

TRANSITIONS

1.0. GENERAL

In the event of a contract transition the following paragraphs are intended to provide needed information about transition requirements. Additional requirements or variations may be made after negotiation by the Contracting Officer. For purposes of transitions, the incumbent contractor shall be designated as the outgoing contractor at the time of award of successor contract to another contractor. The successor contractor is designated as the incoming contractor. The incoming contractor shall perform required start-up services during the period between the date of contract award and initiation of health care services under this contract, based on a plan for the conduct of start-up services accepted by TMA. Basically the same services will be performed for any states added during option years. A minimum of six months is guaranteed for the transition.

1.1. Post-Award Conference

Within 15 calendar days following the award of the contract, the incoming contractor shall attend a post-award conference with the TMA Contracting Officer. This meeting is in addition to the required Transition Specifications Meeting.

1.2. Transition Specifications Meeting(s)

The incoming contractor shall send representatives with the experience, expertise, and authority to establish project commitments and approvals on behalf of the organization to a meeting at the site(s) of the outgoing contractor(s), within 15 calendar days following notice of award by TMA, for the purpose of discussing their phase-in plan and for finalizing a schedule of phase-out/phase-in activities. The TMA shall notify the parties of the exact date of the meeting. Prior to the Transition Specifications Meeting, TMA will prepare a draft transition schedule according to the format established in the contract and provide it to the incoming and outgoing contractors.

1.3. Phase-In Plan And Transition Schedule

Revisions to the draft TMA transition schedule will be forwarded to the contractors within ten calendar days following the Transition Specifications Meeting. By the 15th calendar day following the Transitions Specifications Meeting, the contractor shall submit their phase-in plan revisions to TMA, as stated in the proposal, incorporating all specifications of the official transition schedule developed during the Transition Specifications Meeting.

1.4. DEERS Interface Meeting

The incoming contractor shall host a meeting for TMA, DEERS, and their technical personnel between the seventh and tenth calendar day following the Transition Specifications Meeting for the purpose of discussing DEERS implementation plans, requirements, and scheduling. The contractor representatives shall include technically qualified personnel who will be directly involved in the implementation. The eligibility verification system is to be linked to DEERS 90 days prior to the start of health care delivery unless another time frame is agreed to between DEERS, the contractor and TMA. TRICARE Service Centers shall be linked to DEERS no later than 30 days prior to the start of health care delivery.

2.0. START-UP REQUIREMENTS

2.1. Systems Development

2.1.1. In accordance with the approved start-up plan, the contractor shall develop systems required to:

- Record and monitor enrollment under the TRICARE Prime option and, where appropriate; receive, safeguard and properly account for any required enrollment fees.
- Indicate Primary Care Manager assignment
- Operate the “health care finder” mechanism for authorizations, referrals, and other assigned functions
- Implement utilization review mechanisms and quality assurance programs
- Operate an approved claims processing system
- Operate required beneficiary and provider service functions.
- Satisfy management information systems requirements

2.1.2. Approximately 30 days prior to the initiation of delivery of services, the non-claims processing systems and the telecommunications interconnections between these systems shall be reviewed by the TMA or its designees, to include a demonstration by the contractor of the system(s) capabilities, to determine whether the systems satisfy the requirements of TMA as otherwise provided in the contract. This includes the telecommunications links with TMA and DEERS. The review will also confirm that the hardware, software, and communications links required for operating the automated TRICARE Duplicate Claims System have been installed and are ready for TMA installation of the Duplicate Claims System application software (see the [ADP Manual, Chapter 11, Section 9.](#)) This review is in addition to the Benchmark testing requirement of [paragraph 6.0.](#) The contractor shall effect any modifications required by TMA prior to the initiation of services.

2.2. Execution Of Agreements With Contract Providers

2.2.1. All contract provider agreements shall be executed 60 calendar days prior to the start date of TRICARE Prime in the catchment area or at such other time as is mutually agreed between the contractor and TMA.

2.2.2. The contractor is required to report on a monthly basis during the transition and for the first six months following the start of health care delivery, and quarterly thereafter, on the network adequacy. These reports are due to the Contracting Officer within ten calendar days following the last day of the reporting period and shall provide the following information:

- The number of network providers by specialty;
- The number of network additions and deletions, by specialty;
- Activities undertaken to contract with additional providers in areas lacking adequate networks to meet the prescribed network standards; and
- A listing of PCMs, (both civilian and military) and the number of enrollees assigned to each PCM, by catchment area.

2.3. Execution Of Memoranda Of Understanding (MOU) With MTF Commanders

Sixty days prior to the start of health care delivery, the contractor shall have executed Memoranda of Understanding with all MTF Commanders in the Region. The contractor shall provide two copies of each executed MOU to the Contracting Officer within ten calendar days following the execution of the MOU.

2.4. Phase-In Of TRICARE Prime Enrollment Program And Benefit Programs

The contractor shall begin the enrollment process for the TRICARE Prime program no earlier than 60 calendar days, but no later than 30 calendar days prior to the scheduled start of health care delivery, subject to TMA approval of systems under the contract. In addition to other contractually required enrollment reports, the contractor, within 30 calendar days following the start of health care delivery, and within ten calendar days following the close of each calendar month through the seventh month following the start of health care delivery, shall provide a report to TMA on progress made in implementing TMA approved enrollment plan, to include:

2.4.1. Identifying those areas in the contractor's approved start-up plan to be serviced by TRICARE Prime in which enrollment significantly exceeds or falls short of the enrollment targets established by the contractor in the approved enrollment plan; and

2.4.2. Outlining corrective action plans for any deficiencies in the contractor's enrollment process responsible for significant deviations from the approved enrollment plan.

2.5. Phase-In Requirements Related To The Health Care Finder Function

2.5.1. The hiring and training of health care finder staff will be completed no later than 40 calendar days prior to the start of health care delivery for TRICARE Prime in each catchment area.

