

amounts. No provider may bill an active duty member any amount in excess of the CHAMPUS allowable amount.

(e) *Waiver authority.* With the exception of statutory requirements, any restrictions or limitations pursuant to the general rule in paragraph (c) of this section, and special rules and procedures in paragraph (d) of this section, may be waived by the Director, OCHAMPUS, at the request of an authorized official of the uniformed service concerned, based on a determination that such waiver is necessary to assure adequate availability of health care services to active duty members.

(f) *Authorities.* (1) The Uniformed Services may establish additional procedures, consistent with this part, for the effective administration of the supplemental care program in their respective services.

(2) The Assistant Secretary of Defense for Health Affairs is responsible for the overall policy direction of the supplemental care program and the administration of this part.

(3) The Director, OCHAMPUS shall issue procedural requirements for the implementation of this section, including requirement for claims submission similar to those established by § 199.7.

[56 FR 23801, May 24, 1991, as amended at 58 FR 58963, Nov. 5, 1993]

§ 199.17 TRICARE program.

(a) *Establishment.* The TRICARE program is established for the purpose of implementing a comprehensive managed health care program for the delivery and financing of health care services in the MHSS.

(1) *Purpose.* The TRICARE program implements management improvements primarily through managed care support contracts that include special arrangements with civilian sector health care providers and better coordination between military medical treatment facilities (MTFs) and these civilian providers. Implementation of these management improvements includes adoption of special rules and procedures not ordinarily followed under CHAMPUS or MTF requirements. This section establishes those special rules and procedures.

(2) *Statutory authority.* Many of the provisions of this section are authorized by statutory authorities other than those which authorize the usual operation of the CHAMPUS program, especially 10 U.S.C. 1079 and 1086. The TRICARE program also relies upon other available statutory authorities, including 10 U.S.C. 1099 (health care enrollment system), 10 U.S.C. 1097 (contracts for medical care for retirees, dependents and survivors; alternative delivery of health care), and 10 U.S.C. 1096 (resource sharing agreements).

(3) *Scope of the program.* The TRICARE program is applicable to all of the uniformed services. Its geographical applicability is all 50 states and the District of Columbia. In addition, if authorized by the Assistant Secretary of Defense (Health Affairs), the TRICARE program may be implemented in areas outside the 50 states and the District of Columbia. In such cases, the Assistant Secretary of Defense (Health Affairs) may also authorize modifications to TRICARE program rules and procedures as may be appropriate to the area involved.

(4) *MTF rules and procedures affected.* Much of this section relates to rules and procedures applicable to the delivery and financing of health care services provided by civilian providers outside military treatment facilities. This section provides that certain rules, procedures, rights and obligations set forth elsewhere in this part (and usually applicable to CHAMPUS) are different under the TRICARE program. In addition, some rules, procedures, rights and obligations relating to health care services in military treatment facilities are also different under the TRICARE program. In such cases, provisions of this section take precedence and are binding.

(5) *Implementation based on local action.* The TRICARE program is not automatically implemented in all areas where it is potentially applicable. Therefore, provisions of this section are not automatically implemented. Rather, implementation of the TRICARE program and this section requires an official action by an authorized individual, such as a military medical treatment facility commander, a

Surgeon General, the Assistant Secretary of Defense (Health Affairs), or other person authorized by the Assistant Secretary. Public notice of the initiation of the TRICARE program will be achieved through appropriate communication and media methods and by way of an official announcement by the Director, OCHAMPUS, identifying the military medical treatment facility catchment area or other geographical area covered.

(6) *Major features of the TRICARE program.* The major features of the TRICARE program, described in this section, include the following:

(i) *Comprehensive enrollment system.* Under the TRICARE program, all health care beneficiaries become classified into one of five enrollment categories:

(A) Active duty members, all of whom are automatically enrolled in TRICARE Prime;

(B) TRICARE Prime enrollees, who (except for active duty members) must be CHAMPUS eligible;

(C) TRICARE Standard eligible beneficiaries, which covers all CHAMPUS-eligible beneficiaries who do not enroll in TRICARE Prime or another managed care program affiliated with TRICARE;

(D) Medicare-eligible beneficiaries, who, although not eligible for TRICARE Prime, may participate in many features of TRICARE; and

(E) Participants in other managed care program affiliated with TRICARE (when such affiliation arrangements are made).

