VHA HANDBOOK 1660.06 Transmittal Sheet May 16, 2008

VA-TRICARE NETWORK AGREEMENTS

- 1. **REASON FOR ISSUE.** This Veterans Health Administration (VHA) Handbook contains instructions on how to develop Department of Veterans Affairs (VA)-Department of Defense (DOD) TRICARE network agreements.
- 2. SUMMARY OF CONTENTS OR MAJOR CHANGES. This VHA Handbook incorporates revisions necessary due to changes in Departmental policies and VHA reorganizations. VA-DOD direct sharing agreements and VA-TRICARE activities have evolved into distinct activities and so these two programs are separated. *NOTE:* VA-DOD direct sharing agreements are located VHA Handbook 1660.04. Significant changes in this Handbook include:
- a. Instructions on how to develop agreements with TRICARE Managed Care Support Contractors (MCSCs).
 - b. Types of DOD beneficiaries eligible for care in VA medical facilities are clarified.
 - c. Policy on beneficiaries eligible for both VA and TRICARE benefits is updated.
 - d. Policy on collecting TRICARE patient cost shares is modified.
- e. VA and DOD jointly developed and implemented guidelines for a standardized, uniform payment and reimbursement schedule in accordance with Title 38 United States Code (U.S.C.) 8111 (a). This legislation and subsequent Memoranda of Agreements (MOAs) between the two Departments effectively eliminated the requirement for a disclosure statement when a TRICARE Network agreement does not include full costs.
- f. Indirect Medical Education (IDME) cannot be included as a cost in developing agreements. VA medical centers receive separate funding for education through Veterans Equitable Resource Allocation (VERA) system.
- g. The Veterans Integrated Service Network (VISN) role in developing TRICARE agreements and VA TRICARE Regional Office (TRO) Liaison Coordinators' responsibilities are stated.
- h. Instructions on how VA medical facilities need to handle care for TRICARE beneficiaries seeking to utilize VA medical facilities for medical treatment under the TRICARE for Life (TFL) Program are updated.
 - i. A TRICARE Reserve Select Program paragraph has been added.
- 3. REFERENCES. VHA Handbook 1660.04.
- **4. RESPONSIBLE OFFICE.** The VA-DOD Liaison and Sharing Office (10D2) is responsible for the contents of this Handbook. Questions should be directed to 202-461-6632.

- **5. RECISSIONS.** VHA Handbook 1660.4, VA-DOD Health Care Resources Sharing, dated March 31, 2004; and VHA Directive 2006-046, dated August 17, 2006, TRICARE Patient Cost Sharing Collections, are rescinded.
- **6. RECERTIFICATION.** This VHA Handbook is scheduled for recertification on or before the last day of May 2013.

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VA-TRICARE NETWORK AGREEMENTS

1. PURPOSE

This Veterans Health Administration (VHA) Handbook establishes procedures that Department of Veterans Affairs (VA) medical facilities, Veterans Integrated Service Networks (VISNs), and other organizational components need in order to develop agreements with TRICARE Managed Care Support Contractors (MCSCs).

2. AUTHORITIES

The VA-Department of Defense (DOD) Health Care Resources Sharing and Emergency Operations Act, Title 38 United States Code (U.S.C) 8111, and Public Law 107-314, are the authorities for this program.

3. SCOPE

VA-DOD sharing activities covered within the scope of this Handbook include: eligibility for care; VA medical center and VISN responsibilities; development of TRICARE Network agreements, reimbursement and billing; and approval of TRICARE Network agreements. TRICARE Network agreements are never to reduce services or diminish the quality of care for veterans.

4. ELIGIBILITY AND DUAL ELIGIBILITY

- a. <u>Eligibility.</u> TRICARE beneficiaries eligible for care under 10 U.S.C. §1074 may be provided health care at VA facilities under participation agreements negotiated between VA medical facilities and MCSCs. These beneficiaries are: active duty members of the armed services, military retirees, active duty family members and family members of retirees. TRICARE beneficiaries treated at VA medical facilities may be referred by a Military Treatment Facility (MTF), by a TRICARE MCSC, or may self-refer. VA medical facilities may elect to have staff identified as Primary Care Managers (PCMs).
- b. <u>**Dual Eligibility.**</u> Some TRICARE beneficiaries may be eligible for both VA and TRICARE benefits:
- (1) If a dual-eligible veteran is seeking care for a <u>service-connected</u> condition in a VA medical facility, the veteran must receive that care under that veteran's benefits. VA may not bill TRICARE for treatment of a service-connected condition.
- (2) If a veteran is seeking care for a <u>non-service connected</u> condition in a VA medical facility, the veteran may receive that care under either the veteran's benefits or TRICARE benefits for that episode of care. It is the beneficiary's responsibility to declare at each episode of care which benefit is being used. *NOTE: TRICARE Training Guide, Appendix E, "VA TRICARE Dual Eligibility," can be found at: http://vaww1.va.gov/cbo/rcbilling/tricare.asp.*