2.5.2. Health Care Finder space will be occupied and all equipment and supplies in place not later than 30 calendar days prior to the start of health care delivery.

2.5.3. The provider/beneficiary community will be advised of the procedures for accessing the health care finder function no later than 30 calendar days prior to the start of health care delivery.

2.6. Phase-In Requirements Of The TRICARE Service Centers (TSCs)

2.6.1. The outgoing contractor shall vacate the TSCs on the 40th calendar day prior to the start of health care delivery and will establish a centralized Health Care Finder function, unless otherwise negotiated with the incoming contractor during the Transition Specifications Meeting. NOTE: This section only applies when the incoming and outgoing contractors both have TSCs included in their contracts.

2.6.2. The incoming contractor will occupy the TSCs beginning the 39th calendar day prior to the start of health care delivery. The TSCs will be fully operational 30 calendar days prior to the start of health care delivery. These functions include, but are not limited to, assisting beneficiaries by enrolling them in Prime, providing marketing and educational material, assisting in Primary Care Manager (PCM) assignments, providing referrals and authorizations, and providing assistance with contacting the outgoing contractor as necessary.

2.7. Phase-In Requirements Related to Transitional Cases

2.7.1. Unless otherwise indicated in the outgoing contractor's contract, the outgoing contractor is responsible for processing to completion all network claims, to include adjustments, for services rendered during its period of health care delivery.

2.7.2. Transitional cases *for non-network claims* are those cases (patients) that are inpatients (occupying an inpatient bed) at 0001 hours on the first day of any health care contract period in which the incoming contractor is beginning delivery of health care services. During the Transition Specifications Meeting, the contractor shall consult with relevant TRICARE contractor staff and TMA to finalize methods for handling transitional cases.

2.7.3. For transitions involving both incoming and outgoing at-risk contractors *for non-network claims*, the following provisions apply:

- In the case of DRG reimbursement, the outgoing contractor is responsible for payment through the first month of health care delivery or the date of discharge, whichever occurs first.

- If the facility is reimbursed on a per diem basis, the outgoing contractor is responsible for payment of all the institutional charges *accrued prior to 0001 hours on the first day* of health care delivery, under the *incoming contractor*. *The incoming contractor thereafter is responsible for payment.*
- Professional services related to the transitional cases is the responsibility of the outgoing contractor for services delivered prior to 0001 hours on the first day of health care delivery and of the incoming contractor thereafter. Professional health care claims may be split as required.
- In the case of RTC care, both the incoming and outgoing contractors are responsible for authorizing that part of the stay falling within their area of responsibility; however, the incoming contractor may utilize the authorization issued by the outgoing contractor as the basis for continued stay.
- If the outgoing contractor succeeds itself, costs related to each contract will be kept separate for purposes of contract accountability, according to the above guidelines.

2.8. Phase-In Of Claims Processing For The Outgoing Contractor's Remaining Claims

See [paragraph 5.2](#).

3.0. HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

The covered entity may honor an authorization or other express legal document obtained from an individual permitting the use and disclosure of protected health information prior to the compliance date (HHS Privacy Regulation, §164.532).

4.0. CLAIMS PROCESSING SYSTEM AND OPERATIONS

During the period between the date of award and the start of health care delivery, the incoming contractor shall, pursuant to an implementation schedule approved by TMA, meet the following requirements:

4.1. Acquisition Of Resources

The incoming contractor shall hire sufficient experienced staff to oversee the implementation of each functional area throughout the transition period and shall hire or transfer to the project adequate operational staff to meet the minimum performance requirements from the start of health care services delivery and acquire all non-human resources necessary to support the TRICARE operation. All TRICARE Service Center and Field Representatives shall be fully trained and available for all duties no less than 30 calendar days prior to initiation of health care services.

4.2. Contractor File Conversions And Testing

The incoming contractor shall perform initial conversion and testing of all ADP files (e.g., provider files, pricing files, and beneficiary history and deductible files) not later than 30 calendar days following receipt of the magnetic tape files from the outgoing contractor(s).

All ADP file conversions shall be fully tested and operational for the Benchmark ([paragraph 6.0.](#))

4.3. Receipt Of Outgoing Contractor's Weekly Shipment Of History Updates And Dual Operations

4.3.1. Beginning with the 60 calendar day prior to the start of health care delivery and continuing for 180 calendar days after the start of health care delivery, the contractor shall convert the weekly shipments of the beneficiary history and deductible file updates from the outgoing contractor(s) within two work days following receipt. These files shall be validated by the incoming contractor before use. Tests for claims, update of catastrophic cap, and duplicate claims shall be performed within two work days following conversion. Following the start of health care delivery, these files shall be loaded to history and used for claims processing on the first processing cycle following the check for duplicate deductibles.

4.3.2. During the 180 calendar days after the start of health care delivery that both the incoming and outgoing contractors are processing claims, both contractors will be required to maintain close interface on history update exchanges and provider file maintenance. During the first 60 days of dual operations the contractors will exchange beneficiary history updates with each contractor's claims processing cycle run. Thereafter, the exchange shall not be less than twice per week until the end of dual processing. The incoming and outgoing contractors shall have joint responsibility for the maintenance of the provider file records during the first 60 calendar days following the incoming contractor's start of health care delivery. The incoming contractor shall assume total responsibility for the maintenance of the provider file records 60 days after the start of health care delivery. However, they will coordinate and cooperate with the outgoing contractor to ensure that the outgoing contractor can continue to process claims accurately; conversely, the outgoing contractor has responsibility to notify the incoming contractor of any change in provider status that they become aware of through their operations.

4.4. ADP System Documentation

The incoming contractor shall have complete system documentation available for TMA inspection not later than 15 calendar days prior to the start of health care delivery.

4.5. TMA Ongoing System Testing Throughout Transition Period

At the discretion of TMA, the incoming contractor shall participate in a series of demonstrations based on the milestone chart throughout the system's transition period. The frequency and complexity of these demonstrations will be based on the incoming contractor level of operational status on the award date.

