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TRICARE
MANAGEMENT ACTIVITY

OD

CHANGE 132
6010.51-M
DECEMBER 22, 2011

**PUBLICATIONS SYSTEM CHANGE TRANSMITTAL
FOR
TRICARE OPERATIONS MANUAL (TOM), AUGUST 2002**

The TRICARE Management Activity has authorized the following addition(s)/revision(s).

CHANGE TITLE: ENROLLMENT ALLOTMENT PROCESS

CONREQ: 15368

PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): This change documents the process for contractors who collect enrollment fees through retired military pay allotments. Currently, contractors have individual agreements with Defense Finance and Accounting Service (DFAS) (and Public Health Service (PHS)/Coast Guard) for processing enrollment fee payments by allotment. Documenting the process in the Manuals eliminates the need for individual agreements; rather there will be one Memorandum of Understanding (MOU) between the TRICARE Management Activity (TMA) and DFAS with contractor requirements documented in the manuals. The process outlined in the Manual changes is essentially the same process that contractors are currently using to process allotment requests.

EFFECTIVE AND IMPLEMENTATION DATE: Upon direction of the Contracting Officer.

This change is made in conjunction with Aug 2002 TSM, Change No. 92.

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Director, Operations Division

ATTACHMENT(S): 28 PAGES
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there is additional overage, the overage shall be applied to the next policy period when the policy is established on DEERS (i.e., 45 days prior to the expiration of the current policy).

2.6.3. When all contracts have transitioned to TNEX, DEERS will perform a final consolidation of all split families. DEERS will provide the incoming contractors with reports of the beneficiaries who have been consolidated. If needed, the incoming MCSC shall communicate to beneficiaries whose policies have been consolidated and apply any overage of fees to the next fee obligation. The fee overage must be applied first to the existing policy period. If there is additional overage, the overage shall be applied to the next policy period when the policy is established on DEERS (i.e., 45 days prior to the expiration of the current policy).

2.6.4. The incoming contractor shall send enrollment renewal notices for all enrollees whose current enrollment period expires on or after the start of health care delivery. The incoming contractor shall send billing statements where the enrollment fee payment would be due on or after the start of health care delivery. The incoming contractor shall start sending billing notices and process renewals 45 days prior to the start of health care.

2.6.5. Outstanding enrollment record discrepancies and issues reported to the DEERS Support Office (DSO) by the outgoing contractor will be transferred to the incoming contractor for reconciliation. Records will be reconciled in accordance with TRICARE Systems Manual (*TSM*), [Chapter 3, Section 1.6](#).

2.7. Enrollment Fees

2.7.1. The incoming contractor shall obtain the cumulative total of enrollment fees and paid through dates for the policies from the outgoing MCSCs with the enrollment transition information. The contractor who collects the enrollment fee will retain the enrollment fee based on the start date of the enrollment. The incoming contractor shall resolve any discrepancies of cumulative enrollment fees and paid through dates with the outgoing contractor within 90 days of start of health care on policies inherited during the transition. The incoming contractor shall send the corrected fee information to DEERS using DOES or the batch fee interface outlined in the *TSM*, [Chapter 3](#).

2.7.2. *The incoming contractor shall coordinate the transition of allotment data, through TMA Purchased Care Systems Integration Branch (PCSIB) and/or the applicable TMA Program Office, with the Defense Finance and Accounting Service (DFAS), the Public Health System (PHS) and the U.S. Coast Guard (USCG) during the transition-in period of the contract (see the TSM, Chapter 1, Section 1.1).*

2.8. Phase-In Requirements Related To The Health Care Finder (HCF) Function

The hiring and training of HCF staff shall be completed no later than 40 calendar days prior to the start of health care delivery for TRICARE Prime in each Prime service area. HCF space will be occupied and all equipment and supplies in place not later than 40 calendar days prior to the start of health care delivery. The provider/beneficiary community shall be advised of the procedures for accessing the HCF function no later than 40 calendar days prior to the start of health care delivery.

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

2.9.1. In the event the incoming contractor will utilize the existing TSCs of the outgoing contractor, the outgoing contractor shall allow reasonable access to the incoming contractor throughout the Transition Period to install communication lines, equipment and other essential work to fully manage and operate the TSCs.

2.9.2. The final schedule for access to and occupancy of the TSCs will be determined at the Transition Specification Meeting. The approved schedule must allow the outgoing contractor to fulfill all contract requirements through the last day of health care delivery, and must provide the incoming contractor sufficient access to install equipment and train staff to undertake all required functions on the first day of health care delivery.

2.9.3. Acquisition Of Resources

All TSC and Field Representatives shall be fully trained and available for all duties no less than 40 calendar days prior to initiation of health care services.

2.10. 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:

2.10.1. 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) not later than 30 calendar days following receipt of the files from the outgoing contractor(s). All ADP file conversions shall be fully tested and operational for the Benchmark (see [paragraph 3.0.](#)). Integration testing will be conducted to validate the contractor's internal interfaces to each of the TRICARE MHS Systems. This testing will verify the contractor's system integration, functionality, and implementation process. The incoming contractor shall be responsible for the preparation and completion of Integration Testing prior to the start of Benchmark Testing.

TMA Test Managers will work with the contractor to plan, execute and evaluate the Integration Testing efforts. The contractor shall identify a primary and a back-up Testing Coordinator to work with the TMA Test Managers. The Testing Coordinator is responsible for contractor testing preparations, coordination of tests, identification of issues and their resolution, and verification of test results. A web application will be available for use by contractor Test Coordinators to report and track issues and problems identified during integration testing.

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

2.10.2.1. Beginning with the 120th calendar day prior to the start of health care delivery and continuing for 180 calendar days after the start of health care delivery, the incoming contractor shall convert the weekly shipments of the beneficiary history updates from the

outgoing contractor(s) within two work days following receipt. The incoming contractor shall load enrollment year catastrophic cap totals from the outgoing contractor within two working 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 workdays 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.

NOTE: As of October 1, 2003, a former spouse will be considered a sponsor in their own right and will no longer be identified by their previous relationship to a military service member. Former spouses will be identified by their own individual Social Security Number and not the SSN of the military service member. DMDC will provide contractors with a crosswalk file for former spouses previously identified by the military service member's SSN.

2.10.2.2. During the 180 calendar days after the start of health care delivery when both the incoming and outgoing contractors are processing claims, both contractors shall maintain close interface on history update exchanges and provider file information. During the first 60 calendar days of dual operations, the contractors shall 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 outgoing contractor shall have total responsibility for the maintenance of the Health Care Provider Record (HCPR) to support HCSR submission during the 180 day phase out period. The incoming contractor shall assume total responsibility for the maintenance of the TRICARE Encounter Provider Record (TEPRV) beginning with the start of health care delivery. The incoming contractor shall not rely on the outgoing contractor HCPR for creation of the TEPRV, but will create new TEPRVs for submission. The incoming contractor 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 changes in provider status that they become aware of through their operations.

2.10.3. Phase-In Requirements Related To Transitional Cases

In notifying beneficiaries of the transition to another contractor, both the incoming and outgoing contractors shall include instructions on how the beneficiary may obtain assistance with transitional care. If the outgoing contractor succeeds itself, costs related to each contract will be kept separate for purposes of contract accountability.

