

AWARD / CONTRACT		1. This Contract is a rated order under DPAS (15 CFR 700)		Rating C9E		Page of Pages 1 92	
2. Contract (Proc., Inst., Ident.) No. MDA90603C0009		3. Effective Date Aug 27, 2003		4. Requisition / Purchase Request / Project No. 03-PRO-0072*D01			
5. Issued By DEPARTMENT OF DEFENSE TRICARE MANAGEMENT ACTIVITY/CM 16401 E. CENTRETECH PARKWAY AURORA, CO 80011-9066 BRUCE MITTERER K11 bruce.mitterer@tma.osd.mil		Code MDA906		6. Administered By (if other than item) See Item 5		Code MDA906	
7. Name and address of Contractor (No., Street, City, state and Zip Code) TRIWEST HEALTHCARE ALLIANCE 16010 NORTH 28TH AVENUE PHOENIX AZ 85053				Vendor ID: 00003284 DUNS: 945580587 CEC: 945580587 Cage Code: 07TQ3		8. Delivery <input type="checkbox"/> FOB Origin <input type="checkbox"/> Other (See below)	
Code				Facility Code		9. Discount for prompt payment Net 30	
11. Ship To / Mark For DOD/TRICARE MANAGEMENT ACTIVITY 16401 E. CENTRETECH PARKWAY AURORA, CO 80011-9066				Code ZD06		12. Payment will be made by DEPARTMENT OF DEFENSE (RMF) FINANCE AND ACCOUNTING BRANCH 16401 E. CENTRETECH PARKWAY AURORA, CO 80011-9066	
13. Authority for using other than full and open competition <input type="checkbox"/> 10 U.S.C 2304(c)() <input type="checkbox"/> 41 U.S.C. 253 (c)()				14. Accounting and Appropriation Data 9703030130.1889.102000			
15A ITEM NO.	15B SUPPLIES/SERVICES			15C QUANTITY	15D UNIT	15E UNIT PRICE	15F AMOUNT
0001	WEST CONTRACT BASE PERIOD 1 September 2003 - 31 March 2004 Transition			1	LT	61,082,217.00	61,082,217.00
15G. TOTAL AMOUNT OF CONTRACT							\$ 14,313,589,814.32
16. Table of Contents							
(x)	Sec.	Description	Pages	(x)	Sec.	Description	Pages
Part I – The Schedule				Part II – Contract Clauses			
X	A	Solicitation/Contract Form	1-1	X	I	Contracts Clauses	77-90
X	B	Supplies or Services and Prices/Cost	2-21	Part III – List of Documents, Exhibits and other attach.			
X	C	Description/Specs/Work Statement	22-39	X	J	List of Attachments	91-92
X	D	Packaging and Marking	40-40	Part IV – Representations and Instructions			
X	E	Inspection and Acceptance	41-40		K	Representations, Certifications and other statements of Offerors	
X	F	Deliveries or Performance	41-52		L	Instrs., Conds, and Notices to Offerors	
X	G	Contract Administration Data	53-56		M	Evaluation factors for Award	
X	H	Special Contract Requirements	57-76				
Contracting Officer will complete item 17 or 18 as applicable							
17. <input type="checkbox"/> CONTRACTOR'S NEGOTIATED AGREEMENT (Contractor is required to sign this document and return _____ copies to issuing office.) Contractor agrees to furnish and deliver all items or perform all the services set forth or otherwise identified above and on any continuation sheets for the consideration stated herein. The rights and obligation of the parties to this contract shall be subject to and governed by the following documents: (a) this award/contract, (b) the solicitation, if any, and (c) such provisions, representations, certifications, and specifications, as are attached or incorporated by reference herein. (Attached are listed herein.)				18. <input type="checkbox"/> AWARD (Contractor is not required to sign this document.) Your offer on Solicitation number _____ including the additions or changes made by you which additions or changes are set forth above, is hereby accepted as to the items listed above and on any continuation sheets. This award consummates the contract which consists of the following documents: (a) the Government's solicitation and your offer, and (b) this award/contract. No further contractual document is necessary.			
19A. Name and Title of Signer (Type or Print)				20A. Name of Contracting Officer CHARLES R. BROWN 303-676-3652 charles.brown@tma.osd.mil			
19B. Name of Contractor		19C. Date Signed		20B. United States of America		20C. Date Signed	
By _____ (Signature of person authorized to sign)				By _____ (Signature of Contracting Officer)			

Supplies or Services and Prices/Costs

Item No.	Supplies/Services	Quantity	Unit	Unit Price	Amount
000101	Transitional Geographic Area 11 1 September 2003 - 31 May 2004 (\$10,470,501.00)	0	LT	(b)(4)	
000102	Transitional Geographic Area 9/10/12 1 September 2003 - 30 June 2004 (\$42,525,218)	0	LT		
000103	Transitional Geographic Area Central 1 December 2003 - 30 September 2004 (\$8,386,498)	0	LT		
0002	Transition Geographic Area 9/10/12 1 September 2003 - 31 March 2004 (Firm fixed price line item)	7	MO		
0003	Transition Geographic Area Central 1 December 2003 - 31 March 2004 (Firm fixed price line item)	4	MO		
0004	Change Order Implementation	0	EA		
0004AA	NEW DEERS IMPLEMENTATION	1	LT		
0004AB	TSM Change 5	1	LT		
0004AC	TRM Change 5	1	LT		
0004AD	TOM Change 6	1	LT		
0004AE	TPM Change 5	1	LT		
0004AF	EWRAS Implementation (TSM8)	1	LT		
0005	Change Order On-going Administration OPTION PERIOD I 1 April 2004 - 31 March 2005	0	EA		
0101	Transition Geographic Area 11 1 April 2004 - 31 May 2004	2	MO		
0102	Transition Geographic Area 9/10/12 1 April 2004 - 30 June 2004 (Firm fixed price line item)	3	MO		
0103	Transition Geographic Area Central 1 April 2004 - 30 September 2004 (Firm fixed price line item)	6	MO		
ADMINISTRATIVE SUPPORT SERVICES					
0104	Claims Processing (Fixed unit rate) (Requirements line item)	0	EA		
0104AA	Electronic claim rate (quantity is estimated)	5800097	EA		
0104AB	Paper claim rate (quantity is estimated)	1023546	EA		
0105	Per Member Per Month (Fixed unit rate per member month) (Requirements line item)	10	MO		
0105AA	4 month contract period	3704348	MM		

Supplies or Services and Prices/Costs

Item No.	Supplies/Services	Quantity	Unit	Unit Price	Amount
	The estimated number of MHS eligible beneficiaries (926,087) multiplied by 4 months = the number of member months (the quantity). The number of member months (quantity) multiplied by the fixed unit rate per member (unit price) = the amount for the 4 month contract period				
0105AB	Adjusted 6 month contract period	15721824	MM	(b)(4)	
	The estimated number of MHS eligible beneficiaries (2,620,304) multiplied by 6 months = the number of member months (the quantity). The number of member months (quantity) multiplied by the fixed unit rate per member (unit price) = the amount for the 6 month contract period				
0106	Disease Management (Cost plus fixed fee line item)		0 LT		
0106AA	Estimated cost = \$2,520,000 (Government provided estimate)		1 LT		
0106AB	Fixed Fee		10 MO		
0107	Customer Satisfaction Award Fee Pool		0 EA		
0107AA	First Quarter		0 EA		
0107AB	Second Quarter		1 EA		
0107AC	Third Quarter		1 EA		
0107AD	Fourth Quarter		1 EA		
0108	Contracting Officer Directed Travel = \$50,000 (Government provided estimate)		1 LT		
0109	Transition Out (Firm fixed price line item)		1 LT		
0110	TRICARE Service Centers (Firm fixed price)		10 MO		
0111	Underwritten Health Care Costs		0 YR		
011101	Underwritten HealthCare Target Cost		0 EA		
0111AA	(b)(4) duty		1 YR		
0111AB	MTF Enrollees Care Cost Navy Non-Active Duty		1 YR		
0111AC	MTF Enrollees Care Cost Air Force Non-Active Duty		1 YR		
0111AD	MTF Enrollees Care Cost TMA Civilian Network Enrollees and Non-Enrollees Costs		1 YR		
0112	Underwriting Fee Fee Percentage (b)(4)		1 LT		
011201	Underwriting Fee Target (b)(4)		0 EA		
0113	Non-Underwritten Supply re		0 EA		

Supplies or Services and Prices/Costs

Item No.	Supplies/Services	Quantity	Unit	Unit Price	Amount
0113AA	Army Supplemental Health Care	1	YR	(b)(4)	
0113AB	Navy Supplemental Health Care	1	YR		
0113AC	Air Force Supplemental Health Care	1	YR		
0120	Change Order Implementation	0	EA		
0120AA	EWRAS Contingency, Ref & Auth and Med Necessity, On-going admin (TPM9, TOM12, TRM10)	1	LT		
0120AB	TSM consolidated changes TSM 13 and TOM 13 Implementation	1	LT		
0120AC	Revised Personnel Security ADP/IT Requirements (TSM 14)	1	LT		
0120AD	Implementation costs - Alaska CMAC waiver	1	LT		
0120AE	Implementation of Medicare Part A Under 65 Dual Eligible (TOM 15)	1	LT		
0120AF	Implementation of TNEX Combo TPM 11 and TSM 17	1	LT		
0120AG	Implementation for the Extended Care Health Option (ECHO) - Start Up (TOM 21, TRM 23, TSM 23 TPM 17)	1	LT		
0120AH	Implementation, 2002 NDAA Provisions/Revisions to (DME) - (TPM13, TRM19, TPM18, TRM24, TPM26)	1	LT		
0120AJ	TRICARE Reserve Select TOM 18 & TSM 22	1	LT		
0120AK	Implementation of NDAA05 Section 703 -Early Eligibility (TOM20 TPM16)	1	LT		
0120AL	HPSA Bonus Payments-Psychiatrists-Implementation (TPM19/TRM25/TOM22 and TPM 20)	1	LT		
0121	Change Order On-going Administration	0	EA		
0121AA	Custodial Care Transitional Policy (CCTP) (TPM 7)	1	LT		
0121AB	HIPAA T&Cs Compliance Extension (TOM9)	1	LT		
0121AC	Operation Noble Eagle/Operation Enduring Freedom (TOM10, TRM7, TSM9, TSM12, TSM19, TOM16 & TRM17)	0	MO		
0121AD	Ongoing Administration, NDAA04, Section 703 Early Eligibility (90 days) (TOM11)	1	LT		
0121AE	Ongoing Administration, NDAA04, Section 704, TAMP (TOM11)	1	LT		
0121AF	EWRAS Contingency, Ref & Auth and Med Necessity On-going Admin (TPM9, TOM12, TRM10)	4	MO		
0121AG	Ongoing Administration, NDAA05 - Section 703- Early Eligibility (TOM 20 TPM 16)	1	LT		
0121AH	Ongoing Admin, NDAA05 Section 706 - Extended TAMP (TOM 20 TPM 16)	1	LT		
0121AJ	Change Order On-Going Administration, TOM 6 Changes	1	LT		
0122	EWRAS Contingency, Ref & Auth and Med Necessity, On-going admin (TPM9, TOM12, TRM10, TSM8)	6	MO		
0130	Clinical Support Agreement Program (indefinite-quantity CLIN)	1	LT	NSP	NSP

Supplies or Services and Prices/Costs

Item No.	Supplies/Services	Quantity	Unit	Unit Price	Amount
	Min. Order: -0- Max. Order: \$10,000,000				
	OPTION PERIOD II 1 April 2005 - 31 March 2006				
	ADMINISTRATIVE SUPPORT SERVICES				
0201	Claims Processing (Fixed unit rate) (Requirements line item)	0	EA	(b)(4)	
0201AA	Electronic claim rate (quantity is estimated)	9594539	EA	(b)(4)	
0201AB	Paper claim rate (quantity is estimated)	1693154	EA	(b)(4)	
0202	Per Member Per Month (Fixed unit rate per member month) (Requirements line item)	12	MO	(b)(4)	
0202AA	First 6 month contract period	15731778	MM	(b)(4)	
0202AB	Adjusted 6 month contract period The estimated number of MHS eligible beneficiaries (2,621,963) multiplied by 6 months = the number of member months (the quantity). The number of member months (quantity) multiplied by the fixed unit rate per member (unit price) = the amount for the 6 month contract period	15731778	MM	(b)(4)	
0203	Disease Management (Cost plus fixed fee line item)	0	LT	(b)(4)	
0203AA	Estimated Cost = \$3,860,000 (Government provided estimate)	1	LT	(b)(4)	
0203AB	Fixed Fee	12	MO	(b)(4)	
0204	Customer Satisfaction Award Fee Pool	0	EA	(b)(4)	
0204AA	First Quarter	1	EA	(b)(4)	
0204AB	Second Quarter	1	EA	(b)(4)	
0204AC	Third Quarter	1	EA	(b)(4)	
0204AD	Fourth Quarter	1	EA	(b)(4)	
0205	Contracting Officer Directed Travel = \$50,000 (Government provided estimate)	1	LT	(b)(4)	
0206	Transition Out	1	LT	(b)(4)	

Supplies or Services and Prices/Costs

Item No.	Supplies/Services	Quantity	Unit	Unit Price	Amount
	(Firm fixed price line item)				
0207	TRICARE Service Centers (Firm fixed price line item)	12	MO	(b)(4)	
0208	Underwritten Health Care Costs	0	YR		
020801	Underwritten Health Care Target Cost - (b)(4)	0	EA		
0208AA	MTF Enrollees Care Cost	1	YR		
0208AB	Navy Non-Active Duty MTF Enrollees Care Cost	1	YR		
0208AC	Air Force Non-Active Duty MTF Enrollees Care Cost	1	YR		
0208AD	TMA Civilian Network Enrollees and Non-Enrollees Costs	1	YR		
0209	Underwriting F Fee Percentage (b)(4)	1	YR		
020901	Underwriting F (b)(4)	0	EA		
0210	Non-Underwritten Supplemental Health Care	0	EA		
0210AA	Army Supplemental Health Care	1	YR		
0210AB	Navy Supplemental Health Care	1	YR		
0210AC	Air Force Supplemental Health Care	1	YR		
0220	Change Order Implementation	0	EA		
0220AA	Implementation costs FMC, Delta Junction, Alaska CMAC waiver	1	LT		
0220AB	Implementation EWRAP Short-Term Changes (TOM 23)	1	LT		
0220AC	Implementation - Reducing Deemed Enrollment Period for Newborns/Adoptees TOM24/TRM26/TPM21	1	LT		
0220AD	Implementation Consolidated Admin Changes, TOM 27 and TPM 30	1	LT		
0220AE	Implementation of Enrollment Fee Refunds for Medicare Eligibles (TOM28, TPM31)	1	LT		
0220AF	Implementation electric breast pump for premature infants, TPM 32, TSM 26 and TSM 27	1	LT		
0220AG	Implementation of TRICARE's Adoption of Outpatient Prospective Payment System (OPPS) Phase I Development (TRM28, TPM,28 TSM25)	1	LT		
0220AH	Implementation DEERS Phase II	1	LT		
0220AJ	Tobacco Cessation Demo TSM 30 TOM31	1	LT		
0220AK	Implementation Costs - Locality Based CMAC Waiver, Perinatology Services in Anchorage, Alaska	1	LT		
0221	Change Order On-going Administration	0	EA		
0221AA	Custodial Care Transitional Policy (CCTP) (TPM 7)	1	LT		
0221AB	Continuation of Custodial Care Transitional Policy (CCTP) (TPM 29)	1	LT		
0221AC	Ongoing Administration of Enrollment Fee Refunds for Medicare Eligibles (TOM28, TPM31)	1	LT		
0221AD	Recoup CAP/DME Overpayments 1992 - 1997	1	LT		
0221AF	Change Order On-Going Administration, TOM 6 Changes	1	LT		
0221AG	On-Going Admin, EWRAP Short-Term Changes	1	LT		

Supplies or Services and Prices/Costs

Item No.	Supplies/Services	Quantity	Unit	Unit Price	Amount		
0221AH	(TOM 23) On-Going Admin	1	LT	(b)(4)			
0221AJ	On-going Admin, 2002 NDAA	1	LT				
0222	Provisions/Revisions to DME (TPM 13, TRM19, TPM18, TRM24 TPM26) EWRAS Contingency, Ref & Auth, and Med Necessity, On-going admin (TPM9, TOM12, TRM10, TSM8)	12	MO				
0223	Implementation of CMAC update based on Site of Service (TRM 20)	1	LT				
0224	Implementation of SNF & Hospice Wage Index Changes	1	LT				
0225	Implementation of TRICARE Bonus Payment process to include Physician Scarcity Areas (PSAs)	1	LT				
0226	Implementation of DRG Updates	1	LT				
0230	Clinical Support Agreement Program (indefinite-quantity CLIN) Min. Order: -0- Max. Order: \$10,000,000	1	LT				
0231	Resource Sharing (indefinite-quantity CLIN) Min. Order: -0- Max. Order: \$10,000,000.00	1	LT			NSP	NSP
	OPTION PERIOD III 1 April 2006 - 31 March 2007						
	ADMINISTRATIVE SUPPORT SERVICES						
0301	Claims Processing (Fixed unit rate) (Requirements line item)	0	EA	(b)(4)			
0301AA	Electronic claim rate (quantity is estimated)	10370279	EA				
0301AB	Paper claim rate (quantity is estimated)	1830049	EA				
0302	Per Member Per Month (Fixed unit rate per member month) (Requirements line item)	12	MO				
0302AA	First 6 month contract period The number of MHS eligible beneficiaries (2,625,259) multiplied by 6 months = the number of member months (the quantity). The number of member months (quantity) multiplied by the fixed unit rate per member (unit price) = the amount for the 6 month contract period	15751554	MM				
0302AB	Adjusted 6 month contract period The estimated number of MHS eligible beneficiaries (2,625,259) multiplied by 6 months = the number of member months (the quantity). The number of member months (quantity) multiplied by the fixed unit rate per member (unit price) = the	15751554	MM				

Supplies or Services and Prices/Costs

Item No.	Supplies/Services	Quantity	Unit	Unit Price	Amount
	amount for the 6 month contract period				
0303	Disease Management (Cost plus fixed fee line item)	0	LT	(b)(4)	
0303AA	Estimated Cost = \$4,000,000 (Government provided estimate)	1	LT	(b)(4)	
0303AB	Fixed fee	12	MO	(b)(4)	
0304	Customer Satisfaction Award Fee Pool	0	EA	(b)(4)	
0304AA	First Quarter	1	EA	(b)(4)	
0304AB	Second Quarter	1	EA	(b)(4)	
0304AC	Third Quarter	1	EA	(b)(4)	
0304AD	Fourth Quarter	1	EA	(b)(4)	
0305	Contracting Officer Directed Travel = \$50,000 (Government provided estimate)	1	LT	(b)(4)	
0306	Transition Out (Firm fixed price line item)	1	LT	(b)(4)	
0307	TRICARE Service Centers (Firm fixed price)	12	MO	(b)(4)	
0308	Underwritten Health Care Costs	0	YR	(b)(4)	
030801	Underwritten HealthCare Target Cost - (b)(4)	0	EA	(b)(4)	
0308AA	MTF Enrollees Care Cost	1	YR	(b)(4)	
0308AB	Navy Non-Active Duty MTF Enrollees Care Cost	1	YR	(b)(4)	
0308AC	Air Force Non-Active Duty MTF Enrollees Care Cost	1	YR	(b)(4)	
0308AD	TMA Civilian Network Enrollees and Non-Enrollees Costs	1	YR	(b)(4)	
0308AE	Underwritten Health Care Costs (October 1, 2006 - March 31, 2007)	1	YR	(b)(4)	
0309	Underwriting Fee Percentage (b)(4)	1	YR	(b)(4)	
030901	Underwriting Fee Target - (b)(4)	0	EA	(b)(4)	
0310	Non-Underwritten Supple	0	EA	(b)(4)	
0310AA	Army Supplemental Health Care	1	YR	(b)(4)	
0310AB	Navy Supplemental Health Care	1	YR	(b)(4)	
0310AC	Air Force Supplemental Health Care	1	YR	(b)(4)	
0320	Change Order Implementation	0	EA	(b)(4)	
0320AA	Consolidated change, TOM 32, TPM 38, TSM 33; including change to TPRADFM eligibility for transitional survivors.	1	LT	(b)(4)	
0320AB	Payment of Home Infusion Drugs at 95 percent of Average Wholesale Price (AWP). (TRM 39)	1	LT	(b)(4)	
0320AC	Implementatin of TOM33 and TSM36, TRICARE Reserve Select (TRS) program authorized by the	1	LT	(b)(4)	

Supplies or Services and Prices/Costs

Item No.	Supplies/Services	Quantity	Unit	Unit Price	Amount
0320AD	NDAA FY06 Sections 701 & 702 Implementation Direct Funding (TSM34)	1	LT	(b)(4)	
0320AE	Implementation - Alaska CMAC Waiver - Plastic Surgery	1	LT		
0320AF	Implementation - Alaska CMAC Waiver - Pain Management	1	LT		
0320AG	Implement changes to transition VA/DoD MOA claims processing (TOM 34)	1	LT		
0320AH	Implementation, TOM 36, Unique Identifier Number	1	LT		
0320AJ	Implementation of TOM 40-Elimination of Beneficiary Notification for Same Day/72 Hour Referrals	1	LT		
0320AK	Implementation - Transitional Survivor (TOM41, TPM51, TRM48)	1	LT		
0320AL	Implementation of Financial Reports and Recoupments (TOM42 TRM55)	1	LT		
0320AM	Implementation Maternity Ultrasound	1	LT		
0320AN	Implementation OPPS (TOM 43, TRM 57, TSM 40) in OP3	1	LT		
0320AP	Implementation of AK CMAC waiver for Sleep Studies	1	LT		
0320AQ	National Provider Identifier (NPI) Implementation (TOM45)	1	LT		
0321	Change Order On-going Administration	0	EA		
0321AA	Timeframe for Refund of Enrollment Fees (TOM39)	1	LT		
0321AB	Change Order On-Going Administration, TOM 6 Changes	1	LT		
0321AC	On-Going Admin, EWRAP Short-Term Changes (TOM 23)	1	LT		
0321AD	On-going Admin	1	LT		
0321AE	Change Order Ongoing Admin, ADSM Referrals/Authorization (TOM46)	1	LT		
0321AF	Ongoing Admin - ECHO and continuation of CCTP (TOM17, TRM18, TPM12, TPM14 TSM20 TOM21, TRM23, TPM17, TSM23 TPM25 TPM27)	1	LT		
0321AG	On-going Admin, 2002 NDAA Provisions/Revisions to DME (TPM13, TRM19, TPM18, TRM24, TPM26)	1	LT		
0322	EWRAS Contingency, Ref & Auth and Med Necessity, On-going Admin	12	MO		
0323	Implementation of Home Health Agency Prospective Payment System TRM 41	1	LT		
0324	PEPM OP3	1	LT		
0325	PEPM for TRS II in OP3 TOM48 & TSM42 Adj to Tiers 2 & 3	3863	EA		
0330	Clinical Support Agreement Program (indefinite-quantity CLIN) Min. Order: -0- Max. Order: \$10,000,000	1	LT		

Supplies or Services and Prices/Costs

Item No.	Supplies/Services	Quantity	Unit	Unit Price	Amount
0331	Resource Sharing (indefinite-quantity CLIN) Min. Order: -0- Max. Order: \$10,000,000.00	1	LT	NSP	NSP
0331AC	Cancelled OPTION PERIOD IV 1 April 2007 - 31 March 2008 ADMINISTRATIVE SUPPORT SERVICES	0	LT	(b)(4)	(b)(4)
0401	Claims Processing (Fixed unit rate) (Requirements type line item)	0	EA	(b)(4)	(b)(4)
0401AA	Electronic claim rate (quantity is estimated)	11146019	EA	(b)(4)	(b)(4)
0401AB	Paper claim rate (quantity is estimated)	1966944	EA	(b)(4)	(b)(4)
0402	Per Member Per Month (Fixed unit rate per member month) (Requirements line item)	12	MO	(b)(4)	(b)(4)
0402AA	First 6 month contract period	15761376	MM	(b)(4)	(b)(4)
0402AB	Adjusted 6 month contract period	15761376	MM	(b)(4)	(b)(4)
0403	Disease Management (Cost plus fixed fee)	0	LT	(b)(4)	(b)(4)
0403AA	Estimated cost = \$4,140,000 (Government provided estimate)	1	LT	(b)(4)	(b)(4)
0403AB	Fixed Fee	12	MO	(b)(4)	(b)(4)
0404	Customer Satisfaction Award Fee Pool	0	EA	(b)(4)	(b)(4)
0404AA	First Quarter	1	EA	(b)(4)	(b)(4)
0404AB	Second Quarter	1	EA	(b)(4)	(b)(4)
0404AC	Third Quarter	1	EA	(b)(4)	(b)(4)
0404AD	Fourth Quarter	1	EA	(b)(4)	(b)(4)
0405	Contracting Officer Directed Travel = \$50,000 (Government provided estimate)	1	LT	(b)(4)	(b)(4)
0406	Transition Out (Firm fixed price line item)	1	LT	(b)(4)	(b)(4)
0407	TRICARE Service Centers (Firm fixed price)	12	MO	(b)(4)	(b)(4)
0408	Underwritten Health Care Costs	1	YR	(b)(4)	(b)(4)
040801	re Target Cost - (b)(4)	0	EA	(b)(4)	(b)(4)
0408AA		0	EA	(b)(4)	(b)(4)
0408AB	CANCELLED	0	EA	(b)(4)	(b)(4)
0408AC	CANCELLED	0	EA	(b)(4)	(b)(4)

Supplies or Services and Prices/Costs

Item No.	Supplies/Services	Quantity	Unit	Unit Price	Amount
0408AD	CANCELLED	0	EA	(b)(4)	
0409	Underwriting F Fee Percentage (b)(4)	1	YR		
040901	Underwriting F (b)(4)	0	EA		
0410	CANCELLED	0	EA		
0410AA	CANCELLED	0	EA		
0410AB	CANCELLED	0	EA		
0410AC	CANCELLED	0	EA		
0420	Change Order Implementation	0	EA		
0420AA	Implementation of TSM Changes Chapter 2 includes DITSCAP/DIACAP (TSM41)	1	LT		
0420AB	Implementation of TRICARE Reserve Select III TOM48 & TSM42	1	LT		
0420AC	Implementation Costs for 85% Reimbursement to Certified Psychiatric Nurse Specialists (CPNS) TRM59	1	LT		
0420AD	Implementation Cost for the Critical Access Hospital (CAH) Reimbursement portion of the Alaska Demo TOM50 & 53 / TSM44	1	LT		
0420AE	TPM57, to implement dental anesthesia and institutional benefits.	1	LT		
0420AF	Implementation Claim Rate Payment Cancellation (TSM45, TOM51)	1	LT		
0420AG	Implementation Paper Claims Forms (TOM52, TPM60, TRM63, TSM47)	1	LT		
0420AH	Implementation of Medicare Part D, TRICARE Systems Manual 7950.1-M, Change 46, (TSM46)	1	LT		
0420AJ	TSM 48 changes adding the most current HIPAA and DEERS values	1	LT		
0420AK	Implementation of higher reimbursement rates for services from Juneau bone and joint center	1	LT		
0420AL	Implementation to changes in Public Key Infrastructure (PKI) requirements per TSM 50	1	LT		
0420AM	Referrals / Pre-Authorizations / Authorizations TRICARE Operations Manual Chg 55 (TOM55)	1	LT		
0420AN	OP4 Implementation of Behavioral Health Care Provider Locating and Appointment Assistance. (TOM57)	1	LT		
0420AP	Request for Higher Reimbursements for Perinatologists in Anchorage, AK (b)(4) increase).	1	LT		
0420AQ	Implementation of OPPS - Phase I P4 TOM74/TPM68 & 91/TRM88 /TSM53	1	LT		
0420AR	Implementation Autism Demonstration Project (TSM 56, 59 & 64 / TPM 72 & 87 / TOM 60, 62, 64 & 69)	1	LT		
0420AS	Implementation of CY08 Updates to the Home	1	LT		

Supplies or Services and Prices/Costs

Item No.	Supplies/Services	Quantity	Unit	Unit Price	Amount	
	Health Prospective Payment System (HH-PPS) in OP4. TRM72 / TSM55					
0421	Change Order On-going Administration	0	EA	(b)(4)		
0421AA	On-going Administration - Transitional Survivor (TOM41, TPM51, TRM48)	1	LT			
0421AB	Ongoing Admin - ECHO and continuation of CCTP (TOM17, TRM18, TPM12, TPM14 TSM20 TOM21, TRM23, TPM17, TSM23 TPM25 TPM27)	1	LT			
0421AC	On-going Admin 2002 NDAA Provisions/Revisions to DME (TPM13, TRM19, TPM18, TRM24, TPM 26)	1	LT			
0421AD	OP4 Administrative costs of Behavioral Health Care Provider Locating and Appointment Assistance. (TOM57)	1	LT			
0422	EWRAS Contingency, Ref & Auth and Med Necessity, On-going admin (TPM9, TOM12, TRM10, TSM8)	12	MO			
0423	PEPM OP4	171250	EA			
0425	PEPM for TRS II in OP4 TOM48 & TSM42 Adj to Tiers 2 & 3	6082	EA			
0426	Reimbursement of Administrative Costs associated with prior Govt cancellations of eligible Claim Rate (TSM45, TOM51)	1	LT			
0429	Behavioral / Mental Health Initiatives in OP4 (Indefinite Quantity CLIN) for Task Orders	1	LT		NSP	NSP
0430	Clinical Support Agreement Program (indefinite-quantity CLIN) Min. Order: -0- Max. Order: \$10,000,000	1	LT		NSP	NSP
0431	Resource Sharing (indefinite-quantity CLIN) Min. Order: -0- Max. Order: \$10,000,000.00 OPTION PERIOD V 1 April 2008 - 31 March 2009	1	LT		NSP	NSP
	ADMINISTRATIVE SUPPORT SERVICES					
0501	Claims Processing (Fixed unit rate) (Requirements type line item)	0	EA		(b)(4)	
0501AA	Electronic claim rate (quantity is estimated)	11921758	EA			
0501AB	Paper claim rate (quantity is estimated)	2103840	EA			
0502	Per Member Per Month (Fixed unit rate per member month) (Requirements line item)	12	MO			

Supplies or Services and Prices/Costs

Item No.	Supplies/Services	Quantity	Unit	Unit Price	Amount	
0502AA	First 6 month contract period The estimated number of MHS eligible beneficiaries (2,626,896) multiplied by 6 months = the number of member months (the quantity). The number of member months (quantity) multiplied by the fixed unit rate per member (unit price) = the amount for the 6 month contract period	15761376	MM	(b)(4)		
0502AB	Adjusted 6 month contract period The estimated number of MHS eligible beneficiaries (2,626,896) multiplied by 6 months = the number of member months (the quantity). The number of member months (quantity) multiplied by the fixed unit rate per member (unit price) = the amount for the 6 month contract period	15761376	MM			
0503	Disease Management (Cost plus fixed fee)	0	LT			
0503AA	Estimated Cost = \$4,290,000 (Government provided estimate)	1	LT			
0503AB	Fixed Fee	12	MO			
0504	Customer Satisfaction Award Fee Pool	0	EA			
0504AA	First Quarter	1	EA			
0504AB	Second Quarter	1	EA			
0504AC	Third Quarter	1	EA			
0504AD	Fourth Quarter	1	EA			
0505	Contracting Officer Directed Travel = \$50,000 (Government provided estimate)	1	LT			
0506	Transition Out (Firm fixed price line item)	1	LT			
0507	TRICARE Service Centers (Firm fixed price)	12	MO			
0508	Underwritten Health Care Costs	1	YR			
050801	Care Target Cost: (b)(4)	0	EA			
0508AA	CANCELLED	0	EA	0.00		0.00
0508AB	CANCELLED	0	EA	0.00		0.00
0508AC	CANCELLED	0	EA	0.00		0.00
0508AD	CANCELLED	0	EA			
0509	Underwriting Fee Percentage (b)(4)	1	LT	(b)(4)		
050901	Underwriting Fee Target - (b)(4)	0	EA			
0510	CANCELLED	0	EA	0.00	0.00	
0510AA	CANCELLED	0	EA	0.00	0.00	
0510AB	CANCELLED	0	EA	0.00	0.00	
0510AC	CANCELLED	0	EA	0.00	0.00	