(ii) *Establishment of a triple option benefit.* A second major feature of TRICARE is the establishment for CHAMPUS-eligible beneficiaries of three options for receiving health care:

(A) Beneficiaries may enroll in the “TRICARE Prime Plan,” which features use of military treatment facilities and substantially reduced out-of-pocket costs for CHAMPUS care. Beneficiaries generally agree to use military treatment facilities and designated civilian provider networks, in accordance with enrollment provisions.

(B) Beneficiaries may participate in the “TRICARE Extra Plan” under which the preferred provider network may be used on a case-by-case basis,

with somewhat reduced out-of-pocket costs. These beneficiaries also continue to be eligible for military medical treatment facility care on a space-available basis.

(C) Beneficiaries may remain in the “TRICARE Standard Plan,” which preserves broad freedom of choice of civilian providers (subject to nonavailability statement requirements of § 199.4), but does not offer reduced out-of-pocket costs. These beneficiaries continue to be eligible to receive care in military medical treatment facilities on a space-available basis.

(iii) *Coordination between military and civilian health care delivery systems.* A third major feature of the TRICARE program is a series of activities affecting all beneficiary enrollment categories, designed to coordinate care between military and civilian health care systems. These activities include:

(A) Resource sharing agreements, under which a TRICARE contractor provides to a military medical treatment facility, personnel and other resources to increase the availability of services in the facility. All beneficiary enrollment categories may benefit from this increase.

(B) Health care finder, an administrative activity that facilitates referrals to appropriate health care services in the military facility and civilian provider network. All beneficiary enrollment categories may use the health care finder.

(C) Integrated quality and utilization management services, potentially standardizing reviews for military and civilian sector providers. All beneficiary categories may benefit from these services.

(D) Special pharmacy programs for areas affected by base realignment and closure actions. This includes special eligibility for Medicare-eligible beneficiaries.

(iv) *Consolidated schedule of charges.* A fourth major feature of TRICARE is a consolidated schedule of charges, incorporating revisions that reduce differences in charges between military and civilian services. In general, the TRICARE program reduces out-of-pocket costs for civilian sector care.

(7) *Preemption of State laws.* (i) Pursuant to 10 U.S.C. 1103 and section 8025

(fourth proviso) of the Department of Defense Appropriations Act, 1994, the Department of Defense has determined that in the administration of 10 U.S.C. chapter 55, preemption of State and local laws relating to health insurance, prepaid health plans, or other health care delivery or financing methods is necessary to achieve important Federal interests, including but not limited to the assurance of uniform national health programs for military families and the operation of such programs at the lowest possible cost to the Department of Defense, that have a direct and substantial effect on the conduct of military affairs and national security policy of the United States.

(ii) Based on the determination set forth in paragraph (a)(7)(i) of this section, any State or local law relating to health insurance, prepaid health plans, or other health care delivery or financing methods is preempted and does not apply in connection with TRICARE regional contracts. Any such law, or regulation pursuant to such law, is without any force or effect, and State or local governments have no legal authority to enforce them in relation to the TRICARE regional contracts. (However, the Department of Defense may by contract establish legal obligations of the part of TRICARE contractors to conform with requirements similar or identical to requirements of State or local laws or regulations).

(iii) The preemption of State and local laws set forth in paragraph (a)(7)(ii) of this section includes State and local laws imposing premium taxes on health or dental insurance carriers or underwriters or other plan managers, or similar taxes on such entities. Such laws are laws relating to health insurance, prepaid health plans, or other health care delivery or financing methods, within the meaning of the statutes identified in paragraph (a)(7)(i) of this section. Preemption, however, does not apply to taxes, fees, or other payments on net income or profit realized by such entities in the conduct of business relating to DoD health services contracts, if those taxes, fees or other payments are applicable to a broad range of business activity. For purposes of assessing the ef-

fect of Federal preemption of State and local taxes and fees in connection with DoD health and dental services contracts, interpretations shall be consistent with those applicable to the Federal Employees Health Benefits Program under 5 U.S.C. 8909(f).

(b) *Triple option benefit in general.* Where the TRICARE program is implemented, CHAMPUS-eligible beneficiaries are given the options of enrolling in the TRICARE Prime Plan (also referred to as "Prime"); being a participant in TRICARE Extra on a case-by-case basis (also referred to as "Extra"); or remaining in the TRICARE Standard Plan (also referred to as "Standard").

(1) *Choice voluntary.* With the exception of active duty members, the choice of whether to enroll in Prime, to participate in Extra, or to remain in Standard is voluntary for all eligible beneficiaries. This applies to active duty dependents and eligible retired members, dependents of retired members, and survivors. For dependents who are minors, the choice will be exercised by a parent or guardian.

