

I. PROVIDER NETWORK DEVELOPMENT

The contractor shall establish a provider network throughout the Region(s) to support TRICARE Prime and TRICARE Extra and to complement MTF capabilities. The network shall meet the standards in [Section I.B.](#) of this chapter. The final plan detailing all phases of network implementation shall be submitted through the Lead Agent(s) to the Contracting Officer no later than one hundred eighty (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 service areas required in this chapter and in the Lead Agent requirements specified in the contract. The Contracting Officer will approve, deny, or direct changes to the plan no later than the one hundred fiftieth (150th) calendar day prior to the start of healthcare delivery.

A. Geographic Availability

The contractor shall establish and maintain provider networks, supporting TRICARE Prime and TRICARE Extra, in all catchment areas, non-catchment areas (where cost-effective), Base Realignment and Closure (BRAC) sites, and areas specified in the Lead Agent Requirements of the contract. In each area where TRICARE Prime is offered (TRICARE Prime service area), the contractor shall permit enrollment by beneficiaries under the terms and conditions of [OPM Part Three, Chapter 4](#). Beneficiaries who live outside TRICARE Prime service areas may enroll in TRICARE Prime, however, they must waive the access standards listed in [Section I.B.2.c.](#), below.

1. Areas Where Establishment of TRICARE Prime and TRICARE Extra is Required

The contractor shall establish and maintain provider networks supporting TRICARE Prime and TRICARE Extra and fulfilling the requirements of the [OPM Part Three, Chapter 1, Section I.](#), throughout all healthcare delivery periods of the contract. The contractor shall make TRICARE Prime and TRICARE Extra available in all catchment areas (see definition in [OPM Part Two, Chapter 11](#)), at all Base Realignment and Closure (BRAC) sites, and in all noncatchment zip code areas designated in the Lead Agent Requirements of each contract. A listing of all zip codes and geographic locations associated with MTF catchment areas is available in the Catchment Area Directory published by the Defense Medical Systems Support Center. Where, because of unique circumstances in a catchment area or in areas that become noncatchment areas 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 Contracting Officer. The request must include the Lead Agent's comments and supporting documentation for a waiver or delay.

2. Retail Network Pharmacy Service

The contractor shall provide a retail network pharmacy service in the Regions. The retail pharmacy services shall serve all TRICARE eligible beneficiaries and Medicare eligible beneficiaries affected by BRAC site closures. The contractor shall provide a pharmacy patient profile system that will support the requirements of [OPM Part Two, Chapter 7](#). Authorized medications and other supplies will be dispensed in accordance with [32 CFR 199.4\(d\)\(3\)\(vi\)](#), Prescription Drugs and Medicines, and Policy Manual, [Chapter 7, Section 7.1](#). *Retail network pharmacies shall only be reimbursed for drugs dispensed based*

on the quantity limits and prior authorization listed at www.pec.ha.osd.mil/nmop/nmophome.htm. The DoD Pharmacy and Therapeutics Committee update the formulary on a quarterly basis. The contractor will implement updated changes to the formulary within thirty (30) calendar days of publication on the web site at no additional cost to the government. Generic drugs listed with an "A" rating in the current Approved Drug Products with Therapeutic Equivalence Evaluations (Orange Book), published by FDA, and generic equivalents of grandfather or Drug Efficacy Study Implementation (DESI) category drugs, are required to be used as substitutes to brand name drugs. *The contractor shall comply with the Policy Manual, Chapter 13, Section 3.6 to meet* all pharmacy services and claims processing requirements.

3. 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 A.1. above. 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 noncatchment areas shall be submitted with fully supporting documentation through the Lead Agent to the Contracting Officer for approval.

4. Beneficiary Access to Care

For areas where TRICARE Prime and Extra are not available, the contractor shall establish a telephone service for all MHS beneficiaries as required by [OPM Part Three, Chapter 4, Section VI.B.](#), to assist beneficiaries in locating participating providers.

B. Provider Network Requirements and Standards

The contractor shall establish, in consonance with the Lead Agent Requirements specified in the contract, provider networks through contractual arrangements. In areas *that 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) prior to allowing participation by any other provider. Network requirements and standards are listed below.

1. Lead Agents and MTF Interface in Provider Network Development

Prior to the contractor finalizing provider contracts, MTF Commanders and the Lead Agents shall be given an opportunity to provide input into the development of the network in their catchment areas. The contractor shall meet with the Lead Agent and all MTF Commanders within thirty (30) calendar days of the award to obtain their network size and specialty makeup input. The contractor shall follow the MTF Commander's directions, in consonance with the Lead Agent's Requirements, as specified in the contract, 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.

