

Administration

VIII. TRANSITIONS

A. 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 (6) months is guaranteed for the transition.

1. Post-Award Conference

Within fifteen (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.

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 fifteen (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.

3. Phase-in Plan and Transition Schedule

Revisions to the draft *TMA* transition schedule will be forwarded to the contractors within ten (10) calendar days following the Transition Specifications Meeting. By the fifteenth (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.

4. DEERS Interface Meeting

The incoming contractor shall host a meeting for *TMA*, DEERS, and their technical personnel between the seventh (7th) and tenth (10th) 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 ninety (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 thirty (30) days prior to the start of health care delivery.

B. Start-Up Requirements

1. Systems Development

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

(1) Record and monitor enrollment under the *TRICARE* Prime option and, where appropriate; receive, safeguard and properly account for any required enrollment fees.

(2) Indicate Primary Care Manager assignment

(3) Operate the “health care finder” mechanism for authorizations, referrals, and other assigned functions

(4) Implement utilization review mechanisms and quality assurance programs

(5) Operate an approved claims processing system

(6) Operate required beneficiary and provider service functions.

(7) Satisfy management information systems requirements

b. Approximately thirty (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 *ADP Manual, Chapter 12, Section IX.*) This review is in addition to the Benchmark testing requirement of *Section VIII.E.* The contractor shall effect any modifications required by *TMA* prior to the initiation of services.

2. Execution of Agreements with Contract Providers

a. All contract provider agreements shall be executed *sixty (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*.

b. The contractor is required to report on a monthly basis during the transition and for the first six (6) 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 (10) calendar days following the last day of the reporting period and shall provide the following information:

(1) The number of network providers by specialty;

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(2) The number of network additions and deletions, by specialty;

(3) Activities undertaken to contract with additional providers in areas lacking adequate networks to meet the prescribed network standards; and

(4) A listing of PCMs, (both civilian and military) and the number of enrollees assigned to each PCM, by catchment area.

3. Execution of Memoranda of Understanding (MOU) with MTF Commanders

Sixty (60) 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 (10) calendar days following the execution of the MOU.

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 sixty (60) calendar days, but no later than **thirty (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 **thirty (30)** calendar days following the start of health care delivery, and within **ten (10)** calendar days following the close of each calendar month through the seventh (**7th**) 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:

a. 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

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

5. Phase-In Requirements Related to the Health Care Finder Function

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

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

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

6. Phase-In Requirements of the TRICARE Service Centers (TSCs)

a. The outgoing contractor shall vacate the TSCs on the fortieth (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.

b. The incoming contractor will occupy the TSCs beginning the thirty-ninth (39th) calendar day prior to the start of health care delivery. The TSCs will be fully operational thirty (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.

7. Phase-In Requirements Related to Transitional Cases

a. 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.

b. Transitional cases 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.

c. Reserved

d. For transitions involving both incoming and outgoing at-risk contractors, the following provisions apply:

(1) 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.

(2) If the facility is reimbursed on a per diem basis, the outgoing contractor is responsible for payment of all the institutional charges through the date of discharge or the end of the first month of health care delivery under the contract, whichever occurs first. (Exception: Network providers that would otherwise be reimbursed under DRGs.)

(3) 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.

(4) 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

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responsibility; however, the incoming contractor may utilize the authorization issued by the outgoing contractor as the basis for continued stay.

(5) 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.

8. Reserved

9. Phase-In of Claims Processing for the Outgoing Contractor's Remaining Claims

See [Section VIII.D.2.](#)

C. 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:

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 ([OPM Part One, Chapter 1, Section VIII.](#)) shall be fully trained and available for all duties no less than thirty (30) calendar days prior to initiation of health care services.

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 thirty (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 ([Section VIII.E.](#))

3. Receipt of Outgoing Contractor's Weekly Shipment of History Updates and Dual Operations

a. Beginning with the sixtieth (60) calendar day prior to the start of health care delivery and continuing for one hundred eighty (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 (2) 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 (2) 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.

b. During the one hundred eighty (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 sixty (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 sixty (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 *sixty (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. ADP System Documentation

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

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.

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 twentieth (20th) calendar day following "Notice of Award" by TMA through the one hundred eightieth (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.

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 forty-fifth (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 ninety (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

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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 ninety (90) calendar days following the start of health care delivery.

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.

9. Installation and Operation of the Automated TRICARE Duplicate Claims System

a. 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 sixty (60) days prior to the start of the health care delivery. See [ADP Manual, Chapter 11, Section 9](#), for hardware, software, printer, configuration and communications requirements and contractor installation responsibilities.

b. Approximately thirty to forty-five (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 [ADP Manual, Chapter 11, Section 9, paragraph 6.3.](#), Training, requirements.

c. 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.)