Supplies or Services and Prices/Costs

Item No.	Supplies/Services	Quantity	Unit	Unit Price	Amount
0520	Change Order Implementation	0	EA	(b)(4)	
0520AA	Severity DRGs and POAs (TPM81/ TRM79/ TSM62)	1	LT		
0520AB	Implementation of Revised Wounded, Ill and Injured (WII) (TSM63 TOM68)	1	LT		
0520AC	Funding for Contractor Administrative Costs for Implementation of CMAC Waiver for Juneau Bone and Joint Clinic in Alaska	1	LT		
0520AD	Implementation for Interim NPI Change for TED Records (TSM66) (Definitized)	1	LT		
0520AE	Respite Care Benefit in OP4 (TPM89/TOM70/TSM65) (Definitized)	1	LT		
0520AF	Implementation May 2007 Consolidated Change Package (TSM67/TOM72/TPM/90/TRM83)	1	LT		
0520AG	Implementation of PSA Bonus Payments (TRM 75)	1	LT		
0520AH	Recoup CAP/DME Overpayments 1992 - 2004.	1	LT		
0520AJ	Implementation in OP5 TOM75 Changes to TRICARE policy on Access to Care (ATC) and Prime Service Areas (PSAs)	1	LT		
0520AK	Implementation of Cancer Clinical Trials (TOM59 TPM 71 TSM54)	1	LT		
0520AL	Implementation of NQMC and MCSC/TDEFIC integration (TOM Change 76)	1	LT		
0520AM	Implementation for ECHO Cap increase (TOM77 TPM94)	1	LT		
0520AN	Implementation of Substance Abuse Disorder Change (TPM92)	1	LT		
0521	Change Order On-going Administration	0	EA		
0521AA	OP5 (FY08) Ongoing Administrative Costs for Behavioral Health Care Provider Locating and Appointment Assistance. (TOM57)	1	LT		
0521AB	On-Going Administration in OP5; TOM75 Changes to TRICARE policy for Access to Care (ATC) and Prime Service Areas (PSAs)	1	LT		
0522	EWRAS Contingency, Ref & Auth and Medical Necessity, On-going Admin (TPM9, TOM12, TRM10, TSM8)	12	MO		
0523	PEPM OP5	334919	EA		
0524	Implementation of New Discharge Codes (TSM57)	1	LT		
0529	Behavioral / Mental Health Initiatives in OP5 (Indefinite Quantity CLIN) for Task Orders	1	LT	NSP	NSP
0530	Clinical Support Agreement Program (indefinite-quantity CLIN) Min. Order: -0- Max. Order: \$10,000,000	1	LT	NSP	NSP
0531	Resource Sharing	1	LT	NSP	NSP

Supplies or Services and Prices/Costs

Item No.	Supplies/Services	Quantity	Unit	Unit Price	Amount
0532AG	(indefinite-quantity CLIN) Min. Order: -0- Max. Order: \$10,000,000.00 Deleted OPTION PERIOD 6 1 April 2009 - 31 March 2010	1	LT	(b)(4)	
0601	ADMINISTRATIVE SUPPORT SERVICES Claims Processing (Fixed unit rate) (Requirements type line item)	0	EA	(b)(4)	
0601AA	Electronic claim rate (quantity is estimated)	8900312	EA	(b)(4)	
0601AB	Paper claim rate (quantity is estimated)	3387687	EA	(b)(4)	
0602	Per Member Per Month (Fixed unit rate per member month) (Requirements line item)	12	MM	(b)(4)	
0602AA	First 6 month contract period The estimated number of MHS eligible beneficiaries (2,792,609.5) multiplied by 6 months = the number of member months (the quantity). The number of member months (quantity) multiplied by the fixed unit rate per member (unit price) = the amount for the 6 month contract period	16755657	MM	(b)(4)	
0602AB	Adjusted 6 month contract period The estimated number of MHS eligible beneficiaries (2,792,609.5) multiplied by 6 months = the number of member months (the quantity). The number of member months (quantity) multiplied by the fixed unit rate per member (unit price) = the amount for the 6 month contract period	16755657	MM	(b)(4)	
0602AJ	New Reimbursement Method for Critical Access Hospitals (TSM74/TOM86/TRM98). This SubContract Line Item has been replaced by 0620AJ.	1	LT	(b)(4)	
0602AY	Deleted	0	EA	(b)(4)	
0603	Disease Management (Cost plus fixed fee)	0	LT	(b)(4)	
0603AA	Estimated Cost = \$4,239,458.00 (Government provided estimate)	1	LT	(b)(4)	
0603AB	Fixed Fee	12	MO	(b)(4)	
0604	Customer Satisfaction Award Fee Pool	0	EA	(b)(4)	
0604AA	First Quarter	1	EA	(b)(4)	
0604AB	Second Quarter	1	EA	(b)(4)	

Supplies or Services and Prices/Costs

Item No.	Supplies/Services	Quantity	Unit	Unit Price	Amount
0604AC	Third Quarter	1	EA	(b)(4)	
0604AD	Fourth Quarter	1	EA		
0605	Contracting Officer Directed Travel = \$50,000 (Government provided estimate)	1	LT		
0606	Transition Out (Firm fixed price line item)	1	LT		
0607	TRICARE Service Centers (Firm fixed price)	12	MO		
0608	Underwritten Health Care Costs	1	YR		
060801	Under Range (b)(4)	1	YR		
0609	Under Fee Percentage (b)(4)	1	YR		
060901	Underwriting Fee Target - (b)(4)	1	YR		
0620	Change Order Implementa	0	EA		
0620AA	Implementation of Web-based TRICARE Assistance Program (TRIAP) Demonstration / Telemental Health Medicine (TPM101/104 and TOM82/85/96)	1	LT		
0620AB	Implementation of Preauthorizations for VA Care for ADSMS on Terminal Leave (TOM79).	1	EA		
0620AC	Implementation of Operation Noble Eagle/Enduring Freedom - Permanent Benefit (TPM96/TSM71)	1	LT		
0620AD	Waiver of Cost-Shares for Certain Clinical Preventive Services (TPM99/TRM95/TPM112)	1	LT		
0620AE	Implementation of Replacement of Implanted Devices (TSM72 TRM96)	1	EA		
0620AF	Periodic Physical Exams for Members on TDRL (TOM83/TSM73)	1	LT		
0620AG	Implementation for extending home rehabilitation therapies to the alternative provider categories (TPM102)	1	EA		
0620AH	Implementation of Alaska Locality Based Reimbursement Rate Waiver (LBW) for medically necessary Neurosurgical Services in Alaska.	1	LT		
0620AJ	New Reimbursement Method for Critical Access Hospitals (TSM74/TOM86/TRM98).	1	LT		
0620AK	Implementation of TED #Covered Days (TSM75).	1	LT		
0620AL	NDAA FY08 Section 1637, Transitional Care for Service-Related Conditions (TCSRC) (TOM88/TSM76)	1	EA		
0620AM	Implementation of Medical and Dental Care for Former Members with Serious injuries or Illness (TOM87)	1	EA		

Supplies or Services and Prices/Costs

Item No.	Supplies/Services	Quantity	Unit	Unit Price	Amount
0620AN	Implementation of Number of Services by Procedure Code (TSM77).	1	LT	(b)(4)	
0620AP	Forensic Exams following sexual assault or domestic violence (TOM90), (TPM108), and (TRM103).	1	EA		
0620AQ	Home Infusion Claims, (TRM105)	1	LT		
0620AR	Implementation of Locality Based Waiver of CMAC Rates for Pain Management Services in and around Anchorage, Alaska.	1	LT		
0620AS	Smoking Cessation Counseling (TPM110)	1	EA		
0620AT	2009 Consolidated TED Changes TSM78	1	EA		
0620AU	Implementation of Alaska's Bundled Locality Based Waiver (LBW) for Rheumatology, Orthopedics, and Otolaryngology Services in Alaska.	1	LT		
0620AV	Morbid Obesity - Adjustment of LAP Band, (TPM117)	1	LT		
0620AW	Withdrawal of Home Rehabilitation Therapies to Alternative Providers (TPM118).	1	EA		
0620AX	Smoking Cessation Triage Program	1	LT		
0620AY	Outpatient Propsective Payment System (OPPS) Technical Changes, February 2010- TOM94, TPM119, TRM110 and TSM79.	1	EA		
0620AZ	Implementation of Locality Based CMAC Waiver (LBW) for Network Neonatal Services for the Hawaii Prime Service Area.	1	LT		
0620BA	NDAA 2009 Sections 1174 and 734, TAMP Expansion (TPM120)	1	EA		
0621	Change Order On-going Administration	0	EA		
0621AA	ONGOING ADMIN COSTS for Smoking Cessation Counseling (TPM110)	1	EA		
0622	EWRAS Contingency, Ref & Auth and Medical Necessity, On-going Admin (TPM9, TOM12, TRM10, TSM8)	12	MO		
0623	PEPM OP6	516039	EA		
0629	Behavioral / Mental Health Initiatives in OP6 (Indefinite Quantity CLIN) for Task Orders	1	LT	NSP	NSP
0630	Clinical Support Agreement Program (indefinite-quantity CLIN) Min. Order: -0- Max. Order: \$10,000,000	1	LT	NSP	NSP
0631	Resource Sharing (indefinite-quantity CLIN) Min. Order: -0- Max. Order: \$10,000,000.00 OPTION PERIOD 7 1 April 2010 - 30 September 2010	1	LT	NSP	NSP
0701	ADMINISTRATIVE SUPPORT SERVICES Claims Processing (Fixed unit rate) (Requirements type line item)	0	EA	(b)(4)	
0701AA	Electronic claim rate (quantity is estimated)	4560524	EA		

Supplies or Services and Prices/Costs

Item No.	Supplies/Services	Quantity	Unit	Unit Price	Amount
0701AB	Paper claim rate (quantity is estimated)	1929179	EA	(b)(4)	
0702	Per Member Per Month (Fixed unit rate per member month) (Requirements line item)	6	MO		
0702AA	6 month contract period The estimated number of MHS eligible beneficiaries (2,792,609.5) multiplied by 6 months = the number of member months (the quantity). The number of member months (quantity) multiplied by the fixed unit rate per member (unit price) = the amount for the 6 month contract period	16755657	MM		
0703	Disease Management (Cost plus fixed fee)	1	LT		
0703AA	Estimated Cost = \$2,119,729.00 (Government provided estimate)	1	LT		
0703AB	Fixed Fee	6	MO		
0704	Customer Satisfaction Award Fee Pool	0	EA		
0704AA	First Quarter	1	EA		
0704AB	Second Quarter	1	EA		
0705	Contracting Officer Directed Travel = \$25,000 (Government provided estimate)	1	LT		
0706	Transition Out (Firm fixed price line item)	1	LT		
0707	TRICARE Service Centers (Firm fixed price)	6	MO		
0708	Underwritten Health Care Costs	1	YR		
070801	Underwritten Health Care Target Cost: (b)(4)	1	YR		
0709	Fee Percentage (b)(4)	1	YR		
070901	Underwriting F (b)(4)	0	EA		
0720	Change Order Implementa	0	EA		
0720AA	Coding and Clarification Updates Dec 09 TSM80/TOM97/TPM122/TRM115	1	EA		
0720AB	Implementation of Electronic Questionnaires for Investigation Processing (e-QIP) TSM81	1	EA		
0720AC	Implementation of TRICARE Retired Reserve (TRR).	1	EA		
0720AD	OPPS Temporary Military Contingency Payment Adjustments (TMCPA s) (TRM116)	1	LT		

Supplies or Services and Prices/Costs

Item No.	Supplies/Services	Quantity	Unit	Unit Price	Amount
0720AF	Implementaion of TED Interim Hospital Billing; TSM82 and TRM117.	1	LT	(b)(4)	
0721	Change Order On-going Administration	0	EA		
0721AA	On-Going Administration for Web-based TRICARE Assistance Program (TRIAP) Demonstration / Telemental Health Medicine (TPM101/104 and TOM82/85/96)	6	MO		
0722	EWRAS Contingency, Ref & Auth and Medical Necessity, On-going Admin (TPM9, TOM12, TRM10, TSM8)	6	MO		
0723	PEPM OP7	294000	EA		
0729	Behavioral / Mental Health Initiatives in OP7 (Indefinate Quantity CLIN) for Task Orders	1	LT		
0730	Clinical Support Agreement Program (indefinite-quantity CLIN) Min. Order: -0- Max. Order: \$10,000,000	1	LT	NSP	NSP
0731	Resource Sharing (indefinite-quantity CLIN) Min. Order: -0- Max. Order: \$10,000,000.00 OPTION PERIOD 8 1 October 2010 - 31 March 2011	1	LT	NSP	NSP
0801	ADMINISTRATIVE SUPPORT SERVICES Claims Processing (Fixed unit rate) (Requirements type line item)	0	EA	(b)(4)	
0801AA	Electronic claim rate (quantity is estimated)	5092813	EA		
0801AB	Paper claim rate (quantity is estimated)	1563630	EA		
0802	Per Member Per Month (Fixed unit rate per member month) (Requirements line item)	6	MO		
0802AA	6 month contract period The estimated number of MHS eligible beneficiaries (2,792,609.5) multiplied by 6 months = the number of member months (the quantity). The number of member months (quantity) multiplied by the fixed unit rate per member (unit price) = the amount for the 6 month contract period	16755657	MM		
0803	Disease Management (Cost plus fixed fee)	0	LT		
0803AA	Estimated Cost = \$2,119,729.00 (Government provided estimate)	1	LT		
0803AB	Fixed Fee	6	MO		

Supplies or Services and Prices/Costs

Item No.	Supplies/Services	Quantity	Unit	Unit Price	Amount
0804	Customer Satisfaction Award Fee Pool	0	EA	(b)(4)	
0804AA	First Quarter	1	EA		
0804AB	Second Quarter	1	EA		
0805	Contracting Officer Directed Travel = \$25,000 (Government provided estimate)	1	LT		
0806	Transition Out (Firm fixed price line item)	1	LT		
0807	TRICARE Service Centers (Firm fixed price)	6	MO		
0808	Underwritten Health Care Costs	1	YR		
080801	Target Cost: (b)(4)	1	YR		
0809	Underwriting F Fee Percentage (b)(4)	1	YR		
080901	Underwriting Fee Target (b)(4)	0	EA		
0820	Change Order Implement	0	EA		
0821	Change Order On-going Administration	0	EA		
0822	EWRAS Contingency, Ref & Auth and Medical Necessity, On-going Admin (TPM9, TOM12, TRM10, TSM8)	6	MO		
0823	PEPM OP8	154422	EA		
0829	Behavioral / Mental Health Initiatives in OP8 (Indefinite Quantity CLIN) for Task Orders	1	LT		
0830	Clinical Support Agreement Program (indefinite-quantity CLIN) Min. Order: -0- Max. Order: \$10,000,000	1	LT	NSP	NSP
0831	Resource Sharing (indefinite-quantity CLIN) Min. Order: -0- Max. Order: \$10,000,000.00	1	LT	NSP	NSP
4020AT	Deleted	0	LT	(b)(4)	
4021AJ	Deleted	0	LT		
4022AB	Deleted	0	LT		
4023AV	Deleted	0	EA		

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SECTION C
DESCRIPTION/SPECIFICATIONS/WORK STATEMENT

C.1

C-1. General. Section C includes two categories of outcome based statements. The “Objectives” represent the outcomes for this contract. The objectives are supported by technical requirements. These requirements represent specific tasks, outcomes, and/or standards that, at a minimum, must be achieved. The purpose of this contract is to provide Managed Care Support (MCS) to the Department of Defense TRICARE program. The Managed Care Support contractor shall assist the Regional Director and Military Treatment Facility (MTF) Commander in operating an integrated health care delivery system combining resources of the military’s direct medical care system and the contractor’s managed care support to provide health, medical, and administrative support services to eligible beneficiaries.

C-2. Objectives.

C-2.1. Statement of Objectives. There are five objectives included in this contract. They are listed below.

Objective 1 – In partnership with the Military Health System (MHS), optimize the delivery of health care services in the direct care system (see the definition of Military Treatment Facility Optimization in the TRICARE Operations Manual, Appendix A) for all MHS beneficiaries (active duty personnel, Military Treatment Facility (MTF) enrollees, civilian network enrollees, and non-enrollees).

Objective 2 - Beneficiary satisfaction at the highest level possible throughout the period of performance, through the delivery of world-class health care as well as customer friendly program services. Beneficiary must be highly satisfied with each and every service provided by the contractor during each and every contact.

Objective 3 - Attain “best value health care” (See TRICARE Operations Manual, Appendix A) services in support of the MHS mission utilizing commercial practices when practical.

Objective 4 - Fully operational services and systems at the start of health care delivery. Minimal disruption to beneficiaries and MTFs.

Objective 5 - Ready access to contractor maintained data to support the Department of Defense’s (DoD) financial planning, health systems planning, medical resource management, clinical management, clinical research, and contract administration activities.

C-3. Documents

C-3.1. The following documents, including all changes thereto, are hereby incorporated by reference and made a part of the contract. These documents form an integral part of this contract. Documentation incorporated into this contract by reference has the same force and effect as if set forth in full text. The technical baseline for this contract, at award, includes all changes dated prior to November 27, 2002. This includes changes 1-5 to the TRICARE Operations Manual, changes 1-4 to the TRICARE Policy Manual, changes 1-4 to the TRICARE Systems Manual and Changes 1-4 to the TRICARE Reimbursement Manual.

Title 10, United States Code, Chapter 55

32 Code of Federal Regulations, Part 199

TRICARE Operations Manual (TOM) 6010.51-M, August 1, 2002

TRICARE Policy Manual (TPM) 6010.54-M, August 1, 2002

TRICARE Reimbursement Manual (TRM) 6010.55-M, August 1, 2002

TRICARE Systems Manual (TSM) 7950.1-M, August 1, 2002

C-3.2. The contractor’s subcontracting plan is hereby incorporated and made a part of the contract.

C-4. Definitions. Definitions are included in Appendix A of the TRICARE Operations Manual.

SECTION C
DESCRIPTION/SPECIFICATIONS/WORK STATEMENT

C-5. Government-Furnished Property and Services. Government property furnished to the contractor for the performance of this contract includes the furnishing of telephone lines and computer drops in accordance with General Services Administration (GSA) direction. At certain MTFs, space and equipment may be provided for the TRICARE Service Center (TSC). This may include information management hardware and software to allow the contractor to access the Composite Health Care System (CHCS). Equipment at the TRICARE Service Centers is described in Attachment 8, List of Data Package Contents. Records of Government Furnished Property will be maintained by the MTF in accordance with FAR 52.245-1 and will be included in the MOU between the MTF, the contractor and the Regional Director.

C-6. Contractor-Furnished Items. The contractor furnishes all necessary items not provided by the Government for the satisfactory performance of this contract.

C-7. Technical Requirements. The contractor must fulfill the technical requirements listed below in accomplishing the overall objectives of this contract.

C-7.1. The contractor shall provide a managed, stable, high-quality network, or networks, of individual and institutional health care providers which complements the clinical services provided to MHS beneficiaries in MTFs and promotes access, quality, beneficiary satisfaction, and "best value health care" for the Government. (See the TOM, Appendix A for the definition of best value health care.)

C-7.1.1. The contractor's network shall be accredited by a nationally recognized accrediting organization no later than 18 months after the start of health care delivery in all geographic areas covered by this contract. When this contract and the accrediting body both have standards for the same activity, the higher standard shall apply.

C-7.1.2. MTFs will only refer their TRICARE Prime enrollees to a non-network civilian provider when it is clearly in the best interest of the Government and the beneficiary, either clinically or financially. Such cases are expected to be rare. Federal health care systems (for example Veterans Administration and Indian Health Service) are excluded from this Government policy.

C-7.1.3. Provider networks for the delivery of Prime and Extra services shall be established to ensure that all access standards are met at the start of health care delivery and continuously maintained in all TRICARE Prime areas. TRICARE Prime areas are defined as a forty-mile radius around catchment areas, the designated military treatment facilities in Section J, Attachment 11, Base Realignment and Closure (BRAC) sites, and additional Prime sites in Springfield, Missouri; Minneapolis, Minnesota; Des Moines, Iowa, and all locations in the West offering Prime non-catchment areas as listed in Section J, Attachment 8. The network must include providers that accept Medicare assignment in sufficient quantity and diversity to meet the access standards of 32 CFR 199.17 for the MHS Medicare population residing in the area.

C-7.1.4. The contractor shall inform the Government within 24 hours of any instances of network inadequacy relative to the Prime and/or Extra service areas and shall submit a corrective action plan with each notice of an instance of network inadequacy. (Network inadequacy is defined as any failure to meet the access standards.) The contractor shall respond to any inquiries from agents of the Government concerning network adequacy, including requests for information on provider turnover, from a Contracting Officer, Contracting Officer's Representative (COR), or Regional Director. The response shall be accomplished within two business days from receipt of a request.

C-7.1.5. The contractor shall ensure that provider networks and services can be adjusted as necessary to compensate for changes in MTF capabilities and capacities. The contractor shall also ensure that all eligible beneficiaries who live in Prime service areas have the opportunity to enroll, add additional family members, or remain enrolled in the Prime program regardless of such changes. MTF capabilities and capacities may change frequently over the life of the contract without prior notice. The contractor shall adjust the capabilities and capacities of the network to compensate for such changes when and where they occur over the life of the contract, including short notice of unanticipated facility expansion, provider deployment, downsizing and/or closures.

The contractor will meet with the MTF Commander as soon as possible, but not later than (b)(4) after a (b)(4)

C-7.1.6. The contractor shall inform potential network providers, through network provider agreements, that they agree to being reported to the Department of Veterans Affairs (DVA) as a TRICARE network provider. The contractor shall request potential non-institutional network providers to accept requests from the DVA to provide care to veterans. The

SECTION C
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agreement will give the DVA the right to directly contact the provider and request that he/she provide care to veteran (VA) patients on a case by case basis. The TRICARE network provider is never obligated to see the VA patient, but, if seen by the network provider, any documentation of the care rendered to the VA patient and reimbursement for the care is a matter between the referring VA Medical Center (VAMC) and the provider. The referral and instructions for seeking reimbursement from the VAMC will be provided by the patient at the time of the appointment. Those providers who express a willingness to receive DVA queries as to availability shall be indicated in a readily discernable manner on all public network provider listings. (Note: Nothing prevents the VA and the provider from establishing a direct contract relationship if the parties so desire. When a direct contract is in place, the contractor may deviate from this section.)

C-7.1.6.1. The contractor shall inform potential network providers, through network provider agreements, that they agree to being reported to Civilian Health and Medical Program of the Veteran's Administration (CHAMPVA) as a TRICARE network provider. The contractor shall request potential network providers (individual, home health care, free-standing laboratories, and radiology only) that they accept assignment for CHAMPVA beneficiaries. The contractor shall ask all providers proposed for the network to accept assignment (see the CHAMPVA beneficiary locations in the data package, Attachment 8). The contractor shall not make this request a condition of participating in the TRICARE network but an option. Providers need see only CHAMPVA beneficiaries when their practice availability allows and shall not give preferential appointment scheduling to CHAMPVA over TRICARE appointments. Network providers are not required to meet access standards for CHAMPVA beneficiaries, but are encouraged to do so. The contractor shall also provide to the provider the CHAMPVA-furnished claims processing instructions (Attachment 1) on submitting CHAMPVA claims to the VA Health Administration Center (P.O. Box 65024, Denver, CO 80206-9024) for payment. Providers at their discretion may offer the negotiated TRICARE discount directly to CHAMPVA. For any published network provider listing, the contractor shall indicate in a readily discernable manner which providers accept CHAMPVA assignment on claims.

C-7.1.7. The contractor shall ensure that the standards for access, in terms of beneficiary travel time, appointment wait time, and office wait time for various categories of services contained in 32 CFR 199.17(p)(5) are met for beneficiaries residing in a TRICARE Prime service area. These standards shall be met in a manner which achieves beneficiary satisfaction with access to network providers and services as set forth in the contract.

C-7.1.8. The contractor shall maintain an accurate, up-to-date list of network providers including their specialty, gender, work address, work fax number, and work telephone number for each service area, whether or not they are accepting new beneficiaries. The contractor shall provide easy access to this list, to include making it available upon request, for all beneficiaries, providers, and Government representatives. The contractor shall, at a minimum, maintain this list in a mutually agreeable format. The contractor agrees not to claim any proprietary interest. For the purposes of this requirement, "up-to-date" means an electronic, paper, telephone or combination of these approaches that accurately reflects the name, specialty, gender, work address, and work telephone number of each network provider and whether or not the provider is accepting new patients. The information contained on all electronic lists shall be current within the last 30 calendar days.

C-7.1.9. The network, or networks, shall complement services provided by MTFs in the region. They shall be sufficient in number, mix, and geographic distribution of fully qualified providers to provide the full scope of benefits for which all Prime enrollees are eligible under this contract, as described in 32 CFR 199.4, 199.5, and 199.17. The contractor's provider networks shall also support the requirements of special programs described in the TRICARE Operations Manual and TRICARE Policy Manual.

C-7.1.10. The contractor shall ensure that (b)(1) of all claims submitted by network providers are submitted electronically for Option Period 2. The required annual (b)(4) percentage of network claims which must be submitted electronically for Option Periods 3 – 8, is as follows:

Option Period 3:	(b)(4)
Option Period 4:	
Option Period 5:	
Option Period 6:	
Option Period 7:	
Option Period 8:	

When electronic claims fall below the required percentage for any Option Period, the Government shall recover the overpayments on an annual basis. Within 30 days after the end of an Option Year, the Contractor shall submit to the Government a Network Electronic Media Claims Report to include the total number of network claims accepted through TEDs (fully or provisionally) during the Option Year; the total number of network claims submitted electronically

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(excluding Alaska); the percent of the network claims submitted electronically compared to the total network claims processed to completion; the number of network claims required to meet the standard; and, the difference between the number of network claims submitted electronically and the number of network claims submissions required to meet the standard.

The report will list any amount owed to the Government if the Contractor did not meet the contract percentages. The calculation will be based on the difference between the paper claim rate and the electronic claim rate specified in Section B of the contract for the number of claims that exceed the stated annual average percentage of electronic claims to be submitted by network providers. The Contractor shall remit payment of any amount owed to the Government within 30 days.

C-7.1.11. All acute-care medical/surgical hospitals in the contractor's provider networks are encouraged to become members of the National Disaster Medical System (NDMS).

C-7.1.12. The contractor shall ensure that all network providers and their support staffs gain a sufficient understanding of applicable TRICARE program requirements, policies, and procedures to allow them to carry out the requirements of this contract in an efficient and effective manner which promotes beneficiary satisfaction. This requirement pertains to all network providers and their staff and to TRICARE-authorized providers in the region. The contractor shall use the education material provided by the Government.

C-7.1.13. When provided by DVA, the contractor shall make available marketing and educational information on the VA and CHAMPVA at any provider briefings. [The contractor shall furnish the VA Health Administration Center (P.O. Box 65024, Denver, CO 80206-9024) its central address for delivery of these materials.] The contractor is not required to, but may, brief these materials.

C-7.1.14. All network and non-network providers who provide services and receive reimbursement under this contract shall be TRICARE-authorized providers in accordance with the criteria set forth in 32 CFR 199.6. The contractor shall verify all providers' authorized status through the TRICARE Management Activity centralized TRICARE Encounter Provider Record (TEPRV) or, if not listed, shall obtain and maintain documentary evidence that the provider meets the criteria set forth in 32 CFR 199.6, the TRICARE Policy Manual, and TRICARE Reimbursement Manual.

C-7.1.15. The contractor shall ensure that no network provider requires payment from a beneficiary for any excluded or excludable service that the beneficiary received from a network provider (i.e. the beneficiary shall be held harmless) unless the beneficiary has been properly informed that the services are excludable and has agreed in advance of receiving the services, in writing, to pay for such services. An agreement to pay must be evidenced by written records. A beneficiary who is informed that care is potentially excludable and proceeds with receiving the potentially excludable service shall not, by receiving such care, constitute an agreement to pay. General agreements to pay, such as those signed by the beneficiary at the time of admission, is not evidence that the beneficiary knew specific services were excluded or excludable.

C-7.1.16. The TRICARE Operations Manual language at Chapter 8 Section 5 paragraph 7.2.3.1 and 7.2.3.2 regarding CLR will not apply to this Contract for Option Periods 3 - 8. For Military Treatment Facility (MTF) Prime enrolled beneficiaries, the contractor shall ensure that network specialty providers provide clearly legible specialty care consultation or referral reports, operative reports and discharge summaries to the beneficiary's initiating provider. If the accreditation standards organization has a more stringent specialty referral-reporting requirement, the contractor shall adhere to that standard.

C-7.1.16.1. Evaluate-Only Referrals – Referrals of MTF Prime-enrolled patients for specialty care to a network provider for evaluation of a medical concern. For these patients, the MTF provider desires a report of the provider's findings and recommendations for clinical care of the patient. For these referrals, the MTF provider intends to continue managing care of the patient's condition and is awaiting the servicing specialist's clinical recommendations.

C-7.1.16.1.1. Standard: Evaluate-Only Referrals – The contractor shall provide 98% of referral reports to the Referral Management Center or MTF single Point of Contact (POC) within 10 business days following completion of the servicing network provider's evaluation of the patient. This standard excludes the state of Alaska.

C-7.1.16.2. Evaluate and Treat Referrals – Referrals of MTF Prime-enrolled patients for specialty care to a network provider by the MTF provider for an episode of care with the intent the servicing provider conduct both evaluation and treatment of the patient's condition for which they are being referred. For these referrals, the MTF provider desires a report from the servicing provider following completion of the episode of care for which the patient was referred. That

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information is needed for continuity of care and ongoing management of the patient by the Primary Care Manager (PCM). In those circumstances where the patient is undergoing long term specialty care (i.e., oncology) and the PCM desires an interim clinical report, the Contractor will, upon request, obtain such reports.

C-7.1.16.2.1. Standard: Evaluate and Treat Referrals – The contractor shall provide 100% of network specialty reports or the operative reports and/or the narrative summaries of hospitalizations to the Referral Management Center or MTF single POC not later than 30 business days following the patient’s discharge from the hospital or completion of treatment. This standard excludes the state of Alaska.

C-7.1.16.3. Urgent / Emergent Referrals – Referrals of MTF Prime-enrolled patients for emergency care or specialty evaluation which must be accomplished within 24 hours or less, as the clinical needs of the patient dictate. For those patients who have been referred by the MTF medical staff under urgent or emergent circumstances to a network emergency room or network specialist, the contractor shall provide copies of the servicing provider’s report to the Referral Management Center or MTF single POC not later than 24 hours following completion of the emergency care, urgent care or specialty evaluation.

C-7.1.16.3.1. Standard: Urgent / Emergent Referrals – The initial report may be provided via telephone, fax or other means, as the clinical needs of the patient dictate. The contractor shall provide 98% of the formal written reports to the Referral Management Center or MTF single POC within 10 business days of the emergency care or specialty evaluation.

C-7.1.16.4. Exclusions – All MTF referrals to network providers, other than those listed below as exclusions, will be tracked and reported:

- Behavioral Health
- Obstetrics (OB) (management of pregnancy, delivery and post partum care)
- Retroactive Authorizations (i.e., emergency and urgent care)
- Primary care received in civilian facilities whether the patient has been referred by the MTF or not
- Sensitive Diagnosis
 - i. Alcoholism, International Classification of Diseases, 9th revision, Clinical Modification (ICD-9-CM) codes 291.9, 303.0 – 303.9 and 305
 - ii. Drug Abuse, ICD-9-CM codes 292 – 292.9, 304 – 304.9 and 305.2 – 305.9
 - iii. Acquired Immune Deficiency Syndrome (AIDs), ICD-9-CM codes 079.53 and 042
 - iv. Abortion, ICD-9-CM codes 634 – 639.9 and 779.6
 - v. Sexually Transmitted Diseases, ICD-9-CM codes 090 – 099.99 and 054.1 – 054.19
- Out of Area Referrals
- Laboratory Studies
- Durable Medical Equipment
- Home Health
- Long Term Care
- Hospice
- Dialysis for long term (Medicare) patients
- Referrals of patients with other health insurance (OHI) which serves as primary payor
- Self Referral by patients
- Those referrals where no healthcare has been rendered

C-7.1.16.5. Monthly Clear and Legible Report to the MTF Commander – By the 15th calendar day of each month, the Contractor shall provide two reports to each MTF Commander regarding referrals and consult tracking results specific to their MTF. The reports will be in a format that allows the MTF to manipulate the data. All reports will include a legend.