5. RESPONSIBILITIES

The VA-DOD Sharing Law (38 U.S.C. 8111) gives VA medical facilities and VISNs the flexibility to negotiate TRICARE agreements covering a broad spectrum of health related activities. Since prospective agreements may affect health care resources within a VISN, VA medical centers need to consult with VISNs <u>before</u> submitting these agreements to the VA-DOD Liaison and Sharing Office (10D2) for approval.

- a. VISNs or VA medical centers may develop agreements. Typically, VISNs develop agreements that cover the entire VISN.
 - b. VHA Central Office is responsible for developing national agreements.

6. VA TRICARE REGIONAL OFFICE (TRO) LIAISON COORDINATORS' RESPONSIBILITIES

VA TRICARE Regional Office (TRO) Liaison Coordinators' responsibilities include:

- a. Acting as liaison with the regional MCSC, VISNs, VHA, and TRICARE Management Activity (TMA) to resolve problems;
- b. Communicating with DOD entities and VA staff concerning VA's role in the TRICARE program;
- c. Formulating proposals, in coordination with TRO and TMA, to improve VA medical centers' participation; and
 - d. Coordinating provider education.

7. DEVELOPING NETWORK AGREEMENTS

- a. <u>Identify Points of Contact.</u> VA medical facilities and VISNs need to identify individuals to serve as points of contact (POC) with their MCSCs. VA POCs need to seek to establish close working relationships with MCSCs.
- b. <u>Areas of TRICARE Coverage</u>. TRICARE agreements cover only those medical services specified in DOD's agreement with its TRICARE contractors.
- c. <u>Potential for Agreements.</u> VISNs may explore the potential for TRICARE agreements on a medical center or VISN basis. Agreements are to be negotiated only where capacity is available. The VA-DOD Liaison and Sharing Office (10D2) establishes the participation template in conjunction with VA General Counsel. VISNs and VA medical centers have the authority to negotiate reimbursement rates with the MCSCs and to restrict services due to lack of capacity. Unlike VA-DOD sharing agreements, there is no mandated discount reimbursement rate off the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)

Maximum Allowable Charge (CMAC). The VA-DOD Liaison and Sharing Office (10D2) provides the appropriate template upon request.

- d. <u>Items to be Included in TRICARE Agreement Discussions.</u> After potential areas for providing services are identified, VISN or medical center staff need to discuss projected costs, workload, and resources with TROs and TRICARE contractors, as appropriate. Discussions must result in a clear understanding of what health information will be provided to TRICARE for the payment of services rendered. *NOTE: This information is included in TRICARE boilerplate agreements.*
- e. <u>TRICARE Mental Health and Substance Abuse Services.</u> Mental health and substance abuse services are usually included as amendments to the "boilerplate" contracts; typically, MCSCs have negotiated subcontracts for these services. As is the case with providing medical services, VA medical centers or VISNs may negotiate rates for these services.
- f. TRICARE Pharmacy Services. VA medical centers and VISNs may <u>not</u> enter into agreements to provide outpatient prescriptions, unless approved by VHA's Pharmacy Benefits Management (119) and the Chief Business Office (16). Eligible beneficiaries may fill prescription medications at MTF pharmacies, through the TRICARE Mail Order Pharmacy (TMOP), at TRICARE retail network pharmacies (TRRx), and at non-network pharmacies. Beneficiaries need a written prescription and a valid Uniformed Services identification card to have a prescription filled.
- g. <u>Dental Services.</u> VA medical centers usually do not participate in this program because of limited dental resources. TRICARE has negotiated a separate contract covering dental services for other than active duty DOD beneficiaries. If VA facilities and VISNs wish to pursue opportunities in this area, they need to contact United Concordia-TRICARE Dental Program for Family Members of Active Duty and Reserve Component or Delta Dental for retirees and family members of retirees TRICARE Dental Program. Currently, the Military Medical Support Office (MMSO) in Great Lakes, IL, processes dental authorizations and dental claims for service members on active duty for more than 30 days and certain reserve component service members not on active duty, but with approved line of duty determinations for dental injuries (see the instructions at http://mmso.med.navy.mil/). NOTE: A separate contract for active duty dental care is expected to be awarded during Fiscal Year (FY) 2008.

