Chapter 5

Section 1

Network Development

Revision:  C-31, December 19, 2024

**1.0  GENERAL**

**1.1**The contractor shall provide a plan for establishing a provider network throughout the region to support TRICARE Prime and TRICARE Select and to complement Market/Military Medical Treatment Facility (MTF) capabilities. This section does not apply to the Uniformed Services Family Health Plan (USFHP), TRICARE Medicare Eligible Program (TMEP), or pharmacy contracts.

**1.2**The National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2016, Section 717, required the development of a system by which any non-Department mental health care provider that meets eligibility criteria established by the Secretary of Defense relating to knowledge of: (1) military culture; and, (2) evidence-based treatments that have been approved by the Department for the treatment of mental health issues among members of the Armed Forces, receives a mental health provider readiness designation. It further required the Department to establish and update as necessary a publicly available registry of all non-Department mental health care providers with the “provider readiness designation” related to knowledge of military culture and evidence-based treatments.

**1.3**The contractor shall use a “provider readiness designation” to identify, in its provider directory, all non-Department mental health providers including psychiatrists and other mental health physicians (i.e., clinical psychologists, certified psychiatric nurse specialists (CPNSs), certified clinical social workers (CCSWs), marriage and family therapists, TRICARE certified mental health counselors (CMHCs), and certified pastoral counselors under a physician’s supervision) who have knowledge of military culture and evidence based treatments. The mental health provider readiness designation does not apply to the TRICARE Overseas Program (TOP).

**1.3.1**The contractor shall designate or identify those providers who furnish proof (i.e., certificates) that they have completed:

The “Military Culture: Core Competencies for Healthcare Professionals” course developed by the Department of Defense (DoD) and the Department of Veterans Affairs/Veterans Health Administration (DVA/VHA) under the auspices of Integrated Mental Health Strategy (IMHS); and

**•**The following courses: “Cognitive Processing Therapy for Post-Traumatic Stress Disorder (PTSD) in Veterans and Military Personnel,” “Prolonged Exposure (PE) Therapy for PTSD in Veterans and Military Personnel,” and “Depression in Service Members and Veterans in evidence-based treatments,” offered by the Center for Deployment Psychology (CDP) of the Uniformed Services University of the Health Sciences.

**1.3.2**The contractor shall actively promote attainment of the provider readiness designation in its education materials to applicable providers.

**2.0  GEOGRAPHIC AVAILABILITY**

**2.1**The contractor shall establish and maintain a preferred provider network of individual and institutional providers, capable of meeting minimum access standards for 100% of TRICARE Prime beneficiaries and at least 85% of TRICARE Select beneficiaries in the contractor’s geographic area of responsibility throughout all health care delivery periods of the contract. (See [Chapter 16](https://manuals.health.mil/pages/DisplayManualHtmlFile/2025-01-17/AsOf/TOT5/c16toc.html) for TRICARE Prime Remote (TPR) network requirements).

**2.2**The contractor shall establish and maintain a network and services to TRICARE Prime and TRICARE Select enrolled beneficiaries that ensures access to care (ATC) and the opportunity to choose, enroll, add additional family members, or remain enrolled in the TRICARE plans.

**2.3**The contractor shall establish minimum health care provider-to-beneficiary ratios. The provider to beneficiary ratios shall be for the purposes of network sizing only. Regardless of the provider to beneficiary ratio, the contractor’s network shall meet or exceed minimum access standards as the first priority.

**2.4**The contractor shall consider the health characteristics of the beneficiaries in a given market, including an analysis of disease prevalence and overall health and well-being of such beneficiaries, and shall use predictive analytics in the development of its network implementation plan.

**2.5**The contractor shall establish and maintain a network of individual and institutional providers that ensures that at least 85% of TRICARE Select enrolled beneficiaries residing in the geographic area of responsibility have access to a network that meets minimum access time standards in each of the contractor’s geographic areas of responsibility, each United States (US) and District of Columbia (East only).

**2.6**In developing and maintaining its network in each state/territory, the contractor shall consider the entire beneficiary population of the state including any overlap with TRICARE Prime Service Areas (PSAs).

**2.7**In overseas regions, the contractor shall establish a network as authorized by the Director to support a special TRICARE Prime program; this network may be accessed by TRICARE 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, Defense Health Agency (DHA) to be economically in the best interest of the DoD.

**2.8  TRICARE Prime Service Areas (PSAs)**

**2.8.1**The contractor shall offer TRICARE Prime in areas where the Director, Defense Health Agency (DHA) determines that it is appropriate to support the effective operation of one or more Markets/MTFs. The locations where TRICARE Prime will be offered will be determined by the Director, DHA and announced prior to the annual open enrollment period.