C-7.1.16.5.1. A 30 Day Patient Level Detail Report (PDR) which constitutes a by-name listing of all referrals received by the contractor from the Referral Management Center or MTF single POC for the preceding month. It will serve as a baseline report of the referrals that were listed as evaluate only or evaluate and treat, and whether the consultation reports are considered trackable. This report will serve as a baseline report for future determination of the final outcomes of the consult tracking function for that month.

C-7.1.16.5.2. A 90 day PDR which constitutes an accounting of the referrals for the month that ended three (3) months prior to the beginning of the current month. This report will provide a detailed report of each patient that was referred during the month being reported (in the 30 Day PDR) and whether care was received and reports were provided within the standards of the managed care support contract. It will also provide summary statistics for evaluate only and evaluate

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and treat referrals, the number referred for each category, the percentage of reports that were received for each category and the number that were considered trackable.

C-7.1.16.6. Monthly Clear & Legible Report to the Regional Director – On a monthly basis, by the 15th day following the end of the month, the Contractor will provide a report that specifies the outcomes achieved in the consult tracking function for each MTF for the month that ended three (3) months prior to the current month. The reports will be in a format that allows the Regional Director to manipulate the data. The report will include a legend and the following information:

1. The number of “Evaluate Only” and “Evaluate and Treat” reports received by the contractor for each MTF and the number of each category that is considered trackable and subject to performance guarantees
2. By MTF the number and percentage of trackable consultation reports received from network providers and presented to the MTF within the specified submission timelines for each category of reports.
3. The percentage of reports that were received within contract standards for each category.

C-7.2. The contractor shall audit two percent or ten referrals, whichever is greater, of referrals from each MTF monthly to validate the return of all required information within the standard addressed in paragraph C-7.1.16. The two percent sample shall be selected randomly. The contractor shall report the results of the audit to the Contracting Officer located at the Regional Office with a copy to the Regional Director no later than 45 calendar days following the month from which the sample was selected.

C-7.3. The contractor’s referral management processes shall include a provision for evaluating the proposed service to determine if the type of service is a TRICARE benefit and informing the beneficiary prior to the visit in the event the requested service is not a TRICARE benefit. This shall not be a preauthorization review. Rather, this process shall be a customer service/provider relation’s function providing an administrative coverage review. This service shall be accomplished for every referral received by the contractor regardless of whether it was generated by an MTF, network provider or non-network provider.

C-7.3.1. In TRICARE Prime areas that include an MTF, the MTF has the right of first refusal for all referrals and shall be addressed in the MOU. First right of refusal is defined as providing the MTF with an opportunity to review each referral from a civilian provider to determine if the MTF has the capability and capacity to provide the treatment. All electronic referrals to an MTF shall be by the appropriate HIPAA-compliant transaction.

C-7.3.2. Ninety-six percent of referrals of MHS beneficiaries, residing in TRICARE Prime service areas who seek care through the contractor, shall be referred to the MTF or a civilian network provider during the first option period. The contractor will increase the percentage of referrals annually by (b) (4) when the referral level of MHS beneficiaries referred to the MTF or civilian network providers will be (b) . This percentage shall include services rendered in network institutions by hospital-based providers even though no formal referral was made to that individual. The Contracting Officer located at the Regional Office may grant an exception to this requirement based upon a fully justified written request from the contractor demonstrating that it is in the best interest of the Government to grant the exception.

C-7.4. The contractor shall ensure that civilian medical care funded through this contract, including mental health care, is medically necessary and appropriate and complies with the TRICARE benefits contained in 32 CFR 199.4 and 199.5. The contractor shall not perform medical necessity reviews or factual determinations on referrals to the MTF. The contractor shall use best practices consistent with law, regulation and TRICARE policy in reviewing and approving care and establishing medical management programs to carry out the validation of medical necessity and appropriateness to the extent authorized by law. Notwithstanding the contractor’s authority to utilize its best practices in managing, reviewing and authorizing health care services, the contractor shall comply with the provisions of 32 CFR 199.4, 32 CFR 199.5, and the TRICARE Policy Manual when reviewing and approving medical care. The contractor shall be considered a multi-function Peer Review Organization (PRO) under this contract and shall follow all standards, rules, and procedures of the TRICARE PRO program.

C-7.5. The contractor shall establish a system that ensures that care received outside the MTF and referred by the MTF for MTF enrollees is authorized (when medically necessary and a TRICARE benefit) and entered into the contractor’s claims processing system to ensure the appropriate adjudication of claims for enrollee’s care. The MTF will transmit

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referral information in a HIPAA compliant manner. The contractor, using its authority as a Peer Review Organization, shall apply its own utilization management practices to care received by MTF enrollees in a civilian setting consistent with MTF referral instructions. The contractor shall fax a copy (or by other electronic means addressed in each MTF MOU) of these utilization management decisions to the MTF Commander the day the decision is made.

C-7.6. The contractor shall provide comprehensive, readily accessible customer services that includes multiple, contemporary avenues of access (for example, e-mail, World Wide Web, telephone, facsimile, et cetera) for the MHS beneficiary. Customer services shall be delivered in a manner that achieves the objectives of this contract without charge to beneficiaries or providers.

C-7.7. The contractor shall operate a medical management program for all MHS eligible beneficiaries receiving care in the civilian sector, except as specified in Section C-7.7.1, that achieve the objectives of this contract. The contractor's medical management program must fully support the services available within the MTF.

C-7.7.1. The contractor shall operate programs designed to manage the health care of individuals with high-cost conditions or with specific diseases for which proven clinical management programs exist. These programs shall be available to TRICARE eligible beneficiaries authorized to receive reimbursement for civilian health care per 32 CFR 199. These programs shall also be available to active duty personnel whose care occurs or is projected to occur in whole or in part in the civilian sector. These programs shall exclude MEDICARE dual eligible beneficiaries. When care occurs within an MTF, the contractor is responsible for coordinating the care with the MTF clinical staff as well as the civilian providers. The contractor shall propose medical management programs and patient selection criteria for review of the Contracting Officer located at the Regional Office prior to implementation and annually thereafter.

C-7.7.1.1. For disease management conditions identified by the Government to be included in the disease management program, the Government will identify the population, risk stratification and minimum measurements of success and evaluation. The contractor shall submit an implementation plan that demonstrates the disease management intervention(s) and confirms patients meet inclusion criteria in the disease management program using the Government provided patient identification lists, selection criteria, and risk stratification. The contractor's plan shall include the information that will be provided in sufficient detail to allow the Government to effectively evaluate the disease management program in accordance with the Government provided measures of success and elements of evaluation. In order for the Government to be able to evaluate the disease management program, the contractor shall include a plan for accounting and reporting on the cost and performance of all disease management programs, plus provide the specific guidelines and protocols they will utilize. The plan and cost estimate are subject to review and approval by the Contracting Officer located at the Regional Office prior to implementation and annually thereafter. The Government will not prescribe strict program protocols, e.g. how often to call patients or use of technology.

C-7.7.1.2. For disease management conditions identified by the contractor to be included in the disease management program, the contractor shall identify the patient selection criteria, i.e. population and risk stratification, for review and approval. The contractor shall submit a cost estimate and comprehensive plan. The plan and cost estimate are subject to review and approval by the Contracting Officer located at the Regional Office prior to implementation and annually thereafter. In order for the Government to be able to evaluate the contractor's disease management program, the contractor will separately account for all costs associated with contractor initiated disease management conditions from those conditions initiated by the Government.

C-7.7.1.3. In cooperation with the MTF, the contractor shall coordinate the care and transfer of patients who require a transfer from one location to another. This function shall include coordination with the primary clinician at the losing and gaining sites, the patient's family, arranging medically appropriate patient transport, ensuring all necessary supplies are available during the transport and at the receiving location, arranging for and ensuring the presence of all necessary medical equipment during transport and at the receiving location, and identifying and ensuring the availability of necessary resources to accomplish the transfer. Transfers may occur as a result of medical, social, or financial reasons and include moves of non-institutionalized and institutionalized patients.

C-7.8. Reserved.

C-7.9. The contractor shall meet with and establish a Memorandum of Understanding with TMA Communications and Customer Service Directorate (C&CS) in accordance with the TRICARE Operations Manual, Chapter 12, Section 1. The MOU shall address all interface requirements necessary to effectively administer the program. The contractor shall partner and collaborate with C&CS on the identification and development of marketing and education materials required to support the accomplishment of the Marketing and Education Plan submitted in accordance with the TRICARE Operations Manual, Chapter 12.

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C-7.10. All enrollments, re-enrollments, disenrollments, and transfers, to include enrollment activities of TRICARE Plus, shall be in accordance with the provisions of the TRICARE Operations Manual, Chapter 6 and the TRICARE Systems Manual. The contractor shall accomplish primary care manager by name assignment in accordance with the TRICARE Systems Manual.

C-7.11. The contractor shall use the TRICARE Enrollment and Disenrollment Forms, available on the DOD Website. The contractor shall reproduce the form as necessary to ensure ready availability to all potential enrollees. The contractor shall implement enrollment processes that take advantage of current technology while ensuring access and assistance to all beneficiaries which does not duplicate Government systems.

C-7.12. Beneficiaries choosing TRICARE Prime enrollment shall be enrolled to the MTF, on a first come, first served basis, until the enrollment capacity established by the MTF Commander is reached. The contractor shall ensure that MTF capacity is reached before beneficiaries may be enrolled to the contractor's network.

C-7.12.1. The MTF Commander, with prior notification to the Regional Director, may make exceptions to the requirement to enroll all beneficiaries to the MTF prior to enrollment to the contractor's network. Such instances should be rare and should be based on valid clinical capability to meet the individual healthcare needs of the patient.

C-7.13. The contractor shall enroll, re-enroll, disenroll, transfer enrollments, clear enrollment discrepancies assign or change Primary Care Manager (PCM), and related functions for all active duty personnel in TRICARE Prime following the same procedures applicable to non-active duty beneficiaries (TRICARE Operations Manual, Chapter 6). For beneficiaries returning from or transferring to OCONUS, the contractor shall follow the requirements of the TRICARE Policy Manual.

C-7.14. The contractor shall provide commercial payment methods for Prime enrollment fees that best meets the needs of beneficiaries. The contractor shall accept payment of fees by payroll allotment or electronic funds transfer from a financial institution as well as other payment types (e.g., check, credit cards) in sufficient variations to achieve beneficiary satisfaction. The contractor shall not require beneficiaries to pay an administrative fee of any kind for use of a particular payment option offered by the contractor. The contractor shall accept payment of enrollment fees on a monthly, quarterly, or annual basis. The contractor shall provide beneficiaries with written notice of a payment due in accordance with the TRICARE Operations Manual and when beneficiaries are delinquent.

C-7.15. The contractor shall ensure that enrollment on transition phase-in and transfers of enrollment, i.e., portability, as described in the TRICARE Operations Manual, Chapter 6, are accomplished in a way that allows for uninterrupted coverage for the TRICARE Prime enrollee. During transition, the incoming contractor shall enroll all TRICARE Prime beneficiaries to their assigned PCM and maintain the beneficiary's enrollment periods from the outgoing contractor. If a beneficiary's civilian primary care manager remains in the TRICARE network, the beneficiary may retain their primary care manager. If the beneficiary must change primary care managers, all enrollments shall be to the MTF until MTF capacity, as determined by the MTF Commander, is reached.

C-7.16. The contractor shall establish a customer service presence for all MHS eligible beneficiaries, including traveling beneficiaries, at each catchment area, designated MTF in Attachment 11, Prime service area, and BRAC site, either within the MTF or on the base if space is available, or if a BRAC site, at a location convenient to beneficiaries. These sites, and any other similar site established by the contractor, shall be named TRICARE Service Centers (TSCs) regardless of the extent of services offered. The data package described in Attachment 8 describes the space, if available, at each MTF. Where the space is insufficient to support all TRICARE Service Center activities, the contractor shall establish those customer service activities not available on site in a manner that is convenient to beneficiaries and provides the highest service levels. The contractor shall maintain a sufficient supply of TRICARE education and marketing materials at each TSC to adequately support information requests. When furnished by the DVA, the contractor shall maintain quantities of information on VA and CHAMPVA at each TSC [the contractor shall furnish the VA Health Administration Center (P.O. Box 65024, Denver, CO 80206-9024) its central address for delivery of these materials.]. The contractor shall have the ability to provide TSC services during periods when access to the TSC physical space is limited or terminated as a result of weather, war, security, or MTF/Base Commander's decision.

C-7.17. The contractor shall provide customer service support equal to (b) person-hours per week to be used at the discretion of and for the purpose specified by the MTF Commander. Examples of possible uses of this time include in-processing briefings/enrollments, TRICARE briefings, and specialty briefings on specific components of TRICARE or focused to a specific subset of TRICARE beneficiaries. (The Regional Director may provide input for needed non MTF

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area activities.) This is in addition to the requirements for briefings and attendance at meetings specified in the TRICARE Operations Manual, Chapter 12.

C-7.18. The contractor shall provide assistance in accessing information about other Department of Defense programs and applicable community/state/federal health care and related resources for all MHS eligible beneficiaries who require benefits and services beyond TRICARE. This function shall be referred to as Health Care Finder Services.

C-7.19. The contractor shall ensure that all contractor personnel working in DoD Medical Treatment Facilities meet the MTF-specific requirements of the facility in which they will be working and comply with all local Employee Health Program (EHP) and Federal Occupational Safety and Health Act (OSHA) Blood borne Pathogens (BBP) Program requirements.

C-7.20. All customer assistance provided by telephone shall be without long distance charges to the beneficiary.

C-7.20.1. The contractor shall perform all customer service functions with knowledgeable, courteous, responsive staff.

C-7.20.2. The contractor shall establish twenty-four hour, seven days a week, nationally accessible (to include Hawaii and Alaska) telephone service, without long distance charges, for all MHS beneficiaries, including beneficiaries traveling in the contractor's area seeking assistance, in locating a network provider. This function shall be accomplished with live telephone personnel only.

C-7.21. The contractor shall establish, maintain, and monitor an automated information system to ensure claims are processed in an accurate and timely manner, and meet the functional system requirements as set forth in the technical requirements, TRICARE Operations Manual, and the TRICARE Systems Manual. The claims processing system shall be a single data base and be HIPAA compliant.

C-7.21.1. The contractor shall ensure that TRICARE claims/encounters (including adjustments) are timely and accurately adjudicated for all care provided to beneficiaries based on the timeliness and quality standards of the TRICARE Operations Manual, Chapter 1, Section 3.

C-7.21.2. The contractor shall provide data at the beneficiary, non-institutional and institutional level, with the intent of providing the Government with access to the contractor's full set of data associated with TRICARE. The data shall include, but is not limited to, data concerning the provider network, enrollment information, referrals, authorizations, claims processing, program administration, beneficiary satisfaction and services, and incurred cost data.

C-7.21.3. Nationally recognized paper claim forms (UB-92, HCFA 1500s, and their successors) or TRICARE-specific paper claim forms (DD Form 2642) shall be accepted for processing. Standardized electronic transactions and code sets as required by the Administrative Simplification section of the Health Insurance Portability and Accountability Act (HIPAA) shall be accepted.

C-7.21.4. The contractor shall, as one means of electronic claims submission, establish and operate a system for two-way, real time interactive Internet Based Claims Processing (IBCP) by providing web based connectivity to the claims/encounter processing system for both institutional and non-institutional claims processing. This IBCP system shall provide immediate eligibility verification by connectivity to DEERS and provide current deductible, Catastrophic Cap, and cost share/co-payment information to the provider on-line by connectivity to the DEERS catastrophic loss protection function and connectivity to the authorization system. The IBCP system shall comply with Department of Defense accreditation and encryption requirements as outlined in the TSM Chapter 1. The contractor shall regularly update the IBCP system to utilize newer encryption security protocols.

C-7.21.5. The contractor's claims/encounter processing system shall interface with and accurately determine eligibility and enrollment status based on the Defense Enrollment Eligibility Reporting System (DEERS) in accordance with the TRICARE Systems Manual.

C-7.21.6. The contractor's claims processing/encounter system shall accurately process claims in accordance with the TRICARE benefit policy as delineated in 32 CFR Part 199.4 and 199.5, the TRICARE Policy Manual, and TRICARE Reimbursement Manual.

C-7.21.7. The contractor's claims processing/encounter system shall accurately process claims in accordance with the program authorizations (e.g., Program for Persons with Disabilities, inpatient mental health, adjunctive dental).

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C-7.21.8. The contractor's claims processing/encounter system shall correctly apply deductible, co-pay/coinsurance, cost shares, catastrophic cap, and point-of-service provisions in accordance with the TRICARE benefit policy as delineated in 32 CFR Part 199.4 and 199.5, 199.17 and 199.18, the TRICARE Policy Manual, and TRICARE Reimbursement Manual.

C-7.21.9. The contractor's claims/encounter processing system shall accurately coordinate benefits with other health insurances to which the beneficiary is entitled as required by 32 CFR 199.8, the TRICARE Policy Manual, and TRICARE Reimbursement Manual.

C-7.21.10. Claims requiring additional information may be returned or developed for the missing information. The contractor shall ensure that all required information is requested with the initial return or development action and that no claim/encounter is returned/developed for information that could have been obtained internally or from DEERS. The contractor shall ensure that an adequate audit trail is maintained for all returned or denied claims.

C-7.21.11. The contractor shall ensure non-network claims received more than 12 months after the date of service are denied unless the requirements contained in 32 CFR 199.7 are met. Timely filing requirements for network providers shall be governed by the network provider agreement, but shall not exceed 12 months from date of service (or discharge).

C-7.21.12. The contractor shall accurately adjudicate claims under the Program for Persons with Disabilities and the special programs listed in the TRICARE Policy Manual, TRICARE Reimbursement Manual and 32 CFR 199.5.

C-7.21.13. The contractor shall accurately identify and adjudicate claims involving third party liability (TPL) and worker's compensation (WC), as required by the TRICARE Operations Manual, Chapter 11.

C-7.21.14. The contractor shall accurately reimburse network providers in accordance with the payment provisions contained in the provider agreement/contract. The contractor's reimbursement to network providers shall not exceed the amount which would have been reimbursed using the TRICARE payment methodologies and limits contained in 32 CFR 199.14, the TRICARE Policy Manual, and TRICARE Reimbursement Manual. The following area and specialty indicated have been approved by the TMA Director for a reimbursement rate increase of 600% of CMAC or the billed rate, whichever is less, before 01 February 2007 and 565% of CMAC after 01 February 2007, as authorized by 32 CFR 199.14(j)(1)(iv)(D) and documented in a Memorandum to the Director, TRICARE Regional Office – West Region, dated August 2, 2004.

Juneau AK for the following specialty: Non-routine GYN services – Nell Wagoner, Tax Identification Number

(b)(4)

The following area and specialty have been approved by the TMA Director for reimbursement rate increases to the Department of Veteran's Affairs rates as authorized by 32 CFR 199.14(j)(1)(iv)(D) and documented in a Memorandum to the Director, TRICARE Regional Office – West Region, dated October 28, 2004

Northern Hospital Associates at Fairbanks Memorial Hospital - Internal Medicine Hospitalists Limited to non-Evaluation and Management (E+M) inpatient services, Tax Identification Number (b)(4) The zip codes include: 99701; 99702; 99703; 99705; 99706; 99707; 99708; 99709; 99710; 99711; 99712; 99716; 99725; and 99775.

The following areas and specialties indicated have been approved by the TMA Director for reimbursement rate increases of 115% of CMAC rates or the billed rate, whichever is less, as authorized by 32 CFR 199.14(j)(1)(iv)(E) and documented in a Memorandum to the Director, TRICARE Regional Office – West Region, dated August 2, 2004.

a. Mountain Home Air Force Base Catchment area for the following specialties: Allergy, dermatology, gastroenterology, neurology, neurosurgery, orthopedic surgery, otolaryngology, rheumatology and thoracic surgery.

b. Cheyenne, Wyoming for the following specialties: Newborn care services reporting under CPT codes 99432, 99433, and 99436

c. Ft. Leonard Wood, MO for the following specialties: endocrinology, dermatology, neurosurgery, pulmonary disease, hematology/oncology, infectious disease, rheumatology, plastic surgery, thoracic surgery, gastroenterology, and physical medicine.

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The waiver for Dr. Raymond E. Andreassen, - Tax Identification Number (b) (4), effective 30 March 2005, performing services at The Family Medical Center, Delta Junction and Tok, Alaska regarding non-Mental Health care services, reimbursement rate increases of 115% is effective until 31 January 2007 and then withdrawn.

The following area and specialty has been approved by the TMA Director for reimbursement rate increases of 40% over CMAC from 21 November 2005 through 31 January 2007 and 105% of CMAC from 01 February 2007 through 20 November 2007 and 35% above the TRICARE Provider Reimbursement Demonstration Project rate for the State of Alaska as of 21 November 2007 as authorized by 32 CFR 199.14(j)(1)(iv)(D) and documented in a Memorandum to the Director, TRICARE Regional Office – West Region, dated November 21, 2005 and November 21, 2007.

Perinatology services rendered by Alaska Perinatology Associates (APA), Dr Sherrie D. Richey and Dr. Nelson B. Isada, Tax Identification Number (b) (4) and Alaska Native Medical Center (ANMC), Dr. George J. Gilson, Tax Identification Number (b) (4)

The following area and specialty indicated has been approved by TMA Director for a reimbursement rate increase to the Alaska Veterans Administration (VA) rate for professional services as authorized by 32 CFR 199.14(j)(1)(iv)(D) and documented in a Memorandum to the Director, TRICARE Regional Office – West Region, dated May 18, 2006. When the billed amount is less than the VA rate, the billed amount will be used. When the VA rate is less than the CMAC, the VA rate will be used. When the CPT is not priced under the VA fee schedule but a CMAC rate exists, the claim shall be paid using the CMAC rate. If no VA or CMAC rate exists for a CPT code, the contractor shall follow the procedures in the TRICARE Reimbursement Manual, Chapter 5, Section 1. When multiple procedures are performed during the same operative or outpatient session, pricing shall follow the VA fee schedule, but reimbursement shall follow Chapter 1, Section 16 of the TRICARE Reimbursement Manual. TriWest will receive annually an updated VA rate list from the TRICARE Regional Office-West (TROW). The updated VA rates will be effective for dates of service on or after the date TriWest receives the updated list from the TROW. When either TriWest or the government becomes aware of a plastic surgeon in Alaska who is not identified as such in the provider file, the identifying party will coordinate with the other to ensure an accurate listing of Alaska providers in this specialty. The contractor shall carry up to three iterations of VA pricing.

Alaska for the following specialty: Plastic Surgery

The following area and specialty indicted has been approved by the TMA Director for a reimbursement rate increase to 115% of CMAC rates as authorized by 32 CFR 199.14(j)(1)(iv)(E) and documented in a memorandum to the Director, TRICARE Regional Office – West, dated May 16, 2006.

Ellsworth AFB Prime Service Area: OB/GYN services provided by network providers.

The following area and specialty indicated has been approved by the TMA Director for a reimbursement rate increase to 252% of CMAC before 01 February 2007 and 217% of CMAC after 01 February 2007, for pain management services as authorized by 32 CFR 199.14(j)(1)(iv)(D) and documented in a Memorandum to the Director, TRICARE Regional Office – West, dated June 2, 2006. This waiver shall only apply to services for which the provider submits a TRICARE claim as a participating provider (i.e. accepts assignment). The waiver does not apply to supplies, DME, IV or injectable drugs, or clinical lab codes and all codes in the CPT code range 80000-89999, but does apply to pain management codes in the CPT code range of 20000-99999. The bilateral or multiple surgery rate reduction rules still apply.

Fairbanks Alaska for the following specialty: Pain Management - Dr. McGregor (ID (b)(4) Sub ID D007) and Dr. Jiang (ID (b)(4) Sub ID D019). The zip codes include: 99701; 99702; 99703; 99705; 99706; 99707; 99708; 99709; 99710; 99711; 99712; 99716; 99725; and 99775. Effective August 06, 2007 add the Advanced Pain Centers of Alaska (group provider number of (b) (4) -B001, the group NPI is 1184729600). Providers in the group include: Stinson, Lawrence W MD (Provider Number (b) (4) B004, NPI #1437163938); Cross, Nancy E MD (Provider Number (b) (4) B005, NPI #1174537674); Pulver, Francine M Number (b) (4) 1-B006, NPI #1689645947); and Slonimski, Marc MD (Provider Number (b)(4) B003, NPI #1891700522). Effective January 01, 2008 the provider numbers were changed.

The following area and specialty indicated has been approved by the TMA Director for a reimbursement rate increase to the AK Veterans Administration (VA) rate for Pulmonary (Sleep Studies) services as authorized by 32 CFR 199.14(j)(1)(iv)(D) and documented in a Memorandum to the Director, TRICARE Regional Office – West, dated December 13, 2006. This waiver shall only apply to services rendered by Chest Medicine of Fairbanks, P.C., (Tax

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Identification Number (b)(4) when they submit a TRICARE claim as a participating provider (i.e. accepts assignment).

Fairbanks Alaska for the following specialty: Pulmonary (Sleep Studies) Services for three study codes, CPT 95805, 95810 and 95811, including modifiers. The zip codes include: 99701; 99702; 99703; 99705; 99706; 99707; 99708; 99709; 99710; 99711; 99712; 99716; 99725; and 99775.

The following area and specialty indicated has been approved by the TMA Director for a reimbursement rate increase to 115% of CMAC rates as authorized by 32 CFR 199.14(j)(l) (iv)(E) and documented in a Memorandum to the Director, TRICARE Regional Office – West, dated July 13, 2007.

Ellsworth AFB Prime Service Area: Services of Black Hill Orthopedic and Spine Center (BHOSC).

The following area and specialty indicated has been approved by the TMA Director for a reimbursement rate increase to 15% above the TRICARE Provider Reimbursement Demonstration Project for the State of Alaska rate for the Juneau Bone and Joint Center services as authorized by 32 CFR 199.14(j)(l)(iv)(D) and documented in a Memorandum to the Director, TRICARE Regional Office – West, dated August 06, 2007 through September 04, 2008. Effective September 05, 2008, the TMA Director approved a reimbursement rate increase to 135% of Alaska CMAC rate (equivalent to 50% of Premera Blue Cross Blue Shield allowed rates for Alaska, weighted by services). This waiver shall only apply to services rendered by the Juneau Bone and Joint Center, to include Alan S. Gross, MD; Daniel R. Harrah, MD; Gordon R. Bozarth, MD; Ted L. Schwarting, MD and John P. Bursell, MD. This group will use Tax Identification Number (b)(4) and submit a TRICARE claim as a participating provider.

Juneau Alaska for the following specialty: Juneau Bone and Joint Center services for orthopedics, physical medicine and rehabilitation and evaluation and management codes effective August 06, 2007 through September 04, 2008. Effective September 05, 2008, Juneau Alaska for the following specialty: orthopedic and physical medicine rehabilitation services, excluding magnetic resonances imaging, physical therapy, clinical laboratory, durable medical equipment and alpha Healthcare Common Procedure Coding System codes.

The following area and specialty indicated has been approved on 14 July 2009 by the Deputy TMA Director to grant a locality based reimbursement rate waiver for medically necessary neurosurgical services in Alaska. The LBW waiver will apply to certain individual provider tax identifications (ID) who provide neurosurgical services and assistant surgery services, and have signed agreements for negotiated rates with TAO Alaska. The waiver is not to be applied to any other providers who may use their practice ID, if they are not neurosurgeons or providing assistant at surgery services for the designated neurosurgeons. The waiver only applies to professional services with CMAC rates. Clinical lab codes would be excluded (i.e., codes without CMACs for different provider classes, such as 80047-80440, 81000-85055, etc.). Codes subject to the waiver would have a CMAC of 250 percent of the Alaska CMAC (CMAC x 2.5).

Alaska for the following specialty: Neurosurgical Services

The following Neuro-Surgical Providers list with their Tax IDs apply to the Alaska Locality Based Reimbursement Rate Waiver (LBW):

TIN: (b)(4)
Alaska Neuroscience Associates, LLC
Jensen, Paul, L, MD
Wright, Kim, B, MD
Lawn, Marisa, A, PA
Smythies, Christopher, J, MD
Sonnenburg, Jane, M, PA
Dalessio, Patrick, M, PA

TIN: (b)(4)
Alaska Neurological Surgery
Kohler, Erik, P, MD

TIN: (b)(4)
Anchorage Neurosurgical Associates
Kralick, Louis, L, MD
Cohen, Timothy, I, MD

MDA906-03-C-0009

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Bernard, Estrada, J, MD
Tolbert, Marshall, E, MD
Hickel, Candace, D, PAC
Magid, Gail, A, MD (locum tenens)

The following area and specialty indicated has been approved on 17 November 2009 by the Deputy TMA Director to grant a reimbursement rate increase to 217 percent of CMAC for pain management services performed by anesthesiologists and other providers as authorized by 32 CFR 199. 14 (j) (1) (iv) (D) and documented in this memorandum.

The waiver applies to four pain management practices in the Alaska Anchorage area:

1. Interventional Pain Consultants of Alas (b)(4)
2. Rehabilitation Medical Associates (TIN (b)(4))
3. AA Pain Clinic (TIN (b)(4)), and
4. Advanced Pain Centers of Alaska (TIN (b)(4))

The waiver only applies for pain management codes in the Current Procedural Terminology code range of 20000-99999, where the principal diagnosis on the claim is in the range 330-357 or 710-739, and the provider submits a TRICARE claim as a participating provider (i.e., accepts assignment). The waiver does not apply to lab codes in the range 80000-89999, mental health codes in the range 90800-90899, and Physical Therapy/Occupational Therapy codes in the range 97001-98929. The bilateral or multiple surgery rate reduction rules still apply. The listed provider groups have signed Letters of Intent accepting the 217 percent of CMAC.

Alaska for the following specialty: Pain Management Services in and around Anchorage, Alaska.

C-7.21.15. The contractor shall accurately reimburse non-network provider claims in accordance with applicable statutory (Chapter 55, Title 10, United States Code) and regulatory provisions (32 CFR 199.14), and implementing instructions in the TRICARE Policy Manual and TRICARE Reimbursement Manual.

C-7.21.16. The contractor shall ensure that TRICARE Prime beneficiaries have no liability for amounts billed, except for the appropriate co-payment, for referred care, including ancillary services from a non-network provider as a result of a medical emergency or as a result of the TRICARE Prime beneficiary being referred to a non-network provider by the contractor. For example, this provision applies when a beneficiary is referred for surgery from a network surgeon in a network hospital, but the anesthesiologist is a non-network provider. Amounts paid in excess of the CHAMPUS Maximum Allowable Charge (CMAC), diagnosis related groups (DRG), or prevailing charge to non-network providers shall not be reported or used as health care costs for the purpose of the actual costs reported for health care fee determination under Section H.

C-7.22. The contractor shall provide to each beneficiary and each non-network participating provider an Explanation of Benefits (EOB) that describes the action taken on claims. The contractor may issue EOBs to network providers, as stipulated in the network provider agreement. The EOB must clearly describe the action taken on the claim or claims; provide information regarding appeal rights, including the address for filing an appeal; information on the deductible and catastrophic cap status following processing; and, sufficient information to allow a beneficiary to file a claim with a supplemental insurance carrier. The contractor shall mail the requested EOB, without charge to the beneficiary, within 5 calendar days of receiving a request (written, verbal, electronic) for an EOB from a beneficiary, regardless of their status. At the option of the providers, HIPAA-compliant electronic remittance advices shall be provided.