4.6. Contractor Weekly Status Reporting

The contractor shall submit a weekly status report of phase-in and operational activities and inventories to TMA beginning the 20th calendar day following "Notice of Award" by TMA through the 180th calendar day after the start of health care delivery (or as directed by the Contracting Officer based on the status of the transition and other operational factors) under a new contract according to specifications in the official transition schedule. The status report will address only those items identified as being key to the success of the

transition as identified in the Transition Specifications Meeting or in the contractor's start-up plan.

4.7. Public Notification Program - Provider And Congressional Mailing

The contractor shall prepare a mailing to all non-network TRICARE providers and Congressional offices within the region by the 45th calendar day prior to the start of health care delivery according to the specifications of the official transition schedule. The proposed mailing shall be submitted to the Contracting Officer for approval not later than 90 calendar days prior to the start of each health care delivery period. No Provider materials shall be released under any circumstances without prior Contracting Officer approval. The mailing shall discuss any unique processing requirements of the contractor and any other needed information dictated by the official transition schedule. In addition, the contractor is also responsible for conducting a series of educational meetings for Congressional offices, beneficiaries, providers, and Health Benefits Advisors in accordance with the contractor's proposed Public Notification Program. These meetings are to be completed within 90 calendar days following the start of health care delivery.

4.8. Microfilming Of Tricare Contractor Claims Records And Adjustments Prior To Transfer

During a transition, the outgoing contractor shall provide a copy of microfilm for all its claims-related TRICARE records prior to transferring them to the incoming contractor or to the Federal Records Center. The outgoing contractor must provide the incoming contractor with specifications for accessing information on the microfilmed TRICARE contractor claims records.

4.9. Installation And Operation Of The Automated TRICARE Duplicate Claims System

4.9.1. The incoming contractor shall have purchased, installed, configured, and connected the personal computers and printers required to operate the Duplicate Claims System no later than 60 days prior to the start of the health care delivery. See the [ADP Manual, Chapter 11, Section 9](#), for hardware, software, printer, configuration and communications requirements and contractor installation responsibilities.

4.9.2. Approximately 30-45 days prior to health care delivery, TMA will provide and install the Duplicate Claims System application software on the incoming contractor designated personal computers and provide on-site training for users of the Duplicate Claims System in accordance with the [ADP Manual, Chapter 11, Section 9, paragraph 6.3](#).

4.9.3. Following the start of health care delivery, the Duplicate Claims System will begin displaying identified potential duplicate claim sets for which the incoming contractor has responsibility for resolving. The incoming contractor shall begin using the Duplicate Claims System to resolve potential duplicate claim sets in accordance with [ADP Manual, Chapter 11](#) and the transition plan requirements. (See [ADP Manual, Chapter 11, Addendum C](#) and [Addendum D](#), for Transition Schedule Guides for transition requirements.)

5.0. PHASE-OUT

5.1. Data

The outgoing contractor shall provide to TMA (or, at the option of TMA, to a successor contractor) such information as TMA shall require to facilitate transitions from the contractor's operations to operations under any successor contract. Such information may include, but is not limited to, the following:

- The data contained in the contractor's enrollment information system.
- The data contained in the contractor's claims processing systems.
- Information about the management of the contract that is not considered, under applicable Federal law, to be proprietary to the contractor.

5.1.1. Transitions Specifications Meeting

The outgoing contractor shall provide for a meeting with representatives of the incoming contractor and TMA within 15 calendar days following the notice of award by TMA for the purpose of developing a schedule of phase-out/phase-in activities. TMA shall notify the contractor as to the exact date of the meeting. Prior to the Transition Specifications Meeting, TMA will prepare a draft transition schedule according to the format established in the contract and provide it to the incoming and outgoing contractors. The outgoing contractor is required to provide a proposed phase-out plan at the Transition Specifications Meeting.

5.1.2. Phase-Out Plan

Revisions to the draft TMA transition schedule will be forwarded to the contractors within ten calendar days following the Transition Specifications Meeting. The contractor shall submit to TMA a revised phase-out plan for all inventory types, staffing level requirements, and other resource needs for each operational function by the 15th calendar day following the Transition Specifications Meeting. The plan shall incorporate all specifications of the official transition schedule.

5.2. Phase-Out Of Claims

5.2.1. Upon termination of health care delivery services under the contract, the outgoing contractor shall remain responsible for payment of all network claims and adjustments (*except for dual eligible claims received on or after the start of the new contract as addressed below*) for services incurred prior to the termination of delivery of health care services for a period of 180 calendar days following the start of the incoming contractor's health care delivery period. The contractor should require institutional network providers to submit all claims within 30 calendar days after discharge. Non-institutional claims for services rendered during the outgoing contractor's health care delivery period should be submitted within 30 days following the start of the incoming contractor's first health care delivery period. Providers should be required to submit adjustment requests within an appropriate time frame to allow the outgoing contractor sufficient time to finalize all claims and adjustments prior to the 180 day limit. Any network payment or claims processing

requirements related to the close-out of the contract, including requirements for timely submission of claims for payment, shall be set forth in the contracted provider agreements. The outgoing contractor will remain responsible for completing all processing for network claims and submitting the necessary HCSRs to TMA.

5.2.2. *For dual eligible claims regardless of network status or date of service, the outgoing contractor shall transfer any claims received on or after the start of the new contract to the TDEFIC contractor for processing. The claims shall be forwarded to the incoming contractor by the outgoing contractor by overnight delivery, within 48 hours of receipt.*

5.2.3. Upon termination of health care delivery services under the contract, the outgoing at-risk contractor shall remain responsible, for a period of 90 calendar days, for the receipt and processing of non-network claims (*other than TFL and dual eligible claims which are explained below*) and adjustments for services incurred prior to the termination of delivery of health care services and for payment of all claims received within the three months following the start of health care delivery under the new contract. The same terms and conditions are applicable as when the contract was in full force and effect. For the purpose of this provision, the determination of whether a contractor is liable for payment for a service shall be based on the date care was provided. All non-network claims and adjustments received after the 90 day period following cessation of health care delivery under the contract will be forwarded to the incoming contractor, irrespective of the incurred date of the services. The outgoing contractor shall then have an additional 90 calendar days in which to process all claims to completion received through the ninetieth day.

