



TRICARE
MANAGEMENT ACTIVITY

MB&RB

**OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
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accordance with the utilization management rules and procedures of Prime.

(vi) In accordance with guidelines issued by the Assistant Secretary of Defense for Health Affairs, certain travel expenses may be reimbursed when a TRICARE Prime enrollee is referred by the primary care manager for medically necessary specialty care more than 100 miles away from the primary care manager's office received on or after October 30, 2000. Such guidelines shall be consistent with appropriate provisions of generally applicable Department of Defense rules and procedures governing travel expenses.

(3) Point-of-service option. TRICARE Prime enrollees retain the freedom to obtain services from civilian providers on a point-of-service basis. In such cases, all requirements applicable to standard CHAMPUS shall apply, except that there shall be higher deductible and cost sharing requirements (as set forth in paragraphs (m)(1)(i) and (m)(2)(i) of this section).

(o) TRICARE program enrollment procedures. There are certain requirements pertaining to procedures for enrollment in Prime and TRICARE Prime Remote for Active Duty Family Members. (These procedures do not apply to active duty members, whose enrollment is mandatory).

(1) Open enrollment. Beneficiaries will be offered the opportunity to enroll in Prime on a continuing basis.

(2) Enrollment period. (i) Beneficiaries who select the TRICARE Prime option or the TRICARE Prime Remote for Active Duty Family Members option remain enrolled for 12 month increments until: They take action to disenroll; they are no longer eligible for enrollment in TRICARE Prime or TRICARE Prime Remote for Active Duty Family Members; or they are disenrolled for failure to pay required enrollment fees. For those who remain eligible for TRICARE Prime enrollment, no later than 15 days before the expiration date of an enrollment, the sponsor will be sent a written notification of the pending expiration and renewal of the TRICARE Prime enrollment. TRICARE Prime enrollments shall be automatically renewed upon the expiration of the enrollment unless the renewal is declined by the sponsor. Termination of enrollment for failure to pay enrollment fees is addressed in paragraph (o)(3) of this section.

(ii) Exceptions to the 12-month enrollment period.

(A) Beneficiaries who are eligible to enroll in TRICARE Prime but have less than one year of TRICARE eligibility remaining.

(B) The dependents of a Reservist who is called or ordered to active duty or of a member of the National Guard who is called or ordered to full-time federal National Guard duty for a period of more than 30 days.

(3) Installment payments of enrollment fee. The enrollment fee required by Sec. 199.18(c) may be paid in monthly or quarterly installments. Monthly fees may be payable by an allotment from retired or retainer pay, or paid from a financial institution through an electronic transfer of funds. For beneficiaries paying enrollment fees on an installment basis, failure to make a required installment payment on a timely basis [including a grace period, as determined by the Assistant Secretary of Defense (Health Affairs)] will result in termination

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of the beneficiary's enrollment in Prime and disqualification from future enrollment in Prime for a period of one year.

(4) Voluntary disenrollment. **Any non-active duty beneficiary may disenroll at any time. Disenrollment will take effect in accordance with administrative procedures established by the Assistant Secretary of Defense (Health Affairs). Retired beneficiaries and their family members who disenroll prior to their annual enrollment renewal date will not be eligible to reenroll in Prime for a -1-year period from the effective date of the disenrollment. Active Duty family members may change their enrollment status twice in an enrollment year. Any additional disenrollment changes will result in an enrollment lock out for a 1-year period from the effective date of the disenrollment. Enrollment rules may be waived by the Assistant Secretary of Defense (Health Affairs) based on extraordinary circumstances.**

(5) Period revision. Periodically, certain features, rules or procedures of Prime, Extra and/or Standard may be revised. If such revisions will have a significant effect on participants' costs or access to care, beneficiaries will be given the opportunity to change their enrollment status coincident with the revisions.

(6) Effects of failure to enroll. Beneficiaries offered the opportunity to enroll in Prime, who do not enroll, will remain in Standard and will be eligible to participate in Extra on a case-by-case basis.

(7) Special procedures for certain dependents of active duty members in pay grades E-1 to E-4. As an exception to other procedures in paragraph (o) of this section, dependents of active duty members in pay grades E-1 to E-4, if such dependents reside in a catchment area of a military hospital, are automatically enrolled in TRICARE Prime. The applicable military hospital shall provide written notice of the automatic enrollment to the member and the affected dependents. The effective date of such automatic enrollment shall be the date of the written notice, unless an earlier effective date is requested by the member or affected dependents, so long as the affected dependents were as of the effective date dependents of an active duty member in pay grades E-1 to E-4 and residents in a catchment area of a military hospital. Dependents who are automatically enrolled under this paragraph may disenroll at any time. Such disenrollment shall remain in effect until such dependents take specific action to reenroll which such dependents may do at any time.