(2) *Active duty members.* For active duty members located in areas where the TRICARE program is implemented, enrollment in Prime is mandatory.

(c) *Eligibility for enrollment in Prime.* Where the TRICARE program is implemented, all CHAMPUS-eligible beneficiaries are eligible to enroll. However, some rules and procedures are different for dependents of active duty members than they are for retirees, their dependents and survivors. In addition, where the TRICARE program is implemented, a military medical treatment facility commander or other authorized individual may establish priorities, consistent with paragraph (c) of this section, based on availability or other operational requirements, for when and whether to offer the enrollment opportunity.

(1) *Active duty members.* Active duty members are required to enroll in Prime when it is offered. Active duty members shall have first priority for enrollment in Prime. Because active duty members are not CHAMPUS eligible, when active duty members obtain care from civilian providers outside the military medical treatment facility,

the supplemental care program and its requirements (including § 199.16) will apply.

(2) *Dependents of active duty members.*

(i) Dependents of active duty members are eligible to enroll in Prime. After all active duty members, dependents of active duty members will have second priority for enrollment.

(ii) If all dependents of active duty members within the area concerned cannot be accepted for enrollment in Prime at the same time, the MTF Commander (or other authorized individual) may establish priorities within this beneficiary group category. The priorities may be based on first-come, first-served, or alternatively, be based on rank of sponsor, beginning with the lowest pay grade.

(3) *Retired member, dependents of retired members, and survivors.* (i) All CHAMPUS-eligible retired members, dependents of retired members, and survivors are eligible to enroll in Prime. After all active duty members are enrolled and availability of enrollment is assured for all active duty dependents wishing to enroll, this category of beneficiaries will have third priority for enrollment.

(ii) If all CHAMPUS-eligible retired members, dependents of retired members, and survivors within the area concerned cannot be accepted for enrollment in Prime at the same time, the MTF Commander (or other authorized individual) may allow enrollment within this beneficiary group category on a first come, first served basis.

(4) *Participation in extra and standard.* All CHAMPUS-eligible beneficiaries who do not enroll in Prime may participate in Extra on a case-by-case basis or remain in Standard.

(d) *Health benefits under Prime.* Health benefits under Prime, set forth in paragraph (d) of this section, differ from those under Extra and Standard, set forth in paragraphs (e) and (f) of this section.

(1) *Military treatment facility (MTF) care.*—(i) *In general.* All participants in Prime are eligible to receive care in military treatment facilities. Participants in Prime will be given priority for such care over other beneficiaries. Among the following beneficiary groups, access priority for care in mili-

tary treatment facilities where TRICARE is implemented as follows:

(A) Active duty service members;

(B) Active duty service members' dependents and survivors of service members who died on active duty, who are enrolled in TRICARE Prime;

(C) Retirees, their dependents and survivors, who are enrolled in TRICARE Prime;

(D) Active duty service members' dependents and survivors of service members who died on active duty, who are not enrolled in TRICARE Prime; and

(E) Retirees, their dependents and survivors who are not enrolled in TRICARE Prime. For purposes of this paragraph (d)(1), survivors of members who died while on active duty are considered as among dependents of active duty service members.

(ii) *Special provisions.* Enrollment in Prime does not affect access priority for care in military treatment facilities for several miscellaneous beneficiary groups and special circumstances. Those include Secretarial designees, NATO and other foreign military personnel and dependents authorized care through international agreements, civilian employees under workers' compensation programs or under safety programs, members on the Temporary Disability Retired List (for statutorily required periodic medical examinations), members of the reserve components not on active duty (for covered medical services), military prisoners, active duty dependents unable to enroll in Prime and temporarily away from place of residence, and others as designated by the Assistant Secretary of Defense (Health Affairs). Additional exceptions to the normal Prime enrollment access priority rules may be granted for other categories of individuals, eligible for treatment in the MTF, whose access to care is necessary to provide an adequate clinical case mix to support graduate medical education programs or readiness-related medical skills sustainment activities, to the extent approved by the ASD(HA).

(2) *Non-MTF care for active duty members.* Under Prime, non-MTF care needed by active duty members continues to be arranged under the supplemental care program and subject to the rules

and procedures of that program, including those set forth in §199.16.

(3) *Benefits covered for CHAMPUS eligible beneficiaries for civilian sector care.* The provisions of §199.18 regarding the Uniform HMO Benefit apply to TRICARE Prime enrollees.