5.2.4. *For TFL and dual eligible claims, the outgoing contractor shall transfer all non-network claims regardless of dates of service, to the TDEFIC claims processor, that are received by the outgoing contractor on or after the start of TDEFIC claims processing for the outgoing processor's region. The claims shall be forwarded to the incoming contractor by the outgoing contractor by overnight delivery, within 48 hours of receipt.*

5.2.5. At the end of the 90 days following cessation of health care delivery of the outgoing contractor, the outgoing contractor and TMA shall, based on the most recent complete TMA historical claims log data, project the number of non-network claims and benefit dollars incurred, but not received by the 90th day following cessation of health care delivery, and estimated capital and direct medical education (DME) liability, where appropriate. The contractor will then remit to TMA a lump sum payment which shall include both the estimated benefit dollar amount and the estimated administrative claim processing costs. The administrative claims processing costs shall be determined by taking the estimated number of outstanding incurred claims times a predetermined rate as specified in the contract. This payment will be made to TMA within 30 calendar days following the calculation of incurred claims and benefit dollars.

5.2.6. The outgoing contractor shall also be liable, after the termination of services under this contract, for any payments to subcontractors of the contractor arising from events that took place during the period of this contract.

5.2.7. For transitional case requirements, refer to [paragraph 2.7](#).

5.3. Phase-Out Of The Contractor's Claims Processing Operations

Upon notice of award to another contractor, and during the procurement process leading to a contract award, the contractor shall undertake the following phase-out activities regarding services as an outgoing contractor.

5.3.1. Provide Information

The contractor shall, upon receipt of written request from TMA, provide to potential offerors such items and data as shall be required by TMA. This shall include non-proprietary information, such as record formats and specifications, field descriptions and data elements, claims and correspondence volumes, etc.

5.3.2. Transfer Of ADP File Specifications

The outgoing contractor shall transfer to the incoming contractor by express mail or similar overnight delivery service, not later than three calendar days following award announcement, the record layouts with specifications, formats, and definitions of fields, and data elements, access keys and sort orders, for the following:

- The TRICARE Provider Files
- The TRICARE Pricing Files
- The Beneficiary History and Deductible Files (Including Eligibility Files, if applicable)
- The Enrolled Beneficiary and Primary Care Manager (PCM) Assignment Files (Including Enrollment Fee Payment Information, Civilian/Networks and Resource Sharing, PCM Names and Provider ID Numbers)
- Mental Health Provider Files - The outgoing contractor must assure that the incoming contractor has been given accurate provider payment information on all mental health providers paid under the TRICARE inpatient mental health per diem payment system. This should include provider name; tax identification number; address including zip code; high or low volume status; if high volume, provide the date the provider became high volume; and the current per diem rate along with the two prior year's per diem amounts. The providers under the per diem payment system must be designated by Medicare, or meets exemption criteria, as exempt from the inpatient prospective payment system (DRGs). If an acute care hospital has an exempt inpatient mental health unit, the unit would be identified as the provider under the TRICARE inpatient mental health per diem payment system.

5.3.3. Transfer Of ADP Files (Magnetic Tapes)

The contractor shall prepare in magnetic tape format and transfer to the incoming contractor or TMA, by the 15th calendar day following the Transition Specifications meeting unless, otherwise negotiated by the incoming and outgoing contractors, all specified ADP files, in accordance with specifications in the official transition schedule.

5.3.4. Transfer Of ADP Files (Hard Copy)

The contractor shall transfer to the incoming contractor, in hard copy form, by the 15th calendar day following the date of contract award by TMA, the Provider file(s), and the Pricing File(s) according to specifications in the official transition schedule, unless otherwise negotiated at the Transition Specifications Meeting.

5.3.5. Outgoing Contractor Weekly Shipment Of History Updates

The outgoing contractor shall transfer to the incoming contractor, in magnetic tape format, all beneficiary history and deductible transactions (occurring from the date of preparation for shipment of the initial transfer of such history files and every week thereafter) beginning the 60th calendar day following notice of award by TMA (until such a time that all processing is completed by the outgoing contractor) in accordance with the specifications in the official transition schedule. See dual operations in [paragraph 4.3](#).

5.3.6. Transfer Of Non-ADP Files

The outgoing contractor shall transfer to the incoming contractor all non-ADP files (e.g., preauthorization files, clinic billing authorizations, and tapes which identify catchment areas, microfilm/microfiche files, Congressional and TMA completed correspondence files, appeals files, TRICARE medical utilization, and administration files) in accordance with the specifications in the official transition schedule and [Chapter 2](#). The hard copies of the Beneficiary History Files are to be transferred to the incoming contractor or Federal Records Center as required by [Chapter 2](#). The contractor shall provide samples and descriptions of these files to the incoming contractor at the Transition Specification Meeting.

5.3.7. EOB Record Data Retention And Transmittal

If the contractor elects to retain the EOB data on a computer record, it must, in the event of a transition to another contractor, provide either a full set of microfile records covering the current and two prior years, or, at the Contracting Officer's discretion, provide the data and necessary programs to reproduce the EOB in acceptable form and transfer such data and programs to the successor contractor or to TMA. TMA shall be the final authority in determining the form and/or acceptability of the data and/or microcopies. (See [Chapter 8, Section 11](#).)

5.3.8. Outgoing Contractor Weekly Status Reporting

Until all inventories have been processed, the outgoing contractor shall submit a weekly status report of inventories and phase-out activities to TMA beginning the 20th calendar day following notice of award by TMA until otherwise notified by the Contracting Officer to discontinue. This shall be done in accordance with specifications of the official transition schedule.

