the Flight Medicine Care.

We would now like to ask you some more general questions:

How would you rate 3rd Medical Group on the following:

- a. Pharmacy services
b. X-ray services
c. Laboratory services
d. Medical record services

- Poor Fair Good Very Good Excellent Haven't Used
☐ ☐ ☐ ☐ ☐ ☐
☐ ☐ ☐ ☐ ☐ ☐
☐ ☐ ☐ ☐ ☐ ☐
☐ ☐ ☐ ☐ ☐ ☐

Are you enrolled in TRICARE Prime?

- ☐ Yes
☐ No (GO TO Q16)

- ☐ Not eligible to enroll (GO TO Q16)
☐ Don't know (GO TO Q16)

Is DR. PRICE (or the provider you saw) your Primary Care Manager?

- ☐ Yes ☐ No ☐ Don't know

If you were given the option, would you:

- ☐ Enroll in TRICARE Prime ☐ Disenroll from TRICARE Prime
☐ Re-enroll in TRICARE Prime ☐ Not enroll in TRICARE Prime

- ☐ TRICARE Prime is not available in this area

- Excellent Very Good Good Fair Poor
☐ ☐ ☐ ☐ ☐

In general, would you say your health is:

If you would like to tell us about your last visit or your overall experience with the Flight Medicine Care or DR. PRICE, please write your comments on a separate sheet of paper and return it with this survey. The separate sheet will be forwarded directly to the Commander of 3rd Medical Group.

BJA-0006

Thank you for completing this survey. Please return it in the postage-paid envelope at your earliest possible convenience.

4Z01VB0BB%

(8382595)