(p) Civilian preferred provider networks. A major feature of the TRICARE program is the civilian preferred provider network.

(1) Status of network providers. Providers in the preferred provider network are not employees or agents of the Department of Defense or the United States Government. Rather, they are independent contractors of the government (or other independent entities having business arrangements with the government). Although network providers must follow numerous rules and procedures of the TRICARE program, on matters of professional judgment and professional practice, the network provider is independent and not operating under the direction and control of the Department of Defense. Each preferred provider must have adequate professional liability insurance, as required by the Federal Acquisition Regulation, and must agree to indemnify the United States Government for any liability that may be assessed against the United States Government that is attributable to any action or omission of the provider.

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(2) Utilization management policies. Preferred providers are required to follow the utilization management policies and procedures of the TRICARE program. These policies and procedures are part of discretionary judgments by the Department of Defense regarding the methods of delivering and financing health care services that will best achieve health and economic policy objectives.

(3) Quality assurance requirements. A number of quality assurance requirements and procedures are applicable to preferred network providers. These are for the purpose of assuring that the health care services paid for with government funds meet the standards called for in the contract or provider agreement.

(4) Provider qualifications. All preferred providers must meet the following qualifications:

(i) They must be CHAMPUS authorized providers and CHAMPUS participating providers.

(ii) All physicians in the preferred provider network must have staff privileges in a hospital accredited by the Joint Commission on Accreditation of Health Care Organizations (JCAHO). This requirement may be waived in any case in which a physician's practice does not include the need for admitting privileges in such a hospital, or in locations where no JCAHO accredited facility exists. However, in any case in which the requirement is waived, the physician must comply with alternative qualification standards as are established by the MTF Commander (or other authorized official).

(iii) All preferred providers must agree to follow all quality assurance, utilization management, and patient referral procedures established pursuant to this section, to make available to designated DoD utilization management or quality monitoring contractors medical records and other pertinent records, and to authorize the release of information to MTF Commanders regarding such quality assurance and utilization management activities.

(iv) All preferred network providers must be Medicare participating providers, unless this requirement is waived based on extraordinary circumstances. This requirement that a provider be a Medicare participating provider does not apply to providers not eligible to be participating providers under Medicare.

(v) The provider must be available to Extra participants.

(vi) The provider must agree to accept the same payment rates negotiated for Prime enrollees for any person whose care is reimbursable by the Department of Defense, including, for example, Extra participants, supplemental care cases, and beneficiaries from outside the area.

(vii) All preferred providers must meet all other qualification requirements, and agree to comply with all other rules and procedures established for the preferred provider network.

(5) Access standards. Preferred provider networks will have attributes of size, composition, mix of providers and geographical distribution so that the networks, coupled with the MTF capabilities, can adequately address the health care needs of the enrollees. Before offering enrollment in Prime to a beneficiary group, the MTF Commander (or other

authorized person) will assure that the capabilities of the MTF plus preferred provider network will meet the following access standards with respect to the needs of the expected number of enrollees from the beneficiary group being offered enrollment:

(i) Under normal circumstances, enrollee travel time may not exceed 30 minutes from home to primary care delivery site unless a longer time is necessary because of the absence of providers (including providers not part of the network) in the area.

(ii) The wait time for an appointment for a well-patient visit or a specialty care referral shall not exceed four weeks; for a routine visit, the wait time for an appointment shall not exceed one week; and for an urgent care visit the wait time for an appointment shall generally not exceed 24 hours.

(iii) Emergency services shall be available and accessible to handle emergencies (and urgent care visits if not available from other primary care providers pursuant to paragraph (p)(5)(ii) of this section), within the service area 24 hours a day, seven days a week.

(iv) The network shall include a sufficient number and mix of board certified specialists to meet reasonably the anticipated needs of enrollees. Travel time for specialty care shall not exceed one hour under normal circumstances, unless a longer time is necessary because of the absence of providers (including providers not part of the network) in the area. This requirement does not apply under the Specialized Treatment Services Program.

(v) Office waiting times in nonemergency circumstances shall not exceed 30 minutes, except when emergency care is being provided to patients, and the normal schedule is disrupted.