8. BILLING AND REIMBURSEMENTS

a. <u>Outpatient and Inpatient Rates.</u> When negotiating acceptable reimbursement rates with TRICARE contractors, the VISN or medical center must use, at a minimum, incremental cost as a basis for recovering the additional costs of providing care to DOD beneficiaries. *NOTE:* Prior to negotiation meetings with a TRICARE MCSC, VA staff need to initiate a business case analysis to determine appropriate and acceptable reimbursements. Third-party payers are always the primary payer and TRICARE a secondary payer for DOD beneficiaries, with the exception of active duty service members. TRICARE is the primary payer for active duty service members without any coordination requirements with third-party insurance. NOTE: Guidance for specific TRICARE billing is developed jointly by the Chief Business Office (CBO) (16), and the VA-DOD Liaison and Sharing Office (10D2). Information on this can also be

found within the VA TRICARE Guide which can be found at: http://vaww1.va.gov/cbo/rcbilling/tricare.asp.

- (1) VHA facilities and VISNs must monitor actual costs and revenues on an ongoing basis to ensure that revenues exceed incremental costs and that the agreements are valid business arrangements.
- (2) If VA receives an Explanation of Benefits (EOB) that indicates denial of a claim due to Other Health Insurance (OHI), VA needs to submit the claim to the OHI payer as the primary payer. The MCSC must provide complete OHI information to VA.
- b. <u>TRICARE Mental Health and Substance Abuse Services.</u> Typically, MCSCs have negotiated subcontracts for these services. As is the case with providing medical services, VA medical centers or VISNs may negotiate rates for these services.
- c. <u>Highly Specialized Services Reimbursement Modification.</u> VISNs may request alternative reimbursement methodologies to discounts on CMAC and Diagnosis Related Groups (DRG) (such as inpatient per diem rates) covering high cost and/or highly-specialized services, such as traumatic brain injury (TBI), blind rehabilitative, or spinal cord injury (SCI) for other than active duty service members. The request is to be forwarded to the appropriate VA TRO liaison as an amendment to the existing agreement. The VA TRO liaison must obtain authorization for the modification, in writing, from both the MCSC and TRICARE Management Activity (TMA) <u>before</u> the proposal is submitted to the VA-DOD Liaison and Sharing Office (10D2) for approval. For active duty service members, VISNs and VA medical centers need to follow special authorization procedures from the MMSO, and TMA billing guidance to TRICARE contractors for TBI, blind rehabilitative, or SCI which are covered under the national VA-DOD sharing agreement.
 - d. **Patient Cost Sharing Collections.** VA medical center staff are responsible for:
- (1) Informing TRICARE patients, who are using their TRICARE benefit at the time of enrollment (registration), that TRICARE co-payments and cost shares will not be waived.
- (2) Ensuring each TRICARE patient agrees to pay the fees as a condition of a VA medical center registration.
- (a) Dual-eligible beneficiaries must be informed that it is their responsibility, at each episode of care, to identify which entitlement they are using. VA pays for care for a rated service-connected condition while TRICARE pays if a service-connected veteran chooses to use a TRICARE benefit for a non service-connected condition.
- (b) TRICARE beneficiaries must be asked for OHI, and advised as to how the MCSC is responsible for providing that information if requested by VA.
- (c) TRICARE For Life (TFL) beneficiaries must be counseled at enrollment (registration) and informed of the program and how it is administered in a VA facility.