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2. Standards for Network Providers

Below are network and access to care standards set by the Government. The network shall comply with the more stringent standards set by the Government or standards proposed by the contractor. Each catchment or noncatchment area 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.

a. Requirements for Providers

(1) General

(a) Institutional and individual providers shall comply with contract certification requirements (refer to [32 CFR 199.6](#); Policy Manual, [Chapter 10](#); this chapter [Section I.](#) and [Section IV.](#); [Addendum A](#) and [Addendum B](#); [OPM Part Two, Chapter 2](#)) and the Lead Agent Requirements as specified in the contract.

(b) The contractor shall ensure that institutional and individual providers understand and comply with the provisions of the TRICARE clinical quality management and utilization management review programs (see [OPM Part Three, Chapter 3, Section I.](#) and [II.](#)). The contractor shall notify the Lead Agent, in writing, within ten (10) calendar days of learning of a change in an institutional provider's JCAHO or equivalent accreditation status.

(c) Provider agreements shall address the provision of medical records and other documentation by providers whose cases come under review in either the TRICARE clinical quality management program or the utilization management program ([OPM Part Three, Chapter 3, Section III.](#)) as well as contractor operated quality and utilization review programs. Provider contracts shall also contain a provision authorizing the National Quality Monitoring Contractors to release all review data to the contractor (see [OPM Part Three, Chapter 3, Section III.](#)).

(2) Department of Veteran's Affairs Providers

Contractors may consider Department of Veteran's Affairs providers for participation in contractors' networks.

(a) Department of Veterans' Affairs Health Care Facilities (DVAHCF) may participate in accordance with Policy Manual, [Chapter 10, Section 1.1.](#)

(b) Individual providers who meet the Department of Veterans' Affairs requirements shall be deemed to meet the requirements under this contract for health care services provided in the DVAHCF.

(3) Institutional Providers

(a) An institutional network provider file shall contain documented evidence of the network provider's qualifications fulfilling each and every requirement. Each year the contractor shall conduct an audit [at the eighty-five percent (85%) confidence level and five percent (5%) precision level] of all prime contractors' and sub-contractors' institutional provider files. The audit shall be completed prior to the

start of each option period. Thirty (30) calendar days prior to each audit, the contractor shall invite the Lead Agent to monitor and/or participate in the audit. Not less than eighty-five percent (85%) of the audited files shall be in full compliance with [Addendum B](#) of this chapter. Within five (5) business days of the completion of the audit's provider file review, the contractor shall submit to the contracting officer and the Lead Agent a written corrective action plan which addresses all files not in full compliance. Within thirty (30) calendar days after completion of the audit's provider file review, the incomplete or incorrect files shall be corrected to full compliance.

(b) The contractor shall notify the Lead Agent, in writing, within ten (10) days of learning of a change in an institutional providers' JCAHO or equivalent accreditation status.

(4) Individual Network Providers

Contractors may meet some credentialing requirements for individual network providers by furnishing documentation of accreditation ([Addendum B](#), paragraph V.A.) or by subcontracting with credentials verification organizations that use primary source files. Contractors may use subcontractors to fulfill contractor credentialing responsibilities. Provider certification/credentialing files may be located in the credentialing subcontractor's facility.

(a) Individual Network Provider Certification, Credentialing, and Privileging Files

Contractors shall verify provider certification/credentialing file information either through the primary source, through NCQA accredited database repositories, or by subcontracting with credentials verification organizations that use primary source files. Refer to [32 CFR 199.6](#); Policy Manual, [Chapter 10](#); [OPM Part Two, Chapter 2](#); [Section I](#). and [Section IV](#). of this chapter; and [Addendum B](#), paragraph V.A., for documentation requirements.

(b) Provider File Audits

Each year, the contractor shall conduct an audit [at the eighty-five percent (85%) confidence level and five percent (5%) precision level] of all prime contractors' and sub-contractors' individual network provider credentialing and privileging files. The audit shall be completed prior to the start of each option period. Thirty (30) calendar days prior to each audit, the contractor shall invite the Lead Agent to monitor and/or participate in the audit. Not less than eighty-five percent (85%) of the audited files shall be in full compliance with all provider file requirements. Within five (5) business days of the completion of the audit's provider file review, the contractor shall submit to the administrative contracting officer and the Lead Agent a written corrective action plan which addresses all credentialing and privileging files not in full compliance. Within thirty (30) calendar days after completion of the audit's provider file review, the incomplete or incorrect files shall be corrected to full compliance.