C-7.22.1. The contractor shall suppress EOBs in accordance with the TRICARE Operations Manual, Chapter 8.

C-7.23. The contractor shall accurately capture and report TRICARE Encounter Data (TED) related to claims adjudication in accordance with the provisions of the TRICARE Systems Manual and shall ensure the standards contained in this contract are achieved according to the TRICARE Operations Manual. All TED records shall comply with the information management requirements of this contract and shall be reported in compliance with the standards in the TRICARE Operations Manual.

C-7.23.1. The contractor shall submit information on all providers authorized by the contractor, to the TRICARE Management Activity centralized TRICARE Encounter Provider Record system in accordance with the provisions of the TRICARE Systems Manual.

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C-7.24. The contractor shall establish and maintain sufficient staffing and management support to meet the requirements of this contract and comply with all management standards in the TRICARE Operations Manual, Chapter 1, Section 4.0.

C-7.24.1. The contractor shall participate in quarterly round table meetings with the Government, all other Managed Care Support contractors, and any other participants that the Government determines is necessary. The round table requires high level managerial participation from the contractors (CEOs, Medical Directors, etc.) and participation by the contractor's technical and cost experts as determined by the agenda. The first round table will be held no later than 6 months after the start of health care delivery of the last Managed Care Support contract. The round table is tasked with reviewing current policies and procedures to determine where proven best practices from the participants' Government and private sector operations can be implemented in the administration of TRICARE to continue TRICARE's leading role as a world class health care delivery system.

C-7.25. The contractor shall establish and continuously operate an internal quality management/quality improvement program covering every aspect of the contractor's operation, both clinically and administratively. A copy of the documents describing the internal quality management/quality improvement program shall be provided to the Contracting Officer in accordance with Section F, paragraph F.5. A report listing problems identified by the contractor's internal quality management/quality improvement program and the corrective actions planned/initiated shall be provided to the Contracting Officer in accordance with Section F, paragraph F.5. The contractor shall provide a quarterly briefing in person or via video teleconference, as proposed by the contractor to the Regional Director and TMA staff on the contractor's ongoing internal quality improvement program. The contractor shall also comply with the Clinical Quality Management requirements of the TRICARE Operations Manual, Chapter 7, Attachment 10, National Quality Forum, "Serious Reportable Events in Healthcare"; and the vulnerability assessment requirements of the TRICARE Operations Manual, Chapter 1.

C-7.25.1. Annually, the Government will measure selected HEDIS-like (Health Plan Employer Data and Information Set) measures to compare the performance of the Military Health System with health plans reporting HEDIS measures. Annually, the contractor shall assist the Regional Director in evaluating the MHS' success, and in identifying the causes for successes and reasons for the MHS achieving results less than the civilian sector. Annually, the contractor shall assist the Regional Director in the development of a comprehensive plan for increasing the MHS' success in achieving HEDIS success rates when compared to the commercial sector. The contractor shall dedicate highly knowledgeable and skilled personnel to both the evaluation of performance results and the creation of plans to achieve excellence when the MHS is compared to the best commercial health plans. It is anticipated that a minimum of one FTE will be required.

C-7.26. The Government intends to establish a presence at TriWest, the prime contractor's headquarters locations in Phoenix, AZ; San Diego, CA; Wisconsin Physicians Service Insurance Corporation (WPS), first tier subcontractor headquarters in Madison, WI; and at each of the prime contractor's Hub locations in: Phoenix, AZ, Colorado Springs, CO, Tacoma, WA, and Honolulu, HI.

C-7.27. The prime Contractor's first tier subcontractor, WPS, shall provide full-time office space and support services for Government uses. The office space shall be fully furnished with desk, chair, PC, laser printer, phone and photocopy or access to photocopy equipment. The PC shall have access to the WPS claims system as well as the Internet. The phone shall have unlimited United States capability. With appropriate advance notice from the Government, all first tier Subcontractors shall also accommodate other Government representatives for periodic visits with temporary space. This could be in office or conference room space.

The prime Contractor shall provide full-time office space suitable for one Government representative in the Corporate Headquarters of Phoenix, AZ. Additionally, the prime Contractor shall provide office space in Hub locations for one Government representative in Honolulu, HI; two each Government representatives in Phoenix, AZ; Tacoma, WA; and three Government representatives in Colorado Springs, CO. Offices shall include a fully functional office including a private, lockable office with appropriate office furnishings and routine office supplies comparable to the senior managers. The prime Contractor shall have at least one office available at the Hawaii and Tacoma Hub and two at the Hub's in Colorado Springs and Phoenix to house the Government representatives. The Contractor may choose to provide alternate space for the second or third Government representative within the same area. All space provided must be able to be locked and secured. Each Government representative shall be supplied with a PC with email and World Wide Web access; telephone instrument with unlimited United States capability; and access to photocopy and fax equipment. Each office area shall have a laser printer. With appropriate advance notice from the Government, the prime Contractor will also accommodate additional Government representatives for periodic visits with temporary space in any of the Prime Contractor's Hubs or Corporate locations. This could be in office or conference room space. Additionally, the prime Contractor shall provide lockable space and office furnishings to the Defense Contract Audit Agency (DCAA)

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in Phoenix AZ. The DCAA will provide its own PCs, printer(s), and supplies. The prime Contractor will provide the DCAA with phones with United States capability.

C-7.28. The contractor shall locate a senior executive with the authority to obligate the contractor's resources within the scope of this contract within a fifteen-minute drive of the TRICARE Regional office.

C-7.29. The contractor shall comply with the Appeals and Hearings Process contained in the TRICARE Operations Manual, Chapter 13.

C-7.30. The contractor shall collaborate with the Regional Director and MTF Commanders to ensure the most efficient mix of health care delivery between the MHS and the contractor's system within the area. Collaboration includes, but is not limited to, right of first refusal for referrals for all or designated specialty care, including ancillary services; Centers of Excellence (COE); and coordinated preventive health care. The Memorandum of Understanding (drafted by the contractor) between the Regional Director, MTF Commander, and the contractor shall be in writing and must be approved by the Regional Director. The contractor shall initiate discussions related to and prepare the collaborative agreement. (See the TRICARE Operations Manual, Chapter 16). In lieu of separate MOUs for each MTF a single MOU may cover multiple MTFs at the discretion of the senior responsible MTF commander.

C-7.30.1. The contractor shall develop and implement, in conjunction with each MTF and the Regional Director, a contingency program designed to ensure that health care services are continuously available to TRICARE eligible beneficiaries as the MTFs respond to war, operations other than war, deployments, training, contingencies, special operations, et cetera. The documented contingency program shall be provided to the Regional Director 6 months following the start of option period one and updated annually.

C-7.31. The contractor shall participate in each MTF's Installation Level Contingency Exercise twice each year. The purpose of the exercise is to test the contingency program under a variety of situations and to provide information from which the contractor's contingency program shall be updated. The contractor shall also participate in Regionally Coordinated Table Top Contingency Exercises twice each year.

C-7.32. The contractor shall implement the contingency program at any or all locations within forty-eight (48) hours of being notified by the Regional Director that a contingency exists.

C-7.33. The contractor shall implement processes and procedures that ensure full compliance with the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry's Consumer Bill of Rights and Responsibilities. (See <http://www.hcqualitycommission.gov/>)

C-7.34. At midnight Pacific Time on the last day of health care delivery under this contract, the contractor shall assign its rights to the telephone number serving the region to the incoming MCS contractor.

C-7.35. The contractor shall provide information management and information technology support as needed to accomplish the stated functional and operational requirement of the TRICARE program and in accordance with the TRICARE Systems Manual and the MHS Enterprise Architecture (See <http://www.hirs.osd.mil/hdp/index.html>).

C-7.36. Personnel Security. The contractor shall meet the requirements of DoD 5200.2-R "Personnel Security Program," January 1987, and the TRICARE Systems Manual for employees and subcontractor employees that require access to Government information technology (IT) systems or access to contractor/subcontractor IT systems that process DoD sensitive but Unclassified (SBU) information and are directly connected to Government IT systems, and/or to those contractor/subcontractor personnel who have access to or process DoD sensitive information.

C-7.36.1. System Security. The contractor shall comply with the DOD accreditation process for safeguarding DOD information accessed, maintained and used in the operation of systems of records under this contract as described in the TSM Chapter 1. The contractor shall cooperate with and assist the Government's Information Assurance evaluation team during all phases of the accreditation process.

C-7.36.2. The contractor shall comply with DoD Directive 8500.1, Information Assurance, Privacy Act Program Requirements (DoD 5400.11), and Personnel Security Program Requirements (5200.2-R). The contractor shall also comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requirements, specifically the administrative simplification provisions of the law and the associated rules and regulations published by the Secretary, Health and Human Services (HHS) and the published TMA implementation directions. This includes the Standards for Electronic Transactions and the Standards for Privacy of Individually Identifiable Health Information. It is expected that

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the contractor shall comply with all HIPAA-related rules and regulations as they are published and as TMA requirements are defined (including security standards, identifiers for providers, employers, health plans, and individuals, and standards for claims attachment transactions).

C-7.36.3. The contractor shall ensure that all electronic transactions, for which a standard has been named, comply with HIPAA rules and regulations and TMA requirements. The Standards for Electronic Transactions apply to all health plans, all health care clearinghouses, and all health care providers that electronically transmit any of the electronic transactions for which a standard has been adopted by the Secretary, HHS. Electronic transmission includes transmission using all media, even when the transmission is physically moved from one location to another using magnetic tape, disk or CD media. Transmission over the Internet, Extranet, leased lines, dial-up lines and private networks are all included. Transmissions of covered data content via telephone conversations, fax machines, and voice response systems are not covered by the Standards for Electronic Transactions, however privacy and security requirements apply to these transmissions. Health plans and other covered entities conducting transactions through business associates must assure that the business associates comply with all HIPAA requirements that apply to the health plans or covered entities themselves.

C-7.37. The contractor shall furnish the DoD TRICARE Information Center and all Health Benefits Advisors and Beneficiary Counseling and Assistance Coordinators located in each region with read only access to claims data. The contractor shall provide training and ongoing customer support for this access.

C-7.37.1. The contractor shall provide unlimited read-only off-site electronic access to all TRICARE related data maintained by the contractor. Minimum access shall include two authorizations at each MTF, two authorizations at each Surgeon General's Office, two authorizations at the Regional Director's Office, two authorizations at Health Affairs, two authorizations at TMA-Washington, two authorizations at TMA-Aurora, two authorizations for each Intermediate Command listed in Attachment 9, and authorization for each on-site Government representative. The contractor will (b) (4)

C-7.38. The contractor shall coordinate its activities to establish enrollment protocols to effect the optimum enrollment mix and numbers in the MTFs for beneficiaries living within TRICARE Prime areas. The contractor will follow MTF guidelines for assigning MTF PCMs.

C-7.39. The contractor shall meet with each Regional Director and each MTF in a collaborative and partnering manner to ensure balanced specialty workloads using the contractor's referral protocols with the MTF as the first referral site. The contractor shall provide each MTF with referral information concerning any MTF enrollee within 24 hours of a referral.

C-7.40. The contractor shall comply with the provisions of the TRICARE Operations Manual, Chapter 7, regarding coordination and interaction with the National Quality Monitoring Contract (NQMC) contractor(s).

C-7.41. The contractor shall provide, no less than weekly, a listing of beneficiaries who have other health insurance (OHI) and the details of that insurance to the Pharmacy Data Transaction Services (PDTS) – the MHS' Pharmacy data repository – contractor. The form and transmission protocol shall be mutually agreeable to each, and approved by TMA. With the implementation of New DEERS, this requirement at some point may become unnecessary. If this occurs, the Contracting Officer will notify the contractor.

C-7.42. The contractor shall provide pharmaceuticals to beneficiaries in situations where the pharmaceuticals are not obtained from a retail pharmacy and consistent with the coverage usually provided under an outpatient pharmacy benefit. Pharmaceuticals obtained by a beneficiary from a retail pharmacy, the TRICARE Mail Order Pharmacy, or from specialized pharmacies as a component of the consolidated retail pharmacy benefit are not the responsibility of the contractor.

C-7.43. The contractor shall have an active provider education program designed to enhance the provider's awareness of TRICARE requirements, to include emphasis on achieving the leading health care indicators of Healthy People 2010, and encourage participation in the program.

C-7.44. The contractor shall provide all services required by this contract in the state of Alaska in accordance with the TRICARE Operations Manual, Chapter 23. The provisions of Section H.8.l. and H.8.m. are not applicable to services rendered in the State of Alaska.

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C-7.44.1. In a Memorandum of Understanding between the TRICARE Alaska Regional Office (TARO) and the Managed Care Support Contractor, the parties shall agree on how and when all requirements of the contract are phased in for services in the state of Alaska. The MOU shall be completed in accordance with Section F, paragraph F.5.c. (23).

C-7.45. The Contractor shall support all initiatives in support of the Behavioral / Mental Health program. The contracting officer will issue a task order with a Statement of Work describing what is required to support each initiative.

C-7.46. The contractor shall provide Smoking Cessation Triage Services

C-7.46.1. The contractor shall provide toll-free telephone based smoking cessation referral services in accordance with best commercial practices. Each smoking cessation contact representative shall be trained to possess basic familiarity with and understanding of the processes or stages of smoking addiction and cessation and the ability to adequately triage callers and recommend appropriate treatment resources. Services shall be available to eligible beneficiaries via a toll-free telephone line. Beneficiaries shall be advised when calling of the availability of additional web based information and interactive chat services that can be accessed via the Government's website <http://www.ucanquit2.org>.

C-7.46.2. The contractor shall provide a toll-free telephone service to assist eligible beneficiaries in obtaining resources to quit smoking. The line shall be available to all non-Medicare eligible beneficiaries who are current smokers or former smokers concerned about relapse .

C-7.46.3. Toll-free telephone services shall be provided to all eligible beneficiaries 24 hours daily, including weekends and holidays.

C-7.46.4. The contractor shall include in its existing website, links to the Government's tobacco cessation website <http://www.ucanquit2.org>. The contractor shall indicate that this site contains information covering all aspects of smoking/tobacco cessation (to include but not limited to health, cost-savings, impact on others, withdrawal expectations and tips for quitting). The contractor shall also indicate that this site provides online instant messaging (chat) technology as a real-time alternative to the telephonic toll-free line, and also provides referral to non-copyrighted, downloadable educational materials and links to other cessation related sites. . The contractor shall further indicate that this web based functionality is available year-round, 24 hours daily, including weekends and holidays.

C-7.46.5. The contractor shall provide via the U.S. mail smoking/tobacco cessation materials to those eligible beneficiaries who are unable to access the web-based support materials.

C-7.46.6. In providing smoking cessation triage services, the contractor shall follow the "5 A's" model (Ask, Advise, Assess, Assist, Arrange).

C-7.46.6.1. Each caller will be asked about their current smoking habit.

C-7.46.6.2. Each caller will be urged in a strong, clear and personalized manner to quit.

C-7.46.6.3. Each caller will be assessed as to their current willingness to make a quit attempt at the present time as well as their current level of tobacco dependence.

C-7.46.6.4. Based on the information received, each caller will be aided in their quit attempt by offering them a quit plan and then as appropriate, assist and/or recommend the beneficiary contact a TRICARE authorized provider who can further assist them in carrying out that plan.

C-7.46.6.5. Arrange for each caller to receive basic educational materials on smoking/tobacco cessation in order to support their quit attempt.

C-7.46.7. The contractor shall assist TMA's Office of Communications and Customer Service (C&CS) in the development of marketing materials to alert the beneficiary population of the contractor's toll-free smoking cessation services. The contractor shall provide C&CS with the toll-free phone number by which beneficiaries attain access to the smoking quit line 30 days prior to the initial start of service. This information may be included in quarterly newsletters published by TRICARE Managed Care Support contractors, published on TMA's web site, or included in emailed/mailed packages to beneficiaries.

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C-7.46.8. The contractor shall verify eligibility of each beneficiary through the Defense Enrollment Eligibility Reporting System (DEERS) prior to providing any telephonic or web-based chat services.

C-7.46.9. The contractor shall provide the following reports:

C-7.46.9.1. The contractor shall submit a quarterly report listing the staff providing services during the previous three months and listing their completed training. The listing shall include the course title, course dates, length of the course, and cumulative hours the individual has completed to date. The report shall be submitted not later than ten calendar days following the reported quarter.

C-7.46.9.2. The contractor shall submit a monthly report with the toll-free telephone line utilization rate and other data including but not limited to, accessibility metrics, demographics, number of callers, beneficiary category, number of telephonic contacts, time and length of calls. The report shall be submitted not later than ten calendar days following the reported month.

C-7.46.9.3. (Reserved)

C-7.46.10. The contractor shall deliver written materials to beneficiaries, upon request, who are not able to obtain them via the Internet. These materials shall be sent via first-class mail within three working days of request (reference paragraph C-7.46.5).

SECTION D
PACKAGING AND MARKING

D.1

Preservation, Packaging and Marking

The reports and other products to be furnished hereunder shall be adequately packaged and packed to ensure safe delivery at destination. All products must be clearly marked to identify the contents, the sender, and the individual/office to which they are being sent. Extra care shall be taken in packaging electronic media to protect against damage and to ensure that the electronic media does not become separated from the routing markings. All reports and other products to be furnished are to be shipped via a method that provides for acknowledgment of receipt. The contractor shall retain such receipts. Shipments containing electronic media shall be marked as such and shall include the statement "Do Not X-Ray". The contractor shall include the contract number on all products to be furnished under the contract.

SECTION E
INSPECTION AND ACCEPTANCE

E.1

E.1. 52.246-4 INSPECTION OF SERVICES--FIXED-PRICE (AUG 1996)
(Reference 46.304)

E.2. 52.246-5 INSPECTION OF SERVICES--COST-REIMBURSEMENT (APR 1984)
(Reference 46.305)

E.3. Inspection Locations

All inspections shall be conducted either at TRICARE Management Activity (TMA), the contractor's and/or subcontractor's facilities, Regional Director's offices or other locations where work is performed. Inspection and acceptance of services provided hereunder shall be accomplished by the Contracting Officer or his/her designee(s). Inspections include, but are not limited to, payment record audits, performance audits, program integrity audits, and contractor/TMA quality assurance audits.

SECTION F
DELIVERIES OR PERFORMANCE

F.1

F.1. 52.242-15 STOP-WORK ORDER (AUG 1989)
(Reference 42.1305)

F.2 42-15 I STOP-WORK ORDER (AUG 1989)--ALTERNATE I (APR 1984)
(Reference 42.1305)

F.3 Period of Performance

a. Base Period: 1 September 2003 - 30 September 2004
Option Period 1: 1 April 2004 - 31 March 2005, if exercised, Options 2, 3, 4, 5, 6, 7 and 8 are:

Option Period 2: 1 April 2005 - 31 March 2006

Option Period 3: 1 April 2006 - 31 March 2007

Option Period 4: 1 April 2007 - 31 March 2008

Option Period 5: 1 April 2008 - 31 March 2009

Option Period 6: 1 April 2009 – 31 March 2010

Option Period 7: 1 April 2010 – 30 September 2010

Option Period 8: 1 October 2010 – 31 March 2011

b. Contract Transition

Former Region 11: 1 September 2003 - 31 May 2004

Former Region 9/10/12: 1 September 2003 - 30 June 2004

Former Region Central: 1 December 2003 - 30 September 2004

F.4. Geographic Area of Coverage

The contract shall be referred to as the Managed Care Support (MCS), West . It will require development, implementation and operation of a health care delivery and support system for TRICARE and other MHS beneficiaries residing in the extreme western portion of Texas and certain Texas zip codes which are included in the catchment area of Cannon Air Force Base, New Mexico, as well as the states of Arizona, Colorado, Idaho, Iowa (except the clinic coverage area which has been assigned to the MCS, North Contract), Kansas, Minnesota, Missouri (except for those zip codes which have been assigned to MCSS, North Region), Montana, Nebraska, New Mexico, Nevada, North Dakota, South Dakota, Utah, Wyoming, California, Washington, Oregon, Hawaii and Alaska. These geographic areas and states are hereinafter referred to as the West Contract and defined by zip codes in Section J, Attachment 8.

F.5. Reports and Meetings

All reports shall be submitted electronically in mutually agreeable format and in a secure manner to the Government unless otherwise specified.

a. Evolving Practices, Devices, Medicines, Treatments and Procedures

The Contractor shall be responsible for routinely reviewing the hierarchy of reliable evidence, as defined in 32 C.F.R. 199.2, and bringing to the Government's attention drugs, devices, medical treatments, or medical procedures that they believe have moved from unproven to proven. This shall be done on a calendar quarter basis in a written report to the Government. Accompanying the report will be the reliable evidence substantiating that the drugs, devices, medical treatments, or medical procedures have moved from unproven to proven.

b. Start-Up Transitions

(I) Attend Post-Award Conference

Quantity: 1

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DELIVERIES OR PERFORMANCE

Time of Delivery: Within 15 calendar days after contract award.

(2) Attend Transition Specifications Meeting - Incoming and Submit Transition Plan

Quantity: 1

Time of Delivery: Within 15 calendar days following contract award

c. Transition In and Contract Deliverables –

Whenever there is a delivery date that specifies a number of days prior to or after health care delivery that is understood to be a different date for each individual outgoing region. (i.e. for item F.5.c.(2) the delivery dates would be 1 May 03 for Region 11; 1 Jun 03 for Region 9/10/12; and 1 Sep 03 for the Central Region)

(1) Schedule and host Interface Meetings

Quantity: 1

Time of Delivery: Within 30 calendar days after contract award

Contract Reference: TOM, Ch 1, Sec 8, 1.3.

Distribution: Incoming Contractor to Contracting Officer

(2) Reserved

(3) Systems Interconnections

Quantity: 1

Time of Delivery: 12 calendar days prior to start of health care delivery

Contract Reference: TSM Ch 1, Sec 1, 2.2

Distribution: Contractor to provide to TMA as part of authority to operate documentation under DITSCAP.

(4) Reserved

(5) Executed Collaborative Agreements with MTF Commanders

Quantity: one per MTF

Time of Delivery: 60 calendar days prior to the start of health care delivery

Contract Reference: TOM Ch 1, Sec 8, 2.4.1.

Distribution: Original to Contractor, copy to the Contracting Officer, TRO, MTF

(6) Memorandum of Understanding regarding marketing and education with the Government

Quantity: 1

Time of Delivery: 60 calendar days after contract award

Contract Reference: C. 7.9 and TOM Ch 1, Sec 8, 2.4.2

Distribution: Original To C&CS, copy to the Contracting Officer, COR

(7) Enrollment Plan

Quantity: 1

Time of Delivery: 90 calendar days prior to the start of each health care delivery period

Contract Reference: TOM Ch 6, Sec 1

Distribution: Original to TRO, copy to the Contracting Officer, COR

(8) DEERS: New enrollment applications

Quantity: 1

Time of Delivery: 40 calendar days prior to the start of healthcare delivery

Contract Reference: TOM Ch 1, Sec 8, 2.9.3

Distribution: Contractor to Beneficiaries

(9) Enrollment reports

Quantity: 1

Time of Delivery: Within 30 calendar days following the start of health care delivery and 10 calendar days following the close of each month, through the seventh month following the start of health care delivery

Contract Reference: TOM Ch 1, Sec 8, 2.5.2

Distribution: Original to TRO, copy to the Contracting Officer, COR

SECTION F
DELIVERIES OR PERFORMANCE

- (10) Contractor File Conversion and Testing
Quantity: 1
Time of Delivery: 30 calendar days following receipt of the magnetic tape files from the outgoing contractor
Contract Reference: TOM Ch 1, Sec 8, 2.10.1.

- (11) Weekly History Updates - Incoming
Quantity: 1
Time of Delivery: 120 calendar days prior to the start of health care delivery, to continue for 180 calendar days after the start of health care delivery
Contract Reference: TOM Ch 1, Sec 8, 2.10.2.
Distribution: Outgoing Contractor to Incoming Contractor.

- (12) Network Development Plan
Quantity: 1
Time of Delivery: 180 calendar days prior to the start of health care delivery
Contract Reference: TOM Ch 5, Sec 1
Distribution: Original to TRO, copy to the Contracting Officer, COR

- (13) Network Adequacy Reports
Quantity: 1
Time of Delivery: 30 calendar days after contract award and every 30 calendar days thereafter through the first 6 months of the health care delivery period. Thereafter quarterly throughout the life of the contract.
Contract Reference: TOM Ch 15, Sec 3,1.0
Distribution: Performance Assessment Tool (PAT)

- (14) Ordering of TRICARE marketing and educational materials from the Government
Quantity: 1
Time of Delivery: 180 calendar days prior to the start of health care delivery and by the 90th calendar day for all subsequent contract periods
Contract Reference:
Distribution: Contractor to C&CS

- (15) Distribution of education and marketing materials
Quantity: 1
Time of Delivery: No earlier than 60 calendar days and no later than 30 days prior to the start of health care delivery
Contract Reference: TOM Ch 12, Sec 1, 4.0
Distribution: As Applicable to beneficiaries and network providers

- (16) TRICARE Service Center Operations
Quantity: 1
Time of Delivery: 40 calendar days prior to the start of health care delivery
Contract Reference:
Distribution: Contractor TSCs operational 40 days prior to health care delivery.

- (17) Public Notification Program
Quantity: 1
Time of Delivery: No later than 45 calendar days prior to the start of health care delivery
Contract Reference:
Distribution: Contractor to beneficiaries.

- (18) Web-based Services
Quantity: 1
Time of Delivery: No later than 15 calendar days prior to the start of health care delivery
Contract Reference:
Distribution: Available on-line by the Contractor.

- (19) Incoming Contractor Weekly Status Report

**SECTION F
DELIVERIES OR PERFORMANCE**

- Quantity: 1
Time of Delivery: Beginning 20 calendar *days* after contract award through the 180th calendar day after the start of health care delivery
Contract Reference: TOM Ch 8, Sec 2, 4.3.7.
Distribution: Original to Contracting Officer, copy to TRO, COR
- (20) Contingency Program
Quantity: 1
Time of Delivery: Six (6) months following the start of option period 1 and updated annually.
Contract Reference: C-7.30.1.
Distribution: Performance Assessment Tool (PAT)
- (21) Internal Quality Management/Quality Improvement Program
Quantity: 1
Time of Delivery: Initial submission within 30 calendar days of award; subsequent submissions due to updates or changes to the program are to be submitted within 10 calendar days of the update or change. The requirement to maintain and update the Internal Quality Management/Quality Improvement Program will continue for the entire period of performance of the contract.
Contract Reference: C.7.25
Distribution: Performance Assessment Tool (PAT)
- (22) Internal Quality Management/Quality Improvement Reports
Quantity: 1
Time of Delivery: 10 calendar days following the reported month of problems identified and corrective actions Planned/initiated
Contract Reference: C-7.25
Distribution: Performance Assessment Tool (PAT)
- (23) Executed Memorandum of Understanding with the TRICARE Alaska
Office Quantity: 1
Time of Delivery: 30 calendar days following award
Contract Reference:
Distribution: Original to Contractor, copy to the Contracting Officer, TRO, COR, TAO
- (24) Subcontracting Plan
Quantity: 1
Time of Delivery: With Proposal
Contract Reference: C-3.2
Distribution: With proposal
- (25) Start Up Plan
Quantity: 1
Time of Delivery: 10 days after the award
Contract Reference: TOM Ch 1, Sec 8, 1.1
Distribution: Original to Contracting Officer, copy to COR
- (26) REVISED Transition Plan
Quantity: 1
Time of Delivery: 15 days following interface meeting
Contract Reference: TOM Ch 1, Sec 8, 1.1.
Distribution: Original to Contracting Officer, copy to COR
- (27) Clinical Quality Management Plan
Quantity: Not Specified
Time of Delivery: Annually
Contract Reference: TOM Ch 7, Sec 4, 1.0
Distribution: Performance Assessment Tool (PAT)
- (28) Marketing and Education Plan
Quantity: 90 days prior to start of each option period

SECTION F
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Time of Delivery: 180 days prior to the start of Health Care Delivery

Contract Reference: TOM Ch 12, Sec 1, 1.2

Distribution: Performance Assessment Tool (PAT)

- (29) Resource Sharing Plan Quantity: Annually
Time of Delivery: 60 days prior to start of each new Health Care Delivery option period
Contract Reference: TOM Ch 16, Sec 2, 2.2
Distribution: Performance Assessment Tool (PAT)
- (30) Utilization Management Plan
Quantity: 1
Time of Delivery: 90 days prior to the start of each new Health Care Delivery option period
Contract Reference: TOM Ch 7, Sec 1.2 - 1.5
Distribution: Performance Assessment Tool (PAT)
- (31) Enrollment/ Claims Processing Statistics
Quantity: Weekly
Time of Delivery: First business day after week reported
Contract Reference: TOM Ch 15, Sec 2, 3.0
Distribution: Performance Assessment Tool (PAT)
- (32) Evolving Practices Report
Quantity: Quarterly
Time of Delivery: 90 days after the start of Health Care Delivery
Contract Reference: F-5.a
Distribution: Performance Assessment Tool (PAT)
- (33) Claims Aging Report by Status/Location
Quantity: Weekly
Time of Delivery: After 1st week of Health Care Delivery
Contract Reference: TOM Ch 15, Sec 2, 5.0
Distribution: Performance Assessment Tool (PAT)
- (34) Network Status Report
Quantity: Monthly
Time of Delivery: 10th Day after Reported Month
Contract Reference: TOM Ch15, Sec 3, 3.0
Distribution: Performance Assessment Tool (PAT)
- (35) Network Inadequacy Report
Quantity: 10 days after end of reported month
Time of Delivery: 40 days after start of Health Care Delivery
Contract Reference: TOM Ch 15, Sec 3, 2.0
Distribution: Performance Assessment Tool (PAT)
- (36) Non-Financially Underwritten Bank Account Reconciliation Report
Quantity: Within 30 days after end of month
Time of Delivery: 30 days after start of Health Care Delivery
Contract Reference: TOM Ch 3, Sec 10, 1.0
Distribution: Original to TMA CRM, copy to the Contracting Officer, COR
- (37) Account Receivable Report
Quantity: Monthly
Time of Delivery: 2nd workday of subsequent month after 1st month of Health Care Delivery
Contract Reference: TOM Ch 3, Sec 10, 2.0
Distribution: Original to TMA CRM, copy to the Contracting Officer, COR
- (38) Accounts Receivable – Amounts Written Off Detail Report
Quantity: Monthly

SECTION F
DELIVERIES OR PERFORMANCE

Time of Delivery: 5th workday of subsequent month
Contract Reference: TOM Ch 3, Sec 10, 2.1
Distribution: Original to TMA CRM, copy to the Contracting Officer, COR

- (39) Accounts Receivable – Debts Transferred to TMA Detail Report
Quantity: Monthly
Time of Delivery: 5th workday of subsequent month
Contract Reference: TOM Ch 3, Sec 10, 2.1
Distribution: Original to TMA CRM, copy to the Contracting Officer, COR
- (40) Accounts Receivable – Ending Outstanding Receivables Detail Report
Quantity: Monthly
Time of Delivery: 5th workday of subsequent month
Contract Reference: TOM Ch 3, Sec 10, 2.1
Distribution: Original to TMA CRM, copy to the Contracting Officer, COR
- (41) Customer Satisfaction Report
Quantity: 10th day after reported month
Time of Delivery: 40 days after start Health Care Delivery
Contract Reference: TOM Ch 15, Sec 3, 12.0
Distribution: Performance Assessment Tool (PAT)
- (42) Productivity Report
Quantity: 10th day after reported month
Time of Delivery: 40 days after start Health Care Delivery
Contract Reference: TOM Ch 15, Sec 3, 13.0
Distribution: Performance Assessment Tool (PAT)
- (43) Quality Management Activity Report
Quantity: 10th day after reported month
Time of Delivery: 40 days after start Health Care Delivery
Contract Reference: TOM Ch 15, Sec 3, 9.0
Distribution: Performance Assessment Tool (PAT)
- (44) Education Presentation Report
Quantity: 10th day after reported month
Time of Delivery: 40 days after start Health Care Delivery
Contract Reference: TOM Ch 15, Sec 3, 11.0
Distribution: Performance Assessment Tool (PAT)
- (45) Beneficiary Services and Access Reports
Quantity: 10th day after reported month
Time of Delivery: 40 days after start Health Care Delivery
Contract Reference: TOM Ch 15, Sec 3, 10.0
Distribution: Performance Assessment Tool (PAT)
- (46) Medical Management Report
Quantity: Monthly
Time of Delivery: 40 days after start Health Care Delivery
Contract Reference: TOM Ch 15, Sec 3, 8.0
Distribution: Performance Assessment Tool (PAT)
- (47) Referral Report
Quantity: Monthly
Time of Delivery: 40 days after start Health Care Delivery
Contract Reference: TOM Ch 15, Sec 3, 6.0
Distribution: Performance Assessment Tool (PAT)
- (48) Listing of Beneficiaries with OHI Report
Quantity: No less than Weekly
Time of Delivery: 1 Week after start Health Care Delivery