PLEASE DO NOT WRITE IN THIS AREA - FOR OFFICE USE ONLY

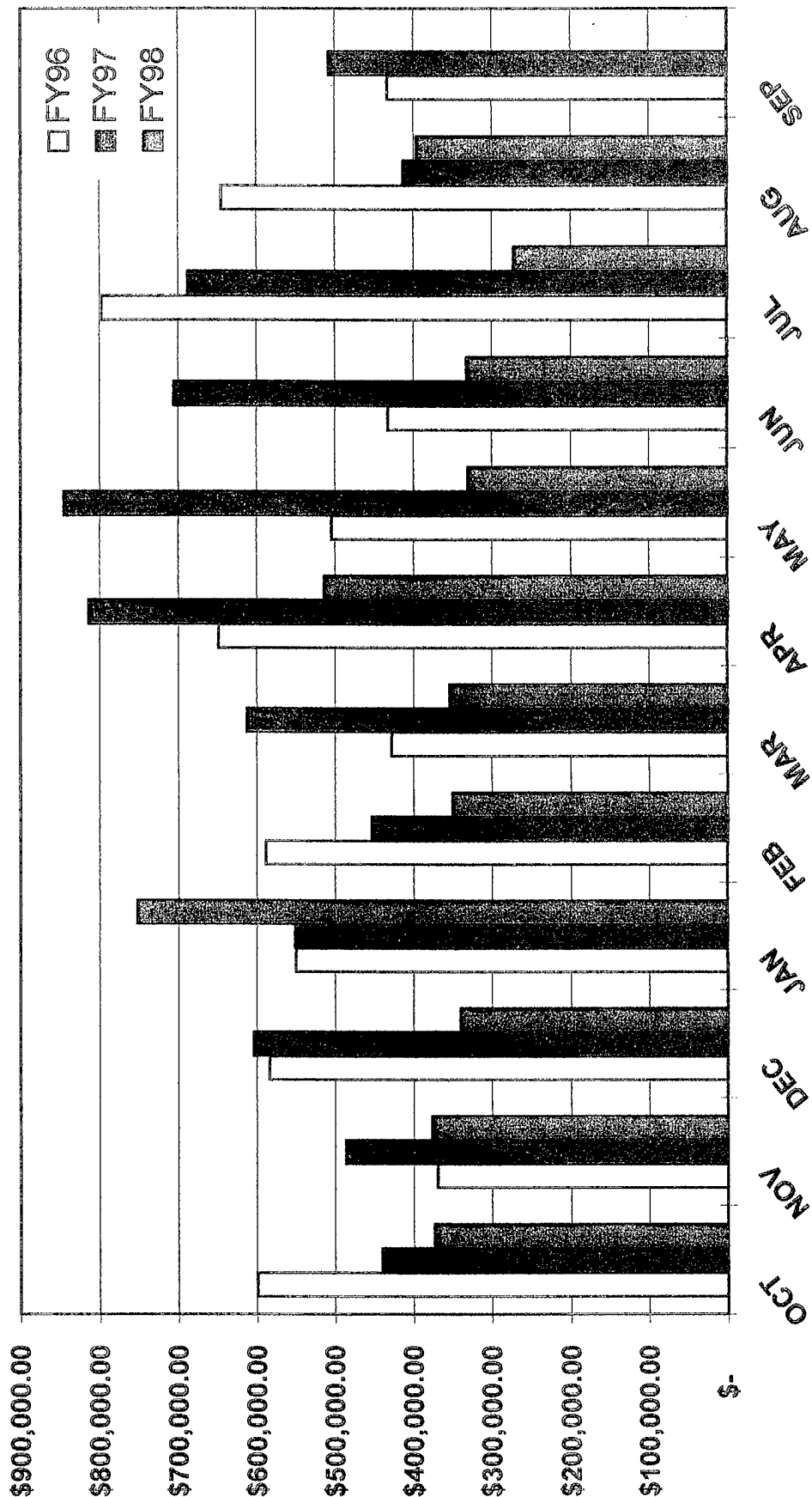


A (0598)

2013

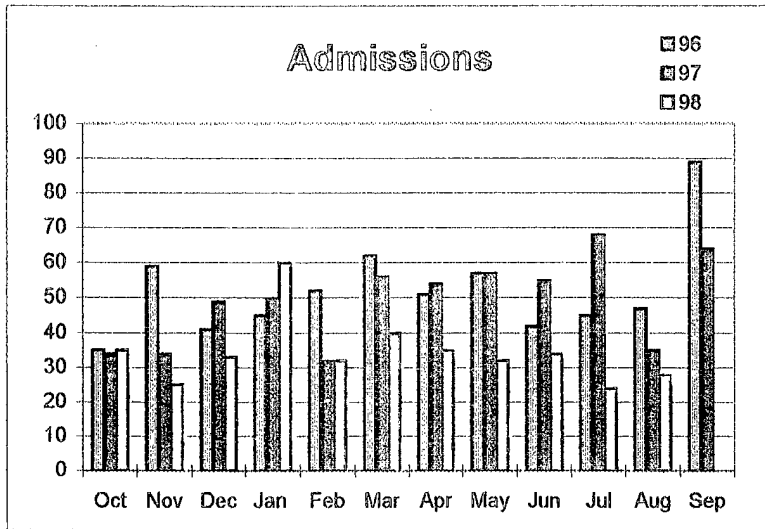
J

OCHAMPUS TOTAL EXPENDITURES by Month (Inpatient and Outpatient CHAMPUS Area Billing Report)

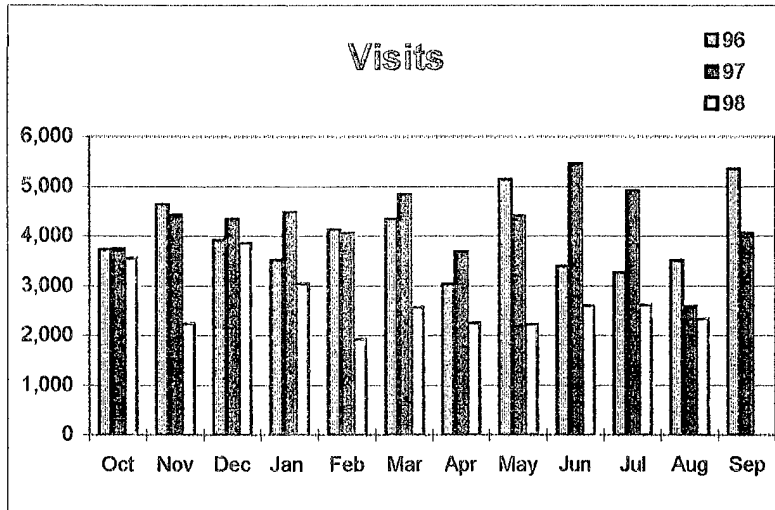


OCHAMPUS EXPENDITURES FY 98

Admissions			
	96	97	98
Oct	35	34	35
Nov	59	34	25
Dec	41	49	33
Jan	45	50	60
Feb	52	32	32
Mar	62	56	40
Apr	51	54	35
May	57	57	32
Jun	42	55	34
Jul	45	68	24
Aug	47	35	28
Sep	89	64	
	625	588	378
Avg	52	49	38 (10mo)