(c) Provider Background Checks

Contractors shall conduct background checks on individuals working in MTFs and on network providers not working in MTFs according to the following requirements:

1 Criminal History Background

Checks

Contractors shall perform criminal history background checks in accordance with [Addendum C](#), DoDI 1402.5, "Criminal History Background Checks on Individuals in Child Care Services," for resource sharing and resource support personnel working in an MTF involved on a frequent and regular basis in the provision of care and services to children under the age of eighteen (18). The background checks are required by Criminal Control Act, P.L. 101-647, Section 231 (CC Act 1990, 42 U.S.C. Section 13041). The contractor shall assemble all necessary documentation required by [Addendum C](#) for the background checks and forward the documentation to the office designated by the administrative contracting officer (ACO) or to the office designated in the Memorandum of Understanding (see [OPM Part Three, Chapter 2, Addendum A](#)).

a For health care practitioners requiring MTF clinical privileges, the contractor shall furnish completed background check documentation to the MTF commander prior to the award of privileges.

b For individuals who require background checks but not clinical privileges, the contractor shall furnish the completed documentation to the MTF commander prior to employment at, or assignment to, the MTF.

c While waiting the thirty (30) day minimum period for a background check to be completed, the contractor shall follow the Criminal History Background Check Procedures outlined in [Addendum C](#).

2 Criminal History Checks

Contractors shall perform criminal history checks on certain physician (see subparagraph [a](#) below) and non-physician (see subparagraph [b](#) below) network providers. Contractors may search federal, state, and county public records in performing criminal history checks. Contractors may subcontract for these services; for example, MEDI-NET, Inc., provides physician screening services, and ADREM Profiles, Inc., performs criminal history checks. The contractor shall document, in a form of the contractors' choosing, the AMA screen and the results of all criminal history checks.

a Contractors shall screen their TRICARE network physicians' licensure and discipline histories using the American Medical Association's (AMA's) master file. Contractors shall check the criminal histories of physicians with anomalies in their licensure history [i.e., who have four (4) or more active and/or expired licenses] or who have been disciplined.

b Contractors also shall perform criminal history checks on all non-physician providers who practice independently and who are not supervised by a physician (refer to [32 CFR 199.6\(c\)\(3\)](#), for types of providers).

3 The contractor shall maintain a copy of all background check documentation with the provider certification files as required by [Addendum B](#).

4 The contractor is financially responsible for all credentialing requirements, including background checks.

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(5) All acute care hospitals in the network shall be members of the National Disaster Medical System (NDMS) network unless it can be shown that they do not qualify for membership.

NOTE:

The Contracting Officer may approve waivers of this requirement on a case-by-case basis. All waiver requests shall be submitted through the Lead Agents to the Contracting Officer.

b. Participation on Claims

All network provider contracts shall require the provider to participate on all claims and submit claims on behalf of all MHS and Medicare beneficiaries. Refer to [Section II.A.1.a.\(3\)\(b\)](#) for information on claims for emergency and referred care supplied by providers who do not participate.

(1) Balance Billing

(a) 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/MCS contractors for services provided to active duty 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 and shall provide the Lead Agents and each MTF Commander with a list of all network providers, their addresses and phone numbers, their specialties or types of service (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 Lead Agent.)

(b) 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 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) Billing for Non-Covered Services (Hold

Harmless)

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) unless the beneficiary has been properly informed that the services are excluded or excludable and has agreed in advance in writing to pay for the services. An agreement to pay must be evidenced by written records,

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preferably the written consent of the beneficiary. A beneficiary's agreement to pay for a potentially excludable service cannot be imputed from his or her conduct in proceeding to receive the service after having been properly informed that the care is potentially 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. 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. (See [OPM Part Two, Chapter 1, Section IV.H.2.e.](#) for additional details.)

c. Access Standards

The network shall include a complement of civilian providers to ensure access to care for TRICARE Prime and Extra beneficiaries. Access shall comply with the following guidelines:

(1) Number and Mix of Providers

The network shall include the number and mix of providers, both primary care and specialists, necessary to satisfy demand and to ensure access to all necessary types and levels of primary care. Overall provider availability should be in a ratio of one (1) provider (all physician categories) to every twelve hundred (1,200) TRICARE Prime enrollees. The Primary Care Manager (PCM) requirement is a ratio of one (1) PCM to every two thousand (2,000) enrollees. Provider requirements are expressed as full-time equivalents.

(2) Delivery Sites

Except for any special services not sufficiently available in the area to make inclusion in the network practical, the network shall include sufficient delivery sites to ensure access to care. The contractor may request exceptions for a special services not sufficiently available in the area to make inclusion in the network practical. Such requests shall be submitted through the Lead Agent to the Contracting Officer for approval.

(3) Primary Care Availability

The network shall include primary care delivery sites to ensure that beneficiary travel time does not exceed thirty (30) minutes from home to delivery site. An exception may be granted only when longer travel time is justified by the absence of providers in the area. The contractor shall submit requests for exceptions through the Lead Agents to the Contracting Officer.

