Chapter 1 Section 1.1

General Policy And Responsibilities

Issue Date:
Authority: 32 CFR 199
Revision: C-25, June 15, 2018

1.0 PROGRAM DESCRIPTION

TRICARE is the Department of Defense's (DoD) managed health care program for Service members, service families, retirees and their families and survivors. A key feature of the DoD's managed care implementation is the creation within the United States (U.S.) of two Health Services Regions. Within each region, a Director, TRICARE Regional Offices (TROs) is responsible for managing health care services in the region.

2.0 OFFICE OF RECORD

The Medical Benefits and Reimbursement Division (MB&RD) is the "office of record" for the TRICARE Policy Manual (TPM) and TRICARE Reimbursement Manual (TRM). In accordance with Federal Acquisition Regulations (FAR), Subpart 37.203, contractors cannot make policy decisions, as this is an inherent Government function. Consistent with Subpart 7.503, the Office of MB&RD has the responsibility for ensuring that all medical benefits considered for cost-sharing under TRICARE are supported by scientific peer reviewed literature and within the constraints of the law and regulation. These responsibilities include promulgating policy interpretations and maintaining continuous regulatory and policy updates based on Congressional mandate and the current standards of medical care.

3.0 GENERAL POLICY

3.1 Through December 31, 2017, TRICARE offers beneficiaries three health care options:

3.1.1 TRICARE Prime Plan

Beneficiaries who enroll in TRICARE Prime are assigned or select a Primary Care Manager (PCM). A PCM is a provider of primary care, who furnishes or arranges for all health care services required by the Prime enrollee. Military Treatment Facility (MTF)/Enhanced Multi-Service Market (eMSM) Commanders have the authority and responsibility to set priorities for enrollment to MTF/eMSM PCMs. When an MTF's/eMSM's primary care capacity is full, civilian PCMs, who are all part of the contractor's network, are available to provide care to patients.

3.1.1.1 Expanded benefits. As enrollees of Prime, patients receive certain clinical preventive services that are provided without cost-share for the patient.

3.1.1.2 Reduced cost. Prime enrollees' cost-share for civilian services is substantially reduced from that which is applicable under TRICARE Extra and TRICARE Standard. In addition, when a TRICARE Prime enrollee is referred to a non-participating provider, the enrollee is only responsible for the copayment amount, but not for any balance billing amount by the non-participating provider.

3.1.2 TRICARE Extra Plan

Beneficiaries who do not enroll in Prime may still benefit from using the providers in the contractor's network where possible. On a case by case basis, beneficiaries may participate in TRICARE Extra by receiving care from a network provider. The beneficiary will take advantage of the reduced charges under Extra and a reduction in cost-shares. Covered services are the same as under TRICARE Standard. This option is terminated as of December 31, 2017 and replaced by TRICARE Select.

3.1.3 TRICARE Standard Plan

The TRICARE Standard plan is a fee-for-service program. This option is terminated as of December 31, 2017 and replaced by TRICARE Select.

3.2 Beginning January 1, 2018, the TRICARE program consists of three options: TRICARE Prime, TRICARE Select, and TRICARE For Life (TFL). See 10 United States Code (USC) 1072(7).

3.2.1 TRICARE Prime Plan

TRICARE Prime is a Health Maintenance Organization (HMO)-like program. It generally features use of MTFs and substantially reduced out-of-pocket costs for authorized care provided outside MTFs. Beneficiaries generally agree to use MTFs and designated civilian provider networks and to follow certain managed care rules and procedures. Beneficiaries who enroll in TRICARE Prime are assigned or select a PCM. A PCM is a provider of primary care, who furnishes or arranges for all health care services required by the Prime enrollee. MTF/Enhanced Multi-Service Market (eMSM) Commanders have the authority and responsibility to set priorities for enrollment to MTF/ eMSM PCMs. When an MTF's/eMSM's primary care capacity is full, civilian PCMs, who are all part of the contractor's network, are available to provide care to patients.

