NETWORK DEVELOPMENT

The contractor shall establish a provider network throughout the region to support TRICARE Prime and TRICARE Extra and to complement *Military Treatment Facility (*MTF*)* capabilities. The network shall meet the standards in paragraph 2.0. The final plan detailing all phases of network implementation shall be submitted through the Regional Director *(RD)* to the Contracting Officer *(CO)* no later than 180 calendar days prior to the initiation of the delivery of health care services. The plan shall address all components of network development, implementation, and operation in all TRICARE Prime *S*ervice *A*reas *(PSAs)* required in this chapter and specified in the contract. The *CO* will approve, deny, or direct changes to the plan no later than the 150th calendar day prior to the start of health care delivery.

1.0. GEOGRAPHIC AVAILABILITY

The contractor shall establish and maintain provider networks, supporting TRICARE Prime and TRICARE Extra, in all *PSAs*, non-*PSAs* (where cost-effective), Base Realignment and Closure (BRAC) sites, throughout all healthcare delivery periods of the contract. (See Chapter 17 for TRICARE Prime Remote *(TPR)* network requirements.) In each area where TRICARE Prime is offered (TRICARE *PSA*), the contractor shall permit enrollment by beneficiaries under the terms and conditions of Chapters 6 and 12. Beneficiaries who live outside TRICARE *PSAs* may enroll in TRICARE Prime, however, they must waive the access standards.

1.1. Areas Where Establishment Of TRICARE Prime And TRICARE Extra Is Required

The contractor shall make TRICARE Prime and TRICARE Extra available in all *PSAs* (see definition in Appendix A), and at all BRAC sites. A listing of all zip codes and geographic locations associated with MTF *PSAs* is available in the Catchment Area Directory published by the Defense Medical Systems Support Center. Where, because of unique circumstances in a *PSA* or in areas that become non-*PSAs* as a result of base closures, the establishment or continuation of TRICARE Prime and/or TRICARE Extra is not feasible, the contractor may request a waiver or delay of this requirement from the *CO*. The request must include the *RD*'s comments and supporting documentation for a waiver or delay.

1.2. Areas Where Establishment Of TRICARE Prime And TRICARE Extra Is Optional

To the extent that it is cost-effective, the contractor may expand TRICARE Prime and TRICARE Extra to areas not described in paragraph 1.1. The geographic availability of TRICARE Extra may exceed that of TRICARE Prime in these areas. For areas where the establishment of TRICARE Prime and Extra is optional, the contractor shall identify the zip codes included in the TRICARE Prime and Extra service areas. After the start of health care delivery, any request to establish TRICARE Prime and TRICARE Extra in non-*PSAs* shall be submitted with fully supporting documentation through the *RD* to the *CO* for approval.

1.3. *Areas Where Establishment Of An Originating Site For Telemental Health (TMH) Is Required*

As a minimum, one civilian originating site within 40 miles of each MTF (defined by Section J of each MCS contract), and one civilian originating site more than 40 miles from an MTF (defined by Section J of each MCS contract) with a high concentration of TPR and/or TRICARE Reserve Select (TRS) for each region.

2.0. NETWORK REQUIREMENTS AND STANDARDS

The contractor shall establish, in consonance with the *RD*s, provider networks through contractual arrangements. In areas where TRICARE networks are in existence, the contractor shall offer all existing network providers the opportunity to participate in the contractor's network (subject to the conditions, criteria and standards established for the Regions). Network requirements and standards are listed below.

2.1. *RD*s And MTF Interface In Provider Network Development

Prior to the contractor finalizing the civilian network, MTF Commanders and the *RD*s shall be given an opportunity to provide input into the development of the network in their *PSAs* and the BRAC sites. The contractor shall meet with the *RD* and all MTF Commanders within 30 calendar days of the award to obtain their network size and specialty makeup input. The contractor shall follow the MTF Commander's directions regarding the priorities for the assignment of enrollees to primary care managers. MTF Commanders have sole authority for granting clinical privileges to resource sharing providers at the MTFs.

2.2. Standards For Network Providers

Network and access to care standards are in 32 CFR 199.17. The network shall comply with standards set by the Government or standards proposed by the contractor, whichever are more stringent. Each *PSA* or non-*PSA* where TRICARE Prime is established is considered to be a separate service area to which the standards apply. The contractor shall develop and implement a system for continuously monitoring and evaluating network adequacy.

2.3. Participation On Claims

All network provider contracts shall require the provider to participate on all claims and submit claims on behalf of all *Military Health System (*MHS*)* and Medicare beneficiaries.