5.3.9. Final Processing Of Outgoing Contractor

The outgoing contractor shall:

- Process all claims and adjustments (*except for TFL and dual eligible non-network claims whose process is described below*) identified by the 90th day following cessation of the outgoing contractor's health care delivery. Processing of these claims shall be completed within 180 calendar days following the start of the incoming contractor's health care delivery.
- *For TFL and dual eligible non-network claims received prior to start work of the new contract, processing shall be completed by the 90th calendar day after the new contract start work date.*
- Process all correspondence, allowable charge complaints, and incoming telephonic inquiries which pertain to claims or services processed or delivered under this contract within the time frames established for response by the standards of the contract.
- Complete all appeal/grievance cases which pertain to claims or services processed or delivered under this contract within the time frames established for response by the standards of the contract.

5.3.10. Correction Of Edit Rejects

The outgoing contractor shall retain sufficient resources to ensure correction (and reprocessing through TMA) of all health care service record edit errors not later than 210 calendar days following the start of the incoming contractor's health care delivery.

5.3.11. Phase-Out Of The Automated TRICARE Duplicate Claims System

The outgoing contractor shall phase-out the use of the automated TRICARE Duplicate Claims System in accordance with the [ADP Manual, Chapter 11](#) and transition plan requirements. (See the [ADP Manual, Chapter 11, Addendum C](#) and [Addendum D](#), for Transitional Guides for transition requirements.)

5.4. Phase-Out Of The Contractor's Provider Network, TRICARE Service Centers, And MTF Agreements

Upon notice of award to another contractor, the outgoing contractor shall provide full cooperation and support to the incoming contractor, to allow an orderly transition, without interruption, of all functions relating to the MTF interface and the establishment of a provider network by the incoming contractor. This shall include, but is not limited to, data relating to on-site service centers, resource sharing agreements, equipment, telephones and all other functions having an impact on the MTFs.

5.4.1. Within 15 calendar days of the Transitions Specifications Meeting the outgoing contractor shall draft and submit in the revised phase-out plan a plan for transition of the MTF interfaces. Resolution of differences identified through the coordination process must be accomplished in collaboration with the Transition Monitor appointed by TMA and according to the guidelines in the transition schedule.

5.4.2. The outgoing contractor shall allow the incoming contractor unencumbered access to incumbent resource sharing providers for purposes of recruitment, and shall make

available to the incoming contractor within five calendar days of a request, copies of all resource sharing agreements in effect as of the date of award. The above notwithstanding, the outgoing contractor will not be required to disclose any information recognized by Federal law and regulation as proprietary. Questionable situations must be referred to the TMA designated Transition Monitor for resolution.

5.4.3. The outgoing contractor shall vacate the TRICARE Service Centers (TSCs) on the 40th calendar day prior to the start of health care delivery and will establish a centralized Health Care Finder function, unless otherwise negotiated with the incoming contractor during the Transition Specifications Meeting. NOTE: This section only applies when both the incoming and outgoing contractors have TSCs.

5.4.4. The outgoing contractor will terminate marketing activity 40 calendar days prior to the start of the incoming contractor's health care delivery.

5.4.5. The outgoing contractor will continue to issue prior authorizations for care for which it is financially responsible. However, authorization-related information shall be shared between the incoming and the outgoing contractors to preclude requiring a provider or beneficiary to duplicate the paperwork and other effort related to establishing prior authorizations. The outgoing contractor may issue prior authorizations as late as midnight on the day prior to the end of its health care delivery for inpatient stays that will continue as transitional cases. The Health Care Finders of the two contractors shall interface on the clinical issues of a case where both contractors will, or can reasonably expect to have periods of liability for the same episode of care.

5.4.6. The outgoing contractor shall maintain toll-free lines, accessible to the public during the first 90 calendar days of dual operations (*except lines attributable to TFL and dual eligible inquiries which may be phased out during the 90 days of final claims processing, as inquiry volume decreases coordinating the phase out with the TMA contracting officer*) in order to properly respond to inquiries related to claims processed for services incurred during the period of their respective liability. Beneficiary inquiry lines will continue to be staffed as defined in the contract. In general, the outgoing contractor will be required to maintain adequate toll-free line coverage to ensure that the blockage rate does not exceed the blockage rate on the contractor's most critical private or other government business access line.

5.5. Phase-out of Enrollment Activities

5.5.1. During the transition period, the outgoing contractor will remain responsible for enrollment actions with an effective date prior to the start of health care delivery of the incoming contractor (e.g., reenrollments, transfers in, transfers out, PCM changes, etc.). Prior to the start of health care delivery under the successor contract, the Government will provide the outgoing contractor with the software for the DEERS On-line Enrollment System (DOES) version to be used during transition, guidance as to when the version should be loaded and used for the phase-out of enrollment activities. The incoming contractor will perform all enrollment actions with an effective date on or after the start of health care delivery.

5.5.2. The outgoing contractor shall continue to send enrollment renewal notices/billing notices for all enrollees whose current enrollment period or payment period expires before the start of the incoming contractor's health care delivery period. For all enrollment renewals or payments in which the new enrollment period or period covered by the

premium payment will begin on the start of the health care delivery period under the new contract, the incoming contractor will be responsible for sending renewal/billing notices to these enrollees. Any enrollment fees collected by the outgoing contractor for a period which begins on or after the start of health care delivery under the new contractor shall be forwarded to the incoming contractor.

5.5.3. Approximately 40 days prior to the start of health care delivery under the new contract, DEERS/DMDC will provide the incoming contractor with an initial enrollment load file ('Gold File'). Within that same time period, outgoing contractors are required to provide incoming contractors with all enrollment fee data in the format specified during transition meetings. (NOTE: Each TNEX contract transition shall require a three-day freeze of enrollment activities. The freeze will occur the first weekend that precedes the 40-day window prior to the start of health care delivery. The actual calendar dates will be determined during the transition meeting.)