**2.8.2  Government Designated Authorities (GDAs) And Market/MTF Interface In Provider Networks**

**2.8.2.1**The contractor shall ensure that, in PSAs with Direct Care (DC) markets or MTFs, its network complements the existing military capabilities and optimizes the market in support of military readiness. The contractor shall adjust provider networks and services to compensate for changes in Market/MTF capabilities and capacities including those resulting from facility/service expansion, provider deployment, or MTF access downsizing.

**2.8.2.2**The contractor shall meet, at a minimum annually, with the GDA and each Market Director/MTF Director to discuss Market/MTF optimization efforts. The purpose of these meetings is to ensure the Market/MTF optimizes care in accordance with their business plan/optimization initiatives.

**2.8.2.3**The contractor shall meet with the GDA and all Market Directors and MTF Directors within 30 calendar days of the award to obtain their network size and specialty makeup input.

**2.8.2.4**The contractor shall provide Market Directors/MTF Directors and the GDA the opportunity to provide input into the development of the network in the geographic area of responsibility prior to finalizing the civilian network.

**2.8.3  MTF/Market Collaboration Events**

**2.8.3.1**The contractor shall, when requested by the Market/MTF, assist in planning and conducting provider collaboration events in the local markets.

**2.8.3.2**The contractor shall, when a date and agenda is confirmed by the Market/MTF, assist in administrative processes that include procuring the venue, coordinating event logistics, creating and delivering invitations to civilian providers, and catering refreshments as permitted by Service-specific and other regulations.

**3.0  ENROLLMENT**

**3.1**In each area where enrollment is offered, the contractor shall permit enrollment by beneficiaries under the terms and conditions of [Chapters 6](https://manuals.health.mil/pages/DisplayManualHtmlFile/2025-01-17/AsOf/TOT5/c6toc.html) and [11](https://manuals.health.mil/pages/DisplayManualHtmlFile/2025-01-17/AsOf/TOT5/c11toc.html).

**3.2**The contractor shall assign TRICARE Prime beneficiaries only to Market/MTF Primary Care Managers (PCMs) or to PCMs in the PSA network.

**3.3**The contractor shall follow Market Director/MTF Director directions regarding the priorities for the assignment of enrollees to PCMs.

**4.0  NETWORK REQUIREMENTS AND STANDARDS**

**4.1**The contractor shall obtain health network accreditation of its provider network from a nationally recognized accrediting organization no later than 18 months after the start of health care delivery (SHCD).

**4.2**The contractor shall actively seek institutional and individual providers (medical and mental health) for their network who:

**4.2.1**Produce the best quality clinical outcomes;

**4.2.2**Use “evidence-based medicine, including appropriate national standards of care;”

**4.2.3**Report outcome data, preventive measures date, and laboratory data; and

**4.2.4**Are willing to refer/transfer TRICARE beneficiaries for care at Markets/MTFs when appropriate.

**4.3**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.

**4.4**The contractor shall ensure profiles and parameters are 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.

**4.5**The contractor shall not refer beneficiaries to providers with poor outcomes.

**4.6**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.

**5.0  Provider Directory**

**5.1**The contractor shall develop and maintain a timely and accurate network provider directory for use by beneficiaries and the Government to assist with health care, referral management, and claims. Additionally, the contractor shall develop and maintain an on-line authorized non-network provider list.

**5.2**The contractor shall ensure that the information is refreshed with any updated data in the on-line network provider directory no less than once every 24 hours.

**5.3**The contractor shall provide web access to the directory and list, making it available for all beneficiaries, providers, and Government representatives.

**5.4**The contractor’s on-line network provider directory shall include a search tool that allows beneficiaries to locate providers based on a wide range of avenues, to include but not limited to name, specialty, sub-specialty, group, body part or condition. Results from the beneficiary search shall have the capability of sorting on all elements of provider data including mapping providers by distance to the beneficiary.

**5.5**The contractor’s on-line authorized non-network provider list shall include a search tool that allows beneficiaries to locate providers with results based on claims submissions for a rolling 14 month period. The accuracy standard does not apply to the authorized non-network provider list.

**6.0  Standards for TRICARE Beneficiary Access to Network Providers**

**6.1**The contractor shall ensure access standards for appointments for health care that meet or exceed those of high-performing health care systems in the US.

**6.2**The contractor shall maintain networks through the life of the contract and adjust the size of the networks to ensure beneficiaries in the geographic areas meet or exceed ATC standards.

**6.3**The contractor shall establish mechanisms for monitoring and reporting compliance with access standards.

**6.4**Where MTFs use an Integrated Referral and Medical Appointment Center or Referral and Appointment Center, data received from the appointing center about availability of appointments in the contractor’s network shall be included in compliance monitoring metrics.