Visits			
	96	97	98
Oct	3,740	3,748	3,559
Nov	4,645	4,438	2,239
Dec	3,931	4,346	3,861
Jan	3,520	4,488	3,044
Feb	4,141	4,059	1,931
Mar	4,348	4,845	2,572
Apr	3,040	3,697	2,256
May	5,139	4,417	2,223
Jun	3,401	5,458	2,604
Jul	3,269	4,916	2,626
Aug	3,518	2,594	2,338
Sep	5,351	4,068	
	48,043	51,074	29,253
Avg	4,004	4,256	2,925 (10mo)



3MDG Catchment Area Top 10 CHAMPUS Costs and Providers for FY 97

Top 10 Inpatient Provider (CHAMPUS)

Facility	Bed Days	Total Gov Cost
Providence Alaska Medical Center	1451	\$1,551,860.79
Charter North Counseling Center (Psy)	720	\$430,015.05
West Hills Hospital (RTC)	888	\$392,888.09
Columbia Alaska Regional Hospital	103	\$172,527.31
Westbridge Treatment Center (RTC)	192	\$96,441.01
Valley Hospital	46	\$84,945.81
BHC Olympus View Hospital (RTC)	197	\$67,038.90
CPC Olympus View Hospital (RTC)	145	\$50,331.10
Charter North Star Behavioral	78	\$48,750.00
Emanuel Hospital Rehab	26	\$38,897.91

Top 10 Services Provided by CHAMPUS Provider by ICD9

ICD9	Bed Days	Admits	Total Gov Cost
76503 Extreme Immature/750-999G	170	1	\$300,569.07
V3001 Single LB, Hosp, Del by CD	176	8	\$251,818.75
V3000 Single LB-IN Hosp NEC	176	11	\$243,645.78
29620 MDD, Single Episode, NOS	418	20	\$229,619.49
311 Depressive Disorder NEC	369	10	\$176,850.72
31401 ADD, Child, with Hyperact	307	8	\$159,035.22
76502 Extreme Immature/500-749G	107	1	\$155,091.83
29570 Schizo affective - unspec	225	7	\$137,034.90
29633 Recurrent MDD-severe	277	7	\$121,354.95
41401 COR AS-Native Vessel	35	9	\$91,980.30

Top 10 Outpatient Providers (CHAMPUS)

Facility/Provider	Visits	Services	Total Gov Cost
Providence Alaska Medical Center	1153	5569	\$299,350.53
Health Links Inc.	3614	6	\$162,977.58
Columbia Alaska Regional Hospital	69	860	\$154,274.37
Alaska Neonatal Associates	9	663	\$136,372.53
Margaret Barnett	4351	63	\$100,379.31
Sterling Medical	2421	115	\$77,456.60
Charter North Counseling Center	757	333	\$58,661.14
Providence Anchorage Anesthesia	0	225	\$50,681.59
Philip Ricker	1020	0	\$41,820.72
Ophthalmic Assoc.	105	62	\$34,195.96

Top 10 Services Provided by CHAMPUS Providers by CPT4

Facility/Provider	Visits	Services	Total Gov Cost
Special Supplies	641	5390	\$240,062.63
Individual Psychotherapy	609	81	\$227,133.50
Office/Outpatient Visit, EST (99214)	3101	13	\$112,857.79
Unusual Physician Travel	75	112	\$104,571.52
Office/Outpatient Visit, EST (99213)	3115	30	\$75,073.28
Special Family Therapy	271	25	\$71,415.36
Neonatal Critical Care	14	169	\$68,267.79
Special Group Therapy	207	1	\$51,997.82
Radiographic Procedure	274	432	\$44,996.00
Subsequent Hospital Care	100	588	\$40,753.96

3MDG Catchment Area Top 10 CHAMPUS Costs and Providers for FY 98

Top 10 Inpatient Provider (CHAMPUS)