D. Phase-Out

1. General

a. 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:

(1) The data contained in the contractor's enrollment information system.

(2) The data contained in the contractor's claims processing systems.

(3) Information about the management of the contract that is not considered, under applicable Federal law, to be proprietary to the contractor.

b. Transitions Specifications Meeting

The outgoing contractor shall provide for a meeting with representatives of the incoming contractor and TMA within fifteen (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.

c. Phase-Out Plan

Revisions to the draft TMA transition schedule will be forwarded to the contractors within ten (10) 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 fifteenth (15th) calendar day following the Transition Specifications Meeting. The plan shall incorporate all specifications of the official transition schedule.

2. Phase-out of Claims

a. Upon termination of health care delivery services under the contract, the outgoing contractor shall remain responsible for payment of all network claims and adjustments for services incurred prior to the termination of delivery of health care services for a period of one hundred eighty (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 thirty (30) calendar days after discharge. Non-institutional claims for services rendered during the outgoing contractor's health care delivery period should be submitted within thirty (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 one hundred eighty (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.

b. Upon termination of health care delivery services under the contract, the outgoing at-risk contractor shall remain responsible, for a period of ninety (90) calendar days, for the receipt and processing of non-network claims 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 (3) months following the start of health care delivery under the new the 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

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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 ninety (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 ninety (90) calendar days in which to process all claims to completion received through the ninetieth day.

c. At the end of the ninety (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 ninetieth (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 thirty (30) calendar days following the calculation of incurred claims and benefit dollars.

d. 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.

e. For transitional case requirements, refer to [Section VIII.B.7.](#)

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.

a. 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.

b. 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 (3) 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:

- (1)** The TRICARE Provider Files
- (2)** The TRICARE Pricing Files
- (3)** The Beneficiary History and Deductible Files (Including Eligibility Files, if applicable)

(4) The Enrolled Beneficiary and Primary Care Manager Assignment Files.

c. Transfer of ADP Files (Magnetic Tapes)

The contractor shall prepare in magnetic tape format and transfer to the incoming contractor or TMA, by the fifteenth (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.

d. Transfer of ADP Files (Hard Copy)

The contractor shall transfer to the incoming contractor, in hard copy form, by the fifteenth (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.

e. 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 sixtieth (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 [Section VIII.C.3](#).

f. 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 the [OPM Part One, 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 the [OPM Part One, Chapter 2](#). The contractor shall provide samples and descriptions of these files to the incoming contractor at the Transition Specification Meeting.

g. 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 [OPM Part Two, Chapter 1, Section VI](#).)

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h. 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 twentieth (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.

i. Final Processing of Outgoing Contractor

The outgoing contractor shall:

(1) Process all claims and adjustments identified by the ninetieth (90th) day following cessation of the outgoing contractor's health care delivery. Processing of these claims shall be completed within one-hundred eighty (180) calendar days following the start of the incoming contractor's health care delivery.

(2) 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.

(3) 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.

j. 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 two hundred ten (210) calendar days following the start of the incoming contractor's health care delivery.

k. 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 [ADP Manual, Chapter 11](#) and transition plan requirements. (See [ADP Manual, Chapter 11, Addendum C](#) and [Addendum D](#), for Transitional Guides for transition requirements.)

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.

a. Within fifteen (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.

b. 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 (5) 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.

c. The outgoing contractor shall vacate the TRICARE Service Centers (TSCs) on the fortieth (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.

d. The outgoing contractor will terminate marketing and enrollment activity forty (40) calendar days prior to the start of the incoming contractor's health care delivery. Any enrollment requests or applications received after the fortieth (40th) day shall be transferred to the incoming contractor.

e. 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.

f. The outgoing contractor shall maintain toll-free lines, accessible to the public during the first ninety (90) calendar days of dual operations 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. Phase-Out of Enrollment Processing Activities and Transfer of Prorated Enrollment Fees

a. Phase--Out of Enrollment Processing Activities

(1) Prior to the start of health care delivery under the successor contract, for all enrollment renewals or quarterly payments in which the new enrollment period or period covered by the premium payment will begin under the new contract, the outgoing contractor shall amend renewal notices and billing statements (or include a stuffer/insert) to advise the enrollee to direct any enrollment-related correspondence and enrollment fee payments to the successor contractor.

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(2) Any enrollment-related correspondence and/or enrollment fee payments subsequently received by the outgoing contractor shall be forwarded to the incoming contractor within three (3) business days of receipt.

(3) The incoming contractor shall be responsible for sending enrollment renewal notices for all enrollees whose current enrollment period expires more than thirty days after the start of health care delivery under the successor contract and for quarterly billing statements where the premium payment would be due more than thirty days after the start of health care delivery.

