Chapter 5 Section 1

Network Development

The contractor shall provide a plan for establishing a provider network throughout the region to support TRICARE Prime and TRICARE Extra (through December 31, 2017) and TRICARE Select (starting January 1, 2018) and to complement Military Treatment Facility (MTF) capabilities. The network shall meet the standards in paragraph 2.0. This section does not apply to the Uniformed Services Family Health Plan (USFHP), TRICARE Dual Eligible Fiscal Intermediary Contract (TDEFIC), or pharmacy contracts.

In this section, reference to TRICARE Select are required as of January 1, 2018.

The requirement to establish and maintain provider networks specifically to support TRICARE Select enrollees does not apply to transitioning out Managed Care Support (MCS) contracts.

1.0 GEOGRAPHIC AVAILABILITY

1.1 The contractor shall establish and maintain provider networks, supporting TRICARE Prime and TRICARE Extra (through December 31, 2017) and TRICARE Select (starting January 1, 2018), in all Prime Service Areas (PSAs), and non-Prime Service Areas (nPSAs) throughout all health care delivery periods of the contract. (See Chapter 16 for TRICARE Prime Remote (TPR) network requirements.) In each area where enrollment 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 TRICARE Prime beneficiaries only to MTF Primary Care Managers (PCMs) or to PCMs in the PSA network. The locations where TRICARE Prime will be offered will be determined by the Director, Defense Health Agency (DHA) and announced prior to the annual open enrollment period. TRICARE Prime will be offered in areas where the Director, DHA determines that it is appropriate to support the effective operation of one or more Military Treatment Facilities (MTFs). In addition, provider networks shall be available to at least 85% of the TRICARE Select beneficiaries residing within the region (50 United States (US) and District of Columbia only). In overseas regions, the contractor shall establish a network as authorized by the Director to support a special Prime program; this network may be accessed by Select enrollees based on available resources. In addition to support for the TRICARE Overseas Program (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 Department of Defense. The requirement to establish and maintain provider networks in nPSAs specifically to support TRICARE Select enrollees does not apply to transitioning out Managed Care Support Contractors (MCSCs).

1.1.1 TRICARE Prime

The contractor shall establish a network with the capability and capacity to grant new enrollments to TRICARE Prime enrollees who reside inside a PSA. The contractor shall grant a request for a new TRICARE Prime 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 mental health) for their network who:

- Produce the best quality clinical outcomes;
- Use "evidence-based medicine;"
- Report outcome data, preventive measures data, and laboratory data; and
- Are willing to refer/transfer TRICARE beneficiaries for care at MTFs 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 all 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 a PCM. 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 for non-network list).

1.2 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 (defined by Section J of each Managed Care Support (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. 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.

1.3 Provisions Of Telemedicine (Other Than TMH)

Health care services covered by TRICARE and provided through the use of telehealth modalities are covered services to the same extent as if provided in person at the location of the patient if those services are medically necessary and appropriate for such modalities. 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 TRICARE Regional Office (TRO) Chief Operating Officers (COOs), provider networks through contractual arrangements. Network requirements and standards are listed below.

2.1 TRO COOs And MTF Interface In Provider Network Development

Prior to the contractor finalizing the civilian network, MTF Commanders and the TRO COOs shall be given an opportunity to provide input into the development of the network in the region. The contractor shall meet with the TRO COO 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 PCMs.

2.2 Standards For Access To Network Providers

2.2.1 Network and access to care standards for TRICARE Prime enrollees are in 32 CFR 199.17. Each PSA established is considered to be a separate service area with a separate provider network. The contractor shall develop and implement a system for continuously monitoring and evaluating network adequacy.

2.2.2 Under TRICARE Select, eligible beneficiaries will not have restrictions on their freedom of choice with respect to health care providers with reduced out-of-pocket costs for use of civilian network providers. At least 85% of the TRICARE Select enrollees in each region (50 United States and District of Columbia only) shall have access to a network of providers. Contractors shall utilize their sizing models to establish network contracting targets sufficient to support the program's access standards and network expansion that meets or exceeds the National Defense Authorization Act (NDAA) for FY 2017 requirement.

2.2.3 The contractor must ensure access standards for appointments for health care for nPSAs that meet or exceed those of high-performing health care systems in the United States, establish mechanisms for monitoring compliance with access standards, establish health care provider-to-beneficiary ratios, monitor on a monthly basis complaints by beneficiaries with respect to network adequacy and the availability of health care providers, establish requirements for mechanisms to monitor the responses to complaints by beneficiaries, and establish mechanisms to evaluate the quality metrics of the network providers established under NDAA FY 2017, Section 728. This paragraph only applies to the contractors in the 50 United States and District of Columbia unless as directed in overseas areas by the Director, DHA. See TPM, Chapter 1, Section 1.1.

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 (DVA)/Veterans Health Administration (VHA) 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/contractors for services provided to Active Duty Service Members (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.

2.4.2 Network providers shall never bill an MHS eligible beneficiary for more than the contractually agreed amount, regardless of the beneficiary's TRICARE health plan coverage. 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 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 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, or 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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