**6.5**The contractor shall ensure ATC standards listed in [32 CFR 199.17(p)(5)](https://manuals.health.mil/pages/DisplayManualHtmlFile/2025-01-17/AsOf/fr16/c17.html#FM1033431) are met for enrollees.

**6.5.1**The contractor shall ensure travel time does 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.The contractor shall ensure that travel time for specialty care does not exceed one hour, unless a longer time is necessary because of the absence of providers (including providers not part of the network) in the area.The contractor shall ensure that the wait time for an appointment for a well-patient visit or a specialty care referral for enrollees do 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.The contractor shall ensure that emergency services be available and accessible to handle emergencies (and urgent care visits if not available from other primary care providers (PCPs) within the service area 24 hours a day, seven days a week (24/7) for enrollees.

**7.0  Urgent Care Centers (UCCs) Network Requirements and Standards**

**7.1**The contractor shall establish network agreements with TRICARE authorized UCCs and publish information, including on a website, informing TRICARE beneficiaries of the availability and access to network UCCs.

**7.2**The contractor shall ensure adequate access to UCCs when Markets/MTFs are unavailable or unable to provide such services. See the website (<https://manuals.health.mil/pages/DownloadManualFile.ashx?Filename=Definitions.pdf>) for the definition of UCC. The NDAA FY 2017, Section 704(a) enacted 10 United States Code (USC) 1077a, in part, to improve access to urgent care services both in military Markets/MTFs and the TRICARE Network.

**7.3**The contractor shall include in network agreements with UCCs located in all Market/MTF PSAs within the 50 US and District of Columbia the following to better integrate care between Markets/MTFs and network UCCs:

**7.3.1**The contractor shall instruct UCCs in Market/MTF PSAs for TRICARE Prime beneficiaries enrolled to a Market/MTF to send a Clear and Legible Report (CLR) of the UCC encounter within two business days to the Market/MTF where the beneficiary is enrolled.

**7.3.1.1**The CLR shall include the patient’s encounter specifics (histories and physicals, progress notes, notes on Episodes Of Care (EOC), and other patient information (such as laboratory reports, x-ray readings, operative reports), and discharge summaries).

**7.3.1.2**The CLR shall include any follow-up appointments recommended during the urgent care visit.

**7.3.2**Advise TRICARE Prime beneficiaries enrolled to a Market/MTF that non-emergency follow-on care should be sought at the enrollees’ Market/MTF PCM whenever possible.

**7.3.3**The contractor shall provide the network UCCs with Market/MTF fax numbers.

**7.4**The contractor shall ensure that TRICARE authorized UCCs practice standard of care based on the NCQA Health Effectiveness Data and Information Set (HEDIS) using the guidelines for the following four conditions:

**7.4.1**Children With Pharyngitis (CWP).

**7.4.2**Appropriate treatment for children with Upper Respiratory Infection (URI).

**7.4.3**Avoidance of Antibiotic for Adults with Bronchitis (AAB).

**7.4.4**Use of imaging studies for Low Back Pain (LBP).

**7.5**The contractor shall ensure that all beneficiaries in its geographic region have access to a 24/7 telehealth urgent care option available through a computer and smartphone application.

**8.0  Participation On Claims**

**8.1**The contractor shall only include in their network Medicare participating providers (unless they are not eligible to be a Medicare participating provider) and shall be sufficient in number, mix, and geographic distribution to provide the full scope of benefits for which all TRICARE Prime and TRICARE Select enrollees are eligible under this contract, as described in [32 CFR 199.4](https://manuals.health.mil/pages/DisplayManualHtmlFile/2025-01-17/AsOf/fr16/c4.html), [199.5](https://manuals.health.mil/pages/DisplayManualHtmlFile/2025-01-17/AsOf/fr16/c5.html), and [199.17](https://manuals.health.mil/pages/DisplayManualHtmlFile/2025-01-17/AsOf/fr16/c17.html).

**8.2**The contractor shall ensure that all network provider agreements 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:

**8.2.1**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 or her professional service by his or her employee under his or her immediate personal supervision, except as otherwise permitted by Medicare or TRICARE regulations.

**8.2.2**Services, to be considered as “incident” to a physician’s professional service, must:

**8.2.2.1**Be rendered under the physician’s immediate personal supervision by his or her employee;

**8.2.2.2**Be an integral, although incidental part of a covered physician’s service;

**8.2.2.3**Consist of commonly furnished in physician’s offices; and

**8.2.2.4**Be included on the physician’s bills for services of non-physicians.

**8.2.3**The non-institutional network provider/supplier further certifies that he or she (or any employee) who rendered services is not an active duty member of the Uniformed Services or a civilian employee of the US Government (refer to 5 USC 5536).