(4) Throughout the transition period, the outgoing and incoming contractors shall coordinate enrollment files no less than weekly to ensure that new enrollments and enrollment renewals are accurately and timely reflected in the incoming contractor's enrollment files and in DEERS.

b. Transfer of Enrollment Fees

(1) No later than the first day of the month prior to the month of the start of health care delivery under the successor contract, the outgoing contractor shall transfer to the incoming contractor the prorated portion of the collected enrollment fees which corresponds to the portion of the enrollment periods occurring on or after the start of health care delivery under the successor contract.

(2) The enrollment fee amount to be transferred shall be calculated by prorating at a monthly level.

(3) The prorated enrollment fees which are transferred shall be accompanied by and in balance with a file identifying the individual and family enrollments to which the prorating has been applied, the date through which enrollment fees have been paid, the frequency of payment (annual or quarterly) and the ending date of the current enrollment period.

E. Instructions for Benchmark Testing

1. General Information

a. 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.

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

(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.

(2) Incoming contractors are required to participate in Benchmark Testing. Generally, the test will be comprised of approximately one thousand (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 twelve (12) months. The twelve (12) months will be calculated from the calendar month in which the previous benchmark test was performed.

(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.

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

2. Conducting the Benchmark

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

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b. 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

(1) The contractor will be informed at the pre-benchmark meeting (see [Section VIII.E.3.a.](#)) 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.

(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.

c. 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.

d. The Benchmark Team will require a conference room that can be locked with a table(s) large enough to accommodate up to twelve (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.

e. 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.

f. The incoming contractor shall provide a minimum of three (3) 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.

g. The contractor shall provide a stand alone Hewlett-Packard Laserjet or compatible (series IIID or later) laser printer with preferably four (4) or more megabytes of memory but no less than two (2) megabytes.

h. 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.

3. Procedures

a. Approximately one hundred and eighty (180) 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 one hundred and twenty (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 one hundred and twenty (120) 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.

b. 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.

c. 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.

d. 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.

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

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f. 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.

g. 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 forty-five (45) days of the last day of the test.

h. Within seven (7) 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 one hundred percent (100%) of the original benchmark test HCSRs have passed the edits and are accepted by TMA.

i. The contractor has forty-five (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.

j. 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 one hundred percent (100%) of the HCSRs have been accepted by TMA.

4. Operational Aspects

a. 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.

b. 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.

c. 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, Contractor Evaluation 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.

d. 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, Contractor Evaluation Office, for direct interface with the

TMA, Operations/Advanced Technology Integration (O/ATIC), for HCSR submission procedures for the Benchmark Test claims.

F. Discontinuance of MCS Contractor Mail Order Pharmacy Programs

Effective October 6, 1997, the Department of Defense began offering a National Mail Order Pharmacy (NMOP) service. The NMOP benefit is independent of and separate from all other TRICARE benefits and will not be administered by MCS contractors. The NMOP is a Preferred Agent Concept and the Preferred Agent List (formulary) can be found at www.dscp.dla.mil/medical/pharm/mcrx.htm. The DAPA pricing files may be accessed by using FTP software applications, and connecting to host: 131.86.13.234, user: mopftp, password: enter password, remote: \\dmlss\nmop. Passwords will be distributed to the MCS contractors through their CORs. The file names are MC0498.ldb and MC0498.mdb. The data base contains two tables in an MS Access format. The Primesum table contains DAPA and Government Depot pricing. The Secondsum table contain FSS and AWP (Average Wholesale Price) pricing.

1. Phase I

Upon notification by the contracting officer, MCS contractors shall discontinue any and all separate Mail Order Pharmacy operations which have previously existed in the Regions. The following paragraphs detail the activities which must be undertaken by the MCS contractor in support of the Department's transition to the NMOP program. Effective October 6, 1997, the Department of Defense began offering a National Mail Order Pharmacy (NMOP) service to:

- a.** Active duty beneficiaries,
- b.** TRICARE beneficiaries residing in Alaska and Puerto Rico;
- c.** Medical Treatment Facility (MTF) Prime enrollees (Note: these beneficiaries are eligible to use either the MCS mail order pharmacy or the NMOP);
- d.** Overseas TRICARE beneficiaries listed in DEERS (with APO or FPO addresses);
- e.** Base Realignment and Closure (BRAC) Medicare eligible beneficiaries in Regions 1, 2, & 5; Adak, AK; Ft. Chaffee, AR; Sierra Army Depot, CA; Naval Branch Clinic, Treasure Island, CA; Naval Branch Clinic, Alameda, CA; and
- f.** Regions 1, 2, & 5 MTF Primary Care Managed enrollees prior to the start of the managed care contract.

