SOLICITATION, OFFER AND AWARD

1. THIS CONTRACT IS A RATED ORDER UNDER DPAS (15 CFR 700)	RATING	PAGE OF PAGES
	DO-C9	1 | 199

2. CONTRACT NUMBER	3. SOLICITATION NUMBER	4. TYPE OF SOLICITATION	5. DATE ISSUED	6. REQUISITION/PURCHASE NUMBER
	HT940220R0005	☐ SEALED BID (IFB) ☒ NEGOTIATED (RFP)	04/15/2021	

7. ISSUED BY	CODE	8. ADDRESS OFFER TO (If other than Item 7)
DEFENSE HEALTH AGENCY DEFENSE HEALTH AGENCY-AURORA 16401 E CENTRETECH PARKWAY AURORA CO 80011	HT9402	

NOTE: In sealed bid solicitations "offer" and "offeror" mean "bid" and "bidder".

SOLICITATION

9. Sealed offers in original and (Refer to L.4. Proposal Preparation) copies for furnishing the supplies or services in the Schedule will be received at the place specified in Item 8, or if hand carried, in the depository located in (Refer to L.4.1. Electronic Proposal Submission and Proposal Due Date) until 1200 MDT (Hour) local time 08/13/2021 (Date)

CAUTION: LATE Submissions, Modifications, and Withdrawals: See Section L, Provision No. 52.214-7 or 52.215-1. All offers are subject to all terms and conditions contained in this solicitation.

10. FOR INFORMATION CALL:	A. NAME	B. TELEPHONE (NO COLLECT CALLS)			C. E-MAIL ADDRESS
		AREA CODE	NUMBER	EXT.	
	Marcus Webb	303	676-3906		marcus.r.webb.civ@mail.mil

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OFFER *(Must be fully completed by offeror)*

NOTE: Item 12 does not apply if the solicitation includes the provisions at 52.214-16, Minimum Bid Acceptance Period.

12. In compliance with the above, the undersigned agrees, if this offer is accepted within 270 calendar days (60 calendar days unless a different period is inserted by the offeror) from the date for receipt of offers specified above, to furnish any or all items upon which prices are offered at the price set opposite each item, delivered at the designated point(s), within the time specified in the schedule.

13. DISCOUNT FOR PROMPT PAYMENT *(See Section I, Clause No. 52.232.8)*	10 CALENDAR DAYS (%)	20 CALENDAR DAYS (%)	30 CALENDAR DAYS (%)	CALENDAR DAYS (%)

14. ACKNOWLEDGEMENT OF AMENDMENTS *(The offeror acknowledges receipt of amendments to the SOLICITATION for offerors and related documents numbered and dated):*	AMENDMENT NO.	DATE	AMENDMENT NO.	DATE

15A. NAME AND ADDRESS OF OFFEROR	CODE	FACILITY	16. NAME AND TITLE OF PERSON AUTHORIZED TO SIGN OFFER *(Type or print)*

15B. TELEPHONE NUMBER			15C. CHECK IF REMITTANCE ADDRESS	17. SIGNATURE	18. OFFER DATE
AREA CODE	NUMBER	EXT.	☐ IS DIFFERENT FROM ABOVE - ENTER SUCH ADDRESS IN SCHEDULE.		

AWARD *(To be completed by government)*

19. ACCEPTED AS TO ITEMS NUMBERED	20. AMOUNT	21. ACCOUNTING AND APPROPRIATION

22. AUTHORITY FOR USING OTHER THAN FULL AND OPEN COMPETITION:	23. SUBMIT INVOICES TO ADDRESS SHOWN IN *(4 copies unless otherwise specified)*	ITEM
☐ 10 U.S.C. 2304 (c) ( ) ☐ 41 U.S.C. 253 (c) ( )		

24. ADMINISTERED BY *(If other than Item 7)*	CODE	25. PAYMENT WILL BE MADE BY	CODE

26. NAME OF CONTRACTING OFFICER *(Type or print)*	27. UNITED STATES OF AMERICA	28. AWARD DATE
EVAN ZASLOW 303-676-3646 EVAN.J.ZASLOW.CIV@MAIL.MIL	*(Signature of Contracting Officer)*	

IMPORTANT - Award will be made on this Form, or on Standard Form 26, or by other authorized official written notice.

ITEM NO. (A)	SUPPLIES/SERVICES (B)	QUANTITY (C)	UNIT (D)	UNIT PRICE (E)	AMOUNT (F)
	BASE YEAR; TRANSITION-IN PERIOD 1 Jan 2023 - 31 December 2023				
0001	Transition-In (Firm-Fixed-Price) Planning and Implementation of Transition-In as stated in C.2.12.19				
	BASE YEAR; TRANSITION-IN PERIOD 1 Jan 2023 - 31 December 2023				
0001AA	Transition Readiness Milestone (5% of CLIN 0001 Amount) (Firm-Fixed-Price)	1	EA	_____	_____
	BASE YEAR; TRANSITION-IN PERIOD 1 Jan 2023 - 31 December 2023				
0001AB	Pre-Startup Validation Milestone (10% of CLIN 0001 Amount) (Firm-Fixed-Price)	1	EA	_____	_____
	BASE YEAR; TRANSITION-IN PERIOD 1 Jan 2023 - 31 December 2023				
0001AC	Pre-Open Season Milestone (40% of CLIN 0001 Amount) (Firm-Fixed-Price)	1	EA	_____	_____
	BASE YEAR; TRANSITION-IN PERIOD 1 Jan 2023 - 31 December 2023				
0001AD	Start of Health Care Delivery Milestone (45% of CLIN 0001 Amount) (Firm-Fixed-Price)	1	EA	_____	_____
0002	Contract Data Requirements List (DD Form				NSP

Continued ...

ITEM NO. (A)	SUPPLIES/SERVICES (B)	QUANTITY (C)	UNIT (D)	UNIT PRICE (E)	AMOUNT (F)
	1423-1)(Not Separately Priced) Transition-In				
	OPTION PERIOD 1 - 1 Jan 2024 - 31 December 2024				
1001	Underwritten Health Care Cost for Contractor Network Prime Enrollees, Non-Prime Underwritten Beneficiaries, and MTF Enrollees (Cost Plus Fixed Fee)(Estimated Cost) (Option Line Item)	12	MO	_____	_____
1002	Future Potential Demonstrations ($15,000,000 Government Plug-in Amount) Anticipated Award Type: Firm-fixed-price (Option Line Item)	12	MO	1,250,000	15,000,000
1003	Managed Care Support Services (Option Line Item)				
1003AA	Per Member Per Month (PMPM) in accordance with Performance Requirements Section C (Firm-Fixed-Price)(Estimated Quantity)(1st Quarter of Calendar Year(CY)) (Option Line Item)		IE	_____	_____
1003AB	Per Member Per Month (PMPM) in accordance with Performance Requirements Section C (Firm-Fixed-Price)(Estimated Quantity)(2nd Quarter of CY)) (Option Line Item)		IE	_____	_____
1003AC	Per Member Per Month (PMPM) in accordance with Performance Requirements Section C (Firm-Fixed-Price)(Estimated Quantity)(3rd Quarter of CY)) (Option Line Item) Continued ...		IE	_____	_____

ITEM NO. (A)	SUPPLIES/SERVICES (B)	QUANTITY (C)	UNIT (D)	UNIT PRICE (E)	AMOUNT (F)
1003AD	Per Member Per Month (PMPM) in accordance with Performance Requirements Section C (Firm-Fixed-Price)(Estimated Quantity)(4th Quarter of CY)) (Option Line Item)		IE	_____	_____
1004	Clinical Support Agreements (CSAs)(Firm-Fixed-Price) (Option Line Item)				
1005	MTF/Guard/Reserve/MSO/VSO Briefings ($200,000 Ceiling) (Cost Reimbursable) (Option Line Item)	1	LO		
1006	Contract Data Requirements List (DD Form 1423-1)(Not Separately Priced) (Option Line Item)				NSP
1007	Service Assist Teams (Mobile Disaster)($200,000 Ceiling)(Cost Reimbursable) (Option Line Item)	1	LO		
	OPTION PERIOD 2 - 1 Jan 2025 - 31 December 2025				
2001	Underwritten Health Care Cost for Contractor Network Prime Enrollees, Non-Prime Underwritten Beneficiaries, and MTF Enrollees (Cost Plus Fixed Fee)(Estimated Cost) (Option Line Item)	12	MO	_____	_____
2002	Future Potential Demonstrations ($15,000,000 Government Provided Plug-in Amount) (Option Line Item)	12	MO	1,250,000	15,000,000

Continued ...

ITEM NO. (A)	SUPPLIES/SERVICES (B)	QUANTITY (C)	UNIT (D)	UNIT PRICE (E)	AMOUNT (F)
2003	Managed Care Support Services (Option Line Item)				
2003AA	Per Member Per Month (PMPM) in accordance with Performance Requirements Section C (Firm-Fixed-Price)(Estimated Quantity)(1st Quarter of Calendar Year(CY)) (Option Line Item)		IE	_____	_____
2003AB	Per Member Per Month (PMPM) in accordance with Performance Requirements Section C (Firm-Fixed-Price)(Estimated Quantity)(2nd Quarter of CY)) (Option Line Item)		IE	_____	_____
2003AC	Per Member Per Month (PMPM) in accordance with Performance Requirements Section C (Firm-Fixed-Price)(Estimated Quantity)(3rd Quarter of CY)) (Option Line Item)		IE	_____	_____
2003AD	Per Member Per Month (PMPM) in accordance with Performance Requirements Section C (Firm-Fixed-Price)(Estimated Quantity)(4th Quarter of CY)) (Option Line Item)		IE	_____	_____
2004	Clinical Support Agreements (CSAs)(Firm-Fixed-Price) (Option Line Item)				
2005	MTF/Guard/Reserve/MSO/VSO Briefings ($200,000 Ceiling) (Cost Reimbursable) (Option Line Item)	1	LO		

Continued ...

ITEM NO. (A)	SUPPLIES/SERVICES (B)	QUANTITY (C)	UNIT (D)	UNIT PRICE (E)	AMOUNT (F)
2006	Contract Data Requirements List (DD Form 1423-1)(Not Separately Priced) (Option Line Item)				NSP
2007	Service Assist Teams (Mobile Disaster) ($200,000 Ceiling) (Cost Reimbursable) (Option Line Item)	1	LO		
	OPTION PERIOD 3 - 1 Jan 2026 – 31 December 2026				
3001	Underwritten Health Care Cost for Contractor Network Prime Enrollees, Non-Prime Underwritten Beneficiaries, and MTF Enrollees (Cost Plus Fixed Fee)(Estimated Cost) (Option Line Item)	12	MO	_____	_____
3002	Future Potential Demonstrations ($15,000,000 Government Plug-in Amount) (Option Line Item)	12	MO	1,250,000	15,000,000
3003	Managed Care Support Services (Option Line Item)				
3003AA	Per Member Per Month (PMPM) in accordance with Performance Requirements Section C (Firm-Fixed-Price)(Estimated Quantity)(1st Quarter of Calendar Year(CY)) (Option Line Item)		IE	_____	_____
3003AB	Per Member Per Month (PMPM) in accordance with Performance Requirements Section C (Firm-Fixed-Price)(Estimated Quantity)(2nd Quarter of CY)) (Option Line Item)		IE	_____	_____
3003AC	Per Member Per Month (PMPM) in accordance with Performance Requirements Section C Continued ...		IE	_____	_____

ITEM NO. (A)	SUPPLIES/SERVICES (B)	QUANTITY (C)	UNIT (D)	UNIT PRICE (E)	AMOUNT (F)
	(Firm-Fixed-Price)(Estimated Quantity)(3rd Quarter of CY)) (Option Line Item)				
3003AD	Per Member Per Month (PMPM) in accordance with Performance Requirements Section C (Firm-Fixed-Price)(Estimated Quantity)(4th Quarter of CY)) (Option Line Item)		IE	_____	_____
3004	Clinical Support Agreements (CSAs)(Firm-Fixed-Price) (Option Line Item)				
3005	MTF/Guard/Reserve/MSO/VSO Briefings ($200,000 Ceiling) (Cost Reimbursable) (Option Line Item)	1	LO		
3006	Contract Data Requirements List (DD Form 1423-1)(Not Separately Priced) (Option Line Item)				NSP
3007	Service Assist Teams (Mobile Disaster) ($200,000 Ceiling) (Cost Reimbursable) (Option Line Item)	1	LO		
	OPTION PERIOD 4 - 1 Jan 2027 – 31 December 2027				
4001	Underwritten Health Care Cost for Contractor Network Prime Enrollees, Non-Prime Underwritten Beneficiaries, and MTF Enrollees (Cost Plus Fixed Fee)(Estimated Cost) (Option Line Item)	12	MO	_____	_____
4002	Planned Competitive Demonstrations Transition-Out ($3,000,000 Government Plug-in Amount) (Option Line Item)	12	MO	250,000	3,000,000

Continued ...

ITEM NO. (A)	SUPPLIES/SERVICES (B)	QUANTITY (C)	UNIT (D)	UNIT PRICE (E)	AMOUNT (F)
4003	Managed Care Support Services (Option Line Item)				
4003AA	Per Member Per Month (PMPM) in accordance with Performance Requirements Section C (Firm-Fixed-Price)(Estimated Quantity)(1st Quarter of Calendar Year(CY)) (Option Line Item)		IE	_____	_____
4003AB	Per Member Per Month (PMPM) in accordance with Performance Requirements Section C (Firm-Fixed-Price)(Estimated Quantity)(2nd Quarter of CY)) (Option Line Item)		IE	_____	_____
4003AC	Per Member Per Month (PMPM) in accordance with Performance Requirements Section C (Firm-Fixed-Price)(Estimated Quantity)(3rd Quarter of CY)) (Option Line Item)		IE	_____	_____
4003AD	Per Member Per Month (PMPM) in accordance with Performance Requirements Section C (Firm-Fixed-Price)(Estimated Quantity)(4th Quarter of CY)) (Option Line Item)		IE	_____	_____
4004	Clinical Support Agreements (CSAs)(Firm-Fixed-Price) (Option Line Item)				
4005	MTF/Guard/Reserve/MSO/VSO Briefings ($200,000 Ceiling) (Cost Reimbursable) (Option Line Item)	1	LO		
4006	Contract Data Requirements List (DD Form Continued ...				NSP

ITEM NO. (A)	SUPPLIES/SERVICES (B)	QUANTITY (C)	UNIT (D)	UNIT PRICE (E)	AMOUNT (F)
	1423-1)(Not Separately Priced) (Option Line Item)				
4007	Service Assist Teams (Mobile Disaster) ($200,000 Ceiling) (Cost Reimbursable) (Option Line Item)	1	LO		
	OPTION PERIOD 5 - 1 Jan 2028 – 31 December 2028				
5001	Underwritten Health Care Cost for Contractor Network Prime Enrollees, Non-Prime Underwritten Beneficiaries, and MTF Enrollees (Cost Plus Fixed Fee)(Estimated Cost) (Option Line Item)	12	MO	_____	_____
5002	Future Potential Demonstrations (Option Line Item)	12	MO		
5003	Managed Care Support Services (Option Line Item)				
5003AA	Per Member Per Month (PMPM) in accordance with Performance Requirements Section C (Firm-Fixed-Price)(Estimated Quantity)(1st Quarter of Calendar Year(CY)) (Option Line Item)		EA	_____	_____
5003AB	Per Member Per Month (PMPM) in accordance with Performance Requirements Section C (Firm-Fixed-Price)(Estimated Quantity)(2nd Quarter of CY)) (Option Line Item)		EA	_____	_____
5003AC	Per Member Per Month (PMPM) in accordance with Performance Requirements Section C (Firm-Fixed-Price)(Estimated Quantity)(3rd Quarter of CY)) (Option Line Item) Continued ...		EA	_____	_____

ITEM NO. (A)	SUPPLIES/SERVICES (B)	QUANTITY (C)	UNIT (D)	UNIT PRICE (E)	AMOUNT (F)
5003AD	Per Member Per Month (PMPM) in accordance with Performance Requirements Section C (Firm-Fixed-Price)(Estimated Quantity)(4th Quarter of CY)) (Option Line Item)		EA	_____	_____
5004	Clinical Support Agreements (CSAs)(Firm-Fixed-Price) (Option Line Item)				
5005	MTF/Guard/Reserve/MSO/VSO Briefings ($200,000 Ceiling) (Cost Reimbursable) (Option Line Item)	1	LO		
5006	Contract Data Requirements List (DD Form 1423-1)(Not Separately Priced) (Option Line Item)				NSP
5007	Service Assist Teams (Mobile Disaster) ($200,000 Ceiling) (Cost Reimbursable) (Option Line Item)	1	LO		
	OPTION PERIOD 6 - 1 Jan 2029 - 31 December 2029				
6001	Underwritten Health Care Cost for Contractor Network Prime Enrollees, Non-Prime Underwritten Beneficiaries, and MTF Enrollees (Cost Plus Fixed Fee)(Estimated Cost) (Option Line Item)	12	MO	_____	_____
6002	Future Potential Demonstrations (Option Line Item)	12	MO		
6003	Managed Care Support Services (Option Line Item) Continued ...				

ITEM NO. (A)	SUPPLIES/SERVICES (B)	QUANTITY (C)	UNIT (D)	UNIT PRICE (E)	AMOUNT (F)
6003AA	Per Member Per Month (PMPM) in accordance with Performance Requirements Section C (Firm-Fixed-Price)(Estimated Quantity)(1st Quarter of Calendar Year(CY)) (Option Line Item)		IE	_____	_____
6003AB	Per Member Per Month (PMPM) in accordance with Performance Requirements Section C (Firm-Fixed-Price)(Estimated Quantity)(2nd Quarter of CY)) (Option Line Item)		IE	_____	_____
6003AC	Per Member Per Month (PMPM) in accordance with Performance Requirements Section C (Firm-Fixed-Price)(Estimated Quantity)(3rd Quarter of CY)) (Option Line Item)		IE	_____	_____
6003AD	Per Member Per Month (PMPM) in accordance with Performance Requirements Section C (Firm-Fixed-Price)(Estimated Quantity)(4th Quarter of CY)) (Option Line Item)		IE	_____	_____
6004	Clinical Support Agreements (CSAs)(Firm-Fixed-Price) (Option Line Item)				
6005	MTF/Guard/Reserve/MSO/VSO Briefings ($200,000 Ceiling) (Cost Reimbursable) (Option Line Item)	1	LO		
6006	Contract Data Requirements List (DD Form 1423-1)(Not Separately Priced) (Option Line Item)				NSP

Continued ...

ITEM NO. (A)	SUPPLIES/SERVICES (B)	QUANTITY (C)	UNIT (D)	UNIT PRICE (E)	AMOUNT (F)
6007	Service Assist Teams (Mobile Disaster) ($200,000 Ceiling) (Cost Reimbursable) (Option Line Item)	1	LO		
	OPTION PERIOD 7 - 1 Jan 2030 – 31 December 2030				
7001	Underwritten Health Care Cost for Contractor Network Prime Enrollees, Non-Prime Underwritten Beneficiaries, and MTF Enrollees (Cost Plus Fixed Fee)(Estimated Cost) (Option Line Item)	12	MO	_____	_____
7002	Future Potential Demonstrations (Option Line Item)	12	MO		
7003	Managed Care Support Services (Option Line Item)				
7003AA	Per Member Per Month (PMPM) in accordance with Performance Requirements Section C (Firm-Fixed-Price)(Estimated Quantity)(1st Quarter of Calendar Year(CY)) (Option Line Item)		IE	_____	_____
7003AB	Per Member Per Month (PMPM) in accordance with Performance Requirements Section C (Firm-Fixed-Price)(Estimated Quantity)(2nd Quarter of CY)) (Option Line Item)		IE	_____	_____
7003AC	Per Member Per Month (PMPM) in accordance with Performance Requirements Section C (Firm-Fixed-Price)(Estimated Quantity)(3rd Quarter of CY)) (Option Line Item)		IE	_____	_____
7003AD	Per Member Per Month (PMPM) in accordance with Continued ...		IE	_____	_____

ITEM NO. (A)	SUPPLIES/SERVICES (B)	QUANTITY (C)	UNIT (D)	UNIT PRICE (E)	AMOUNT (F)
	Performance Requirements Section C (Firm-Fixed-Price)(Estimated Quantity)(4th Quarter of CY)) (Option Line Item)				
7004	Clinical Support Agreements (CSAs)(Firm-Fixed-Price) (Option Line Item)				
7005	MTF/Guard/Reserve/MSO/VSO Briefings ($200,000 Ceiling) (Cost Reimbursable) (Option Line Item)	1	LO		
7006	Contract Data Requirements List (DD Form 1423-1)(Not Separately Priced) (Option Line Item)				NSP
7007	Service Assist Teams (Mobile Disaster) ($200,000 Ceiling) (Cost Reimbursable) (Option Line Item)	1	LO		
	OPTION PERIOD 8 - 1 Jan 2031 - 31 December 2031				
8001	Underwritten Health Care Cost for Contractor Network Prime Enrollees, Non-Prime Underwritten Beneficiaries, and MTF Enrollees (Cost Plus Fixed Fee)(Estimated Cost) (Option Line Item)	12	MO	_____	_____
8002	Future Potential Demonstrations (Option Line Item)	12	MO		
8003	Managed Care Support Services (Option Line Item)				
8003AA	Per Member Per Month (PMPM) in accordance with Performance Requirements Section C		IE	_____	_____

Continued ...

ITEM NO. (A)	SUPPLIES/SERVICES (B)	QUANTITY (C)	UNIT (D)	UNIT PRICE (E)	AMOUNT (F)
	(Firm-Fixed-Price)(Estimated Quantity)(1st Quarter of Calendar Year(CY)) (Option Line Item)				
8003AB	Per Member Per Month (PMPM) in accordance with Performance Requirements Section C (Firm-Fixed-Price)(Estimated Quantity)(2nd Quarter of CY)) (Option Line Item)		IE	_____	_____
8003AC	Per Member Per Month (PMPM) in accordance with Performance Requirements Section C (Firm-Fixed-Price)(Estimated Quantity)(3rd Quarter of CY)) (Option Line Item)		IE	_____	_____
8003AD	Per Member Per Month (PMPM) in accordance with Performance Requirements Section C (Firm-Fixed-Price)(Estimated Quantity)(4th Quarter of CY)) (Option Line Item)		IE	_____	_____
8004	Clinical Support Agreements (CSAs)(Firm-Fixed-Price) (Option Line Item)				
8005	MTF/Guard/Reserve/MSO/VSO Briefings ($200,000 Ceiling) (Cost Reimbursable) (Option Line Item)	1	LO		
8006	Contract Data Requirements List (DD Form 1423-1)(Not Separately Priced) (Option Line Item)				NSP
8007	Service Assist Teams (Mobile Disaster) ($200,000 Ceiling) (Cost Reimbursable) (Option Line Item)	1	LO		

Continued ...

ITEM NO. (A)	SUPPLIES/SERVICES (B)	QUANTITY (C)	UNIT (D)	UNIT PRICE (E)	AMOUNT (F)
9001	Transition Out (Option Line Item)	6	Q1	_____	_____
9002	Contract Data Requirements List (DD Form 1423-1) Transition-Out (Not Separately Priced) (Option Line Item)				NSP
	EXTENSION PERIOD 1 JAN 2032 - 30 JUN 2032				
9003	Extension of Services (FAR 52.217-8) 6-Month Option Period Extension, If Required (Option Line Item)	6	MO	_____	_____

C.1. GENERAL

C.1.1. The purpose of this contract is to provide Managed Care Support (MCS) to the Department of Defense (DoD) TRICARE program. The MCS Contractor shall assist the Military Health System (MHS) in operating an integrated healthcare delivery system combining resources of the military's direct medical care system and the Contractor's managed care support to provide health, medical, and administrative support services to TRICARE-eligible beneficiaries.

C.1.2. Contract Objectives

C.1.2.1. Objective 1 - Readiness: Support the MHS readiness mission by partnering with the Military Medical Treatment Facilities (MTFs) to optimize the delivery of health care services to enhance the clinical expertise of providers in the direct care system (see definition of MTF optimization in the TRICARE Manual, Definitions[1]) for all TRICARE-eligible beneficiaries (see definition at Title 32 Code of Federal Regulations (CFR) Part 199.17(a)(6)(i)).

C.1.2.2. Objective 2 - Experience of Care: Provide a care experience that is patient and family centered, compassionate, convenient, equitable, safe, and always of the highest quality.

C.1.2.3. Objective 3 - Manage Per Capita Cost: Create value by focusing on quality, eliminating waste, and reducing unwarranted variation; considering the total cost of care over time, not just the cost of an individual health care activity.

C.1.2.4. Objective 4 - Population Health: Within the constraints, boundaries, and benefits of the current program, encourage beneficiaries and providers to seek ways to improve health.

C.1.3. Definitions of terms are provided in 32 CFR Part 199.2 and the TRICARE Manual, Definitions.

C.1.4. The following documents are hereby incorporated by reference and form an integral part of this contract. Documentation incorporated into this contract by reference has the same force and effect as if set forth in full text.

- Title 10, United States Code, Chapter 55
- 32 CFR Part 199
- TRICARE Policy Manual (TPM) 6010.60-M, April 2021
- TRICARE Reimbursement Manual (TRM) 6010.61-M, April 2021
- TRICARE Systems Manual (TSM) 7950.3-M, April 2021
- TRICARE Operations Manual (TOM) 6010.59-M, April 2021

C.1.4.1. The TRICARE Manuals provide instruction, guidance, and responsibilities in addition to the requirements set forth in the incorporated federal statutes and regulations and may not be

[1]Definitions are available at:
https://manuals.health.mil/pages/v3/DownloadManualFile.aspx?Filename=Definitions.pdf

interpreted in contradiction thereto. Among the Manuals, the TPM takes precedence over the other three TRICARE Manuals. The TRM takes precedence over the TSM and the TOM. The TSM takes precedence over the TOM.

C.2. PERFORMANCE REQUIREMENTS

C.2.1. Provider Networks

C.2.1.1. The Contractor shall establish and maintain a preferred provider network of individual and institutional providers (see 32 CFR 199.17(p)) who produce high quality clinical outcomes for TRICARE beneficiaries.

C.2.1.1.1. The Contractor shall ensure that all of its network providers are Medicare participating providers (unless they are not eligible to be participating providers under Medicare) and that the providers in its network are sufficient in number, mix, and geographic distribution to provide the full scope of benefits for which all TRICARE enrollees are eligible under this contract, as described in 32 CFR 199.4, 32 CFR 199.5, and 32 CFR 199.17.

C.2.1.1.2. The Contractor shall provide Prime Service Areas (PSAs) at all locations listed in the attachments applicable to its geographic area of responsibility: Attachments J-1 through J-6, Mandatory Government Required PSA Lists; and J-1a through J-2a, Mandatory Government Required Base Relocation and Closure (BRAC) PSA Lists.

C.2.1.1.3. The Contractor shall adjust provider networks and services as necessary to compensate for changes in Market/MTF capabilities and capacities when and where they occur over the life of the contract, including those resulting from unanticipated facility expansions, Market/MTF provider deployments, facility downsizing, or facility closures.

C.2.1.1.4. The Contractor shall submit a network implementation plan detailing all phases of its network development and implementation in accordance with the TOM, Chapter 2, Section 3. For plan details see DD Form 1423-1, Contract Data Requirements List (CDRL), located in Section J.

C.2.1.2. The Contractor’s network implementation plan shall address all components of network development, including the Contractor's network sizing model and the formula(s) used to derive network specialty targets, by provider specialty in its geographic area of responsibility.

C.2.1.3. TRICARE Minimum Appointment Access Standards

C.2.1.3.1. The Contractor’s network shall meet minimum appointment access standards (see 32 CFR 199.17(p)(5)) for all provider types in the network.

C.2.1.4. TRICARE Minimum Travel Time Standards

C.2.1.4.1. The Contractor shall, at a minimum, take into account normal traffic conditions and geographic barriers such as bridges, mountains, and tunnels in calculating beneficiary travel times.

C.2.1.4.2. The Contractor shall not use telemedicine access in the calculation of minimum travel time standards.

C.2.1.5. Network Service Area Reporting

C.2.1.5.1. The Contractor shall specify areas, through ZIP codes, where its network is available to TRICARE beneficiaries.

C.2.1.5.2. The Contractor shall ensure its network ZIP code list is updated with changes from DHA and that such changes are implemented within its systems each month. For reporting requirements see DD Form 1423-1, CDRL, located in Section J.

C.2.1.6. The Contractor's network shall meet all access to care standards listed in 32 CFR 199.17(p)(5). The Contractor's network shall provide network coverage for at least 85 percent of TRICARE Select enrollees. For reporting requirements, see DD Form 1423-1, CDRL, located in Section J.

C.2.1.6.1. The Contractor shall develop and implement a system for continuously monitoring, and evaluating network adequacy and for reporting network adequacy or access issues to the Government. For reporting requirements see DD Form 1423-1, CDRL, located in Section J.

C.2.1.6.2. The Contractor shall submit a plan for reporting on access to care for TRICARE beneficiaries. The Contractor's plan shall explain how the Contractor will report access to care data at the PSA, Market, and State level for the Contractor's geographic area of responsibility. The Contractor shall report on how it measured appointment availability (e.g., by employing surveys). For plan reporting requirements see DD Form 1423-1, CDRL, located in Section J.

C.2.1.7. The contractor shall develop and implement a system for continuously monitoring network appointment availability for all provider and facility types. The Contractor shall assess appointment availability for each provider type in its network, at a minimum annually and otherwise as requested by the Government, to ensure beneficiary access to care. When directed by the Government, the contractor shall assess bed availability for each type of network facility. For reporting requirements see DD Form 1423-1, CDRL, located in Section J.

C.2.1.8. The Contractor shall measure enrolled beneficiary access to telehealth services in rural, remote, and isolated areas. For reporting requirements see DD Form 1423-1, CDRL, located in Section J.

C.2.1.9. The Contractor shall monitor and report, on a monthly basis, all complaints by beneficiaries with respect to network adequacy or the availability of health care providers. For reporting requirements, see DD Form 1423-1, CDRL, located in Section J.

C.2.1.10. The Contractor shall inform the Government, in a monthly report, of any instances of network inadequacy and shall submit a corresponding Corrective Action Plan (CAP). Network inadequacy is defined as any failure to provide health care services within the network within the access standards, unless a Network Adequacy Waiver applies. The Contractor shall respond within two business days upon receipt of any inquiries from the Contracting Officer's Representative (COR) concerning network inadequacy. For reporting requirements see DD Form 1423-1, CDRL, located in Section J.

C.2.1.11. Network Adequacy Waivers

C.2.1.11.1. The Contractor may apply for a waiver of network adequacy for a single provider type in a geographic area. Such an application must:

1. Be made in writing,
2. Identify the provider saturation rate for the specified geographic area: Calculated by dividing Providers Recruited into Network divided by number of providers (of the same type) in the specified area,
3. Identify all good faith efforts to bring providers into the network. If no providers of the specific provider type is available in the geographic area, the Contractor shall submit documentation to the Government and,
4. Demonstrate that the Contractor has exhausted its efforts to create a locality-based reimbursement rate waiver (see TRM, Chapter 5, Section 2).

C.2.1.11.2. The Contractor may remove a provider category from the network adequacy calculation in a geographic area (for the time period specified in the waiver) if the Government grants a Network Adequacy Waiver for that provider category.

C.2.1.12. Network Quality

C.2.1.12.1. The Contractor shall maintain accreditation by a national accrediting organization of its healthcare network in all geographic areas of responsibility throughout the life of this contract and all exercised options. National certification, in lieu of accreditation, is insufficient to meet this requirement. For reporting requirements, see DD Form 1423-1, CDRL, located in Section J. Network accreditation shall be from a national body that considers quality benchmarks for network management, provider credentialing, quality management and improvement, and consumer protection.

C.2.1.12.2. The Contractor shall ensure the higher standard applies when this contract and the accrediting body have differing standards for the same activity.

C.2.1.12.3. The Contractor shall establish mechanisms to evaluate network providers using the quality metrics specified in the TOM Chapter 7, Section 6 and attachment J-11. The Contractor shall display meaningful quality metrics, at the individual provider and facility level, in an easily understood and accessible format as part of its online network directory.

C.2.1.12.4. The Contractor shall develop and submit a value-based steerage model for referrals. The Contractor's steerage model shall be constructed to achieve the following outcomes: (1) improved access to care, (2) utilization of high quality health care providers, (3) MTF optimization (see paragraph C.2.12.10) and readiness of the force (e.g., taking into account provider effectiveness in returning clinical information to referring MTFs (see paragraph C.2.9) (when applicable), and (4) lowering average per capita healthcare costs. For plan reporting requirements see DD Form 1423-1, CDRL, located in Section J.

C.2.1.12.4.1. The Contractor shall submit a monthly report on its Value-Based Steerage Model/Plan's performance on each of the four elements described in C.2.1.12.4, at the Market level, as an expression of total value. For reporting requirements see DD Form 1423-1, CDRL, located in Section J.

C.2.1.13. Network Provider Directory

C.2.1.13.1. The Contractor's network provider directory shall clearly communicate the following information to beneficiaries:

1. Provider Name
2. Provider Gender
3. Provider place of practice address
4. Provider appointment telephone number
5. Primary Care Manager (PCM) (Y/N)
6. TRICARE Provider Readiness Designation (Y/N)
7. Provider Type
8. Provider Specialty
9. Provider Subspecialty
10. Provider quality indicator(s)
11. Provider website (if available)
12. Telehealth availability

C.2.1.13.2. The provider directory shall clearly communicate the following information to the DHA:

1. Provider Name
2. Provider Gender
3. Provider place of practice and address
4. Provider billing address
5. Provider Type
6. Provider Specialty
7. Provider Subspecialty
8. Provider quality indicator(s)
9. Provider website (if available)

10. Provider business phone number
11. Provider appointment phone number
12. Provider fax number
13. Provider electronic address (Health Information Service Provider (HISP) address)
14. Participates in Health Information Exchange (Y/N)

C.2.1.13.3. The Contractor shall ensure that its on-line network provider directory is accessible to users on a continual (24 hours/7 days a week) basis except for scheduled downtime for system maintenance.

C.2.1.13.4. The Contractor shall schedule downtime for system maintenance of its on-line directory in accordance with the TRICARE Systems Manual.