2.10.3.1. Non-Network Inpatient Transitional Cases

These are beneficiaries who are inpatients (occupying an inpatient bed) at 0001 hours on the first day of any health care contract period in which the incoming contractor begins health care delivery. In the case of DRG reimbursement, the outgoing contractor shall pay 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.

2.10.3.2. Non-Network Outpatient/Professional Transitional Cases

These are cases, such as obstetric care, that are billed and payable under “Global” billing provisions of CPT-4, HCPCS or local coding in use at the time of contract transition, and where an episode of care shall have commenced during the period of health care delivery of the outgoing contractor and continues, uninterrupted, after the start of health care delivery by the incoming contractor. Outpatient/Professional services related to transitional cases are 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.

2.10.3.3. Network Inpatient Care During Contract Transition

The status of a network provider changes (provider’s network agreement with the outgoing contractor is terminated resulting in the provider’s loss of network status) with the start of health care delivery of the new contract. As a result, claims for inpatient care shall be reimbursed in accordance with [paragraph 2.10.3.1.](#) for non-network transitional cases. Beneficiary copay is based on the date of admission; therefore, Prime beneficiaries who are inpatients as described in [paragraph 2.10.3.1.](#), shall continue to be subject to Prime network copayments and shall not be subject to Point-of-Service (POS) copayments.

2.10.3.4. Home Health Care (HHC) During Contract Transition

HHC, for a 60-day episode of care, initiated during the outgoing contractor’s health care delivery period and extending, uninterrupted, into the health care delivery period of the incoming contractor are considered to be transitional cases. Reimbursement for both the Request for Anticipated Payment (RAP) and the final claim shall be the responsibility of the outgoing contractor for the entire 60-day episodes covering the transition period from the outgoing to the incoming contractor.

2.10.4. Prior Authorizations And Referrals

The incoming contractor shall honor outstanding prior authorizations and referrals issued by the outgoing contractor, covering care through 60 days after the start of health care delivery under the incoming contract, in accordance with the outgoing contractors existing practices and protocols, within the scope of the TRICARE program and applicable regulations or statutes. In the case of RTC care, both the incoming and outgoing contractors are responsible for authorizing that part of the stay falling within their areas of responsibility; however, the incoming contractor may utilize the authorization issued by the outgoing contractor as the basis for continued stay.

2.10.5. 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).

2.10.6. Installation And Operation Of The Duplicate Claims System

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 [Chapter 9](#) and [10](#), for hardware, software, printer, configuration and communications requirements and contractor installation responsibilities. 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 [Chapter 9](#) and [10](#). 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 [Chapter 9](#) and [10](#) and the transition plan requirements.

2.11. Contractor Weekly Status Reporting

The incoming contractor shall submit a weekly status report of phase-in and operational activities and inventories to the TMA CO and COR 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.

2.12. 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 CO and the COR, and the TMA Marketing and Education Committee for approval not later than 90 calendar days prior to the start of each health care delivery period. The mailing shall discuss any unique processing requirements of the contractor and any other needed information dictated by the official transition schedule.

2.13. Web-Based Services And Applications

No later than 15 days prior to the start of health care delivery, the incoming contractor shall demonstrate to TMA successful implementation of all Web-based capabilities as described in the proposal.

2.14. TRICARE Handbook Mailing

No later than thirty days prior to the start of health care delivery, the MCS contractor shall mail one TRICARE Handbook to every residence in the region based off DEERS.

3.0. INSTRUCTIONS FOR BENCHMARK TESTING

3.1. General

3.1.1. Prior to the start of health care delivery, the incoming contractor shall demonstrate the ability of its staff and its automated enrollment, authorization and referral, and claims processing systems 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 the contractor under the oversight of TMA and must be completed NLT 60 days prior to the start of services delivery. In the event that an incumbent contractor succeeds itself, the extent of Benchmark testing may be reduced at the discretion of the TMA Contracting Officer.

3.1.2. A Benchmark Test shall consist of up to 1,000 network and non-network claims, testing a multitude of claim conditions including, but not limited to, TRICARE covered/non-covered services, participating/non-participating providers, certified/non-certified providers and eligible/non-eligible beneficiaries. This Benchmark Test will require a TMA presence at the contractor's site.

3.1.3. 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 after the initial one will include new test claims, as well as claims not completed during preceding cycles. 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.

3.1.4. The contractor shall demonstrate its ability to conduct enrollment, authorization and referral, and claims processing functions to include: claims control and development, accessing and updating internal and external enrollment data, accessing and updating DEERS for eligibility status, calculating cost-shares and deductibles, querying and updating internal and external family and patient deductible and cost share files on the CCDD, submitting and modifying provider and pricing records, issuing referrals and authorizations, applying allowable charge parameters, performing duplicate checking, applying prepayment utilization review criteria, adjusting previously processed claims, demonstrating recoupment and offset procedures and producing the required output for paper and electronic transactions (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. Enrollment and case management functions may also be included in the benchmark. The Benchmark Test may include testing of any and all systems (internal and external) used by the contractor to process claims. In addition to testing claims processing records, the Benchmark will test generation and acceptance of TRICARE Encounter Data (TED) records 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.

3.1.5. The Benchmark Test will be comprised of both paper and electronic claims. The contractor shall be required to create test claims, including referrals and authorizations from

test scenarios provided to the incoming contractor by TMA. The contractor shall supplement these test scenarios with any internal conditions they feel appropriate for testing to ensure a minimum of 1,000 claims are tested. Under certain circumstances, however, this number may be reduced at the discretion of the Contracting Officer.

3.1.6. A Benchmark Test of a current contractor’s system may be administered at any time by TMA upon instructions by the Contracting Officer. All contractor costs incurred to comply with the performance of the Benchmark Test are the responsibility of the contractor.

3.2. Conducting The Benchmark

3.2.1. At the time of the scheduled Benchmark Test a TMA Benchmark Team comprised of up to 12 people will arrive at the contractor’s work site to conduct the testing and evaluate the Benchmark Test results.

3.2.2. The amount of time a contractor shall have to process the Benchmark Test claims and provide all of the output (excluding TEDs) 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

3.2.3. The contractor will be informed at the pre-benchmark meeting (see [paragraph 3.3.1.](#)) of the exact number of days to be allotted for processing the Benchmark claims and test scenarios and providing all of the output (excluding TEDs) to the Benchmark Team for evaluation.

3.2.4. The Benchmark Team will provide answers to all contractors written and telephonic development questions related to the test scenarios provided by TMA and will evaluate the contractor’s output against the Benchmark Test conditions.

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

3.2.6. The incoming contractor shall provide up-to-date copies of the TRICARE Operations Manual (*TOM*), *TSM*, TRICARE Policy Manual (*TPM*), and TRICARE Reimbursement Manual (*TRM*), a complete set of current ICD- 9-CM diagnostic coding manuals, the currently approved CPT-4 procedural coding manual, 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.

3.2.7. The incoming contractor shall provide an appropriate printer and a minimum of three computer 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 (TEPRVs), including the contracted rate files for each provider; pricing files (TEPRCs) (area prevailing and CHAMPUS Maximum Allowable Charge pricing) DEERS; catastrophic cap and deductible 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.