(6) Special reimbursement methods for network providers. The Director, OCHAMPUS, may establish, for preferred provider networks, reimbursement rates and methods different from those established pursuant to Sec. 199.14. Such provisions may be expressed in terms of percentage discounts off CHAMPUS allowable amounts, or in other terms. In circumstances in which payments are based on hospital-specific rates (or other rates specific to particular institutional providers), special reimbursement methods may permit payments based on discounts off national or regional prevailing payment levels, even if higher than particular institution-specific payment rates.

(7) Methods for establishing preferred provider networks. There are several methods under which the MTF Commander (or other authorized official) may establish a preferred provider network. These include the following:

(i) There may be an acquisition under the Federal Acquisition Regulation, either conducted locally for that catchment area, in a larger area in concert with other MTF Commanders, regionally as part of a CHAMPUS acquisition, or on some other basis.

(ii) To the extent allowed by law, there may be a modification by the Director, OCHAMPUS, of an existing CHAMPUS fiscal intermediary contract to add TRICARE program functions to the existing responsibilities of the fiscal intermediary contractor.

(iii) The MTF Commander (or other authorized official) may follow the "any qualified provider" method set forth in paragraph (q) of this section.

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(iv) Any other method authorized by law may be used.

(q) Preferred provider network establishment under any qualified provider method.

The any qualified provider method may be used to establish a civilian preferred provider network. Under this method, any CHAMPUS-authorized provider within the geographical area involved that meets the qualification standards established by the MTF Commander (or other authorized official) may become a part of the preferred provider network. Such standards must be publicly announced and uniformly applied. Also under this method, any provider who meets all applicable qualification standards may not be excluded from the preferred provider network. Qualifications include:

- (1) The provider must meet all applicable requirements in paragraph (p)(4) of this section.
- (2) The provider must agree to follow all quality assurance and utilization management procedures established pursuant to this section.
- (3) The provider must be a Participating Provider under CHAMPUS for all claims.
- (4) The provider must meet all other qualification requirements, and agree to all other rules and procedures, that are established, publicly announced, and uniformly applied by the commander (or other authorized official).
- (5) The provider must sign a preferred provider network agreement covering all applicable requirements. Such agreements will be for a duration of one year, are renewable, and may be canceled by the provider or the MTF Commander (or other authorized official) upon appropriate notice to the other party. The Director, OCHAMPUS shall establish an agreement model or other guidelines to promote uniformity in the agreements.

(r) General fraud, abuse, and conflict of interest requirements under TRICARE program. All fraud, abuse, and conflict of interest requirements for the basic CHAMPUS program, as set forth in this part 199 (see especially applicable provisions of Sec. 199.9) are applicable to the TRICARE program. Some methods and procedures for implementing and enforcing these requirements may differ from the methods and procedures followed under the basic CHAMPUS program in areas in which the TRICARE program has not been implemented.

(s) Partial implementation. The Assistant Secretary of Defense (Health Affairs) may authorize the partial implementation of the TRICARE program. The following are examples of partial implementation:

- (1) The TRICARE Extra Plan and the TRICARE Standard Plan may be offered without the TRICARE Prime Plan.
- (2) In remote sites, where complete implementation of TRICARE is impracticable, TRICARE Prime may be offered to a limited group of beneficiaries. In such cases, normal requirements of TRICARE Prime which the Assistant Secretary of Defense (Health Affairs) determines are impracticable may be waived.
- (3) The TRICARE program may be limited to particular services, such as mental health services.

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(f) **Inclusion of Department of Veterans Affairs Medical Centers in TRICARE networks.** TRICARE preferred provider networks may include Department of Veterans Affairs health facilities pursuant to arrangements, made with the approval of the Assistant Secretary of Defense (Health Affairs), between those centers and the Director, OCHAMPUS, or designated TRICARE contractor.

(u) **Care provided outside the United States to dependents of active duty members.** The Assistant Secretary of Defense (Health Affairs) may, in conjunction with implementation of the TRICARE program, authorize a special CHAMPUS program for dependents of active duty members who accompany the members in their assignments in foreign countries. Under this special program, a preferred provider network will be established through contracts or agreements with selected health care providers. Under the network, CHAMPUS covered services will be provided to the covered dependents with all CHAMPUS requirements for deductibles and copayments waived. The use of this authority by the Assistant Secretary of Defense (Health Affairs) for any particular geographical area will be announced in the Federal Register. The announcement will include a description of the preferred provider network program and other pertinent information.

(v) **Administrative procedures.** The Assistant Secretary of Defense (Health Affairs), the Director, TRICARE Management Activity, and MTF Commanders (or other authorized officials) are authorized to establish administrative requirements and procedures, consistent with this section, this part, and other applicable DoD Directives or Instructions, for the implementation and operation of the TRICARE program.

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