(e) *Health benefits under the TRICARE extra plan.* Beneficiaries not enrolled in Prime, although not in general required to use the Prime civilian preferred provider network, are eligible to use the network on a case-by-case basis under Extra. The health benefits under Extra are identical to those under Standard, set forth in paragraph (f) of this section, except that the CHAMPUS cost sharing percentages are lower than usual CHAMPUS cost sharing. The lower requirements are set forth in the consolidated schedule of charges in paragraph (m) of this section.

(f) *Health benefits under the TRICARE standard plan.* Where the TRICARE program is implemented, health benefits under Prime, set forth under paragraph (d) of this section, and Extra, set forth under paragraph (e) of this section, are different than health benefits under Standard, set forth in this paragraph (f).

(1) *Military treatment facility (MTF) care.* All nonenrollees (including beneficiaries not eligible to enroll) continue to be eligible to receive care in military treatment facilities on a space available basis.

(2) *Freedom of choice of civilian provider.* Except as stated in §199.4(a) in connection with nonavailability statement requirements, CHAMPUS-eligible participants in Standard maintain their freedom of choice of civilian provider under CHAMPUS. All nonavailability statement requirements of §199.4(a) apply to Standard participants.

(3) *CHAMPUS benefits apply.* The benefits, rules and procedures of the CHAMPUS basis program as set forth in this part, shall apply to CHAMPUS-eligible participants in Standard.

(4) *Preferred provider network option for standard participants.* Standard participants, although not generally required to use the TRICARE program preferred provider network are eligible

to use the network on a case-by-case basis, under Extra.

(g) *Coordination with other health care programs.* [Reserved]

(h) *Resource sharing agreements.* Under the TRICARE program, any military medical treatment facility (MTF) commander may establish resource sharing agreements with the applicable managed care support contractor for the purpose of providing for the sharing of resources between the two parties. Internal resource sharing and external resource sharing agreements are authorized. The provisions of this paragraph (h) shall apply to resource sharing agreements under the TRICARE program.

(1) In connection with internal resource sharing agreements, beneficiary cost sharing requirements shall be the same as those applicable to health care services provided in facilities of the uniformed services.

(2) Under internal resource sharing agreements, the double coverage requirements of §199.8 shall be replaced by the Third Party Collection procedures of 32 CFR part 220, to the extent permissible under such part. In such a case, payments made to a resource sharing agreement provider through the TRICARE managed care support contractor shall be deemed to be payments by the MTF concerned.

(3) Under internal or external resource sharing agreements, the commander of the MTF concerned may authorize the provision of services, pursuant to the agreement, to Medicare-eligible beneficiaries, if such services are not reimbursable by Medicare, and if the commander determines that this will promote the most cost-effective provision of services under the TRICARE program.

(i) *Health care finder.* The Health Care Finder is an administrative activity that assists beneficiaries in being referred to appropriate health care providers, especially the MTF and preferred providers. Health Care Finder services are available to all beneficiaries. In the case of TRICARE Prime enrollees, the Health Care Finder will facilitate referrals in accordance with Prime rules and procedures. For Standard participants, the Finder will provide assistance for use of Extra.

For Medicare-eligible beneficiaries, the Finder will facilitate referrals to TRICARE network providers, generally required to be Medicare participating providers. For participants in other managed care programs, the Finder will assist in referrals pursuant to the arrangements made with the other managed care program. For all beneficiary enrollment categories, the finder will assist in obtaining access to available services in the medical treatment facility.

(j) *General quality assurance, utilization review, and preauthorization requirements under TRICARE program.* All quality assurance, utilization review, and preauthorization requirements for the basic CHAMPUS program, as set forth in this part 199 (see especially applicable provisions of §§ 199.4 and 199.15), are applicable to Prime, Extra and Standard under the TRICARE program. Under all three options, 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. Pursuant to an agreement between a military medical treatment facility and TRICARE managed care support contractor, quality assurance, utilization review, and preauthorization requirements and procedures applicable to health care services outside the military medical treatment facility may be made applicable, in whole or in part, to health care services inside the military medical treatment facility.

(k) *Pharmacy services, including special services in base realignment and closure sites*—(1) *In general.* TRICARE includes two special programs under which covered beneficiaries, including Medicare-eligible beneficiaries, who live in areas adversely affected by base realignment and closure actions are given a pharmacy benefit for prescription drugs provided outside military treatment facilities. The two special programs are the retail pharmacy network program and the mail service pharmacy program.