- (3) Ensuring each TRICARE beneficiary provide a Social Security Number (SSN) and DOD photo identification at enrollment (registration). VA staff must make a copy of the military identification card, and if the beneficiary is enrolled in TRICARE Prime, also make a copy of the TRICARE Prime card. The front and back of all identification (ID) cards must be copied and placed in the administrative folder.
- (4) Assigning the sponsor's SSN to the appropriate insurance screen when registering, and ensuring that the sponsor's SSN is entered in the appropriate insurance data fields. *NOTE: Refer to the VA TRICARE Guide for specific guidance.*
- (5) Knowing that patient cost share information is available on the EOB provided to the VA facility after the claim has been adjudicated. VA is to contact the MCSCs for changes in patient cost sharing amounts if an EOB has not been received in a timely manner.
- (6) Knowing that active duty service members or active duty family members enrolled to TRICARE PRIME or TRICARE Prime Remote <u>never</u> pay a co-payment. The only exception to this is if the active duty family member was using the Point of Service Option under the TRICARE Prime plan. Active duty service members do not have a point of service option. **NOTE:** Information on current co-payment and cost sharing amounts may also be found at http://www.tricare.osd.mil/tricarecost.cfm.
- (7) Utilizing mandated offset programs, including internal Debt Management Collection (DMC) and the Treasury Offset Program (TOP), to assess Federal payments to the sponsor.
- (a) The TRICARE sponsor is responsible for any co-payment debt belonging to a beneficiary of a sponsor. This is in addition to any Federal payments the spouse is receiving if the spouse's co-payments become delinquent.
- (b) Failure to make co-payments resulting in a debt balance of over \$100 for more than 180 days may result in VA's refusal to treat the TRICARE patient for non-emergency care. If care is terminated, VA must assist the beneficiary in finding alternative care.
- e. **Revenue Source Codes.** The following revenue source codes need to be used for revenue generated under a TRICARE agreement:
- (1) **8028** Medical services agreements for inpatient services, i.e., services which involve an overnight stay.
- (2) **8029** Medical services agreements for outpatient services, e.g., laboratory work, physicals, etc.
 - (3) **8030** First-party co-pays, cost shares, and deductibles paid by TRICARE patients.

NOTE: TRICARE billing guidance may be found at: http://www.tricare.osd.mil/claims. VA
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TRICARE billing guidance can be found at: http://www.tricare.osd.mil/claims. vand on the VHA CBO Webpage at: http://www.l.va.gov/cbo/rcbilling/tricare.asp.

- f. <u>Electronic Claims Processing.</u> Claims are to be transmitted to the appropriate TRICARE fiscal intermediary (FI) for processing utilizing the Electronic Data Interchange (EDI). TFL claims are to be transmitted directly to Wisconsin Physician Services (WPS) utilizing EDI. *NOTE: TFL Claims must not be submitted using the eMRA process.* An electronic copy of VA's "TRICARE and VA Training Guide," which standardizes administrative and billing processes, can be downloaded from the Veterans Health Information and Technology Architecture (VistA) University web page at: http://vaww1.va.gov/cbo/rcbilling/tricare.asp.
- (1) VA medical centers are responsible for ensuring that incremental costs of delivering health care under this program are covered and that these agreements are valid business arrangements. Cost benefit analysis documentation must be retained in the agreement file. <u>VA medical care appropriations are not to be used to subsidize TRICARE.</u>
 - (2) Collections from TRICARE contractors are available in the fiscal year they are received.

9. APPROVAL OF NETWORK AGREEMENTS

a. Approval Process for New Agreements

- (1) Local veterans' service organizations must be consulted prior to forwarding the proposed agreement to the VA-DOD Liaison and Sharing Office (10D2).
- (2) TRICARE agreements submitted from the VA medical center Director, or VISN Director, to the VA-DOD Liaison and Sharing Office (10D2) for approval must be signed by the TRICARE contractor, but not signed by the VA medical center Director or VISN Director. Proposed agreements must include a statement that:
 - (a) Consultation with local veterans groups has been completed; and
- (b) The contract will not result in the denial of, or delay in, providing care to veterans at that facility.
- (3) The medical center or VISN is to send the proposed agreement to the VA-DOD Liaison and Sharing Office (10D2) for final approval by the Under Secretary for Health, or designee.
- (4) The Under Secretary for Health must certify to the Secretary of Veterans Affairs that agreements involving TRICARE beneficiaries will not result in the denial of, or delay in, providing access to care for any veteran at that facility.
- (5) After the Under Secretary for Health has approved the contract, the VA-DOD Liaison and Sharing Office (10D2) forwards the approved proposed agreement to the medical center Director or VISN Director for signature.
- b. <u>Renewals, Modifications or Amendments.</u> Once approved, TRICARE agreements can be modified, extended, or amended without going through the formal approval process described

in subparagraph 9a. However, modifications, extensions, or amendments to existing agreements still need to be sent to the VA-DOD Liaison and Sharing Office (10D2) for review and approval.