2. Phase II

At a future date as directed by the Contracting Officer, NMOP benefits will also be provided to:

- a.** BRAC Medicare eligible beneficiaries in Regions other than 1, 2, & 5; Adak, AK; Ft. Chaffee, AR; Sierra Army Depot, CA; Naval Branch Clinic, Treasure Island, CA; Naval Branch Clinic, Alameda, CA; and

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b. All beneficiaries now covered by managed care support (MCS) contractors (both enrolled and non-enrolled).

3. General

a. Public Notifications

(1) Upon notification by the contracting officer, the MCS contractor shall initiate action, using existing information dissemination mechanisms, to notify as many TRICARE beneficiaries as possible of the date for discontinuance of the contractor's mail order pharmacy and the name and address of the NMOP contractor.

(2) These notifications may include but are not limited to:

(a) Inclusion of notices in enrollee, HBA and other currently produced newsletters.

(b) Use of EOB "flash" messages or stuffers.

(c) Addition of messages on recordings played while incoming calls are on hold.

(d) Notices or flyers available to be picked up at the TSCs.

(e) Addition of messages on any existing automated bulletin boards or internet home pages.

(3) MCS contractors shall not undertake special mailings, install new systems or otherwise initiate new notification mechanisms which do not already exist, solely in support of this NMOP program public notification effort.

b. Data

The NMOP contractor will utilize only the claims payment history which accrues from their own processing. Therefore, the MCS contractor will not be required to provide to the NMOP contractor any information to facilitate transitions from the contractor's operations to operations under the NMOP contract.

4. Phase-out of Mail Order Pharmacy Operations

The Contracting Officer will notify MCS contractors of the implementation date of Phase II. The MCS contractor shall cease mail order pharmacy operations as of that date. Requests for refills received after the implementation date shall be returned to the beneficiary with direction to obtain a new prescription and send it to the NMOP contractor. Prescriptions received more than ninety (90) calendar days after the implementation date of Phase II shall be returned to the beneficiary with direction to send the prescription to the NMOP contractor. (Refer to [Figure 1-1-A-4](#) for sample notification letter.)

5. MCS Contractor Weekly Status Reporting

Upon direction of the Contracting Officer, and continuing until all pending claims for mail order pharmacy services have been processed to disposition, the

MCS contractor shall submit to TMA, Chief, Managed Care Support Office (MCSO), a weekly status report of mail order pharmacy prescription inventories.

6. Correction of Edit Rejects

The MCS contractor shall remain responsible for correction (and reprocessing through TMA) of all mail order pharmacy health care service record edit errors resulting from their processing of the initial claims.

7. Application of Catastrophic Loss Protection Provisions Under the NMOP

Until such time as the NMOP contractor has implemented an automated interface with the centralized repositories of catastrophic cap data (the CDCF, the MCS Contractors' Enrollment Year Catastrophic Cap files, or their successor files), they will process all claims and apply appropriate cost shares under an assumption that catastrophic cap thresholds have not been met. However, if a beneficiary specifically affirms to the NMOP contractor that the catastrophic cap thresholds have been met, the NMOP contractor will not apply deductibles or cost shares. Some beneficiaries may choose to provide documentation to the NMOP contractor, in the form of a EOB, to establish that the catastrophic cap has been met. MCS contractors shall comply with all beneficiary requests for copies of EOBs in support of this requirement.

8. Coordination of Benefits under the NMOP

The NMOP contractor will have no Other Health Insurance (OHI) coordination of benefit responsibilities other than an initial screening for a declaration that pharmacy coverage under OHI is or is not available. Beneficiaries who have pharmacy coverage under OHI will be required to utilize their other available pharmacy coverage and their prescriptions will be returned unfilled. TRICARE will remain available as second payer under applicable double coverage rules. When future DEERS upgrades permit access to OHI pharmacy coverage information, the NMOP contractor will be required to utilize that information in their processing.

9. Freedom of Choice and Availability of Benefits

Beneficiaries are not required to utilize the NMOP mechanism. At their discretion, they may continue to use TRICARE network or non-network retail pharmacy providers to the extent that they are permitted to do so under their existing TRICARE coverage. Similarly, if the drug which has been prescribed is not on the NMOP Preferred Agent List, the NMOP contractor will contact the prescribing physician to change the prescription to a preferred agent. If the prescriber cannot or will not change the prescription, it will still be filled. Overseas Prime enrollees listed as such on DEERS may utilize the NMOP program provided the pharmaceuticals are mailed to an address within the United States, including APO or FPO addresses.