Facility	Bed Days	Total Gov Cost
Providence Alaska Medical Center	250	\$204,826.94
Columbia Alaska Regional Hospital	56	\$179,558.39
Charter North Counseling Center (Psych)	232	\$130,880.00
West Hills Hospital (RTC)	171	\$64,121.09
University of WA Medical Center	49	\$48,181.17
Deacons Medical Center	59	\$18,275.00
San Diego Center for Children	62	\$17,748.03
BHC Olympus View Hospital (RTC)	64	\$17,014.00
Franklin Medical Hospital ME	2	\$10,881.84
Health Care Rehabilitation, Autin, TX (RTC)	14	\$6,950.00

Top 10 Services Provided by CHAMPUS Provider by ICD9

ICD9	Bed Days	Admits	Total Gov Cost
85205 Traumatic SAH-Deep Coma	39	1	\$164,434.59
V3000 Single LB-IN Hosp NEC	62	1	\$94,043.14
31230 Impulse Control PBX NOS	171	2	\$64,121.09
31401 ADD, Child, with Hyperact	97	3	\$43,755.91
29624 MDD, SEV W Psych	87	4	\$35,403.49
V581 Chemotherapy Encounter	25	1	\$32,888.67
29630 Recurrent MDD Unspec	82	4	\$32,288.46
29620 MDD, Single Episode, NOS	48	3	\$32,037.14
1916 MAL Neopl Cerebellum NOS	19	1	\$27,580.37
30113 Cyclothymic Disorder	58	3	\$26,298.10

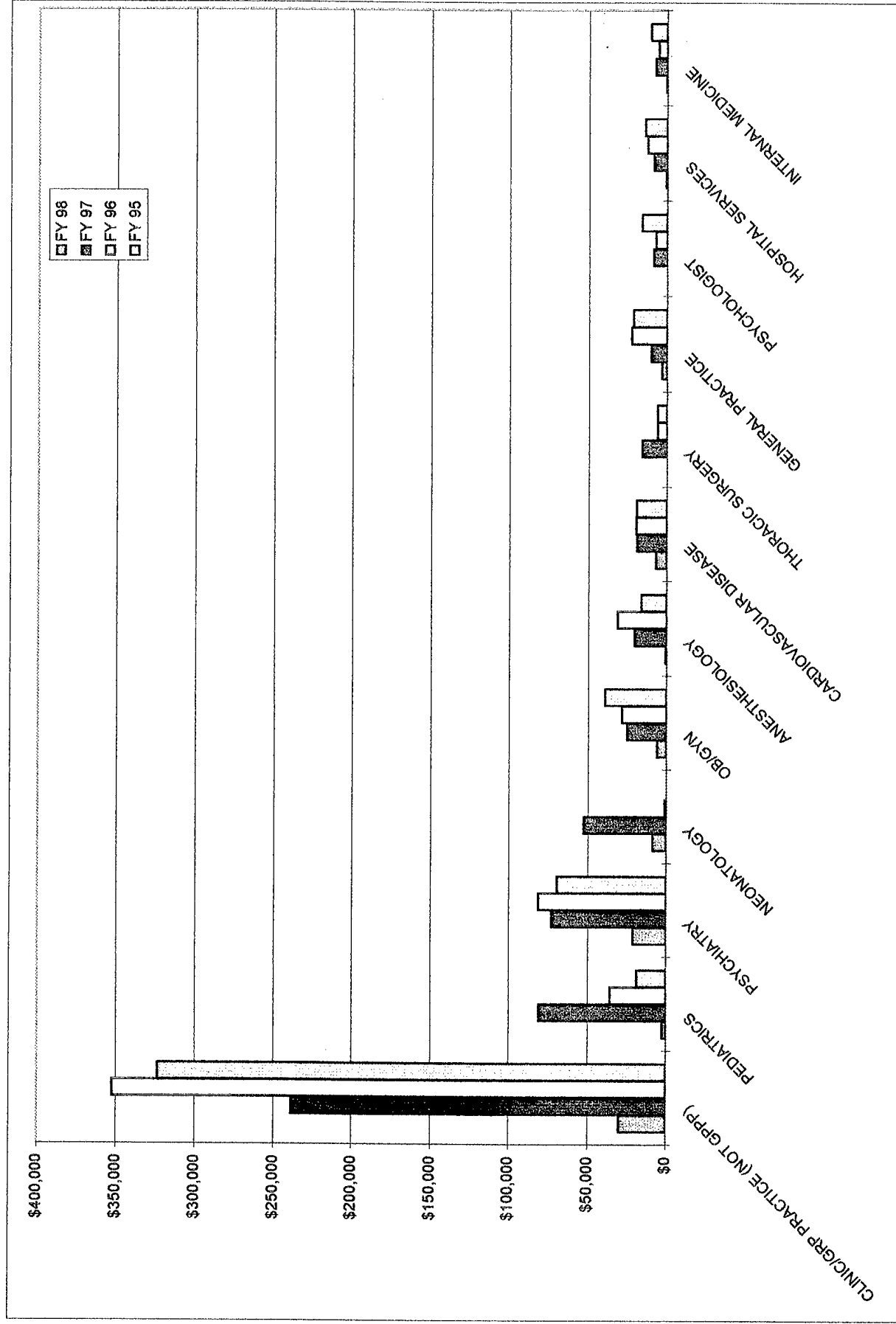
Top 10 Outpatient Providers (CHAMPUS)