C.2.1.13.4.1. The Contractor shall provide access on its website to a directory of TRICARE authorized, non-network providers who have submitted a claim to TRICARE over the past 14 months. The Contractor shall refresh this directory no less than semi-annually.

C.2.1.13.5. Provider Directory Accuracy

C.2.1.13.5.1. The Contractor shall use electronic means of verification in addition to manual outreach efforts to continuously maintain provider directory accuracy.

C.2.1.13.5.2. If a provider has not submitted a claim within 14 months or if there is no response from a provider through electronic or manual outreach efforts, the Contractor shall not display the provider in the directory.

C.2.1.13.5.3. The Contractor shall maintain a minimum network provider directory accuracy rate as follows:

Transition	OP1	OP2	OP3	OP4	OP5	OP6	OP7	OP8	Extension
71%	72%	74%	74%	76%	76%	78%	78%	80%	80%

C.2.1.13.5.4. The Contractor shall calculate provider directory accuracy for each PSA and non-PSA area.

C.2.1.13.5.5. The Contractor shall calculate the network provider directory accuracy with the following data elements: provider name, provider specialty, provider sub-specialty, provider place of practice address, provider fax number and provider appointment telephone number. Accuracy is defined as a directory record that contains correct information for all of the above data elements listed in this paragraph. The Contractor shall calculate network provider directory accuracy by dividing the total number of directory entries (records) that contain 100% correct information (no data element errors) by the total number of records. Requirements for data accuracy are not applicable to the on-line directory of TRICARE authorized, non-network providers.

C.2.1.13.5.6. Provider directory accuracy shall be reported monthly in accordance with DD Form 1423-1, CDRL, located in Section J.

C.2.1.13.5.7. The Contractor shall contact network providers biannually to validate information contained in the network provider directory.

C.2.2. Enrollment

C.2.2.1. The Contractor shall perform enrollments, re-enrollments, dis-enrollments, transfer enrollments, correct enrollment discrepancies, and assign or change beneficiary PCMs in accordance with the requirements of the TOM Chapter 6.

C.2.2.2. The Contractor shall utilize leading industry best practice automation in processing billing and enrollment transactions and such automation shall include the capability to capture email and other information needed to conduct electronic transactions.

C.2.3. Medical Management (MM)

C.2.3.1. The Contractor shall develop, implement, and maintain a MM Program, that includes behavioral health, in accordance with the requirements in the TOM Chapter 7, as well as complies with the TRICARE benefits provisions of 32 CFR 199.4, 32 CFR 199.5, and the TPM in order to provide health care for eligible beneficiaries to the extent authorized by law.

C.2.3.1.1. The Contractor's MM programs shall support all services provided within each Market/MTF and shall be described in its Memorandum of Understanding (MOU) with each Market/MTF (see paragraph C.2.12.9).

C.2.3.2. The Contractor shall develop, implement, and maintain an electronic MM data system that complies with the TOM, Chapter 7, Sections 1, 2 and 3.

C.2.3.3. The Contractor shall use predictive analytics in the operation of its MM program (as described in the TOM Chapter 7, Section 1, Paragraph 5), which are designed to support and manage the health care of individuals with high-cost conditions and complex medical conditions, inpatient admissions and discharges, pharmacy (specialty drugs, multiple medications or pharmacies), and beneficiaries receiving low quality care.

C.2.3.3.1. The Contractor, in order to provide the operations described in paragraph C.2.3.3, shall establish a beneficiary-centric data warehouse (for data pertaining to TRICARE Prime and Select enrolled beneficiaries) and employ industry best practice analytic tools/systems to exhibit sophisticated data analysis techniques with evidence-based algorithms. The Contractor shall provide the Government with real-time access to view all such data.

C.2.3.4. The Contractor shall obtain and maintain throughout the life of the contract accreditation from a nationally recognized accrediting organization for the following MM programs: utilization management, case management, and disease management.

C.2.3.4.1. The Contractor shall obtain accreditation no later than 18 months after the Start of Healthcare Delivery (SHCD) and shall maintain such accreditation in all geographic areas of responsibility throughout the life of the contract, inclusive of all exercised option periods. National certification, in lieu of accreditation, is insufficient to meet this requirement.

C.2.3.4.2. The Contractor shall submit letters of accreditation and re-accreditation and supporting documentation to the Government within 5 business days of receipt of the documents from the accrediting organization.

C.2.4. Case Management (CM)

C.2.4.1. The Contractor shall develop, implement, and maintain a CM Program in accordance with the TOM Chapter 7, Section 2.

C.2.4.2. The Contractor shall provide CM services via a dedicated point of contact for beneficiaries with sensitive, rare, high-profile, or high-visibility needs, as well as beneficiaries in the categories identified in TOM Chapter 7, Section 2. If a beneficiary declines case management services, the Contractor shall offer care coordination navigation and a dedicated POC until an issue is resolved.

C.2.4.3. The Contractor shall use tools and assessments to identify beneficiaries in need of in-home CM services and offer in-home CM services to beneficiaries who have a high-need for care and are at high-risk of re-admission for 30 calendar days following discharge from an inpatient setting. In such cases, the contractor shall ensure that a case manager makes an in-home visit 48 to 72 hours post discharge.

C.2.5. Population Health (PH) Care

C.2.5.1. The Contractor shall develop, implement, and maintain integrated, whole person PH care within the constraints, boundaries, and benefits of the Current TRICARE program and in accordance with the TOM Chapter 7, Section 3.

C.2.5.2. The Contractor shall incorporate Chronic Care/Disease Management (CC/DM) conditions into its PH care.

C.2.5.3. The Contractor shall collaborate annually with the Government Designated Authority (GDA) to identify targeted diseases.

C.2.5.4. The Contractor shall establish a process for MTFs and network providers to refer beneficiaries for CC/DM services and shall communicate this process to all MTFs via its MTF MOUs (see paragraph C.2.12.9) and to all network providers via its provider handbook.

C.2.6. Utilization Management (UM)

C.2.6.1. The Contractor shall develop, implement, and maintain a UM Program in accordance with the TOM Chapter 7, Section 4.

C.2.6.2. The Contractor shall apply its UM practices for all TRICARE eligible beneficiaries receiving care in the private sector care system and in a manner consistent with the TOM Chapter 7, Section 4.

C.2.6.3. The Contractor shall ensure that care provided is reviewed for medical necessity (if applicable), is appropriately authorized, and complies with the TRICARE benefits contained in 32 CFR 199.4 and 199.5, and the TPM.

C.2.7. Referral Management (RM)

C.2.7.1. The Contractor shall develop, implement, and maintain a RM Program in accordance with the TOM, Chapter 7, Section 5.

C.2.7.2. The Contractor shall utilize a secure, HIPAA-compliant computer-based method, as described in the TOM Chapter 7, Section 5, paragraph 1.3, to process referrals between itself and the Markets/MTFs in its geographic area of responsibility.

C.2.7.3. The Contractor shall address referral and authorization information requirements, directed referral guidelines, and the methods of communicating referral and authorization information in its MOUs with the Markets/MTFs (see paragraph C.2.12.9) in its geographic area of responsibility.

C.2.7.4. The Contractor shall implement a computer-based referral management system to process MTF-generated and contractor-initiated referrals for the Contractor's geographic area of responsibility through an interface with MHS GENESIS as described in paragraph C.2.12.12.1., and allows clinical and administrative documents to be uploaded and associated to referrals. The Contractor's electronic system shall exchange referrals between the Contractor's system and MHS GENESIS in a HIPAA compliant 278 message in accordance with paragraph C.2.12.12.1.

C.2.7.5. The Contractor's RM Program and referral management system shall optimize referrals and authorizations to MTFs for beneficiaries enrolled in TRICARE Prime.

C.2.8. Clinical Quality Management (CQM)

C.2.8.1. The Contractor shall develop, implement, and maintain a CQM and Patient Safety Program in accordance with the TOM, Chapter 7, Section 6.

C.2.8.2. The Contractor shall have a provider credentialing program that complies with the requirements in the TOM Chapter 4, Section 1. When this contract and the accrediting

organization have differing credentialing standards for the same activity, the Contractor shall use the higher standard in performance of this contract.

C.2.8.3. The contractor shall collect and process all data necessary to produce the metrics identified in Attachment J-8, Clinical Quality Metrics, in accordance with the requirements of the TOM, Chapter 7, Section 3. The Government reserves the right to update Attachment J-8 in accordance with FAR 52.243-1, Alternate 1.

C.2.9. Return of Clinical Information (including Clear and Legible Reports (CLRs))

C.2.9.1. The Contractor shall ensure that its network providers make available or transmit to the Government (see paragraph C.2.9.2. below) accurate, complete, and legible clinical records and information pertaining to care delivered, pursuant to referrals or orders from MTF providers, to (1) active duty service members, and (2) TRICARE Prime beneficiaries assigned to MTF PCMs. The contractor shall ensure that its network providers comply with all applicable privacy and confidentiality laws and regulations when returning such records and information to the Government.

C.2.9.1.1. The term "clinical records and information" includes but is not limited to the following:

1. Specialty evaluations (initial and follow up notes)
2. Laboratory results
3. Radiology study reports
4. Preventive services
5. Discharge summaries and emergency room reports
6. Clinical procedures, clinical pathology reports, reports of care from ancillary services including but not limited to physical therapy, occupational therapy, speech and language therapy, and audiology
7. Other clinical documents, such as documentation reflecting that a clinical diagnosis has been added, removed, or discontinued; documentation reflecting that a medication has been added, discontinued, and/or modified; documentation reflecting a referral to another provider; and documentation of provider orders.

The following documents are specifically excluded from the definition of clinical records and information: Documents associated with (1) ordering Durable Medical Equipment, (2) providing ambulance services, and (3) providing home health care services.

C.2.9.2. The Contractor shall ensure that its network providers use one of the following methods for returning clinical records and information to the Government:

C.2.9.2.1. Making the clinical records and information (including CLRs) electronically available, via connection to the eHealth Exchange, or another health information exchange (HIE) network or HIE framework (such as the CommonWell® Health Alliance or Carequality) that is connected

to the Government's electronic health record system, so that the Government may easily access such records and information. This is the preferred method.

C.2.9.2.2. Transmitting the clinical records and information to the designated point-of-contact (POC) at the applicable Market/MTF. The Government will provide all necessary POC information to the Contractor through the MOU process (see paragraph C.2.12.9.). The Contractor shall provide this POC information to all of its network providers in Markets/PSAs and shall require its network providers in these areas to transmit clinical records and information to the identified POC, consistent with the timeliness requirements of paragraph C.2.9.3, in cases where the providers are not connected to the eHealth Exchange or another HIE network or framework connected to the Government's electronic health record system.

C.2.9.3. The Contractor shall ensure that its network providers make the required clinical records and information available to the Government, or transmit them to the Government, within 10 business days from the date of a patient's visit/date of service or within 40 business days from the date of a patient's discharge from inpatient care.

C.2.9.3.1. The Contractor shall establish a process to routinely follow up with network providers (no less than every 30 days) for missing clinical information/consultation reports.

C.2.9.3.2. The Contractor shall establish roles, responsibilities, and POCs for this follow-up process for each Market/PSA.

C.2.9.4. The Contractor shall maximize the inclusion, within its MTF referral networks, of individual and institutional providers that have and maintain access to, and comply with applicable technical standards to ensure ongoing connection with, the eHealth Exchange or another HIE network or HIE framework (such as the CommonWell® Health Alliance or Carequality) that is connect to the Government's electronic health records system.

C.2.10. Communications and Customer Service

C.2.10.1. The Contractor shall provide comprehensive readily accessible customer services for TRICARE-eligible beneficiaries and providers in accordance with the TOM, Chapter 11.

C.2.10.2. The Contractor shall provide outreach and communication consistent with those services offered to its (or its parent or affiliate organization's) commercial customers. Customer services shall be formatted to TRICARE specifications and include multiple, contemporary avenues of access (for example, email, World Wide Web, telephone, texting, smart phone applications, and social media) for TRICARE-eligible beneficiaries in accordance with the TOM, Chapter 11.

C.2.10.3. The Contractor shall perform all customer service functions with knowledgeable, courteous, responsive staff that results in highly satisfied beneficiaries.

C.2.10.3.1. The Contractor shall ensure that its customer service program is delivered in a manner that achieves the objectives of this contract without charge to beneficiaries or providers.

C.2.10.4. The Contractor's call center shall be certified by a nationally-recognized certification agency or program no later than 18 months after the SHCD and such certification shall be maintained throughout the life of this contract and all exercised options.

C.2.10.5. The Contractor shall provide customer service support for Markets, MTFs, Guard/Reserve Component units/commands, and the DHA office overseeing TRICARE Customer Service.

C.2.10.6. The Contractor shall comply with all requirements related to TRICARE publications, social media, beneficiary outreach, website management, TRICARE branding, and media relations as described in the TOM, Chapter 11, Section 6.

C.2.10.7. Call Resolution

C.2.10.7.1. The Contractor shall provide the beneficiary with an inquiry control number with each beneficiary (or beneficiary representative) call to the Contractor's service center.

C.2.10.7.2. The Contractor shall group and record all beneficiary concerns expressed on the call under the single control number.

C.2.10.7.3. The Contractor shall resolve all beneficiary concerns during the initial call.

C.2.10.7.4. The Contractor shall, if different departments/expertise is required to resolve a beneficiary question or concern, continue resolving the issue under the single beneficiary control number.

C.2.10.8. Call Backs

C.2.10.8.1. The Contractor's Automated Response Unit system shall allow the beneficiary to call about an open issue from a previous call for up to 30 calendar days (from the time of the previous call) and direct the beneficiary into a queue for resolving previous issues.

C.2.10.8.2. The Contractor shall, if the beneficiary cannot provide an inquiry control number from a previous call, research the previous control number based on the issue, date, or beneficiary ID.

C.2.10.8.3. The Contractor may, if the beneficiary's previous inquiry control number is over 30 calendar days old, assign the beneficiary a new inquiry control number.

C.2.10.8.4. The Contractor shall, if a beneficiary calls back regarding a previous issue within 30 calendar days for any reason associated with an open inquiry control number, not count the issue as resolved in its first call resolution report.

C.2.11. Claims Processing

C.2.11.1. The Contractor shall establish and maintain an automated claims processing system for TRICARE claims.

C.2.11.1.1. The Contractor's claims system shall utilize modern software development based on the ability to create clean claims and route claims for optimal processing using systems capable of intelligent decisioning that combine business rules management, decision processing, real-time event detection, decision governance, and powerful advanced analytics to automate and manage decisions across the enterprise. The Contractor's claims system shall also be capable of automated high volume data capture and routing focused on the Government's requirement for continuous delivery.

C.2.11.1.2. The Contractor's claims system shall be configured such that functionality necessary for timely and appropriate reconfiguration and adaptation for claims processing changes are quickly made at the lowest possible cost to the Government.

C.2.11.2. The Contractor shall process claims in accordance with the TRICARE benefit policy as delineated in 32 CFR Part 199.4 and 199.5, the TPM, TOM, and TRM.

C.2.11.3. The Contractor's claims processing system shall accurately apply deductible, co-pay, coinsurance, cost shares, catastrophic cap, referral/authorization requirements, and point-of-service (POS) provisions in accordance with the TRICARE benefit policy as delineated in 32 CFR Parts 199.4, 199.5, 199.17 and 199.18, as well as all applicable sections of the TPM, TOM, and TRM.

C.2.11.4. The Contractor's claims processing system shall accurately coordinate benefits with Other Health Insurance (OHI) plans to which the beneficiary is enrolled as required by 32 CFR Part 199.8, the TPM, and TRM.

C.2.11.5. The Contractor's claims processing system shall interface with and accurately determine eligibility and enrollment status based on the Defense Enrollment Eligibility Reporting System (DEERS) in accordance with the TSM.

C.2.11.6. The Contractor shall capture and report TRICARE Encounter Data (TED) related to claims adjudication in accordance with the TSM.

C.2.11.7. The Contractor shall provide designated DHA and military services personnel (including military services personnel at the Market and MTF level) access to real-time TRICARE claims data.

C.2.11.7.1. The Contractor's read-only claims data system shall be made accessible to users on a continual (24 hours per day/7 days per week) basis except for scheduled downtime for system maintenance. To the maximum extent practicable, the Contractor shall schedule system

maintenance windows during weekends or non-peak hours to minimize disruption of services to Government users.

C.2.11.7.2. The Contractor shall provide training and ongoing customer support for its claims data system to Government users.

C.2.11.7.3. The Contractor shall provide training for its claims data system either in-person/onsite or virtually.

C.2.11.7.4. The Contractor shall ensure that its claims data system training materials are updated and current and made available to designated DHA and military services personnel (including military services personnel at the Market/MTF level)

C.2.11.8. The Contractor shall use commercial best business practices to identify and update OHI information stored in the DEERS database for non-active duty service members who have no commercial health insurance information on file.

C.2.11.8.1. The commercial best practices employed by the Contractor shall include, but are not limited to, the use of external data bases to achieve the goal of identifying accurate and complete OHI information.

C.2.11.8.2. Contractor use of its commercial data base is insufficient to meet this requirement if it only checks/verifies for OHI within its own commercial health plan.

C.2.11.9. The Contractor shall comply with all requirements regarding adjustments/recovery of underpayments, overpayments, recoupments, Third Party Liability (TPL), and collections in accordance with the TOM, Chapter 10.

C.2.12. Management

C.2.12.1. Contractor Leadership

C.2.12.1.1. The Contractor shall establish and maintain experienced and qualified leadership personnel and sufficient staffing and management support to meet the requirements of this contract.

C.2.12.1.2. The Contractor shall identify to the Government a senior level team member or members who possess the authority and have the ability to make management decisions for the Contractor within the scope of the contract, and who will attend meeting(s) with the GDA, either via telephone conference call, video teleconference (VTC), or other agreed-upon electronic methods of communication. The Contractor shall promptly update the Government when there are changes in these leadership positions.

C.2.12.1.3. The Contractor's leadership team shall be prepared to address urgent matters with the Government. To that end, the Contractor shall identify to the Government a senior level team

member or members who possess the authority and have the ability to obligate resources within the scope of the contract, and who are able to attend in-person meeting(s) with the GDA on short notice (i.e., within two business days) at a location identified by the GDA.

C.2.12.2. Quality Management (QM)/Quality Improvement (QI) Program (QM/QI)

C.2.12.2.1. The Contractor shall establish and operate a QM/QI program in accordance with the TOM Chapter 7, Section 6.

C.2.12.2.2. The Contractor's QM processes shall focus on the clinical quality of health care rendered and outcomes, program processes and procedures, standardization, identifying and resolving access to care problems, and fostering a consistent, efficient, and effective TRICARE program for beneficiaries.

C.2.12.2.3. The Contractor's QI processes shall focus on process improvements and shall foster innovation by incorporating healthcare best business practices and healthcare industry standards that lead to quality healthcare access, quality health care rendered, and quality health care outcomes.

C.2.12.2.4. The Contractor’s QM/QI program shall be comprehensive and coordinated, covering all aspects of the TRICARE program, with oversight by Contractor senior leadership, ensuring that QM/QI information and processes are incorporated and communicated across its entire enterprise.

C.2.12.2.5. The Contractor shall submit an annual QM/QI plan. For plan reporting requirements see DD Form 1423-1, CDRL, located in Section J.

C.2.12.2.6. The Contractor shall provide visibility of QM/QI processes and reports to the Government on a routine basis. The Government will determine the reporting frequency and may adjust the frequency as it deems necessary.

C.2.12.2.7. The Contractor shall initiate and conduct monthly operational and assessment reviews for the Government during which the Contractor will present its performance against all quality standards. The venue and manner of presentation will be determined by the Government.

C.2.12.2.8. The Contractor shall initiate Quality Improvement Projects (QIPs) to address performance issues identified by the Government as being out of contract compliance for three or more consecutive reporting periods, and to address any other significant instances of non-conformance.

C.2.12.2.9. The Contractor shall, if problems are identified through its internal QM/QI Program, electronically submit a QM/QI report to the GDA within 10 calendar days following the end of the month when the problem was identified. The report shall include corrective actions that were initiated and those that are planned with identified target compliance/resolution achievement dates. For reporting requirements see DD Form 1423-1, CDRL, located in Section J.

C.2.12.2.9.1. The Contractor shall submit a monthly update/status report until all corrective actions have been accomplished. For reporting requirements see DD Form 1423-1, CDRL, located in Section J.

C.2.12.3. Coordination/Integration of Healthcare Delivery

C.2.12.3.1. The Contractor shall ensure the efficient and effective coordination of healthcare delivery between its networks and the direct care system, within its area of geographic responsibility, by closely collaborating with Market Directors/MTF Directors and associated Government staff. Such efforts shall be accomplished without compromising network access for enrolled beneficiaries who are not assigned an MTF PCM.

C.2.12.3.2. The Contractor's coordination and collaboration with the Markets/MTFs, and its MOUs with the Markets/MTFs (see paragraph C.2.12.9), shall address the following subjects, at a minimum: preventive care, overflow capacity for primary and specialty care, ancillary services, referrals for designated specialty care, points of contact, and beneficiary enrollment.

C.2.12.4. Contingency Operations Program

C.2.12.4.1. The Contractor shall, in addition to complying with the requirements regarding the continuation of essential Contractor services described in DFARS Clause 252.237-7023, submit a contingency operations plan no later than 120 calendar days prior to the SHCD. For plan reporting requirements, see DD Form 1423-1, CDRL, located in Section J.

C.2.12.4.1.1. The Contractor's contingency operations plan shall describe how the Contractor will provide all necessary health care services for TRICARE-eligible beneficiaries when Market and MTF personnel must respond to wars, operations other than war, deployments, training events, contingencies, special operations, and natural disasters (including pandemics) thereby diminishing the capacities and capabilities of impacted Markets and MTFs.

C.2.12.4.1.2. The Contractor's contingency operations plan shall detail how the Contractor will ensure that healthcare services will be continuously available for beneficiaries in the event of such changes in Market and MTF capabilities, to include changes in bed capacity.

C.2.12.4.1.3. The Contractor's contingency operations plan shall describe the processes it will employ to ensure coordination with Markets, MTFs, and TRICARE Health Plan personnel, as well as outside agencies including U.S. Transportation Command (USTRANSCOM), the Department of Health and Human Services, the Department Homeland Security, the Department of Defense, the Department of Veterans Affairs, and the National Disaster Medical System for planning and operations.

C.2.12.4.2. The Contractor shall participate in contingency exercises, including regionally coordinated table-top contingency exercises, twice each calendar year for each Market and MTF.

C.2.12.4.2.1. The Contractor shall implement its contingency program at any and all affected exercise locations within 48 hours of being notified by the GDA that a contingency exists.

C.2.12.4.2.2. The Contractor shall maintain contingency operations communications with the DHA, Markets, and MTFs during the course of the exercise.

C.2.12.4.2.3. The Contractor shall submit an exercise participation report at the conclusion of each exercise. For reporting requirements, see DD Form 1423-1, CDRL, located in Section J.

C.2.12.4.3. The Contractor shall deploy mobile Service Assist Team (SATs) necessary to perform customer service functions in disaster areas, Active Component and Reserve Component troop mobilization areas, Base Realignment and Closure (BRAC) areas, or any area deemed necessary by the GDA.

C.2.12.4.3.1. The Contractor shall deploy a SAT only after the Contracting Officer has issued a contract modification defining the requirements for the SAT.

C.2.12.4.3.2. The Contractor will deploy one or more SAT teams on an as needed basis for a finite period of time as defined in the modification.

C.2.12.4.3.3. The Contractor shall deploy one or more SAT teams within seven calendar days after notification from the CO.

C.2.12.4.3.4. SATs shall provide assistance with beneficiary enrollment, access to care, and referrals, and shall provide TRICARE program information to a variety of markets and community network providers.

C.2.12.4.4. The Contractor shall cooperate with Markets and MTFs to coordinate the care and transfer of patients who require transfer to another location/area as a result of contingency operations. Transfers may occur as a result of medical, social, or financial reasons and include moves of non-institutionalized and institutionalized patients

C.2.12.4.4.1. The Contractor's participation in the coordination of care shall include coordinating with the primary clinician at the losing and gaining sites and the patient's family (as applicable); arranging medically appropriate patient transport (ground or air); ensuring all necessary supplies are available during the transport and at the receiving location; arranging for and ensuring the presence of all necessary medical equipment during transport and at the receiving location; and identifying and ensuring the availability of necessary resources to accomplish the transfer.

C.2.12.4.4.2. In the case of contingency military operations, the Contractor shall ensure collaboration between military and civilian transport, particularly at the time of initial receipt of patients from Continental United States (CONUS) intermodal transportation and distribution hubs to higher echelons of care, as defined by U.S. Transportation Command (USTRANSCOM).

C.2.12.5. Information System/Data Repository

C.2.12.5.1. The Contractor shall develop and maintain an information system/data repository through which the Government may access data at the beneficiary, non-institutional, and institutional level. (This requirement is in addition to the MM/UM data access requirement and beneficiary-centric data warehouse and analytic tools/system described at paragraph C.2.3.3.1.) The Contractor shall ensure that the information in its system/data repository is current and refreshed no less frequently than once every 24 hours.

C.2.12.5.2. The Contractor shall make its information system/data repository accessible to Government users (described in paragraphs C.2.12.5.3 and C.2.12.5.3.1) on a continual (24 hours per day, 7 days per week) basis except during scheduled downtime for system maintenance.

C.2.12.5.2.1. The Contractor shall schedule system maintenance windows on weekends or during non-peak hours to minimize disruption of services to Government users.

C.2.12.5.3. The Contractor shall provide at least two system access authorizations for each MTF and USCG clinic, two authorizations for each Market, two authorizations for each Intermediate Service Command, two authorizations for each military department Surgeon General's Office, five authorizations for the Chief, TRICARE Health Plan, five authorizations for DHA (various locations), two authorizations for Health Affairs, two authorizations for DHA-Falls Church, and two authorizations for DHA-Aurora.

C.2.12.5.3.1. The Contractor shall make available an additional 30 authorizations for Government personnel or contractor employees acting on the Government's behalf (e.g., analysts).

C.2.12.5.3.2. The Contractor shall submit to the Government a recurring report listing all Government users provided access to its information system/data repository. For reporting requirements, see DD Form 1423-1, CDRL, located in Section J.

C.2.12.5.4. The Contractor's information system/data repository shall address/encompass the following data elements, at a minimum: details concerning the provider network, referrals, authorizations, claims processing, program administration, beneficiary satisfaction and services, incurred health care costs, enrollment, geo-mapped data elements and clinical data (case management, chronic care/population health, utilization management, medical management), and all data pertaining to the execution of the Prime and Select benefits both inside and outside PSAs/Markets.

C.2.12.5.5. The Contractor shall satisfy user requirements for ad-hoc capability reports, standardized reports, and special reports within timelines mutually agreed upon by the Contractor and Government users, but such timelines shall never exceed five business days.

C.2.12.5.5.1. The Contractor shall submit to the Government a recurring report listing all ad-hoc reports, standardized reports, and special reports provided to the Government. For reporting requirements see DD Form 1423-1, CDRL, located in Section J.

C.2.12.5.6. The Contractor shall build a user-friendly search capability into its information system/data repository.

C.2.12.5.6.1. The Contractor's system shall, at a minimum, accommodate data queries/searches on a Regional, MTF PSA, and standard geographic area (State, County, and ZIP Code) basis.

C.2.12.5.7. The Contractor shall collaborate with the GDA to select a mutually acceptable data access interface no later than 150 calendar days prior to the SHCD.

C.2.12.5.8. The Contractor shall provide user training (which may be web-based) and ongoing customer support to facilitate user access to the information system/data repository.

C.2.12.5.8.1. The Contractor shall deploy its training no later than 75 calendar days prior to the SHCD and shall make additional training available on an ongoing basis.

C.2.12.5.8.2. The Contractor shall provide a recurring report listing all Government personnel who have been trained to use and access its information system/data repository. For reporting requirements see DD Form 1423-1, CDRL, located in Section J.

C.2.12.5.9. The Contractor shall provide customer service support to assist Government users during normal Government business hours, Monday through Friday (excluding holidays) for all time zones in its geographic area of responsibility.

C.2.12.5.10. The Contractor shall provide information management and information technology support as needed to accomplish the stated functional and operational requirement of the TRICARE program and in accordance with the TSM.

C.2.12.6. Information Systems Security

C.2.12.6.1. The Contractor shall provide a completed system security plan (or extract thereof) and any associated plans of action developed to satisfy the security requirements of DFARS 252.204-7012, and in accordance with NIST Special Publication (SP) 800-171, "Protecting Controlled Unclassified Information in Nonfederal Systems and Organizations," to describe the Contractor's unclassified information system(s) and network(s) where DoD controlled unclassified information associated with the performance of this contract is processed, stored, or transmitted. For reporting requirements, see DD Form 1423-1, CDRL, located in Section J.

C.2.12.6.2. The Contractor shall, upon request, provide the Government with access to the system security plan(s) (or extracts thereof) and any associated plans of action for each of its subcontractors that processes, stores, or transmits DoD controlled unclassified information associated with the performance of this contract.

C.2.12.6.3. The Contractor shall identify and verify marking requirements for all DoD controlled unclassified information associated with the performance of this contract as prescribed by DoDM 5200.01, Volume 4, Controlled Unclassified Information, and DoDI 5230.24, Distribution Statements on Technical Documents.

C.2.12.6.4. The Contractor shall identify, track, and safeguard all DoD controlled unclassified information associated with the performance of this contract.

C.2.12.6.4.1. The Contractor shall document, maintain, and provide to the Government, a record of any subcontractor that receives or develops DoD controlled unclassified information, as defined in DFARS Clause 252.204-7012, and associated with the performance of this contract. For reporting requirements, see DD Form 1423-1, CDRL, located in Section J.

C.2.12.6.5. The Contractor shall restrict unnecessary sharing and flow-down of DoD controlled unclassified information associated with the performance of this contract, in accordance with any marking and dissemination requirements specified elsewhere in the contract and based on a 'need-to-know' to perform the requirements of this contract.

C.2.12.6.6. The Contractor shall participate in the post-award Systems Integration Meeting (SIM), where the Government will present an overview or briefing on protecting DoD controlled unclassified information and compliance with DFARS Clause 252.204-7012.

C.2.12.7. Personnel Security Program

C.2.12.7.1. The Contractor shall implement a personnel security program as described in the TSM, Chapter 1, Section 1.1.

C.2.12.8. Contractor Employee Identification

C.2.12.8.1. The Contractor shall ensure that its employees always identify themselves as Contractor employees and do not act, or advertise themselves, as Government employees, agents, or representatives. This identification requirement shall apply in the context of telephone conversations, formal and informal written correspondence (paper and electronic), and in all other circumstances and situations in which a reasonable person mistakenly could construe the contractor employee's actions as the acts of a Government official.

C.2.12.9. Memorandums of Understanding (MOUs)

C.2.12.9.1. The Contractor shall develop and execute MOUs with DHA, the Markets, and individual MTFs as described the TOM, elsewhere in this Section C, and in applicable DHA Policy instructions.

C.2.12.9.2. The Contractor shall maintain open communications, and develop MOUs, with the other TRICARE contractors listed in paragraph C.2.12.9.2.1. Such MOUs shall delineate,

among other things, each contractor's responsibilities for addressing any issues that arise when beneficiaries and beneficiary information cross contract boundaries.

C.2.12.9.2.1. The Contractor shall develop MOUs with the following TRICARE contractors: the other regional T-5 Managed Care Support Contractor, the TRICARE Dental Contractors, the TRICARE Overseas Program (TOP) Contractor, the TRICARE Medicare Eligible Program (TMEP) Contractor, the TRICARE Pharmacy (TPharm) Contractor, the Nurse Advice Line (NAL) Contractor, the TRICARE Quality Monitoring (TQMC) Contractor, the TRICARE Claims Review Services (TCRS) Contractor, any future EEE contractor (as described in paragraph H.17.2), and any contractor awarded a contract pursuant to a "competitive demonstration" (as described in paragraph H.17) in the Contractor's geographic area of responsibility.

C.2.12.9.2.2 Topics addressed in these MOUs should include, but need not be limited to, the following: case management, care coordination, medication reconciliation, referrals and authorizations, beneficiary notifications, claims, OHI, disease surveillance/prevention, and beneficiary facility transfers. The MOUs should also address any other topics that will facilitate cooperation between Contractors and/or the effective and efficient integration of direct care and private sector care systems and processes.

C.2.12.9.3. The Contractor shall execute all MOUs no later than 90 calendar days prior to the SHCD, with the exception that the Contractor shall execute any MOUs with "competitive demonstration" contractors no later than 60 days after the award of any such contracts.

C.2.12.10. Market/MTF Optimization

C.2.12.10.1. The Contractor shall support Market/MTF business plan objectives and shall collaborate with the Government to support Market and MTF optimization in the following areas:

1. Improved patient experience for referrals to and from the Contractor.
2. Capture of Knowledge, Skills, and Abilities (KSA) procedures to direct care system from the Contractor's network in the MTF/Market service areas.
3. Timely return of clinical information (include CLRs) and maximization of the inclusion, within the Contractor's MTF referral networks, of individual and institutional providers that have and maintain access to the eHealth Exchange or another HIE network or HIE framework that connects with the Government's electronic health records system (see paragraph C.2.9).
4. Recapture of TRICARE Prime-enrolled beneficiaries with MTF PCMs to direct care system inpatient facilities, including emergency room repatriation and inpatient admissions.
5. Decreased secondary referrals when beneficiary care needs can be supported by the direct care system.
6. Utilization of the Market/MTF 24/7 Operator Cell for coordination of beneficiary care needs such as urgent referrals.

C.2.12.10.2. The Contractor shall use commercially available web-based mapping software to calculate distance and time standards.

C.2.12.10.3. The Contractor shall provide user access to this software for up to 12 Government users at no additional cost no later than 120 calendar days prior to the SHCD to enable the Government to evaluate the Contractor's calculations.

C.2.12.10.4. The Contractor shall utilize the Government-provided Catchment Area Directory (CAD) file to update its processes/files as appropriate.

C.2.12.11. Systems Integration

C.2.12.11.1. The Contractor shall comply with all Government systems integration requirements covering general automated data processing, TEDs, DEERS, and the TRICARE Duplicate Claims System (DCS) in accordance with the TSM.

