CHAPTER 13
SECTION 13.1

HEALTH MAINTENANCE ORGANIZATIONS (HMOS)

Issue Date: December 29, 1982
Authority: 32 CFR 199.8 and 32 CFR 199.12

I. ISSUE

How will TRICARE reimburse for services rendered to TRICARE beneficiaries by professional corporations and associations and hospitals affiliated with HMOs?

II. BACKGROUND

A. Initially TRICARE did not allow payment for any services provided by HMOs. However, as HMO coverage became more common as primary coverage for TRICARE beneficiaries, we encountered an increasing number of situations where an HMO had specific limitations on what it would cover. The result was that TRICARE beneficiaries were often caught in the middle--this is, they were required to get services through their HMO, but they frequently had to pay significant amounts for those services because of payment limits of the HMO. As a result, TRICARE policy was changed to allow secondary payment where an HMO had specific payment limitations. TRICARE continued to prohibit payment for user's fees, though, since they were nearly always nominal amounts which were less than the administrative cost of processing a claim under TRICARE.

B. HMO coverage continues to expand as well as become more diverse. Limitations on payment continue, but there are also many user's fees which are now quite large. It is not uncommon for an HMO to require its members to pay several hundred dollars for every inpatient admission. Again this results in an unfair burden on many TRICARE beneficiaries.

III. POLICY

A. TRICARE Benefits Provided. Since HMO coverage has become almost as diverse as other third-party coverage, both in terms of benefits and in beneficiary out-of-pocket payments, coverage by an HMO is to be treated the same as any other primary coverage, and normal double coverage procedures as contained in the Policy Manual, the COM-FI, and the OPM are to be followed. Since HMOs frequently have unique provider structures and provide preventive services which are normally not covered by TRICARE, it's important that contractors ensure the following conditions are met for TRICARE payment to be made on a secondary basis.

1. The provider, whether institutional or professional, must meet TRICARE provider certification standards.

2. The services must be a TRICARE benefit and must be medically necessary.

IV. POLICY CONSIDERATIONS

A. HMO Coverage Limitations. When the HMO has a limitation on how much it will pay, TRICARE will reimburse only for that portion of the charge which the HMO does not cover. (This includes emergency services received outside the HMO's normal service area.)

B. Payment Calculations. Calculation of the TRICARE payment will depend upon the bill and follows the same procedures used for pre-paid prescription plans (see Chapter 13, Section 13.3). For services provided directly by an HMO, the only billed charges indicated often will be the beneficiary cost-share / user's fee. Contractors are not required to develop the claim for any other charges, but will process the claim using the indicated billed charge (cost-share / user's fee).

EXAMPLE: $15.00 charge shown for HMO visit
- 3.75 retiree 25% cost-share (deductible has been met)
$11.25 TRICARE payment

When the claim submitted to TRICARE shows total charges for the services and the amount covered by the HMO (either directly or by indicating the remaining beneficiary liability), it will be processed as any other claim with double coverage.

EXAMPLE: $62.00 charge for HMO visit
$15.00 beneficiary liability

Step 1: $62.00 billed charge
$15.50 retiree 25% cost-share (deductible has been met)
$46.50 amount payable by TRICARE without OHI

Step 2: $62.00 billed charge
$47.00 paid by HMO
$15.00 unpaid balance

Step 3: TRICARE pays $15.00

C. Services Rendered to Nonmembers. All covered medically necessary services rendered by an HMO to TRICARE beneficiaries who are not members of the HMO can be reimbursed by TRICARE.

D. HMOs and Partnership. Special provisions exist for beneficiaries with HMO coverage who opt to use Partnership Program services in the military treatment facility. See the OPM Part Two, Chapter 14.

E. Services Obtained Outside the HMO.

1. General. Except as provided above, TRICARE will not reimburse for services which are available through an HMO to its members if for any reason the member obtains the services outside the HMO. Thus, if the HMO would normally cover the services, but it

denies payment because the services could have been provided by the HMO (e.g., psychiatric services which the beneficiary obtained outside the HMO because he didn't like the HMO psychiatrist), TRICARE will not reimburse any amount on the claim. Of course, just as for other double coverage situations, TRICARE will pay for any covered services or amounts which the HMO certifies in writing that they would not have paid or covered even if the services had been obtained through the HMO.

2. Point-of-Service (POS) Options. Some HMOs offer a POS option under which the member may obtain services outside the HMO, but, as a consequence, the member must pay significantly higher cost-shares and/or deductibles. Since TRICARE beneficiaries are prohibited from waiving benefits under a primary coverage, TRICARE will not reimburse the higher cost-shares and/or deductibles under any HMO POS option. Whenever a POS option is used, TRICARE reimbursement is to be limited to any covered services or amounts which the HMO certifies in writing that they would not have paid or covered even if the services had been obtained through the HMO.

V. EXCEPTIONS

This policy does not pertain to cost-saving initiatives under guidelines prescribed by the Secretary of Defense and adopted by the Executive Director, TMA (such as the Health Care Finder - Participating Provider Program (HCF-PPP) under which a MTF may enter into a contractual agreement with a PPO or HMO for the purpose of providing care to TRICARE beneficiaries at discounted rates.)

VI. EFFECTIVE DATE

Upon direction by the Contracting Officer.

- END -