SECTION F
DELIVERIES OR PERFORMANCE

Contract Reference: C-7.41
Distribution: Performance Assessment Tool (PAT)

- (49) Implementation of Enrollment Plan Report
Quantity: 10th day after reported month thru 7th month
Time of Delivery: 30 Days after start Health Care Delivery
Contract Reference: TOM Ch 15, Sec 3, 5.0
Distribution: Original to TRO, copy to the Contracting Officer, COR

- (50) Toll-Free Telephone Report
Quantity: 15th day after end of reported month
Time of Delivery: 45 days after start Health Care Delivery
Contract Reference: TOM Ch 15, Sec 3, 12.0
Distribution: Performance Assessment Tool (PAT)

- (51) Workload and Cycle Time Report
Quantity: 15th day after end of reported month
Time of Delivery: 45 days after start Health Care Delivery
Contract Reference: TOM Ch 15, Sec 4, 1.0
Distribution: Performance Assessment Tool (PAT)

- (52) Resource Sharing Reporting and Certification
Quantity: Last day of month following month reported
Time of Delivery: Last day of 2nd month after Health Care Delivery
Contract Reference: TOM Ch 15, Sec 3, 7.0
Distribution: Performance Assessment Tool (PAT)

- (53) Health Care Finder Report
Quantity: 10 days after end of quarter reported
Time of Delivery: 10 Days after 1st Qtr after Health Care Delivery
Contract Reference: TOM Ch 15, Sec 5, 5.0
Distribution: Performance Assessment Tool (PAT)

- (54) Fraud and Abuse Report
Quantity: Quarterly
Time of Delivery: 45 days after the last day of each quarter
Contract Reference: TOM Ch 15, Sec 5, 1.0
Distribution: Performance Assessment Tool (PAT)

- (55) Congressional/ HBA Visit Report
Quantity: 10 days after end of quarter reported
Time of Delivery: 30 days after end of first contract quarter Contract Reference: TOM Ch 15, Sec 5, 2.0
Distribution: Performance Assessment Tool (PAT)

- (56) Utilization Management Report
Quantity: 45 days after end of quarter reported
Time of Delivery: 45 days after end of 1st quarter of health care delivery
Contract Reference: TOM Ch 15, Sec 5, 3.0
Distribution: Performance Assessment Tool (PAT)

- (57) Providers & Beneficiaries on Prepayment Review Report
Quantity: 45 days after end of quarter reported
Time of Delivery: 45 day after end of 1st contract quarter
Contract Reference: TOM Ch 15, Sec 5, 4.0
Distribution: Performance Assessment Tool (PAT)

- (58) Quality Management Committee Meeting Minutes
Quantity: 10 days after end of quarter reported
Time of Delivery: 10 Days after 1st quarter after Health Care Delivery

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SECTION F
DELIVERIES OR PERFORMANCE

- Contract Reference: TOM Ch 15, Sec 3, 9.0
Distribution: Performance Assessment Tool (PAT)
- (59) Contingency program update (see plan above)
Quantity: Annual update
Time of Delivery: 6 months after start of Option 1
Contract Reference: C-7.30.1 and F.5.c(20)
Distribution: Performance Assessment Tool (PAT)
- (60) Fraud Prevention Savings Report
Quantity: Annually
Time of Delivery: Not Specified
Contract Reference: TOM Ch 15, Sec 6, 2.0 TOM Ch 14, Sec 5
Distribution: Original to TMA PI, copy to Contracting Officer, COR
- (61) Clinical Quality Management Report
Quantity: Annually
Time of Delivery: 90 Days after the end of each Fiscal Year
Contract Reference: TOM Ch 15, Sec 6, 1.0
Distribution: Performance Assessment Tool (PAT)
- (62) Enrollment Transfer Annual Report
Quantity: Annually
Time of Delivery: 30 days after end of Option Year
Contract Reference: TOM Ch 15, Sec 3, 4.0
Distribution: Performance Assessment Tool (PAT)
- (63) Internal Quality Management/ Quality Improvement Reports
Quantity: As required
Time of Delivery: 10 days following the reported month of problems identified and corrective actions planned
Contract Reference: C-7.25
Distribution: Performance Assessment Tool (PAT)
- (64) Clinical Support Agreement Report
Quantity: Monthly
Time of Delivery: Not Specified
Contract Reference: TOM Ch 15, Sec 3, 17.0
Distribution: Performance Assessment Tool (PAT)
- (65) Report on Audit of Referrals
Quantity: 45 days after end of month reported
Time of Delivery: 45 day after month in which audit sample was selected
Contract Reference: C-7.2
Distribution: Performance Assessment Tool (PAT)
- (66) Network Electronic Media Claims Report
Quantity: Annually
Time of Delivery: Within 30 days after the end of an Option Year
Contract Reference: Section C-7.1.10
Distribution: Performance Assessment Tool (PAT)
- (67) Monthly Clear & Legible Report to the MTF Commander – 30 Day PDR
Quantity: Monthly
Time of Delivery: By the 15th calendar day of each month
Contract Reference: Section C-7.1.16.5.1
Distribution: Performance Assessment Tool (PAT)
- (68) Monthly Clear & Legible Report to the MTF Commander – 90 Day PDR
Quantity: Monthly
Time of Delivery: By the 15th calendar day of each month
Contract Reference: Section C-7.1.16.5.2
Distribution: Performance Assessment Tool (PAT)

SECTION F
DELIVERIES OR PERFORMANCE

- (69) Monthly Clear & Legible Report to the Regional Director
Quantity: Monthly Time of Delivery: By the 15th calendar day of each month Contract
Reference: Section C-7.1.16.6
Distribution: Performance Assessment Tool (PAT)
- (70) Smoking Cessation Triage Quarterly Report
Time of Delivery: Ten calendar days after the end of the reported quarter
Contract Reference: C-7.46.9.1.
Distribution: Performance Assessment Tool (PAT)
- (71) Smoking Cessation Triage Monthly Telephone Report
Contract Reference: C-7.46.9.2.
Time of Delivery: Ten Calendar days after the end of the reported month
Distribution: Performance Assessment Tool (PAT)

d. Transition Out

- (1) Schedule Transition Specification Meeting - Outgoing
Quantity: 1
Time of Delivery: 15 calendar days following contract award of the successor contractor
Contract Reference: TOM Ch 1, Sec 8, 4.1
Distribution: Original copy to the Contracting Officer, copy to TRO, COR
- (2) Transition Out Plan
Quantity: 1
Time of Delivery: 15 calendar days following the Transition Specification Meeting - Outgoing
Contract Reference: TOM Ch 1, Sec 8, 4.1
Distribution: Original copy to the Contracting Officer, copy to TRO, COR
- (3) Transition Out of the Duplicate Claims System
Quantity: 1 lot
Time of Delivery: In accordance with the transition schedule
Contract Reference: TOM Ch 1, Sec 8, 4.4.2.
Distribution: Outgoing Contractor to phase-out use of duplicate claims system.
- (4) Transfer of Contractor File Specifications
Quantity: 1 lot
Time of Delivery: 3 calendar days following contract award
Contract Reference: TOM Ch 1, Sec 8, 4.3.2.
Distribution: Outgoing Contractor to Incoming Contractor
- (5) Transfer of ADP Files (Electronic)
Quantity: 1 lot
Time of Delivery: 15 calendar days following the Transition Specifications meeting (unless otherwise negotiated by the incoming and outgoing contractors)
Contract Reference: TOM Ch 1, Sec 8, 4.3.3.
Distribution: Original copy to the Contracting Officer
- (6) Transfer of Provider Information
Quantity: 1 lot
Time of Delivery: At the direction of the Contracting Officer following the date of successor contract award (unless otherwise negotiated at the Transition Specifications meeting)
Contract Reference: TOM Ch 1, Sec 8, 4.3.1.
Distribution: Outgoing Contractor to Contracting Officer Upon written request.
- (7) Weekly History Updates - Outgoing
Quantity: 1

SECTION F
DELIVERIES OR PERFORMANCE

Time of Delivery: Beginning 120 calendar prior to the start of health care delivery until completed in accordance with the transition schedule

Contract Reference: TOM Chi, Sec8, 4.3.4.

Distribution: Outgoing Contractor to Incoming Contractor.

- (8) Weekly Status Report
Quantity: 1
Time of Delivery: Beginning 20 calendar days following the Transition Specifications Meeting unless otherwise notified by the Contracting Officer
Contract Reference: TOM Ch 1, Sec 8, 4.3.5.
Distribution: Original to the Contracting Officer
- (9) Transfer of Non-ADP Files
Quantity: 1 lot
Time of Delivery: In accordance with the transition schedule
Contract Reference: TOM Ch 1, Sec 8, 4.3.5.
Distribution: Original copy to the Contracting Officer
- (10) Claims processing and adjustments
Quantity: 1 lot
Time of Delivery: 180 calendar days following the start of health care delivery
Contract Reference: TOM Ch 1, Sec 8, 4.4.
Distribution: N/A as claims processing guidelines.
- (11) Correct all Edit Rejects
Quantity: 1 lot
Time of Delivery: 210 calendar days following the start of health care delivery
Contract Reference: TOM Ch 1, Sec 8, 4.4.1.
Distribution: N/A as claims processing guidelines.
- (12) Phase-Out of MTF Interfaces Revised Plan
Quantity: 1 Time of Delivery: 15 calendar days after the Transition Specifications Meeting
Contract Reference: TOM Ch 1, Sec 8, 4.4.3.2.
Distribution: Outgoing Contractor to Contracting Officer
- (13) Transfer of Enrollment Applications
Quantity: 1 lot
Time of Delivery: 40 calendar days after the start of health care delivery of the successor contract award
Contract Reference: TOM Ch 1, Sec 8, 4.5.4.
Distribution: Outgoing Contractor to Incoming Contractor.

e. Benchmark Testing

Claims Systems Demonstration (Benchmark)

Quantity: 1

Time of Delivery: 120 calendar days prior to the start of health care delivery

Contract Reference: TOM Ch 1, Sec 8, 3.1.1.

Distribution: Original copy to Contracting Officer

f. DRG Outlier Rate Audits

As specified in H.13.c

Quantity: 1 Per MTF Commander

Time of Delivery: Annually

Contract Reference: H.13.c.

Distribution: MTF access on Contractors' Internet site or send to MTF commander

g. Acknowledgement to E-Mail Inquiries

SECTION F
DELIVERIES OR PERFORMANCE

As specified in H.13.d

Quantity: 1

Time of Delivery: Monthly

Contract Reference: H.13.d

Distribution: Original copy to Contracting Officer

SECTION G
CONTRACT ADMINISTRATION DATA

G.1

G-1. Contract Administration

The Procuring Contracting Officer (PCO) for this contract is:

Contracting Officer
Office of the Assistant Secretary of Defense for Health Affairs
TRICARE Management Activity
Contract Management Division
16401 East Centretch Parkway
Aurora, CO 80011-9066

G-2. Administrative Contracting Officer (ACO), Contracting Officer's Representative (COR)

Subsequent to contract award, the PCO will appoint one or more ACOs, one or more CORs who will be designated certain contract administration responsibilities in that region. The contractor shall work directly with the ACO(s), COR(s) on those matters delegated to them. The ultimate responsibility for overall administration of this contract rests with the PCO, TRICARE Management Activity, Aurora, Colorado. The contractor will be provided copies of all delegation letters.

G-3. Contract Payment

a. Contract Payments Disbursed by TMA Aurora

(1) General

(a) The basis for payment to the contractor shall be the prices specified in Section B of this contract.

(b) Methods of Payment to the Contractor

[1] All payments made by the Government will be made by electronic funds transfer (EFT).

[2] Non-underwritten benefit payments will be facilitated by permitting the contractor to withdraw funds directly from the Federal Reserve. These draws must be based on approved contractor payments clearing the contractor's bank account (less related deposits) as described in Chapter 3 of the TRICARE Operations Manual (TOM). TED data submissions for non-underwritten benefit payments shall be grouped into TED Vouchers by the 'Batch/Voucher ASAP Account Number' (defined in TRICARE Systems Manual, Chapter 2, Section 2.2).

(2) Invoices

(a) TEDs Supported Invoices. Submission of TEDs to TMA will be considered submittal of an invoice.

(b) Non-TEDs Supported Invoices

[1] Electronic invoices are the preferred method of submittal. The contractor can submit electronic invoices by accessing the TMA provided invoicing website, when available. The TMA website will provide electronic forms (e.g. SF 1034 or DD 250) that can be completed and submitted on-line. Supporting documentation may be attached electronically.

[2] Non-TEDs supported invoices for Behavioral/Mental Health Initiatives task orders shall also be submitted to the TRICARE Regional Office Contracting Officer for approval prior to payment. Copies of the invoices shall still be submitted to TRICARE Management Activity - Aurora in accordance with the preceding paragraph.

(c) Non-TEDs supported invoices shall be sent to the Contracting Officer (CO) with copies provided to Resource Management (RM) and the Contracting Officers Representative (COR).

(3) Payments

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SECTION G
CONTRACT ADMINISTRATION DATA

(a) Claims Processing CLINs – Electronic Claims and Paper Claims (see TOM Chapter 3, Section 9)

[1] Claims rate processing payments are based on TEDs being accepted provisionally or clearing all edits, whichever comes first. These are identified in the TEDs manual. Payments will be based on a claim rate times the number of claims clearing edits. Payments for claims the contractor receives within 120 calendar days following the cessation of health care delivery (for services rendered during the health care delivery period) are made based on the claim rate in effect during the health care delivery period immediately preceding transition-out. The Government will not pay the outgoing contractor the health care or administrative cost associated with claims not processed to completion within 210 calendar days from the cessation of health care delivery

[2] Payment terms. Claims processing payments are paid 30 days from the date of the cycle that included the accepted or cleared TEDs. If cycle processing is delayed by TMA, this period will be shortened to account for TMA downtime.

[3] No separate invoices are required for claims processing payments based on the automated processes tied to claims clearing TEDs edits. However, invoices are required for non-automated payment requests, unless otherwise instructed by the Contracting Officer. If TEDs is not operating normally, see TOM Chapter 3 Section 9 paragraph 1.2.

[4] Claims processing payments procedures are the same for both underwritten and non-underwritten benefit claims.

(b) TRICARE Service Centers (TSCs). Invoice on a monthly basis. The contractor shall submit an invoice only after completion of a particular month.

(c) Per Member per Month (PMPM). Invoice on a monthly basis. The contractor shall submit an invoice only after completion of a particular month for no more than one-sixth of the CLIN amount except for Option period One FY04 where the contractor may invoice for no more than one fourth of the CLIN amount.

(d) Disease Management – Cost Reimbursement. Unless otherwise directed by the Contracting Officer, interim vouchers (i.e. SF1034) should be submitted monthly to Defense Contract Audit Agency (DCAA) for approval with a copy provided to the Contracting Officer.

(e) Disease Management – Fixed Fee. Unless otherwise directed by the Contracting Officer, submit interim vouchers (i.e. SF1034) on a monthly basis to the DCAA with a copy provided to the Contracting Officer.

(f) Award Fee. Payment will be made by TMA following determination of the Award Fee amount as specified in the corresponding clause in Section H.

(g) Contracting Officer Directed Travel. Submit invoice, with supporting documentation, following completion of travel. Supporting documentation shall include original receipts for airline tickets, hotels, rental cars and any miscellaneous expense over \$75.00.

(h) Transition-In. Submit invoices on a monthly basis.

Transition Payment Schedule

September, 2003
October, 2003
November, 2003
December, 2003
January, 2004
February, 2004
March, 2004
April, 2004
May, 2004
June, 2004
July, 2004
August, 2004
September, 2004



(i) Transition-Out. Submit invoice following completion of work.

(j) Underwritten Health Care Costs.

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SECTION G
CONTRACT ADMINISTRATION DATA

[1] General Description. Payment of underwritten health care cost claims will be made to the Contractor within five Federal business days after the associated TEDS records are accepted provisionally or clear all edits, whichever comes first.

[2] Payment under this process are considered interim payments.

[3] The contractor will process underwritten health care claims and pay the provider or beneficiary from the contractor's account.

[4] The associated underwritten health care cost TEDS will be submitted to TMA and will be considered submittal of an invoice. If some or all of the TEDS fail edits, they will be returned to the contractor for corrective action. Those records that pass, at a minimum, validity edits will be included in an automated report which includes both amounts to be paid by the Government to the Contractor and amounts to be paid by the Contractor to the Government.

From the start of healthcare delivery through September 30, 2006, TED data submissions for underwritten cost payments shall be grouped into TED Vouchers by contract CLIN/Fiscal Year/Region (contractor will use 'Batch/Voucher ASAP Account Number' (defined in TRICARE Systems Manual, Chapter 2, Section 2.2)) field in the Voucher Header to identify the contract CLIN, the fiscal Year of funding associated with the CLIN, and the contract region. Batch/Voucher ASAP Account Number format for underwritten healthcare vouchers is: CLIN identified in Section B of the contract (six positions), fiscal year of funding on the CLIN (one position, NOTE: all underwritten CLINS will have at least two fiscal years of monies associated with them), and a single digit region indicator (W=West, N=North & S=South contract)(e.g. if ASAP number = 1001AA4W then: CLIN=1001AA, fiscal year = 2004, & Region = West). TMA will provide an algorithm for grouping TED records by CLIN and incorporate it into a TRICARE Manual.

For the period of October 1, 2006 through the end of the contract, all financially underwritten benefit payments must use BATCH/VOUCHER ASAP account number containing the TMA benefit CLIN (positions 1 through 6 of ASAP).

[5] TMA will disburse payment to the contractor based on the automated TED report. If the TEDS are credits, which will result in a payment to the Government, collection will be made based on the same terms as payment for that respective CLIN. (Credit must be applied back to the same sub-CLIN from which it came.)

[6] If TEDs is not operating normally, notification will be received from the Contracting Officer and the contractor may invoice for reimbursement of underwritten payments using an interm voucher (i.e. SF1034). The voucher may be submitted daily and will be paid within five Federal business days. Once TEDs is processing, all claims that have been held up will be processed and the exact amounts due to the contractor will be determined and will be offset by the disbursements made by the Government via the temporary public voucher process.

(k) Non-Underwritten Benefits

[1] General Description. Payment to the contractor for benefit payments will be facilitated by allowing the Contractor (through the Contractor's financial institution) to draw money from the designated Federal Reserve Bank. These draws may only be done to cover payments that have been approved for release by TMA and are clearing the contractor's financial institution on the day the draw is being accomplished. These draws must be reduced by deposits so the bank account will have close to a zero dollar balance at the end of each day.

[2] The contractor shall comply with the detailed instructions for these transactions outlined in the TOM, Chapter 3. Advance payments are not allowed. All payments must be for processed claims and approved prior to payment being issued. Unapproved payments will be immediately collected and subject the Contractor to penalties.

[3] TMA will disburse payment to the contractor based on the automated TED report. If the TEDS are credits, which will result in a payment to the Government, collection will be made based on the same terms as payment for that respective CLIN. (Credit must be applied back to the same sub-CLIN from which it came.)

[4] Types of Non-Underwritten Benefits

(i) TEDs Related Benefit Payments. These are payments to a provider or beneficiary supported by a TEDs submission to TMA. See TOM Chapter 3, Section 3. See Section H.1.a.(1) for a list of non-financially underwritten claims.

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(ii) CAP/DME and other Non-TEDs Routine Payments. These are payments that cannot be supported by TEDs because they are based on more than one patient. See TOM Chapter 3, Section 4.

(iii) Non-Routine Payments and Vouchers. These are payments that are rare, unusual and will only be approved by the Contracting Officer due to exceptional circumstances. These are transactions that must be done manually. If a transaction can be done through TEDs or other standard procedures they must be done by those procedures – see TOM Chapter 3, Section 5.

(iv) Residual Claims. These are claims for service provided prior to the start of this contract. See TOM Chapter 1, Section 8.

(l) Reserved

(m) Underwriting Fee Payments

[1] Partial underwriting fee payments will be determined and paid in accordance with Section H.2.(a) The contractor will invoice monthly the amount addressed in H.2.(a) after the completion of a month.

[2] Interim underwriting fee payments will be determined and paid in accordance with Section H.3. The contractor will invoice after the interim fee calculations are complete.

[3] Final fee will be determined and paid in accordance with Section H.1. The contractor will invoice after the final fee calculations are complete.

(n) Performance Guarantees. Collections will be made by withholding the determined amount from the next payment to the contractor.

b. Contract Payments related to Military Treatment Facility (MTF)

(1) Underwritten payments will be made for MTF Prime Enrollees in accordance with G-3.a.(3)(j) above. Non-underwritten payments will be made for MTF Prime Enrollees in accordance with G-3.a.(3)(k) above.

(a) TMA disbursements to the contractor will be the same as described in Underwritten Health Care Costs, paragraph G-3.a.(3)(j)[1] above.

[1] TED records will be grouped, based on MTF enrollment, by DOD Service per MTF designation or as TMA claims for other than MTF enrollees (see Section B for Underwritten and SHCP CLINS).

[2] TED data submissions and headers will be in the same manner as the Underwritten Health Care Costs procedures in paragraph G-3.a.(3)(j)[4] above.

(2) Resource Sharing: The paying activity, invoicing and payment details will be specified in each Resource Sharing Agreement.

(3) Fee-for-Service Resource Sharing: Terms will be specified in each agreement. Notwithstanding TRICARE Operations Manual, Chapter 16, Section 2, Paragraph 3.1, task orders are not applicable for fee-for-service Resource Sharing Agreements. See TRICARE Systems Manual, Chapter 2, Section 1.1, Paragraph 8 for process for reporting to TMA.

c. Clinical Support Agreement Program Invoice and Payments. The paying activity, invoice and payment instructions will be identified on each individual task order.

G-4. ORDERING ACTIVITY

The following describes the ordering authority and procedures for the requirements contract line item numbers (CLINs) of this contract, which are the Per Member per Month and the Claims processing CLINs, and for the indefinite-quantity CLINs of this contract, which are the Clinical Support Agreement Program CLINs, Resource Sharing Agreement CLINs and Behavioral / Mental Health Initiative CLINs.

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Ordering Authority. The TMA-Aurora Procuring Contracting Officer (PCO) has authority to issue delivery orders or task orders under the requirements CLINs of this contract. Any authorized contracting officer in support of the military health system (MHS) has the authority to issue task orders under the indefinite-quantity Clinical Support Agreement CLINs of this contract. The Contracting Officer located at the Regional Office has the authority to issue task orders under the indefinite-quantity Resource Sharing CLINs and Behavioral / Mental Health Initiative CLINs.

Ordering Procedures for the requirements CLINs. The PCO will issue delivery orders or task orders on DD Form 1155, Order for Supplies or Services. Orders may be placed by facsimile transmission, mail, or courier.

Ordering Procedures for indefinite-quantity CLINs. Orders placed under the indefinite-quantity CLINs may be issued on DD Form 1155, Order for Supplies and Services. Orders for Resource Sharing Program Agreements may be on a non-personal services basis only. Any Task Orders for the Clinical Support Agreement Program may be on a personal services basis or non-personal services basis as indicated in TOM Chapter 16, Section 3, Paragraph 3.1.3. Task Orders issued on a personal services basis shall comply with DOD Instruction 6025.5, entitled Personal Services Contracts (PSCs) for Health Care Providers (HCPs), and shall contain the information stated in part 6.3 of the same DOD Instruction. All task orders will be performance based or receive appropriate approval in accordance with DFARS 237.170-3. Orders may be placed by facsimile transmission, mail or courier. A copy of the Clinical Support Agreement order shall be provided to the contracting officer identified in block 6 of the award document (SF 26) plus the Contracting Officer located at the Regional Office. A copy of the Resource Sharing Agreement order shall be provided to the contracting officer identified in block 6 of the award document (SF 26) plus the MTF who requested the Agreement. A copy of the Behavior / Mental Health Initiative task order shall be provided to the TMA-Aurora PCO.

G-5. MILITARY HEALTH SYSTEM (MHS) ELIGIBLE BENEFICIARIES

The Government will unilaterally determine the number of MHS eligible beneficiaries two times each option period under the Per Member per Month contract line item numbers, once for the first six month period and once for the seventh through twelfth month. This will be done using an average of six of the seven previous months of eligible beneficiaries as reported by the MHS Data Repository in their monthly "Point-In-Time Extract" as adjusted by TMA (see Attachment 4). Using the number of MHS eligible beneficiaries, the Government will issue a delivery order for a six month period.

In order to provide for payment of the administrative price of change orders in future option periods, the negotiated increase or decrease in the administrative price will be divided by the PMPM unit price to arrive at a number of eligibles. The resulting number will be added or subtracted from the Government determined number of MHS eligible beneficiaries. The derived number of eligibles for an option period will be divided by 2 and will then be added to the Government determined number each six month period.

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H.1

H.1. Contractor Financial Underwriting of Healthcare Costs

a. General Discussion

(1) The Managed Care Support (MCS) contractor will underwrite the cost of civilian health care services (also referred to as “purchased care” which is defined as care rendered outside the Direct Care System) provided to all CHAMPUS-eligible beneficiaries* residing in the contract area except:

- outpatient retail and mail order pharmacy services (on separate contracts)
- Active Duty/Supplemental including TRICARE Prime Remote for service members (SM) only (family members (FM)s are underwritten by the MCS contractor)
- Continued Health Care Benefits Program (CHCBP)
- Foreign/OCONUS Claims (all)
- Medicare dual-eligible TRICARE beneficiaries (separate contract)
- Cancer prevention and treatment Clinical Trials demonstration (for those beneficiaries enrolled in the demonstration on or before March 31, 2008)
- State of Alaska
- In-Utero Fetal Surgical Repair of Myelomeningocele Clinical Trial Demonstration
- Bonus Payments In Medically Underserved Areas [Health Professional Shortage Areas] (HPSA)
- Capitol and Direct Medical Education Costs (CDME)
- TRICARE Reserve Select
- Custodial Care Transitional Program (CCTP)
- Individual Case Management Program for Persons with Extraordinary Conditions (ICMP-PEC)
- Autism Services Demonstration
- TRICARE Retired Reserve (TRR)

*CHAMPUS-eligible beneficiaries are defined as those beneficiaries that meet the requirements in Title 10, United States Code, Chapter 55.

(2) The underwriting mechanism will consist of an underwriting fee which may be considered to be an underwriting premium associated with the risk assumed by the contractor. It will be subject to a fee-adjustment formula or “fee curve,” which allows for increases or decreases inversely related to the actual costs. There is potential for the contractor to earn a negative fee if the actual healthcare costs for a given contract year were significantly higher than a specified target cost for that year. The adjustment mechanism is described in the subsequent paragraphs.

b. Administration of Financial Underwriting by Contractor

(1) This paragraph defines and explains the mechanics and the administration process of the following:

- target healthcare cost
- target underwriting fee
- minimum and maximum fee
- formula to determine the underwriting fee within the minimum and maximum based on the relationship of actual costs to target costs (a “fee curve”)
- actual healthcare costs

Each of these parameters is explained below.

(2) Target health care cost. The target health care cost for each period of health care delivery will be set as follows:

(a) The target cost for health care delivery in option period 1 under the contract is set forth in Section B. This target cost includes the purchased-care costs for non-TRICARE/Medicare dual-eligible CHAMPUS beneficiaries residing in the area, whether they are enrolled with an MTF PCM, a network PCM, or are non-enrolled. The target cost will not change except for definitized healthcare changes or other equitable adjustment.

(b) For option period 2 and subsequent periods, the Government and the contractor will negotiate the target cost before the start of each option period and incorporate them in Section B of the contract. The negotiation process shall begin

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with the submission of a proposal by the contractor not later than the first day of the seventh month of option period one and subsequent periods. Once the target cost for the next year is established, the only adjustments that would be made for that year would be for negotiated healthcare changes, definitized healthcare change orders, other equitable adjustment healthcare change orders issued after the completion of the negotiations that affect the year just negotiated. If an agreement cannot be reached on the target cost by 30 days before the start of the next option period, the option will be exercised using the prior option period's target cost as specified in Section B as the estimated target cost in Section B. A target-setting formula will be used to determine the target cost. This formula will set the target for the option period retroactively 12 to 18 months after that option period is completed. The contractor will continue to receive payments for underwritten health care costs as addressed in Section G, "Payments", and a portion of fee as addressed in Section H-2, "Partial Payment of Underwriting Fee during Performance".

(c) The retroactive target cost is calculated as follows:

-- actual underwritten CHAMPUS health care costs in the area in the previous option period is multiplied by the national trend factor for underwritten CHAMPUS healthcare costs from the beginning of the previous year up to the end of that year.

(3) Target Underwriting Fee

The term, "target underwriting fee" is equivalent to target fee. The target underwriting fee for all option periods is established at contract award using the contractor's proposed dollar amount for the initial contract award as set forth in Section B. When the parties negotiate the target cost for option period 2 and/or subsequent periods, the parties will apply the fee percentage proposed at contract award (for the relevant time period) to the negotiated target cost to determine the actual target fee. In the event the parties are unable to negotiate the target cost for option period 2 and/or subsequent periods, the target underwriting fee will be the dollar amount established at contract award. The target underwriting fee is then only adjusted by negotiated healthcare changes, definitized healthcare change orders, or other equitable adjustments. The parties agree to utilize the same fee percentage proposed for the initial award in these negotiated adjustments.

(b)(4)

(b)(4)

(4) Minimum and Maximum Fee

The minimum and maximum are as follows:

(a) The minimum fee that may be realized by the contractor will be negative 4 percent of the target cost for each contract year.

(b) The maximum fee that may be realized by the contractor will be 10 percent of the target cost for each contract year.

(5) Fee Determination

The underwriting fee will be determined using the fee adjustment formula as follows:

(a) When underwritten actual costs are less than the target cost, the fee will be the lesser of two amounts: (1) the target fee plus 20% of the difference between the target cost and the actual cost, or (2) the maximum fee amount.

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(b) When underwritten actual costs exceed the target, the fee will be the greater of two amounts: (1) the target fee plus 20% of the difference between the target cost and the actual cost (a negative number), or (2) the minimum fee amount (a negative number).

(c) Mathematically, this formula may be expressed as:

$$\text{Target Fee} + .20(\text{Target Cost} - \text{Actual Cost})$$

(b)(4)

The final determination of fee will occur approximately 12 to 18 months after the end of the Option Period to which it applies. This final determination will be based on underwritten TEDs accepted by TMA through the ninth month (Option Periods 1 and 2) and through the sixth month (Option Periods 3 through 8), after the end of the Option Period. However, prior to the fee determination, the Government will determine an interim fee approximately three months after the end of the contract year to which it applies based on the available TED data and the Government's estimate to completion. Partial and final payment of the fee will be conducted in accordance with H-2 and H-3.

(6) Actual Underwritten Healthcare Costs.

Actual underwritten costs for fee determination purposes will be measured from TRICARE Encounter Data (TEDs) accepted by the Government, less unallowable costs determined by audits, and estimated to completion (by the Government). The actual costs will include resource-sharing costs and any other valid, underwritten health-care costs not reported on TEDs, but previously agreed upon by the Government. Healthcare cost details and clarifications include:

(a) Underwritten costs. The target and actual costs will both include all non-TRICARE/Medicare dual-eligible CHAMPUS eligible beneficiaries enrolled with MTF PCMs in addition to all network-enrolled and non-enrolled non-TRICARE/Medicare dual-eligible beneficiaries.