C.2.12.12. Interface with MHS GENESIS

C.2.12.12.1. The Contractor shall establish an electronic system interface with MHS GENESIS to ensure the complete exchange of all required data needed to perform referral management activities and to process referral management messages between the Contractor's system and MHS GENESIS, consistent with the requirements of Attachments J-13 (MHS GENESIS Supplement – Interface Control Document), J-14 (MHS GENESIS Performance Work Statement), and J-17 (Referral Management Data Elements Table).

C.2.12.12.2. The Contractor shall, following establishment of its interface to MHS GENESIS, maintain the interface through the life of the contract.

C.2.12.13. Program Integrity (PI)

C.2.12.13.1. The Contractor shall have a PI unit dedicated to the TRICARE program that performs, at a minimum, the following tasks and activities: predictive analytics, provider education, prevention, and prepayment- and post-payment reviews tailored to ensuring that necessary medical, pharmacy, and dental services provided under the Program are delivered exclusively to TRICARE eligible beneficiaries by authorized providers and that reimbursements are provided to eligible beneficiaries and providers through appropriate claims adjudication processes and in a manner consistent with existing law, regulation, and DHA policies and instructions.

C.2.12.13.2. The Contractor's PI Unit shall focus its efforts on prevention, detection, correction, and deterrence of fraud and abuse in the TRICARE program.

C.2.12.13.3. The Contractor's PI unit shall be compromised of experienced professionals who have anti-fraud experience and hold degrees, designations, and/or certifications such as (but not

limited to) the following: Registered Nurse/Bachelor of Science in Nursing (RN/BSN), Certified Professional Coder (CPC), Certified Coding Specialist (CCS), Clinical Documentation Specialist (CCDS), Certification in Healthcare Compliance (CHC), Healthcare Anti-Fraud Associate (HCAFA), Accredited Healthcare Fraud Investigator (AHFI), Certified Fraud Examiner (CFE), and Juris Doctor (JD).

C.2.12.13.4. The Contractor shall refer for disposition by DHA PI cases that involve $250,000 or greater in potential losses to the Government following procedures prescribed in 32 CFR 199.9 and the TOM, Chapter 13.

C.2.12.14. Privacy

C.2.12.14.1. The Contractor shall establish and maintain a privacy program which meets Federal, DoD, and DHA privacy requirements detailed in the TSM and TOM, Chapter 19.

C.2.12.15. Records Management

C.2.12.15.1. The Contractor shall operate and maintain a records management program in accordance with DoD Instruction (DoDI) 5015.02, "DoD Records Management Program," February 24, 2015.

C.2.12.15.2. The Contractor's records management program shall be operational no later than 120 calendar days prior to the SHCD.

C.2.12.15.3. The Contractor's records management program shall adhere to the requirements outlined in the TOM, Chapter 9, Records Management.

C.2.12.15.4. The Contractor shall appoint and maintain the staff necessary to meet the records management requirement including a Records Manager with the overall responsibility for the requirement and to liaise with the DHA Records Management Office.

C.2.12.15.4.1. The Contractor's Records Manager shall have or obtain within one year of appointment the Certified Records Managers (CRM) credential issued through the Institute of Certified Records Managers.

C.2.12.15.4.2. The Contractor's Records Manager shall have oversight of the Contractor's records management program to ensure the planning, controlling, directing, organizing, training, promoting, and other managerial activities related to the creation, maintenance and use, and disposition of records, are carried out in such a way as to achieve adequate and proper documentation of Federal policies and transactions and effective and economical management of operations.

C.2.12.16. Financial Management

C.2.12.16.1. The Contractor shall comply with all financial management requirements covering payments, claims refunds and collection procedures, invoicing, stale-dated checks, Electronic Funds Transfer (EFT), financial audits, and enrollment fee transfers in accordance with Sections G and H of this contract, and the TOM, Chapter 3.

C.2.12.17. Appeals and Hearings

C.2.12.17.1. The Contractor shall comply with all requirements related to reconsideration procedures, appeals of medical necessity determinations, appeals of factual determinations, and DHA appeals in accordance with the TOM, Chapter 12.

C.2.12.18. Telehealth

C.2.12.18.1. The Contractor shall develop a telehealth program that maximizes the availability of telehealth throughout its provider networks and facilitates delivery of telehealth services in accordance with the TOM, Chapter 27 and TPM, Chapter 7.

C.2.12.19. Transition

C.2.12.19.1. The Contractor shall employ the necessary resources to complete all transition-in requirements outlined in the TOM, Chapter 2 and the TSM.

C.2.12.19.2. The Contractor shall ensure its services and systems are fully operational at the SHCD and shall also ensure minimal disruption to beneficiaries and the Markets/MTFs.

C.2.12.19.3. The Contractor shall employ the necessary resources to fully comply with all transition-out requirements outlined in the TOM, Chapter 2 and the TSM.

C.2.12.19.4. The Contractor shall ensure that all operational areas and systems related to the seven key contract areas being evaluated during Performance Readiness Validation (PRV) and Performance Readiness Assessment and Verification (PRAV) are staffed with a sufficient number of qualified, trained personnel and that all systems and programs are functional prior to the SHCD in accordance with the timelines and performance thresholds identified in the TOM, Chapter 2, Section 1.

C.2.12.19.4.1. The Contractor shall ensure that its staff are equipped to facilitate the evaluation of performance readiness in the following key contract areas: (1) provider networks, (2) enrollment, (3) customer service, (4) records management, (5) referral management, (6) claims processing, and (7) clinical operations. (See the TOM, Chapter 2 for a description of the PRV/PRAV processes and specific requirements.)

C.2.13. Interoperability

C.2.13.1. The Contractor's claims, referral, and population health systems shall be capable of CMS-9123-P final rule interoperability standards prior at the SHCD.

(End of Section)

SECTION D
PACKAGING AND MARKING

D.1. PACKAGING

Preservation, packaging, and packing for shipment or mailing of all work delivered hereunder, by other than electronic means, shall be in accordance with good commercial practice and adequate to insure acceptance by common carrier and safe transportation at the most economical rate(s). The Contractor shall not utilize certified or registered mail or private parcel delivery service for the distribution of reports under this contract without the advance approval of the Contracting Officer. CD-ROMs (or other electronic media) shall be packed in labeled cartons in accordance with the best commercial practices that meet the packing requirements of the carrier and ensure safe delivery at the destination.

D.2. MARKING

Each package, report or other deliverable shall be accompanied by a letter or other document which:

D.2.1. Identifies the contract by number under which the item is being delivered.

D.2.2. Identifies the deliverable Item Number or Report Requirement which requires the delivered item(s).

D.2.3. Indicates whether the Contractor considers the delivered item to be a partial or full satisfaction of the requirement.

D.3. Packages, reports, or other deliverables which contain Protected Health Information (PHI) or Personally Identifiable Information (PII) must comply with applicable law, regulation, DoD issuances, and TRICARE Manuals. (See TOM Chapter 1, Section 5; Chapter 19).

(End of Section)

SECTION E
INSPECTION AND ACCEPTANCE

FAR 52.246-4 Inspection of Services--Fixed-Price (AUG 1996)

FAR 52.246-5 Inspection of Services--Cost-Reimbursement (APR 1984)

E.1. INSPECTION LOCATIONS

Inspections may be conducted electronically or by physical inspection. Inspections will be performed at the Defense Health Agency (DHA), the Contractor's and/or subcontractor's facilities, or any other locations at which work is performed. Inspection of services provided hereunder will be accomplished by the Contracting Officer or his/her designee(s).

E.2. ACCEPTANCE

E.2.1. Transition-In and Transition-Out: The Contractor shall submit one DD250, Material Inspection and Receiving Report after accomplishing the required Transition-In and Transition-Out requirements. The DD250 shall be sent to the Contracting Officer's Representative with a copy provided to the Contracting Officer.

E.2.2. Formal acceptance or rejection of all other services provided under the terms and conditions of this contract will be accomplished by the Contracting Officer or Contracting Officer's Representative on an annual basis after each option period using a DD250, Material Inspection and Receiving Report. The Contractor shall submit a DD250 after accomplishing all required services in each respective option period. The DD250s shall be sent to the Contracting Officer's Representative with copies provided to the Contracting Officer.

(End of Section)

FAR 52.242-15 Stop-Work Order. (Aug. 1989)

FAR 52.242-15 Stop-Work Order. (Aug. 1989) – Alternate I (Apr 1984)

F.1. PERIOD OF PERFORMANCE

F.1.1. Base Period (January 1, 2023 through December 31, 2023): The Contractors shall begin transition-in activities and complete specific activities by the timelines specified in the TRICARE Operations Manual (TOM) Chapter 2. All transition-in activities shall be accounted for and documented as required in the Contractor's Integrated Master Plan (IMP)/Integrated Master Schedule (IMS).

F.1.2. Option Periods 1 through 8 will be 12 months each if exercised.

Option Period 1: January 1, 2024 through December 31, 2024

Option Period 2: January 1, 2025 through December 31, 2025

Option Period 3: January 1, 2026 through December 31, 2026

Option Period 4: January 1, 2027 through December 31, 2027

Option Period 5: January 1, 2028 through December 31, 2028

Option Period 6: January 1, 2029 through December 31, 2029

Option Period 7: January 1, 2030 through December 31, 2030

Option Period 8: January 1, 2031 through December 31, 2031

F.1.2.1. Transition-Out is an 18 month CLIN with Period of Performance beginning no later than 180 days after the start of any Option Period (1-8).

F.1.3. The option periods identified herein are hereby defined as the period in which health care is delivered to TRICARE beneficiaries. The Start of Healthcare Delivery (SHCD) is the first day of Option Period 1. In order to meet the requirements of the contract for health care delivered for a given period, the contractor will be performing incidental administrative tasks associated with the given health care delivery period beyond that period.

F.1.4. The transition-out period may be exercised during any one of the health care delivery periods specified above. The contractor will begin transition-out activities upon transition-out option exercise and complete the timelines as specified in TOM Chapter 2. All transition-out activities shall be completed within the 18 month transition-out period of performance.

F.2. GEOGRAPHIC AREA OF COVERAGE

F.2.1. East Region Contract: The contract shall be referred to as the East Region Contract. The East Region contract will require development, implementation and operation of a healthcare delivery and support system for the TRICARE Prime and Select benefits for all TRICARE beneficiaries residing in the following states and District:

Table F.2.1.

Alabama	Maryland	Pennsylvania
Connecticut	Massachusetts	Rhode Island
Delaware	Michigan	South Carolina
District of Columbia	Mississippi	Tennessee
Florida	New Hampshire	Vermont
Georgia	New Jersey	Virginia
Indiana	New York	West Virginia
Kentucky	North Carolina	
Maine	Ohio	

These geographic areas are, hereinafter, referred to as the East Region contract. The East Region contractor shall be responsible for administering and complying with all Continued Health Care Benefit Program (CHCBP) requirements in the entire United States.

F.2.1.1. West Region Contract: The contract shall be referred to as the West Region contract. The West Region contract will require development, implementation and operation of a healthcare delivery and support system for the TRICARE Prime and Select benefits for all TRICARE beneficiaries residing in the following states:

Table F.2.1.1.

Alaska	Kansas	Oklahoma
Arizona	Louisiana	Oregon
Arkansas	Minnesota	South Dakota
California	Missouri	Texas
Colorado	Montana	Utah
Hawaii	Nebraska	Washington
Idaho	Nevada	Wisconsin
Illinois	New Mexico	Wyoming
Iowa	North Dakota	

These geographic areas and states are hereinafter referred to as the West Region Contract.

F.2.2. Zip codes within each Region are defined in the Request for Proposal, Attachment J-19.

F.2.3. Attachments J-1 through J-6 identify Large and Small Market MTF and Stand-Alone MTF within the East and West Regions.

F.3. REPORTS AND PLANS

Unless otherwise specified, the Contractor shall electronically submit all Contract Data Requirements List items (CDRL) (contract plans, reports, etc.) in the specified format using Microsoft Office Excel, Word, PDF, or other specified software. If no format is specified, the Contractor may use its own format. The Defense Health Agency (DHA) E-Commerce Extranet application facilitates the submission and tracking of contract deliverables. The contractor shall submit all required deliverables to the DHA via the E-Commerce Extranet unless otherwise directed by DD Form 1423, CDRL, located in Section J of the applicable contract.

F.3.1. The Contractor shall provide all reports and plans that are specified in this Section. The Contractor is accountable for assuring that reports contain accurate and complete data. The Contractor shall prepare written procedures describing the source of information as well as the specific steps followed in the collection and preparation of data for each report. All reports must be supported with sufficient documentation and audit trails. The reports shall be titled as listed. The Contractor shall submit a negative report if there is no data to report. Required reports include:

F.3.1.1. Daily Reports

D010 Non-Financially Underwritten Contractor Payment/Check Issue Data

D020 Financially Underwritten Contractor Payment/Check Issue Data

D030 Prime Travel Benefit Program Attestation Report
D040 Daily Rolling Authorizations Inventory Report
D050 Daily Rolling Referral Inventory Report

F.3.1.2. Weekly Reports

W010 Integrated Master Plan (IMP) Status Report
W020 Transition Out (Phase Out) Status Report
W030 Integrated Master Schedule (IMS) Status Report
W040 Deferred Claims Report
W050 Risk and Mitigation Report
W060 Program Integrity Cases (Work Products)

F.3.1.3. Monthly Reports

M010 Value-Based Steerage Plan Performance Report
M020 Provider Directory Accuracy Report
M030 Referral Accuracy Report
M040 Resource Sharing Program (ERSA, IRSA, CSA) Report
M050 HIPAA Privacy Complaint Report
M060 TRS/TYA/TRR Premium Activity Report
M070 Beneficiary Services Report
M080 Un-activated Referrals
M090 Management Report
M100 Medical Management Programs Report
M110 Network Status Report (NSR)
M120 Network Inadequacy Report
M130 Non-Financially Underwritten Accounts Receivable Summary Report (Government)
M140 Non-Financially Underwritten Accounts Receivable Summary Report (Non-Government)
M150 Non-Financially Underwritten Bank Account Reconciliation Report
M160 Non-Financially Underwritten Bank Cleared Payment Data
M170 Financially Underwritten Bank Cleared Payment Data
M180 Non-Financially Underwritten Bank Account Statement Report
M190 Overpayment Cases Against VA Facilities

M200 Customer Support Hours Used Report
M210 Access Standards Report
M220 Network Adequacy/Access-Referrals to MTF and Network Report
M230 CHCBP Adjusted Premiums Report (CHCBP Contractor)
M240 CHCBP Enrollment Premium Report (CHCBP Contractor)
M250 CHCBP Enrollment Report (CHCBP Contractor)
M260 CHCBP Premiums Summary Report (CHCBP Contractor)
M270 CHCBP Workload Report (CHCBP Contractor)
M280 Referrals from Contractor to Market/MTF Report
M290 Call Center Quality Monitoring Report
M300 Referrals and Authorizations Transferred Between Contractors Report
M310 Capital and Direct Medical Education Cost Report
M320 Market/MTF/Network Directed Referrals Report
M330 Clinical Quality Management (CQM) Quality Intervention Report
M340 Contractor Records Accountability Report
M350 Access to Data Training
M360 DHA-GL Deferred Claims Report
M370 Outgoing Records Transfer Report
M380 Incoming Records Transfer Report
M390 Preauthorizations/Authorizations and Referral Timeliness Report
M400 Access Authorizations to Government Personnel
M410 Adjudicated Referral/Claims Report
M420 TRICARE Prime and Select Enrollment Fees Wire Transfers Report
M430 Rare Disease & Treatment Review Report
M440 Ad-hoc Report Requests
M450 Load File Completion Report
M460 Freestanding Behavioral Health Facility Report
M470 Beneficiary Access Assistance Report
M480 Inpatient Admissions Summary Report
M490 Concurrent Review Report
M500 Employee Access to DoD IS/Networks Report

M510 Provider Moonlighting and Claims

M520 Rejected/Returned Referrals Report

M530 Performance Assessment Report

M540 RESERVED

M550 RESERVED

M560 DOD VA Hearing Aid Demonstration Report

F.3.1.4. Quarterly Reports

Q010 End-of-Process Quality Review Report

Q020 Beneficiary Publications Use Report

Q030 Clinical Quality Data Report (Q)

Q040 Fraud and Abuse Summary and ROI Reporting

Q050 Referrals Received by Specialty Report

Q060 Evolving Practices Report

Q070 Quality Assessment Report

Q080 Behavioral Health Network Status Report

Q090 MTF/Market Level Contingency Exercise Participation Report

Q100 Comprehensive Autism Care Demonstration Report (Q)

Q110 Mental Health Counselor Status Report

Q120 Beneficiary Satisfaction Survey Report

Q130 Predictive Analytics/Modeling Report

Q140 Listing of Prime Service Areas (PSA) Zip Codes

Q150 Health System Area Assessment Report

Q160 TRICARE Quality Monitoring Contract (TQMC) Findings Response Report

Q170 Prescription Monitoring Program (PMP) Geographic Area of Responsibility Response Report

Q180 Ambulatory Retrospective Review Report

Q190 Advanced Rehabilitation Center and Amputation Referrals

Q200 Network Status Report - Telehealth (NSR - T)

Q210 Provider Prescription Monitoring Program Report

Q220 RESERVED

Q230 Beneficiary Publications Return Report

Q240 Tobacco and Vaping Quit Line Staff Report

Q250 Tobacco and Vaping Quit Line Report

Q260 Beneficiary Outreach Report

Q270 Low Back Pain Physical Therapy Demo Report

Q280 Clinical Quality Management (CQM) Data Dashboard

F.3.1.5. Semiannual Reports

S010 Behavioral Health Standardized Measures Audit Report

S020 Access Standards Summary Report

S030 Agency for Healthcare Research and Quality (AHRQ) Patient Safety Indicators (PSIs) Report

S040 Retrospective Review for Other Than Diagnostic Related Group (DRG) Validation Report

S050 Population Health Outreach and Interactive Capability Report

S060 RESERVED

S070 Clinical Quality Data Report (S)

F.3.1.6. Annual Reports

A010 Clinical Quality Management Program (CQMP) Report

A020 Indirect Medical Education (IDME) Ratio for Children's Hospitals Report

A030 Third Party Recoveries for Fiscal Year Report

A040 State Prevailing Annual Update Report

A050 Service Organization Control Report (SOC1) - SSAE No. 18 (Prime with Subservice Organization)

A055 Bridge Letter in Support of Service Organization Control Report (SOC1) - Statement on Standards for Attestation Engagements, SSAE No. 18 (Prime with Subservice Organization)

A060 Service Organization Control Report (SOC1) - Statement on Standards for Attestation Engagements, SSAE No. 18 (Subservice Organization)

A065 Bridge Letter in Support of Service Organization Control Report (SOC1)-Statement on Standards for Attestation Engagements, SSAE No. 18 (Subservice Organization)

A070 Comprehensive Autism Care Demonstration (A)

A080 Fetal Surgery and Procedures Toll-Free Number or Call Tree Option Report

A090 Disaster Recovery Test Results Report

A100 Risk Assessment Letter of Assurance

A110 Evaluation of Population Health (PH) Care

A120 MOU with (Nurse Advice Line Contractor Name)

A130 MOU with (TRICARE Claims Review Services Contractor Name)

A140 MOU with (TRICARE Quality Monitoring Contractor Name)

A150 MOU with (MCSC(s) Contractor Name)

A160 MOU with (TPharm Contractor Name)

A170 MOU with (TMEP Contractor Name)

A180 MOU with (TOP Contractor Name)

A190 MOU with (Active Duty Dental Program Contractor Name)

A200 MOU with (TRICARE Dental Program Contractor Name)

A210 Provider Credentialing and Privileging File Audit Report

A220 Prescription Monitoring Program (PMP) Geographic Area of Responsibility Summary Status Report

A230 Performance-Based Maternity Payments (P-BMP) Report

A240 Listing of High Volume Providers Report

A250 Organ Standard Acquisition Costs

A260 Residential Treatment Center (RTC) List

A270 TRICARE Select Survey Report

A280 Alternative Payment Models (APM) Report

A290 NIST SP 800-171 DoD Assessment Methodology

A300 Network Appointment Availability Report

F.3.1.7. Annual Plans

P010 Enrollment Plan

P020 Medical Management (MM) Program Plan

P030 Clinical Quality Management Program (CQMP) Plan

P040 MTF/Market Optimization Support Plan

P050 Contingency Plan

P060 Education Plan

P070 Value-Based Steerage Model/Plan

P080 Network Implementation Plan (NIP)

P090 Continuity of Operations Plan (COOP)

P100 Quality Management/Quality Improvement (QM/QI) Program Plan

P110 Comprehensive Program Integrity Plan

P120 RESERVED

P130 Beneficiary Outreach Plan

P140 Integrated Master Plan (IMP)

P150 Telehealth Network Implementation Plan

P160 Call Center Risk Management Plan

P170 System Security Plan and Associated Plans of Action for a Contractor's Internal Unclassified Information System

P180 Integrated Master Schedule (IMS)

P190 Transition Out (Phase Out) Plan

P200 Access to Care Plan

P210 Systems Integration Test Plans

F.3.1.8. As Required Plans/Reports

R010 Beneficiary Email List Report

R020 Serious Reportable Events (SREs) Report

R030 Accreditation Reports and Documentation

R040 Service Assist Team (SAT) After Action Report

R050 Designated Standards Maintenance Organization (DSMO) Meeting Summary Report

R060 DHA/MTF Fraud and Abuse Referral Cover Sheet

R070 Fraud/Abuse Patient Harm-Initial Notification Checklist

R080 Audit Detail Worksheet

R090 Program Integrity Standard Operating Procedures

R100 MOU with Healthcare Operations Directorate (HCO)

R110 Breach Report

R120 Appeals Processing Guidelines, Desk Instructions and Reference Materials

R130 Purchased Care MTF Prime Enrolled Inpatient Report

R140 Market Capability and Capacity Report

R150 Declaration of Transfer and Destruction of Records

R160 SOR with (Market Name/Standalone MTF Name)

R170 HA/DHA Custodial Ownership of Records

R180 Telehealth Network Accreditation & Certification Report

R190 Special Programming Ad Hoc Reports

R200 CHCBP Ad Hoc Reports (CHCBP Contractor)

R210 Quality Management/Quality Improvement (QM/QI) Report

R220 Provider Credentialing and Privileging File Audit Corrective Action Report

R230 B2B Gateway Questionnaire

R240 Clinical Quality Data Performance Improvement Strategies

R250 Bed Availability Report

R260 Network Appointment Availability Report (R)

(End of Section)

G.1. CONTRACT ADMINISTRATION

G.1.1. Contracting Officer (CO)

The CO is responsible for the administration of this contract and is solely authorized to take action on behalf of the Government. The CO for this contract is:

Evan Zaslow
Defense Health Agency
Managed Care Contracting Division (MC-CD)
16401 East Centretech Parkway
Aurora, CO 80011-9066
303-676-3646
evan.j.zaslow.civ@mail.mil

G.1.2. Administrative Contracting Officer (ACO)

Defense Contract Management Agency (DCMA) ACO: The CO will delegate a limited number of functions listed in FAR 42 to the DCMA ACO. The Contractor will be provided copies of all delegation letters.

G.1.3. Contracting Officer's Representative (COR)

The CO will designate a COR in writing, and provide a copy of the designation letter to the Contractor. The designation letter will delineate the scope of authority of the COR to act on behalf of the CO. The COR has no authority to make any commitments or changes that affect any term or condition of the contract.

G.1.4. Contractor Points of Contact Personnel

The names, addresses, phone numbers and email addresses of the Contractor's primary and alternate point of contact (POC) for contract implementation and compliance are as follows:

Primary: Alternate:

G.1.5. Paying office

Defense Health Agency
ATTN: Contract Resource Management (CRM)
16401 East Centretech Parkway
Aurora, CO 80011-9066

G.2. PMPM MILITARY HEALTH SYSTEM (MHS) ELIGIBLE BENEFICIARIES

G.2.1. For the purpose of this CLIN, counts of MHS eligible beneficiaries under the

PMPM includes all MHS eligible beneficiaries, underwritten and non-underwritten, with the exception of those covered under Uniformed Services Family Health Plan (USFHP) or under a Competitive Demonstration plan (see H.17.). The contract region's count of MHS eligible beneficiaries under the PMPM CLINs is based on the eligible beneficiary's address as contained in Defense Enrollment Eligibility Reporting System (DEERS). This includes Prime enrollees who may be enrolled in a different region.

G.2.1.1. The count is taken from the MHS Data Repository (MDR) data derived from DEERS. The MDR data reflects the information on beneficiary status and address on the first day of each month as currently known in the MDR at the time the PMPM data are tabulated.

G.2.2. The Government will unilaterally determine the number of MHS eligible beneficiaries prospectively two times for each option period under each PMPM SLIN, once for the first six months of each option period under SLINs X003AA (first – third months) and X003AB (fourth – sixth months) and once for the seventh through twelfth months of each option period under SLINs X003AC (seventh – ninth months) and SLINs X003AD (tenth – twelfth months).

G.2.2.1. The number of MHS eligible beneficiaries will be based on an average of the most recent six previous months of eligible beneficiaries that are available at the time the PMPM data are tabulated from the MDR, as reported above.

G.2.2.2. Using the number of MHS eligible beneficiaries, the Government will calculate the PMPM quantity for the next semi-annual period as follows: The number of MHS eligible beneficiaries multiplied by the number of months (3) equals the number of member months (the quantity). The number of member months is then multiplied by the fixed unit price to determine the extended amount for the period.

G.3. STANDARDS ROUNDING LANGUAGE

G.3.1. Performance Standard & Metric Reporting: All numerical representations of performance standards and other calculated metrics must be interpreted by the context of the standard and accompanying language. Absent any narrative, normal rounding and significant digit convention shall be used, as prescribed by this Paragraph G.3. If any inconsistencies exist for the performance standard throughout the contract, then the Order of Precedence – Uniform Contract Format shall apply (see FAR 52.215-8). Performance standards or other metrics represented in dollars or units shall be rounded to the nearest dollar or unit using standard rounding conventions (round half up).

G.3.1.1. For Government performance standards and other metrics represented as percentages, each Contractor calculated performance standard or other metric percentage shall meet or exceed the respective Government contract performance standard or other metric to the hundredth of a percent in order to remain in compliance with the contract.

G.3.1.2. To ensure consistent practices for rounding and reporting of performance standards or other metrics stated as percentages, all Contractor performance standard or other metrics calculations and reporting shall be completed as follows:

Step 1 - Contractor Actual Performance Calculations:
The Contractor shall carry out its performance standard calculations to the hundred thousandths decimal place. All digits following hundred thousandths decimal place shall be dropped.

Examples:

	Contract Performance Standard (Carried out to the hundredth of a percent)	Step 1 Contractor Actual Performance	Step 2 Percentage Conversion	Step 3 Rounding	Assessment
Example 1	X ≥ 98.00%	3,924,500 / 4,000,000 = 0.98112	0.98112 = 98.112%	98.112% = 98.11% (Drop last digit)	Pass 98.11% > 98.00%
Example 2	X ≥ 98.00%	3,918,300 / 4,000,000 = 0.97957	0.97957 = 97.957%	97.957% = 97.96% (Drop last digit, increase preceding digit by 1)	Fail 97.96% < 98.00%
Example 3	X ≤ 1.50%	65,185 / 4,000,000 = 0.01629	0.01629 = 1.629%	1.629% = 1.63% (Drop last digit, increase preceding digit by 1)	Fail 1.629% > 1.50%

Step 2 - Percentage Conversion: The calculated values from Step 1 shall then be converted to a percentage while retaining all remaining digits.

Step 3 - Rounding: The percentage values from Step 2 shall be rounded under standard rounding conventions (round half up) to the hundredth of a percent (ten thousandths decimal place under decimal values). Under standard rounding conventions, for the final digit, numerical values of 0-4 are dropped, while values of 5-9 are dropped and the preceding digit is increased by 1.

G.4. INVOICING

The Contractor shall, when invoicing the Government, use one of the following submission methods: (1) TRICARE Encounter Data System (TEDS), (2) Wide-Area Workflow (WAWF), or (3) Other.

G.4.1. TEDS Submittal Instructions (Underwritten and Non-underwritten Health Care)

G.4.1.1. The Contractor shall submit TEDS in accordance with TSM requirements. TEDS shall be grouped under the correct Batch/Voucher CLIN/ASAP Account Number (assigned by DHA-

CRM) in accordance with TSM Chapter 2, Section 1.1., Paragraph 6.0.

G.4.1.1.1. All TED records submitted using an incorrect CLIN/ASAP Account Number in the Batch/Voucher and where a payment transfer has occurred will be reported daily on the Contractors Resource Center (CRC) website (https://dha-contractors.csd.disa.mil) by the following categories: (1) TED Record Indicator (TRI), and (2) by line item the calendar day following receipt of TED data by DHA.

G.4.1.2. The Contractor shall report all payment data on the daily NUW and UW Payment/Check Issue Data Report. For reporting requirements, see Contract Data Requirements List (CDRL), DD Form 1423, located in Section J.

G.4.1.2.1. The Contractor shall require its Bank to report all payment cleared data on the monthly NUW and UW Bank Cleared Data Report. For reporting requirements, see Contract Data Requirements List (CDRL), DD Form 1423, located in Section J.

G.4.2. Voucher Transmission Requirements

G.4.2.1. The Contractor shall transmit Batch/Vouchers by 10:00 AM Eastern time to be considered for that day's business. Any Batch/Vouchers received after 10:00 AM Eastern time will be considered received the next business day for payment and check release authorization purposes. Batch/Vouchers must pass all TED header edits as specified in the TSM. If any header edits fail, the Batch/Voucher will be rejected and returned to the Contractor.

G.4.3. Voucher Integrity
Voucher header and detail amounts transmitted by the Contractor become "fixed" data elements in the finance and accounting system for purposes of control and integrity.

G.4.3.1. The Contractor shall process corrections or adjustments to reported (payment) amounts on separate voucher transmissions (TSM, Chapter 2, Section 1.1, paragraph 3.0.).

G.4.4. RESERVED

G.4.5. Federal Fiscal Year-end Processing

G.4.5.1. The Contractor shall submit its final fiscal year TED data no later than 10:00 AM Eastern time on September 28.

G.4.5.2. The Contractor shall not submit Batch/Vouchers to DHA between September 28, 10:00 AM Eastern time or before October 1. Any Batch/Voucher received during this time period will be rejected by DHA.

G.4.5.2.1. The Contractor shall resubmit any rejected Batch/Vouchers using next fiscal year Batch/Voucher CLIN/ASAP Account Numbers and associated bank accounts.

G.4.5.3. The Contractor shall submit TEDs related to Voided/Stale-dated payments using the same Batch/Voucher CLIN/ASAP Account Numbers associated with the original TED submission.

G.4.5.4. The Contractor may test their new fiscal year's transactions in TEDs benchmark starting September 1. Like production, benchmark data must be received at DHA by 10:00 AM Eastern time on September 28. After 10:00 AM Eastern time on September 28 until October 1, no benchmark data can be transmitted to DHA.

G.4.5.5. Federal Fiscal Year-end Processing of Non-TED Vouchers: September non-TED vouchers that are submitted in the month of October shall utilize the current fiscal year CLIN/ASAP Account Number.

G.5. UNDERWRITTEN HEALTH CARE (COST REIMBURSEMENT) - TEDS

G.5.l. The Government will reimburse the Contractor for each TED record that clears all TED detail edits. Reimbursement will occur within seven calendar days of acceptance.

G.5.1.1. TED records resulting in a credit due to the Government do not have to pass all TED detail edits. DHA will collect all Underwritten credits from the Contractor within one business day.

G.5.2. TED Adjustment Procedure for Additional Payment or Collections Citing an Active CLIN (Also See TOM Chapter 10 Claims, Adjustments, and Recoupments)

G.5.2.1. The Contractor shall report additional payments or collections as an adjustment to the original TED record.

G.5.2.2. The Contractor shall use the "Begin Date of Care" for non-institutional or "Admission Date" for institutional claims to determine option period and then select the appropriate CLIN/ASAP Account Number. This should be the same CLIN/ASAP Account Number used to report the original payment or collection on TED records.

G.5.3. TED Underwritten CLIN Closure Procedures

G.5.3.1. The Government will close underwritten healthcare CLINs no earlier than 13 months after the expiration of the option period. An exception will be for the final Option Period where CLIN closure will occur no earlier than 30 calendar days after the end of healthcare delivery. The CO will notify the Contractor at least 30 calendar days before the underwritten CLIN closure process is initiated.

G.5.3.2. The contactor shall, upon notification of CLIN closure, clear all rejected (Bad Master) claims before the scheduled CLIN closure date. On the date the CLIN is scheduled to be closed and after all TED data received before the 10:00 AM Eastern Time cutoff has been processed, DHA-CRM will change the CLIN status from 'Active' to 'Closed'. When the CLIN is closed

any Batch/Vouchers that remain in a Rejected/Bad Master status will be manually closed by DHA-CRM. Any new TED data submissions received after CLIN closure and citing the 'Closed' CLIN shall be rejected.

G.5.4. Reconciliation of the Closed CLIN

G.5.4.1. The Contractor shall work with the Government to conduct a reconciliation of the total amount billed against the CLIN. The reconciliation will include all Contractor invoices (TED data submissions and any non-TED vouchers) citing the CLIN prior to CLIN closure.

G.5.4.2. The Government will determine the value of the CLIN based on the payments made by DHA-CRM taking into account incorrect billings, manual closures, and transfers, therefore the total amount billed against the CLIN and the total (paid) value of the CLIN may be different.

G.5.4.3. CLIN closure does not constitute final settlement of the value of the CLIN. The CLIN closure only ends the TEDs transactional phase (billing and payment). Contract specified audits and future events may also affect the final value of the CLIN. Final CLIN closure occurs upon issuance of contract modification and contract closeout.

G.5.5. Resuming TED Claims Processing after CLIN Closure

G.5.5.1. The Contractor shall process all health care claims with dates of care that fall within a closed CLIN(s) period of performance as Non-Underwritten health care costs using the current fiscal year Non-Underwritten Bank Account. Claims processing as non-underwritten can resume immediately after the date of CLIN closure.