3.2.2 TRICARE Select Plan

TRICARE Select is a self-managed, Preferred Provider Organization (PPO) program. It allows beneficiaries to use the TRICARE civilian provider network, with reduced out-of-pocket costs compared to care from non-network providers, as well as military facilities (where they exist and when space is available). Similar to the long-operating "TRICARE Extra" and "TRICARE Standard" plans, which this replaces, a major feature of TRICARE Select is that enrollees will not have restrictions on their freedom of choice with respect to health care providers. TRICARE Select is based primarily on 10 USC 1075 (as added by Section 701 of National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2017 and 10 USC 1097.

3.2.3 TFL Plan

TFL is the Medicare wraparound coverage plan under 10 USC 1086(d).

3.3 Eligibility for TRICARE

3.3.1 Active Duty Eligibility

All active duty members are considered TRICARE Prime. They must, however, take action to be enrolled in Prime, and be assigned to a PCM (see the TRICARE Operations Manual (TOM) for PCM provisions under the TRICARE Prime Remote (TPR) program).

3.3.2 Non-Active Duty Eligibility

All individuals entitled to civilian health care under 10 USC Sections 1079 or 1086, are eligible for TRICARE. Beginning January 1, 2018, beneficiaries other than TFL beneficiaries must enroll in a TRICARE plan to receive care outside the Direct Care (DC) only system. Non-active duty individuals, commonly referred to as "TRICARE eligibles", include the spouse and children of active duty personnel, retirees and their spouses and children, and survivors.

Note: This group also includes former spouses as defined in 10 USC Section 1072(2). Not included are those individuals who are entitled to care in the DC system, on a space available basis, but ordinarily are not entitled to civilian care, such as family member parents and parents-in-law.

3.3.3 TFL

Pursuant to Section 712 of the NDAA for FY 2001, Medicare eligible beneficiaries based on age, whose TRICARE eligibility is determined by 10 USC Section 1086, are eligible for Medicare Part A, and those who are enrolled in Medicare Part B, are eligible for the TRICARE benefit effective October 1, 2001. These beneficiaries are not eligible to enroll in TRICARE Prime. TFL beneficiaries older than age 65 cannot enroll in TRICARE Prime (exception for grandfathered Uniformed Services Family Health Plan (USFHP) enrollees). Retirees and their family members under age 65 who have Medicare coverage due to disability or with end stage renal disease can enroll in TRICARE Prime if they have Medicare Part B. Their Prime enrollment fees are waived if they have Part B coverage. Retirees, dependents, and survivors with any Medicare coverage at any age are not eligible to enroll in TRICARE Select because they are excluded from the "Retired Category" for TRICARE Select as defined in 10 USC 1075(b)(1)(B).

3.3.4 Supplemental Health Care Program (SHCP) and TPR Program

See the TOM, Chapters 16 and 17.

3.3.5 Non-DoD TRICARE Eligibles

TRICARE eligibles sponsored by non-DoD uniformed services (the Public Health Service (PHS), the U.S. Coast Guard (USCG), and the National Oceanic and Atmospheric Administration (NOAA)) are eligible for TRICARE and may enroll in TRICARE Prime or TRICARE Select (beginning January 1, 2018).

3.3.6 North Atlantic Treaty Organization (NATO) And Partnership For Peace (PFP) Beneficiaries

3.3.6.1 NATO or PFP Active Duty Service Member (ADSM)

As specified in applicable Status of Forces Agreements (SOFAs), active duty members of the

armed forces of NATO and PFP nations qualify for TRICARE outpatient services in similar fashion as their U.S. Armed Forces counterparts. There is no coverage for inpatient purchased care sector care. See the TOM, Chapter 17, Section 3, for more information.

3.3.6.2 NATO or PFP Family Members

Family members of active duty members of the armed forces of NATO and PFP nations are eligible for outpatient care under TRICARE and may access care under TRICARE Standard/Extra with ADFM cost-shares through December 31, 2017. Effective January 1, 2018, their outpatient-only care may be accessed under the TRICARE Select program with Group B ADFM cost-shares. There is no eligibility or coverage for TRICARE inpatient services. See TOM, Chapter 17, Section 3 and TRM, Chapter 2, Section 2, for more information..