3.2.8. 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 Test by function (e.g. data entry, development, medical review, etc.) is also required. Claims flow/decision diagrams including authorization and referral requirements will be provided prior to the Benchmark Test.

3.3. Procedures

3.3.1. Approximately 60 calendar days following award to the contractor, 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 discuss the dates of the test and information regarding the administration of the Benchmark Test. At this time, TMA will provide the test scenarios to the contractor that are to be used in the development of their test claims.

NOTE: At TMA's discretion, the test must be completed NLT 60 days prior to the start of health care delivery to allow time to make any needed corrections. 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 the contractor adequately prepares all files prior to the Benchmark. Electronic transaction requirements shall be discussed to include timing and logistics.

3.3.2. 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.

3.3.3. During the Benchmark Test the contractor shall process the claims and provide TMA with all output, including EOBs, summary vouchers, suspense reports, checks, claims histories, etc. Paper checks and EOBs may be printed on plain paper, with EOB and check overlays. Electronic output is required for electronic transactions.

3.3.4. The contractor shall provide output for evaluation by the TMA Benchmark Team 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.

3.3.5. TMA personnel will compare the Benchmark Test claim output against the benchmark test conditions for each claim processed during the test and provide the findings to contractor personnel. All appropriate contractor and Benchmark Team personnel shall be present to answer any questions raised during the Benchmark Test claims review.

3.3.6. At the conclusion of the Benchmark Test, an exit conference may 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 calendar days of the last day of the test. 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 claims. The contractor's response to the Initial Benchmark Test Report shall be submitted to the TMA CO within 30 calendar days following the contractor's response. TMA shall provide the Final Benchmark Test Report to the contractor within 30 calendar days.

3.3.7. The contractor shall prepare and submit the initial TRICARE Encounter Data (TEDs) submission to TMA for evaluation during the Benchmark Test. A TED record shall be prepared for each Benchmark claim processed to completion, whether allowed or denied, within two calendar days from the processed date. TED records will not be created for claims removed from the contractor's processing system, i.e., out of jurisdiction transfers. The contractor shall be notified of any TEDs failing the TMA edits. The contractor shall make the necessary corrections and resubmit the TEDs until 100% of the original Benchmark Test TEDs have passed the edits and are accepted by TMA. TEDs submission files related to the Benchmark Tests must be identified by transmission file and batch/voucher numbers prior to submission to TMA.

3.3.8. The contractor has 45 calendar days from the date of the initial Benchmark Test report to submit the final corrected TEDs to TMA. New TEDs need not be generated to reflect changes created from claims processing corrections, however, all TEDs originally submitted for the Benchmark Test claims which did not pass the TMA edits must continue to be corrected and resubmitted until all edit errors have been resolved and 100% of the TEDs have been accepted by TMA. TEDs submission files related to the Benchmark Tests must be identified by transmission file and batch/voucher numbers prior to submission to TMA.

3.4. Operational Aspects

3.4.1. 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 system interconnections and features proposed for the production system in the contractor's proposal. When the Benchmark Test is conducted on the contractor's production system, the contractor shall prevent checks and EOBs from being mailed to the beneficiaries and providers, and prevent production TEDs from being generated and sent to TMA.

3.4.2. Certain external test systems and files (e.g., DEERS) are an integral component of the Benchmark Test and the contractor is expected to perform all necessary verifications, queries, etc., according to TRICARE procedures and policy. The contractor shall coordinate through the TMA, Contract Operations Branch, and the TMA IT contractor to ensure that

direct interface with any required external test systems (i.e., DEERS) is established and operational prior to the Benchmark Test.

3.4.3. TEDs 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 with the TMA, Operations/Advanced Technology Integration (O/ATIC), for TED submission procedures.

4.0. CONTRACT PHASE-OUT

4.1. Transitions Specifications Meeting

The outgoing contractor shall attend a meeting with representatives of the incoming contractor and TMA at the TMA office in Aurora, CO, within 15 calendar days following contract award. This meeting is for the purpose of developing a schedule of phase-out/phase-in activities. TMA will notify the contractor as to the exact date of the meeting. The outgoing contractor shall provide a proposed phase-out plan at the Transition Specifications Meeting.

4.2. 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.

4.3. 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.

4.3.1. Provide Information

The contractor shall, upon receipt of written request from TMA, provide to potential offerors such items and data as 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.

4.3.2. Transfer of Electronic 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, electronic copies of 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 (TEPRVs).
- The TRICARE Pricing Files (TEPRCs).
- The Enrolled Beneficiary and Primary Care Manager Assignment Files.
- 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 mental health unit, the unit would be identified as the provider under the TRICARE inpatient mental health per diem payment system.

4.3.3. Transfer Of ADP Files (Electronic)

The outgoing contractor shall prepare in electronic 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, such as the Provider and Pricing files, in accordance with specifications in the official transition schedule and will continue to participate in preparation and testing of these files until they are fully readable by the incoming contractor or TMA.

4.3.4. Outgoing Contractor Weekly Shipment Of History Updates

The outgoing contractor shall transfer to the incoming contractor, in electronic 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 120th calendar day prior to the start of health care delivery (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 2.10.2](#).

4.3.5. Transfer Of Non-ADP Files

The outgoing contractor shall transfer to the incoming contractor all non-ADP files (e.g., authorization files, clinic billing authorizations, and tapes/CDs, etc. which identify Prime service areas, 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.

4.3.6. 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 electronic 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.

4.3.7. 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 the Specifications Meeting until otherwise notified by the Contracting Officer to discontinue. This shall be done in accordance with specifications of the official transition schedule.

4.4. Final Processing Of Outgoing Contractor

The outgoing contractor shall:

- Process all claims and adjustments for care rendered prior to the start of health care delivery of the new contract that are received through the 120th 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. All claims shall meet the same standards as outlined in the outgoing contract. Any residual claim received after 120 days shall be forwarded to the incoming contractor within 24 hours of receipt.
- 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.
- Refer to [paragraph 2.10.3.](#), for transitional case requirements.
- 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 and grievance cases that pertain to claims or services processed or delivered under this contract within the time frames established for response by the standards of the contract.

4.4.1. Correction Of Edit Rejects

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

4.4.2. 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 [Chapters 9](#) and [10](#) and transition plan requirements.

4.4.3. Phase-Out Of The Contractor's Provider Network, TSCs, And MTF Agreements

4.4.3.1. 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.

4.4.3.2. Within 15 calendar days of the Transitions Specifications Meeting the outgoing contractor shall draft and submit a revised 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.

4.4.3.3. 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 HCF function to continue through the last date of health care delivery under the current contract, 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.

4.4.3.4. The outgoing contractor shall 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 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.

4.4.3.5. The outgoing contractor shall maintain toll-free lines and Web-based customer service capabilities, accessible to the public during the first 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 shall 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.

4.5. Phase-Out Of Enrollment Activities

4.5.1. Prior to the start of health care delivery under the successor contract, for all enrollment renewals or 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.

4.5.2. 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. The software version should be loaded and used for the phase-out of enrollment activities.