5.5.4. After the 'Gold File' is created and provided to the incoming contractor, the outgoing contractor is required to coordinate all enrollment transactions with the incoming contractor for any actions effective during the period from when the 'Gold File' is provided to the incoming contractor through the start of health care delivery.

5.5.4.1. Enrollment actions involving current enrollees (i.e., those enrollees on the "Gold File") will require that the outgoing contractor request cancellation of the future enrollment segment by the incoming contractor before the outgoing contractor can process their enrollment action. Once the outgoing contractor is notified by the incoming contractor that the future enrollment segment has been cancelled, the outgoing contractor will then process their enrollment action. After the outgoing contractor completes their action, they must notify the incoming contractor so that the incoming contractor can reinstate the future segment (if necessary). These actions include transfers out, PCM changes, disenrollments, etc.

5.5.4.2. Enrollment actions involving new enrollees (i.e, those enrollments or transfers in after the 'Gold File' is created and with an enrollment effective date prior to the start of health care delivery) will be completed by the outgoing contractor. Upon completion, the outgoing contractor will notify the incoming contractor of the new enrollment so that the incoming contractor can create a future enrollment segment.

5.5.4.2.1. **EXCEPTION:** No enrollments shall be assigned a begin date that is equal to the last day prior to the start of health care delivery of the incoming contractor. Enrollments that would normally have a begin date on the last day prior to the start of health care delivery of the incoming contractor shall be given a begin date of one day prior. For example, if the last day prior to the start of health care delivery of the incoming contractor is March 31, the begin date for any enrollment that would normally have been March 31, shall be given a begin date of March 30.

5.5.5. After the start of health care delivery, the incoming contractor will assume responsibility for all enrollment transactions. If the outgoing contractor requires a retroactive change, they shall coordinate the request with the incoming contractor who will actually perform the change. The incoming contractor will notify the outgoing contractor when the action is complete. Both the incoming and the outgoing contractor will coordinate and

cooperate for required enrollment transactions in a timely manner during the transition period.

6.0. BENCHMARK TESTING

6.1. General Information

6.1.1. Prior to the start of health care delivery a new or incumbent contractor shall be required to demonstrate the ability of its staff and its automated claims processing system to accurately process TRICARE claims in accordance with current requirements. This will be accomplished through a comprehensive Benchmark Test. The Benchmark Test is administered by TMA.

6.1.2. A benchmark may consist of up to 1,000 network and non-network claims, testing a multitude of conditions. This benchmark may require up to 17 consecutive calendar days at the contractor's site.

6.1.2.1. A benchmark test is comprised of one or more cycles or batches of claims. When more than one cycle is used, each cycle may be submitted on consecutive days. Each cycle subsequent to the initial one will include new test claims, as well as claims not completed during preceding cycles, including suspended claims. All aspects of claims processing may be tested, e.g., receiving and sending electronic transactions, provider file development and maintenance including interface with the National Provider System when implemented, screening, coding, data entry, editing, pricing, data management, data linking, record building, access control, etc. The contractor must demonstrate its ability to execute claims processing functions to include: claims control and development, accessing and updating internal and external eligibility and enrollment data, accessing and updating DEERS for eligibility and enrollment status, calculating cost-shares and deductibles, querying and updating internal and external family and patient deductible and cost share files, querying and updating Deductible and catastrophic cap amounts on DEERS, submitting and modifying provider records, submitting and modifying pricing records, issuing referrals and authorizations, applying allowable charge parameters, performing duplicate checking, generating and applying authorization and enrollment data, applying prepayment utilization review criteria, adjusting previously processed claims, demonstrating recoupment and offset procedures and producing the required output for paper and electronic transactions as appropriate (EOBs, summary vouchers, payment records, checks, and management reports). Clerical functions will be evaluated including correctly coding diagnoses, medical and surgical procedures and accurately resolving edit exceptions. Health Care Finder, enrollment, and case management functions may also be included in the benchmark. In addition to testing claims processing functions, the benchmark test may include testing of any and all systems (internal and external) utilized by the contractor to process claims, produce encounter data, and update provider files. In addition to testing claims processing records the benchmark will test generation and acceptance of Health Care Service Records (HCSRs) for every test claim. Contractor compliance with applicable Health Insurance Portability and Accountability Act of 1996 requirements and security requirements will be included in benchmark tests as appropriate.

6.1.2.2. Incoming contractors are required to participate in Benchmark Testing. Generally, the test will be comprised of approximately 1,000 test claims. Benchmark test claims may be submitted to the contractor on paper or electronically. The contractor may be required to

create test claims, referrals and authorizations from test scenarios submitted prior to the Benchmark Test. Under certain circumstances, however, this number may be reduced at the discretion of the Contracting Officer. An example of circumstances that may warrant consideration by the Contracting Officer to reduce the number of benchmark test claims is when an existing TRICARE contractor is awarded an additional contract and the claims processing system proposed for the new contract is the same as the system used for the existing contract and the existing claims processing system has successfully passed a benchmark test within the previous 12 months. The 12 months will be calculated from the calendar month in which the previous benchmark test was performed.

6.1.2.3. A benchmark test of a current contractor’s system may be administered at any time by the TRICARE Management Activity (TMA) upon instructions by the Contracting Officer.

6.1.3. All contractor costs incurred to comply with the performance of the Benchmark test are the responsibility of the contractor.

6.2. Conducting The Benchmark

6.2.1. The Benchmark Team will be comprised of up to 12 people depending on the scope of the benchmark and the volume of claims to be tested.

6.2.2. The amount of time a contractor will have to process the benchmark test claims and provide all of the output (excluding HCSRs) to the Benchmark Team for evaluation will vary depending on the scope of the benchmark and volume of claims being tested. As a guide, the following table is provided for contractor planning purposes:

| NUMBER OF BENCHMARK CLAIMS/SCENARIOS | NUMBER OF DAYS TO COMPLETE PROCESSING |
|--------------------------------------|---------------------------------------|
| UP TO 100 | 1-2 |
| UP TO 500 | 2-4 |
| UP TO 1000 | 4-7 |

6.2.2.1. The contractor will be informed at the pre-benchmark meeting (see [paragraph 6.3.1.](#)) of the exact number of days to be allotted for processing the benchmark claims and test scenarios and providing all of the output (excluding HCSRs) to the Benchmark Team for evaluation.