(2) *Retail pharmacy network program.* To the maximum extent practicable, a retail pharmacy network program will

be included in the TRICARE program wherever implemented. Except for the special rules applicable to Medicare-eligible beneficiaries in areas adversely affected by military medical treatment facility closures, the retail pharmacy network program will function in accordance with TRICARE rules and procedures otherwise applicable. In addition, a retail pharmacy network program may, on a temporary, transitional basis, be established in a base realignment or closure site independent of other features of the TRICARE program. Such a program may be established through arrangements with one or more pharmacies in the area and may continue until a managed care program is established to serve the affected beneficiaries.

(3) *Mail service pharmacy program.* A mail service pharmacy program will be established to the extent required by law as part of the TRICARE program. The special rules applicable to Medicare-eligible beneficiaries established in this paragraph (k) shall be applicable.

(4) *Medicare-eligible beneficiaries in areas adversely affected by military medical treatment facility closures.* Under the retail pharmacy network program and mail service pharmacy program, there is a special eligibility rule pertaining to Medicare-eligible beneficiaries in areas adversely affected by military medical treatment facility closures.

(i) *Medicare-eligible beneficiaries.* The special eligibility rule pertains to military system beneficiaries who are not eligible for CHAMPUS solely because of their eligibility for part A of Medicare.

(ii) *Area adversely affected by closure.* To be eligible for use of the retail pharmacy network program or mail service pharmacy program based on residency, a Medicare-eligible beneficiary must maintain a principal place of residency in the catchment area of the MTF that closed. In addition, there must be a retail pharmacy network or mail service pharmacy established in that area. In identifying areas adversely affected by a closure, the provisions of this paragraph (k)(4)(ii) shall apply.

(A) In the case of the closure of a military hospital, the area adversely affected is the established 40-mile

catchment area of the military hospital that closed.

(B) In the case of the closure of a military clinic (a military medical treatment facility that provided no in-patient care services), the area adversely affected is an area approximately 40 miles in radius from the clinic, established in a manner comparable to the manner in which catchment areas of military hospitals are established. However, this area will not be considered adversely affected by the closure of the clinic if the Director, OCHAMPUS determines that the clinic was not, when it had been in regular operation, providing a substantial amount of pharmacy services to retirees, their dependents, and survivors.

(iii) *Other Medicare-eligible beneficiaries adversely affected.* In addition to beneficiaries identified in paragraph (k)(4)(ii) of this section, eligibility for the retail pharmacy network program and mail service pharmacy program is also established for any Medicare-eligible beneficiary who can demonstrate to the satisfaction of the Director, OCHAMPUS, that he or she relied upon an MTF that closed for his or her pharmaceuticals. Medicare beneficiaries who obtained pharmacy services at the facility that closed within the 12-month period prior to its closure will be deemed to be reliant on the facility. Validation that any such beneficiary obtained such services may be provided through records of the facility or by a written declaration of the beneficiary. Beneficiaries providing such a declaration are required to provide correct information. Intentionally providing false information or otherwise failing to satisfy this obligation is grounds for disqualification for health care services from facilities of the uniformed services and mandatory reimbursement for the cost of any pharmaceuticals provided based on the improper declaration.

(iv) *Effective date of eligibility for Medicare-eligible beneficiaries.* In any case in which, prior to the complete closure of a military medical treatment facility which is in the process of closure, the Director, OCHAMPUS, determines that the area has been adversely affected by severe reductions in access to services, the Director,

OCHAMPUS may establish an effective date for eligibility for the retail pharmacy network program or mail service pharmacy program for Medicare-eligible beneficiaries prior to the complete closure of the facility.

(5) *Effect of other health insurance.* The double coverage rules of §199.8 are applicable to services provided to all beneficiaries under the retail pharmacy network program or mail service pharmacy program. For this purpose, to the extent they provide a prescription drug benefit, Medicare supplemental insurance plans or Medicare HMO plans are double coverage plans and will be the primary payor.

(6) *Procedures.* The Director, OCHAMPUS shall establish procedures for the effective operation of the retail pharmacy network program and mail service pharmacy program. Such procedures may include the use of appropriate drug formularies, restrictions of the quantity of pharmaceuticals to be dispensed, encouragement of the use of generic drugs, implementation of quality assurance and utilization management activities, and other appropriate matters.

(1) *PRIMUS and NAVCARE clinics—(1) Description and authority.* PRIMUS and NAVCARE clinics are contractor owned, staffed, and operated clinics that exclusively serve uniformed services beneficiaries. They are authorized as transitional entities during the phase-in of TRICARE. This authority to operate a PRIMUS or NAVCARE clinic will cease upon implementation of TRICARE in the clinic's location, or on October 1, 1997, whichever is later.