4.5.2.1. Enrollment Actions During 45-Day Transition Period

4.5.2.2. For new enrollments in the Region with an effective date prior to the start of health care delivery (e.g., AD enrollment, mid-month enrollment; transfer-in, etc.), the outgoing contractor must effect an enrollment action with an end date of the current contract period (i.e., one day prior to the start of health care delivery under the incoming contract). Any enrollment fees due for an effective date that is prior to the start of health care delivery will be retained by the outgoing contractor. Once the enrollment is effected, the outgoing contractor will notify the incoming contractor of the new enrollment.

4.5.2.3. When a current enrollment in the Region requires deletion with an effective date prior to the start of health care delivery (e.g., transfers out; disenrollments for failure to pay fees; cancellations, etc.), the outgoing contractor must request the incoming contractor to cancel the future enrollment segment that was included on the Gold File. Once notified by the incoming contractor that the segment has been cancelled, the outgoing contractor completes the appropriate disenrollment action.

4.5.2.4. For all other enrollment actions with an effective date prior to start of health care delivery (e.g., PCM changes; DMIS ID changes; enrollment begin date changes; etc.), the outgoing contractor must request the incoming contractor cancel the future enrollment segment. Once notified that the cancellation has been completed, the outgoing contractor will make the necessary change. Upon completion of the change, the outgoing contractor must notify the incoming contractor so that the future enrollment segment can be restored.

4.5.2.5. The outgoing contractor should complete all pending enrollment actions prior to the DEERS freeze to transition enrollment. Any enrollment action not completed by the

outgoing contractor prior to the freeze (and after the Gold File is created) will have to be accomplished following the above procedures.

4.5.2.6. Once health care delivery begins, all enrollment actions will be accomplished by the incoming contractor. If the outgoing contractor requires a retroactive change, they must submit their request to the incoming contractor who will perform the change and notify the outgoing contractor when it is complete.

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

4.5.4. The outgoing contractor shall terminate marketing and enrollment activity 40 calendar days prior to the start of the incoming contractor's health care delivery. Any enrollment requests or applications received after the 40th calendar day shall be transferred to the incoming contractor by overnight delivery at the outgoing contractor's expense.

4.5.5. 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.

4.6. Cost Accounting

If the outgoing contractor succeeds itself, costs related to each contract shall be kept separate for purposes of contract accountability, according to the above guidelines.

4.7. Records Disposition

The outgoing contractor shall comply with the provisions of [Chapter 2](#), in final disposition of all files and documentation. The contractor shall include a records disposition plan as part of the phase-out plan submitted to TMA at the Transition Specification Meeting.

expiration and renewal of the TRICARE Prime enrollment, and a bill for the enrollment fee, if applicable (since ADSMs must be enrolled but their family members need not be, there is no action required if an ADSM does not have enrolled family members). The bill shall offer the various payment options: annual, quarterly or monthly. The contractor shall issue a delinquency notice to the appropriate individual 15 calendar days after the expiration date. The contractor shall automatically renew enrollments upon expiration unless the enrollee declines renewal, is no longer eligible for Prime enrollment, or fails to pay the enrollment fee on a timely basis, including any grace period allowed. The contractor shall allow a 30 calendar day grace period beginning the first day following the last day of the enrollment period. If the enrollee requests disenrollment during this grace period, the contractor shall disenroll the beneficiary effective retroactive to the enrollment period expiration date. The contractor may pend claims during the grace period to avoid the need to recoup overpayments. If an enrollee does not respond to the re-enrollment notification and fails to make an enrollment fee payment by the end of the grace period, the contractor is to assume that the enrollee has declined re-enrollment. The contractor shall disenroll the beneficiary retroactive to the enrollment expiration date. DMDC sends written notification to the beneficiary of the disenrollment and the reason for the disenrollment within five business days of the disenrollment transaction.

7.3. Disenrollment

The contractor shall automatically disenroll beneficiaries when an enrollment fee payment, either the entire annual amount or an installment payment, is not received by the 30th calendar day following the annual expiration date or the due date for the installment payment. After the 30th calendar day, the contractor shall disenroll the beneficiaries with a disenrollment effective date retroactive to the annual renewal date or the payment due date, whichever applies. Prior to processing a disenrollment with a reason of "non-payment of fees," the MCSC or Uniformed Services Family Health Plan (USFHP) provider must reconcile their fee payment system against the fee totals in DEERS. Once the MCSC confirms that the payment amounts match, the disenrollment may be entered in DOES. The disenrolled beneficiary will be responsible for the deductible and cost-shares applicable under TRICARE Extra or Standard (depending on the provider's status) for any health care received during the 30 day grace period. In addition, the beneficiary shall be responsible for the cost of any services received during the 30 day grace period that may have been covered under TRICARE Prime but are not a benefit under TRICARE Extra or Standard, e.g., preventive care.

7.4. Enrollment Lockout

7.4.1. The contractor shall "lockout" or deny re-enrollment for a period of 12 months from the effective date of disenrollment for the following beneficiaries:

- Retirees and/or their family members who voluntarily disenroll prior to their annual enrollment renewal date;
- ADFMs (E-5 and above) who change their enrollment status (i.e., from enrolled to disenrolled or vice versa) more than twice in an enrollment year (October 1 to September 30) for any reason (refer to this chapter and the TPM, [Chapter 10, Section 2.1](#) and [3.1](#)); and

- Any beneficiary disenrolled for failure to pay required enrollment fees during a period of enrollment.

NOTE: The 12 month lockout provision does not apply to ADFMs whose sponsor's pay grade is E-1 through E-4.

7.4.2. Beneficiaries who decline re-enrollment during their annual renewal period are not subject to the 12 month enrollment lockout. At the end of an annual enrollment period, if the beneficiary declines to continue their enrollment and subsequently requests re-enrollment, a new enrollment form is required and the contractor shall process the request as a "new" enrollment. (If an enrollee did not respond to a re-enrollment notification and failed to make an enrollment fee payment by the end of the grace period, the contractor is to assume that the enrollee declined re-enrollment.)

7.4.3. The contractor shall not grant waivers to the 12 month lockout provision. TRICARE Regional Office (TRO) Directors may grant waivers to the lockout provisions in extraordinary circumstances.

8.0. ENROLLMENT FEES

8.1. General

The contractor shall collect the enrollment fee payment from the TRICARE Prime enrollee, and report enrollment fees to DEERS (see the TSM, [Chapter 3](#)). The Prime enrollee shall select one of the three payment fee options on the Prime Enrollment Application Form:

8.1.1. Annual Payment Fee Option

Annual installment will be collected in one lump sum. For initial enrollments and re-enrollments that are not yet aligned to the fiscal year, the contractor shall prorate the fee from the enrollment date to September 30. The contractor shall accept payment of the annual enrollment fee by personal check, cashier's check, traveler's check, money order or credit card (e.g., Visa/MasterCard).

8.1.2. Quarterly Payment Fee Option

Quarterly installments are equal to one-fourth ($\frac{1}{4}$) of the total annual fee amount. For initial enrollments and re-enrollments that are not yet aligned to the fiscal year, the contractor shall prorate the quarterly fee to covering the period until the next fiscal year quarter (e.g., January 1, April 1, July 1, October 1) and collect quarterly fees thereafter through September 30. The contractor shall accept payment of the quarterly enrollment fee by personal check, cashier's check, traveler's check, money order or credit card (e.g., Visa/MasterCard).