(b) Local Military Treatment Facilities (MTFs) will have control over all beneficiaries who enroll in TRICARE Prime with an MTF Primary Care Manager (PCM). These enrollees will include Active Duty Service Members (ADSMs) as well as CHAMPUS-eligible beneficiaries. Only those dollars expended for non-TRICARE/Medicare dual-eligible CHAMPUS beneficiaries will be accumulated as actual healthcare costs to be compared with the target cost for the period.

(c) Enrollment Fees. Enrollment fees collected by the contractor are considered part of the administrative price and are not considered in the determination of the target cost or the actual cost of healthcare under the contract.

(d) Medical Management Costs. The costs of medical-management activities, such as case management, disease management, and utilization management are not considered as healthcare costs.

(e) As specified in H.1. of Section H and Section B of the contract, care provided in the State of Alaska is "non-underwritten cost" and are not direct "healthcare costs" that are underwritten by the contractor. These terms are defined in H.5. of Section H. From the start of healthcare delivery through September 30, 2006, non-underwritten dollars for Alaska will administratively be processed and disbursed under the Health Care Cost CLINS. Based on the actual TED records submitted, the Alaska disbursements will be subtracted out before comparing the total actual underwritten healthcare cost against the target cost for incentive fee determination purposes addressed in H.1. of Section H. This process will require the Government to obligate Alaska dollars on the Health Care Cost CLINS, so these CLINS will not reflect the true underwritten health care obligation. For the period of October 1, 2006 through the end of the contract, Alaska claims will be handled as non-underwritten pass-through.

(f) Capitated Arrangements. Capitation arrangements are prohibited.

H.2. Partial Payment of Underwriting Fee During Performance

In addition to the requirements and procedures specified in this section regarding interim and final health care underwriting fee determination, the Government will make partial payments against the target fee as specified below.

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- a. During performance of each option period, the Government will pay the contractor, on a monthly pro-rated basis, an amount equal to 50% of the target fee.
- b. Interim and final determination of fee for the base period and each subsequent option period will be in accordance with paragraphs H.1 and H.3.

H.3. Interim Fee Determination

- a. If the interim fee calculation described in H.1. indicates that a positive fee will be earned upon final determination, the Government will pay the contractor an amount equal to 90% of the interim fee for that period. This will be paid in a lump sum to the contractor; less any partial fee payments made for that period. The final balance for fee will be paid 12-18 months after the contract period in accordance with the final fee determination scheme.
- b. If the interim fee calculation indicates that a negative fee will be earned upon final determination, no interim fee payments will be made. Final fee determination will be made in accordance with paragraph H.1.

H.4. Resource Sharing

- a. Resource sharing is an alternative means of satisfying the purchased-care needs of non-TRICARE/Medicare dual-eligible CHAMPUS beneficiaries and is a tool that may be used by the Parties to reduce purchased-care and overall underwritten expenditures. All resource sharing agreements (See the TRICARE Operations Manual, Chapter 16) shall be cost effective to the Government and the contractor.
- b. Any allowable resource-sharing expenditure will be reimbursed and will count as actual underwritten healthcare.
- c. Although resource sharing is intended primarily to provide care to underwritten CHAMPUS-eligible beneficiaries, when a resource sharing asset provides care to non-underwritten beneficiaries, the costs of providing such care is counted as actual underwritten costs for fee determination, just like resource sharing expenditures for underwritten beneficiaries.
- d. There will be no need to account for the number of Military Treatment Facility outpatient visits or admissions enabled by resource sharing for purposes of determining contract payments, which is separate from the progress reports required under TRICARE Operations Manual, Chapter 15, Section 3. See TRICARE Systems Manual, Chapter 2, Section 1.1, Paragraph 8 for process for reporting Fee-for Service to TMA.

H.5. Allowable Health Care Cost and Payment

- a. The purpose of this clause is to define reimbursable healthcare costs and to clarify how healthcare costs apply to FAR clause 52.216-7, "Allowable Cost and Payment". This clause does not apply to reimbursable costs associated with the disease management administrative services contract line item number. This clause does not substitute any portion of, and does not make changes to FAR 52.216-7.

"Healthcare costs", as used in this clause, are direct healthcare costs that are underwritten by the contractor.

"Allowable cost", as used in this clause and FAR 52.216-7 are healthcare costs that pass the TEDs edits. These costs are reimbursed with obligated funds dispersed under this contract. A submission by the contractor to the TEDs system alone does not make it an allowable cost.

Non-underwritten "costs" are costs to the Government, and are not costs to the contractor. Non-underwritten "payments" are draws of funds directly from the Federal Reserve by the contractor and /or disbursed by TMA to the contractor. These draws are not considered payments to the contractor, and not considered a reimbursement of allowable healthcare costs from funds obligated on the contract.

- b. A submission to TEDs as described in the TRICARE Operations Manual is considered an acceptable invoice or voucher required in accordance with FAR 52.216-7(a)(1).
- c. Due to the nature of health care costs, the portions of FAR 52.216-7 that relate to materials, direct labor, direct travel, other direct costs, indirect costs, incidental expenses, and pension plan contributions are not applicable. As such, any portions of FAR 52.216-7 that relate to indirect cost rates and billing rates are not applicable.

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d. In reference to FAR 52.216-7 (g), “audits”, as used in this clause includes audits on statistically valid samples. The audit results will be applied to the entire universe from which the audit sample was drawn to determine total unallowable costs. Overpayments made by the contractor, whether found in an audited sample or audit results applied to the entire universe from which the sample was drawn, are unallowable costs. The Contracting Officer will notify the contractor of intent to disallow costs in accordance with FAR 52.242-1, Notice of Intent to Disallow Costs. Underpayments made by the contractor that are found in an audit are not used to offset overpayment adjustments.

e. In reference to FAR 52.216-7 (h)(2), the Contracting Officer will not approve contractor’s expense to secure refunds, rebates, credits, or other amounts (including incentives), as allowable costs for reimbursement under the cost-reimbursable line items, including health care line items.

H.6. Evolving Practices, Devices, Medicines, Treatments and Procedures

a. Medical practices and procedures are expected to continue developing during the period of this contract. Some will increase and some will decrease the cost of medical care. These changes will include practices, devices, medicines, treatments and procedures that previously were excluded from the benefits as unproven. There shall be no change in the Target Cost or Target Fee as a result of changes in the approval status of drugs, devices, medical treatments and medical procedures. The contractor underwrites all costs of all drugs covered under this contract, devices, medical treatments or medical procedures that move from unproven to proven. Changes caused by changes in the statutory definitions of the benefit or new benefits added by statute will be implemented under the Changes clause.

b. TRICARE can only cover costs for medically necessary supplies and services. Regulatory procedures are in place at 32 C.F.R. 199.4(g)(15) that describe the procedure for evaluating the safety and efficacy of unproven drugs, devices, medical treatments, or medical procedures. The contractor shall be responsible for routinely reviewing the hierarchy of reliable evidence, as defined in 32 C.F.R. 199.2, and shall bring to the Government’s attention drugs, devices, medical treatments, or medical procedures that they believe have moved from unproven to proven in a written report to the Government in accordance with F-5.

H.7. Integrated Process Teams

The Government may develop major contract and program changes through Integrated Process Teams (IPTs). This provision describes the contractor’s participation in this process. The contractor will provide the appropriate personnel (as agreed to by the Contracting Officer and the contractor) to serve on IPTs to develop and/or improve the technical, business, and implementation approach to any and all proposed TRICARE program contract changes within 14 calendar days after notification by the Contracting Officer. The contractor will participate in the entire process with the Government team from concept development through incorporating the change into the contract. This process includes developing budgetary cost estimates, requirement determination, developing rough order of magnitude cost estimates, preparing specifications/statements of work, and establishing a mutually agreeable equitable adjustment to the contract price as a result of incorporating the change (including pricing, negotiations, etc). IPTs will not be formed for all contract changes, but generally will be formed for complex, system-wide issues. The contractor shall participate in all required meetings as determined by the Government team leader, regardless of how they are held (in person, via teleconference, by video-teleconference, or through electronic conferences within the TMA web site). The frequency and scheduling will vary depending on the topic.

H.8. Performance Guarantee

a. The performance guarantee described in this provision is the contractor’s guarantee that the contractor’s performance will not be less than the performance standards described below. The rights of the Government and remedies described in the Performance Guarantee provision are in accordance with, and in addition to all other rights and remedies of the Government. Specifically, the Government reserves its rights and remedies set forth in the Inspection of Services clause (FAR 52.246-4, 52.246-5) and the Default clause (FAR 52.249-8, 52.249-6).

b. The contractor guarantees that performance will meet or exceed the standards in this provision. For each occurrence the contractor fails to meet each guaranteed standard, the Government will withhold from the contractor the amount listed in the schedule below. Performance guarantee withholds will continue until the guarantee amount for the respective option period is depleted or the contractor’s performance improves to meet or exceed the standard. Performance will be measured as specified below. The contractor will be notified and withholds made on a quarterly basis. For the purposes of this provision, the term “performance standard” is defined as the contract standards that are restated in this provision.

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c. Performance Guarantee Amounts:

- Option Period 1 \$ 4,704,728
- Option Period 2 \$ 6,090,376
- Option Period 3 \$ 7,147,732
- Option Period 4 \$ 8,333,812
- Option Period 5 \$ 9,852,720
- Option Period 6 \$ 11,443,116.72
- Option Period 7 \$ 5,901,497.02
- Option Period 8 \$ 5,920,019.02

d. Telephone Service (Busy Signals)

Standard: Not less than 95% of all calls shall be received without the caller encountering a busy signal

A performance guarantee shall be applied as follows:

Based on the contractor's monthly report, the Government will withhold a performance guarantee amount of \$0.50 per blocked call in excess of the standard (not less than 95% of all calls shall be received without the caller encountering a busy signal). For example, if 92% of calls are received but 8% are blocked by a busy signal, then a performance guarantee equal to 3% of the calls [3% represents the difference between the actual number of blocked calls and the standard] will be assessed. If 3% equates to 100 calls, the performance guarantee withhold will be \$50.00 or 100 times \$0.50. The blockage rate shall be determined no less frequently than once per hour.

'All calls' is defined as any call to any contractor operated TRICARE customer service telephone number. Customer service shall be interpreted in the broadest terms including, but not limited to, telephone calls from beneficiaries, providers, Government representatives, and interested parties about general program information, network providers, enrollment, eligibility, benefits, referrals, preauthorization's/authorizations, claims, complaints, processes and procedures.

e. Telephone Service (Total Hold Time)

Standard: 95% of all calls shall not be on hold for a period of more than 30 seconds during the entire telephone call

A performance guarantee shall be applied as follows:

If performance falls below the standard for each individual call that has a total hold time of more than 30 seconds based on the contractor's monthly report (calls exceeding the 30 second total hold time divided by total calls received during the month), the Government will withhold a performance guarantee amount of \$0.50. For example, if only 92% of calls that have a total hold time of 30 seconds or less, the actual number of calls failing the 95% standard will be assessed a performance guarantee. In this example, the difference equals 3%. If 3% of calls equates to 100 calls not meeting the 30 second total hold time standard, the performance guarantee withhold will be \$50.00 or, 100 times \$0.50.

f. Claims Processing Timeliness (Retained Claims and Adjustment Claims)

(b)(4)

(b)(4)

Standard: (b)(4)

(b)(4)

A performance guarantee shall be applied as follows:

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If the contractor fails to meet the standard, the Government will withhold a performance guarantee amount of \$1.00 per retained claim in excess of the (b) (4) (b) (4). For example, if only 91% of retained claims are processed within 30 calendar days, a performance guarantee will be assessed equal to 4% of the claims processed that month. The 4% represents the difference between the actual performance of 91% and the standard of 95%. If 4% equates to 600 claims, the performance guarantee withhold will be \$600.00 or 600 times \$1.00. The number of claims failing to meet the standard will be determined monthly based on the TMA TED database.

g. Claims Processing Timeliness (Retained Claims)

Standard: 100% of retained claims shall be processed to completion within 60 calendar days

A performance guarantee shall be applied as follows:

If the contractor fails to meet the standard of 100% of retained claims processed to completion within 60 days, the Government will withhold a performance guarantee amount of \$1.00 per retained claim not meeting the standard. For example, if actual performance is 99% of retained claims processed to completion within 60 days, the contractor will be assessed a performance guarantee equal to 1% (the difference between the contractor's actual performance and the standard. If 1% equates to 100 claims, the withhold will be \$100.00, or 100 times \$1.00. The number of claims failing to meet the standard will be determined monthly based on the TMA TED database.

h. Claims Processing Timeliness (Excluded Claims)

Standard: 100% of all claims shall be processed to completion within 120 calendar days.

A performance guarantee shall be applied as follows:

If the contractor fails to meet the standard and falls below the standard of all claims processed to completion within 120 calendar days, the Government will withhold a performance guarantee amount of \$1.00 per claim not meeting the standard. For example, if 1% (the difference between the contractor's actual performance and the standard) of all claims are not processed to completion within 120 calendar days from the date of receipt, and that equates to 1,000 claims, the performance guarantee amount will be \$1,000.00 or, 1,000 times \$1.00. The number of claims failing to meet the standard will be determined monthly based on the TMA TED database. The Government will assess a performance guarantee amount monthly until the claim is processed to completion.

i. Payment Errors

Standard: The absolute value of the payment errors for sampled TEDs (initial submissions, re-submissions, and adjustments/cancellation submissions) shall not exceed 2%.

A performance guarantee shall be applied as follows:

If payment errors exceed the standard, the Government will withhold 10% of the value of payment errors exceeding the 2% standard. The Government will not net errors as a result of overpayments and underpayments. Rather, the Government will withhold a performance guarantee amount equal to 10% of the sum of all payment errors in excess of the standard. This amount will be based on the actual claims audited in the quarterly TMA audits as specified in Section H.

j. TED Edit Accuracy – Validity Edits

Standard: The accuracy rate for TED validity edits shall be not less than:

95 % after six months of performance during the first option period

and

99% after nine months and thereafter during the entire term of the contract

A performance guarantee shall be applied as follows:

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If the contractor fails to meet the standard and falls below either of the two standards of 95 % after six months or 99 % after nine months, a performance guarantee amount of \$1.00 for each TED record not meeting the standard will be withheld. For example, if only 90% of all TEDs pass validity edits after six months, then a performance guarantee amount equal to 5% of all TEDs failing the edits during the quarter will be withheld (5% equals the difference between the contractor's actual performance and the standard in this example). If 5% equates to 1,000 TEDs, the performance guarantee amount will be \$1,000.00 or 1,000 times \$1.00. The number of TEDs failing to meet the standard will be determined monthly based on the TMA TED database.

k. TED Edit Accuracy – Provisional Edits

Standard: The accuracy rate for provisional edits shall not be less than:

90 % after six months of performance during the first option period

and

95 % after nine months and thereafter during the entire term of the contract

A performance guarantee shall be applied as follows:

If the contractor fails to meet the standard and falls below either of the two standards of 90 % after six months or 95 % after nine months, a performance guarantee amount of \$1.00 for each TED not meeting the provisional edit standard will be withheld. For example, if only 85% of all TEDs pass provisional edits after six months, a performance guarantee equal to 5%, or the difference between the contractor's actual performance and the standard, will be assessed. If, as in this example, 5% equates to 1,000 TEDs, the performance guarantee will be \$1,000.00 or 1,000 times \$1.00. The number of TEDs failing to meet the standard will be determined monthly based on the TMA TED database.

l. Contractor Network Adequacy

Standard: Excluding the state of Alaska, not less than 96% of contractor referrals of beneficiaries residing within a Prime service area shall be to a MTF or network provider with an appointment available within the access standards.

Based on the contractor's monthly report, a performance guarantee shall be applied as follows for referrals failing the standard:

if less than 96% and more than or equal to 93%	\$25.00 per referral*
if less than 93% and more than or equal to 91%	\$50.00 per referral*
if less than 91% and more than or equal to 90%	\$75.00 per referral*
if less than 90%	\$100.00 per referral*

*The withhold will be based on the difference between the contractor's actual performance and the standard.

For purposes of this provision, a referral is the offer of an appropriate appointment within the access standards. If the beneficiary elects not to accept the offered appointment, the contractor has met the standard. In determining the performance guarantee, the applicable amount will be determined based on the offeror's actual performance. For instance, if the contractor's actual performance is 90%, the performance guarantee will equal \$75 per referral in excess of 96%. In this example if 5% equals 1,000 referrals failing the standard, the performance guarantee will equal \$75,000. It is critical that the contractor recognize that the highest per referral withhold will be applied to all referrals failing the standard. The Government will not stratify the performance guarantee based on the above.

m. Specialty Care Referral/Consultation/Operative Reports

Option Period 2 – MTF Referrals - The contractor shall provide 98% of consultation or referral reports, operative reports, and discharge summaries to the Referral Management Center or MTF single POC within 10 business days following completion of the servicing network provider's evaluation of the patient. This excludes the State of Alaska. For the purpose of calculating the performance guarantee (PG), all referrals, minus the following exclusions, will be counted:

- Behavioral Health
- Obstetrics (OB) (management of pregnancy, delivery and post partum care)
- Retroactive Authorizations (i.e., emergency and urgent care)
- Primary care received in civilian facilities whether the patient has been referred by the MTF or not
- Sensitive Diagnosis

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- i. Alcoholism, International Classification of Diseases, 9th revision, Clinical Modification (ICD-9-CM) codes 291.9, 303.0 – 303.9 and 305
 - ii. Drug Abuse, ICD-9-CM codes 292 – 292.9, 304 – 304.9 and 305.2 – 305.9
 - iii. Acquired Immune Deficiency Syndrome (AIDs), ICD-9-CM codes 079.53 and 042
 - iv. Abortion, ICD-9-CM codes 634 – 639.9 and 779.6
 - v. Sexually Transmitted Diseases, ICD-9-CM codes 090 – 099.99 and 054.1 – 054.19
- Out of Area Referrals
 - Laboratory Studies
 - Durable Medical Equipment
 - Home Health
 - Long Term Care
 - Hospice
 - Dialysis for long term (Medicare) patients
 - Referrals of patients with other health insurance (OHI) which serves as primary payor
 - Self Referral by patients
 - Those referrals where no healthcare has been rendered
 - In those circumstances where the patient is undergoing long term specialty care (i.e., oncology) and the PCM desires an interim clinical report, the Contractor will, upon request, obtain such reports.
 - Regarding Urgent / Emergent Referrals the requirement to have a report within 24 hours.

Based on the contractor's monthly report, a performance guarantee amount of \$100 for each report not provided timely will be withheld. For example, out of 100 referrals 98% were due within 10 business days and only 96% were completed; the Government will withhold \$200 (\$100 x 2 missing/late reports).

Contractor has 30 calendar days after signed mutual agreement to submit any revised reports.

Option Periods 3 – 8:

(1) Standard: Evaluate-Only MTF Referrals – The contractor shall provide 98% of network consultation or referral reports to the Referral Management Center or MTF single Point of Contact (POC) within 10 business days following completion of the servicing network provider's evaluation of the patient.

(2) Standard: Evaluate and Treat MTF Referrals – The contractor shall provide 100% of network specialty reports or the operative reports and/or the narrative summaries of hospitalizations to the Referral Management Center or MTF single POC not later than 30 business days following the patient's discharge from the hospital or completion of treatment.

A performance guarantee shall be applied as follows:

For each month, on the 15th day of the fourth month following the close of the reportable month, TriWest will provide a report of the performance metrics associated with consult tracking requirements utilizing processed claims (to determine if care was received) for month being reported plus the three following months. For example, for referrals received during August 2006 TriWest will utilize claims processed for those referrals during August and claims that lag for the following three months (September – November). TriWest will be assessed a performance guarantee if the number of Consult Reports received does not meet the performance standards for "evaluate only" and "evaluate and treat". The following table identifies, for each Option Period, the performance guarantee rate for those reports not received within the prescribed performance standards.

Option Period 3	(b)(4)
Option Period 4	
Option Period 5, first 6 months	
Option Period 5, second 6	
Option Period 6, 7 and 8	

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(b)(4)

Care starting in the last month of the last exercised Option will not be on the reports.

For the Option Period 3 months of April – July 2006, the computation of the PG will be based upon the monthly average of the PG for the period August 2006 through March 2007. This eight month average dollar amount of the PG will be applied to each of the four months April, May, June, and July. This calculation for April through July will occur on July 15, 2007.

For the purpose of calculating the PG, all MTF referrals, minus the following exclusions, will be counted:

- Behavioral Health
- Obstetrics (OB) (management of pregnancy, delivery and post partum care)
- Retroactive Authorizations (i.e., emergency and urgent care)
- Primary care received in civilian facilities whether the patient has been referred by the MTF or not
- Sensitive Diagnosis
 - i. Alcoholism, International Classification of Diseases, 9th revision, Clinical Modification (ICD-9-CM) codes 291.9, 303.0 – 303.9 and 305
 - ii. Drug Abuse, ICD-9-CM codes 292 – 292.9, 304 – 304.9 and 305.2 – 305.9
 - iii. Acquired Immune Deficiency Syndrome (AIDs), ICD-9-CM codes 079.53 and 042
 - iv. Abortion, ICD-9-CM codes 634 – 639.9 and 779.6
 - v. Sexually Transmitted Diseases, ICD-9-CM codes 090 – 099.99 and 054.1 – 054.19
- Out of Area Referrals
- Laboratory Studies
- Durable Medical Equipment
- Home Health
- Long Term Care
- Hospice
- Dialysis for long term (Medicare) patients
- Referrals of patients with other health insurance (OHI) which serves as primary payor
- Self Referral by patients
- Those referrals where no healthcare has been rendered
- In those circumstances where the patient is undergoing long term specialty care (i.e., oncology) and the PCM desires an interim clinical report, the Contractor will, upon request, obtain such reports.
- Regarding Urgent / Emergent Referrals the requirement to have a report within 24 hours.

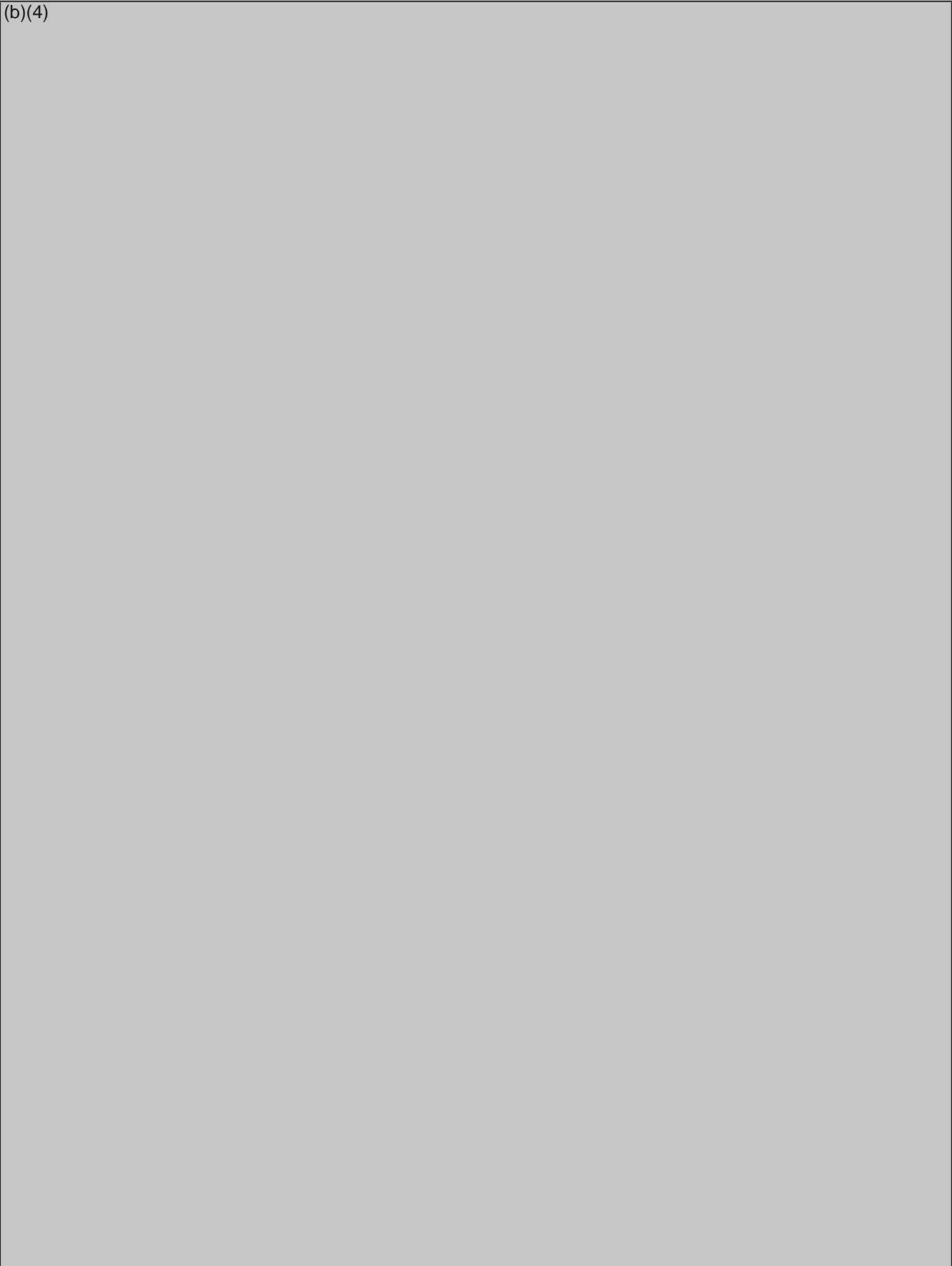
The above standards exclude the State of Alaska. Based on the contractor's monthly report, a performance guarantee for each report not provided timely will be withheld. For example, out of 100 referrals 98% are due within 10 business days for Evaluate Only, 96% were completed; the Government will withhold \$50 (\$25 x 2 missing/late reports) for Option Period 3. For example, out of 100 referrals 100% are due within 30 business days for Evaluate & Treat but only 96% were completed; the Government will withhold \$100 (\$25 x 4 missing/late reports) for Option Period 3.

n. Additional Performance Guarantees

(b)(4)

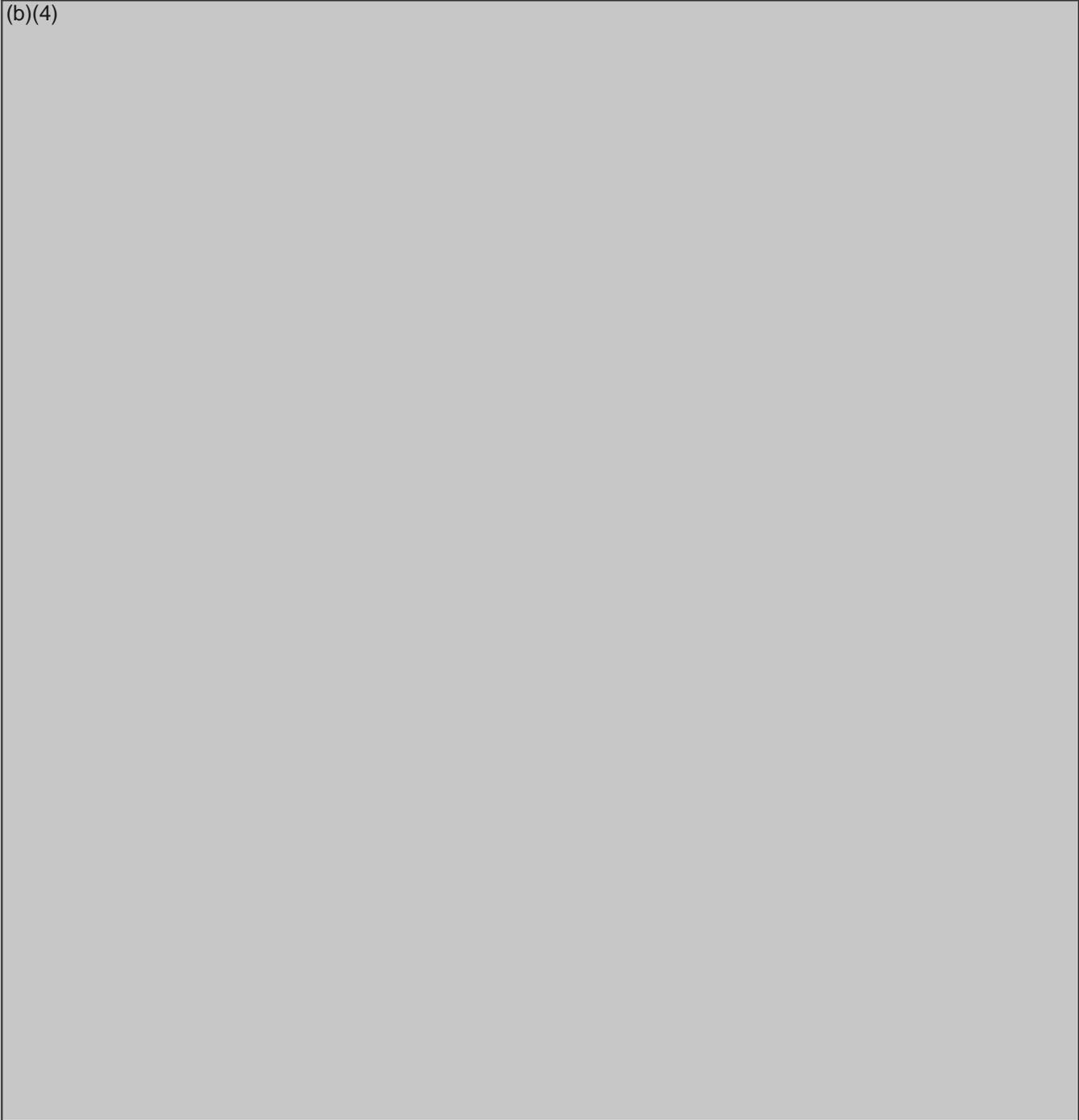
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(b)(4)



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(b)(4)



H.9. Award Fee

The award fee will be administered quarterly following the completion of each contract quarter in accordance with the award fee plan. The award fee pool is prorated into three quarters for Option Period 1, four equal amounts for Option Years 2 through 6 and two quarters for Option Periods 7 and 8 as shown in Section B and awarded portions disbursed quarterly in accordance with the award fee plan. Unawarded portions of the award fee pool are not available for any subsequent period. The results of the Government administered surveys will be considered in determining the award fee and that any contractor administered survey results are specifically excluded from consideration.

H.10. Processing of Newborn Claims

For those newborns that are covered under the “deemed enrollment” benefit, the contractor shall code these claims as civilian PCM Prime until a formal enrollment action or the end of the “deemed enrollment” period, whichever is earlier. If the newborn is formally enrolled during this “deemed enrollment” period, for claims incurred after the formal

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enrollment the contractor shall code the claims according to the formal PCM assignment. If the newborn is not formally enrolled after the “deemed enrollment” period, for claims subsequently incurred, the contractor shall process these claims as a non-enrolled beneficiary, applying the appropriate TRICARE cost shares and deductibles. Note that this PCM coding approach during the “deemed enrollment” period does not affect the status of these newborns for purpose of the contract’s underwriting provisions, as underwriting applies to eligible newborns regardless of their enrollment or PCM status. Similarly, this PCM coding approach during the “deemed enrollment” period does not change TRICARE policy regarding the actual payment of the claim from a beneficiary or provider perspective.

H.11. Claim Cycle time and Audit Methodology

a. Claim Cycle Time Measurement.

The Government will calculate the claim cycle time based on data submitted on TRICARE Encounter Data (TEDs). The cycle time is calculated as one plus the difference between the Julian date that the claim or adjustment claim was processed to completion and the Julian date of receipt or the Julian date the claim was identified as an adjustment. Only a single cycle time will be calculated per claim. This cycle time will be calculated using all unedited TEDs initial submission vouchers (Voucher Resubmission Number equals zero) which are received by TMA during each quarter and which pass the voucher header edits. TEDs in vouchers which fail the voucher header edits or which are otherwise unprocessable as submitted by the Contractor and TEDs in resubmission vouchers (Voucher Resubmission Number is greater than zero) will be excluded from the claim cycle time calculation.