**8.2.4**An exception exists for part-time DVA/VHA employees fulfilling the requirements of [Chapter 4, Section 1](https://manuals.health.mil/pages/DisplayManualHtmlFile/2025-01-17/AsOf/TOT5/c4s1.html#FM63551).

**8.3**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.

**9.0  Balance Billing**

**9.1**The contractor shall include the following provision in provider contracts:

**9.1.1**Providers in the contractor’s network will only bill MHS beneficiaries for applicable deductibles, copayments, and/or cost-sharing amounts.

**9.1.2**Providers will not bill for charges which exceed contractually allowed payment rates.

**9.1.3**Network providers will only bill Markets/MTFs/contractors for services provided to Service members at the contractually agreed amount, or less, and will not bill for charges which exceed the contractually agreed allowed payment amount.

**9.2**If a network provider bills a beneficiary for more than the contractually agreed upon amount, the contractor shall require the provider to reverse the charges and refund any overpayment to the beneficiary.

**9.3**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 will be equal to or less than the TRICARE allowable amount minus the discount the contractor negotiated with the provider.

**9.5**Active Duty Service Members (ADSMs) and Active Duty Family Members (ADFMs) without MTF audiology access continue to be tested, treated, and fitted by their network audiologists.

**10.0  Billing For Non-Covered Services (Hold Harmless)**

**10.1**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:

**10.1.1**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.

**10.1.2**If the beneficiary was informed that the services were excluded or excludable and he or she agreed in advance to pay for the services, the provider may bill the beneficiary.

**10.2**An agreement to pay must be evidenced by written records. “Written records” include for example:

**10.2.1**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;

**10.2.2**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;

**10.2.3**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).

**10.3**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.

**10.4**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.

**10.5**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.

**10.6**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.

**10.7**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 DHA advised the beneficiary that he or she was not liable for the excludable services.

**10.8**The time limit may be extended where good cause is shown. Good cause is defined as:

**10.8.1**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.

**10.8.2**Mental incompetence of the beneficiary or, in the case of a minor child, mental incompetence of his or her guardian, parent, or sponsor.

**10.8.3**Adjudication delays by Other Health Insurance (OHI) (when not attributable to the beneficiary), if such adjudication is required under [32 CFR 199.8](https://manuals.health.mil/pages/DisplayManualHtmlFile/2025-01-17/AsOf/fr16/c8.html).

**11.0  Health Information Exchanges (HIEs)**

**11.1**The contractor shall include in its network, to the extent possible, and give priority in its MTF referral steerage model to providers (both individual and institutional) who are connected to the eHealth Exchange or another HIE network or framework that connects with the Government’s electronic health record (EHR) system so that network providers can make available or exchange necessary clinical information with the MTF providers.

**11.2**The contractor shall designate network providers who utilize a HIE system in the Government view of the online provider directory.

**12.0  Network Provider Education**

**12.1**The contractor shall provide an education program for network providers in accordance with [Chapter 11](https://manuals.health.mil/pages/DisplayManualHtmlFile/2025-01-17/AsOf/TOT5/c11toc.html).

**12.2**The contractor shall provide an outreach and education program on TRICARE requirements for all network and TRICARE-authorized providers. The program shall include education on applicable TRICARE program requirements, policies, and procedures to allow providers to carry out the requirements of this contract in an efficient and effective manner which promotes beneficiary satisfaction. The outreach program shall include information on the Centers for Medicare and Medicaid Services (CMS) Meaningful Use (MU) Program.

**12.3**The contractor outreach shall include information about DoD/VA clinical practice guidelines, quality/value improvement efforts, and information about collection and reporting of outcomes data.

**12.4**The contractor shall educate network providers about the certified HIEs and national health standards to ensure they comply with Title VI of the 21st Century Cures Act in relation to HIE (e.g., CMS) and Office of the National Coordinator (ONC) for Health Information Technology (HIT) interoperability rules including use of Health Level 7 (HL7) Fast Healthcare Interoperability Resources (FHIR) and the United States Core Data for Interoperability (USCDI).

**12.5**At least biannually and for all new network providers, the contractor shall educate providers of the importance of updating their information in the provider directory (e.g., beneficiary satisfaction, MTF satisfaction, loss of referrals).

**13.0  Durable Medical Equipment (DME) Providers**

The contractor shall establish preferred provider contracts with national or regional DME vendors for specific categories of DME supplies which will allow for volume discounts and specialized service. DME supplies include, but are not limited to, infant formula, diabetic supplies, home infusion supplies, and breast pumps.