6.2.2.2. When a weekend falls within the number of days allotted to complete claims processing and to provide all of the output for evaluation, the contractor will have the option of working the weekend days and having them count in the total number of days allotted to complete processing or not working the weekend and having the count resume on the following Monday. The decision as to whether a weekend will be worked shall be agreed upon at the pre-benchmark meeting.

6.2.3. The Benchmark Team will provide answers to all contractor’s written and telephonic development questions and will evaluate the contractor’s output against the benchmark’s test conditions.

6.2.4. The Benchmark Team will require a conference room that can be locked with a table(s) large enough to accommodate up to 12 people. A key to the conference room shall be provided to the Team Leader. The conference room must also be equipped with two telephones with access to internal and outside telephone lines.

6.2.5. The incoming contractor shall provide a complete, up-to-date Operations Manual, ADP Manual, Policy Manual and TRICARE Regulation, a complete set of current ICD-9-CM diagnostic coding manuals, the currently approved CPT-4 procedural coding manual, the most recent applicable drug pricing reference, in either hard copy or on-line, whichever is used by the contractor, explanations of the contractor's EOB message codes, edits, and denial reason codes, and any overlays required to evaluate EOBs, checks or summary vouchers.

6.2.6. The incoming contractor shall provide a minimum of three terminals in the conference room with on-line access to all internal and external systems used to process the benchmark test claims to include, but not limited to: provider files, including the contracted rate files for each provider; pricing files (area prevailing and CHAMPUS Maximum Allowable Charge pricing). DEERS; catastrophic cap and deductible files; authorization files; referral files; enrollment files; and any other files used in processing claims, authorizations, referrals, enrollments, etc. The contractor's requirements for issuing system passwords for members of the Benchmark Team will be discussed at the pre-benchmark meeting.

6.2.7. The contractor shall provide a stand alone Hewlett-Packard Laserjet or compatible (series IIID or later) laser printer with preferably four or more megabytes of memory but no less than two megabytes.

6.2.8. The contractor shall provide an organizational chart and personnel directory including telephone numbers. A listing of the contractor's staff involved in performing the benchmark by function (e.g., data entry, development, medical review, etc.) is also required. Claims flow/decision diagrams including authorizations and referrals, will be required prior to the benchmark test. These diagrams shall be discussed during the pre-benchmark meeting.

6.3. Procedures

6.3.1. Approximately 180 calendar days prior to the start of health care delivery, representatives from TMA will meet with the incoming contractor's staff to provide an overview of the benchmark test process, receive an overview of the claims processing system, collect data for use in the benchmark, and to discuss the dates of the test and information regarding the administration of the benchmark test. Note: The test must be completed NLT 120 calendar days prior to the start of health care delivery to allow time to make any needed corrections. At TMA's discretion, benchmark testing may be conducted in less than 120 calendar days prior to the start of health care delivery, but no less than 90 calendar days prior to health care delivery. The pre-benchmark meeting will be conducted at the incoming contractor's claims processing site. Provider and beneficiary data, to include enrollment forms, physician referrals, and authorizations will be coordinated at the pre-benchmark meeting to ensure that all files are adequately prepared by the contractor prior to the benchmark. Electronic transaction requirements shall be discussed to include timing and logistics.

6.3.2. On the first day of the benchmark test, a brief entrance conference will be held with contractor personnel to discuss the schedule of events, expectations and administrative instructions.

6.3.3. During the Benchmark Test the contractor will be required to process the claims and provide TMA with all output, including EOBs, summary vouchers, suspense reports, checks and relevant supporting reports such as system printouts, claims histories, procedure code listings, etc. Paper checks and EOBs may be printed on plain paper, with EOB and check overlays. Electronic output may be required for electronic transactions.

6.3.4. The contractor shall provide output to the Benchmark Team for evaluation as the claims are processed to completion. The specific schedule for claims processing and the procedures for providing the output to the Benchmark Team will be discussed with the contractor at the pre-benchmark meeting.

6.3.5. TMA will compare the contractor's output against the Benchmark Test conditions for each claim processed during the test.

6.3.6. During the course of the test, the Benchmark Team Leader may periodically brief key contractor staff on major findings. All appropriate contractor and Benchmark Team personnel will be present to answer any questions raised.

6.3.7. At the conclusion of the benchmark test an exit conference will be held with the contractor staff to brief the contractor on all findings identified during the benchmark. A draft report of the initial test results will be left with the contractor for review. The initial Benchmark Test report will be forwarded to the contractor by TMA within 45 days of the last day of the test.

6.3.8. Within seven days of the last day of the benchmark test, the contractor shall prepare and submit the initial HCSRs submission to the TMA, Operations/Advanced Technology Integration Center (O/ATIC) for evaluation. The contractor shall be notified of any HCSRs failing the TMA edits. The contractor shall make the necessary corrections and resubmit the HCSRs until 100% of the original benchmark test HCSRs have passed the edits and are accepted by TMA.

6.3.9. The contractor has 45 days from the date of the initial benchmark test report to submit to TMA the corrected claims and HCSRs. For any claims processing errors assessed with which the contractor disagrees, a written description of the disagreement along with any specific references must be included with the corrected claims.

6.3.10. While new HCSRs need not be generated to reflect changes created from claims processing corrections, all HCSRs originally submitted for the benchmark test claims which did not pass the TRICARE Management Activity (TMA) edits must continue to be corrected and resubmitted until all edit errors have been resolved and 100% of the HCSRs have been accepted by TMA.

