Chapter 5 Section 1

Network Development

Revision:

The contractor shall provide a plan for establishing a provider network throughout the region to support TRICARE Prime and TRICARE Extra and to complement Military Treatment Facility (MTF)/ Enhanced Multi-Service Market (eMSM) capabilities. The network shall meet the standards in paragraph 2.0.

1.0 GEOGRAPHIC AVAILABILITY

1.1 The contractor shall establish and maintain provider networks, supporting TRICARE Prime and TRICARE Extra, in all Prime Service Areas (PSAs), throughout all health care delivery periods of the contract. (See Chapter 16 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 11. The contractor shall enroll beneficiaries only to MTF/ eMSM Primary Care Managers (PCMs) or to PCMs in the PSA network.

1.1.1 The contractor will not be required to establish a network with the capability and capacity to grant new enrollments to beneficiaries who reside outside a PSA. The contractor shall grant a request for a new enrollment to the network from a beneficiary residing outside a PSA provided there is sufficient unused network capability and capacity to accommodate the enrollment, the PSA network PCM to be assigned is located less than 100 miles from the beneficiary's residence, and the beneficiary waives both primary and specialty care travel time standards.

1.1.2 The contractor shall actively seek institutional and individual providers (medical and behavioral health) for their network who:

- Produce the best quality clinical outcomes;
- Use "evidence-based medicine;"
- Report outcome data, preventive measures date, and laboratory data; and
- Are willing to refer/transfer TRICARE beneficiaries for care at MTFs/eMSMs when appropriate.

1.1.3 The contractor shall profile and monitor individual and institutional provider performance in an ongoing manner using profiling/monitoring parameters that address, but are not limited to, cost-of-care, clinical quality of care to include population health/prevention practices as appropriate, patient satisfaction and access. These profiles and parameters shall be based on current and evolving sources of outcomes and performance data (i.e., Hospital Compare), kept current (updated biannually

at a minimum) and available for review by the Government at all times. Beneficiaries shall be referred to providers with the best outcomes wherever possible. Where available, National Committee for Quality Assurance (NCQA) accredited (or other nationally accepted accrediting organizations) primary care medical homes shall be recruited to the network to provide care for beneficiaries with two or more chronic illnesses.

1.1.4 The contractor shall create and maintain an on-line list of network providers. The list shall include provider specialty, sub-specialty, gender, work address, work fax number, and work telephone number for each service area, and whether or not they are accepting new beneficiaries. The contractor shall provide web access to this list, making it available for all beneficiaries, providers, and Government representatives (refer to Chapter 11, Section 4, paragraph 5.1 for non-network list).

1.2 Areas Where Establishment Of TRICARE Prime And TRICARE Extra Is Required

The contractor shall make TRICARE Prime and TRICARE Extra available in all PSAs. PSAs are the entire area of all the zip codes lying within or intersected by the 40-mile radius around enrolling MTFs/eMSMs and Base Realignment and Closure (BRAC) sites. Each contract contains a list of mandatory PSA sites.

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

To the greatest extent practical, the contractor shall establish one civilian originating site within 40 miles of each MTF/eMSM (defined by Section J of the contract), and one civilian originating site more than 40 miles from an MTF/eMSM with a high concentration of TPR and/or TRICARE Reserve Select (TRS) for each region. (See the TRICARE Policy Manual (TPM), Chapter 7, Section 22.1 for additional information.) These originating site criteria are not applicable to telemedicine other than TMH (see paragraph 1.4).

1.4 Provision Of Telemedicine (Other Than TMH)

To the greatest extent practical, the contractor shall offer telemedicine (other than TMH) to all TRICARE beneficiaries, regardless of location. There are no geographical restrictions or limitations regarding originating site locations, other than the general requirements for originating and distant sites as identified in the TPM, Chapter 7, Section 22.1.

2.0 NETWORK REQUIREMENTS AND STANDARDS

The contractor shall establish, in consonance with the Director, TRICARE Regional Offices (TROs), provider networks through contractual arrangements. Network requirements and standards are listed below.

2.1 Director, TROs And MTF/eMSM Interface In Provider Network Development

Prior to the contractor finalizing the civilian network, MTF Commanders/eMSM Managers and the Director, TROs 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 Director, TROs and all MTF Commanders/eMSM Managers within 30 calendar days of the award to obtain their network size and specialty makeup input. The contractor shall follow the MTF Commander's/eMSM Manager's directions

regarding the priorities for the assignment of enrollees to PCMs.

2.2 Standards For Network Providers

Network and access to care standards are in 32 CFR 199.17. Each PSA 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 and for reporting network adequacy or access issues according to contract requirements. The contractor shall submit its implementation plan for network access standard reporting in accordance with the Contract Data Requirements List (CDRL).

2.3 Participation On Claims

All network provider agreements shall require the provider to participate on all claims and submit claims on behalf of all Military Health System (MHS) and Medicare beneficiaries. All network provider agreements shall include the following provision:

2.3.1 The submission of a claim by a physician or supplier or their representative certifies that the services shown on the claim are medically indicated and necessary for the health of the patient and were personally furnished by the physician/supplier or furnished incident to his/her professional service by his/her employee under his/her immediate personal supervision, except as otherwise permitted by Medicare or TRICARE regulations. For services to be considered as "incident" to a physician's professional service:

- They must be rendered under the physician's immediate personal supervision by his/her employee;
- They must be an integral, although incidental part of a covered physician's service;
- They must be of kinds commonly furnished in physician's offices; and
- The services of non-physicians must be included on the physician's bills.

2.3.2 The non-institutional network provider/supplier further certifies that he/she (or any employee) who rendered services is not an active duty member of the Uniformed Services or a civilian employee of the U.S. Government (refer to 5 United States Code (USC) 5536). An exception exists for part-time Department of Veterans Affairs employees fulfilling the requirements of Chapter 4, Section 1, paragraph 3.0. Anyone who misrepresents or falsifies essential information to receive payment from Federal funds may upon conviction be subject to fine and imprisonment under applicable Federal law.

2.4 Balance Billing

2.4.1 Providers in the contractor's network may only bill MHS beneficiaries for applicable deductibles, copayments, and/or cost-sharing amounts. They may not bill for charges which exceed contractually allowed payment rates. Network providers may only bill MTFs/eMSMs/contractors for services provided to Service members 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.

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 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. 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 approved, alternative reimbursement method 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 shall 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.The beneficiary shall 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 the Defense Health Agency (DHA) 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, of an officer or employee of

DHA 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 Other Health Insurance (OHI) (when not attributable to the beneficiary), if such adjudication is required under 32 CFR 199.8.

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