(1) Claim Audit Sampling and Error Determinations

(a) Sampling Methodology

Sample means will be used as point estimates of payment and occurrence errors. There will be two kinds of payment samples, one for non-denied claims and one for denied claims. The design of non-denied payment and the occurrence samples utilizes a ninety percent (90%) confidence level, while the denied payment sample design uses an eighty percent (80%) confidence level. Precision estimates are 1.0 percent (1%) for the non-denied payment sample, 2.0 percent (2%) for the denied payment sample, and 1.5 percent (1.5%) for the occurrence sample. The non-denied payment sample will be drawn from all records with government payments of \$100 to \$100,000. In addition, all records with a government payment of \$100,000 and over will be audited. The denied payment sample will be drawn from all records with billed amounts of \$100 to \$100,000. In addition, all records with billed amounts of \$100,000 and over will be audited. The non-denied and denied payment samples will be stratified at multiple levels within the \$100 to \$100,000 range. Samples will be drawn on a quarterly basis from TEDs which pass TMA validity edits. Records to be sampled will be “net” records (i.e. the sum of transaction records available at the time the sample was drawn related to the initial transaction record). TEDs in vouchers which fail TRICARE validity edits or which are otherwise unprocessable as submitted by the contractor will be excluded from the sampling frame.

(b) Required Contractor Documentation.

[1] Upon receipt of the TEDs Internal Control Number (ICN) listing from TMA or designated audit contractor, the Contractor shall retrieve and compile processing documentation for each selected claim. The Contractor shall submit one legible copy of each claim and the following required documents via registered mail, certified mail or similarly guaranteed delivery service. All documentation must be received at TMA or designated audit contractors within 30 calendar days from the date of the TMA or designated audit contractors letter transmitting the ICN listing:

- (i) Claim-related correspondence when attached to claim or related to the adjudication action, such as status inquiries, written and/or telephone, development records, other telephone conversation records.
- (ii) Other claim-related documentation, such as medical reports and medical review records, coding sheets, all authorization and referral forms and their supporting documentation, referrals for civilian medical care (SF Forms 513 or 2161), other health insurance and third party liability documents, discounted rate agreements to include the following information: 1) provider name, 2) provider identification number, 3) effective and termination dates of agreements; and 4) negotiated rate or fee schedule and such other documents as are required to support the action taken on the claim.
- (iii) A copy of the EOB (or EOB facsimile) for each claim selected.
- (iv) The contractor shall send via electronic data input on a 3480 cartridge the current family

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history (15 to 27 months) for each selected claim. This electronic data containing all required data fields must be received by TMA or designated audit contractor within 30 calendar days from the date of the TMA or designated audit contractor letter transmitting the ICN listing.

[2] Payment errors or occurrence errors will be assessed if the Contractor does not provide the above claim-related documents or if the documents provided are not legible. The Contractor has the option of submitting the original document in those cases where the copy is not legible. TMA or designated audit contractors will return original documents upon completion of the audit process.

(c) Additional Data to be Furnished by the Contractor.

[1] Description of data elements by field position in family history file printout. Initial submission to TMA is due by the commencement of claims processing and revisions as they occur.

[2] Claim adjudication guidelines used by processors; automated prepayment utilization review screens; automated duplicate screening criteria and manual resolution instructions shall be submitted to TMA by the commencement of claims processing.

[3] Unique internal procedure codes with narrative and cross-reference to approved TRICARE codes and pricing manuals used in claims processing. Initial submission to TRICARE is due by the commencement of claims processing and revisions as they occur, but not later than the 5th work day of the month following the change.

[4] Specifications for submission of the provider and pricing files are described in the TEDs System Manual. Initial submission to TMA is due by the commencement of claims processing and updates to the files are to be submitted as specified in the TEDs System Manual.

(d) Payment Error and Process Error Determinations.

[1] There are two categories of payment errors: (1) a payment error which cannot be removed by contractor post payment processing actions and (2) a payment error which can be removed by contractor post payment processing actions (see list of audit error codes defining payment error categories). Payment errors which can be removed by contractor post payment actions will also be assessed a process error at audit. If contractor post payment actions substantiate the initial processing decision, the payment error will be removed but the process error will remain. If the initial processing action is not substantiated, both the payment and the process error will remain. Claims containing process errors will not affect payment or occurrence error rates, but will be used as a performance indicator.

[2] Payment errors are the amount of over/under payments on a claim, including but not limited to a payment in the correct amount but sent to the wrong payee, denial of a payable claim, misapplication of the deductible, payment of a noncovered service/supplies, or services/supplies for which a benefit determination cannot be based on the information available at the time of processing. Process errors result from: noncompliance with a required procedure or process, such as development required but not performed, medical emergency not substantiated, medical necessity review not evident and are cited in conjunction with a payment error. Process error determinations are based on the claim information available and those processing actions which have passed the TMA TED Validity edits up to the time the audit sample is pulled.

[3] Payment errors which may not be removed by Contractor post payment actions (see audit error categories) are based only on the claim information available and those processing actions which have passed the TMA TED Validity edits up to the time the audit sample is pulled. Actions and determinations occurring subsequent to the date the audit sample is pulled or actions and determinations which have not passed the TMA TED Validity edits are not a consideration of the audit regardless of whether resolution of a payment error results. Because adjustment transactions are not allowed on total claim denials, subsequent reprocessing actions to the denied claim which occur prior to the date the audit sample is pulled will be considered during the audit.

[4] The measure of the payment error is the TED record. The audit process (for the payment samples) projects universe value based on the audit results. The samples (non-denied and denied) are separately projected to the universe of claims for each quarter. The results of these projections are then combined into the following categories: total number of claims in the universe, government payment estimation, correct government payment, error amount and the estimated error percent in the universe of claims.

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[5] All incorrectly coded financial fields on a TED are considered to be occurrence errors regardless of whether associated errors exist.

(e) Computation of the “Total Amount Billed” for Denied Claims.

[1] For treatment encounters for which no per diem, negotiated rate or DRG-based amount applies for consideration of payment, the “total amount billed” is the actual amount billed on the claims. This applies to treatment encounters involving services from DRG-exempt hospitals and hospital units, those involving DRG-exempt services and those which would otherwise be subject to the DRG-based payment methodology but for which a DRG allowed amount cannot be computed, regardless of whether or not these claim are paid;

[2] For treatment encounters subject to the TRICARE per diem payments, negotiated rate, or the DRG-reimbursement methodology, the “total amount billed” is the correct per diem, negotiated rate, or DRG-based allowable amount including any applicable outlier amounts.

[3] If a claim is selected for audit and the Contractor cannot produce the claim or the claim provided is not auditable, a 100 percent payment error based upon the total amount billed will be assessed. For health care services records which do not represent a legitimate condition requiring submission of a record as defined in the TRICARE Systems Manual, a 100 percent error will be assessed. The payment error amount will be based upon the total amount billed. This condition is considered to be an unsupported TED.

(f) TED Occurrence Error Determination

[1] The TED occurrence error rate is defined as the total number of errors divided by the total number of data fields in the sample times 100.

[2] Occurrence errors determinations are based on only the claim information available and those processing actions taken at the time of adjudication. Actions and determinations occurring subsequent to the processed date of an audited claim, such as obtaining other health insurance documentation, adjusting a claim to correct financial or other data fields, or developing for required information not obtained prior to processing, are not a consideration of the audit regardless of whether a resolution of the incorrectly coded TED results.

[3] Occurrence errors result from an incorrect entry in any data field of the TED. There are no exceptions. Any error, including errors in financial fields, shall be counted as occurrence errors.

[4] Some TED error conditions are not attributable to any one specific data field but apply to the record as a whole or to certain parts of the record. In addition to erroneous data field coding, the following error conditions involving incorrect or unsupported records will result in occurrence errors being assessed as indicated.

Following are error conditions and the associated number of occurrence errors assessed with each condition; payment error codes that post payment actions do not apply; payment error codes that post-payment actions do apply, and process error codes.

ERROR CONDITION	NUMBER OF ERRORS
Unlike Procedures/Providers Combined (Noninstitutional Record)	7 errors for each additional utilization data set*
Unlike Revenue Codes Combined (Institutional Record)	5 errors for each erroneous revenue code set**
Services Should Be Combined	1 error for each additional revenue code/utilization data set
Missing Noninstitutional Utilization Data Set	7 errors for each missing data set*
Extra Noninstitutional Utilization Data Set	7 errors for each extra data set*
Missing Institutional Revenue Code Set	5 error for each missing revenue code set**
Extra Institutional Revenue Code Set	5 errors for each extra revenue code set**
Incorrect Record Type	5 errors
Claim Not Provided for Audit	1 error plus 1 error for each revenue code utilization data set in the TED
Claim Not Auditable	1 error plus 1 error for each revenue code utilization data set in the TED

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Unsupported TED Transaction	1 error plus 1 error for each revenue code utilization data set in the TED
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*Not to exceed 21 errors for combination of these error conditions

**Not to exceed 15 errors for combination of these error conditions

The following are payment errors on which post payment actions are either not applicable or would not remove the payment errors assessed.

- 01K-Authorization / PreAuthorization Needed (all — except PPWD* and Adjunctive Dental Authorizations)
- 03K-Billed Amount Incorrect
- 04K-Cost-share / Deductible Error
- 07K- Duplicate Services Paid
- 08K- Eligibility Determination — Patient
- 09K- Eligibility Determination — Provider
- 12K- Non-Availability Statement Error
- 13K-OHI/TPL — Govt. Pay Miscalculated
- 16K- Payee Wrong- Provider
- 17K- Participating/Non-Participating Error
- 18K- Pricing Incorrect
- 19K-Procedure Code Incorrect
- 20K-Signature Error
- 22K- DRG Reimbursement Error
- 24K-Incorrect Benefit Determination
- 25K-Claim Not Provided
- 26K-Claim Not Auditable
- 27K-Incorrect MCS System

The following are payment errors on which post-payment actions may support original processing. On rebuttal, if documentation is provided that supports the processing actions, the payment errors could be removed but the process errors would remain.

- 01K-Authorization/Pre-Authorization Needed (PPWD* and adjunctive dental authorizations)
- 02K-Unsupported Benefit Determination
- 05K-Development Claim Denied Prematurely
- 06K-Development Required
- 10K-Medical Emergency Not Substantiated
- 11K-Medical Necessity/Review Not Evident
- 21K-Timely—Filing Error
- 23K-Contract Jurisdiction Error
- 99K-Other - This payment error is very general and claims would have to be reviewed on an individual basis with regard to post-payment actions.

*PPWD – Program for Persons with Disabilities

The following are process errors which will be assessed for noncompliance of a required procedure/process. These errors are neither occurrence errors or payment errors and are not used to calculate the occurrence error or payment error rate. A payment error will be assessed along with the process error. Upon rebuttal if the process is followed to conclusion and the actions support the original decision, the payment error will be removed but the process error will remain.

- 01P - Authorization/Pre-authorization needed (PPWD and dental authorizations)
- 02P - Unsupported Benefit Determinations
- 05P - Development Claim Denied Prematurely
- 06P - Development Required
- 10P - Medical Emergency Not Substantiated
- 11P - Medical Necessity/Review Not Evident
- 21P - Timely Filing Error
- 23P - Contract Jurisdiction Error
- 99P - Other

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(2) Error Determination Rebuttals

(a) Contractor rebuttals of audit error findings must be submitted to TMA or the designated quality audit within 45 calendar days of the date of the audit transmittal letters. Rebuttals not postmarked within 45 calendar days of the audit letter will be excluded from further consideration. Rebuttal responses are final and will not receive further consideration except when during the audit rebuttal process the contractor submits a claim not previously submitted with the audit and an error is assessed, or when the contractor's explanation of the basis on which a claim was processed results in the assessment of a new error not previously reviewed by the contractor. Contractor rebuttals to new errors assessed by TMA or the designated audit contractor during the initial rebuttal process must be postmarked within 30 calendar days of the TRICARE or designated quality review contractor rebuttal response letter. Rebuttals to new errors not postmarked within 30 calendar days from the date of the rebuttal letter will be excluded from further consideration. The due dates of rebuttals will be calculated by adding 45 to the Julian calendar date of the TMA or designated audit contractor audit letter or by adding 30 to the Julian calendar date of the TMA or designated audit contractor rebuttal response letter.

b. Health Care Cost Audit

TRICARE Encounter Data (TED) batch/voucher payment records are utilized to determine allowable cost. The total allowable amount is calculated on a per record basis, using all fields used to calculate a batch/voucher header total, and for dates of service falling within a specified option period. The total government paid amount will be calculated using all edited TEDs batch/vouchers with resubmission number equal to zero and which are received by TMA Batch/voucher records that have not passed validity edits on the TED record or which are otherwise unprocessable as submitted by the contractor will be excluded from the sample.

(1) Claim Audit Sampling and Error Determinations.

(a) Sampling Methodology and Application of Results for Option Period One

A stratified random sample of claims from the universe of non-denied underwritten claims will be used to estimate the mean overpayment amount per claim in the claims universe and the lower limit of a one-sided ninety-percent (90%) confidence interval (estimated mean - 1.2815 x standard error). All claims in the sample determined to have been underpaid will be deemed to have an overpayment amount of zero. The lower limit of the confidence interval will be used as the recovery amount per claim in the universe of claims from which the sample is drawn. The total recovery amount will be calculated as the recovery amount per claim multiplied by the number of claims in the universe from which the sample is drawn. The payment samples will be drawn from all records with Government payments of \$100 to \$100,000. In addition, all records with a government payment of \$100,000 and over will be audited. The payment samples will be stratified at multiple levels within the \$100 to \$100,000 range. Samples will be drawn from those underwritten TED records which are fully or provisionally accepted, with end dates of service in the option period, through the ninth month after the end of option period one. The Government reserves its rights to perform specific and/or more frequent audits than annual. Records to be sampled will be "net" records (i.e. the sum of transaction records available through the ninth month after the end of the option period). TEDs in batch/vouchers, that fail TRICARE validity edits or which are otherwise unprocessable as submitted by the contractor will be excluded from the sampling frame.

(b) Sampling Methodology and Application of Results for Option Periods 2 through 8

For Option Periods 2 through 8, the same sampling methodology used will be as described in Section H.11.b.(1) (a) above for Option Period 1. For Option Period 2, samples will be drawn from those underwritten TED records which are fully or provisionally accepted, with end dates of service in the option period through the ninth month. For Option Periods 3 through 6, samples will be drawn from those underwritten TED records which are fully or provisionally accepted, with end dates of service in the respective option period, through the sixth month after the end of the option period.

For Option Periods 7 and 8, a single audit will be performed. If only Option Period 7 is exercised, and audit sample will be drawn from the underwritten TED records with end dates of service in Option Period 7. Should the Government exercise Option Period 8, an audit sample will be drawn from underwritten TED records with end dates of service for both Option Periods 7 and 8. Samples for Option Periods 7 and 8 will be drawn from underwritten TED records which are fully or provisionally accepted, with end dates of service in the respective Option Period, through the sixth month after the end of the last exercised Option Period.

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For the last Option Period exercised by the Government, samples will be drawn from underwritten TED records which are fully or provisionally accepted, with end dates of service in the respective Option Period, through 120 days after the end of the last exercised Option Period. This matches the outgoing contractor's claims processing responsibilities. If the contractor is not awarded the successor contract for the West Region, the Government and the Contractor may negotiate a health care audit settlement for the last period exercised based on prior audit results.

For Option Periods 3 through 8, the Government will draw the sample no later than seven (7) months after the end of the applicable/respective option period. For the last Option Period exercised, the sample draw date will be no later than five (5) months from the end of the Option Period. The Government reserves its rights to perform specific and/or more frequent audits than annual. Records to be sampled will be "net" records (i.e. the sum of the option period transaction records available through the sixth month after the end of the option period). The total overpayment recovery amount for each option period will be determined based on the lower bound of a one-sided ninety-percent (90%) confidence interval. The Government shall provide, at the same time the sample is requested, a complete listing of all TED records that encompass the audit universe for each respective Option Period. The contractor must identify all TED records that it believes should be excluded from the audit universe which includes non-underwritten claims and claims that were not within the dates of service range for the respective Option Period and provide documentation justifying their exclusion not later than thirty (30) days after receipt of the listing.

(c) Required Contractor Documentation

[1] Upon receipt of the TEDs Internal Control Number (ICN) listing from TMA or designated audit contractor, the Contractor shall retrieve and compile processing documentation for each selected claim. All documentation must be received at TMA or designated audit contractors within thirty (30) calendar days from the date of the TMA or designated audit contractors letter transmitting the ICN listing. The Contractor shall submit one legible copy of each claim and the following required documents via registered mail, certified mail or similarly guaranteed delivery service:

(i) Claim-related correspondence when attached to claim or related to the adjudication action, such as status inquiries, written and/or telephone, development records, other telephone conversation records.

(ii) Other claim-related documentation, such as medical reports and medical review records, coding sheets, all authorization and referral forms and their supporting documentation, referrals for civilian medical care (SF Forms 513 or 2161), other health insurance and third party liability documents, discounted rate agreements to include the following information: 1) provider name, 2) provider identification number, 3) effective and termination dates of agreements; and 4) negotiated rate or fee schedule and such other documents as are required to support the action taken on the claim

(iii) A copy of the EOB (or EOB facsimile) for each claim selected.

(iv) The current family history (15 to 27 months) for each selected claim. The Contractor shall send this via electronic data input on a 3480 cartridge.

[2] If a claim is selected for audit and the Contractor cannot produce the claim or the claim provided is not auditable, a 100 percent payment error based upon the total Government Pay Amount will be assessed. For TEDs which do not represent a legitimate condition requiring submission of a record as defined in the TRICARE Systems Manual, a 100 percent error will be assessed. The payment error amount will be based upon the total Government Pay Amount. This condition is considered to be an unsupported TED. The contractor has the option of submitting the original document in those cases where the copy is not legible. TMA or designated audit contractors will return original documents upon completion of the audit process.

(d) Additional Data to be Furnished by the Contractor

[1] Description of data elements by field position in family history file printout. Initial submission to TMA is due by the commencement of claims processing and revisions as they occur.

[2] Claim adjudication guidelines used by processors; automated prepayment utilization review screens; automated duplicate screening criteria and manual resolution instructions shall be submitted to TMA by the commencement of claims processing.

[3] Unique internal procedure codes with narrative and cross-reference to approved TRICARE codes and pricing manuals used in claims processing. Initial submission to TRICARE is due by the commencement of claims processing and revisions as they occur, but not later than the fifth (5th) work day of the month following the change.

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[4] Specifications for submission of the provider and pricing files are described in the TEDs System Manual. Initial submission to TMA is due by the commencement of claims processing and updates to the files are to be submitted as specified in the TEDs System Manual.

(e) Payment Error Determination for Allowable Cost Audit

[1] The audit error codes (K codes) indicated in above will apply to the cost audit. Payment errors are based on the claim information available and those processing actions which occur prior to the date the audit sample is pulled. Consideration will be given to subsequent processing actions that occur prior to the date the audit sample is pulled, including actions that have not passed the TMA TED edits, only if supporting documentation to indicate the action taken and the date the action was completed is submitted. Actions and determinations occurring after the date the audit sample is pulled will not be considered in the audit regardless of whether resolution of payment error exists.

[2] Payment errors are the amount of over payments on a claim, including but not limited to misapplication of the deductible, payment of non-covered service/supplies, or payment of services/supplies for which a benefit cannot be determined based on the information available at the time of processing or a payment in the correct amount but sent to the wrong payee.

[3] The measure of the payment error is the TRICARE Encounter Data record. The audit process (for the payment samples) projects universe value based on the audit results.

(2) Cost Audit Rebuttals

(a) Contractor rebuttals of audit error findings must be submitted to TMA or the designated quality auditor within forty five (45) calendar days of the date of the audit transmittal letters. Rebuttals not postmarked within forty five (45) calendar days of the audit letter will be excluded from further consideration. Rebuttal responses are final and will not receive further consideration except when, during the audit rebuttal process, the contractor submits a claim not previously submitted with the audit and an error is assessed, or when the contractor's explanation of the basis on which a claim was processed results in the assessment of a new error not previously reviewed by the contractor. Contractor rebuttals to new errors assessed by TMA or the designated audit contractor during the initial rebuttal process must be postmarked within 30 calendar days of the TRICARE or designated quality review contractor rebuttal response letter. Rebuttals to new errors not postmarked within 30 calendar days from the date of the rebuttal letter will be excluded from further consideration. The due dates of rebuttals will be calculated by adding 45 to the Julian calendar date of the TMA or designated audit contractor audit letter or by adding 30 to the Julian calendar date of the TMA or designated audit contractor rebuttal response letter.

(b) The rebuttal for the healthcare cost audit shall be certified by a responsible official of the contractor as to accuracy and completeness. The rebuttal submission and the rebuttal process used by the contractor shall be subject to review by the Government. The corporation and/or certifying individual may be subject to criminal prosecution for any false certifications made.

(3) Post Audit Recoupment.

(a) When the contractor submits a TED record cancel or adjustment due to a recoupment action, the TED system will automatically withhold the identified overpayment. As it is not possible to prevent these double recoupments from occurring in the existing TEDs processing environment, it will be necessary to utilize an off line automated process designed by the Government for providing reimbursement to the contractor for these recoupments.

(b) In order to evaluate these recoupments the Government will require quarterly reports for all overpayments recouped from records that were included in the audit universe. This report will be due to the Contracting Officer no later than the end of the month following the end of each contract quarter (June 30, September 30, Dec 31, and Mar 31). The report will identify records included in the audit universe by TED Record Indicator (TRI), date of recoupment action, cycle in which the recoupment/ adjusted TED record was accepted into the TEDs database, and the amount of the recoupment/ adjustment. Within 60-days of receipt of the report, the Government will validate that the identified records were included in the audit universe, the recoupment amount, and the acceptance of the TED record (passes all validity edits). The information will be validated against the TRICARE transactions file. Any TED record that does not meet the reporting criteria and is unable to be validated will be included in a report requesting additional information to justify reimbursement.

SECTION H
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(c) The initial quarter review will be based on transactions that have processed and passed all validity edits from the month following the audit extract date up to and through the report receipt date. Upon completion of the TMA review the contractor will be instructed to invoice the government for all verified claims amounts.

(d) In order to provide the contractor with a reasonable time to accomplish recoupments after the AHCC audit, submit adjusted TED records and receive payment for those recoupments, and also to provide the government the opportunity to close out the process provided for in this letter for each option period, the contractor will only be able to use this process for four full calendar quarters following the sample claim pull. After that date the contractor will be required to submit a formal Request for Equitable Adjustment for recoupments which may be eligible for reimbursement. For example: If the audit sample is drawn on October 31st then this procedure outlined in this letter can be used by the contractor through December 31st of the following year with the final list of recoupments provided to the Government no later than the last day of the following month.

H.12. Assumption of Performance in a Second TRICARE Contract Area

TRICARE is a statutory entitlement program under which there can be no lapse in program execution or interruption of services. It is the Government's duty to take all reasonable steps to ensure the ready availability of alternative contract sources to facilitate stability in administration of the statutory entitlement program, help avoid unnecessary disruption in healthcare provider and patient relationships, and insure continuation of critical health services. Recognizing the potential that circumstances may arise under which the Government may require an alternative contractor to assume, on an interim basis, contract performance in one of the three TRICARE contract areas, the Government will consider other options, including substituting contract performance by one or both of the other contractors pending competitive acquisition of a successor. The Government agrees to negotiate in good faith fair and reasonable compensation for the additional work to be performed. The contractor retains all rights to equitable adjustments under the Changes clause in this matter.

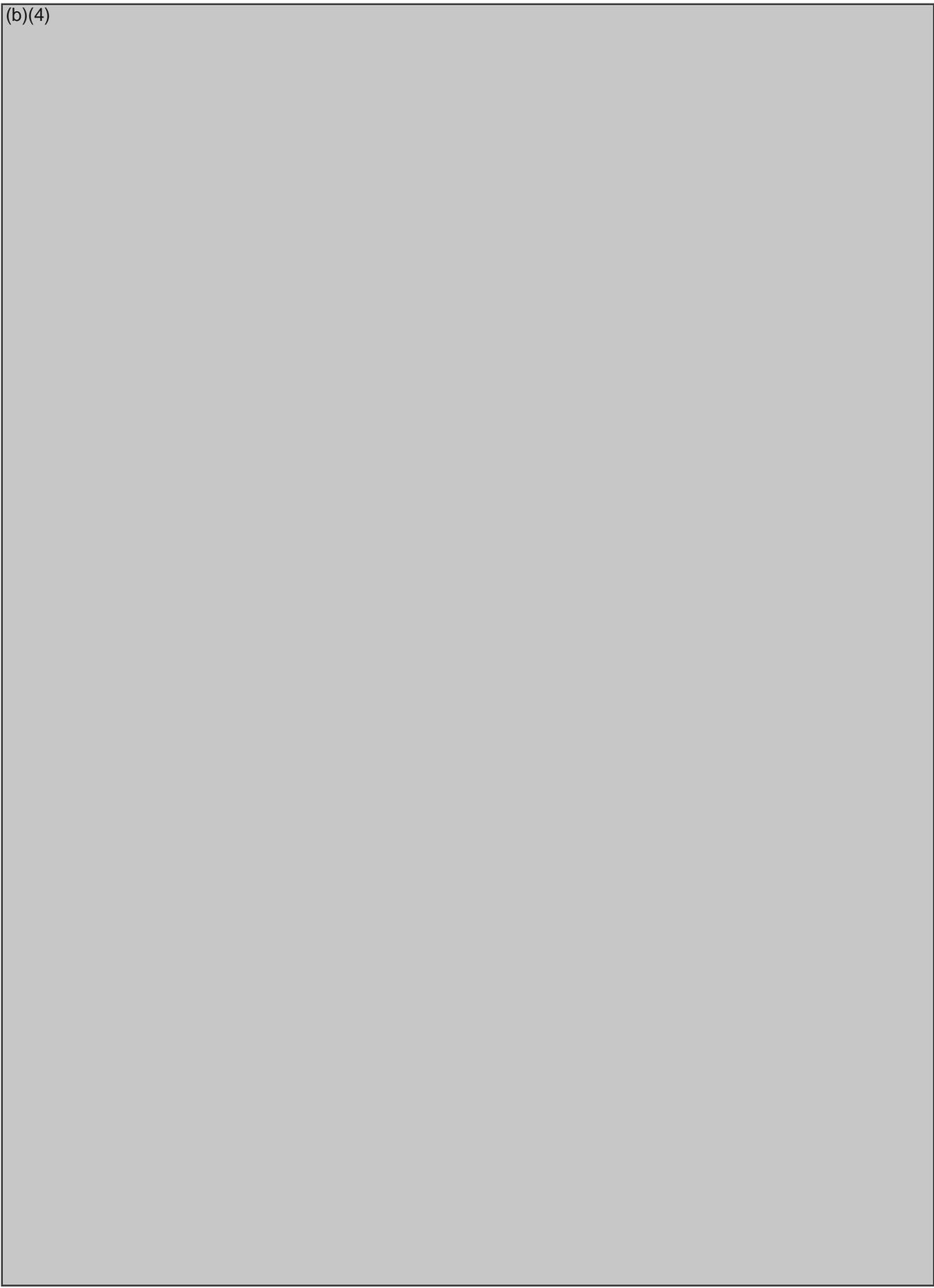
H.13. Additional Performance Standards

(b)(4)



SECTION H
SPECIAL CONTRACT REQUIREMENTS

(b)(4)



**SECTION H
SPECIAL CONTRACT REQUIREMENTS**

(b)(4)

H.14. Indemnification and Medical Liability Insurance

The contractor is responsible for determining the medical malpractice coverage required in the state (including state risk pools if applicable) for each network provider (both professional and institutional), and ensuring that each network provider is in compliance with this standard. In the absence of state law requirement for medical malpractice insurance coverage, the contractor is responsible for determining the local community standard for medical malpractice coverage, and the contractor must maintain the documentation evidencing both the standard and compliance by network providers. In no case shall a network provider not have medical malpractice coverage.

The contractor agrees to be solely liable for and expressly agrees to indemnify the government for the costs of defense and any liability resulting from services provided to MHS eligible beneficiaries by a network provider or, in the alternative, the contractor agrees that all network provider agreements used by the contractor shall contain a requirement, directly or indirectly by reference to applicable regulations or TMA policies, that the provider agrees to indemnify, defend and hold harmless TMA and the Government from any and all claims, judgments, costs, liabilities, damages and expenses, including attorney's fees, whatsoever, arising from any acts or omissions in the provision of medical services by the provider to MHS eligible beneficiaries.

Each network provider agreement must indicate the required malpractice coverage. Evidence documenting the required coverage of each network provider under the contract shall be provided to the Contracting Officer upon request. The Contracting Officer, after consulting with the contractor, retains the authority to determine whether state and/or local requirements for medical malpractice coverage have been met by a network provider and whether the contractor has documented the required coverage.