Facility/Provider	Visits	Services	Total Gov Cost
Columbia Alaska Regional Hospital	104	420	\$80,230.43
Providence Alaska Medical Center	349	1345	\$48,067.33
Health Links Inc.	980	7	\$47,073.78
Sterling Medical	802	24	\$28,399.71
Charter North Counseling Center	265	71	\$17,471.10
Valley Hospital Palmer	118	390	\$14,785.83
Providance Anchorage Anesthesia	0	37	\$13,126.60
Philip Ricker	309	0	\$12,716.19
Anchorage Rad Therapy	1	152	\$12,421.03
Marget Barnett	0	83	\$12,131.81

Top 10 Services Provided by CHAMPUS Providers by CPT4

Facility/Provider	Visits	Services	Total Gov Cost
Special Supplies	0	1465	\$67,913.49
Individual Psychotherapy	875	11	\$47,512.01
Office/Outpatient Visit, EST (99214)	630	-3	\$23,154.19
Left Heart Catheterization	10	5	\$19,258.01
Special Family Therapy	237	7	\$16,198.91
Psychiatric Interview	188	9	\$14,868.78
Subsequent Hospital Care	0	158	\$11,398.25
New Eye Exam & Treatment	242	0	\$10,370.09
Radiographic Procedure	0	38	\$10,223.53
Special Group Therapy	405	3	\$9,566.37

CHAMPUS EXPENSES BY PROVIDER MAJOR SPECIALTY (INPATIENT)



Note: FY 98 data is as of 8 May 98

Source: MASS

Health Links		* MASS	as of 10 May 98	
CPT Code	Procedure	Episodes	Patient Paid	Govt Paid
90801	PSYCHIATRIC INTERVIEW	112	\$ 163.11	\$ 6,986.26
90844	PSYCHOTHERAPY 45-50 MIN.	296	\$ 125.00	\$ 2,552.05
90847	SPECIAL FAMILY THERAPY	112	\$ 868.24	\$ 16,829.09
90853	SPECIAL GROUP THERAPY	367	\$ 256.76	\$ 8,695.24
Health Links		887	\$ 1,413.11	\$ 35,062.64

Totals FY98		* MASS	as of 18 May 98	
CPT Code	Procedure	Episodes	Patient Paid	Govt Paid
90801	PSYCHIATRIC INTERVIEW	180	\$ 3,686.47	\$ 14,868.78
90844	PSYCHOTHERAPY 45-50 MIN.	875	\$ 23,213.27	\$ 47,512.01
90847	SPECIAL FAMILY THERAPY	237	\$ 3,739.53	\$ 16,198.91
90853	SPECIAL GROUP THERAPY	405	\$ 917.53	\$ 9,566.37
Totals FY98		1,517	\$ 31,536.80	\$ 88,146.07

Health Links		* MASS		
CPT Code	Procedure	Episodes	Patient Paid	Govt Paid
90801	PSYCHIATRIC INTERVIEW	360	\$ 476.74	\$ 22,471.44
90844	PSYCHOTHERAPY 45-50 MIN.	1,380	\$ 2,489.79	\$ 78,320.09
90847	SPECIAL FAMILY THERAPY	438	\$ -	\$ 29,923.76
90853	SPECIAL GROUP THERAPY	1,879	\$ 410.69	\$ 49,113.52
Health Links		4,057	\$ 3,377.22	\$ 179,828.81