8.1.3. Monthly Payment Fee Option

Monthly installments are equal to one-twelfth ($\frac{1}{12}$) of the total annual fee amount. Monthly enrollment fees must be paid through an allotment from retirement pay or through Electronic Funds Transfer (EFT) from the enrollee's designated financial institution.

8.1.3.1. Enrollees who elect the monthly fee payment option must pay the first quarter installment (first three months) at the time the enrollment application is submitted to allow time for the allotment or EFT to be established. The contractor shall accept payment of the first quarterly installment by personal check, cashier's check, traveler's check, money order or credit card (e.g., Visa/MasterCard).

8.1.3.2. The contractor shall be responsible for verifying the information necessary to initiate monthly allotments and EFTs.

8.1.3.3. The contractor shall direct bill the beneficiary only when a problem occurs in initially setting up the allotment or EFT. In the event that there are insufficient funds to process a monthly EFT, the contractor may assess the account holder a fee of up to 20 U.S. dollars.

8.1.3.4. *Allotments from retired pay will be coordinated through the contractor with the Defense Finance and Accounting Service (DFAS), U.S. Coast Guard (USCG), or Public Health Service (PHS), as appropriate (see the TSM, Chapter 1, Section 1.1, paragraph 8.10. for Payroll Allotment Interface Requirements). The contractor shall process all allotment requests submitted by beneficiaries.*

8.1.3.5. *The contractor shall also research all requests that have been rejected or not processed by DFAS, USCG, or PHS. If the contractor's research results in the positive application of the allotment action, the contractor shall resubmit the allotment request.*

8.1.3.6. *Within five business days, the contractor will notify the beneficiary of rejected allotment requests and issue an invoice to the beneficiary for any outstanding enrollment fees due. The contractor will respond to all beneficiary inquiries regarding allotments.*

NOTE: During the enrollment year to fiscal year alignment process, (which occurs upon an initial enrollment or upon the first re-enrollment performed by the MCSC) enrollment fees will be prorated to the end of the current fiscal year (September 30th). The next enrollment period will begin on October 1st. At that point, the enrollment year is considered aligned with the fiscal year.

8.2. Member Category

The sponsor's member category on the effective date of the initial enrollment, as displayed in DOES, shall determine the requirement for an enrollment fee.

NOTE: Unremarried former spouses became sponsors in their own right as of October 1, 2003. However, although sponsors in their own right, they cannot "sponsor" any family members, including children. Enrolled unremarried former spouses must pay an annual individual enrollment fee. Children of unremarried former spouses residing with the unremarried former spouse, and whose eligibility for benefits is based on the ex-spouse (former sponsor) are identified under the ex-spouse's (former sponsor's) on DEERS and the enrollment record for the ex-spouse. A family enrollment fee must be collected and applied under the ex-spouse (former sponsor's) enrollment, in addition to the individual enrollment fee collected for the unremarried former spouse's enrollment fee. For example, a contractor will collect the annual enrollment fee for an unremarried former spouse, now a sponsor in their own right. The contractor will also collect an annual family enrollment fee for the

eligible (as determined by the status of the ex-spouse [former and original sponsor] and not the unremarried former spouse) children living with the unremarried former spouse.

8.3. Overpayment Of Enrollment Fees

If enrollment fees are overpaid during the payment of installments during an enrollment year, MCS contractors can maintain a credit of those fees and apply the credit to any outstanding payments due. If credits of the overpayment of enrollment fees are not maintained, MCS contractors are required to refund any overpayments of \$1 or more. When TRICARE Prime enrollment changes from an individual to a family prior to annual renewal, the unused portion of the enrollment fee will be prorated on a monthly basis and shall be applied toward a new enrollment period.

8.4. Medicare Part B - Fee Waiver

Each Prime enrolled beneficiary under age 65, who maintains enrollment in Medicare Part B, is entitled to a \$230 waiver of their TRICARE Prime enrollment fee.

8.4.1. Each Prime enrolled beneficiary under age 65, who maintains enrollment in Medicare Part B, with a single enrollment will have no enrollment fee.

8.4.2. For a family enrollment in TRICARE Prime, where one family member is under age 65 and maintains enrollment in Medicare Part B, \$230 of the \$460 family enrollment fee is waived and the remaining \$230 must be paid. The \$230 enrollment fee shall be collected in accordance with the payment method selected on the enrollment form.

For a family enrollment in TRICARE Prime, where two or more family members are under age 65 and maintain enrollment in Medicare Part B, the \$460 family enrollment fee is waived regardless of the number of family members that are not entitled to Medicare Part B.

8.5. Mid-Month Enrollees

The contractor shall collect any applicable enrollment fee from the mid-month enrollee at the time of enrollment; however there will be no additional enrollment fee collected for the days between the effective enrollment date and the determined enrollment date. The determined enrollment date shall be determined using the existing 20th day of the month rule (e.g., A member submits a request to remain in Prime prior to his retirement date which is May 15th. The effective enrollment date will be May 15th and the determined enrollment date will be June 1st. If the retirement date is May 27th, the effective enrollment date will be May 27th and the determined enrollment date will be July 1st). Reference the TPM, [Chapter 10, Section 3.1](#).

9.0. ENROLLMENT/NETWORK PROVIDER TYPE ASSIGNMENT DURING IN-PROCESSING

9.1. The MCSCs shall provide a process to enroll eligible beneficiaries into TRICARE programs using the TRICARE enrollment form. All TRICARE enrollments shall be performed through the government furnished DEERS application. Enrollment will include

designation of a Primary Care Location in accordance with MTF MOUs. The Network Provider Type assignment shall be accomplished based on utilizing a MOU, to be developed between each MTF within their region, appropriate RD and the MCSC, to prescribe the Primary Care Location assignment business rules. Family members of active duty E-1 through E-4 who reside within the PSA of a MTF and who are not already enrolled in TRICARE Prime should be encouraged to enroll upon in-processing or when otherwise identified as a candidate for enrollment in accordance with the provisions of [paragraph 10.0](#).

9.2. The MCSCs shall administer the TRICARE enrollment form, verify accuracy of information and initiate the enrollment process through the DEERS enrollment application.

9.2.1. The equipment needed to run the DEERS desktop enrollment application shall be furnished by the MCSC and shall meet technical specifications in the TSM, [Chapter 3](#).

9.3. The MCSC representative will provide a current Primary Care Location listing to the enrollee during enrollment processing, and will provide guidance to the enrollee related to Primary Care Location selection. The MCSC representative will assign enrollees to Primary Care Locations until maximum capacity is reached. In accordance with approved MTF MOUs, the MTF will provide a listing of Primary Care Locations with associated groups.

9.4. The Defense Manpower Data Center (DMDC) will centrally print the Universal TRICARE Beneficiary Card generated from DMDC/DEERS enrollment data on a regular basis at the intervals and events required under current contract requirements. DMDC will centrally mail all Universal TRICARE Beneficiary Cards directly to the enrollee at the residential mailing address specified on the enrollment application. The return address on the envelope mailed by DMDC will be that of the respective MCS contractor. In the case of receiving returned mail, the MCSC shall develop a process to fulfill the delivery of the Universal TRICARE Beneficiary Card to the enrollee.