G.5.6. Fiscal Year Start-Up of Underwritten Health Care

G.5.6.1. The Contractor may resume TED data submissions on 1 October. Underwritten CLINs shall use the same Batch/Voucher CLIN/ASAP Account Numbers for the life of the contract.

G.5.6.2. The Contractor shall submit all TED Batch/Voucher Headers for the new fiscal year citing a Batch/Voucher Date equal to or greater than October 1. This includes any rejected data submissions prior to October 1.

G.5.7. Manual Process for the Approval of TED Invoices

G.5.7.1. The Contractor may request manual clearance for claims that cannot pass the TED edit process.

G.5.7.1.1. The Contractor shall submit the request to the COR and shall include the specific TED Record Indicators (TRIs) involved.

G.5.7.1.2. The Government, if approved, will clear the record and pay the Contractor the amounts due within seven calendar days.

G.5.8. Wide-Area Work Flow (WAWF)

G.5.8.1. The Contractor shall submit its non-TED invoices in accordance with DFARS 252.204-7006, DFARS 252.232-7003, and DFARS 252.232-7006, incorporated by reference in Section I.

G.5.8.1.1. The Contractor shall use the following data elements for WAWF:

Pay Official DoDAAC HT0010
Issue By DoDAAC HT9402
Admin DoDAAC HT9402
Inspect By DoDAAC N/A
Ship To Code HT0064
Ship From Code N/A
Mark For Code N/A
Service Approver (DoDAAC)
Service Acceptor (DoDAAC) HT0064
Accept at Other DoDAAC N/A
LPO DoDAAC N/A
DCAA Auditor DoDAAC HAA150
Other DoDAAC(s) N/A
Send Additional Email Notifications: dha.buckley.crm.mbx.aurcrm-invoices@mail.mil
(mandatory data element).

G.5.9. WAWF Invoices and Payments

The Contractor shall, for the following CLINs, submit invoices according to the instruction below:

G.5.9.1. Transition-In

G.5.9.1.1. Transition-In Milestone Payments will be paid in accordance with the Milestone Payment Schedule as set forth in Attachment J-18. Each Milestone payment shall be payable only to the extent it is supported by contractor completion and Government acceptance of all sub-tasks under each Milestone. The four Milestones are:

a. Transition Readiness Milestone (270 days prior to SHCD) (5% of Transition CLIN Amount)
b. Pre-Startup Validation Milestone (180 days prior to SHCD) (10% of Transition CLIN Amount)
c. Pre-Open Season Milestone (90 days prior to SHCD) (40% of Transition CLIN Amount)

d. Start of Health Care Delivery Milestone (45% of Transition CLIN Amount)

The Milestone payments are not representative of the cost to the Contractor to accomplish the work included in the Milestone, but rather, the payment allocations represent the importance of completion of the Government-identified sub-tasks necessary to facilitate a timely and seamless transition effort.

The contractor will only be paid a Milestone payment upon completion of all sub-tasks identified under each Milestone. If the contractor does not complete all sub-tasks under a Milestone, the contractor forfeits its right to that Milestone Payment until completion of the total transition effort.

If the contractor does not complete a Milestone and non-completion negatively impacts the subsequent Milestone, the Milestone payment schedule for the subsequent Milestone will not change to accommodate any schedule slippage, and the contractor may forfeit subsequent Milestone payments until completion of the total transition effort.

Upon Contractor assertion of completion of a Milestone, the Government will verify and accept completion of the sub-tasks under the Milestone. Upon Government acceptance of completed sub-tasks, the contractor may invoice for the Milestone payment. For missed Milestones, the Contract may not submit an invoice until completion of the total transition effort.

The Milestone Payment Schedule and terms do not impact or have any effect on any other contractual rights of the Government for contractor non-performance during transition, or other penalties, such as performance guarantees, that may be established under other terms and conditions of this contract.

G.5.9.2. Underwritten Health Care - Fixed Fee

G.5.9.2.1. The Contractor shall submit invoices monthly after the end of the month.

G.5.9.3. PMPM

G.5.9.3.1. The Contractor shall submit invoices monthly after the end of the month for no more than one-third (rounded to the nearest dollar) of the extended SLIN amount for SLINs X003AA-X003AD.

G.5.9.4. Earned Performance Incentive

G.5.9.4.1. The Contractor shall invoice as instructed by the CO following determination of any performance incentive amounts.

G.5.9.5. Transition-Out

G.5.9.5.1. The Contractor shall submit an invoice for one-sixth of the CLIN amount, once every three months after transition-out performance begins.

G.5.9.6. Award Fee, Performance and Award Fee, Transition-Out

G.5.9.6.1. The Contractor shall invoice as instructed by the CO following determination of any award fee amounts.

G.5.9.7. Modifications

G.5.9.7.1. The Contractor shall invoice for change order definitizations, Clinical Support Agreements, Service Assist Teams, MTF/Guard/Reserve/MSO/VSO Briefings or other modifications after the CO provides instructions and authorization to invoice.

G.6. OTHER INVOICING METHODS

G.6.1. The Contractor shall submit all credit invoices to DHA-CRM via email at dha.buckley.crm.mbx.aur-crm-invoices@mail.mil with a copy to the COR as WAWF cannot process credit invoices. The email must clearly state 'WAWF not used' in the subject line.

G.6.2. The Contractor may, if WAWF is unavailable and instructed by DHA-CRM, submit their invoices to DHA-CRM at dha.buckley.crm.mbx.aur-crm-invoices@mail.mil with a copy to the COR. Email invoice(s) that are not submitted thru WAWF must clearly state "WAWF not used' in the subject line. The email receipt date shall be used as the invoice receipt date.

G.6.3. Procedure if TEDS is Not Available

G.6.3.1. The Contractor may use the following process for underwritten invoicing in the event that the TED system is unavailable:

G.6.3.1.1. The Contractor shall, upon notification by the CO, submit summary invoices by Batch/Voucher Headers (data elements listed below) as a MS Excel spreadsheet email attachments and sent to dha.buckley.crm.mbx.aur-crm-invoices@mail.mil.

ELN Element Name
0-001 Header Type Indicator
0-005 Contract Identifier
0-010 Contract Number
0-015 Batch/Voucher Identifier
0-020 Batch/Voucher Number
0-025 Batch/Voucher ASAP Account Number
0-030 Batch/Voucher Date YYYYDDD
0-035 Batch/Voucher Sequence Number
0-040 Batch/Voucher Resubmission Number
0-045 Total Number of Records

0-050 Total Amount Paid

G.6.3.1.2. Manual payments will be made within seven calendar days of receipt of invoice. All amounts paid based on manual invoices submitted during healthcare claims processing system outages shall be considered interim payments and will be offset against payments based on actual TED data submissions when claim processing resumes.

G.6.3.1.3. The Contractor shall have 30 calendar days to clear all vouchers where interim payments have been made thru the TED header edits (as specified in the TRICARE Systems Manual, Chapter 2).

G.6.3.1.4. Failure to clear all header edits for any vouchers where the Contractor was paid under this contingency process shall result in the Government collecting back any missing/rejected voucher header(s) totals via payment offset.

G.6.3.1.5. When the missing/rejected vouchers clear the header edits, any monies collected via payment offset shall be refunded to the Contractor (without interest or penalty).

G.7. NON-UNDERWRITTEN HEALTH CARE – TEDS

G.7.1. The Contractor shall adjudicate claims and distribute Government funds for the non-underwritten health care services listed as exceptions to underwritten healthcare costs in Section H.1. These costs are paid using the bank account set-up in accordance with G.7.2. Establishment of Non-Underwritten Bank Accounts.

G.7.2. Establishment of Non-Financially Underwritten Bank Accounts

G.7.2.1. The Contractor shall establish bank account(s) for non-underwritten payments with a commercial bank that has Federal Reserve Wired Network (Fedwire) capability. The bank account will be non-interest bearing and maintain a zero-dollar balance.

G.7.2.1.1. The Contractor shall establish this bank account(s) no later than 90 calendar days prior to the start of health care delivery (SHCD) and for each subsequent federal fiscal year.

G.7.2.2. This bank account(s) with Fedwire capability, along with the Department of Treasury's Automated Standard Application for Payments (ASAP) system, provide a mechanism for disbursement of Government funds for health care services received by TRICARE beneficiaries. These systems allow the Contractor to draw funds directly from the Federal Reserve Bank (FRB) to cover payments clearing the Contractor's bank account.

G.7.2.3. The Contractor shall, once the bank account is established, submit bank information to DHA-CRM no later than 60 calendar days prior to the beginning of processing claims on a new bank account(s).

G.7.2.3.1. The Contractor shall include the following information to DHA-CRM:

- Name of Bank
- Overnight mail address
- American Banking Association (ABA) routing number
- The Contractor's DUNS number
- The Bank's DUNS number
- Taxpayer Identification Number (TIN) (must be the same TIN used for payment)
- Contractor's bank account number (if separate checking and deposit accounts are used, both need to be provided)
- Individual point of contact at the bank and an alternate, including phone numbers and e-mail addresses
- Individual point of contact at the Contractor and an alternate, including phone numbers and e-mail addresses.

G.7.2.4. DHA-CRM will establish the ASAP bank account with the Treasury Department.

G.7.2.4.1. DHA-CRM will notify the Contractor once the bank account(s) have been established and provide codes or other information necessary for the Contractor's bank to make draws against the ASAP account using Fedwire.

G.7.2.4.2. DHA-CRM will establish daily and total dollar limits that can be drawn from the ASAP account(s) and will notify the Contractor of these limits. DHA-CRM will be able to increase these limits if needed. The dollar limits only represent an administrative ceiling and does not constitute any authority to draw funds.

G.7.2.5. The Contractor shall submit a monthly Non-Financially Underwritten Bank Account Reconciliation Report and the associated bank account statements for each account until the bank account is closed. Reports are to be submitted to DHA-CRM. For reporting requirements, see Contract Data Requirements List (CDRL), DD Form 1423, located in Section J.

G.7.3. Authority to Release Non-Underwritten Payments

G.7.3.1. The Contractor shall obtain approval from the DHA-CRM Budget Office prior to releasing payments to providers, beneficiaries, or other entities for non-underwritten claims processed.

G.7.3.1.1. The Government will provide payment release authority to the Contractor each business day no later than 5:00 PM Eastern time by fax or email.

G.7.3.1.2. Authorization will specify contract number, ASAP Account ID Number, and total dollar amount of funds that may be released based on information contained in the Batch/Voucher Header.

G.7.3.1.3. The Government will approve funds release provided the following criteria are met: (1) Voucher submissions must pass all header edits as specified in TSM, Chapter 2,

Section 4.1 Header Edit Requirements; and (2) DHA-CRM Budget Officer has confirmed that funding is available to cover payments.

G.7.3.1.4. The Contractor shall release (EFT) or mail benefit payments no later than two business days after DHA-CRM approval.

G.7.4. The Contractor shall only draw funds from the ASAP account(s) for payments approved for release by DHA-CRM and clearing the Contractor's financial institution on the day the draw is being accomplished. The following types of draws are prohibited: (1) payments to self unless specifically authorized in the contract or approved in advance by DHA-CRM; (2) advance payments; and (3) bank fees or other bank charges.

G.7.4.1. TED records that do not pass all TED detail edits are considered insufficient justification to support draws from the ASAP account(s). TEDs must pass all TED detail edits within 90 calendar days after initial notice of edit failures is sent to the Contractor by DHA-CRM.

G.7.4.1.1. DHA-CRM will, if not corrected in 90 calendar days, collect the total amount of improper payments that have not cleared all TED edits by offsetting other payments to the Contractor. DHA-CRM may return these collections to the Contractor upon correction of the TEDs involved or some other resolution is reached.

G.7.5. Authorization to release payments does not constitute DHA's acceptance that all payments are valid and correct. Detailed records will be audited by the Government for financial compliance. All payments drawn from the ASAP account(s) must be valid and justified. All disputed amounts will remain in the possession of the Government until no longer in dispute.

G.7.5.1. The Contractor may request an Alternate (Manual) Payment Release for non-underwritten benefits due to problems with DHA TED record processing. Upon notification by the Government that the TED Record processing system is not operating, the Contractor's request for manual check release shall include amounts by Batch/Voucher Headers (data elements listed below). The request shall be submitted to the following email address: dha.buckley.crm.mbx.crm-budget@mail.mil.

G.7.5.1.1. The Contractor shall submit the following data elements as a MS Excel spreadsheet (See TRICARE Systems Manual, Chapter 2, Section 2.3 Data Requirements – Header Record Data):

ELN Element Name
0-001 Header Type Indicator
0-005 Contract Identifier
0-010 Contract Number
0-015 Batch/Voucher Identifier
0-020 Batch/Voucher Number
0-025 Batch/Voucher ASAP Account Number

0-030 Batch/Voucher Date YYYYDDD
0-035 Batch/Voucher Sequence Number
0-040 Batch/Voucher Resubmission Number
0-045 Total Number of Records
0-050 Total Amount Paid

G.7.5.1.2. DHA-CRM will return to the Contractor a signed release within four hours of receipt.

G.7.5.1.3. The Contractor shall not release payments until this approval is received.

G.7.5.1.3.1. The Contractor shall release payments to providers and beneficiaries in accordance with G.7.3.1.4.

G.7.5.1.4. The Contractor shall, upon notification by the Government that the TED Record processing system is operating again, discontinue the alternate manual payment release process.

G.7.5.1.5. The Contractor shall submit and clear all vouchers (TED data) held during the alternate manual payment release process within 30 calendar days of notification that the TED Record processing system is operating normally.

G.7.5.1.6. Failure to clear all header edits for any vouchers where the Contractor was authorized under this contingency process to release payments will result in the Government collecting back the rejected voucher header totals via payment offset. When the vouchers clear the header edits, the monies collected via payment offset will be refunded to the Contractor (without interest or penalty).

G.8. ASAP DRAWS ON THE FEDERAL RESERVE

G.8.1. The Contractor shall ensure that cash draws do not exceed the payments authorized, less deposits, as they clear the bank on a given day. Computation of the amount of the draw must include any deposits of funds into the account. These deposits will reduce the amount of cash needed for the draw down on the day of the deposit.

G.8.1.1. The Contractor shall not collect or hold non-underwritten benefit funds before dissemination to the beneficiary or provider and shall ensure that any excess draws are immediately returned to the ASAP account.

G.8.2. The Government will charge interest and a penalties beginning the day after the account is overdrawn and will continue until the overdrawn amount is returned. Interest will accrue daily and is based on the Treasury Current Value of Funds Rate. The penalty will accrue daily and is based on the penalty rates in the Code of Federal Regulations, Title 31, Part 5, Subpart B Sec.5.5. DHA-CRM may initiate immediate payment offset against any payments to the Contractor for the interest, penalties and/or the overdrawn amount.

G.8.3. The Contractor shall prevent the commingling of funds between bank accounts. Failure to properly associate transactions with the correct bank account could result in the over-execution of DHA-CRM budget authority. Transfers of funds between bank accounts are strictly prohibited except for correcting deposits that are in the wrong account.

G.8.3.1. The Contractor shall report immediately to DHA-CRM any transactions citing one bank account and erroneously charging against a different bank account. DHA-CRM will instruct the Contractor as to what action to take to correct the error.

G.8.4. The total amount of funds drawn on the FRB is based on the daily total of benefit payments presented to the bank for payment.

G.8.4.1. The Contractor shall adjust any estimated draws (due to timing of reports) to match the actual draw within one business day.

G.8.4.2. U.S. Treasury regulations do not allow the deposit of funds to an ASAP Account in excess of draws.

G.8.4.2.1. The Contractor is authorized to deposit and hold the funds in their corporate bank account associated with the DHA assigned ASAP account without returning them to the U.S. Treasury via FRB ASAP return process when the Contractor receives collections in excess of ASAP Draws (this should only happen at the beginning of a new federal fiscal year).

G.8.4.2.2. The Contractor is authorized to use the excess collections to offset any payments (reducing the draw on the ASAP account) presented to the bank in accordance with G.8.1.

G.9. FISCAL YEAR START-UP OF NON-UNDERWRITTEN ASAP ACCOUNTS

G.9.1. The Contractor shall establish a separate bank account for each new Government fiscal year following the procedures specified in G.7.2. Establishment of Non-Underwritten Bank Accounts.

G.9.1.1. All payments issued for benefit payments and all refunds received shall be processed against the new account effective the first day of the new fiscal year.

G.9.1.2. The Contractor shall transfer all recoupment installment payments to the new account from the previous year's account.

G.9.2. The Contractor shall continue to make cash drawdowns against the prior fiscal year's bank account (if required) until all payments from the prior year have either cleared or have been cancelled (void/stale-dated).

G.9.2.1. The drawdown authority will discontinue no later than 31 March of the following fiscal year (six months) after the last payments have been made. In case of the final Option Period, close out procedures are described in TOM Chapter 2, Section 8, Paragraph 4.0.

G.9.3. The Government will close ASAP bank accounts no later than 31 March, following the fiscal year end.

G.9.3.1. The Contractor shall work with the Government to conduct a final bank account reconciliation beginning no sooner than 30 calendar days following bank account closure.

G.9.3.2. All transactions that were not previously approved by DHA-CRM shall be explained with supporting documentation on the final Non-Financially Underwritten Bank Account Reconciliation Report. For reporting requirements, see Contract Data Requirements List (CDRL), DD Form 1423, located in Section J.

G.9.3.3. The Government reserves the right to not accept these transactions.

G.9.4. The Contractor shall reimburse DHA for any outstanding balance in the account no later than the required submission date of the final Non-Financially Underwritten Bank Account Reconciliation Report. For reporting requirements, see Contract Data Requirements List (CDRL), DD Form 1423, located in Section J. This balance may be subject to interest if it includes overdrawn amounts that were required to be submitted at an earlier date.

G.9.5. Non-Underwritten Payment Adjustments

G.9.5.1. The Contractor shall submit an adjustment TED record when making an additional payment to, or collection against a previously submitted TED record.

G.9.5.1.1. The Contractor shall report adjustments using the current fiscal year CLIN/ASAP ID without regard to the fiscal year or CLIN/ASAP ID of the previously submitted TED record. The Contractor shall report all TED and adjustment TED records on the monthly Non-Financially Underwritten Bank Account Reconciliation Report. For reporting requirements, see Contract Data Requirements List (CDRL), DD Form 1423, located in Section J.

G.9.5.1.2. The Contractor shall report non-underwritten debts on the Accounts Receivable Summary Report. For reporting requirements, see Contract Data Requirements List (CDRL), DD Form 1423, located in Section J.

G.10. INVOICE AND PAYMENT NON-UNDERWRITTEN - NON-TEDS

The Contractor shall group and electronically process Non-TED vouchers by the correct non-underwritten cost category identified below as a manual non-underwritten payment.

G.10.1. Capital and Direct Medical Education Costs (CAP/DME)

G.10.1.1. The Contractor shall make payments from the Non-Underwritten Bank Account to hospitals requesting reimbursement under the TRICARE/CHAMPUS DRG-Based Payment System (excludes children's hospitals). (See TRM Chapter 6, Section 8).

G.10.1.2. The Contractor shall submit a monthly CAP/DME voucher in a .csv format to DHA-CRM dha.buckley.crm.mbx.aur-crm-invoices@mail.mil no later than the 20th calendar day of the month following receipt of the hospital's request for payment. For reporting requirements, see Contract Data Requirements List (CDRL), DD Form 1423, located in Section J.

G.10.1.3. The Contractor shall submit supporting documentation, including 1) copies of the hospital's claim (.PDF), and 2) the payment calculation in .csv format.

G.10.1.3.1. The Contractor shall submit supporting documentation electronically to dha.buckley.crm.mbx.aur-crm-invoices@mail.mil using approved formats specified in TRM Chapter 6, Section 8.

G.10.1.4. The DHA-CRM will, upon receipt of the CAP/DME voucher, provide authority to release payments to hospitals.

G.10.1.4.1. The Contractor shall subsequently release payments in accordance with section G.7.3.1.4.

G.10.1.4.2. The Contractor shall, for any adjustment CAP/DME transactions (e.g., voids, stale-dated checks, additional payments) report to DHA-CRM on the next voucher, with supporting documentation and notations as to the type of transaction (e.g., void, refund, etc.).

G.10.1.4.3. The Contractor shall report Debts established under this paragraph and related transactions on the monthly Accounts Receivable Report. For reporting requirements, see Contract Data Requirements List (CDRL), DD Form 1423, located in Section J.

G.10.1.5. The Contractor shall, for Fiscal Year-End processing of CAP/DME vouchers, refer to section G.4.5. Federal Fiscal Year-end Processing for guidance.

G.10.2. Bonus Payments (HPSA/PSA)

G.10.2.1. Bonus payments are an addition to the amount normally paid under the allowable charge methodology in order to provide services in medically underserved areas [Health Professional Shortage Areas (HPSA) and Physician Scarcity Areas (PSA)].

G.10.2.2. The Contractor shall, on a monthly basis, submit the HPSA/PSA non-TED voucher, and supporting documentation electronically, citing the current fiscal year CLIN/ASAP ID. The voucher is to be sent to dha.buckley.crm.mbx.aur-crm-invoices@mail.mil.

G.10.2.3. The Contractor shall release payments in accordance with section G.7.3.1.4.

G.10.2.4. The Contractor shall, for adjustment HPSA/PSA transactions (e.g., voids, stale-dated checks, additional payments) report to DHA-CRM on the next monthly non-TED voucher, with supporting documentation and notations as to the type of transaction, e.g., void, refund, etc.).

G.10.2.4.1. The Contractor shall report debts established under this paragraph and related transactions on the monthly Accounts Receivable Report.

G.10.2.5. The Contractor shall submit monthly vouchers in .csv format containing the following information:

a. Format for Vouchers

- CLIN/ASAP Account Number
- Period Covered
- Provider Name
- Taxpayer ID Number (TIN) of Provider
- Provider Address
- Provider Zip Code
- Provider Number (NPI)
- Amount Paid/Collected for Bonus

G.10.2.6. The Contractor shall, for Fiscal Year-End processing of HPSA/PSA vouchers, refer to section G.4.5. Federal Fiscal Year-end Processing for guidance.

G.10.3. Demonstrations/New Benefit Programs.

G.10.3.1. The Contractor shall, for Demonstrations/New Benefit Programs, submit non-TED vouchers when data is incompatible with TED formats.

G.10.3.2. The Contractor shall, on a monthly basis, submit the Demonstrations/New Benefit Programs non-TED voucher, and supporting documentation electronically, citing the current fiscal year CLIN/ASAP ID. The voucher is to be sent to dha.buckley.crm.mbx.aur-crm-invoices@mail.mil.

G.10.3.3. The Contractor shall release payments in accordance with section G.7.3.1.4.

G.10.3.4. The Contractor shall, for adjustment Demonstrations/New Benefit Programs transactions (e.g., voids, stale-dated checks, additional payments) report to DHA-CRM on the next monthly non-TED voucher, with supporting documentation and notations as to the type of transaction, e.g., void, refund, etc.).

G.10.3.4.1. The Contractor shall report debts established under this paragraph and related transactions on the monthly Accounts Receivable Report.

G.10.3.5. The Government will provide detailed instructions in contract modification(s) or other correspondence when such programs are established.

G.10.3.5.1. These payments and any related credits or collections shall be identified on the Non-Financially Underwritten Bank Account Reconciliation Report as additional lines listed by Demonstrations/New Benefit Program. For reporting requirements, see Contract Data Requirements List (CDRL), DD Form 1423, located in Section J.

G.10.4. Other Non-Underwritten Non-TED Payments

G.10.4.1. Other adjustments are rare situations where a payment needs to be made by the Contractor, but does not fall into routine processing such as TEDs, etc. For example, payments related to a claim which cannot be processed through the TED system, legal settlements, or payments directed by DHA.

G.10.4.2. For Government directed Non-Underwritten Non-TED Payments

G.10.4.2.1. The CO will provide the Contractor with detailed instructions, authorizing the Contractor to prepare the payment(s) to the individual, or entity.

G.10.4.2.1.1. The Contractor shall, after release approval by DHA-CRM, make payment in accordance with G.7.3.1.4.

G.10.4.2.1.2. The Contractor shall report these payments on the Non-Financially Underwritten Bank Account Reconciliation Report under DHA approved manual transactions. For reporting requirements, see Contract Data Requirements List (CDRL), DD Form 1423, located in Section J.

G.10.5. For Contractor identified Non-Underwritten Non-TED Payments

G.10.5.1. The Contractor shall submit the request for a non-TED voucher to the COR, CO, and to DHA-CRM with supporting documentation explaining the issues that do not allow a TED record to be created, a copy of the claim (if applicable), computation of the amount to be paid, and other related documents.

G.10.5.1.1. The CO may provide authorization to the Contractor to prepare the payment(s) to the individual, or entity.

G.10.5.2. The Contractor shall, if approved, contact DHA-CRM for payment release authorization.

G.10.5.2.1. The Contractor shall make payments in accordance with G.7.3.1.4.

G.10.5.2.2. The Contractor shall report these payments on the Non-Financially Underwritten Bank Account Reconciliation Report under DHA approved manual transactions. For reporting requirements, see Contract Data Requirements List (CDRL), DD Form 1423, located in Section J.

G.10.5.3. The Contractor shall, for Fiscal Year-End processing of Other non-underwritten non-TED Payments, refer to section G.4.5. Federal Fiscal Year-end Processing for guidance.

G.11. TRICARE RESERVE SELECT (TRS), TRICARE RETIRED RESERVE (TRR), TRICARE YOUNG ADULT (TYA), CONTINUED HEALTH CARE BENEFIT PROGRAM (CHCBP, EAST REGION ONLY), TRICARE PRIME, AND TRICARE SELECT FEES/PREMIUMS

G.11.1. The Contractor shall establish a separate, non-interest bearing account for the collection and disbursement of fees/premiums.

G.11.2. The Contractor shall deposit fee/premium collections to the established account daily.

G.11.3. DHA-CRM Finance and Accounting Office will provide the Contractor with the Government's bank account for wire-transfers.

G.11.4. The Contractor shall wire-transfer the fees/premium collections, net of refund payments, twice monthly (1st and 15th) to the specified Government bank account.

G.11.5. The Contractor shall notify DHA-CRM by email, within one business day of the deposit, specifying the date and amount of the deposit.

G.11.6. The Contractor shall submit monthly reports supporting the wire transfers for each type of fees/premiums. For reporting requirements, see Contract Data Requirements List (CDRL), DD Form 1423, located in Section J.

G.12. TRANSITION OUT AT END OF CONTRACT.

G.12.1. Procedures for processing at the end of the contract are described in TOM Chapter 2, Section 10, Paragraph 4.0. Budget, Finance & Accounting.

G.13. REPORTING

G.13.1. The Contractor shall provide a copy (annually) of the Contractor's System and Organization Controls Report (SOC-1) as prescribed by the American Institute of Certified Public Accountants - Statement of Standards for Attestation Engagements (SSAE) 18 and sub-Contractor's SOC-1. For reporting requirements, see Contract Data Requirements List (CDRL), DD Form 1423, located in Section J.

G.13.2. The Contractor shall, upon Government request, provide annual Bridge Letters for the Contractor and subcontractors addressing any changes that may have occurred between the time of publishing the SOC-1 and the end of the Government fiscal year.

(End of Section)

H.1. CONTRACTOR FINANCIAL UNDERWRITING OF HEALTHCARE COSTS

H.1.1. The Managed Care Support (MCS) Contractor shall underwrite the cost of civilian healthcare services (also referred to as "private sector care" or "purchased care," which is defined as care provided outside of the direct care system) provided to all TRICARE-eligible beneficiaries who are enrolled in TRICARE Prime or TRICARE Select in the Contractor's geographic area of responsibility and for other TRICARE-eligible beneficiaries who reside in the Contractor's geographic area of responsibility, except for the following non-underwritten categories:

- Outpatient retail and mail order pharmacy services (on a separate contract)
- Continued Health Care Benefits Program (CHCBP)
- Active Duty Service Members (ADSMs) including TRICARE Prime Remote (TPR) for ADSMs (Active Duty Family Members (ADFMs) are underwritten)
- Supplemental Health Care Program (SHCP)
- Foreign/OCONUS beneficiaries and CONUS-based beneficiaries who receive care OCONUS (on a separate contract)
- Medicare dual-eligible TRICARE CHAMPUS* beneficiaries (on separate contract)
- State of Alaska (care for beneficiaries who are enrolled in TRICARE Prime in the state of Alaska and care for other TRICARE beneficiaries who reside in the state of Alaska)
- Bonus Payments in Medically Underserved Areas (Health Professional Shortage Areas (HPSAs) and Physician Scarcity Areas (PSAs))
- Capital and Direct Medical Education (Cap/DME)
- TRICARE Reserve Select (TRS)
- Custodial Care Transitional Program (CCTP)
- Individual Case Management Program for Persons with Extraordinary Conditions (ICMP-PEC)
- Residual Claims (date of service prior to the start of healthcare delivery (SHCD) under the contract)
- Autism Services Demonstration
- TRICARE Retired Reserve (TRR)
- Temporary Military Contingency Payment Adjustments
- TRICARE Young Adult Program
- TRICARE Transitional Outpatient Payments
- Laboratory Developed Tests Demonstration Project
- Temporary Disability Retirement List Physical Exams
- Disability Compensation and Pension Examinations (DCPE)
- Transitional Care for Service Related Conditions
- Respite Benefit for Seriously Injured or Ill ADSM
- Pilots and Demonstrations under the authority of 10 USC 1092 when included in pilot design
- State Vaccine Program (2017 NDAA, Section 719)

*CHAMPUS-eligible beneficiaries are defined as those beneficiaries who meet the requirements in Title 32 Code of Federal Regulations (CFR) Part 199.

H.1.2. In this contract, these underwritten beneficiaries may be referred to as "underwritten beneficiaries" or "non-TRICARE/Medicare dual-eligible CHAMPUS eligible beneficiaries." In this contract, the healthcare costs the Contractor underwrites may be referred to as "healthcare cost" or "underwritten healthcare cost."

H.1.3. Other supplemental details regarding underwritten healthcare follow:

H.1.3.1. Beneficiaries may enroll in TRICARE Prime with a Military Treatment Facility (MTF) Primary Care Manager (PCM). Although some Prime beneficiaries will have a MTF PCM, all health care costs for Prime enrolled non-TRICARE/Medicare dual-eligible CHAMPUS beneficiaries incurred outside of the Military Health System (MHS) direct care system are underwritten by the Contractor, except for ADSMs and the other exclusions noted in paragraph H.1.1.

H.1.3.2. The health care costs for enrolled beneficiaries in Prime are underwritten by the Contractor in whose geographic area of responsibility the beneficiary is enrolled, regardless of the address or location of the beneficiary.

H.1.3.3. The costs of medical management activities, such as case management, chronic care/disease management and utilization management, are not considered underwritten health care costs. Costs under separate Clinical Support Agreement (CSA) orders, if issued, are not considered underwritten health care costs.

H.1.4. Underwritten healthcare is cost-reimbursable. These costs are reimbursed with obligated funds that are disbursed under this contract. The associated underwritten fixed fee in Section B of the contract is considered the underwriting fee, or underwriting premium, and is not subject to change after contract award.

H.1.4.1. For underwritten healthcare claims, the Contractor shall assume full financial liability for care which is not eligible for cost-sharing and was provided subsequent to the Contractor's erroneous authorization of services and/or supplies listed as exclusions in the TRICARE Policy Manual (TPM). This provision applies to services/supplies specifically named under an exclusion, and does not apply to general exclusions such as services subsequently determined not to be medically necessary. For cases involving such specific exclusions, the Contractor shall neither deny payment nor recoup erroneous payments from either the provider or the beneficiary. Payment will be made from the Contractor's funds and not reimbursed by the Government. The Contractor shall not be held liable for non-covered services/supplies provided that were not authorized by the Contractor. The Contractor's financial liability under this section is in addition

to, and not limited by, the 2% claims error rate established by the TRICARE Operations Manual (TOM), Chapter 1, Section 3, Paragraph 6.5.1. "Claim Payment Errors."

H.2. AWARD FEE

H.2.1. An Award Fee is available to the Contractor as a performance incentive (see FAR 16.401; FAR 16.402-2). The Government will administer the Award Fee on an annual basis in accordance with the T-5 Award Fee Plan (Attachment J-12a), which has been developed to guide the application of the Award Fee. An Award Fee pool, ($20M per Option Period of health care delivery) is available for the Contractor to earn based on eligibility (as described in the Award Fee Plan) and the Contractor's performance against the identified metrics associated with Access, Readiness (which includes both a Medically Ready Force and a Ready Medical Force), and Quality.

H.2.2. A separate Award Fee is available to the Contractor as a performance incentive during the transition-out period. The Government will administer this Award Fee in accordance with the Award Fee Plan at Attachment J-12b. An Award Fee pool of $1M is available for the Contractor to earn based on eligibility and its performance in relation to the standards identified in the Award Fee Plan during transition-out activities.

H.3. HEALTHCARE UNDERWRITING INCENTIVES

H.3.1. Introduction and Administration: This section addresses the administration of the incentives that are part of the underwriting mechanism of the contract. If the Contractor fails to meet the standards described below and incurs a negative incentive, the Contracting Officer (CO) will offset payments to the Contractor under the Managed Care Support Services CLIN X003 by the negative incentive amount. If the offset amount is greater than any individual monthly payment under CLIN X003, the CO will deduct the additional amount from future CLIN X003 payments. There is no limit on the dollar amount of the underwriting incentives that may be accrued for the Network Discount Guarantee or the Network Usage Incentive.

H.3.1.1. The underwriting incentives described in this paragraph H.3 are administered independently of the results of the annual healthcare cost audits for overpayments to providers (see paragraph H.10). The assessment of any negative incentive dollar amount, and recovery of funds from the Contractor, is conducted separately from the administration of the underwriting fixed-fee payments for each option period. The administration of the Network Discount Guarantee and Network Usage Incentive described herein occurs before the conduct of any cost audit that determines allowable and unallowable healthcare costs.

H.3.2. Incentives. The Government will assess the following incentives based on the Contractor's performance:

H.3.2.1. Network Provider Discount Incentive. The purpose of this incentive is encourage the Contractor to negotiate discounts with network providers and thereby reduce underwritten healthcare costs. The incentive will be calculated based on total underwritten healthcare costs.