3.3.7 Enrollment

Starting in calendar year 2018, beneficiaries other than active duty members and TFL beneficiaries need to elect to enroll in TRICARE Select or TRICARE Prime in order to be covered by the private sector care portion of TRICARE. Enrollment will be done during an open season period prior to the beginning of each plan year, which operates with the calendar year. An enrollment choice will be effective for the plan year. As an exception to the open season enrollment rule, enrollment changes can be made during the plan year for certain qualifying events, such as a change in eligibility status, marriage, divorce, birth of a new family member, relocation, loss of Other Health Insurance (OHI), or other events. Beneficiaries eligible to enroll in TRICARE Prime or TRICARE Select plans who do not enroll or fail to qualify to maintain their TRICARE Prime or TRICARE Select enrollment status no longer have coverage under the TRICARE Program (including the TRICARE retail pharmacy and Mail Order Pharmacy (MOP) programs), and may not qualify to re-enroll until the following annual open season enrollment period or until the sponsor or an eligible family member experiences a Qualifying Life Event (QLE), whichever comes first. Such beneficiaries eligible to enroll in TRICARE Prime or TRICARE Select do not lose any statutory entitlement to space-available care in MTFs/eMSMs.

Note: Included in all of the TRICARE benefit packages is a retail pharmacy network and a mail service pharmacy program. Beneficiaries must be enrolled to a plan to receive pharmacy services outside the DC system.

3.4 Administrative Policy

3.4.1 Benefit Policy

3.4.1.1 Benefit policy applies to the scope of services and items which may be considered for cost-sharing by the TRICARE within the intent of the 32 CFR 199.

3.4.1.2 The current edition of the American Medical Association's (AMA's) **Physicians' Current Procedural Terminology** (CPT) is incorporated by reference into this Manual to describe the scope of services potentially allowable as a benefit, subject to explicit requirements, limitations, and exclusions, in this Manual or in the 32 CFR 199.

3.4.1.3 Procedures listed in the CPT and the Healthcare Common Procedure Coding System (HCPCS) may be cost-shared only when the procedure is "appropriate medical care" <u>and</u> is "medically or

psychologically necessary" and is not "unproven" as defined in the 32 CFR 199.4(g)(15), and the procedure is not explicitly excluded in the TRICARE program.

3.4.2 Program Policy

Program Policy applies to beneficiary eligibility, provider eligibility, claims adjudication, and quality assurance. Program policy implementation instructions are found in the TRICARE Systems Manual (TSM) and the TOM.

3.4.3 Any benefit or program administration issue for which benefits or program operation policy guidance is required, or when TRICARE policy is silent on an issue, the contractor shall describe in writing and submit to the Team Chief, MB&RD, Defense Health Agency (DHA).

3.4.4 Reimbursement Policy

3.4.4.1 Reimbursement policy sets forth the payment procedures used for reimbursing TRICARE claims. The related implementation instructions for these payment procedures are found in the TSM and the TOM.

3.4.4.2 The TRM provides the methodology for pricing allowable services and items and for payment to specific categories and types of authorized allowable services and items and for payment to specific categories and types of authorized providers. These methods allow the contractor to price and render payment for specific examples of services or items which are not explicitly addressed in the Manual but which belong to a general category or type which is addressed in the Manual.

3.5 Administrative and Effective Dates

3.5.1 Issuance Date

The date located on the first page of each separate policy issuance. This is the date that the issuance was initially issued by DHA.

3.5.2 Revision Date

The revision date is at the bottom of each page that has been revised along with the change number. This is the date that DHA changed the issuance in any way. Each time an issuance is changed, the revised page and/or issuance is given a change number. The revision date and the change number together identify a unique version of the issuance on a specific subject.

3.5.3 Effective Date

A date within the body of the text of an issuance which establishes the specific date that a policy is to be applied to benefit adjudication or in program administration. An effective date may be earlier than the issuance or revision date. This date is explicit (e.g., Effective Date: January 1, 2004). The policy effective date takes precedence over the issuance date and the revision date. In the absence of an effective date the policy or instruction is considered to have always been applicable because the newly published policy or instruction confirms the application of existing published program requirements.

3.5.4 Implementation Date

The implementation date of a policy or instruction is not noted in the issuance as this date is determined by the terms of the contract modification between DHA and the contractor. Unless otherwise directed by DHA, contractors are not to identify finalized claims for readjudication under revised or new policy. However, the contractor shall readjudicate any denied claim affected by the policy that is brought to the contractor's attention by any source. Pending claims and denied claims in reconsideration shall be adjudicated using the current applicable policy.