10.0. ENROLLMENT OF FAMILY MEMBERS OF E-1 THROUGH E-4

10.1. Section 712 of the National Defense Authorization Act (NDAA) for Fiscal Year (FY) 1999 modified Chapter 55 of Title 10, United States Code (USC) by adding a new section 1079a which provides for TRICARE Prime enrollment for active duty families of E-1 through E-4 in certain circumstances.

10.2. When family members of E-1 through E-4 reside in a PSA of a military medical treatment facility offering TRICARE Prime, the family members will be encouraged to enroll in TRICARE Prime. Upon enrollment, they will choose or be assigned a PCM located in the military medical treatment facility. Such family members may, however, specifically decline such enrollment without adverse consequences. The choice of whether to enroll in TRICARE Prime, or to decline enrollment is completely voluntary. Family members of E-1 through E-4 who decline enrollment or who enroll in Prime and subsequently disenroll may re-enroll at any time.

10.3. Enrollment processing and allowance of civilian PCM assignments will be in accordance with the MOU between the contractor and the MTF. The completion of an enrollment application is a prerequisite for enrollment of such family members.

10.4. The primary means of identification and subsequent referral for enrollment will occur during in-processing. These non-enrolled families may also be referred to the local TSC by the MTF, Commanders, First Sergeants/Sergeants Major, supervisors, Family Support Centers et. al.

10.5. The local TSC will provide enrollment information and support the family member in making an enrollment decision (i.e., to enroll in TRICARE Prime or to decline enrollment). The contractor shall inform the family members of the benefits and opportunities that accompany Prime enrollment and will give them the opportunity to select or be assigned an MTF PCM, select a civilian PCM if permitted by applicable MOU, or to decline enrollment in TRICARE Prime. The effective date of enrollment shall be determined by the actual date of the enrollment application and consistent with current TRICARE rules (i.e., the “20th of the month” rule, as applied under the current contract arrangements).

10.6. The education of such potential enrollees shall specifically address the advantages of TRICARE Prime enrollment (e.g., guaranteed access, the support of a PCM, etc.), shall reinforce that enrollment is at no cost for family members of E-1 through E-4, and shall discuss the potential effective date of the enrollment, explaining that the actual effective date will depend upon the date the enrollment application is received, consistent with current TRICARE rules (i.e., the “20th of the month” rule, as applied under the current contract arrangements).

10.7. Eligibility effective dates will be assigned consistently with all other TRICARE Prime enrollment policies, i.e., enrollments received on or before the 20th day of the month will become effective on the first day of the following month, etc. These enrollments and enrollment refusals should not be tracked, or the enrollees identified differently than enrollments initiated through any other process, such as the MCSC’s own marketing efforts.

10.8. Enrollment may be terminated at any time upon request of the enrollee, sponsor or other party as appropriate under existing enrollment/disenrollment procedures.

10.9. Contractors are not required to screen every TRICARE claim on an automated basis to determine whether it may be for treatment of a non-enrolled ADFM of E-1 through E-4, living in a PSA. Rather, they are to support the prompt and informed enrollment of such individuals when they have been identified by DoD in the course of such a person’s interaction with the military health care system or personnel community, and have been referred to the contractor for enrollment.

11.0. TRICARE ELIGIBILITY CHANGES

11.1. Refer to the TPM, [Chapter 10, Section 3.1](#) for information on changes in eligibility. The contractor shall allow a TRICARE-eligible beneficiary who has less than 12 months of eligibility remaining (for example, a retiree or a family member who is 64 years of age, a TAMP beneficiary, etc.) to enroll in TRICARE Prime until such time as the enrollee loses his/her TRICARE eligibility. The enrollment transaction to DEERS shall reflect the end date of enrollment to be the same as the end date of eligibility on DEERS. The beneficiary shall have the choice of paying the entire enrollment fee or paying the fees on a more frequent basis (e.g., monthly or quarterly), as allowable under current instructions. If the enrollee chooses to

pay by installments, the contractor shall collect only those installments required to cover the period of eligibility.

11.2. Contractors shall reimburse the unused portion of the TRICARE Prime enrollment fee to retired TRICARE Prime enrollees (and their families) who have been recalled to active duty and report such credits to DEERS. Contractors shall calculate the reimbursement using monthly prorating as defined in [Appendix A](#). If the reactivated member's family chooses continued enrollment in TRICARE Prime, the family shall begin a new enrollment period and shall be offered the opportunity to keep its PCM, if possible. Any enrollment/fiscal year catastrophic cap accumulations shall be applied to the new enrollment period.

11.3. The contractor shall reimburse enrollment fees when a written request with a copy of the death certificate have been received. Reimbursements shall be prorated on a monthly basis. This applies to an individual enrollment and to family enrollments that become individual plans upon the death of one or more family members. For individual enrollments, the contractor will refund remaining enrollment fees when the executor of the estate request reimbursement. For family enrollments, the contractor will make the necessary adjustments to convert the family enrollment to an individual enrollment when notified of the death of one of the two family enrollees. Enrollment fees for family enrollments of three or more members are not impacted upon the death of only one member. The contractor shall record reimbursements of fees in DEERS.

11.4. The MCSCs shall refund the unused portion of the TRICARE Prime enrollment fee to TRICARE Prime enrollees who become eligible for Medicare Part A based on disability, End Stage Renal Disease (ESRD), or upon attaining age 65 and have Medicare Part B coverage. The contractor shall calculate the refund using monthly prorating as defined in [Appendix A](#).

11.4.1. For Prime enrollees who become Medicare eligible upon attaining age 65 and maintain their Medicare Part B coverage, refunds are required for overpayments occurring on and after the start of health care delivery of all MCS contracts whose health care delivery began after March 31, 2004. The contractor shall utilize its files to substantiate any claim of overpayment.

11.4.2. For Prime enrollees who are under 65 years of age and become Medicare eligible due to disability or ESRD and have maintained their Medicare Part B coverage, refunds are required for overpayments starting on the date the enrollee has Medicare Part B, but no earlier than March 26, 1998. Beneficiaries must provide sufficient documentation to support the overpayment for a refund. The contractor shall supplement the beneficiaries' documentation using DEERS and any available internal files, both from the current and prior contracts.

11.4.3. The contractor is not required to research their files to identify these individuals. If the contractor receives a refund request, then the contractor shall refund the unused portion of the enrollment fee determined to be an overpayment in accordance with policy. Beneficiaries age 65 and over who are not entitled to premium free Medicare Part A remain eligible for TRICARE Prime.

NOTE 1: Medicare eligible ADFMs age 65 and over are not required to have Medicare Part B to remain enrolled in TRICARE Prime. To maintain TRICARE coverage upon the sponsor's

retirement, they must enroll in Medicare Part B during Medicare's Special Enrollment Period prior to their sponsor's retirement date. (The Special Enrollment Period is available anytime the sponsor is on active duty or within the first eight months of the sponsor's retirement. If they enroll in Part B after their sponsor's retirement date, they will have a break in TRICARE coverage).