2.4. Balance Billing

2.4.1. Providers in the contractor's network may only bill MHS beneficiaries for applicable deductibles, co-payments, and/or cost-sharing amounts; they may not bill for charges which exceed contractually allowed payment rates. Network providers may only bill MTFs/MCSCs for services provided to *A*ctive *D*uty *S*ervice *M*embers *(ADSMs)* at the contractually agreed amount, or less, and may not bill for charges which exceed the contractually agreed allowed payment amount. The contractor shall include this provision in provider contracts and shall provide the *RD*s and each MTF Commander with a list of all

network providers, their addresses and phone numbers, their specialties or types of service (*Durable Medical Equipment (*DME*)*, supplies, etc.), and their contractually agreed allowable amount (discounts or price list) by the tenth (10th) calendar day prior to the start of health care delivery and by the tenth (10th) calendar day prior to the start of each calendar quarter thereafter. (Such lists shall be provided in an electronic or paper format acceptable to the *RD*.)

2.4.2. Network providers shall never bill an MHS eligible beneficiary for more than the contractually agreed amount for TRICARE Prime enrollees with civilian network *Primary Care Managers (*PCMs*)*. The contractor shall ensure that the amount charged MHS beneficiaries without civilian network PCMs is the same as the amount charged TRICARE Prime enrollees with civilian network PCMs even though the reimbursement mechanism may be different (e.g., capitated reimbursement mechanism may be different (e.g., capitated arrangements for TRICARE Prime enrollees with civilian network PCMs and fee-for-service arrangements for all other MHS beneficiaries). If the contractor is using different reimbursement mechanisms, the contractually agreed amount shall be equal to or less than the CHAMPUS allowable amount minus the discount the contractor proposed receiving as a result of the capitated reimbursement amount agreed to with the provider.

2.5. Billing For Non-Covered Services (Hold Harmless)

2.5.1. A network provider may not require payment from the beneficiary for any excluded or excludable services that the beneficiary received from the network provider (i.e., the beneficiary will be held harmless) except as follows:

- If the beneficiary did not inform the provider that he or she was a TRICARE beneficiary, the provider may bill the beneficiary for services provided.

- If the beneficiary was informed that the services were excluded or excludable and he/she agreed in advance to pay for the services, the provider may bill the beneficiary. An agreement to pay must be evidenced by written records ("written records" include for example: 1) provider notes written prior to receipt of the services demonstrating that the beneficiary was informed that the services were excluded or excludable and the beneficiary agreed to pay for them; 2) a statement or letter written by the beneficiary prior to receipt of the services, acknowledging that the services were excluded or excludable and agreeing to pay for them; 3) statements written by both the beneficiary and provider following receipt of the services that the beneficiary, prior to receipt of the services, agreed to pay for them, knowing that the services were excluded or excludable). General agreements to pay, such as those signed by the beneficiary at the time of admission, are not evidence that the beneficiary knew specific services were excluded or excludable.

2.5.2. Certified marriage and family therapists (both network and non-network), in their participation agreements with TRICARE, agree to hold eligible beneficiaries harmless for non-covered care.

2.5.3. The beneficiary will be entitled to a full refund of any amount paid by the beneficiary for the excluded services, including any deductible and cost-share amounts, provided the beneficiary informed the network provider (or the network or non-network

certified marriage and family therapist) that he or she was a TRICARE beneficiary, and did not agree in advance to pay for the services after having been informed that the services were excluded or excludable. In order to obtain a refund, the beneficiary is not required to ask the provider to return the payments the beneficiary has made for excluded services. Instead, the beneficiary will be refunded any payments made by the beneficiary or by another party on behalf of the beneficiary (excluding an insurer or provider) for the excluded services. The beneficiary, or other party making payment on behalf of the beneficiary, must request a refund in writing from the contractor by the end of the sixth month following the month in which payment was made to the provider or by the end of the sixth month following the month in which the *Peer Review Organization (*PRO*)* or *TRICARE Management Activity (*TMA*)* advised the beneficiary that he or she was not liable for the excludable services. The time limit may be extended where good cause is shown. Good cause is defined as:

- Administrative error, such as, misrepresentation or mistake or an officer or employee of TMA or a PRO if performing functions under TRICARE and acting within the scope of the officer's or employee's authority.

- Mental incompetence of the beneficiary or, in the case of a minor child, mental incompetence of his or her guardian, parent, or sponsor.

- Adjudication delays by *O*ther *H*ealth *I*nsurance *(OHI)* (when not attributable to the beneficiary), if such adjudication is required under 32 CFR 199.8 (Double Coverage).