(2) *Eligible beneficiaries.* All TRICARE beneficiary categories are eligible for care in PRIMUS and NAVCARE Clinics. This includes active duty members, Medicare-eligible beneficiaries and other MHSS-eligible persons not eligible for CHAMPUS.

(3) *Services and charges.* For care provided PRIMUS and NAVCARE Clinics, CHAMPUS rules regarding program benefits, deductibles and cost sharing requirements do not apply. Services offered and charges will be based on those applicable to care provided in military medical treatment facilities.

(4) *Priority access.* Access to care in PRIMUS and NAVCARE Clinics shall

be based on the same order of priority as is established for military treatment facilities care under paragraph (d)(1) of this section.

(m) *Consolidated schedule of beneficiary charges.* The following consolidated schedule of beneficiary charges is applicable to health care services provided under TRICARE for Prime enrollees, Standard enrollees and Medicare-eligible beneficiaries. (There are no charges to active duty members. Charges for participants in other managed health care programs affiliated with TRICARE will be specified in the applicable affiliation agreements.)

(1) *Cost sharing for services from TRICARE network providers.* (i) For Prime enrollees, cost sharing is as specified in the Uniform HMO Benefit in § 199.18, except that for care not authorized by the primary care manager or Health Care Finder, rules applicable to the TRICARE point of service option (see paragraph (n)(3) of this section) are applicable. For such unauthorized care, the deductible is \$300 per person and \$600 per family. The beneficiary cost share is 50 percent of the allowable charges for inpatient and outpatient care, after the deductible.

(ii) For Standard enrollees, TRICARE Extra cost sharing applies. The deductible is the same as standard CHAMPUS. Cost shares are as follows:

(A) For outpatient professional services, cost sharing will be reduced from 20 percent to 15 percent for dependents of active duty members.

(B) For most services for retired members, dependents of retired members, and survivors, cost sharing is reduced from 25 percent to 20 percent.

(C) In fiscal year 1996, the per diem inpatient hospital copayment for retirees, dependents of retirees, and survivors when they use a preferred provider network hospital is \$250 per day, or 25 percent of total charges, whichever is less. There is a nominal copayment for active duty dependents, which is the same as under the CHAMPUS program (see § 199.4). The per diem amount may be updated for subsequent years based on changes in the standard CHAMPUS per diem.

(iii) For Medicare-eligible beneficiaries, cost sharing will generally be

as applicable to Medicare participating providers.

(2) *Cost sharing for non-network providers.* (i) For TRICARE Prime enrollees, rules applicable to the TRICARE point of service option (see paragraph (n)(3) of this section) are applicable. The deductible is \$300 per person and \$600 per family. The beneficiary cost share is 50 percent of the allowable charges, after the deductible.

(ii) For Standard enrollees, cost sharing is as specified for the basic CHAMPUS program.

(iii) For Medicare eligible beneficiaries, cost sharing is as provided under the Medicare program.

(3) *Cost sharing under internal resource sharing agreements.* (i) For Prime enrollees, cost sharing is as provided in military treatment facilities.

(ii) For Standard enrollees, cost sharing is as provided in military treatment facilities.

(iii) For Medicare eligible beneficiaries, where made applicable by the commander of the *military medical treatment facility* concerned, cost sharing will be as provided in military treatment facilities.

(4) *Cost sharing under external resource sharing.* (i) For Prime enrollees, cost sharing applicable to services provided by military facility personnel shall be as applicable to services in military treatment facilities; that applicable to institutional and related ancillary charges shall be as applicable to services provided under TRICARE Prime.

(ii) For TRICARE Standard participants, cost sharing applicable to services provided by military facility personnel shall be as applicable to services in military treatment facilities; that applicable to non-military providers, including institutional and related ancillary charges, shall be as applicable to services provided under TRICARE Extra.

(iii) For Medicare-eligible beneficiaries, where available, cost sharing applicable to services provided by military facility personnel shall be as applicable to services in military treatment facilities; that applicable to non-military providers, including institutional and related ancillary charges shall be as applicable to services provided under Medicare.

(5) *Prescription drugs.* (i) For Prime enrollees, cost sharing is as specified in the Uniform HMO Benefit, except that the copayment under the mail service pharmacy program is \$4.00 for active duty dependents and \$8.00 for all other covered beneficiaries, per prescription, for up to a 90 day supply.

(ii) For Standard participants, there is a 15 percent cost share for active-duty dependents and a 20 percent cost share for retirees, their dependents and survivors for prescription drugs provided by retail pharmacy network providers; for prescription drugs obtained from network pharmacies, the CHAMPUS deductible will not apply. The copayment for all beneficiaries under the mail service pharmacy program is \$4.00 for active duty dependents and \$8.00 for all other covered beneficiaries, per prescription, for up to a 90 day supply. There is no deductible for this program.