H.3.2.1.1. Guaranteed Network Provider Discounts (negative incentive)

The Contractor guarantees the following discounts:

OP1	OP2	OP3	OP4	OP5	OP6	OP7	OP8

H.3.2.1.2. At the end of each option period, the Government will calculate the Guaranteed Network Provider Discount. The Contractor's achieved discount will be measured as the overall average value of discounts from TRICARE allowable charges. The Government's calculation will be based on TRICARE Encounter Data (TED) records accepted during that option period for care provided by Contractor network providers, excluding Other Health Insurance (OHI) claims, non-underwritten care, and TED records for services for which the Contractor or provider has taken full risk under a capitation arrangement. The total value of discounts will be the sum of all dollar amounts reported on TED records in the field "Amount Network Provider Discount" (subject to the limit on credit for professional discounts described in paragraph H.3.2.1.3.). For care provided by Contractor network providers (subject to the exclusions listed previously in this paragraph), the total allowable cost will be the sum of all dollar amounts reported on TED records for all amount allowed fields and all amounts credited from network provider discount fields.

H.3.2.1.3. In calculating the Guaranteed Network Provider Discount, the Government will not credit more than a 5% discount from TRICARE allowable charges for care provided by individual professional providers. To apply this limit when measuring discounts on TED records for administration of this incentive, the Government will credit discounts greater than 5% only for TED Institutional (TED-I) records and for those TED Non-institutional (TED-N) records that have a 10-character Health Care Provider Taxonomy specialty code for which the first two characters are equal to 17-18, 24-34, or 37-38. The Government reserves the right to update the list of codes above if they are affected by an updated release of the taxonomy. The purpose of this limitation is to ensure that discount guarantees do not negatively affect the overall quality of care provided to beneficiaries or beneficiary access to care.

H.3.2.1.4. RESERVED

H.3.2.1.5. The TED records submitted by the Contractor must reflect the actual dollar amount of a network discount, excluding OHI claims. The dollar amount of the network discount is the difference between the network provider's negotiated rate and what the applicable TRICARE reimbursement methodology would have allowed in the absence of the negotiated discount rate. See the TRICARE Systems Manual (TSM), Chapter 2 for the TED record requirements for correctly coding the provider network discount.

H.3.2.1.6. If the calculated average percentage network provider discount obtained by the Contractor for the option period does not exceed the levels listed above at paragraph H.3.2.1.1,

then the Government will offset the calculated deficit amount from the next payment(s) due to the Contractor under CLIN X003.

H.3.2.1.7. The guaranteed discount percentages provided in paragraph H.3.2.1.1 shall not be adjusted to account for changes to TRICARE allowable amounts, the expansion of TRICARE coverage to additional procedures and Durable Medical Equipment (DME), or for any other actions or conditions that may affect the willingness of the Contractor's network providers to accept discounts. The Contractor assumes all risks of future conditions and changes that may affect the Contractor's ability to achieve the guaranteed network provider discounts.

H.3.2.2. Network Usage Incentive (negative incentive). The purpose of this incentive is to promote increased usage of network providers by enrolled beneficiaries, thereby reducing enrollee out-of-pocket costs and potentially reducing underwritten healthcare costs.

H.3.2.2.1. The incentive will be calculated based on a comparison between the number of network provider claims for TRICARE Prime and TRICARE Select enrolled beneficiaries with the total number of claims for these beneficiaries, after excluding claims with OHI, Prime Point-of-Service (POS) claims, claims for care provided out-of-region (out of geographic area of responsibility), TPR claims, claims for urgent care, and claims for emergency care. An exclusion will apply to a claim if any line item on the claim meets the exclusion criteria. If the percentage of network versus total claims meets or exceeds the minimum standard for a given month, the Government will not apply a negative incentive. If the network percentage falls below that standard, the Government will assess a negative incentive on a per-claim basis for the calculated number of non-network claims that fall below the standard. The following are the minimum standards for each option period:

Option Period 1, beginning in the 7th month: 75%
Option Period 2: 78%
Option Period 3: 80%
Option Period 4: 81%
Option Periods 5-8: 82%

No incentive will be applied for the first six months of Option Period 1. Beginning on the first day of the seventh month of Option Period 1, for each month that the Contractor fails to meet the minimum claims percentage, a negative incentive shall apply. The Government will calculate the network usage incentive after the end of the option period based on TED records accepted during each month of the option period. The Government will apply a negative incentive for every claim that falls below the minimum standard. The amount assessed per claim will be based on the percentage below the standard, as follows:

Option Period 1 (months 7-12):
If less than 75% and more than or equal to 72% = $7 per claim
If less than 72% and more than or equal to 69% = $14 per claim

If less than 69% and more than or equal to 66% = $21 per claim
If less than 66% = $28 per claim

Option Period 2:
If less than 78% and more than or equal to 75% = $7 per claim
If less than 75% and more than or equal to 73% = $14 per claim
If less than 73% and more than or equal to 70% = $21 per claim
If less than 70% = $28 per claim

Option Period 3:
If less than 80% and more than or equal to 77% = $7 per claim
If less than 77% and more than or equal to 75%= $14 per claim
If less than 75% and more than or equal to 74% = $21 per claim
If less than 74% = $28 per claim

Option Period 4:
If less than 81% and more than or equal to 78% = $7 per claim
If less than 78% and more than or equal to 76% = $14 per claim
If less than 76% and more than or equal to 75% = $21 per claim
If less than 75% = $28 per claim

Option Periods 5 through 8:
If less than 82% and more than or equal to 79% = $7 per claim
If less than 79% and more than or equal to 77% = $14 per claim
If less than 77% and more than or equal to 76% = $21 per claim
If less than 76% = $28 per claim

H.3.2.2.2. For example, in month 2 of Option Period 2, if the actual percent of claims with a network provider is 74%, then a negative incentive equal to 4% of the claims will be assessed against the Contractor (4% represents the difference between the actual number of claims for care provided by a network provider and the standard). If 4% equates to 200 claims not meeting the standard, the negative incentive assessment for that month will be $2,800 or 200 claims times $14. In calculating the negative incentive, the Government will determine the applicable amount based on the Contractor's actual performance. The Government will apply the highest per claim amount to all claims failing the standard. The Government will not stratify the negative incentive based on the variable per claim amounts. In the example above, the Contractor's actual performance was 74% so the negative incentive will equal $14 for every claim falling below the minimum performance standard of 78%.

H.3.2.2.3. The percentage standards above, and the claims volumes used to calculate performance against those standards, will reflect claims for all TRICARE Prime and Select enrollees in the Contractor's geographic area of responsibility.

H.4. PERFORMANCE INCENTIVES

H.4.1. Introduction: Monetary performance incentives are available to the Contractor. The Contractor may receive a positive performance incentive payment for performance above the levels in customer satisfaction as defined in this section for each option period.

H.4.1.1. Incentive Administration: The Contractor's performance for a given option period will be measured after completion of each option period. When performance exceeds the levels described below, the Government may administratively obligate funding either under the appropriate Per Member Per Month SLIN, or on a standalone Earned Performance Incentive CLIN/SLIN for the applicable option period in Section B. The total Earned Performance Incentive amount will be pooled for the entire option performance period, and after the Government has completed all measurements, the CO will notify the Contractor, and the Contractor may invoice the net amount authorized by the CO.

H.4.2. RESERVED

H.4.3. Customer Satisfaction Incentive: The purpose of this incentive is to promote a high degree of Contractor focus on customer service. The Government will measure customer satisfaction among five categories of stakeholders (beneficiaries, providers, MTF leaders, DHA customers, and Market Directors) via independently administered surveys.

H.4.3.1. Semi-annually, the Government will administer separate surveys to beneficiaries, providers, and Market Directors containing questions designed to elicit responses to measure satisfaction during the applicable preceding performance period. Survey questions are included in the Customer Service Incentive Worksheet at Attachment J-16.

H.4.3.2. Results of the surveys will be used to calculate a weighted average composite score (WACS) whereby the results of the MTF leadership survey carry the greatest weight, and the results of the provider survey carry the least. Survey results will be populated in the Customer Service Incentive Worksheet, Attachment J-16 and the Contractor will receive the incentive amount in accordance with paragraph H.4.3.3.

H.4.3.3. The Government will notify the Contractor within 30 calendar days of survey results being collected. The following scale identifies the potential incentive the Contractor may earn for each semi-annual surveyed performance period.

INCENTIVE

Total Calculated Composite Score	**Incentive Earned**
0-7.000	$ -
7.001-7.500	$ 75,000.00
7.501-8.000	$ 100,000.00
8.001-8.500	$ 200,000.00
8.501-9.000	$ 350,000.00
9.001-9.500	$ 650,000.00
9.501-10.000	$ 1,100,000.00

H.4.3.4. The Government may unilaterally add, delete, or change questions within the surveys applicable to this incentive at any time. In the event the Government makes changes to the surveys, such changes will become effective in the next surveyed performance period after notification is provided to the Contractor.

H.5. PERFORMANCE GUARANTEES

H.5.1. The Performance Guarantees described in this paragraph H.5 are the Contractor's guarantee that the Contractor's performance will meet or exceed the specified performance readiness standards. The rights of the Government and remedies described in the Performance Guarantee Section are in addition to all other rights and remedies of the Government pertaining to the failure of a Contractor to meet contractually-specified performance requirements. Specifically, the Government reserves the rights and remedies set forth in the Inspection of Services clause (FAR 52.246-4, 52.246-5) and Default or Termination clauses (FAR 52.249-8, 52.249-6). See paragraph G.3 for administrative details relating to performance standards. Any reference to "day" within this paragraph H.5 has a meaning of "calendar day."

H.5.2. The Contractor guarantees that its performance will meet or exceed the standards set forth in the paragraphs below. For each occurrence the Contractor fails to meet a guaranteed standard, the Government will reduce payments made to the Contractor in the amount listed for each standard. For administrative purposes, the Government will notify the Contractor of Performance Guarantee reductions on a monthly basis via a unilateral modification in accordance with FAR 43.103(b)(3). The modification will cite this section as the authority for the modification. Reductions will be taken from the next available contract payment under an administrative line item.

H.5.3. RESERVED

H.5.4. Provider Network Loading to Systems

Primary Care Manager (PCM) Loading to Systems:

H.5.4.1. The Contractor shall load PCM information into the requisite systems in accordance with the timeliness standards set forth below (based on the total number of PCMs required by the Contractor's Network Implementation Plan). For all PCMs loaded, the Contractor must have an executed contract/network agreement in place. Standard:

- 50% of PCMs loaded no later than 120 days prior to the SHCD
- 75% of PCMs loaded no later than 100 days prior to the SHCD
- 100% of PCMs loaded no later than 60 days prior to the SHCD

H.5.4.1.1. This Performance Guarantee will be evaluated during the PRAV process. For each day the PCM load standard is not met, a Performance Guarantee shall be applied as follows: based on a comparison of the actual number of PCM loads completed and the total number of PCMs identified in the Contractor's Network Implementation Plan, the Government will assess a Performance Guarantee amount of $10,000 per day for every day the 120 calendar day standard is not met until the standard is met ($200,000 maximum). If the 120 calendar day standard is not met by 100 calendar days prior to the SHCD, the Performance Guarantee will increase to $50,000 per day for every day the standard is not met until the standard is met ($2,000,000 maximum). If the 100 calendar day standard is not met by 60 calendar days prior to the SHCD, the Performance Guarantee will increase to $100,000 for every day the standard is not met ($6,000,000 maximum). The total potential Performance Guarantee equals $8,200,000.

Specialty Providers Loading to Systems:

H.5.4.2. The Contractor shall load Specialty Provider information into the requisite systems in accordance with the timeliness standards below (based on the total number of Specialty Providers required by the Contractor's Network Implementation Plan). Standard:

- 50% of Specialty Providers loaded no later than 120 calendar days prior to the SHCD
- 75% of Specialty Providers loaded no later than 90 calendar days prior to the SHCD
- 100% of Specialty Providers loaded no later than 60 calendar days prior to the SHCD

H.5.4.2.1. This Performance Guarantee will be evaluated during the PRAV process. For each day the Specialty Providers load standard is not met, a Performance Guarantee shall be applied as follows: based on a comparison of the actual number of Specialty Provider loads completed and the total number of Specialty Providers identified in the Contractor's Network Implementation Plan, the Government will assess a Performance Guarantee amount of $3,000 per day for every day the 120 calendar day standard is not met until the standard is met ($90,000 maximum). If the 120 calendar day standard is not met by 90 days prior to the SHCD, the Performance Guarantee will increase to $4,000 per day for every day the standard is not met until the standard is met ($120,000 maximum). If the 90 calendar day standard is not met by 60

days prior to the SHCD, the Performance Guarantee will increase to $5,000 per day for every day the standard is not met ($300,000). Total potential Performance Guarantee equals $510,000.

Behavioral Health (BH) Provider Loading to Systems:

H.5.4.3. The Contractor shall load BH provider information into the requisite systems in accordance with the timeliness standards below (based on the total number of BH providers required by the Contractor's Network Implementation Plan). Standard:

- 75% of BH providers loaded no later than 120 days prior to SHCD
- 100% of BH providers loaded no later than 90 days prior to SHCD

H.5.4.3.1. This Performance Guarantee will be evaluated during the PRAV process. For each day the BH provider load standard is not met, a Performance Guarantee shall be applied as follows: based on a comparison of the actual number of BH Provider loads completed and the total number of BH Providers identified in the Contractor's Network Implementation Plan, the Government will assess a Performance Guarantee amount of $10,000 per day for every day the 120 calendar day standard is not met until the standard is met ($300,000 maximum). If the 120 calendar day standard is not met by 90 days prior to the SHCD, the Performance Guarantee will increase to $100,000 for every day the standard is not met ($9,000,000 maximum). Total potential Performance Guarantee equals $9,300,000.

Inpatient Healthcare Facility Loading to Systems:

H.5.4.4. The Contractor shall load Inpatient Healthcare Facility information into the requisite systems in accordance with the timeliness standards below (based on the total number of Inpatient Healthcare Facilities required by the Contractor's Network Implementation Plan). Standard:

- 50% of inpatient healthcare facilities loaded no later than 120 calendar days prior to the SHCD
- 75% of inpatient healthcare facilities loaded no later than 90 calendar days prior to the SHCD
- 100% of inpatient healthcare facilities loaded no later than 60 calendar days prior to the SHCD.

H.5.4.4.1. This Performance Guarantee will be evaluated during the PRAV process. For each day the Inpatient Healthcare Facility load standard is not met, a Performance Guarantee shall be applied as follows: based on a comparison of the actual number of Inpatient Healthcare Facility loads completed and the total number of Inpatient Healthcare Facilities identified in the Contractor's Network Implementation Plan, the Government will assess a Performance Guarantee amount of $3,000 per day for every day the 120 calendar day standard is not met until the standard is met ($90,000 maximum). If the 120 calendar day standard is not met prior to 90 days before the SHCD, the Performance Guarantee will increase to $4,000 a day for every day the standard is not met until the standard is met ($120,000 maximum). If the 90 calendar day standard is not met by 60 prior to the SHCD, the Performance Guarantee will increase to $5,000

per day for every day the standard is not met ($300,000 maximum). Total potential Performance Guarantee equals $510,000.

H.5.4.5. Independent Application of PCM, Specialty Provider, BH Provider, and Healthcare Facility Performance Guarantees: The Government will assess the four standards described in paragraphs H.5.4.1, H.5.4.2, H.5.4.3, and H.5.4.4 independently, and a Performance Guarantee will apply in each instance the Contractor fails to meet a PCM, Specialty Provider, BH Provider, or Healthcare Facility load standard. For example, if the Government assesses a performance guarantee withhold for the Contractor's failure to meet the 50% /120 calendar day PCM load standard (or any other standard), the Contractor will also still be subject to a performance guarantee withhold if it fails to meet the 75%/90 calendar day BH Provider load standard (or any other standard).

H.5.5. Enrollment Performance Guarantee

H.5.5.1. Standard: 90 calendar days prior to the SHCD, the Contractor's enrollment system shall be fully operational. "Fully operational" is defined as follows: (1) all hardware/software is operational, (2) system access requirements are met, (3) the system correctly interfaces with Government systems, (4) the Contractor can perform all required billing enrollment and collection transactions, and (5) all enrollment rules are loaded and accessible.

H.5.5.2. This Performance Guarantee will be evaluated during the PRAV process. Beginning on the 89th day prior to the SHCD, the Government will assess a Performance Guarantee amount of $5,000 for each calendar day that the Contractor fails to meet the "fully operational" standard. For example, if the Contractor's enrollment system is not fully operational until 85 calendar days prior to the SHCD, a Performance Guarantee of $20,000 will be assessed ($20,000 equates to $5,000 times four, which represents the four days that the system was not fully operational (89 through 86 calendar days prior to the SHCD). The total potential Performance Guarantee equals $450,000.

H.5.6. Customer Service Performance Guarantee

H.5.6.1. Standard: No later than 90 calendar days prior to the SHCD, the Contractor shall demonstrate that its Call Center staff can respond to inquiries with at least 97% accuracy (i.e., responses provided by Call Center staff shall be accurate and complete according to the terms of the contract and all applicable TRICARE program rules, regulations, and policies), as demonstrated through the assessment described in paragraph H 5.6.4.

H.5.6.2. This Performance Guarantee will be evaluated during the PRAV process. For each occurrence when the Call Center response accuracy standard of 97% is not met, a Performance Guarantee in the amount of $150,000 shall be applied. An occurrence shall be considered an assessment with up to 500 phone calls during the PRAV. In the event the Government exercises its right to require a reassessment following an unsuccessful assessment (a final result less than

97% accurate), the final results of the reassessment shall be considered a new occurrence and will also be subject to this Performance Guarantee.

H.5.6.3. RESERVED

H.5.6.4. The Government will conduct a customer service assessment during the PRAV in order to assess the accuracy of the responses provided by the Contractor's Call Center staff. The assessment will consist of the Government placing up to 500 phone calls to the Contractor's Call Center staff and asking questions on a variety of topics including, but not limited to, the following: enrollment, PCM assignment, referrals, service denials, and claims. The Government reserves the right to reassess the Contractor's performance until the 97% accuracy standard is achieved. The Performance Guarantee will continue to apply during any Government reassessment of the Contractor's Call Center response accuracy.

H.5.7. Referral Management PRAV Performance Guarantee

H.5.7.1. RESERVED

H.5.7.2. The Government will first evaluate this Performance Guarantee 31 days after the SHCD. Standard: The Contractor shall demonstrate that its referral management system can process 90% of referrals within 24 hours and 100% of referrals within 2 business days with a 95% accuracy rate, as demonstrated through the assessment described in paragraph H.5.7.3.

H.5.7.3. The Government will review up to 5,000 referrals to assess the Contractor's referral management performance against the timeliness and accuracy standards described in paragraph H.5.7.2. For each failure by the Contractor to meet a referral timeliness or accuracy standard, a Performance Guarantee in the amount of $300,000 shall apply. After the initial assessment, the Government will conduct another assessment every 30 days through 121 days after the SHCD.

H.5.7.4. Independent Application of Referral Management PRAV Performance Guarantee: The Government will apply this Performance Guarantee independently to each referral assessment conducted (i.e., to the initial assessment and each subsequent 30-day assessment). The Government will also apply the Performance Guarantee independently to each of the three standards (timeliness and accuracy) associated with the referral assessments. For example, if the Government assesses a $300,000 Performance Guarantee amount because the Contractor did not meet the 90%/24 hour timeliness standard during the initial assessment, the Contractor will also still be subject to a Performance Guarantee assessment if it fails to meet the 100%/2 business days timeliness standard (during the same assessment) and if it fails to meet the 95% accuracy standard (during the same assessment).

H.5.8. Claims Processing PRAV Performance Guarantee

H.5.8.1. This Performance Guarantee will be evaluated 120 days after the SHCD and into health care performance until the contractor meets claims processing standards.

H.5.8.2. For each occurrence when the claims accuracy standard of 98% for claims processing purposes is not met during the PRAV process, a Performance Guarantee shall be applied as follows:

Tier	Accuracy Rate	Performance Guarantee
Tier 1	> 75% and < 98%	$250,000
Tier 2	> 50% and ≤ 75%	$375,000
Tier 3	≤ 50%	$500,000

H.5.8.3. For each occurrence when the claims first pass auto-adjudication standard of 80% for claims processing purposes is not met during the PRAV process, a Performance Guarantee shall be applied as follows:

Tier	First Pass Auto-Adjudication Rate	Performance Guarantee
Tier 1	> 65% and < 80%	$250,000
Tier 2	> 40% and ≤ 65%	$375,000
Tier 3	≤ 40%	$500,000

H.5.8.4. For calculations of the Performance Guarantees under paragraph H.5.8, an occurrence shall be considered the final result of an assessment of up to 1,000 claims, 120 days after the SHCD to assess the Contractor's claims processing system for accuracy of the claim as well as the first pass auto-adjudication percentage. The Government reserves the right to reassess the Contractor's performance every 30 calendar days thereafter until the Contractor meets the accuracy standard and/or the claims first pass auto-adjudication standard. The final results of each reassessment shall be considered a new occurrence and will be subject to the Performance Guarantee. The Performance Guarantee will continue to apply during any Government reassessment of the accuracy of claims processed through the Contractor's claims processing system.

H.5.9. Claims Processing Health Care Delivery Performance Guarantee

H.5.9.1. This Performance Guarantee will be evaluated quarterly, beginning the second quarter of the first year of health care delivery, throughout the duration of the contract.

H.5.9.2. For each occurrence when the claims accuracy standard of 98% (first two option periods) and 98.25% (all remaining option periods (OPs)) (TOM, Chapter 1, Section 3) for claims processing purposes is not met during the evaluation period, a Performance Guarantee shall be applied as follows:

Tier	Claims Accuracy Rate	Performance Guarantee
Tier 1	> 75% and < 98% (OP 1 & 2)	$187,500

	> 75% and < 98.25% (OP 3-8)	
Tier 2	> 50% and ≤ 75%	$281,250
Tier 3	≤ 50%	$ 375,000

H.5.9.3. For each occurrence when the claims first pass auto-adjudication standard of 80% (increase in percentage by at least 1% in each subsequent option periods (OPs) 1-8) (TOM, Chapter 1, Section 3, paragraph 6.5.2) for claims processing purposes is not met during the evaluation period, a Performance Guarantee shall be applied as follows:

Tier	**First Pass Auto-Adjudication Rate**	**Performance Guarantee**
Tier 1	> 65% and < 80% (OP 1) > 65% and < 81% (OP 2) > 65% and < 82% (OP 3) > 65% and < 83% (OP 4) > 65% and < 84% (OP 5) > 65% and < 85% (OP 6) > 65% and < 86% (OP 7) > 65% and < 87% (OP 8)	$187,500
Tier 2	> 40% and ≤ 65%	$281,250
Tier 3	≤ 40%	$375,000

H.5.9.4. For each occurrence when the claims reprocessing rate exceeds the standard of 2% (first two option periods) and 1.75% (all remaining option periods (OPs)) (TOM, Chapter 1, Section 3), a Performance Guarantee shall be applied as follows:

Tier	**Claims Reprocessing Rate**	**Performance Guarantee**
Tier 1	> 2% and < 5% (OP 1 & 2) > 1.75% and < 5% (OP 3-8)	$187,500
Tier 2	≥ 5% and < 10%	$281,250
Tier 3	≥ 10%	$ 375,000

H.5.9.5. For calculations of the Performance Guarantees under paragraph H.5.9, an occurrence shall be considered the final result of an assessment of a minimum of 1,000 claims received during the prior quarter, beginning the second quarter after the SHCD to assess the Contractor's claims processing system for accuracy of the claim, first pass auto-adjudication percentage, and claims reprocessing rate. The Performance Guarantee will continue to apply quarterly during the duration of the health care delivery option periods.

H.5.10. Provider Directory Accuracy

This Performance Guarantee is assessed 90 days after the SHCD and every three months thereafter.

Standard: The Contractor shall demonstrate that its provider directory meets minimum accuracy standards as described in C.2.1.13.5.3 for all network providers (additionally refer to C.2.1.13.5.4 and C.2.1.13.5.5 for what the standard measures and how it is calculated).

For each occurrence when the provider directory accuracy standard is not met, a Performance Guarantee of $250,000 shall be applied.

An occurrence is considered an assessment where the Government validates up to 500 network provider directory listings.

H.6. EVOLVING PRACTICES, DEVICES, MEDICINES, TREATMENTS AND PROCEDURES

H.6.1. Medical practices and procedures will continue to expand and develop during the period of this contract. Over time, practices, devices, medicines, treatments, and procedures that previously were excluded from coverage under the TRICARE benefit as unproven or as yet unknown will become proven—and thus potentially subject to TRICARE coverage. Some of these expansions and developments in medical practices and procedures will increase the cost of health care delivered to beneficiaries under the TRICARE program, and some will decrease the cost of health care to the TRICARE program. The Contractor shall underwrite (consistent with the terms of paragraph H.1.1) the cost of all practices, medicines covered under this contract, devices, and medical treatments or medical procedures that move, during the entire period of contract performance, from the "as yet unknown or unproven" category (and thus not covered by TRICARE) into a status of TRICARE-covered benefit. The Contractor shall implement the move from as yet unknown or unproven to proven, as required, at no change in contract price or underwriting fixed fee. The Government will implement changes to the requirements caused by changes in the statutory definitions of the benefit (or new benefits added by statute) under the Changes clause.

H.6.2. TRICARE can only cost share for medically necessary supplies and services. Regulatory procedures exist at 32 CFR 199.4(g)(15) describing the procedure for evaluating the safety and efficacy of unproven drugs, devices, medical treatments, or medical procedures. The Contractor shall routinely review the hierarchy of reliable evidence, as defined in 32 CFR 199.2, and shall implement changes to the benefit (as described here and in paragraph H.6.1) into the TRICARE program through changes to its information and claims processing systems and its business processes.

H.7. POST-AWARD ORGANIZATIONAL CONFLICTS OF INTEREST/IMPAIRED OBJECTIVITY

The Contractor shall prevent, avoid, or mitigate any situation where the Contractor may have actual or potential conflicts of interests (e.g., impaired objectivity) in performing contractual requirements due to its other financial interests, conflicting internal allegiances, or other situations or circumstances in which the Contractor (in performing under this contract) may be unable to serve or protect the Government's best interests. This includes, but is not limited to, the Contractor's role as a fiscal intermediary and in its role in pursuing waste, fraud, and abuse (TOM, Chapter 13) involving organizations in which the Contractor has a financial interest. If situations that had not previously been addressed before award of the contract change or emerge after contract award, or at any time during performance of the contract, the Contractor shall

immediately notify the Contracting Officer, in writing, of the nature of the actual or potential conflict of interest. The Contractor shall submit a plan of action to the Contracting Officer within 30 calendar days of notification, outlining the actions the Contractor has taken or proposes to take to avoid, neutralize, or mitigate the actual or potential conflict(s) of interest. The Government reserves the right, in case of a breach, misrepresentation, or nondisclosure associated with or resulting from a Contractor conflict of interest, to terminate this contract, disqualify the Contractor from subsequent related contractual efforts, or pursue any remedy permitted by law or this contract.

H.8. THIRD PARTY INFORMATION

It may become necessary during the performance of this contract for the Contractor's employees to review proprietary information belonging to other Contractors. In such circumstances, the Contractor shall protect all such proprietary information from unauthorized use or disclosure and shall refrain from using the information for any purpose other than that for which it was furnished. At the request of the Contracting Officer, the Contractor shall execute agreements with third party companies furnishing data in connection with work performed under this contract. Nondisclosure agreements shall be completed by the Contractor, all Contractor employees, and any subcontractors or subcontractor employees who obtain access to proprietary information. The Contractor shall implement appropriate safeguards to restrict access to proprietary information (where such access is unnecessary) and to avoid, neutralize, or mitigate potential conflicts of interest that may arise from gaining access to such information.

H.9. PERFORMANCE READINESS VALIDATION (PRV)/PERFORMANCE READINESS ASSESSMENT AND VERIFICATION (PRAV)

H.9.1. Performance Readiness Validation: During contract transition, the Contractor shall conduct validation reviews to assess its performance readiness for accomplishing critical processes in seven key contract areas. This self-assessment process is called Performance Readiness Validation (PRV). The seven key contract areas that are subject to PRV reviews are: (1) provider networks; (2) enrollment; (3) customer service; (4) records management; (5) referral management; (6) claims processing; and (7) clinical operations.

H.9.1.1. Specific validation review activities, techniques, accuracy/timeliness thresholds, and processes are at the Contractor's discretion. However, the Contractor's validation process shall be structured such that it meets or exceeds the specific performance elements that will be verified by the Government during the Performance Readiness Assessment and Verification (PRAV) as discussed in the TOM, Chapter 2. Base validation parameters required to meet the Government PRAV are identified for each critical process, and the Contractor's PRV is expected to provide the necessary information for the Government to complete the PRAV.

H.9.1.2. Timelines for completing PRV reviews will vary by contract area, but all must be completed prior to the SHCD. The Contractor shall identify PRV activities and milestones in its Integrated Master Plan/Integrated Master Schedule (IMP/IMS), and the Contractor shall report

its progress/results to the Government via the Weekly IMP/IMS Status Report and other reports as appropriate.

H.9.1.3. Following the completion of the PRV for each critical process, the Contractor shall provide the Government transition team with a comprehensive briefing on the processes, results, and findings. The briefing should summarize the information that was reported to the Government via the Weekly IMP/IMS Status Reports. The Contractor shall brief results as validated performance against desired PRV/PRAV performance levels and contract standards and/or requirements. The briefing shall include a description of specific performance issues and/or risks identified by the Contractor, any lessons learned, and a comprehensive discussion of the steps contemplated or taken by the Contractor to ensure full performance readiness at the SHCD. The briefing schedule should incorporate adequate time for Government questions and feedback regarding any aspect of the Contractor's performance management and performance readiness review activities. The Contractor shall submit a revised IMP/IMS if the Contractor anticipates any significant deviation from any stated activities and milestones.

H.9.2. PRAV: The Government will conduct PRAV activities during the transition-in period to assess and verify the Contractor's performance readiness to accomplish critical processes in the seven key contract areas described above. Following the completion of all PRAV activities, the Contractor shall participate in a summary out-briefing by the Government on the processes, results, and findings of all PRAV activities. At the Government's discretion, this briefing will be conducted onsite at one of the Contractor's facilities or via teleconference within 14 calendar days following the conclusion of all PRAV activities. If the Government directs the Contractor to provide an onsite briefing, the Contractor shall provide toll-free teleconference support to allow participation by all Government transition team members regardless of their location.

H.9.3. If the Government determines that corrective actions are required (based on any PRV/PRAV activity, contract deliverable, or briefing), the Contracting Officer will notify the Contractor in writing of the performance readiness issues to be resolved prior to the SHCD. The contractor shall take immediate corrective actions on performance readiness issues and shall reduce transition related risks identified by the Government.

H.10. Claims Processing, TEDS Occurrence Errors and Payment Accuracy Reviews

H.10.1. The Government will conduct Quarterly Claims Processing Payment Accuracy reviews, Occurrence reviews, and Annual Underwritten Unallowable Healthcare Cost Compliance Reviews under this contract as described in TOM, Chapter 3, Section 5.

H.10.1.1. RESERVED

H.10.1.2. The Government will use an independent external claims review service under the TRICARE Claims Review Service (TCRS) contract to perform these reviews.

H.10.1.2.1. RESERVED

H.10.1.3. The Government will use results of the Quarterly reviews to determine compliance with the Claims Processing Standards stated in the TOM, Chapter 1, Section 3 "Claims Processing Accuracy."

H.10.1.4. The Government will use results of the Annual Underwritten Unallowable Healthcare Cost Compliance Review to determine the amount of Unallowable costs which will be recovered by the Government pursuant to FAR Clause 52.216-7 (Allowable Cost and Payment).

H.10.1.5. The Government will draw a random sample of TRICARE Encounter Data System (TEDS) records from the universe of claims submitted for Quarterly and Annual reviews. Sampling methodology is described in the TOM, Chapter 3, Section 5.

H.10.1.5.1. The Government will exclude TED records in batch/vouchers submissions that have not passed TEDS validity edits, or which are otherwise unprocessable at the time of the compliance review.

H.10.1.6. The Contractor shall forward to the Government documentation providing any unique internal procedure codes with narrative and cross-reference to approved TRICARE codes and pricing manuals used in claims processing.

H.10.1.6.1. Initial submission of documentation is due to the Government by the commencement of claims processing with the submission of revisions as they occur, by not later than the fifth calendar day of the month following the change.

H.10.1.7. For this contract, Patient Medical Record Documentation will be a requirement for Focus Study Reviews. Error rates may include errors assessed on payment accuracy as well as Medical Records review discrepancies.

H.10.2. Quarterly Claims Processing and Payment Accuracy Compliance Reviews/TEDS Occurrence Reviews.

H.10.2.1. The Government will perform Quarterly Claims Processing and Payment Accuracy Compliance Reviews at the end of each quarter. The Government will include only non-denied claims in this review. Some quarters will not undergo this review during a period when the contract is ending. The purpose of this review is to assess the Contractor's compliance with claims processing accuracy standards stipulated in the TOM, Chapter 1, Section 3 "Claims Processing Accuracy."

H.10.2.1.1. The Contractor shall correct the errors found in these reviews within 60 calendar days on receipt of errors from the Government.

H.10.2.2. The Government will perform Denied Claims Compliance Reviews. The purpose of these reviews is to assess the Contractor's compliance with claims processing accuracy standards stipulated in the TOM, Chapter 1, Section 3 "Claims Processing Accuracy." These reviews will only include denied claims. These reviews will occur at the discretion of the Government and will not occur every quarter during the contract.

H.10.2.2.1. The Contractor shall correct the errors found in these reviews within 60 calendar days on receipt of errors from the Government.

H.10.2.3. The Government will perform TED Record Occurrence Compliance Reviews. The purpose of these reviews is to assess the Contractor's compliance with TEDS record coding requirements as stipulated in the TSM, Chapter 2.2. Results from these reviews will be used to assess Contractor claims processing performance as stipulated in the TOM, Chapter 1, Section 3 "Claim Occurrence Errors." These reviews will occur at the discretion of the Government and will not occur every quarter during the contract.

H.10.2.3.1. The Contractor shall correct the errors found in these reviews within 60 calendar days on receipt of errors from the Government.

