CHAPTER 5
SECTION 2

# LOCALITY-BASED REIMBURSEMENT RATE WAIVER

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## I. APPLICABILITY

This policy is mandatory for reimbursement of services provided by either network or non-network providers. However, alternative network reimbursement methodologies are permitted when approved by the TRICARE Management Activity (TMA) and specifically included in the network provider agreement.

## II. ISSUE

What is the process of the locality-based reimbursement rate waivers?

## III. POLICY

A. On August 28, 2001, the Final Rule was published in the **Federal Register** implementing the FY 2000 and FY 2001 National Defense Authorization Acts (NDAAs) pertaining to waivers to the CHAMPUS Maximum Allowable Charge (CMAC) to ensure access to health care services in the state or locality, assuming that the services are available.

B. Under the locality-based reimbursement rate waiver, two access locations may be considered for provider reimbursement rates above the CMAC. These are:

1. Network Waivers: If it is determined that the availability of an adequate number and mix of qualified health care providers in a network in a specific locality is not found, higher rates may be necessary. The amount of reimbursement would be limited to the lesser of (a) an amount equal to the local fee for service charge; or (b) up to 115% of the CMAC. Our first attempt should be to get the provider to join the network at the prevailing CMAC rate.

2. Locality Waivers: If it is determined that access to specific health care services is severely impaired, higher payment rates could be applied to all similar services performed in a locality, or a new locality could be defined for application of the higher payment rates. Payment rates could be established through addition of a percentage factor to an otherwise applicable payment amount, or by calculating a prevailing charge, or by using another government payment rate. Higher payments will be paid on a claim by claim basis.

C. Coordination of the request for a locality-based reimbursement rate waiver shall be submitted to the TMA Chief, Medical Benefits and Reimbursement Systems (MB&RS) by the

Director, TRICARE Regional Office (DTRO). The Director shall work with the Managed Care Support Contractor (MCSC) to ensure that both are in agreement with the waiver request.

D. The procedures that are to be followed when submitting a waiver are as follows:

1. Identify the waiver that is being requested.

a. Network waivers - needed to ensure availability of an adequate number and mix of qualified network providers.

b. Locality waivers - needed to ensure access to services in a locality defined by a current TRICARE locality or a new one established by zip code.

2. Who can apply:

a. DTRO

b. Providers through the DTRO

c. Beneficiaries through the DTRO

d. MCSC through the DTRO

e. Military Treatment Facility (MTF) through the DTRO

3. How to apply:

a. Applicant must submit a written waiver request to the DTRO. The request must justify that access to health care services is severely impaired due to low reimbursement levels (CMAC payment rates).

b. Justification for the waiver must include at the minimum:

- Number of providers in a locality

- Mix of primary/specialty providers needed to meet patient access standards

- Number of providers who are TRICARE participating

- Number of eligible beneficiaries in the locality

- Availability of MTF providers

- Geographic characteristics

- Efforts that have attempted to create an adequate network, including any additional non-health care payments above the CMAC rates made by the MCSC.

- Letters of intent

- Cost effectiveness

- Other relevant factors that warrant the higher payment to resolve the access to care issue

E. The DTRO shall conduct a thorough analysis and forward recommendations with a cost estimate for approval to the TMA Director or designee through the TMA Contracting Officer (CO) for coordination. Disapprovals by the DTRO will not be forwarded to the TMA Director or designee. The TMA Director or designee is the final approval authority. A decision by the TMA Director or designee to authorize, not authorize, terminate, or modify the authorization of higher payment amounts is not subject to appeal.

1. Network waivers: If the TMA Director or designee approves an increase of up to 15% above the CMAC, the contractor will have the authority to offer designated providers up to 15% above CMAC for joining the network.

2. Locality waivers: If the TMA Director or designee approves a higher payment rate for certain services in a locality, reimbursement rates for those procedure codes in that locality would be adjusted by the managed care support contractor in order to improve the access to services.

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