Totals FY97		* MASS		
CPT Code	Procedure	Episodes	Patient Paid	Govt Paid
90801	PSYCHIATRIC INTERVIEW	569	\$ 17,329.22	\$ 37,118.60
90844	PSYCHOTHERAPY 45-50 MIN.	3754	\$ 80,146.05	\$ 227,133.50
90847	SPECIAL FAMILY THERAPY	1021	\$ 20,624.26	\$ 71,415.36
90853	SPECIAL GROUP THERAPY	1940	\$ 3,833.07	\$ 51,997.82
Total for all facilities		7284	\$ 121,932.60	\$ 387,665.28

Health Links		* MASS		
CPT Code	Procedure	Episodes	Patient Paid	Govt Paid
90801	PSYCHIATRIC INTERVIEW	428	\$ 732.05	\$ 30,943.85
90844	PSYCHOTHERAPY 45-50 MIN.	1,143	\$ 3,159.77	\$ 63,868.72
90847	SPECIAL FAMILY THERAPY	732	\$ 140.99	\$ 51,926.89
90853	SPECIAL GROUP THERAPY	2,323	\$ 525.13	\$ 71,556.64
Health Links		4,626	\$ 4,557.94	\$ 218,294.10

Totals FY96		* MASS		
CPT Code	Procedure	Episodes	Patient Paid	Govt Paid
90801	PSYCHIATRIC INTERVIEW	776	\$ 21,173.22	\$ 50,860.28
90844	PSYCHOTHERAPY 45-50 MIN.	4,600	\$ 112,495.63	\$ 268,909.82
90847	SPECIAL FAMILY THERAPY	1,530	\$ 23,863.56	\$ 111,703.21
90853	SPECIAL GROUP THERAPY	2,648	\$ 4,722.86	\$ 83,761.09
Total for all facilities		9,554	\$ 162,255.27	\$ 515,234.40

Health Links		* MASS		
CPT Code	Procedure	Episodes	Patient Paid	Govt Paid
90801	PSYCHIATRIC INTERVIEW	416	\$ 286.76	\$ 29,665.57
90844	PSYCHOTHERAPY 45-50 MIN.	719	\$ 2,296.96	\$ 39,228.49
90847	SPECIAL FAMILY THERAPY	387	\$ 565.28	\$ 27,131.04
90853	SPECIAL GROUP THERAPY	3,259	\$ 1,280.16	\$ 119,535.43
Total for all facilities		4,701	\$ 4,429.16	\$ 215,561.33

Total FY95		* MASS		
CPT Code	Procedure	Episodes	Patient Paid	Govt Paid
90801	PSYCHIATRIC INTERVIEW	701	\$ 15,595.67	\$ 47,671.00
90844	PSYCHOTHERAPY 45-50 MIN.	4,575	\$ 119,013.71	\$ 263,416.28
90847	SPECIAL FAMILY THERAPY	1,241	\$ 21,317.83	\$ 88,992.16
90853	SPECIAL GROUP THERAPY	3,845	\$ 11,553.44	\$ 143,246.38
Total for all facilities		9,661	\$ 151,884.98	\$ 495,654.82

177,868.17

	FY95	FY 96	FY 97	Estimated FY 98	Projected 1st Yr	Projected 2nd Yr	Projected 3rd Yr
Health Links	\$ 215,561.33	\$ 218,294.10	\$ 179,828.01	\$ 144,318.10	\$ 177,868.17	\$ 170,968.17	\$ 170,968.17
Total Facilities	\$ 495,654.82	\$ 515,234.40	\$ 387,665.28	\$ 352,584.26	\$ 345,600.54	\$ 345,600.54	\$ 345,600.54
	43%	42%	46%	41%	51%	49%	49%

	FY95	FY 96	FY 97	Estimated FY 98	Projected 1st Yr	Projected 2nd Yr	Projected 3rd Yr
MTF	17,588	19,327	13,701	15,606	16,556	16,297	15,540
Health Links	4,781	4,626	4,057	2,767	3,425	3,425	3,425
Total Facilities	9,661	9,554	7,284	4,566	4,566	4,566	4,566
	49%	48%	56%	61%	75%	75%	75%