H.10.2.4. Sampling Methodology:

As stated in the TOM, Chapter 3, Section 5, the Government will generate a random sample of claims. The Government will forward the TEDS Internal Control Number (ICN) listing for the sample to the Contractor with instructions to gather required documentation and forward to the Government (TCRS Contractor). Claims for each type of review will be sampled as follows:

QUARTERLY	QUARTERLY	QUARTERLY
CLAIMS PAYMENT ACCURACY	**DENIED CLAIM COMPLIANCE**	**OCCURRENCE ERROR**
Sampling Methodology:	**Sampling Methodology:**	**Sampling Methodology**:
TED records will be stratified by paid amount and selected via random sampling from the following:	TED records will be stratified by billed amount and selected via random sampling from the following:	TED records will be selected via random sampling from the following:
-Non denied -Net records -UNDERWRITTEN & NON- UNDERWRITTEN CLAIMS -Records greater than low-dollar threshold (at discretion of Government, i.e., $100) − 100% review of records above high-dollar threshold (at discretion of Government, i.e. $200K)	-Denied records -UNDERWRITTEN & NON-UNDERWRITTEN CLAIMS -Records greater than low-dollar threshold (at discretion of Government, i.e., $100) -100% review of records above high-dollar threshold (at discretion of Government, i.e. $200K)	-Non denied -Net records -UNDERWRITTEN & NON- UNDERWRITTEN CLAIMS -Up to 500 TED records -Includes both non-denied and denied claims
Periodicity:	**Periodicity:**	**Periodicity:**
Quarterly	Quarterly, or at the discretion of the Government	Quarterly, or at the discretion of the Government
Sample at time chosen by Government	Sample at time chosen by Government	Sample at time chosen by Government

H.10.2.5. Required Contractor Documentation: The Contractor shall forward all documentation required by the TOM, Chapter 3, Section 5 to the TCRS Contractor within 45 calendar days of receipt of the letter transmitting the ICN listing for the quarterly period. Document and data requirements will be compliant with the MOU between the Contractor and the TCRS Contractor as required by the contract.

H.10.2.6. Payment Errors: Payment errors will be determined in accordance with the TOM, Chapter 3, Section 5. Error Codes are listed in the TOM, Chapter 3, Section 5.

H.10.2.7. Compliance Review Rebuttal Procedures: Contractor rebuttals of initial payment error findings must be submitted to the Government or designated compliance review contractor within 30 calendar days after the date of the Government transmittal letter. Additional guidance on rebuttals is found in the TOM, Chapter 3, Section 5.

H.10.2.8. Results. The Government will provide the results of the Quarterly Claims Processing and Payment Accuracy Compliance Reviews and TEDS Occurrence Reviews to the Contractor via CO letter at the end of the rebuttal process.

H.10.3. Annual Underwritten Unallowable Healthcare Cost Compliance Review (Reference FAR Clause 52.216-7, Allowable Cost and Payment (Deviation Pending Approval)).

H.10.3.1. The Government will conduct an annual payment accuracy review of healthcare claims. The purpose of this review will be to determine unallowable costs charged to the Government. After the end of each Option Period, the Government will draw a sample of claims from the TEDS database for that Option Period. The listing of TEDS ICN will be forwarded to the Contractor.

H.10.3.1.1. The Contractor shall forward the claims documentation to the TCRS Contractor and the CO. Upon completion of the review the error rate for the sample will be determined. The error rate will be extrapolated across the universe to determine a total unallowable cost submitted to the Government.

H.10.3.1.2. The Contractor shall reimburse the Government for this (unallowable) amount either by direct payment/check, offset against future invoice payments, or claims adjustment offsets. The means of reimbursement will be at the discretion of the Government.

H.10.3.2. Sampling Methodology: The Government will draw a sample of claims as stated in the TOM, Chapter 3, Section 5.

H.10.3.2.1. Claims will be sampled as follows:

ANNUAL UNDERWRITTEN UNALLOWABLE HEALTHCARE COST COMPLIANCE REVIEW
Sampling Methodology:
TED records will be stratified by paid amount and selected via random sampling from the following:

-Non-denied -Net records -UNDERWRITTEN CLAIMS ONLY -Up to 10,000 claims in sample -Government paid greater than low-dollar threshold (at discretion of Government i.e., $100) -100% review of records above high-dollar threshold (at discretion of Government, i.e. $200K) -Samples drawn from 1st cycle in the Option period, through last cycle of Option Period
Periodicity: Annually

H.10.3.2.2. The Government will draw samples at the end of the second month following the end of each contract option period. The Government will send the ICN listing to the Contractor.

H.10.3.3. The Government will, at the time the sample listing of ICNs is provided to the Contractor, provide the Contractor with a complete listing of TED records in the universe for the Option Period being reviewed.

H.10.3.3.1. The Contractor shall validate that the universe of claims matches the Contractor's underwritten universe of claims.

H.10.3.4. Required Contractor Documentation. The Contractor shall, upon receipt of the claims sample from the Government, forward all documentation required by the TOM, Chapter 3, Section 5 to the TCRS Contractor within 45 calendar days of receipt of the letter transmitting the ICN listing for the quarterly period. Document and data requirements shall comply with the terms of the MOU between the Contractor and the TCRS Contractor (see Section C, paragraph C.2.12.9.2.1).

H.10.3.5. Payment Errors: Payment errors will be determined in accordance with the TOM, Chapter 3, Section 5. Error Codes are listed in the TOM, Chapter 3, Section 5.

H.10.3.6. Compliance Review Rebuttal Procedures: The Contractor shall submit to the Government, or its designated Contractor, rebuttals of initial payment error findings within 30 calendar days after the date of receiving Government's transmittal letter. (Additional guidance on rebuttals is found in the TOM, Chapter 3, Section 5.)

H.10.3.7. Results: The Government will extrapolate the error rate to the Option Period universe to determine the total unallowed cost. The extrapolation will be based on the estimated average

overpayments to payments in the compliance review universe. Underpayments from the sample will be considered to have an improper payment amount of zero dollars so as to not offset overpayments from the sample.

H.10.3.7.1. The point estimate (E) of unallowed cost in the universe will be deemed the unallowable cost amount.

H.10.3.7.2. The Government will provide the results of the Annual Underwritten Unallowable Healthcare Cost Compliance Review to the Contractor. This will occur at the end of the rebuttal process, and after the final Unallowable Cost has been determined.

H.10.3.8. Unallowable Cost Recoupment Process.
The Government will notify the Contractor in writing of the disallowed amount. The Government will stipulate the method by which the Unallowable Costs shall be recouped. Methods will be:

- Direct reimbursement to the Government (check or Electronic Funds Transfer)
- Offset against future invoices submitted by the Contractor
- TEDS record credits on underwritten healthcare claims resulting from error corrections
- Other means at the discretion of the CO

H.10.3.8.1. The Contractor shall, if reimbursing the Government by check, make payment within 30 calendar days after notification of the results.

H.10.3.8.2. The Government will, if recoupment is to be made by offset against future invoices, make offsets against the first invoices received after notification of the results.

H.10.3.8.3. The Contractor shall, if the Government is to be reimbursed by TEDS record credit, provide a listing of TEDS records credits within 60 calendar days after notification of the Unallowable Amount. TEDS credits must have a processing date after the receipt of the claims in the sample.

H.10.3.8.3.1. The listing of TEDS record credits shall include:

1) TED Record Indicator (TRI)
2) The date of recoupment/adjusted action
3) The cycle in which the recoupment/adjusted TED record was accepted into the TEDs database
4) The amount of the recoupment/adjusted

H.10.3.8.3.2. The Government will, within 90 calendar days of receipt of the report, validate that the records identified were included in the compliance review universe. Any TED record that does not meet the reporting criteria and is unable to be validated will be reported back to the Contractor with a request for additional information to justify reimbursement.

H.10.3.8.3.3. The Government will notify the Contractor when the Government has completed its review of the report, and the Unallowable costs have been satisfactorily returned to the Government.

H.11. INTEGRATED PROCESS TEAMS

H.11.1. The Government may develop major contract and program changes through the use of Integrated Process Teams (IPTs) staffed by Government and Contractor personnel. The Government will not establish IPTs for all contract changes, but generally will establish them to address complex, system-wide issues. The IPT process required in this section will begin the date the CO notifies the Contractor in writing of the Government's intent to establish an IPT. Within 14 days after receiving such written notification, the Contractor shall identify the appropriate personnel (as agreed to by the CO and the Contractor) to serve on the IPT to develop and/or improve the technical, business, and implementation approach to any proposed TRICARE program or contract change.

H.11.2. The Contractor shall participate in all required IPT meetings as determined by the Government designated team lead, regardless of the mode of meeting (in person or via teleconference, video-teleconference, or another electronic conference mode). The frequency and scheduling of such meetings will vary depending on the topic. The Contractor shall participate with the Government team in the entire process from concept development through establishment of the final requirement. The IPT process required in this section may include developing the Government's budgetary cost estimates, identifying requirements, developing associated rough order of magnitude cost estimates, and preparing the final specification/statement of work. The IPT process will not include post-change order activities, such as implementation/coordination meetings and definitization efforts, the costs of which will be allocable to the change order itself.

H.11.3. The Government will have sole discretion to decide to implement an IPT's project outcome based on designed outcomes and budgetary cost estimates. The Contractor shall partner with the Government to make best efforts to pre-review any proposed contract modifications and TRICARE manual changes to ensure that the Government's implementation of such changes does not significantly deviate from the Government's designed outcomes and budgetary cost estimates for the project.

H.12. COST-PLUS-FIXED-FEE (CPFF), FIXED PRICE INCENTIVE FEE (FPIF), AND FIRM-FIXED-PRICE (FFP) CONTRACT CHANGES

The Government may issue changes to contract terms and conditions under the authority granted under FAR Clause 52.243-1 or FAR Clause 52.243-2 throughout the period of contract performance. These changes will be priced as CPFF, FPIF, or FFP at the discretion of the Contracting Officer, based on the contract terms and conditions affected by the change.

H.13. EXPRESSLY UNALLOWABLE HEALTHCARE COSTS

This contract identifies certain cost categories that are not underwritten healthcare costs. These cost categories are known as expressly unallowable underwritten healthcare costs and include, but are not limited to, payment amounts that exceed the allowed amounts specified in the TRICARE Manuals. Any payment made by the Contractor that is expressly unallowable shall be borne by the Contractor and shall not be reported or billed by the Contractor as underwritten healthcare costs. The Contractor must account for these payments at the individual claim level. These unallowable amounts shall be available for review by the CO or designee.

H.14. INSURANCE LIABILITY COVERAGES

In accordance with FAR 52.228-5, INSURANCE – WORK ON A GOVERNMENT INSTALLATION (Jan 1997), the following minimum liability coverages are stated below:

(a) Workers' compensation and employer's liability. The Contractor is required to comply with applicable Federal and State workers' compensation and occupational disease statutes. If occupational diseases are not compensable under those statutes, they shall be covered under the employer's liability section of the insurance policy, except when contract operations are so commingled with a Contractor's commercial operations that it would not be practical to require this coverage. Employer's liability coverage of at least $100,000 shall be required, except in States with exclusive or monopolistic funds that do not permit workers' compensation to be written by private carriers. (See FAR 28.305(c) for treatment of contracts subject to the Defense Base Act).

(b) General liability.

(1) The Contractor shall be required to provide bodily injury liability insurance coverage written on the comprehensive form of policy of at least $500,000 per occurrence.

(2) Property damage liability insurance shall be required only in special circumstances as determined by the agency.

(c) Automobile liability. The Contractor shall be required to provide automobile liability insurance written on the comprehensive form of policy. The policy shall provide for bodily injury and property damage liability covering the operation of all automobiles used in connection with performing the contract. Policies covering automobiles operated in the United States shall provide coverage of at least $200,000 per person and $500,000 per occurrence for bodily injury and $20,000 per occurrence for property damage. The amount of liability coverage on other policies shall be commensurate with any legal requirements of the locality and sufficient to meet normal and customary claims.

H.15. SERVICE CONTRACT ACT WAGE DETERMINATIONS

H.15.1. The Contractor employs personnel in various states and counties to support the contract requirements. Section J, Attachment J-15, Current Wage Determinations, provides the state and counties of personnel work locations and the associated wage determination information.

H.15.2. The Contractor shall comply with FAR 52.222-41 Service Contract Labor Standards (Aug 2018) clause as incorporated into Section I. The Contractor shall use the wage determination for the location with the same effective date as the applicable option period for any wage determinations not incorporated into the contract for new personnel or personnel who relocate to new locations.

H.15.3. The Contractor shall provide an annual update to the Section J, Attachment J-15, Current Wage Determinations, to identify changes in employee work locations with the applicable state and county information. This update shall identify any deletions or additions to address personnel changes. The Contractor shall provide the updated Attachment J-15, Current Wage Determinations, no later than December 1 for each option period.

H.15.4. The Government will revise Section J, Attachment J-15, Current Wage Determinations to incorporate applicable wage determination information. The Government will incorporate a revised Attachment J-15, Current Wage Determinations when options are exercised. Wage determinations referenced on Attachment J-15, Current Wage Determinations, are incorporated into the contract. All referenced wage determinations are available on the Department of Labor Wage Determinations Online website at https://www.wdol.gov/ or at the System for Award Management (SAM) website at, https://www.sam.gov/portal/SAM/.

H.15.5. The Contractor shall request price adjustments according to FAR 52.222-43 -- Fair Labor Standards Act and Service Contract Labor Standards -- Price Adjustment (Multiple Year and Option Contracts) (Aug 2018) as incorporated into Section I.

H.16. FUTURE POTENTIAL DEMONSTRATIONS AND PRODUCT IMPROVEMENTS

H.16.1. The purpose of this section is to describe potential demonstrations and product improvements that the Government may pursue and implement during the contract's period of performance. The Government reserves to itself full discretion to either pursue or not pursue any of the potential requirements addressed in the paragraphs below. When the Government implements a demonstration or product improvement, it may do so under the authority of 10 U.S.C. 1092 (Studies and Demonstration Projects) and/or the changes clause of the contract. Depending on the nature of the requirement, the Government, in order to execute the requirement, also may be required to seek legislative relief, and/or take rulemaking action in order to modify or add language at 32 CFR 199, and/or modify or add language to the TRICARE Manuals. The start dates and scheduling milestones of any future potential demonstration or

product improvement are entirely dependent on the foregoing factors and, as applicable, on completion of the following requirements:

a) The Government will approve, at the appropriate level, the design, cost estimate, and outcome measurements that will facilitate improvements to the quality, efficiency, convenience, and/or cost effectiveness of the TRICARE Program. In general, cost estimates (for health care) associated with any demonstration or product improvement should not exceed the amount that would otherwise be paid for such care under existing TRICARE reimbursement methodologies or what the Government would have paid for the services (including health care and administration costs).

b) The Government will either develop detailed requirements independently and share the requirements with the Contractor or develop requirements in collaboration with the Contractor pursuant to the terms of paragraph H.11 of this section.

c) The Government will carry out necessary efforts to obtain legislative relief or conduct rulemaking activities, as applicable.

d) The Government will execute the necessary contract modification.

e) The Government will update the TRICARE Manuals as required.

H.16.1.1. Advanced Primary Care

H.16.1.1.1. The Contractor shall actively identify and include in its networks Advance Primary Care (APC) practices that promote cost efficiency, clinical quality, improved access and beneficiary experience through practice designs including but not limited to:

H.16.1.1.1.1. Multidisciplinary teams that provide care coordination for complex patients; focus on prevention and provide patient centric resources; and support robust connections with the medical neighborhood and community-based services.

H.16.1.1.1.2. Same or next day appointments, extended appointment length, extensive use of digital health tools, embedded telehealth, chronic condition registries, medication adherence programs, collocation of behavioral health services, and management of life style risks.

H.16.1.1.1.3. Administrative infrastructure that supports value-driven care, population-based care payment, and integration of Government health and wellbeing ecosystem resources.

H.16.1.1.1.4. Timely referrals and interoperable medical record and data transfer capabilities.

H.16.1.1.2. The Contractor shall design and implement an APC monitoring and continuous improvement program. The Contractor shall include metrics for financial performance, beneficiary experience, and risk-adjusted clinical outcomes based on industry best practice.

H.16.1.1.3. The Contractor shall utilize advanced analytic tools to assess APC performance, and provide continuous feedback to improve value-based care delivery.

H.16.1.1.4. The Contractor shall submit a quarterly report on the performance of APCs within its network. For reporting requirements, see DD Form 1423-1, Contract Data Requirements List (CDRL), located in Section J.

H.16.1.1.5. The Contractor shall provide an outreach and education program on APC for TRICARE-eligible beneficiaries. The program shall include education on availability, advantages and incentives (to the extent incentives are authorized under the TRICARE program) to promote beneficiary use of APC providers.

H.16.1.2. RESERVED

H.16.1.3. Advanced Care Management

H.16.1.3.1. The Contractor shall define and integrate all utilization management, case management, behavioral health, and population health programs for a seamless experience for the beneficiary.

H.16.1.3.2. The Contractor shall use predictive analytics, in the operation of its medical management programs, which are designed to support and manage the health care of all beneficiaries as described in the TOM Chapter 7, Section 1.

H.16.1.3.3. The Contractor shall develop, implement, and maintain an integrated, whole person, Advanced Case Management (ACM) Program. At a minimum, Case Management in the ACM program shall meet requirements of the TOM Chapter 7, Section 2.

H.16.1.3.4. The Contractor shall provide ACM services via a dedicated point of contact for beneficiaries with sensitive, rare, high profile, or high-visibility needs that are in addition to the CM beneficiary categories identified in the TOM Chapter 7, Section 2.

H.16.1.3.5. The Contractor shall offer in-home ACM services to beneficiaries who have high-need for care and are at high-risk of readmission within 30 calendar days following discharge from an inpatient setting. The first visit shall be made 48 to 72 hours post discharge.

H.16.1.3.6. The Contractor shall communicate, collaborate, and coordinate on a 24/7 basis with private sector care providers, Markets/MTFs and the Government Designated Authority (GDA) to effectively execute transfers of stabilized patients from one location to another. Transfers may be necessary for medical, social, or financial reasons and will include moves of non-institutionalized and institutionalized patients, to include patients receiving behavioral health

care. The Contractor shall coordinate care (as applicable) with the MTF clinical staff, as well as civilian providers, when care occurs outside an MTF.

H.16.1.4. Care Collaboration Tools Requirements

H.16.1.4.1. The Contractor shall provide either internally or through third party applications, an integrated care collaboration program that facilitates virtual provider-to-provider consultations (eConsult), which reduce costs associated with specialist referrals, reduce wait times for specialist care, and produce the best quality outcomes for TRICARE-eligible beneficiaries. The Contractor shall ensure its e-Consult platform supports information sharing and collaboration via synchronous and asynchronous modalities.

H.16.1.4.2. The Contractor shall promote information sharing and collaboration across the direct and private sector care systems to ensure coordination of care and to expand MTF provider Knowledge, Skills, and Abilities (KSAs) through access to specialist expertise. The Contractor shall include e-Consult services as part of its strategy for mitigating network shortages.

H.16.1.4.3. The Contractor's e-Consult platforms and EHR systems shall support machine-to-machine interoperability using healthcare EDI standards (e.g. HIPAA X12 transactions and Health Level 7® (HL7) Fast Healthcare Interoperability Resources® (FHIR) between the Contractor, its network providers, the Direct Care System, and other authorized contractors.

H.16.1.4.4. The Contractor shall provide an outreach and education program on e-Consult capabilities, requirements, and incentives for all network and TRICARE-authorized providers. The program shall include education on the Contractor's e-Consult policies, and procedures to allow providers to carry out the requirements in an efficient and effective manner, while promoting provider information sharing and collaboration through the use of e-Consult services.

H.16.1.4.5. The Contractor shall create a billing and reimbursement methodology for e-Consults.

H.16.1.4.6. The Contractor shall establish reporting and monitoring mechanisms to track and trend e-Consults by providers, measure provider satisfaction, and assess impact on value. For reporting requirements, see DD Form 1423-1, Contract Data Requirements List (CDRL), located in Section J.

H.16.1.5. Clinically Integrated Networks (CINs)

H.16.1.5.1. The Contractor's provider network shall include Clinically Integrated Networks (CINs) that have demonstrated high quality outcomes, lower cost, and reduction of waste. CIN arrangements shall include value-based incentives that motivate providers to invest in and adopt new approaches to care delivery.

H.16.1.5.2. The Contractor shall design and implement a CIN monitoring and continuous improvement program.

H.16.1.5.3. The Contractor shall use CMS guidelines for developing quality and performance metrics and establishing trends in value-based care (VBC).

H.16.1.5.4. The Contractor shall utilize advanced analytic tools to assess CIN performance and provide continuous feedback to improve VBC delivery.

H.16.1.5.5. The Contractor shall submit a quarterly report on the performance of CINs within its network. For reporting requirements, see DD Form 1423-1, Contract Data Requirements List (CDRL), located in Section J.

H.16.1.5.6. The Contractor shall establish provider/CIN incentives and support beneficiary incentives (as authorized under the TRICARE program) and effective communications methods to promote enrollment in and success of the CINs.

H.16.1.6. Provider Recognition and Reward

H.16.1.6.1. The Contractor shall develop, implement, and maintain a Provider Recognition and Reward (PRR) Program. The Contractor's program shall align with the Government's Clinical Quality Management and Patient Safety Program as outlined in Section C, paragraph C.2.8.

H.16.1.6.1.1. The Contractor shall develop and implement written policies and procedures to measure provider performance and educate providers on the program and steps they can take to improve or maintain performance.

H.16.1.6.1.2. The Contractor shall track provider performance at the individual provider level for outpatient measures (where possible, and at the practice or department level if not possible) and at the hospital level for inpatient measures via a provider performance feedback system (referred to as "provider performance scorecards"). The Contractor shall update administrative data on scorecards at least quarterly. Performance data on scorecards should be updated quarterly, but not less frequently than semi-annually.

H.16.1.6.1.3. The Contractor and the Government will mutually agree upon metrics and methodology to be included in the provider performance scorecards annually.

H.16.1.6.1.4. The Contractor shall measure providers on a risk adjusted basis to ensure providers are not penalized for serving a sicker population.

H.16.1.6.1.5. The Contractor shall provide the GDA with training and real time access to the provider performance scorecards.

H.16.1.6.1.6. The Contractor shall report provider performance scorecard results to providers at the individual and system level to promote individual accountability and performance improvement. Scorecards will include an individual score as well as the individual's score as ranked against all other providers in the same specialty.

H.16.1.6.1.7. The Contractor shall assign levels of provider recognition based on results of provider performance scorecards.

H.16.1.6.1.8. The Contractor shall incentivize providers at the individual level for outpatient measures and at the hospital level for inpatient measures based on performance as measured in the provider performance scorecard. Incentives may be positive or negative as indicated by performance.

H.16.1.6.1.9. If a monetary incentive is used, the Contractor shall pay out earned incentives on the same basis of measurement i.e., monthly, quarterly and annually. In addition, the provider's total reimbursement for care provided may not exceed the applicable TRICARE maximum allowable amounts. Payments outside of claims shall include attribution to individual TRICARE beneficiaries and associated health care claims.

H.16.1.6.2. The Contractor shall ensure that it makes no payment, whether directly or indirectly, under the provider incentive program to a physician/group as an inducement to reduce or limit medically necessary services furnished to an individual beneficiary.

H.16.1.6.3. The Contractor shall develop and submit a Provider Recognition and Reward Plan identifying how it will measure its effectiveness in achieving: (1) MTF optimization/readiness, (2) cost efficiency and (3) high quality. Weighting of these measures for the purpose of provider reporting and provider incentives payments requires Government approval. For plan reporting requirements see DD Form 1423-1, Contract Data Requirements List (CDRL), located in Section J.

H.16.1.7. Targeted Utilization Management (UM)

H.16.1.7.1. The Contractor shall develop, implement, and maintain a Targeted UM program that evaluates the medical necessity, appropriateness, and efficiency of the use of healthcare services, procedures, and facilities.

H.16.1.7.2. The Contractor's Targeted UM program shall include the following components:

H.16.1.7.2.1. Service request (prior authorization, concurrent review, retrospective review) submitted by provider or beneficiary.

H.16.1.7.2.2. Benefit review to determine if requested service is covered.

H.16.1.7.2.3. Clinical review using Medical Necessity Criteria typically completed by clinicians with relevant experience.

H.16.1.7.2.4. If criteria not met or additional clinical discussion needed, review by physician with relevant specialty/experience.

H.16.1.7.2.5. Approvals, denials and/or partial denials

H.16.1.7.3. The Contractor shall design the Targeted UM process such that medical necessity criteria is applied consistently with the intent to ensure that beneficiaries receive the correct services for their conditions, at the necessary frequency, and for the necessary duration. The purpose of the process is also to ensure that medically necessary services are provided, to reduce unnecessary procedures, and to ensure beneficiaries receive care from the highest quality providers available to provide services. The Targeted UM processes are subject to the strict timelines for UM outlined in the TOM Chapter 7, Section 4. The Contractor's Targeted UM program shall demonstrate integration and collaboration with other of the Contractor's medical management programs, including, but not limited to, case management and quality management.

H.16.1.7.4. The Contractor shall administer the Targeted UM program with a collaborative approach to care focused on promoting beneficiary health and safety in addition to fiscal stewardship.

H.16.1.7.5. The Contractor shall select services, providers, or cases subject to the Targeted UM authorization requirements based on evidence based practices with transparency to providers in the services that require authorization. This process should be described in the annual plan, and results reported quarterly throughout the year.

H.16.1.7.6. The Contractor shall implement a Targeted UM evaluation process to identify services that should not require authorization. The evaluation should target specific diagnoses, levels of care, case complexity, and provider types to identify procedures and services that are low cost, have high approval rates, or that have low denial rates where eliminating authorizations provides efficiency in the UM process or reduces unnecessary provider burden.

H.16.1.7.7. The Contractor shall implement a Targeted UM design that identifies high performing providers with consistently very low denial rates for a status (e.g. "Gold Card" or similar) that eliminates the requirement for utilization review. Providers selected by the Contractor must be in good standing and meet all applicable Government requirements (e.g., accurate provider directory information) to achieve and maintain "Gold Card" status. The Contractor shall monitor these providers to ensure continued performance and Gold Card status.

H.16.1.7.8. The Contractor shall obtain and maintain accreditation from a nationally recognized accrediting organization for the following medical management programs: utilization management, case management, and population health.

H.16.1.8. Advanced Telehealth

H.16.1.8.1. The contractor shall enhance its comprehensive, integrated telehealth services, which reduce costs and produce the best quality outcomes for TRICARE-eligible beneficiaries, in accordance with the TOM, Chapter 27 and the TPM, Chapter 7 through the use of Value Based Payments for outcomes in distance specialty care, hub and spoke telehealth in rural and remote areas, and through remote telehealth monitoring.

H.16.1.8.2. The contractor shall develop and implement an equitable provider coding and payment model for telehealth care encounters to promote provider adoption and use of secure, HIPAA compliant telehealth platforms. The Contractor's payment model (which may require advance Government approval) shall not exceed the maximum price that the Government would have paid for the "in person" service.

H.16.1.9. Virtual Value Network

H.16.1.9.1. The Contractor shall create a Virtual Value Network (VVN) inclusive of a subset of high–value, low waste providers, to be identified using consistent, validated third-party metrics for appropriateness of care, clinical outcomes, beneficiary experience, and cost. The Contractor's VVN should not be a "narrow network" but rather a beneficiary-facing guide to support beneficiary selection of high value, low waste providers.

H.16.1.9.2. The Contractor shall use claims data to develop and maintain (on a quarterly basis) VVN provider scorecards and submit monthly reports on performance metrics to the Government. For reporting requirements, see DD Form 1423-1, Contract Data Requirements List (CDRL), located in Section J.

H.16.1.9.3. The Contractor shall provide web and app based tools and call center services to be utilized by beneficiaries to perform provider queries that take quality outcomes and beneficiary cost into account.

H.16.1.9.4. The Contractor shall make provider value rating tools and metrics available 24/7 through secure, HIPAA compliant technology platforms so that beneficiaries are able to make informed decisions and seek the highest quality care when needed.

H.16.1.9.5. The Contractor shall design and implement an engagement and communication strategy to maximize beneficiary awareness and use of VVN providers.

H.16.1.10. Wellness and Disease Management (Population Health)

H.16.1.10.1. The Contractor shall design and implement wellness and disease management program(s) that address the full spectrum of lifestyle risks and promote healthy behaviors, including healthy lifestyle choices (e.g., smoking cessation, weight loss, exercise, weight management, sleep hygiene) and management of chronic conditions. The Contractor's disease management program shall address at least the following chronic conditions: asthma, COPD, atherosclerotic vascular disease, heart failure, diabetes and cancer.

H.16.1.10.1.1. The Contractor shall develop a defined list of programs and opportunities to improve healthy behaviors, with requirements for participation and completion, and an assigned reward incentive value. The programs shall be multi-channel including at least phone/video based coaching, computer and mobile phone apps, and biometric and activity trackers using multi-channel modes of interaction.

H.16.1.10.1.2. The contractor shall develop a variety of financial and non-financial (intrinsic) incentives (consistent with existing TRICARE Program authorities for any such incentives) that best fit beneficiary lifestyles and make such incentives available for beneficiaries to earn based on completion of healthily lifestyle changes resulting in measurable outcomes (e.g. weight loss).

H.16.1.10.2. The Contractor shall develop a beneficiary engagement plan that includes digital multichannel communication strategies, targeted personal communications, and embedded marketing through touchpoints directly with beneficiaries, Contractor call centers, navigation services, and with provider organizations, including Patient-Centered Medical Homes (PCMH), Military Treatment Facilities (MTFs) and other Managed Care Support Contractors. This engagement plan shall educate and motivate beneficiaries about the program(s), healthy behaviors, and the importance of completing activities and shall promote enrollment in these programs. Regular beneficiary touchpoints shall be implemented to assess progress towards obtaining goals.

H.16.1.10.3. The Contractor shall provide beneficiary access to a secure, HIPAA compliant technology platform that assists in identifying risks, selecting health goals, and supports integrated tracking of progress toward goals through self-report and encounter data, which can also be shared with the PCMH/Provider, Contractor, and incentive distributor. Beneficiaries shall have 24/7 access to information about the program, enrollment, status, and the ability to select and use incentives.

H.16.1.10.4. The Contractor shall identify metrics measuring the performance of the program to include, at a minimum, measures of engagement, clinical status, and financial impact, to be agreed upon in collaboration with the Government. The Contractor shall submit reports on wellness and disease management program performance to the Government quarterly and annually.

H.16.1.11 Clinical Centers of Excellence (CCoE)

H.16.1.11.1. The Contractor shall identify and partner with high-performing, high-value providers and facilities outside of the MHS to be used as Clinical Centers of Excellence (CCoEs) when evaluating locations for referring all TRICARE beneficiaries. In order to minimize beneficiary travel, CCoEs shall be available within a 100 mile radius of designated MTF/Markets.

H.16.1.11.2. The Contractor shall develop, implement and maintain a CCoE optimization plan that includes all TRICARE enrolled beneficiaries, integrating care delivered by MTFs, any MHS COEs, and private sector care network providers, to include steerage toward CCoEs incorporated into its network when clinically appropriate. For reporting requirements, see CDRL, DD Form 1423-1, located in Section J.

H.16.1.11.3. The Contractor shall implement a process to maximize medically necessary referrals and authorizations to CCoEs, as appropriate, to enhance a medically ready force and the quality of care for beneficiaries as described in the TOM, Chapter 7, Section 5.

H.16.1.11.4. The Contractor shall reimburse CCoEs through CMS HCP-LAN Alternate Payment Methods (APM) Categories 2c through 4b referenced in Section H.18.

H.16.1.11.5. The Contractor shall establish qualification criteria for CCoEs that considers quality outcomes and savings to the Government.

H.16.1.11.6. Where available, the Contractor shall recruit CCoEs to the network to provide procedures and care for beneficiaries with conditions that are high mortality, high cost, or have highly variable health outcomes. CCoE providers shall be mutually agreed upon between the Contractor and the GDA.

H.16.1.11.7. The Contractor shall establish network agreements with TRICARE authorized providers and publish information informing TRICARE beneficiaries of the availability and access to network CCoEs.

H.16.1.11.8. The Contractor may include opportunities for MHS medical providers to receive training at the CCoEs to maintain and enhance their KSAs to maximize medical force readiness.

H.16.1.11.9. The Contractor shall inform the Government of any instances of facilities or providers losing CCoE designation as soon as the Contractor becomes aware of the change in status and shall remove such providers from the CCoE network.

H.16.1.11.10. The Contractor shall refer beneficiaries to the preferred list of designated CCoE providers for the medical conditions outlined in the annual MOU and in accordance with DoD condition-specific policy, in addition to the identified CCoEs outlined in the annual CCoE optimization plan. The Contractor shall meet with the Government on at least a quarterly basis to identify additional methods to promote utilization of the CCoEs.

H.16.1.11.11. The Contractor shall create and maintain an on-line list of all CCoE network providers. The list shall include information (as applicable) regarding provider specialty, sub-specialty, gender, work address, work fax number, and work telephone number for each service

area, and should indicate whether the provider is a PCM, should supply any Leapfrog scores, and indicate if the provider offers telehealth.

H.17. Future Potential Competitive Demonstrations

H.17.1. The purpose of this section is to notify the Contractor that the Government may, during the period of this contract, conduct one or more demonstrations (under the authority of 10 U.S.C. 1092) that open certain markets in the Contractor's geographic area of responsibility for local and regional providers, other than the Contractor, to compete to provide Managed Care Support to the TRICARE Program and health, medical, and administrative support services to TRICARE-eligible beneficiaries. In such markets, beneficiaries will have the option of receiving health, medical, and administrative support services through either the demonstration contractor or through the Contractor. The option will arise for beneficiaries during each annual enrollment period. The Government will publish standalone requests for proposals for each future market (local/regional) demonstration project. The Contractor will be required to develop an MOU with any such demonstration contractor, as described in Section C, paragraph C.2.12.9.2.1.

H.17.2. The Government intends to competitively award an Eligibility, Enrollment, and Encounter (EEE) Contract to manage the enrollment of beneficiaries under the competitive demonstration contracts. The Contractor will be required to interact, and develop an MOU (as described in Section C, paragraph C.2.12.9.2.1), with the Government's future EEE contractor for the purposes of beneficiary enrollment and jurisdiction of claims.