**SECTION I
CONTRACT CLAUSES**

I.1

I.1. 52.252-2 CLAUSES INCORPORATED BY REFERENCE (FEB 1998)

This contract incorporates one or more clauses by reference, with the same force and effect as if they were given in full text. Upon request, the Contracting Officer will make their full text available. Also, the full text of a clause may be accessed electronically at this/these address(es): <http://www.arnet.gov/far/loadmainre.html>

(End of clause)

I.2. 52.202-1 DEFINITIONS (DEC 2001)

(Reference 2.201)

I.3. 52.203-3 GRATUITIES (APR 1984)

(Reference 3.202)

I.4. 52.203-5 COVENANT AGAINST CONTINGENT FEES (APR 1984)

(Reference 3.404)

I.5. 52.203-6 RESTRICTIONS ON SUBCONTRACTOR SALES TO THE GOVERNMENT (JUL 1995)

(Reference 3.503-2)

I.6. 52.203-7 ANTI-KICKBACK PROCEDURES (JUL 1995)

(Reference 3.502-3)

I.7. 52.203-8 CANCELLATION, RESCISSION, AND RECOVERY OF FUNDS FOR ILLEGAL OR IMPROPER ACTIVITY (JAN 1997)

(Reference 3.104-9(a))

I.8. 52.203-10 PRICE OR FEE ADJUSTMENT FOR ILLEGAL OR IMPROPER ACTIVITY (JAN 1997)

(Reference 3.104-9)

I.9. 52.203-12 LIMITATION ON PAYMENTS TO INFLUENCE CERTAIN FEDERAL TRANSACTIONS (JUN 2003)

(Reference 3.808)

I.10. 52.203-13 CONTRACTOR CODE OF BUSINESS ETHICS AND CONDUCT (DEC 2008)

(Reference 3.1004)

I.11. 252.203-7001 PROHIBITION ON PERSONS CONVICTED OF FRAUD OR OTHER DEFENSE-CONTRACT-RELATED FELONIES (MARCH 1999)

(Reference 203.570-5)

I.12. 252.203-7002 DISPLAY OF DOD HOTLINE POSTER (DEC 1991)

(Reference 203.7002)

I.13. 52.204-4 PRINTED OR COPIED DOUBLE-SIDED ON RECYCLED PAPER (AUG 2000)

(Reference 4.303)

I.14. 52.204-9 PERSONAL IDENTITY VERIFICATION OF CONTRACTOR PERSONNEL (SEPT 2007)

(Reference 4.1303)

I.15. 252.204-7000 DISCLOSURE OF INFORMATION (DEC 1991)

(Reference 204.404-70)

I.16. 252.204-7003 CONTROL OF GOVERNMENT PERSONNEL WORK PRODUCT (APR 1992)

(Reference 204.404-70)

I.17. 252.204-7004 REQUIRED CENTRAL CONTRACTOR REGISTRATION (NOV 2001)

(Reference 204.7304)

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I.18. 252.205-7000 PROVISION OF INFORMATION TO COOPERATIVE AGREEMENT HOLDERS (DEC 1991)
(Reference 205.470-2)

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I.19. 52.209-6 PROTECTING THE GOVERNMENT'S INTEREST WHEN SUBCONTRACTING WITH CONTRACTORS DEBARRED, SUSPENDED, OR PROPOSED FOR DEBARMENT (JUL 1995)
(Reference 9.409)

I.20. 252.209-7000 ACQUISITION FROM SUBCONTRACTORS SUBJECT TO ON-SITE INSPECTION UNDER THE INTERMEDIATE-RANGE NUCLEAR FORCES (INF) TREATY (NOV 1995)
(Reference 209.103-70)

I.21. 252.209-7004 SUBCONTRACTING WITH FIRMS THAT ARE OWNED OR CONTROLLED BY THE GOVERNMENT (MAR 1998)
(Reference 209.409)

I.22. 52.211-15 DEFENSE PRIORITY AND ALLOCATION REQUIREMENTS (SEP 1990)
(Reference 11.604)

I.23. 52.215-2 AUDIT AND RECORDS--NEGOTIATION (JUNE 1999)
(Reference 15.209)

I.24. 52.215-8 ORDER OF PRECEDENCE--UNIFORM CONTRACT FORMAT (OCT 1997)
(Reference 15.209)

I.25 52.215-11 PRICE REDUCTION FOR DEFECTIVE COST OR PRICING DATA--MODIFICATIONS (OCT 1997)
(Reference 15.408)

I.26. 52.215-13 SUBCONTRACTOR COST OR PRICING DATA – MODIFICATIONS (OCT 1997)
(Reference 15.408)

I.27. 52.215-15 PENSION ADJUSTMENTS AND ASSET REVERSIONS (DEC 1998)
(Reference 15.408)

I.28. 52.215-18 REVERSION OR ADJUSTMENT OF PLANS FOR POSTRETIREMENT BENEFITS (PRB) OTHER THAN PENSIONS (OCT 1997)
(Reference 15.208(j))

I.29. 52.215-21 REQUIREMENTS FOR COST OR PRICING DATA OR INFORMATION OTHER THAN COST OR PRICING DATA--MODIFICATIONS (OCT 1997)
(Reference 15.408)

I.30. 252.215-7000 PRICING ADJUSTMENTS (DEC 1991)
(Reference 215.408)

I.31. 252.215-7002 COST ESTIMATING SYSTEM REQUIREMENTS (OCT 1998)
(Reference 215.408(2))

I.32. 52.216-7, Allowable Cost and Payment (DEC 2002) is hereby incorporated by reference. This clause applies to Disease Management CLINS only. (CLINs 0106, 0203, 0303, 0403, 0503)

I.33. 52.216-8 FIXED FEE (Mar 1997)
(Reference 16.307(b))

I.34. 252.217-7027 CONTRACT DEFINITIZATION (OCT 1998)
(Reference 217.7405)

I.35. 52.219-8 UTILIZATION OF SMALL BUSINESS CONCERNS (MAY 2004)
(Reference 19.708)

I.36. 52.219-9 SMALL BUSINESS SUBCONTRACTING PLAN (APR 2008)--ALTERNATE II (OCT 2001)
(Reference 19.708(b))

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I.37. 252.219-7003 SMALL SMALL DISADVANTAGED AND WOMEN-OWNED SMALL BUSINESS SUBCONTRACTING PLAN (DoD CONTRACTS) (APR 1996)

(Reference 219.708(b)(1)(A))

I.38. 52.219-16 LIQUIDATED DAMAGES--SUBCONTRACTING PLAN (JAN 1999)

(Reference 19.708)

I.39. 52.222-1 NOTICE TO THE GOVERNMENT OF LABOR DISPUTES (FEB 1997)

(Reference 22.103-5)

I.40. 52.222-3 CONVICT LABOR (JUNE 2003)

(Reference 22.202)

I.41. 52.222-21 PROHIBITION OF SEGREGATED FACILITIES (FEB 1999)

(Reference 22.810)

I.42. 52.222-26 EQUAL OPPORTUNITY (APR 2002)

(Reference 22.810(e))

I.43. 52.222-35 EQUAL OPPORTUNITY FOR SPECIAL DISABLED VETERANS, VETERANS OF THE VIETNAM ERA, AND OTHER ELIGIBLE VETERANS (DEC 2001)

(Reference 22.1310(a)(1))

I.44. 52.222-36 AFFIRMATIVE ACTION FOR WORKERS WITH DISABILITIES (JUN 1998)

(Reference 22.1408)

I.45. 52.222-37 EMPLOYMENT REPORTS ON SPECIAL DISABLED VETERANS, VETERANS OF THE VIETNAM ERA, AND OTHER ELIGIBLE VETERANS (DEC 2001)

(Reference 22.1310(b))

I.46. 52.222-39 NOTIFICATION OF EMPLOYEE RIGHTS CONCERNING PAYMENT OF UNION DUES OR FEES (DEC2004)

(Reference 22.1605)

I.47. 52.223-6 DRUG-FREE WORKPLACE (MAY 2001)

(Reference 23.505)

I.48. 52.223-14 TOXIC CHEMICAL RELEASE REPORTING (JUNE 2003)

(Reference 23.907)

I.49. 252.223-7004 DRUG-FREE WORK FORCE (SEP 1988)

(Reference 223.570-4)

I.50. 52.224-1 PRIVACY ACT NOTIFICATION (APR 1984)

(Reference 24.104)

I.51. 52.224-2 PRIVACY ACT (APR 1984)

(Reference 24.104)

I.52. 52.225-13 RESTRICTIONS ON CERTAIN FOREIGN PURCHASES (JUNE 2003)

(Reference 25.1103)

I.53. 252.226-7001 UTILIZATION OF INDIAN ORGANIZATIONS AND INDIAN-OWNED ECONOMIC ENTERPRISES-DoD CONTRACTS (SEP 2001)

(Reference 226.104)

I.54. 52.227-1 AUTHORIZATION AND CONSENT (JUL 1995)

(Reference 27.201-2)

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- I.55. 52.227-2 NOTICE AND ASSISTANCE REGARDING PATENT AND COPYRIGHT INFRINGEMENT (AUG 1996)**
(Reference 27.202-2)
- I.56. 52.227-3 PATENT INDEMNITY (APR 1984)**
(Reference 27.203-1)
- I.57. 52.227-14 RIGHTS IN DATA--GENERAL (JUN 1987)**
(Reference 27.409)
- I.58. 52.228-7 INSURANCE--LIABILITY TO THIRD PERSONS (MAR 1996)**
(Reference 28.311-2)
- I.59. 52.229-3 FEDERAL, STATE, AND LOCAL TAXES (APR 2003)**
(Reference 29.401-3)
- I.60. 52.230-2 COST ACCOUNTING STANDARDS (APR 1998)**
(Reference 30.201-4)
- I.61. 52.230-6 ADMINISTRATION OF COST ACCOUNTING STANDARDS (NOV 1999)**
(Reference 30.201-4)
- I.62. 252.231-7000 SUPPLEMENTAL COST PRINCIPLES (DEC 1991)**
(Reference 231.100-70)
- I.63. 52.232-1 PAYMENTS (APR 1984)**
(Reference 32.111)
- I.64. FAR 52.232-3 PAYMENTS UNDER PERSONAL SERVICES CONTRACTS (APR 1984).**
- I.65. 52.232-8 DISCOUNTS FOR PROMPT PAYMENT (FEB 2002)**
(Reference 31.111(c)(1))
- I.66. 52.232-9 LIMITATION ON WITHHOLDING OF PAYMENTS (APR 1984)**
(Reference 32.111)
- I.67. 52.232-11 EXTRAS (APR 1984)**
(Reference 32.111)
- I.68. 52.232-17 INTEREST (JUNE 1996)**
(Reference 32.617)
- I.69. 52.232-18 AVAILABILITY OF FUNDS (APR 1984)**
(Reference 32.705-1(a))
- I.70. 52.232-20 LIMITATION OF COST (APR 1984)**
(Reference 32.705-2)
- I.71. 52.232-22 LIMITATION OF FUNDS (APR 1984)**
(Reference 32.705-2)
- I.72. 52.232-23 ASSIGNMENT OF CLAIMS (JAN 1986)**
(Reference 32.806)
- I.73. 52.232-25 PROMPT PAYMENT (FEB 2002)**
(Reference 32.908(c))
- I.74. 52.232-25 I PROMPT PAYMENT (FEB 2002)--ALTERNATE I (FEB 2002)**
(Reference 32.908(c)(3))

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I.75. 52.232-33 PAYMENT BY ELECTRONIC FUNDS TRANSFER--CENTRAL CONTRACTOR REGISTRATION (MAY 1999)

(Reference 32.1110)

I.76. 52.232-37 MULTIPLE PAYMENT ARRANGEMENTS (MAY 1999)

(Reference 32.1110)

I.77. 252.232-7009 MANDATORY PAYMENT BY GOVERNMENTWIDE COMMERCIAL PURCHASE CARD (JUL 2000)

(Reference 232.1110)

I.78. 252.232-7010 LEVIES ON CONTRACT PAYMENTS (DEC 2006)

(Reference 232.1110)

I.79. 52.233-1 I DISPUTES (JUL 2002)--ALTERNATE I (DEC 1991)

(Reference 32.215)

I.80.. 52.233-3 PROTEST AFTER AWARD (AUG 1996)

(Reference 33.106)

I.81. 52.233-3 I PROTEST AFTER AWARD (AUG 1996)--ALTERNATE I (JUN 1985)

(Reference 33.106)

I.82. 52.237-2 PROTECTION OF GOVERNMENT BUILDINGS, EQUIPMENT, AND VEGETATION (APR 1984)

(Reference 37.110)

I.83. 52.237-3 CONTINUITY OF SERVICES (JAN 1991)

(Reference 37.110)

I.84. 52.239-1 PRIVACY OR SECURITY SAFEGUARDS (AUG 1996)

(Reference 39.107)

I.85. 52.242-1 NOTICE OF INTENT TO DISALLOW COSTS (APR 1984)

(Reference 42.802)

I.86. 52.242-3 PENALTIES FOR UNALLOWABLE COSTS (MAR 2001)

(Reference 42.709-6)

I.87. 52.242-13 BANKRUPTCY (JUL 1995)

(Reference 42.903)

I.88. 252.242-7000 POSTAWARD CONFERENCE (DEC 1991)

(Reference 242.570)

I.89. 52.243-1 CHANGES--FIXED-PRICE (AUG 1987)--ALTERNATE I (APR 1984)

(Reference 43.205)

I.90. 52.243-2 CHANGES--COST-REIMBURSEMENT (AUG 1987)--ALTERNATE I (APR 1984)

(Reference 43.205)

I.91. 52.243-6 CHANGE ORDER ACCOUNTING (APR 1984)

(Reference 42.205)

I.92. 52.243-7, Notification of Changes (APR 1984 is hereby incorporated by reference. Enter "30 days" in the fill in blanks in paragraph (b) and (d).

I.93. 252.243-7001 PRICING OF CONTRACT MODIFICATIONS (DEC 1991)

(Reference 243.205-70)

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I.94. 252.243-7002 REQUESTS FOR EQUITABLE ADJUSTMENT (MAR 1998)
(Reference 243.205-71)

I.95. 52.244-2 SUBCONTRACTS (AUG 1998)--ALTERNATE I (AUG 1998)
(Reference 44.204)

I.96. 52.244-5 COMPETITION IN SUBCONTRACTING (DEC 1996)
(Reference 44.204)

I.97. 52.245-1, Property Records, (APR 1984) is hereby incorporated by reference.

I.98. 52.245-2 GOVERNMENT PROPERTY (FIXED-PRICE CONTRACTS) (JUNE 2003)--ALTERNATE I (APR 1984)
(Reference 45.106(b)(2))

I.99. 52.246-25 LIMITATION OF LIABILITY--SERVICES (FEB 1997)
(Reference 46.805)

I.100. 52.248-1 VALUE ENGINEERING (FEB 2000)
(Reference 48.201)

I.101. 52.249-2 TERMINATION FOR CONVENIENCE OF THE GOVERNMENT (FIXED-PRICE) (SEP 1996)
(Reference 49.502)

I.102. 52.249-6 TERMINATION (COST-REIMBURSEMENT) (SEP 1996)
(Reference 49.503)

I.103. 52.249-8 DEFAULT (FIXED-PRICE SUPPLY AND SERVICE) (APR 1984)
(Reference 49.504)

I.104. FAR 52.249-12 TERMINATION (PERSONAL SERVICES) (APR 1984)

I.105. 52.249-14 EXCUSABLE DELAYS (APR 1984)
(Reference 49.505)

I.106. 52.253-1 COMPUTER GENERATED FORMS (JAN 1991)
(Reference 53-111)

I.107. 252.201-7000 CONTRACTING OFFICER'S REPRESENTATIVE (DEC 1991)

(a) Definition. "Contracting officer's representative" means an individual designated in accordance with subsection 201.602-2 of the Defense Federal Acquisition Regulation Supplement and authorized in writing by the contracting officer to perform specific technical or administrative functions.

(b) If the Contracting Officer designates a contracting officer's representative (COR), the Contractor will receive a copy of the written designation. It will specify the extent of the COR's authority to act on behalf of the contracting officer. The COR is not authorized to make any commitments or changes that will affect price, quality, quantity, delivery, or any other term or condition of the contract.

(End of clause)

I.108. 52.215-19 NOTIFICATION OF OWNERSHIP CHANGES (OCT 1997)

(a) The Contractor shall make the following notifications in writing:

(1) When the Contractor becomes aware that a change in its ownership has occurred, or is certain to occur, that could result in changes in the valuation of its capitalized assets in the accounting records, the Contractor shall notify the Administrative Contracting Officer (ACO) within 30 days.

(2) The Contractor shall also notify the ACO within 30 days whenever changes to asset valuations or any other cost changes have occurred or are certain to occur as a result of a change in ownership.

(b) The Contractor shall--

(1) Maintain current, accurate, and complete inventory records of assets and their costs;

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- (2) Provide the ACO or designated representative ready access to the records upon request;
 - (3) Ensure that all individual and grouped assets, their capitalized values, accumulated depreciation or amortization, and remaining useful lives are identified accurately before and after each of the Contractor's ownership changes; and
 - (4) Retain and continue to maintain depreciation and amortization schedules based on the asset records maintained before each Contractor ownership change.
- (c) The Contractor shall include the substance of this clause in all subcontracts under this contract that meet the applicability requirement of FAR 15.408(k).

(End of clause)

I.109. 52.216-7 ALLOWABLE HEALTH CARE COST AND PAYMENT (FEB 2002) (DEVIATION)

(a) "Invoicing." (1) The Government will make payments to the Contractor when requested as frequently as every Government business day, in amounts determined to be allowable in accordance with the terms of this contract. The submission of health care costs that pass the TED edits will be considered an invoice for reimbursement of health care costs. A contractor invoice for approved resource sharing expenditures will also be reimbursed as an allowable cost.

(2) Contract financing payments are not subject to the interest penalty provisions of the Prompt Payment Act. Interim payments made prior to the final payment under the contract are contract financing payments, except interim payments if this contract contains Alternate I to the clause at 52.232-25.

In the event that the Government requires an audit or other review of a specific payment request to ensure compliance with the terms and conditions of the contract, the designated payment office is not compelled to make payment by the specified due date.

(b) Reimbursing costs. For the purpose of reimbursing allowable costs, the term "costs" includes only those --

- (1) submitted on vouchers either for direct health care costs that, at the time the request for reimbursement has passed the TED edits, fully or provisionally, or for Government-approved resource sharing expenditures; and,
- (2) that the Contractor has actually paid the costs or made the expenditures by issuing a check, electronic fund transfer, or other form of actual payment for health care under this contract.

The costs eligible for reimbursement are the health care costs that pass TED edits involving health care furnished to an eligible beneficiary, health care authorized under TRICARE, health care furnished by an authorized TRICARE provider, and health care costs consistent with authorized TRICARE reimbursement methodologies, as well as Government-approved resource sharing expenditures. Costs reimbursed based on vouchers passing initial TED edits and vouchers for resource sharing costs are subject to further audit and payment adjustment by the Government if determined not to qualify as an allowable cost. The Government's right to audit and recover costs determined not to be allowable health care costs is in addition to all rights under the Inspection of Services clause (FAR 52.246-5).

(d) Audit. At any time or times before final payment, the Contracting Officer may have the Contractor's invoices or vouchers and statements of cost audited. "Audits" as used in this clause, includes audits on statistically valid samples. The audit results will be extrapolated across all the TRICARE medical claims for the region submitted for TED edits during the audited period to determine the total overpayment or underpayment of the TRICARE medical claims population sampled for the region. The results of the audits will be used to adjust for overpayments and underpayments of health care costs. These adjustments are in addition to the Government's rights under the Inspection of Services Clause (FAR 52.246-5). Any payment may be--

- (1) Reduced by amounts found by the Contracting Officer not to constitute allowable costs; or
- (2) Adjusted for prior overpayments or underpayments.

(e) Final Payment. (1) Upon approval of a completion voucher submitted by the Contractor, and upon the Contractor's compliance with all terms of this contract, the Government shall promptly pay any balance of allowable costs and that part of the fee (if any) not previously paid.

(2) The Contractor shall pay to the Government any refunds, rebates, credits, or other amounts (including interest, if any) accruing to or received by the contractor or any assignee under this contract, to the extent that those amounts are properly allocable to costs for which the Contractor has been reimbursed by the Government. Before final

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payment under this contract, the Contractor and each assignee whose assignment is in effect at the time of final payment shall execute and deliver--

(i) An assignment to the Government, in form and substance satisfactory to the Contracting Officer, of refunds, rebates, credits, or other amounts (including interest, if any) properly allocable to costs for which the Contractor has been reimbursed by the Government under this contract; and

(ii) A release discharging the Government, its officers, agents, and employees from all liabilities, obligations, and claims arising out of or under this contract, except—

(A) Specified claims stated in exact amounts, or in estimated amounts when the exact amounts are not known;

(B) Claims (including reasonable incidental expenses) based upon liabilities of the Contractor to third parties arising out of the performance of this contract; provided, that the claims are not known to the contractor on the date of the execution of the release, and that the Contractor gives notice of the claims in writing to the Contracting Officer within 6 years following the release date or notice of final payment date, whichever is earlier.
(End of clause)

I.110. 52.216-10 INCENTIVE FEE (MAR 1997)(DEVIATION)

(a) General. The Government shall pay the Contractor for performing this contract a fee determined as provided in this contract.

(b) Target cost and target fee. The target cost and target fee specified in the Schedule are subject to adjustment if the contract is modified in accordance with paragraph (d) of this clause.

(1) "Target cost," as used in this contract, means the estimated health care cost of this contract as initially or subsequently negotiated, or as otherwise determinable by applying a formula contained in the basic contract, adjusted in accordance with paragraph (d) below.

(2) "Target fee," as used in this contract, means the fee initially negotiated on the assumption that this contract would be performed for a cost equal to the estimated cost initially negotiated, adjusted in accordance with paragraph (d) of this clause.

(c) Withholding of payment. Normally, the Government shall pay the fee to the Contractor as specified in the Schedule. However, when the Contracting Officer considers that performance or cost indicates that the Contractor will not achieve target, the Government shall pay on the basis of an appropriate lesser fee. When the Contractor demonstrates that performance or cost clearly indicates that the Contractor will earn a fee significantly above the target fee, the Government may, at the sole discretion of the Contracting Officer, pay on the basis of an appropriate higher fee. After payment of 85 percent of the applicable fee, the Contracting Officer may withhold further payment of fee until a reserve is set aside in an amount that the Contracting Officer considers necessary to protect the Government's interest. This reserve shall not exceed 15 percent of the applicable fee or \$100,000, whichever is less. The Contracting Officer shall release 75 percent of all fee withholds under this contract after receipt of the certified final indirect cost rate proposal covering the year of physical completion of this contract, provided the Contractor has satisfied all other contract terms and conditions, including the submission of the final patent and royalty reports, and is not delinquent in submitting final vouchers on prior years' settlements. The Contracting Officer may release up to 90 percent of the fee withholds under this contract based on the Contractor's past performance related to the submission and settlement of final indirect cost rate proposals.

(d) Equitable adjustments. When the work under this contract is increased or decreased by a modification to this contract or when any equitable adjustment in the target cost is authorized under any other clause, equitable adjustments in the target cost, target fee, minimum fee, and maximum fee, as appropriate, shall be stated in a supplemental agreement to this contract.

(e) Fee payable. (1) The fee payable under this contract shall be the target fee increased by 20 cents for every dollar that the total allowable cost is less than the target cost or decreased by 20 cents for every dollar that the total allowable cost exceeds the target cost. In no event shall the fee be greater than 10 percent or less than minus 4 percent of the target cost.

(2) The fee shall be subject to adjustment, to the extent provided in paragraph (d) of this clause, and within the minimum and maximum fee limitations in paragraph (e)(1) of this clause, when the total allowable cost is increased or decreased as a consequence of (i) payments made under assignments or (ii) claims excepted from the release as required by paragraph (h)(2) of the Allowable Cost and Payment clause.

(3) If this contract is terminated in its entirety, the portion of the target fee payable shall not be subject to an increase or decrease as provided in this paragraph. The termination shall be accomplished in accordance with other applicable clauses of this contract.

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- (4) For the purpose of fee adjustment, "total allowable cost" shall not include allowable costs arising out of--
- (i) Any of the causes covered by the Excusable Delays clause to the extent that they are beyond the control and without the fault or negligence of the Contractor or any subcontractor;
 - (ii) The taking effect, after negotiating the target cost, of a statute, court decision, written ruling, or regulation that results in the Contractor's being required to pay or bear the burden of any tax or duty or rate increase in a tax or duty;
 - (iii) Any direct cost attributed to the Contractor's involvement in litigation as required by the Contracting Officer pursuant to a clause of this contract, including furnishing evidence and information requested pursuant to the Notice and Assistance Regarding Patent and Copyright Infringement clause;
 - (iv) The purchase and maintenance of additional insurance not in the target cost and required by the Contracting Officer, or claims for reimbursement for liabilities to third persons pursuant to the Insurance Liability to Third Persons clause;
 - (v) Any claim, loss, or damage resulting from a risk for which the Contractor has been relieved of liability by the Government Property clause; or
 - (vi) Any claim, loss, or damage resulting from a risk defined in the contract as unusually hazardous or as a nuclear risk and against which the Government has expressly agreed to indemnify the Contractor.
- (5) All other allowable costs are included in "total allowable cost" for fee adjustment in accordance with this paragraph (e), unless otherwise specifically provided in this contract.
- (f) Contract modification. The total allowable cost and the adjusted fee determined as provided in this clause shall be evidenced by a modification to this contract signed by the Contractor and Contracting Officer.
 - (g) Inconsistencies. In the event of any language inconsistencies between this clause and provisioning documents or Government options under this contract, compensation for spare parts or other supplies and services ordered under such documents shall be determined in accordance with this clause.
- (End of clause)

I.111. 52.216-18 ORDERING (OCT 1995)

- (a) Any supplies and services to be furnished under this contract shall be ordered by issuance of delivery orders or task orders by the individuals or activities designated in the Schedule. Such orders may be issued from 1 April 2004 through 31 March 2005/2006/2007/2008/2009/2010/2011 (depending upon the Option Period).
 - (b) All delivery orders or task orders are subject to the terms and conditions of this contract. In the event of conflict between a delivery order or task order and this contract, the contract shall control.
 - (c) If mailed, a delivery order or task order is considered "issued" when the Government deposits the order in the mail. Orders may be issued orally, by facsimile, or by electronic commerce methods only if authorized in the Schedule.
- (End of clause)

I.112. 52.216-19 ORDER LIMITATIONS (Oct 1995)

- (a) *Minimum order.* When the Government requires supplies or services covered by this contract in an amount of less than \$0, the Government is not obligated to purchase, nor is the Contractor obligated to furnish, those supplies or services under the contract.
 - (b) *Maximum order.* The Contractor is not obligated to honor-
 - (1) Any order for a single item in excess of \$10,000,000.00;
 - (2) Any order for a combination of items in excess of \$100,000,000.00; or
 - (3) A series of orders from the same ordering office within 5 days that together call for quantities exceeding the limitation in paragraph (b)(1) or (2) of this section.
 - (c) If this is a requirements contract (*i.e.*, includes the Requirements clause at subsection 52.216-21 of the Federal Acquisition Regulation (FAR)), the Government is not required to order a part of any one requirement from the Contractor if that requirement exceeds the maximum-order limitations in paragraph (b) of this section.
 - (d) Notwithstanding paragraphs (b) and (c) of this section, the Contractor shall honor any order exceeding the maximum order limitations in paragraph (b), unless that order (or orders) is returned to the ordering office within 10 days after issuance, with written notice stating the Contractor's intent not to ship the item (or items) called for and the reasons. Upon receiving this notice, the Government may acquire the supplies or services from another source.
- (End of clause)

I.113. 52.216-21 REQUIREMENTS (OCT 1995)

- (a) This is a requirements contract for the supplies or services specified, and effective for the period stated, in the Schedule. The quantities of supplies or services specified in the Schedule are estimates only and are not purchased by this contract. Except as this contract may otherwise provide, if the Government's requirements do not result in orders in

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the quantities described as "estimated" or "maximum" in the Schedule, that fact shall not constitute the basis for an equitable price adjustment.

(b) Delivery or performance shall be made only as authorized by orders issued in accordance with the Ordering clause. Subject to any limitations in the Order Limitations clause or elsewhere in this contract, the Contractor shall furnish to the Government all supplies or services specified in the Schedule and called for by orders issued in accordance with the Ordering clause. The Government may issue orders requiring delivery to multiple destinations or performance at multiple locations.

(c) Except as this contract otherwise provides, the Government shall order from the Contractor all the supplies or services specified in the Schedule that are required to be purchased by the Government activity or activities specified in the Schedule.

(d) The Government is not required to purchase from the Contractor requirements in excess of any limit on total orders under this contract.

(e) If the Government urgently requires delivery of any quantity of an item before the earliest date that delivery may be specified under this contract, and if the Contractor will not accept an order providing for the accelerated delivery, the Government may acquire the urgently required goods or services from another source.

(f) Any order issued during the effective period of this contract and not completed within that period shall be completed by the Contractor within the time specified in the order. The contract shall govern the Contractor's and Government's rights and obligations with respect to that order to the same extent as if the order were completed during the contract's effective period; provided, that the Contractor shall not be required to make any deliveries under this contract after 31 March 2011

(End of clause)

I.114. 52.216-22 INDEFINITE QUANTITY (Oct 1995)

(a) This is an indefinite-quantity contract for the supplies or services specified, and effective for the period stated, in the Schedule. The quantities of supplies and services specified in the Schedule are estimates only and are not purchased by this contract.

(b) Delivery or performance shall be made only as authorized by orders issued in accordance with the Ordering clause. The Contractor shall furnish to the Government, when and if ordered, the supplies or services specified in the Schedule up to and including the quantity designated in the Schedule as the "maximum." The Government shall order at least the quantity of supplies or services designated in the Schedule as the "minimum."

(c) Except for any limitations on quantities in the Order Limitations clause or in the Schedule, there is no limit on the number of orders that may be issued. The Government may issue orders requiring delivery to multiple destinations or performance at multiple locations.

(d) Any order issued during the effective period of this contract and not completed within that period shall be completed by the Contractor within the time specified in the order. The contract shall govern the Contractor's and Government's rights and obligations with respect to that order to the same extent as if the order were completed during the contract's effective period; *provided*, that the Contractor shall not be required to make any deliveries under this contract after 31 March 2005/2006/2007/2008/2009/2010/2011 (depending upon the Option Year).

(End of clause)

I.115. 52.217-8 OPTION TO EXTEND SERVICES (NOV 1999)

The Government may require continued performance of any services within the limits and at the rates specified in the contract. These rates may be adjusted only as a result of revisions to prevailing labor rates provided by the Secretary of Labor. The option provision may be exercised more than once, but the total extension of performance hereunder shall not exceed 6 months. The Contracting Officer may exercise the option by written notice to the Contractor within 90 days of contract expiration.

(End of clause)

I.116. 52.217-9 OPTION TO EXTEND THE TERM OF THE CONTRACT (MAR 2000)

(a) The Government may extend the term of this contract by written notice to the Contractor within 30 calendar days provided that the Government gives the Contractor a preliminary written notice of its intent to extend at least 60 calendar days before the contract expires. The preliminary notice does not commit the Government to an extension.

(b) If the Government exercises this option, the extended contract shall be considered to include this option clause.

(c) The total duration of this contract, including the exercise of any options under this clause, shall not exceed 7 years and 10 months.

(End of clause)

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I.117. 52.232-19 AVAILABILITY OF FUNDS FOR THE NEXT FISCAL YEAR (APR 1984)

Funds are not presently available for performance under this contract beyond 30 September 2004/2005/2006/2007/2008/2009/2010/2011 (depending upon the Option Year.) The Government's obligation for performance of this contract beyond that date is contingent upon the availability of appropriated funds from which payment for contract purposes can be made. No legal liability on the part of the Government for any payment may arise for performance under this contract beyond 30 September 2004/2005/2006/2007/2008/2009/2010/2011 (depending upon the Option Year) until funds are made available to the Contracting Officer for performance and until the Contractor receives notice of availability, to be confirmed in writing by the Contracting Officer.

(End of clause)

I.118. Reserved

I.119 52.244-6 SUBCONTRACTS FOR COMMERCIAL ITEMS (APR 2003)

(a) Definitions. As used in this clause--

"Commercial item" has the meaning contained in the clause at 52.202-1, Definitions.

"Subcontract" includes a transfer of commercial items between divisions, subsidiaries, or affiliates of the Contractor or subcontractor at any tier.

(b) To the maximum extent practicable, the Contractor shall incorporate, and require its subcontractors at all tiers to incorporate, commercial items or nondevelopmental items as components of items to be supplied under this contract.

(c)(1) The Contractor shall insert the following clauses in subcontracts for commercial items:

(i) 52.219-8, Utilization of Small Business Concerns (OCT 2000) (15 U.S.C. 637(d)(2) and (3)), in all subcontracts that offer further subcontracting opportunities. If the subcontract (except subcontracts to small business concerns) exceeds \$500,000 (\$1,000,000 for construction of any public facility), the subcontractor must include 52.219-8 in lower tier subcontracts that offer subcontracting opportunities.

(ii) 52.222-26, Equal Opportunity (Apr 2002) (E.O. 11246).

(iii) 52.222-35, Equal Opportunity for Special Disabled Veterans, Veterans of the Vietnam Era, and Other Eligible Veterans (Dec 2001) (38 U.S.C. 4212(a));

(iv) 52.222-36, Affirmative Action for Workers with Disabilities (JUN 1998) (29 U.S.C. 793).

(v) 52.247-64, Preference for Privately Owned U.S.-Flag Commercial Vessels (APR 2003) (46 U.S.C. Appx 1241 and U.S.C. 2631) (flow down required in accordance with paragraph (d) of FAR clause 52.247-64).

(2) While not required, the Contractor may flow down to subcontracts for commercial items a minimal number of additional clauses necessary to satisfy its contractual obligations.

(d) The Contractor shall include the terms of this clause, including this paragraph (d), in subcontracts awarded under this contract.

(End of clause)

I120. 52.252-6 AUTHORIZED DEVIATIONS IN CLAUSES (APR 1984)

(a) The use in this solicitation or contract of any Federal Acquisition Regulation (48 CFR Chapter 1) clause with an authorized deviation is indicated by the addition of "(DEVIATION)" after the date of the clause.

(b) The use in this solicitation or contract of any Defense Federal Acquisition Regulation Supplement (48 CFR Chapter 2) clause with an authorized deviation is indicated by the addition of "(DEVIATION)" after the name of the regulation.

(End of clause)

SECTION J
LIST OF ATTACHMENTS

J.1

Attachment 1	CHAMPVA Fact Sheet 01-16 For Outpatient Providers and Office Managers
Attachment 2	Reserved
Attachment 3	Reserved
Attachment 4	DEERS Point-in-Time Extract Adjustments
Attachment 5	Reserved
Attachment 6	Reserved
Attachment 7	Reserved
Attachment 8	List of Data Package Contents
Attachment 9	Intermediate Commands Requiring Read-Only Access to Contractor's Data Warehouse
Attachment 10	National Quality Forum, "Serious Reportable Events in Healthcare"
Attachment 11	December 2002 DMIS ID Table
Attachment 12	Subcontracting Plan
Attachment 13	Implementation Instructions –CAP/DME Recoupments Calendar Years 1992 – 2004 Based on Revised DCAA Audit Recalculations