NOTE 2: Medicare eligibles age 65 and over who are not entitled to premium-free Medicare Part A are not required to have Medicare Part B to remain enrolled in TRICARE Prime. Because they may become eligible for premium-free Medicare Part A at a later date, under their or their spouse's SSN, they should enroll in Medicare Part B when first eligible at age 65 to avoid the Medicare surcharge for late enrollment.

11.5. The contractor shall include full and complete information about the effects of changes in eligibility and rank in all beneficiary education materials and briefings.

12.0. WOUNDED, ILL, AND INJURED (WII) ENROLLMENT CLASSIFICATION

The WII program provides a continuum of integrated care from the point of injury to the return to duty or transition to active citizenship for the Active Component (AC) or the Reserve Component (RC) service members who have been activated for more than 30 days. These AC/RC service members, referred to as ADSMs, have been injured or become ill while on active duty and will remain in an active duty status while receiving medical care or undergoing physical disability processing. WII programs vary in name according to Service. The Service shall determine member eligibility for enrollment into a WII program, as well as whether or not to utilize these enrollments.

To better manage this population, a secondary enrollment classification of HCDP Plan Coverage Codes, WII 415 and WII 416 were developed. The primary rules apply to the WII HCDP codes:

- ADSMs must be enrolled to a TRICARE Prime program prior to, or at the same time, as being enrolled into a WII 415 or WII 416 program.
- A member cannot be enrolled in WII 415 and WII 416 programs at the same time.
- WII 415 and WII 416 enrollments will terminate at the end of the member's active duty eligibility, when members transfer enrollment to another MTF, change of a plan code, or at the direction of the Service-specific WII entity.
- Any claims processed for WII 415/416 enrollees shall follow the rules associated with the primary HCDP Plan Coverage Code, such as TRICARE Prime, TRICARE Prime Remote (TPR), TRICARE Overseas Program (TOP) Prime, or TRICARE Puerto Rico Contract (TPRC). All claims will process and pay under Supplemental Health Care Program (SHCP) rules. DEERS will not produce specific enrollment cards or letters for WII 415/416 enrollment.

WII 415/416 TRICARE Encounter Data (TED) records shall be coded with the WII 415/416 HCDP Plan Coverage Code; however, the Enrollment/Health Plan Code data element on the TED record shall reflect the appropriate value for the primary HCDP Plan

Coverage Code. For example, a TED record for a WII 416 enrollee with primary enrollment to TPR would reflect the HCDP Plan Coverage Code of "416" but the Enrollment/Health Plan Code would be coded "W TPR Active Duty Service Member".

12.1. WII 415 - Wounded, Ill, And Injured (e.g., Warrior Transition/MEDHOLD Unit (WTU))

12.1.1. Service defined eligible ADSMs assigned to a WII 415 Program such as a MEDHOLD or WTU shall be enrolled to TRICARE Prime or TOP Prime prior to, or at the same time, as being enrolled into the WII 415. Members cannot be enrolled to the WII 415 without a concurrent TRICARE Prime or TOP Prime enrollment. Service appointed WII case managers as determined by the Services, will coordinate with the MTF to facilitate TRICARE Prime PCM assignments for WII 415 members. The contractor shall then assign a PCM in accordance with the MTF MOU and in coordination with the WII case manager. WII 415 enrollment will not run in conjunction with TAMP and members enrolled in TPR, TRICARE Global Remote Overseas (TGRO), or TPRC are not eligible to enroll in the WII 415.

12.1.2. The Service-specific WII entity will stamp the front page of the DD Form 2876, enrollment application form, with WII 415 for new enrollments that begin after the DEERS implementation date. The enrollment form will then be sent to the appropriate contractor or TRICARE Area Office (TAO) who shall perform the enrollment in the DOES and include the following information:

- WII 415 HCDP Plan Coverage Code
- WII 415 Enrollment Start Date (Contractors may change the DOES defaulted start date, which may or may not coincide with the Prime Enrollment Start Date. The start date can be changed up to 289 days in the past or 90 days into the future.)

12.1.3. WII 415 enrollments will be in conjunction with an MTF enrollment only, not to civilian network PCMs under TPR enrollment rules. DEERS will end WII 415 enrollments upon loss of member's active duty eligibility. WII 415 program enrollments will not be portable across programs or regions. TAOs will enter WII 415 enrollments through DOES for Outside the Continental United States (OCONUS) regions.

12.1.4. The contractors shall accomplish the following functions based on receipt of notification from the Service-specific WII program entities:

- Enrollment
- Disenrollment
- Cancel enrollment
- Cancel disenrollment
- Address update
- MCSC can request Policy Notification Transaction (PNT) resend
- Modify begin date
- Modify end date

12.1.5. Service WII entities will provide contractors/TAOs a list by name and SSN of those ADSMs currently assigned to their WII program at the time the program is implemented by DEERS. The contractors/TAOs shall enter these ADSMs into DOES as enrolled in WII 415 with a start date of the date of implementation, unless another date, up to 289 days in the past, is provided by the WII entity.

12.2. WII 416 - Wounded, Ill, And Injured - Community-Based (e.g., Community-Based Health Care Organization (CBHCO))

12.2.1. Service defined eligible ADSMs may be assigned to a WII 416 Program such as the Army's CBHCO and receive required medical care near the member's home. The service member shall be enrolled to TRICARE Prime, TPR, TGRO, or TPRC prior to or at the same time as being enrolled into WII 416. Members cannot be enrolled to the WII 416 program without a concurrent Prime, TPR, TGRO, or TPRC enrollment. Service appointed case managers will coordinate with the contractor or MTF to facilitate TRICARE Prime or TPR PCM assignments for eligible beneficiaries. The contractor shall then assign a PCM based on the MTF MOU and in coordination with the WII entity (e.g., CBHCO). WII 416 enrollments will not run in conjunction with TAMP.

12.2.2. The Service-specific WII Program will stamp the front page of the DD Form 2876, enrollment application form, with WII 416 for all new enrollments. The begin date will be the date the contractors receive the signed enrollment form. A signed enrollment application includes those with (1) an original signature, (2) an electronic signature offered by and collected by the contractor, or (3) the self attestation by the beneficiary when using the BWE system. The enrollment form will then be sent to the appropriate contractor or TAO who shall perform the enrollment in the DOES and include the following information:

- WII 416 HCDP Plan Coverage Code
- WII 416 Enrollment Start Date (Date received by the contractor or the date indicated by the Service-specific WII Program which can be up to 289 days in the past, or 90 days in the future.)

An ADSM or ADFM signature is not required to make enrollment changes when using the Enrollment Portability process outlined in [Chapter 6, Section 2, paragraph 1.4](#).

12.2.3. WII 416 enrollments can be in conjunction with an MTF, TPR, TGRO, or TPRC enrollment. DEERS will end WII 416 enrollments upon loss of member's active duty eligibility. WII 416 program enrollments will not be portable across programs or regions. TAOs will enter WII 416 enrollments through DOES for OCONUS regions.

12.2.4. The contractors shall accomplish the following functions based on receipt of notification from Service-specific WII program entities:

- Enrollment
- Disenrollment
- Cancel enrollment
- Cancel disenrollment
- Address update

- Contractors can request PNT resend
- Modify begin date
- Modify end date

12.2.5. Service-specific WII entities will provide contractors/TAOs a list by name and SSN of those ADSMs currently participating in their WII program at the time the program is implemented by DMDC. The contractors/TAOs shall enter these ADSMs into DOES as enrolled to WII 416 with a start date as the date of implementation, unless another date up to 289 days in the past is provided by the Service-specific WII program entities.