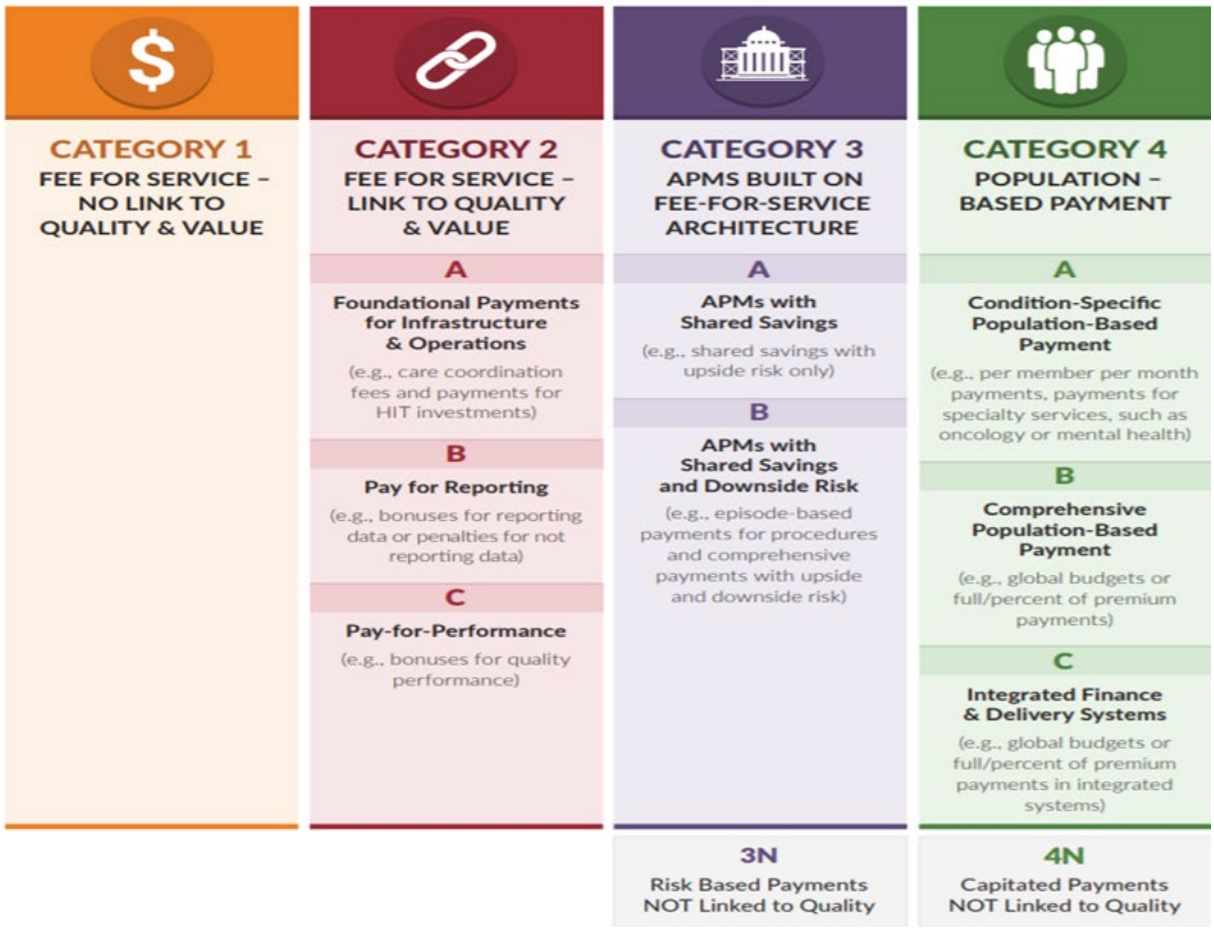
H.17.3. The Government will reduce the Contractor's administrative PMPM payment amount for each beneficiary who opts to receive services through a competitive local or regional demonstration provider (rather than through the Contractor) during the demonstration period in accordance with Section B, CLINs X003, and paragraph G.2. Because the Contractor's PMPM eligibles count reflects an average of the prior six-month historical period, as described in paragraph G.2, the change in the Contractor's administrative PMPM eligibles count due to shifts in enrollment to or from a competitive demonstration (and corresponding change to the contract payment amounts) will lag those shifts.

H.17.4. The markets where the Government will consider the competitive demonstration are identified in attachment J-9.

H.18. **Alternative Payment Models**

DHA will utilize the 2017 Health Care Payment Learning & Action Network (HCPLAN) framework for defining acceptable Alternative Payment Models (APMs):

	Standard: % of total network health care dollars paid under alternative payment models	**Requirements as aligned with 2017 HCPLAN framework.** **Categories 3N and 4N excluded.**	**Acceptable Quality Level (AQL)**	**Inspection – Contract Data Requirements List (CDRL)**
OP 1	15%	Categories 2A-C, 3A-B, or 4A-C, any mix.	5%	CDRL
OP 2	25%	Categories 2C, 3A-B, or 4A-C, any mix.	10%	CDRL
OP 3-5	50%	Categories 3A-B, or 4A-C, any mix.	15%	CDRL
OP 6-8	50%	Categories 3A-B, or 4A-C, any mix.	25%	CDRL



H.19. Uniformity of Benefit

H.19.1. The Government may utilize its authority under FAR Clauses 52.243-1 or 52.243-2, throughout the period of contract performance, to execute contract modifications necessary to meet its obligation to provide a uniform benefit across both TRICARE regions/geographic areas of responsibility. The Contractor is advised that the Government may standardize in both regional contracts (as high level requirements expressed in performance-based terms or as TRICARE Manual edits) any approaches, methods, or processes utilized by the Contractor which create a desired "look, touch, and feel" in the delivery of health, medical, and administrative services to beneficiaries. The Contractor shall cooperate with the Government's efforts to implement a uniform benefit and standardized experience for all TRICARE-enrolled beneficiaries.

H.20. Survival

H.20.1. To the extent that the Contractor must maintain records beyond the termination of this Contract in order to comply with any states' escheat laws, the following obligations will survive the expiration of this Contract until such time as the records are properly transferred to the Government and disposed of in accordance with the terms of this Contract: Section C, paragraph C.2.12.6., Information Systems Security, including all subsections; 36 CFR Chapter XII Subchapter B – Records Management; TOM Chapter 2, Records Management; TOM Chapter 19, Health Insurance Portability and Accountability Act (HIPAA) of 1996; and all other clauses pertaining to the protection of PHI and PII.

(End of Section)

SECTION I
CONTRACT CLAUSES

FAR 52.252-2 Clauses Incorporated By Reference (FEB 1998)

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

FAR 52.202-1 Definitions (JUN 2020)

FAR 52.203-3 Gratuities (APR 1984)

FAR 52.203-5 Covenant Against Contingent Fees (MAY 2014)

FAR 52.203-6 Restrictions on Subcontractor Sales to the Government (JUN 2020)

FAR 52.203-7 Anti-Kickback Procedures (JUN 2020)

FAR 52.203-8 Cancellation, Rescission, and Recovery of Funds for Illegal or Improper Activity (MAY 2014)

FAR 52.203-10 Price or Fee Adjustment for Illegal or Improper Activity (MAY 2014)

FAR 52.203-12 Limitation on Payments to Influence Certain Federal Transactions (JUN 2020)

FAR 52.203-13 Contractor Code of Business Ethics and Conduct (JUN 2020)

FAR 52.203-19 Prohibition on Requiring Certain Internal Confidentiality Agreements or Statements (JAN 2017)

FAR 52.204-4 Printed or Copied Double-Sided Postconsumer Fiber Content Paper (MAY 2011)

FAR 52.204-9 Personal Identity Verification of Contractor Personnel (JAN 2011)

FAR 52.204-10 Reporting Executive Compensation and First-Tier Subcontract Awards (JUN 2020)

FAR 52.204-13 System for Award Management Maintenance (OCT 2018)

FAR 52.204-14 Service Contract Reporting Requirements (OCT 2016)

FAR 52.204-18 Commercial and Government Entity Code Maintenance (AUG 2020)

FAR 52.204-19 Incorporation by Reference of Representations and Certifications (DEC 2014)

FAR 52.204-21 Basic Safeguarding of Covered Contractor Information Systems (JUN 2016)

FAR 52.204-23 Prohibition on Contracting for Hardware, Software, and Services Developed or Provided by Kaspersky Lab and Other Covered Entities (JUL 2018)

FAR 52.204-25 Prohibition on Contracting for Certain Telecommunications and Video Surveillance Services or Equipment (AUG 2020)

FAR 52.209-6 Protecting the Governments Interest When Subcontracting with Contractors Debarred, Suspended, or Proposed for Debarment (JUN 2020)

FAR 52.209-9 Updates of Publicly Available Information Regarding Responsibility Matters (OCT 2018)

FAR 52.209-10 Prohibition on Contracting With Inverted Domestic Corporations (NOV 2015)

FAR 52.210-1 Market Research (JUN 2020)

FAR 52.211-15 Defense Priority and Allocation Requirements (APR 2008)

FAR 52.215-2 Audit and Records – Negotiation (JUN 2020)

FAR 52.215-8 Order of Precedence - Uniform Contract Format (OCT 1997)

FAR 52.215-11 Price Reduction for Defective Certified Cost or Pricing Data - Modifications (JUN 2020)

FAR 52.215-13 Subcontractor Certified Cost or Pricing Data - Modifications (JUN 2020)

FAR 52.215-15 Pension Adjustments and Asset Reversions (OCT 2010)

FAR 52.215-18 Reversion or Adjustment of Plans for Postretirement Benefits (PRB) Other Than Pensions (JUL 2005)

FAR 52.215-19 Notification of Ownership Changes (OCT 1997)

FAR 52.215-21 Requirements for Certified Cost or Pricing Data and Data Other Than Certified Cost or Pricing Data - Modifications (JUN 2020) – Alternate III (OCT 1997)

(c) Submit the cost portion of the proposal via the following electronic media: MICROSOFT EXCEL Format with formulas

FAR 52.215-23 Limitations on Pass-Through Charges (JUN 2020)

FAR 52.216-7 Allowable Cost and Payment (DEVIATION PENDING APPROVAL)

(a) Invoicing.

(1) The Government will make payments to the Contractor when requested, but not more than once every Government business day, in amounts determined to be allowable by the Contracting Officer in accordance with Federal Acquisition Regulation (FAR) subpart 31.2 and with the terms of this contract. The submission of health care costs on a TRICARE Encounter Data (TED) voucher that passes the TED edits will be considered an invoice or voucher for reimbursement of claimed allowable health care costs.

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

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

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

(1) Those submitted on vouchers for direct health care costs that, at the time of the request for reimbursement, have passed the TED edits; and those recorded costs that, at the time of the request for reimbursement, the Contractor has actually paid or expended by cash, check, electronic fund transfer, or other form of actual payment for health care under this contract; and

(2) When those costs eligible for reimbursement are the direct health care costs that pass TED edits involving health care furnished to an eligible beneficiary, healthcare authorized under TRICARE, health care furnished by an authorized TRICARE provider, and health care costs consistent with authorized TRICARE reimbursement methodologies. Costs reimbursed based on vouchers passing initial TED edits are subject to further payment adjustment by the Government if determined not to qualify as an allowable cost.

(c) Audit. At any time or times before final payment, the Contracting Officer may have the Contractor's invoices or vouchers and statements of cost audited. "Audits" as used in this clause, includes audits on statistically valid samples. The audit result will be extrapolated across all the TRICARE medical claims for the region submitted for TED edits during the audited period to determine the total overpayment of the TRICARE medical claims population sampled for the region. The results of the audits will be used to adjust for overpayments of, or other unallowable health care costs. Underpayments made by the contractor that are found in an audit are not to be used to offset overpayment adjustment. These adjustments are in addition to the Government's rights under the Inspection of Services Clause (FAR 52.246-5). Any payment may be -

(1) Reduced by amounts found by the Contracting Officer not to constitute allowable costs;
or

(2) Adjusted for prior overpayments or underpayments.

(d) Final payment.

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

previously paid.

(2) The Contractor shall pay to the Government any refunds, rebates, credits, Contractor's claim overpayment or fraud recoveries, or other amounts (including interest, if any) accruing to or received by the Contractor or any assignee under this contract, to the extent that those amounts are properly allocable to costs for which the Contractor has been reimbursed by the Government and not previously identified and returned to the Government as an unallowable cost. Before final payment under this contract, the Contractor and each assignee whose assignment is in effect at the time of final payment shall execute and deliver

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

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

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

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

FAR 52.216-8 Fixed Fee (JUN 2011)

FAR 52.216-24 Limitation of Government Liability (APR 1984)

FAR 52.217-8 Option to Extend Services (NOV 1999)

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

FAR 52.217-9 Option to Extend the Term of the Contract (MAR 2000)

(a) The Government may extend the term of this contract by written notice to the contractor within a time period that is not later than 15 days prior to expiration of the contract; provided that the Government gives the contractor a preliminary written notice of its intent to extend at least 60 days before the contract expires. The preliminary notice does not commit the Government to an extension.

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

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

FAR 52.219-4 Notice of Price Evaluation Preference for HUBZone Small Business Concerns (MARCH 2020)

FAR 52.219-8 Utilization of Small Business Concerns (OCT 2018)

FAR 52.219-9 Small Business Subcontracting Plan (JUN 2020) Alt II (NOV 2016)

FAR 52.219-16 Liquidated Damages – Subcontracting Plan (JAN 1999)

FAR 52.219-28 Post-Award Small Business Program Representation (NOV 2020)

FAR 52.222-3 Convict Labor (JUN 2003)

FAR 52.222-21 Prohibition of Segregated Facilities (APR 2015)

FAR 52.222-26 Equal Opportunity (SEPT 2016)

FAR 52.222-35 Equal Opportunity for Veterans (JUN 2020)

FAR 52.222-36 Equal Opportunity for Workers with Disabilities (JUN 2020)

FAR 52.222-37 Employment Reports on Veterans (JUN 2020)

FAR 52.222-38 Compliance with Veterans' Employment Reporting Requirements (FEB 2016)

FAR 52.222-40 Notification of Employee Rights Under the National Labor Relations Act (DEC 2010)

FAR 52.222-41 Service Contract Labor Standards (AUG 2018)

FAR 52.222-42 Statement of Equivalent Rates for Federal Hires (MAY 2014)

In compliance with the Service Contract Labor Standards statute and the regulations of the Secretary of Labor (29 CFR part 4), this clause identifies the classes of service employees expected to be employed under the contract and states the wages and fringe benefits payable to each if they were employed by the contracting agency subject to the provisions of 5 U.S.C. 5341 or 5332.

THIS STATEMENT IS FOR INFORMATION ONLY (IT IS NOT A WAGE DETERMINATION):

EMPLOYEE CLASS	MONETARY HOURLY WAGE

FAR 52.222-43 -- Fair Labor Standards Act and Service Contract Labor Standards – Price Adjustment (Multiple Year and Option Contracts) (AUG 2018)

FAR 52.222-49 Service Contract Labor Standards- Place of Performance Unknown (MAY 2014)

a) This contract is subject to the Service Contract Labor Standards statute, and the place of performance was unknown when the solicitation was issued.

(b) Offerors who intend to perform in a place or area of performance for which a wage determination has not been attached or requested may nevertheless submit bids or proposals. However, a wage determination shall be requested and incorporated in the resultant contract retroactive to the date of contract award, and there shall be no adjustment in the contract price.

FAR 52.222-50 Combating Trafficking in Persons (OCT 2020)

FAR 52.222-54 Employment Eligibility Verification (OCT 2015)

FAR 52.222-55 Minimum Wages Under Executive Order 13658 (NOV 2020)

FAR 52.222-62 Paid Sick Leave Under Executive Order 13706 (JAN 2017)

FAR 52.223-2 Affirmative Procurement of Biobased Products Under Service and Construction Contracts (SEP 2013)

FAR 52.223-6 Drug-Free Workplace (MAY 2001)

FAR 52.223-17 Affirmative Procurement of EPA-Designated Items in Service and Construction Contracts (AUG 2018)

FAR 52.223-18 Encouraging Contractor Policies to Ban Text Messaging While Driving (JUN 2020)

FAR 52.224-1 Privacy Act Notification (APR 1984)

FAR 52.224-2 Privacy Act (APR 1984)

FAR 52.224–3 Privacy Training (JAN 2017)

FAR 52.225-13 Restrictions on Certain Foreign Purchases (FEB 2021)

FAR 52.227-1 Authorization and Consent (JUN 2020)

FAR 52.227-2 Notice and Assistance Regarding Patent and Copyright Infringement (JUN 2020)

FAR 52.227-14 Rights in Data--General (MAY 2014)

FAR 52.227-17 Rights in Data – Special Works (DEC 2007)

FAR 52.228-5 Insurance – Work on a Government Installation (JAN 1997)

FAR 52.229-3 Federal, State, and Local Taxes (FEB 2013)

FAR 52.230-2 Cost Accounting Standards (JUN 2020)

FAR 52.230-6 Administration of Cost Accounting Standards (JUN 2010)

FAR 52.232-1 Payments (APR 1984)

FAR 52.232-8 Discounts for Prompt Payment (FEB 2002)

FAR 52.232-11 Extras (APR 1984)

FAR 52.232-17 Interest (MAY 2014)

FAR 52.232-18 Availability of Funds (APR 1984)

FAR 52.232-22 Limitation of Funds (APR 1984)

FAR 52.232-23 Assignment of Claims (MAY 2014)

FAR 52.232-25 Prompt Payment (JAN 2017) - Alternate I (FEB 2002)

FAR 52.232-33 Payment by Electronic Funds Transfer - System for Award Management (OCT 2018)

FAR 52.232-39 Unenforceability of Unauthorized Obligations (JUN 2013)

FAR 52.232-40 Providing Accelerated Payment to Small Business Subcontractors (DEC 2013)

FAR 52.233-1 Disputes (MAY 2014) - Alternate I (DEC 1991)

FAR 52.233-3 Protest after Award (AUG 1996)

FAR 52.233-4 Applicable Law for Breach of Contract Claim (OCT 2004)

FAR 52.237-3 Continuity of Services (JAN 1991)

FAR 52.237-7 Indemnification and Medical Liability Insurance (DEVIATION PENDING APPROVAL)

(a) The Contractor is responsible for determining the medical malpractice coverage

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

(b) The Contractor shall be solely liable for and expressly agrees to indemnify the Government for the costs of defense and any liability resulting from services provided to Military Health System (MHS) eligible beneficiaries by a network provider. As an alternate, the Contractor shall have all network provider agreements used by the Contractor contain a requirement, directly or by reference to applicable regulations or Defense Health Agency policies, that the provider agrees to indemnify, defend, and hold harmless the Government from any and all claims, judgments, costs, liabilities, damages and expenses, including attorney's fees, whatsoever, arising from any acts or omissions in the provision of medical services by the provider to MHS eligible beneficiaries.

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

(d) Liability insurance may be on either an occurrences basis or on a claims-made basis. If the policy is on a claims-made basis, an extended reporting endorsement (tail) for a period of not less than 3 years after the end of the contract term must also be provided, or as long as standard practice in the locality or as may be required by local law or ordinance.

FAR 52.239-1 Privacy or Security Safeguards (AUG 1996)

FAR 52.242-1 Notice of Intent to Disallow Costs (APR 1984)

FAR 52.242-3 Penalties for Unallowable Costs (MAY 2014)

FAR 52.242–5 Payments to Small Business Subcontractors (JAN 2017)

FAR 52.242-13 Bankruptcy (JUL 1995)

FAR 52.243-1 Changes - Fixed-Price (AUG 1987) – Alternate I (APR 1984).

FAR 52.243-2 Changes – Cost Reimbursement (AUG 1987) Alternate I (APR 1984).

FAR 52.243-6 Change Order Accounting (APR 1984)

FAR 52.243-7 Notification of Changes (JAN 2017)

FAR 52.244-2 Subcontracts (JUN 2020)

FAR 52.244-5 Competition in Subcontracting (DEC 1996)

FAR 52.244-6 Subcontracts for Commercial Items (NOV 2020)

FAR 52.245-1 Government Property (JAN 2017) Alternate I (APR 2012)

FAR 52.246-25 Limitation of Liability - Services (FEB 1997)

FAR 52.249-2 Termination for Convenience of the Government (Fixed-Price) (APR 2012)

FAR 52.249-6 Termination (Cost-Reimbursement) (MAY 2004)

FAR 52.249-8 Default (Fixed-Price Supply and Service) (APR 1984)

FAR 52.249-14 Excusable Delays (APR 1984)

FAR 52.252-6 Authorized Deviations in Clauses (NOV 2020)

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

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

FAR 52.253-1 Computer Generated Forms (JAN 1991)

DEFENSE FEDERAL ACQUISITION REGULATION SUPPLEMENT (DFARS) SOLICITATION/CONTRACT CLAUSES

DFARS 252.201-7000 Contracting Officer's Representative (DEC 1991)

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

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

DFARS 252.203-7000 Requirements Relating to Compensation of Former DoD Officials (SEP 2011)

DFARS 252.203-7001 Prohibition on Persons Convicted of Fraud or Other Defense- Contract-Related Felonies (DEC 2008)

DFARS 252.203-7002 Requirement to Inform Employees of Whistleblower Rights (SEP 2013)

DFARS 252.203-7003 Agency Office of the Inspector General (AUG 2019)

The agency office of the Inspector General referenced in paragraphs (c) and (d) of FAR clause 52.203-13, Contractor Code of Business Ethics and Conduct, is the DoD Office of Inspector General at the following address:

Department of Defense Office of Inspector General

Administrative Investigations

Contractor Disclosure Program

4800 Mark Center Drive, Suite 14L25

Alexandria, VA 22350-1500

Toll Free Telephone: 866-429-8011

DFARS 252.203-7004 Display of Hotline Posters (AUG 2019)

(a) Definition. "United States," as used in this clause, means the 50 States, the District of

Columbia, and outlying areas.

(b) Display of fraud hotline poster(s).

(1) The Contractor shall display prominently the DoD fraud hotline poster, prepared by the DoD Office of the Inspector General, in common work areas within business segments performing work in the United States under Department of Defense (DoD) contracts.

(2) If the contract is funded, in whole or in part, by Department of Homeland Security (DHS) disaster relief funds, the DHS fraud hotline poster shall be displayed in addition to the DoD fraud hotline poster. If a display of a DHS fraud hotline poster is required, the Contractor may obtain such poster from:

Not Applicable-is not funded by DHS

(c)(1) The DoD hotline poster may be obtained from: Defense Hotline, The Pentagon, Washington, D.C. 20301-1900, or is also available via the internet at

https://www.dodig.mil/Resources/Posters-and-Brochures/

(2) If a significant portion of the employee workforce does not speak English, then the poster is to be displayed in the foreign languages that a significant portion of the employees speak.

(3) Additionally, if the Contractor maintains a company website as a method of providing information to employees, the Contractor shall display an electronic version of the required poster at the website.

(d) Subcontracts. The Contractor shall include the substance of this clause, including this paragraph (d), in all subcontracts that exceed the threshold specified in Defense Federal Acquisition Regulation Supplement 203.1004(b)(2)(ii) on the date of subcontract award, except when the subcontract is for the acquisition of a commercial item.

DFARS 252.204-7000 Disclosure of Information (OCT 2016)

DFARS 252.204-7002 Payment for Subline Items Not Separately Priced (DEC 1991)

DFARS 252.204-7003 Control of Government Personnel Work Product (APR 1992)

DFARS 252.204-7004 Antiterrorism Awareness Training for Contractors (FEB 2019)

DFARS 252.204-7006 Billing Instructions (OCT 2005)

DFARS 252.204-7009 Limitations on the Use or Disclosure of Third-Party Contractor Reported Cyber Incident Information (OCT 2016)

DFARS 252.204-7012 Safeguarding Covered Defense Information and Cyber Incident Reporting (DEC 2019)

DFARS 252.204-7015 Notice of Authorized Disclosure of Information for Litigation Support (MAY 2016)

DFARS 252.204-7018 Prohibition on the Acquisition of Covered Defense Telecommunications Equipment or Services (JAN 2021)

DFARS 252.204-7020 NIST SP-800-171 DOD Assessment Requirements (NOV 2020)

DFARS 252.204-7021 Cybersecurity Maturity Model Certification Requirements (NOV 2020)

DFARS 252.205-7000 Provision of Information to Cooperative Agreement Holders (DEC 1991)

DFARS 252.209-7004 Subcontracting with Firms That Are Owned or Controlled by the Government Country that is a State Sponsor of Terrorism (MAY 2019)

DFARS 252.211-7007 Reporting of Government-Furnished Property (AUG 2012)

DFARS 252.215-7000 Reserved

DFARS 252.219-7003 Small Business Subcontracting Plan (DoD Contracts) (DEC 2019) Alt I (DEC 2019)

This clause supplements the Federal Acquisition Regulation 52.219-9, Small Business Subcontracting Plan, clause of this contract.

(a) Definitions. As used in this clause—

Summary Subcontract Report (SSR) Coordinator means the individual who is registered in the Electronic Subcontracting Reporting System (eSRS) at the Department of Defense level and is responsible for acknowledging receipt or rejecting SSRs submitted under an individual subcontracting plan in eSRS for the Department of Defense.

(b) Subcontracts awarded to qualified nonprofit agencies designated by the Committee for Purchase From People Who Are Blind or Severely Disabled (41 U.S.C. 8502-8504), may be counted toward the Contractor s small business subcontracting goal.

(c) A mentor firm, under the Pilot Mentor-Protege Program established under section 831 of Public Law 101-510, as amended, may count toward its small disadvantaged business goal, subcontracts awarded to—

(1) Protege firms which are qualified organizations employing the severely disabled; and

(2) Former protege firms that meet the criteria in section 831(g)(4) of Public Law 101-510.

(d) The master plan is approved by the Contractor's cognizant contract administration activity.

(e) In those subcontracting plans which specifically identify small businesses, the Contractor shall notify the Administrative Contracting Officer of any substitutions of firms that are not small business firms, for the small business firms specifically identified in the subcontracting plan. Notifications shall be in writing and shall occur within a reasonable period of time after award of the subcontract. Contractor-specified formats shall be acceptable.

(f)(1) For DoD, the Contractor shall submit reports in eSRS as follows:

(i) The Standard Form 294, Subcontracting Report for Individual Contracts, shall be submitted in accordance with the instructions on that form.

(ii) Submit the consolidated SSR to the Department of Defense.

(2) For DoD, the authority to acknowledge receipt of or reject SSRs submitted under an individual subcontracting plan in eSRS resides with the SSR Coordinator.

(g) Include the clause at Defense Federal Acquisition Regulation Supplement (DFARS) 252.219-7004, Small Business Subcontracting Plan (Test Program), in subcontracts with subcontractors that participate in the Test Program described in DFARS 219.702-70, if the subcontract is expected to exceed the applicable threshold specified in Federal Acquisition Regulation 19.702(a) and to have further subcontracting opportunities.

DFARS 252.223-7004 Drug-Free Work Force (SEP 1988)

DFARS 252.225-7004 Report of Intended Performance Outside the United States and Canada--Submission after Award (OCT 2020)

DFARS 252.225-7012 Preference for Certain Domestic Commodities (DEC 2017)

DFARS 252.225-7013 Duty-Free Entry (APR 2020)

DFARS 252.225-7048 Export-Controlled Items (JUN 2013)

DFARS 252.226-7001 Utilization of Indian Organizations, Indian-Owned Economic Enterprises, and Native Hawaiian Small Business Concerns (APR 2019)

DFARS 252.227-7013 Rights in Technical Data – Noncommercial Items (FEB 2014)

DFARS 252.227-7015 Technical Data – Commercial Items (FEB 2014)

DFARS 252.227-7025 Limitations on the Use or Disclosure of Government-Furnished Information marked with Restrictive Legends (MAY 2013)

DFARS 252.227-7027 Deferred Ordering of Technical Data or Computer Software (APR 1988)

DFARS 252.231-7000 Supplemental Cost Principles (DEC 1991)

DFARS 252.232-7003 Electronic Submission of Payment Requests and Receiving Reports (DEC 2018)

DFARS 252.232-7007 Limitation of Government's Obligation (APR 2014)

(a) Contract line item(s) 0001AA, 0001AB, 0001AC, 0001AD, X001, X003AA, X003AB, X003AC, and X004AD (subject to update at time of contract award) is/are incrementally funded. For this/these item(s), the sum of $ (to be completed at time of contract award) of the total price is presently available for payment and allotted to this contract. An allotment schedule is set forth in paragraph (j) of this clause.

(b) For item(s) identified in paragraph (a) of this clause, the Contractor agrees to perform up to the point at which the total amount payable by the Government, including reimbursement in the event of termination of those item(s) for the Government's convenience, approximates the total amount currently allotted to the contract. The Contractor is not authorized to continue work on those item(s) beyond that point. The Government will not be obligated in any event to reimburse the Contractor in excess of the amount allotted to the contract for those item(s) regardless of anything to the contrary in the clause entitled "Termination for Convenience of the Government." As used in this clause, the total amount payable by the Government in the event of termination of applicable contract line item(s) for convenience includes costs, profit, and estimated termination settlement costs for those item(s).

(c) Notwithstanding the dates specified in the allotment schedule in paragraph (j) of this clause, the Contractor will notify the Contracting Officer in writing at least ninety days prior to the date when, in the Contractor's best judgment, the work will reach the point at which the total

amount payable by the Government, including any cost for termination for convenience, will approximate 85 percent of the total amount then allotted to the contract for performance of the applicable item(s). The notification will state (1) the estimated date when that point will be reached and (2) an estimate of additional funding, if any, needed to continue performance of applicable line items up to the next scheduled date for allotment of funds identified in paragraph (j) of this clause, or to a mutually agreed upon substitute date. The notification will also advise the Contracting Officer of the estimated amount of additional funds that will be required for the timely performance of the item(s) funded pursuant to this clause, for a subsequent period as may be specified in the allotment schedule in paragraph (j) of this clause or otherwise agreed to by the parties. If after such notification additional funds are not allotted by the date identified in the Contractor's notification, or by an agreed substitute date, the Contracting Officer will terminate any item(s) for which additional funds have not been allotted, pursuant to the clause of this contract entitled "Termination for Convenience of the Government."

(d) When additional funds are allotted for continued performance of the contract line item(s) identified in paragraph (a) of this clause, the parties will agree as to the period of contract performance which will be covered by the funds. The provisions of paragraphs (b) through (d) of this clause will apply in like manner to the additional allotted funds and agreed substitute date, and the contract will be modified accordingly.

(e) If, solely by reason of failure of the Government to allot additional funds, by the dates indicated below, in amounts sufficient for timely performance of the contract line item(s) identified in paragraph (a) of this clause, the Contractor incurs additional costs or is delayed in the performance of the work under this contract and if additional funds are allotted, an equitable adjustment will be made in the price or prices (including appropriate target, billing, and ceiling prices where applicable) of the item(s), or in the time of delivery, or both. Failure to agree to any such equitable adjustment hereunder will be a dispute concerning a question of fact within the meaning of the clause entitled "Disputes."

(f) The Government may at any time prior to termination allot additional funds for the performance of the contract line item(s) identified in paragraph (a) of this clause.

(g) The termination provisions of this clause do not limit the rights of the Government under the clause entitled "Default." The provisions of this clause are limited to the work and allotment of funds for the contract line item(s) set forth in paragraph (a) of this clause. This clause no longer applies once the contract is fully funded except with regard to the rights or obligations of the parties concerning equitable adjustments negotiated under paragraphs (d) and (e) of this clause.

(h) Nothing in this clause affects the right of the Government to terminate this contract pursuant to the clause of this contract entitled "Termination for Convenience of the Government."

(i) Nothing in this clause shall be construed as authorization of voluntary services whose acceptance is otherwise prohibited under 31 U.S.C. 1342.

(j) The parties contemplate that the Government will allot funds to this contract in accordance with the following schedule:

On execution of contract	$ to be completed at time of contract award_____
(month) (day), (year)	$ to be completed at time of contract award____
(month) (day), (year)	$ to be completed at time of contract award_____
(month) (day), (year)	$ to be completed at time of contract award

DFARS 252.232-7006 Wide Area Workflow Payment Instructions (DEC 2018)

DFARS 252.232-7010 Levies on Contract Payments (DEC 2006)

DFARS 252.237-7023 Continuation of Essential Contractor Services (OCT 2010)

CONTINUATION OF ESSENTIAL CONTRACTOR SERVICES (OCT 2010)

(a) Definitions. As used in this clause-

(1) Essential contractor service means a service provided by a firm or individual under contract to DoD to support mission-essential functions, such as support of vital systems, including ships owned, leased, or operated in support of military missions or roles at sea; associated support activities, including installation, garrison, and base support services; and similar services provided to foreign military sales customers under the Security Assistance Program. Services are essential if the effectiveness of defense systems or operations has the potential to be seriously impaired by the interruption of these services, as determined by the appropriate functional commander or civilian equivalent.

(2) Mission-essential functions means those organizational activities that must be performed under all circumstances to achieve DoD component missions or responsibilities, as determined by the appropriate functional commander or civilian equivalent. Failure to perform or sustain

these functions would significantly affect DoD s ability to provide vital services or exercise authority, direction, and control.

(b) The Government has identified all of the contractor services performed under this contract as essential contractor services in support of mission essential functions.

(c)(1) The Mission-Essential Contractor Services Plan submitted by the Contractor, is incorporated in this contract.

(2) The Contractor shall maintain and update its plan as necessary. The Contractor shall provide all plan updates to the Contracting Officer for approval.

(3) As directed by the Contracting Officer, the Contractor shall participate in training events, exercises, and drills associated with Government efforts to test the effectiveness of continuity of operations procedures and practices.

(d)(1) Notwithstanding any other clause of this contract, the contractor shall be responsible to perform those services identified as essential contractor services during crisis situations (as directed by the Contracting Officer), in accordance with its Mission-Essential Contractor Services Plan.

(2) In the event the Contractor anticipates not being able to perform any of the essential contractor services identified in accordance with paragraph (b) of this section during a crisis situation, the Contractor shall notify the Contracting Officer or other designated representative as expeditiously as possible and use its best efforts to cooperate with the Government in the Government s efforts to maintain the continuity of operations.