(iii) For Medicare-eligible beneficiaries affected by military medical treatment facility closures, there is a 20 percent copayment for prescriptions provided under the retail pharmacy network program, and an \$8.00 copayment per prescription, for up to a 90-day supply, for prescriptions provided by the mail service pharmacy program. There is no deductible under either program.

(6) *Cost share for outpatient services in military treatment facilities.* (i) For dependents of active duty members in all enrollment categories, there is no charge for outpatient visits provided in military medical treatment facilities.

(ii) For retirees, their dependents, and survivors in all enrollment categories, there is no charge for outpatient visits provided in military medical treatment facilities.

(n) *Additional health care management requirements under TRICARE prime.* Prime has additional, special health care management requirements not applicable under Extra, Standard or the CHAMPUS basic program. Such requirements must be approved by the Assistant Secretary of Defense (Health Affairs). In TRICARE, all care may be subject to review for medical necessity and appropriateness of level of care, regardless of whether the care is provided in a military medical treatment facil-

ity or in a civilian setting. Adverse determinations regarding care in military facilities will be appealable in accordance with established military medical department procedures, and adverse determinations regarding civilian care will be appealable in accordance with § 199.15.

(1) *Primary care manager.* All active duty members and Prime enrollees will be assigned or be allowed to select a primary care manager pursuant to a system established by the MTF Commander or other authorized official. The primary care manager may be an individual physician, a group practice, a clinic, a treatment site, or other designation. The primary care manager may be part of the MTF or the Prime civilian provider network. The enrollees will be given the opportunity to register a preference for primary care manager from a list of choices provided by the MTF Commander. Preference requests will be honored, subject to availability, under the MTF beneficiary category priority system and other operational requirements established by the commander (or other authorized person).

(2) *Restrictions on the use of providers.* The requirements of this paragraph (n)(2) shall be applicable to health care utilization under TRICARE Prime, except in cases of emergency care and under the point-of-service option (see paragraph (n)(3) of this section).

(i) Prime enrollees must obtain all primary health care from the primary care manager or from another provider to which the enrollee is referred by the primary care manager or an authorized Health Care Finder.

(ii) For any necessary specialty care and all inpatient care, the primary care manager or the Health Care Finder will assist in making an appropriate referral. All such nonemergency specialty care and inpatient care must be preauthorized by the primary care manager or the Health Care Finder.

(iii) The following procedures will apply to health care referrals and preauthorizations in catchment areas under TRICARE Prime:

(A) The first priority for referral for specialty care or inpatient care will be to the local MTF (or to any other MTF

in which catchment area the enrollee resides).

(B) If the local MTF(s) are unavailable for the services needed, but there is another MTF at which the needed services can be provided, the enrollee may be required to obtain the services at that MTF. However, this requirement will only apply to the extent that the enrollee was informed at the time of (or prior to) enrollment that mandatory referrals might be made to the MTF involved for the service involved.

(C) If the needed services are available within civilian preferred provider network serving the area, the enrollee may be required to obtain the services from a provider within the network. Subject to availability, the enrollee will have the freedom to choose a provider from among those in the network.

(D) If the needed services are not available within the civilian preferred provider network serving the area, the enrollee may be required to obtain the services from a designated civilian provider outside the area. However, this requirement will only apply to the extent that the enrollee was informed at the time of (or prior to) enrollment that mandatory referrals might be made to the provider involved for the service involved (with the provider and service either identified specifically or in connection with some appropriate classification).

(E) In cases in which the needed health care services cannot be provided pursuant to the procedures identified in paragraphs (n)(2)(iii) (A) through (D) of this section, the enrollee will receive authorization to obtain services from a CHAMPUS-authorized civilian provider(s) of the enrollee's choice not affiliated with the civilian preferred provider network.

(iv) When Prime is operating in noncatchment areas, the requirements in paragraphs (n)(2)(iii) (B) through (E) of this section shall apply.

(v) Any health care services obtained by a Prime enrollee, but not obtained in accordance with the utilization management rules and procedures of Prime will not be paid for under Prime rules, but may be covered by the point-of-service option (see paragraph (n)(3) of this section). However, Prime rules

may cover such services if the enrollee did not know and could not reasonably have been expected to know that the services were not obtained in accordance with the utilization management rules and procedures of Prime.