10. TRICARE FOR LIFE (TFL) PROGRAM

- a. <u>TRICARE for Life (TFL).</u> TFL covers military retirees, spouses, and survivors aged 65 and older, as well as those beneficiaries under age 65 who are eligible for Medicare for any reason. Except for active duty family members, beneficiaries eligible for Medicare Part A (for hospitalization payments) must enroll in Medicare Part B (for other provider payments) to become eligible for TFL.
- b. <u>DOD's Policy for Care Provided at VA.</u> Medicare is not authorized to pay VA. DOD has a separate policy for payment for TFL services to VA medical facilities that is different from its policies with private sector providers; it includes:
- (1) TFL-eligible DOD beneficiaries using VA medical facilities may receive all TRICARE covered benefits.
- (2) Beneficiaries choosing to utilize TFL benefits through VA providers may self-refer if, at that episode of care, they state their intentions to use their TFL benefit, TRICARE functions as first-payer for services and benefits covered by TRICARE, if the beneficiary does not have OHI. TFL beneficiaries must be counseled at enrollment (registration) and informed of the program and how it is administered in a VA facility.
- (3) VA services provided through TFL are subject to cost-sharing requirements, such as applicable annual deductibles and cost shares. VA may not waive TFL beneficiary out-of-pocket cost shares. Beneficiaries must be advised that if the VA facility is a TRICARE Network Provider, the cost-shares are to be calculated at the TRICARE Extra rate, not at the TRICARE Standard rate.
- (4) If the beneficiary has OHI, TRICARE is the second payer (after OHI). Medicare is not authorized to pay VA for any services provided to Medicare-eligible patients, including those covered by TFL.

c. Terms of TFL Reimbursement

- (1) VA health care facilities with TRICARE network agreements may be TFL providers, if capacity is available. TFL WPS reimburses VA facilities at the rate determined as the primary payer specified in the contract. The VA facility must bill OHI, if applicable, before billing WPS for covered services.
- (2) After OHI is billed, VA health care facilities should transmit claims transmitted directly to WPS utilizing EDI (see subpar. 8f).
- d. <u>Cost Sharing.</u> Both "Extra" and Standard" rates require significant cost-sharing on the part of the TFL beneficiary; these amounts are subject to change. The amount of the required cost-share payment assessed to the DOD TFL beneficiary depends on the status of the VA

facility as a TRICARE network or non-network health care provider. VA is responsible for collecting all TRICARE Extra (TRICARE network provider) or Standard (non-TRICARE network provider) cost shares and deductibles.

e. Eligibility for VA Services

- (1) TFL beneficiaries may receive VA care, <u>if space is available</u>. TFL beneficiaries (including dual eligible veterans) requesting to be seen as TFL beneficiaries may be treated subject to verification of their enrollment in the Defense Enrollment Eligibility Reporting System (DEERS).
- (2) Medical facilities must provide information on current cost-sharing requirements for DOD beneficiaries considering utilizing TFL benefits at VA at the time the potential TFL beneficiary presents for any new episode of care. This information is to include cost-sharing information for:
 - (a) TFL services provided by the private sector, and
 - (b) TFL services that would be provided by VA facilities.

NOTE: Additional information concerning TFL consults can be found at: http://www.tricare.osd.mil./; cost-sharing information can be found at: http://www.tricare.osd.mil/tfl/matrix.html.

11. TRICARE RESERVE SELECT PROGRAM

- a. <u>TRICARE Reserve Select (TRS).</u> TRS is a premium-based health plan available for purchase by qualified National Guard and Reserve members.
- b. <u>DOD's Policy for Care Provided at VA.</u> VA medical facilities, which are in the TRICARE Network, may deliver TRICARE Extra covered benefits to TRS beneficiaries in accordance with the terms of their network agreement.
- c. <u>Cost Sharing.</u> Under TRICARE Reserve Select, DOD shares in the cost of health care with covered beneficiaries according to statute, regulation, and policy applicable to active duty family members under TRICARE Extra and TRICARE Standard. In order to receive reimbursement under TRICARE, VA must apply all TRICARE Extra or Standard cost shares and deductibles.

d. Eligibility for VA Services

(1) TRS beneficiaries, including non-veterans, may receive VA care <u>if space is available</u>. TFL beneficiaries (including dual eligible veterans) requesting to be seen as TFL beneficiaries may be treated, subject to verification of their enrollment in the Defense Enrollment Eligibility Reporting System (DEERS).

- (2) VA medical facilities must inform TRS members and their covered family members regarding current cost-sharing requirements when a TRS beneficiary first comes in for care at VA. This information is to include cost-sharing information for:
 - (a) TRS services provided by the private sector,
 - (b) TRS services that would be provided by VA facilities, and
 - (c) A veteran who is seen as a veteran by VA.

NOTE: For additional information concerning TRS go to: <u>www.tricare.mil/</u>