(4) Emergency Services

Emergency Services shall be available and accessible within the service area twenty-four (24) hours a day, seven (7) days a week.

(5) Office Wait Times

The wait time in the office in nonemergency situations shall not exceed thirty (30) minutes.

(6) Appointment Wait Times for Primary Care

TRICARE Prime enrollees shall have access to PCM services on a same-day basis. Access shall be available by telephone or appointment, twenty-four (24) hours per day, seven (7) days per week, to ensure enrollees receive evaluation of illness in a timely manner. If the PCM is not available, adequate coverage must be arranged. The wait time for an appointment for a well visit shall not exceed four (4) weeks; the wait time for routine visits shall not exceed one (1) week, and the wait time for acute illness care shall not exceed one (1) day.

(7) Handicapped Accessibility

The network shall offer facilities which are accessible to handicapped individuals. The contractor is responsible for ensuring that all network facilities are in compliance with Federal and local access standards.

(8) Specialty Care Availability

The network shall include specialty delivery sites to ensure that the beneficiary travel time for specialty care, except in cases of referral to Specialized Treatment Services (STSs), normally shall be no longer than one (1) hour. If, based on the availability of specialists, a longer drive time is required, the beneficiary shall be informed of the situation.

(9) Appointment Wait Times for Specialty Care

Based on the nature of the care required, the referring primary care manager shall determine the appropriate waiting time (not to exceed four (4) weeks) for specialty care appointments.

3. Program Requirements

The contractor shall enter into and administer provider contracts in such a way as to meet the following overall program requirements.

a. Primary Care Manager (PCM) Concept

(1) The network shall be based on the PCM concept. Under this concept, enrolled beneficiaries agree to initially seek all nonemergency, nonmental health care services from a specified provider, or PCM, to whom they are assigned for primary care services at the time of enrollment. The PCM may be a network provider or an MTF primary care manager (PCM) by name/supported by a team.

NOTE:

This requirement precludes enrollees from seeking nonemergency, nonmental health services from MTF or network providers other than the assigned PCM without referral by the PCM unless the services of a civilian provider are being obtained under the Point of Service option.

(2) The PCM also provides or makes arrangements for the enhanced preventive services required by Policy Manual, [Chapter 1, Section 10.1A](#). Primary care includes care rendered for acute illness, minor accidents, follow-up care for ongoing medical problems, and preventive health care as authorized in the benefits plan. Primary care services are typically, although not exclusively, provided by internists, family

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practitioners, pediatricians, general practitioners, obstetricians/gynecologists, physician assistants, nurse practitioners, or certified nurse midwives to the extent consistent with governing state rules and regulations. Providers who agree to be PCMs shall sign agreements that identify the rules and procedures for specialty referrals and the responsibilities of PCMs. In the event the assigned PCM cannot provide the full range of necessary primary care functions, the PCM will ensure access to these necessary health care services as well as any specialty requirements. All PCMs must be authorized TRICARE providers and meet all network provider standards. The PCM is responsible for arranging for beneficiary use of specialist services through an authorization and referral system. The PCM's office is responsible for contacting Health Care Finders to identify sources of specialty care, for coordinating patient care, for maintaining medical records, and for making referrals.

b. Access

The contractor shall ensure that neither network nor program requirements result in limitations on access to care in medical emergencies, limitations on access to specialty services not reasonably available from the network, or beneficiaries not having the opportunity to choose any provider in the network for PCM assignment to the extent possible within MTF Commander guidelines.

c. Quality and Utilization Management

The contractor shall ensure that all institutional and individual providers have a full understanding of and comply with TRICARE utilization management and quality assurance standards as outlined in [OPM Part Three, Chapter 3, Section I. and II.](#)

d. Network Monitoring

The contractor is responsible for monitoring the provider network continuously. Monitoring activities must include verification of the availability of providers in the network, provider adherence to contract requirements, access standards, and investigation and resolution of specific complaints or concerns expressed by beneficiaries or providers.

(1) Responsiveness to MTF and Lead Agent

Concerns

The contractor shall provide MTF Commanders and Lead Agents with an interim written response within two (2) business days of receiving a written complaint about a network provider from an MTF Commander or Lead Agent. The contractor shall provide a final response to the complainant, MTF Commander, and the appropriate Lead Agent within fourteen (14) calendar days.

(2) Beneficiary Education

A section of the health benefits education program shall be designed to inform enrollees regarding accessing services in accordance with their needs.

e. Network Provider Participation

Network providers (individual and institutional) shall be both TRICARE and Medicare participating providers for those classes of providers recognized by

both TRICARE and Medicare. Exceptions to this requirement may be approved by the Contracting Officer, if necessary, to ensure the availability of needed specialty care. Requests for exceptions shall be submitted through the appropriate Lead Agent to the Contracting Officer for approval.