(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. (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.* The Prime enrollment period shall be 12 months. Enrollees must remain in Prime for a 12 month period, at which time they may disenroll. This requirement is subject to exceptions for change of residence and other changes announced at the time the TRICARE program is implemented in a particular area.

(3) *Quarterly installment payments of enrollment fee.* The enrollment fee required by §199.18(c) may be paid in quarterly installments, each equal to one-fourth of the total amount. For any beneficiary paying his or her enrollment fee in quarterly installments, failure to make a required installment payment on a timely basis (including a grace period, as determined by the Director, OCHAMPUS) will result in termination of the beneficiary's enrollment in Prime and disqualification from future enrollment in Prime for a period of one year. If enrollment in TRICARE Prime is terminated for failure to make a required installment payment, services received after the due date of the installment payment will be cost shared under TRICARE Extra.

(4) *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.

(5) *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.

(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.

(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 non-emergency circumstances shall not exceed 30 minutes, except when emergency care is being provided to pa-

tients, 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 § 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.

(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 §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 of-

ferred 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.

(t) *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, OCHAMPUS, 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.

[60 FR 52095, Oct. 5, 1995, as amended at 63 FR 9142, Feb. 24, 1998]

§ 199.18 Uniform HMO Benefit.

(a) *In general.* There is established a Uniform HMO Benefit. The purpose of the Uniform HMO benefit is to establish a health benefit option modeled on health maintenance organization plans. This benefit is intended to be uniform wherever offered throughout the United States and to be included in all managed care programs under the MHSS. Most care purchased from civilian health care providers (outside an MTF) will be under the rules of the Uniform HMO Benefit or the Basic CHAMPUS Program (see § 199.4). The Uniform HMO Benefit shall apply only as specified in this section or other sections of this part, and shall be subject to any special applications indicated in such other sections.

(b) *Services covered under the uniform HMO benefit option.* (1) Except as specifically provided or authorized by this section, all CHAMPUS benefits provided, and benefit limitations established, pursuant to this part, shall apply to the Uniform HMO Benefit.

(2) Certain preventive care services not normally provided as part of basic program benefits under CHAMPUS are covered benefits when provided to Prime enrollees by providers in the civilian provider network. Standards for preventive care services shall be developed based on guidelines from the U.S. Department of Health and Human Services. Such standards shall establish a specific schedule, including frequency or age specifications for:

- (i) Laboratory and x-ray tests, including blood lead, rubella, cholesterol, fecal occult blood testing, and mammography;
- (ii) Pap smears;
- (iii) Eye exams;
- (iv) Immunizations;
- (v) Periodic health promotion and disease prevention exams;
- (vi) Blood pressure screening;
- (vii) Hearing exams;
- (viii) Sigmoidoscopy or colonoscopy;
- (ix) Serologic screening; and

(x) Appropriate education and counseling services. The exact services offered shall be established under uniform standards established by the Assistant Secretary of Defense (Health Affairs).

(3) In addition to preventive care services provided pursuant to paragraph (b)(2) of this section, other benefit enhancements may be added and other benefit restrictions may be waived or relaxed in connection with health care services provided to include the Uniform HMO Benefit. Any such other enhancements or changes must be approved by the Assistant Secretary of Defense (Health Affairs) based on uniform standards.

(c) *Enrollment fee under the uniform HMO benefit.* (1) The CHAMPUS annual deductible amount (see § 199.4(f)) is waived under the Uniform HMO Benefit during the period of enrollment. In lieu of a deductible amount, an annual enrollment fee is applicable. The specific enrollment fee requirements shall be published annually by the Assistant Secretary of Defense (Health Affairs), and shall be uniform within the following groups: dependents of active duty members in pay grades of E-4 and below; active duty dependents of sponsors in pay grades E-5 and above; and retirees and their dependents.

(2) *Amount of enrollment fees.* Beginning in fiscal year 1996, the annual enrollment fees are:

- (i) for dependents of active duty members in pay grades of E-4 and below, \$0;
- (ii) for active duty dependents of sponsors in pay grades E-5 and above, \$0; and
- (iii) for retirees and their dependents, \$230 individual, \$460 family.

(3) *Waiver of enrollment fee for certain beneficiaries.* The Assistant Secretary of Defense (Health Affairs) may waive the enrollment fee requirements of this section for beneficiaries described in 10 U.S.C. 1086(d)(2) (i.e., those who are eligible for Medicare on the basis of disability or end stage renal disease and who maintain enrollment in Part B of Medicare).

(d) *Outpatient cost sharing requirements under the uniform HMO benefit—*
(1) *In general.* In lieu of usual CHAMPUS cost sharing requirements