13.0. TRICARE POLICY FOR ACCESS TO CARE (ATC) AND PRIME SERVICE AREA (PSA) STANDARDS

13.1. This policy requires that non-active duty beneficiaries in the continental United States (CONUS) and Hawaii who reside more than 30 minutes travel time from a MTF to which they desire to enroll must request waivers of the ATC drive-time standards through an MTF Commander to effect enrollment to that MTF. The Commander (or local designee) may approve waivers only for those who they determine will drive less than 100 miles to the MTF to visit their PCM. The TRO Director may approve waiver request from beneficiaries who desire to enroll to the MTF and who reside 100 miles or more from an MTF only if the MTF Commander (or local designee) wishes to accept the enrollment request based on the MTF's capacity and capabilities.

13.2. Due to the unique health care delivery challenges in Alaska, the requirement to request a waiver of ATC standards for beneficiaries residing in Alaska is waived.

13.3. Enrollment Of Beneficiaries Residing More Than 30 Minutes Travel Time From A MTF

13.3.1. The MCSC shall process all requests for enrollment to an MTF in accordance with the MOU between the MCSC and the MTF.

13.3.2. If a beneficiary residing more than 30 minutes travel time from the MTF has requested enrollment or a portability transfer to the MTF, before effecting the enrollment, the MCSC shall ensure that the applicant has waived travel time ATC standards either by signing sections V and VI of the DD Form 2876 enrollment application (this includes an electronic signature offered by and collected by the contractor) or by requesting enrollment via the BWE service. For each approved enrollment to an MTF, whether by DD Form 2876 or BWE, the MCSC shall retain the enrollment request in a searchable electronic file until 24 months after the beneficiary is no longer enrolled to the MTF. The MCSC shall provide the retained files to the successor contractor at the end of the final option period.

13.3.2.1. The MCSC shall notify the MTF Commander (or local designee) when a beneficiary residing 100 miles or more from the MTF, but in the same region, requests a new enrollment or portability transfer to the MTF. Such notification is not necessary if the MOU has already established that the MTF Commander will not accept enrollment of beneficiaries who reside 100 miles or more from the MTF. The MCSC shall make any required notification by any mutually agreeable method specified in the MOU. The MCSC shall not make the MTF enrollment effective unless notified by the MTF to do so.

13.3.2.2. The MTF Commander will notify the TRO Director of their desire to enroll a beneficiary who resides more than 100 miles from the MTF and request approval for the enrollment. The TRO Director will make a determination on whether or not to approve or deny the enrollment and notify the MTF Commander of their decision by a mutually agreeable method.

13.3.2.3. To estimate the travel time or distance between a beneficiary's residence and an MTF the MCSC must use at least one web-based mapping program of the MCSC's choosing. The choice of program(s) is at the discretion of the MCSC, but the MCSC must use a consistent process to determine the driving distance for each enrollee applicant who may reside more than 30 minutes travel time from the MTF. In making this determination the MCSC shall compute the time or distance, as applicable, between the enrollee's residence and the MTF. It is not acceptable to use a geographic substitute, such as a zip code centroid. If an enrollee applicant resides within a zip code previously determined to lie entirely within 30 minutes travel time from the MTF, the MCSC need not compute the travel time for that applicant, nor need the distance from the MTF be computed if the residence is in a zip code previously determined to lie entirely beyond 100 miles from the MTF. The MCSC shall compute the travel time or distance if the enrollee applicant resides in a location not included among those identified in the MOU as containing beneficiaries whom the MTF Commander is willing to consider for enrollment.

13.3.2.4. When the enrollment requires the MTF Commander or TRO Director to consider a request for waiver of travel time access standards, the MCSC's contractual requirement for processing timeliness of an enrollment request will begin when MCSC has obtained direction from the MTF Commander about waiver approval or disapproval.

13.3.3. An approved waiver for a beneficiary residing less than 100 miles from the MTF remains in effect until the beneficiary changes residency location.

13.3.4. The MTF Commander, in the MOU, may specify that enrollment of some or all current enrollees who reside 100 or more miles from the MTF, but in the same region, are not to be renewed at the end of the enrollment period, even if they have previously waived the travel time standard. The MOU shall document a rationale, based on the MTFs capacity and capabilities, for disqualification of re-enrollment that is consistent with the priority, by beneficiary category, for enrollment specified in [32 CFR 199.17\(c\)](#). The MCSC shall inform such beneficiaries no later than two months prior to expiration of the current enrollment period that they are disqualified for renewal of enrollment to the MTF, provide the rationale for this (as documented in the MOUs), and explain that disqualification for re-enrollment is based upon priority, by beneficiary category, for enrollment specified in [32 CFR 199.17\(c\)](#).

13.3.5. If the MCSC determines there is no signed travel time waiver on file for a current MTF enrollee who resides more than 30 minutes from the MTF, the MCSC shall, at the next annual TRICARE Prime enrollment renewal point, require the beneficiary to submit a new DD Form 2876, with the beneficiary's signature in both Sections V and VI. The MCSC will notify the beneficiary of this waiver documentation requirement no later than two months before expiration of the beneficiary's enrollment.

13.3.6. When beneficiary requests are denied for enrollment to an MTF or when a beneficiary is notified that they are disqualified for re-enrollment to an MTF, the MCSC shall

inform the beneficiary of alternative options for enrollment. The beneficiary may in lieu of enrollment to the MTF enroll to a different MTF if available within travel time access standards or enroll to a network PCM if they live within a PSA or live outside a PSA with existing excess enrollment capacity and within 100 miles of a network PCM. The beneficiary must also be made aware of the option to participate in TRICARE Extra, TRICARE Standard, or the USFHP where available.

13.3.7. The MCSC shall apprise the MTF Commander (or local designee) of all enrollees to the MTF who have waived their rights to the travel time access standard. The MCSC shall separate the information into two categories, those who reside within 100 miles of the MTF and those who reside 100 miles or more from the MTF. The notification shall be by any mutually agreeable means specified in the MOU between the MTF Commander and the MCSC.

13.3.8. If the MCSC determines that a beneficiary's residential address, as recorded in the DEERS, is not within the same region as the MTF to which the beneficiary is enrolled and is located outside the MTF PSA, the MCSC shall inform the beneficiary of the discrepant address situation. The MCSC shall not wait for the next annual TRICARE Prime renewal point before contacting the beneficiary. If the beneficiary confirms the DEERS-recorded address is incorrect, the MCSC shall request the beneficiary update DEERS with correct information. If the MCSC determines the beneficiary resides either outside the region in which the beneficiary is enrolled or more than 100 miles outside the MTF PSA, the MCSC shall inform the beneficiary no later than two months prior to expiration of the current enrollment period that the beneficiary's enrollment will not be renewed in a region in which the beneficiary does not reside. The MCSC shall provide information necessary for the beneficiary to contact the MCSC for the region in which the beneficiary resides to request enrollment in that region.