4.0 GENERAL RESPONSIBILITIES

4.1 Director, TROs

The Director, TROs, working with all the MTFs/eMSMs within the region, is responsible for organizing and managing health care delivery for all TRICARE and the Military Health System (MHS) beneficiaries in the region. Supporting the Director, TROs is a contractor with responsibility for establishing a network of health care providers to supplement the care available at the MTFs/eMSMs and for performing a variety of health care administrative services on behalf of the Director, TROs. The Director, TROs are also responsible for planning and delivering services to meet the health needs of the beneficiaries in the region, whether through the MTFs/eMSMs or the contractor. The Director, TROs is primarily responsible for oversight and administration of those tasks in the MCS contract that relate to the delivery and management of care.

4.2 Military Treatment Facility (MTF)/Enhanced Multi-Service Market (eMSM) Commanders

MTF/eMSM Commanders are responsible for managing health care delivery for the active duty personnel and TRICARE eligibles who are enrolled in Prime with MTF/eMSM PCMs, as well as for providing care to other TRICARE and the MHS beneficiaries who are eligible for care in MTFs/eMSMs. The MTF Commander/eMSM Manager sets priorities for assignment of MTF/eMSM PCMs and works directly with the contractor in network development, resource sharing arrangements and similar local initiatives (see the TOM, Chapter 17 for SHCP).

4.3 Contractor

The contractor (managed care support and TRICARE Overseas) shall be responsible for establishing provider networks in those Prime Service Areas (PSAs) and Base Realignment and Closure (BRAC) sites designated by the Director, TROs. Effective January 1, 2018, the contractor is responsible for establishing provider networks in non-PSAs accessible by at least 85% of TRICARE Select enrollees in the region and in overseas areas where a preferred network provider is determined by the Director, Defense Health Agency to be economically in the best interest of the DoD. The provider networks must include both primary care providers and specialists. The contractor shall ensure that first priority for referral of Prime enrollees for specialty care or inpatient care is the MTF/eMSM. The contractor processes all claims for all beneficiaries, except for TFL, who reside in the Region and performs other tasks specified in the contracts and the manuals. The contractor has a number of responsibilities for support of the Director, TROs as well as the MTF/eMSM.

4.4 TRICARE Dual Eligible Fiscal Intermediary Contract (TDEFIC) Contractor

The TDEFIC contractor is responsible for processing all TRICARE claims for services rendered within the 50 U.S. and the District of Columbia, as well as Puerto Rico, Guam, the U.S. Virgin Islands, American Samoa, and the Northern Mariana Islands, to individuals who have dual eligibility under both TRICARE and Medicare.

4.5 Administrative Personnel

The Procurement Contracting Officer (PCO) and the Contracting Officer's Representative (COR) are DHA personnel who oversee the functions of the MCS contract, with special emphasis in areas such as claims processing, and who coordinate contract oversight and administration among the variety of TRICARE Regional Office staff. The PCO is the sole authority for directing the contractor or modifying provisions of the contract (some of this authority may be delegated to the Administrative Contracting Office (ACO) of the Director, TROs).

4.6 Assistant Secretary Of Defense (Health Affairs) (ASD(HA))

Overall policy for TRICARE is established by the ASD(HA).

5.0 GEOGRAPHIC AVAILABILITY

5.1 TRICARE is effective throughout the U.S. TRICARE Overseas Program (TOP) regions are established but operate under different procedures than TRICARE in the U.S.

5.2 Within a region, the contractor is required to create a provider network to support PSAs and BRAC sites. Beginning January 1, 2018, the contractor is required to also provide a network to meet TRICARE Select standards. In overseas regions, the contractor shall establish a network as authorized by the Director, DHA to support a special Prime program; this network may be accessed by Select enrollees based on available resources. In addition to support for the TOP Prime program, a network for TOP Select enrollees shall be established only in geographical areas determined by the Director, DHA to be economically in the best interest of the DoD.

5.3 Through December 31, 2017, the contractor shall be responsible to establish a provider network sufficient to support offering TRICARE Extra in as many non-PSAs as patient population (including enrollees in the TPR Program) and provider availability make cost effective.

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