6.4. Operational Aspects

6.4.1. The benchmark test may be conducted on the contractor's production system or an identical copy of the production system (test system). Whichever system is used for the

benchmark, it must meet all TRICARE requirements and contain all the features proposed for the production system in the contractor's proposal. For purposes of the benchmark test, all requirements in this section must be met.

6.4.2. When the benchmark test is conducted on the contractor's production system, the contractor must be available to prevent checks and EOBs from being mailed to the beneficiaries and providers, and to prevent production payment records from being generated and sent to TMA.

6.4.3. Certain external test systems (e.g., DEERS) are an integral component of the benchmark test and the contractor is expected to perform all necessary verifications, queries, etc. on DEERS according to TRICARE procedures and policy. The contractor shall access test files established for the benchmark test. The contractor shall coordinate through the TMA, Special Contract Operations Office, and the TMA ADP contractor to ensure that direct interface and linkage with any required external test systems (i.e., DEERS) is established and operational prior to the Benchmark Test.

6.4.4. HCSRs shall be generated from the benchmark test claims and provided to TMA for processing as scheduled at the pre-benchmark meeting. The contractor shall coordinate through the TMA, Special Contract Operations Office, for direct interface with the TMA, Operations/Advanced Technology Integration (O/ATIC), for HCSR submission procedures for the Benchmark Test claims.

7.0. DISCONTINUANCE OF MCS CONTRACTOR RETAIL PHARMACY PROGRAM

Effective with the start work date of the TRICARE Retail Pharmacy (TRRx) contract, the MCS contractor shall discontinue their retail pharmacy program.

7.1. Transitions Coordination Meeting

The MCS contractor shall provide for a meeting with representatives of the TRRx contractor and TMA for the purpose of developing a schedule of transition activities and establishing a Memorandum of Understanding with the TRRx contractor. TMA will notify the MCS contractor of the exact date of the meeting.

7.2. Phase-Out Plan

The MCS contractor shall submit to TMA a phase-out plan for all inventory types, staffing level requirements, and other resource needs for each operational pharmacy function by the 30th calendar day following the Transition Coordination Meeting. The plan shall incorporate all specifications of the official transition schedule.

7.3. Marketing Activity

The MCS contractor shall support TRRx marketing activities through its periodic newsletters to beneficiaries. The TRRx contractor will coordinate marketing updates with TMA, Communications & Customer Service Directorate (C&CS) and the MCS contractor through a Memorandum of Understanding not later than 90 calendar days prior to the start of the TRRx contractor's delivery of pharmaceutical services.

7.4. Phase-Out Of Claims

7.4.1. Upon termination of retail pharmacy services under the contract, the MCS contractor shall remain responsible for payment of all pharmacy network claims and adjustments for services incurred prior to the termination of delivery of retail pharmacy services for a period of 180 calendar days following the start of the TRRx contract. Network pharmacies shall submit adjustment requests within an appropriate time frame to allow the MCS contractor sufficient time to finalize all claims and adjustments prior to the 180 day limit. Payment or claims processing requirements related to the close-out of retail pharmacy services under the contract, including requirements for timely submission of claims for payment, shall be set forth in the contracted provider agreements. The MCS contractor shall complete all processing for pharmacy network claims and submit the necessary HCSRs to TMA within the 180 day limit.

7.4.2. Upon termination of retail pharmacy services under the MCS contract, the MCS contractor shall remain responsible, for a period of 90 calendar days, for the receipt and processing of beneficiary submitted claims and adjustments for services incurred prior to the termination of delivery of retail pharmacy services and for payment of all claims received within the three months following the start of retail pharmacy services under the TRRx contract. The same terms and conditions are applicable as when the contract was in full force and effect. For the purpose of this provision, the determination of whether a contractor is liable for payment for a service shall be based on the date the pharmaceutical was provided. All beneficiary submitted claims (paper claims) and adjustments received after the 90 day period following cessation of retail pharmacy services under the MCS contract will be forwarded to the TRRx contractor, irrespective of the incurred date of the services. The MCS contractor shall then have an additional 90 calendar days in which to process all claims to completion received through the ninetieth day.

7.4.3. At the end of the 90 days following cessation of retail pharmacy services of the MCS contractor, the MCS contractor and TMA shall, based on the most recent complete TMA historical claims log data, project the number of beneficiary submitted pharmacy claims and benefit dollars incurred, but not received by the 90th day following cessation of retail pharmacy services. The MCS contractor shall then remit to TMA a lump sum payment which shall include both the estimated benefit dollar amount and the estimated administrative claim processing costs. The administrative claims processing costs shall be negotiated. This payment shall be made to TMA within 120 calendar days following the completion of negotiations.

7.4.4. The MCS contractor shall also be liable, after the termination of services under this contract, for any payments to subcontractors of the contractor arising from events that took place during the period of this contract.

7.5. Provide Information

The MCS contractor shall, upon written request from TMA, provide to the TRRx contractor such items and data as required by TMA. This may include non-proprietary information, such as record formats and specifications, field descriptions and data elements, claims and correspondence volumes, etc.

7.6. Final Processing Of Retail Pharmacy Claims

The MCS contractor shall:

- Process all pharmacy claims and adjustments identified by the 90th day following cessation of the MCS contractor's retail pharmacy program. Processing of these claims shall be completed within 180 calendar days following the start of the TRRx contractor's services.
- Process all pharmacy correspondence, allowable charge complaints, and incoming telephonic inquiries which pertain to claims or services processed or delivered under this contract within the time frames established for response by the standards of the contract.
- Complete all pharmacy appeal/grievance cases which pertain to claims or services processed or delivered under this contract within the time frames established by the standards of the contract.

7.7. Correction Of Edit Rejects

The MCS contractor shall retain sufficient resources to ensure correction (and reprocessing through TMA) of all HCSR errors not later than 210 calendar days following the start of the TRRx contractor's pharmaceutical services.

7.8. Call Center

The MCS contractor shall complete a "hot" transfer to the TRRX contractor for all pharmacy inquiries received after their period of liability, not related to claims being processed by the MCS contractor.