(e) The Government reserves the right in such crisis situations to use Federal employees, military personnel or contract support from other contractors, or to enter into new contracts for essential contractor services.

(f) Changes. The Contractor shall segregate and separately identify all costs incurred in continuing performance of essential services in a crisis situation. The Contractor shall notify the Contracting Officer of an increase or decrease in costs within ninety days after continued performance has been directed by the Contracting Officer, or within any additional period that the Contracting Officer approves in writing, but not later than the date of final payment under the contract. The Contractor s notice shall include the Contractor s proposal for an equitable adjustment and any data supporting the increase or decrease in the form prescribed by the Contracting Officer. The parties shall negotiate an equitable price adjustment to the contract price, delivery schedule, or both as soon as is practicable after receipt of the Contractor s proposal.

(g) The Contractor shall include the substance of this clause, including this paragraph (g), in subcontracts for the essential services.

DFARS 252.239-7018 Supply Chain Risk (FEB 2019)

DFARS 252.242-7005 Contractor Business Systems (FEB 2012)

DFARS 252.242-7006 Accounting System Information (FEB 2012)

DFARS 252.243-7001 Pricing of Contract Modifications (DEC 1991)

DFARS 252.243-7002 Requests for Equitable Adjustment (DEC 2012)

DFARS 252.244-7001 Contractor Purchasing System Administration (MAY 2014)

DFARS 252.245-7001 Tagging, Labeling, and Marking of Government - Furnished Property (APR 2012)

DFARS 252.245-7002 Reporting Loss of Government Property (JAN 2021)

DFARS 252.245-7003 Contractor Property Management System Administration (APR 2012)

DFARS 252.245-7004 Reporting, Reutilization, and Disposal (DEC 2017)

DFARS 252.247-7023 Transportation of Supplies by Sea-Basic (FEB 2019)

(End of Section)

SECTION J
LIST OF ATTACHMENTS AND EXHIBITS

J.1. LIST OF ATTACHMENTS

J-1	Large Market MTF-East Region
J-1a	BRAC PSA List, East Region
J-2	Large Market MTF-West Region
J-2a	BRAC PSA List, West Region
J-3	Small Market MTF-East Region
J-4	Small Market MTF-West Region
J-5	Stand-Alone MTF-East Region
J-6	Stand-Alone MTF-West Region
J-7	Reserved
J-8	Clinical Quality Metrics
J-9	Competitive Demonstration
J-10	KSA Scores by MTF/Code Type
J-11	CQM Metrics for T5
J-12a	Award Fee Plan – Performance
J-12b	Award Fee Plan – Transition-Out Period
J-13	MHS Genesis Supplement-Interface Control Document
J-14	MHS Genesis Supplement-Performance Work Statement
J-15	Department of Labor SCA Governing Wage Determinations (Sample)
J-16	Customer Service Incentive Worksheet
J-17	Referral Data Element Table
J-18	T-5 Transition Payment Milestone Chart
J-19	PSA by Zip Code

J.2. LIST OF EXHIBITS

Exhibit A Master Contract Data Requirements List (DD Forms 1423-1)

(End of Section)

FEDERAL ACQUISITION REGULATIONS (FAR)
SECTION K PROVISIONS

FAR 52.204-8 Annual Representations and Certifications (MAR 2020)

(a)

(1) The North American Industry Classification System (NAICS) code for this acquisition is 524114.

(2) The small business size standard is $38.5M.

(3) The small business size standard for a concern which submits an offer in its own name, other than on a construction or service contract, but which proposes to furnish a product which it did not itself manufacture, is 500 employees.

(b)

(1) If the provision at 52.204-7, System for Award Management, is included in this solicitation, paragraph (d) of this provision applies.

(2) If the provision at 52.204-7, System for Award Management, is not included in this solicitation, and the Offeror has an active registration in the System for Award Management (SAM), the Offeror may choose to use paragraph (d) of this provision instead of completing the corresponding individual representations and certifications in the solicitation. The Offeror shall indicate which option applies by checking one of the following boxes:

[X] (i) Paragraph (d) applies.

[_] (ii) Paragraph (d) does not apply and the offeror has completed the individual presentations and certifications in the solicitation.

(c)

(1) The following representations or certifications in SAM are applicable to this solicitation as indicated:

(i) 52.203-2, Certificate of Independent Price Determination. This provision applies to solicitations when a firm-fixed-price contract or fixed-price contract with economic price adjustment is contemplated, unless–

(A) The acquisition is to be made under the simplified acquisition procedures in Part 13;

(B) The solicitation is a request for technical proposals under two-step sealed bidding procedures; or

(C) The solicitation is for utility services for which rates are set by law or regulation.

(ii) 52.203-11, Certification and Disclosure Regarding Payments to Influence Certain Federal Transactions. This provision applies to solicitations expected to exceed $150,000.

(iii) 52.203-18, Prohibition on Contracting with Entities that Require Certain Internal Confidentiality Agreements or Statements-Representation. This provision applies to all solicitations.

(iv) 52.204-3, Taxpayer Identification. This provision applies to solicitations that do not include the provision at 52.204-7, System for Award Management.

(v) 52.204-5, Women-Owned Business (Other Than Small Business). This provision applies to solicitations that-

(A) Are not set aside for small business concerns;
(B) Exceed the simplified acquisition threshold; and
(C) Are for contracts that will be performed in the United States or its outlying areas.

(vi) 52.204-26, Covered Telecommunications Equipment or Services-Representation. This provision applies to all solicitations.

(vii) 52.209-2, Prohibition on Contracting with Inverted Domestic Corporations-Representation.

(viii) 52.209-5, Certification Regarding Responsibility Matters. This provision applies to solicitations where the contract value is expected to exceed the simplified acquisition threshold.

(ix) 52.209-11, Representation by Corporations Regarding Delinquent Tax Liability or a Felony Conviction under any Federal Law. This provision applies to all solicitations.

(x) 52.214-14, Place of Performance-Sealed Bidding. This provision applies to invitations for bids except those in which the place of performance is specified by the Government.

(xi) 52.215-6, Place of Performance. This provision applies to solicitations unless the place of performance is specified by the Government.
(xii) 52.219-1, Small Business Program Representations (Basic, Alternates I, and II). This provision applies to solicitations when the contract will be performed in the United States or its outlying areas.

(A) The basic provision applies when the solicitations are issued by other than DoD, NASA, and the Coast Guard.

(B) The provision with its Alternate I applies to solicitations issued by DoD, NASA, or the Coast Guard.

(C) The provision with its Alternate II applies to solicitations that will result in a multiple-award contract with more than one NAICS code assigned.

(xiii) 52.219-2, Equal Low Bids. This provision applies to solicitations when contracting by sealed bidding and the contract will be performed in the United States or its outlying areas.

(xiv) 52.222-22, Previous Contracts and Compliance Reports. This provision applies to solicitations that include the clause at 52.222-26, Equal Opportunity.

(xv) 52.222-25, Affirmative Action Compliance. This provision applies to solicitations, other than those for construction, when the solicitation includes the clause at 52.222-26, Equal Opportunity.

(xvi) 52.222-38, Compliance with Veterans' Employment Reporting Requirements. This provision applies to solicitations when it is anticipated the contract award will exceed the simplified acquisition threshold and the contract is not for acquisition of commercial items.

(xvii) 52.223-1, Biobased Product Certification. This provision applies to solicitations that require the delivery or specify the use of USDA–designated items; or include the clause at 52.223-2, Affirmative Procurement of Biobased Products Under Service and Construction Contracts.

(xviii) 52.223-4, Recovered Material Certification. This provision applies to solicitations that are for, or specify the use of, EPA–designated items.

(xix) 52.223-22, Public Disclosure of Greenhouse Gas Emissions and Reduction Goals-Representation. This provision applies to solicitations that include the clause at 52.204-7.)

(xx) 52.225-2, Buy American Certificate. This provision applies to solicitations containing the clause at 52.225-1.

(xxi) 52.225-4, Buy American-Free Trade Agreements-Israeli Trade Act Certificate. (Basic, Alternates I, II, and III.) This provision applies to solicitations containing the clause at 52.225-3.

(A) If the acquisition value is less than $25,000, the basic provision applies.

(B) If the acquisition value is $25,000 or more but is less than $50,000, the provision with its Alternate I applies.

(C) If the acquisition value is $50,000 or more but is less than $83,099, the provision with its Alternate II applies.

(D) If the acquisition value is $83,099 or more but is less than $100,000, the provision with its Alternate III applies.

(xxii) 52.225-6, Trade Agreements Certificate. This provision applies to solicitations containing the clause at 52.225-5.

(xxiii) 52.225-20, Prohibition on Conducting Restricted Business Operations in Sudan-Certification. This provision applies to all solicitations.

(xxiv) 52.225-25, Prohibition on Contracting with Entities Engaging in Certain Activities or Transactions Relating to Iran-Representation and Certifications. This provision applies to all solicitations.

(xxv) 52.226-2, Historically Black College or University and Minority Institution Representation. This provision applies to solicitations for research, studies, supplies, or services of the type normally acquired from higher educational institutions.

(2) The following representations or certifications are applicable as indicated by the Contracting Officer:

[Contracting Officer check as appropriate.]

X (i) 52.204-17, Ownership or Control of Offeror.

X (ii) 52.204-20, Predecessor of Offeror.

__ (iii) 52.222-18, Certification Regarding Knowledge of Child Labor for Listed End Products.
__ (iv) 52.222-48, Exemption from Application of the Service Contract Labor Standards to Contracts for Maintenance, Calibration, or Repair of Certain Equipment-Certification.
__ (v) 52.222-52, Exemption from Application of the Service Contract Labor Standards to Contracts for Certain Services-Certification.
__ (vi) 52.223-9, with its Alternate I, Estimate of Percentage of Recovered Material Content for EPA–Designated Products (Alternate I only).

__ (vii) 52.227-6, Royalty Information.

__ (A) Basic.

__ (B) Alternate I.

__ (viii) 52.227-15, Representation of Limited Rights Data and Restricted Computer Software.

(d)

The offeror has completed the annual representations and certifications electronically in SAM website accessed through https://www.beta.sam.gov. After reviewing the SAM information, the offeror verifies by submission of the offer that the representations and certifications currently posted electronically that apply to this solicitation as indicated in paragraph (c) of this provision have been entered or updated within the last 12 months, are current, accurate, complete, and applicable to this solicitation (including the business size standard applicable to the NAICS code referenced for this solicitation), as of the date of this offer and are incorporated in this offer by reference (see FAR 4.1201); except for the changes identified below *[offeror to insert changes, identifying change by clause number, title, date]*. These amended representation(s) and/or certification(s) are also incorporated in this offer and are current, accurate, and complete as of the date of this offer.

FAR/DFARS Provision #	Title	Date	Change

Any changes provided by the offeror are applicable to this solicitation only, and do not result in an update to the representations and certifications posted on SAM.

(End of Provision)

FAR 52.204-16 Commercial and Government Entity Code Reporting (AUG 2020)

FAR 52.204-24 Representation Regarding Certain Telecommunications and Video Surveillance Services or Equipment (OCT 2020)

FAR 52.215-6 Place of Performance (OCT 1997)

FAR 52.230-1 Cost Accounting Standards Notices and Certification (JUN 2020)

Note: This notice does not apply to small businesses or foreign governments. This notice is in three parts, identified by Roman numerals I through III.

Offerors shall examine each part and provide the requested information in order to determine Cost Accounting Standards (CAS) requirements applicable to any resultant contract.

If the offeror is an educational institution, Part II does not apply unless the contemplated contract will be subject to full or modified CAS coverage pursuant to 48 CFR 9903.201-2(c)(5) or 9903.201-2(c)(6), respectively.

I. Disclosure Statement -- Cost Accounting Practices and Certification

(a) Any contract in excess of $750,000 resulting from this solicitation will be subject to the requirements of the Cost Accounting Standards Board (48 CFR Chapter 99), except for those contracts which are exempt as specified in 48 CFR 9903.201-1.

(b) Any offeror submitting a proposal which, if accepted, will result in a contract subject to the requirements of 48 CFR Chapter 99 must, as a condition of contracting, submit a Disclosure Statement as required by 48 CFR 9903.202. When required, the Disclosure Statement must be submitted as a part of the offeror's proposal under this solicitation unless the offeror has already submitted a Disclosure Statement disclosing the practices used in connection with the pricing of this proposal. If an applicable Disclosure Statement has already been submitted, the offeror may satisfy the requirement for submission by providing the information requested in paragraph (c) of Part I of this provision.

Caution: In the absence of specific regulations or agreement, a practice disclosed in a Disclosure Statement shall not, by virtue of such disclosure, be deemed to be a proper, approved, or agreed-to practice for pricing proposals or accumulating and reporting contract performance cost data.

(c) Check the appropriate box below:

* (1) *Certificate of Concurrent Submission of Disclosure Statement.* The offeror hereby certifies that, as a part of the offer, copies of the Disclosure Statement have been submitted as follows:

(i) Original and one copy to the cognizant Administrative Contracting Officer (ACO) or cognizant Federal agency official authorized to act in that capacity (Federal official), as applicable; and

(ii) One copy to the cognizant Federal auditor.

(Disclosure must be on Form No. CASB DS-1 or CASB DS-2, as applicable. Forms may be obtained from the cognizant ACO or Federal official and/or from the loose-leaf version of the Federal Acquisition Regulation.)

Date of Disclosure Statement: _____ Name and Address of Cognizant ACO or Federal Official Where Filed: _____

The offeror further certifies that the practices used in estimating costs in pricing this proposal are consistent with the cost accounting practices disclosed in the Disclosure Statement.

* (2) *Certificate of Previously Submitted Disclosure Statement.* The offeror hereby certifies that the required Disclosure Statement was filed as follows:

Date of Disclosure Statement: _____ Name and Address of Cognizant ACO or Federal Official Where Filed:

_____

The offeror further certifies that the practices used in estimating costs in pricing this proposal are consistent with the cost accounting practices disclosed in the applicable Disclosure Statement.

* (3) *Certificate of Monetary Exemption.* The offeror hereby certifies that the offeror, together with all divisions, subsidiaries, and affiliates under common control, did not receive net awards of negotiated prime contracts and subcontracts subject to CAS totaling $50 million or more in the cost accounting period immediately preceding the period in which this proposal was submitted. The offeror further certifies that if such status changes before an award resulting from this proposal, the offeror will advise the Contracting Officer immediately.

* (4) *Certificate of Interim Exemption.* The offeror hereby certifies that

(i) the offeror first exceeded the monetary exemption for disclosure, as defined in (3) of this subsection, in the cost accounting period immediately preceding the period in which this offer was submitted and

(ii) in accordance with 48 CFR 9903.202-1, the offeror is not yet required to submit a Disclosure Statement. The offeror further certifies that if an award resulting from this proposal has not been made within 90 days after the end of that period, the offeror will immediately submit a revised certificate to the Contracting Officer, in the form specified under subparagraph (c)(1) or (c)(2) of Part I of this provision, as appropriate, to verify submission of a completed Disclosure Statement.

Caution: Offerors currently required to disclose because they were awarded a CAS-covered prime contract or subcontract of $50 million or more in the current cost accounting period may not claim this exemption (4). Further, the exemption applies only in connection with proposals submitted before expiration of the 90-day period following the cost accounting period in which the monetary exemption was exceeded.

II. Cost Accounting Standards -- Eligibility for Modified Contract Coverage

If the offeror is eligible to use the modified provisions of 48 CFR 9903.201-2(b) and elects to do so, the offeror shall indicate by checking the box below. Checking the box below shall mean that the resultant contract is subject to the Disclosure and Consistency of Cost Accounting Practices clause in lieu of the Cost Accounting Standards clause.

* The offeror hereby claims an exemption from the Cost Accounting Standards clause under the provisions of 48 CFR 9903.201-2(b) and certifies that the offeror is eligible for use of the Disclosure and Consistency of Cost Accounting Practices clause because during the cost accounting period immediately preceding the period in which this proposal was submitted, the offeror received less than $50 million in awards of CAS-covered prime contracts and subcontracts. The offeror further certifies that if such status changes before an award resulting from this proposal, the offeror will advise the Contracting Officer immediately.

Caution: An offeror may not claim the above eligibility for modified contract coverage if this proposal is expected to result in the award of a CAS-covered contract of $50 million or more or if, during its current cost accounting period, the offeror has been awarded a single CAS-covered prime contract or subcontract of $50 million or more.

III. Additional Cost Accounting Standards Applicable to Existing Contracts

The offeror shall indicate below whether award of the contemplated contract would, in accordance with subparagraph (a)(3) of the Cost Accounting Standards clause, require a change in established cost accounting practices affecting existing contracts and subcontracts.

[ ] Yes [ ] No

(End of Provision)

FAR 52.230-7 Proposal Disclosure—Cost Accounting Practice Changes. (APR 2005)

DEFENSE FEDERAL ACQUISITION REGULATION SUPPLEMENT (DFARS) SECTION K PROVISIONS

DFARS 252.203-7005 Representation Relating to Compensation of Former DoD Officials (NOV 2011)

DFARS 252.204-7008 Compliance with Safeguarding Covered Defense Information Controls (OCT 2016)

DFARS 252.204-7016 Covered Defense Telecommunications Equipment or Services—Representation (DEC 2019)

DFARS 252.204-7017 Prohibition on the Acquisition of Covered Defense Telecommunications Equipment or Services—Representation (DEC 2019)

DFARS 252.219-7000 Advancing Small Business Growth (SEP 2016)

DFARS 252.225-7003 Report of Intended Performance Outside the United States and Canada--Submission with Offer (OCT 2020)

DFARS 252.227-7017 Identification and Assertion of Use, Release, or Disclosure Restrictions (JAN 2011)

DFARS 252.227-7028 Technical Data or Computer Software Previously Delivered to the Government (JUN 1995)

(End of Section)

L.1. SOLICITATION PROVISIONS

Federal Acquisition Regulation (FAR) 52.252-1 Solicitation Provisions Incorporated by Reference (Feb 1998)

This solicitation incorporates one or more solicitation provisions by reference, with the same force and effect as if they were given in full text. Upon request, the Contracting Officer (CO) will make their full text available. The Offeror is cautioned that the listed provisions may include blocks that must be completed by the Offeror and submitted with its quotation or offer. In lieu of submitting the full text of those provisions, the Offeror may identify the provision by paragraph identifier and provide the appropriate information with its quotation or offer. Also, the full text of a solicitation provision may be accessed electronically at this address:
https://www.acquisition.gov

(End of Provision)

FAR 52.204-6 Data Universal Numbering System (DUNS) Number (Oct 2016)

FAR 52.204-7 System for Award Management (Oct 2018)

FAR 52.211-14 Notice of Priority Rating for National Defense, Emergency Preparedness, and Energy Program Use (Apr 2008)

Any contract awarded as a result of this solicitation will be [ ] DX rated order; [X] DO rated order certified for national defense, emergency preparedness, and energy program use under the Defense Priorities and Allocations System (DPAS) (15 CFR 700), and the Contractor will be required to follow all of the requirements of this regulation.

(End of Provision)

FAR 52.215-1 Instructions to Offerors - Competitive Acquisition (Jan 2017)

FAR 52.215-16 Facilities Capital Cost of Money (Jun 2003)

FAR 52.215-20 Requirements for Certified Cost or Pricing Data and Data Other than Certified Cost or Pricing (Oct 2010) Alternate III (Oct 1997) AND Alternate IV (Oct 2010).

(a) Submission of certified cost or pricing data is not required.
(b) Provide information described below: Submit the proposal cost schedules and supporting information identified in the paragraphs under L.8.
(c) Submit the “information other than cost or pricing data” portion of the proposal via the following electronic media: As identified in paragraphs under L.8.

(End of Provision)

FAR 52.215-22 Limitations on Pass-Through Charges-Identification of Subcontract Effort (Oct 2009)

FAR 52.216-1 Type of Contract (Apr 1984)

The Government contemplates award of a contract consisting primarily of cost-plus fixed-fee types, with fixed-price elements, cost reimbursable elements and performance incentive fees included resulting from this solicitation.

FAR 52.222-24 Preaward On-Site Equal Opportunity Compliance Evaluation (Feb 1999)

FAR 52.222-46 Evaluation of Compensation for Professional Employees (Feb 1993)

FAR 52.233-2 Service of Protest (Sep 2006)

(a) Protests, as defined in section 33.101 of the FAR, that are filed directly with an agency, and copies of any protests that are filed with the Government Accountability Office (GAO), shall be served on the Contracting Officer (addressed as follows) by obtaining written and dated acknowledgment of receipt from the CO, identified in Block 7 of the Contract Standard Form 33.

(b) The copy of any protest shall be received in the office designated above within one day of filing a protest with the GAO.

(End of Provision)

FAR 52.252-5 Authorized Deviations in Provisions (Apr 1984)
The use in this solicitation of any FAR (48 CFR Chapter 1) provision with an authorized deviation is indicated by the addition of "(DEVIATION)" after the date of the provision.

(End of Provision)

DFARS 225.204-7019 Notice of NIST SP 800-171 DoD Assessment Requirements (Nov 2020)

DHA PGI 233.103-90 – Agency Level Protests (March 22, 2020)

An interested party filing a protest with Defense Health Agency (DHA) has the option of requesting review by either the Contracting Officer (CO) or an Independent Review Official (IRO), who is a DHA official at a level above the CO. Alternately, an interested party may request IRO review as an appeal of the CO's protest decision.

Where applicable, an interested party must clearly state in the protest that IRO review is requested, and must specify the nature of the independent review sought – whether as an alternative to CO review or as an appeal of the CO's decision. Regardless of which review is

requested, all protests must be complete and submitted to the CO within the timeframes specified in FAR Subpart 33.1.

L.2. GENERAL INSTRUCTIONS

L.2.1. The Government will conduct a full and open competition for up to two contract awards for managed care support services. There will be two TRICARE Regions (i.e., geographical areas for contract performance) which may each be awarded to a prime Contractor; however if one Offeror demonstrates the best value for both regions, that Contractor may not be awarded both East and West regions in accordance with Section M.2.1.1. An offeror may propose on one TRICARE region or both, in which case the Offeror shall submit two separate proposals (one for each region) consistent with Section L instructions.

L.2.2. Offerors are cautioned to follow the instructions provided in this section carefully to ensure the Government receives consistent information in a form that will facilitate proposal evaluation. Proposals that take exception to inclusion of specific requirements in the resultant contract shall not be considered. All proposal material shall be labeled in a manner which clearly identifies the region for which the proposal applies.

L.2.3. This section provides general guidance for preparing proposals as well as specific instructions on the format and content of the proposal. In addition to the offer, the Offeror's proposal must include all data and information requested in this solicitation and must be submitted in accordance with these instructions. The offer shall be compliant with the requirements as stated in the solicitation and applicable attachments. Non-conformance with the instructions provided in the solicitation and this section may result in an unfavorable proposal evaluation or rejection of the proposal. The proposal shall be clear, concise, and shall include sufficient detail for effective evaluation and for substantiating the validity of stated claims. Attachment L-1, Sections L, M, and C Cross Reference Table is provided to assist Offerors.

L.2.4. The offer should contain the Offeror's best terms from a price/cost and technical standpoint. The Government reserves the right to award without discussions; therefore, offers shall represent an Offeror's best and final offer from its initial proposal submission. If award is to be made without discussions, the Government reserves the right to request information to clarify certain aspects of proposals (e.g., the relevance of an Offeror's past performance information and adverse past performance information to which the Offeror has not previously had an opportunity to respond), address potential or actual organizational conflicts of interest, or to resolve minor or clerical errors. These requests for clarification or exchanges will not be used to cure weaknesses or material omissions of the offer, or materially alter the technical or cost information in the proposal. The Offeror shall not revise its offer in response to clarification questions under any circumstances; any such revision will not be considered.

L.2.5. If the Government determines that it is necessary to conduct discussions, the CO will establish a competitive range comprised of the most highly rated proposals. If the contracting officer determines that the number of most highly rated proposals that might otherwise be included in the competitive range exceeds the number at which an efficient competition can be conducted, the CO may limit the number of proposals in the competitive range to the greatest

number that will permit an efficient competition among the most highly rated proposals. If the CO decides that an Offeror's proposal should no longer be included in the competitive range, the proposal will be excluded from consideration for award, and written notice of this decision will be provided to unsuccessful Offerors in accordance with FAR 15.503.

L.2.6. The proposal shall not simply rephrase or restate the Government's requirements, but rather shall provide convincing rationale to address how the Offeror intends to meet these requirements. Offerors shall assume that the Government has no prior knowledge of its facilities, capabilities, and experience. The Government will base its evaluation on the information presented in the proposal, plus any additional past performance information obtained by the Government from other sources.

L.2.7. Offerors shall submit their anticipated organizational structure at least fifteen (15) calendar days prior to the proposal due date. The organizational structure must include the prime Contractor and first-tier subcontractors (as defined in Section L.7.1.). The organizational structure shall include addresses and telephone numbers. In the case of a joint venture or other business structure, a clear description of the organizational relationships must be disclosed. This organizational structure is to be emailed to the following address:

Evan J. Zaslow
Contracting Officer
evan.j.zaslow.civ@mail.mil

L.2.8. ORGANIZATIONAL CONFLICTS OF INTEREST

L.2.8.1. The Offeror's attention is directed to FAR, Subpart 9.5, "Organizational and Consultant Conflicts of Interest."

L.2.8.2. It is the position of the Defense Health Agency (DHA) that the following companies, due to the nature of their performance with DHA, have an actual or potential organizational conflict of interest associated with the work to be performed under the contracts resulting from this solicitation, which must be avoided, neutralized, or mitigated. The fact that an organization appears on this list does not preclude Offerors from contracting/subcontracting with the organization; rather, it merely serves to identify that an organizational conflict of interest may exist and that adequate steps must be taken to avoid, neutralize, or mitigate the conflict of interest.

Organizations with an actual or potential conflict of interest include the following: A-Team Solutions, LLC; Architecture, Engineering, Consulting, Operations and Management (AECOM); Axiom Resource Management Inc.; Booz Allen Hamilton; Compliance Automation Inc.; Concept Plus, LLC; Amyx, Inc.; E.R. Williams Inc.; Information Technology Solutions & Consulting, LLC (ITSC); Intellidyne, LLC; Kennell and Associates Inc.; Keystone Peer Review Organization, Inc. (KePRO); Kforce Government Solutions, Inc. (KGS); Lockheed-Martin; Mercer (US), Inc.; ThinkQ; Ernst & Young Global Limited; Ernst and Young; Developing Global Trust with International Interests LLC; and SofTec Solutions, Inc. The actual or potential OCI extends to subsidiaries, parents, and affiliates of these companies. Actual or potential organizational

conflicts of interest may exist for entities not on list above, and it is the Offeror's responsibility to take appropriate action where necessary.

L.2.8.3. The Offeror shall represent in writing within Volume 1 of the proposal that, to the best of the Offeror's knowledge, there are no relevant facts or circumstances concerning any past, present, or potential contracts or financial interest relating to the work to be performed, which could give rise to an organizational conflict of interest, as described in FAR, Subpart 9.5. In the event an actual or potential organizational conflict of interest exists, the Offeror shall submit a mitigation plan to the CO as soon as possible, but no later than 15 calendar days prior to the proposal due date, that describes such actual or potential conflicts and explains how the Offeror intends to mitigate any actual or potential organizational conflict of interest while supporting this contract and any other DHA contract. The Offeror shall also provide the CO, no later than 15 calendar days prior to the proposal due date, with information of previous or ongoing work that is in any way associated with this solicitation. Any organizational conflicts of interest found after proposal submittals shall be disclosed to the CO immediately. Failure to disclose a conflict of interest timely may result in an Offeror being determined ineligible for contract award.

L.2.8.4. The CO will review all mitigation plans to determine whether award to the Offeror is consistent with the FAR, Subpart 9.5. If the CO determines that no conflict would arise or that the mitigation plan adequately protects the interest of the Government, the Offeror will be eligible for award. If the CO determines that the Offeror has not eliminated, avoided, or adequately mitigated an actual or potential organizational conflict of interest, then the Government may consider and/or take appropriate remedial actions, which may include eliminating an Offeror from the solicitation process, terminating a related DHA contract effort already awarded, or negotiating an appropriate mitigation plan.

L.2.8.5. The Offeror shall include the above restrictions in all subcontracts, teaming arrangements, and other agreements calling for performance of work which is subject to the organizational conflict of interest restrictions identified in these provisions.

L.2.8.6. The Offeror shall acknowledge the full force and effect of these provisions. The Government reserves the right, in case of a breach, misrepresentation, or nondisclosure, to terminate the resultant contract, disqualify the Offeror from subsequent related contractual efforts, or pursue any remedy permitted by law, regulation, or the terms and conditions of this solicitation.

L.2.9. Use of Former Department of Defense (DoD)/DHA/TRICARE Management Activity (TMA) Employees and Uniformed Service Members in Proposal Preparation.

The involvement of a former DoD, DHA, or TMA employee/service member in an Offeror's proposal preparation may give rise to an unfair competitive advantage or the appearance thereof, if the former DoD/DHA/TMA employee/member acquired or had access to non-public, competitively-useful information in his or her former position. Such competitively-useful information includes proprietary information regarding a competitor's performance on past or current contracts involving requirements similar to those described in this solicitation or source selection sensitive information pertaining to this procurement. Consequently, the Offeror must

notify the CO *prior to* the involvement in the proposal preparation process by a former DoD/DHA/TMA employee/service member reasonably expected to have had access to such information. Based on the notification, the CO will make a determination whether involvement of the former DoD/DHA/TMA employee/service member in proposal preparation could create an unfair competitive advantage or appearance thereof. The CO will further determine whether any mitigation measures taken or proposed by the Offeror are adequate to alleviate this concern. Failure to comply with these procedures may result in the Offeror's disqualification for award.

L.3. INFORMATION

L.3.1. The solicitation identified CO and Contract Specialist (CS) are the sole points of contact for this procurement. Questions regarding the solicitation or other concerns shall be submitted in accordance with L.3.7.

L.3.2. Summary level historical data on underwritten eligible beneficiaries, underwritten purchased care costs, Per Member Per Month (PMPM) eligibles, and various administrative support services workload volumes are available at no cost to all interested parties in attachments to Section L. These summary level data attachments will be made available via the beta.sam.gov RFP website.

L.3.3. Detail level data on historical purchased care costs and workload, direct care workload, eligible beneficiaries, and pharmacy workload may be ordered by potential Offerors for a processing fee of $2,500 that will include the original data set and updated data sets, if any, for the acquisition. Prior to receiving the detail level data, potential Offerors must also complete a data-sharing agreement to ensure the privacy and security of protected health information. The detail level data package also will include associated documentation files (e.g., record layouts) and a zip code mapping file. Offeror use and interpretation of Government-provided data is at the sole risk of the Offeror. The Offeror shall rely upon its expertise and knowledge in the field of healthcare management and administration in developing its proposal.

L.3.4. Current TRICARE manuals referenced in Section C are included as an attachment to the RFP located on the Federal Business Opportunities website posting at http://beta.sam.gov. Offerors may access previous versions of the TRICARE Manuals through the DHA website at https://manuals.health.mil. Offerors are reminded that only the manuals referenced in Section C of the RFP are applicable to this effort.

L.3.5. The remarks, explanations, and answers provided by Government representatives whether orally, or in writing, shall not change or qualify any of the terms or conditions of the solicitation. The solicitation can only be changed by a formal written amendment issued by the CO.

L.3.6. Non-Government Advisors. Non-Government Advisors: The expertise of Non-Government advisors may be required to support evaluation of technical proposals. The Government plans to use the following Non-Government advisors during proposal evaluations: Kennell and Associates Inc. and Mercer (US), Inc. If an additional Non-Government advisor(s) is used, DHA will immediately provide the name(s) by correspondence to the Offerors. These advisors have broad and comprehensive knowledge of the civilian healthcare industry and

managed healthcare in particular and will apply their expert knowledge of civilian healthcare industry practices and standards to assist the Government in evaluation of proposals. Non-Government advisors are subject to the limitations of FAR 7.503 and FAR Part 37.2 and will not determine ratings or rankings of Offerors' proposals or perform any inherently governmental functions.

Once notified of the identify of a Non-Government advisor(s), if after considering the limitations set out in this section L.3.6, an Offeror with concerns/issues regarding these Non-Government advisors having access to its proposal information should notify the CO of said objection or develop a written agreement between itself and the Non-Government advisor in accordance with FAR 9.505-4(b), and submit such agreement to the CO within seven (7) working days of time of notification. If no agreement or objection to the proposed Non-Government advisors is submitted within the seven (7) working days, the Offeror will be deemed to have consented to the limited access described above.

Note that Axiom Resource Management Inc., and AMYX, Inc. will be performing administrative functions in direct support of this procurement; however, the administrative support contractors' personnel will not have access to Offerors' proposals unless the Offeror is notified in accordance with the notification process described herein.

L.3.6.1. The Release of Proposal Information to Non-Government Advisors. The release of proposal information to Non-Government advisors will be subject to the controls of the DHA.

L.3.6.2. Prohibitions. Non-Government advisors are prohibited from rating or ranking proposals and from recommending the selection of a source. The Government generally does not intend to allow its Non-Government advisors to participate in discussions with Offerors; however, there may be circumstances under which the Source Selection Authority (SSA) determines that such participation is necessary. Similarly, the Government generally does not expect that its Non-Government advisors will participate in Government decision-making meetings (Source Selection Evaluation Board (SSEB) sessions or SSA briefings); however, there may be circumstances under which an evaluation chairperson determines that an advisor needs to be present for a portion of such a meeting to present specific technical information.

L.3.6.3. Access to Proprietary Information. Non-Government advisors that have access to proprietary information in performing their roles for the Government must agree to protect the information from unauthorized use or disclosure for as long as it remains proprietary and refrain from using the information for any purpose other than that for which it was furnished. All non-Government advisors are required to sign a Non-Disclosure Statement, DHA Form 821. The CO will retain the signed agreements in the contract file.

L.3.6.4. Organizational Conflict Of Interest (OCI) and Non-Disclosure Agreements. OCI clauses are included in the contracts under which non-Governmental technical advisors are performing services for the Government. The OCI clauses in the underlying contracts prohibit the companies that employ the advisors from otherwise participating as Offerors, subcontractors, or consultants to an Offeror/subcontractor in relation to this acquisition. The underlying contracts also include a requirement that contractor employees sign proprietary information non-disclosure

agreements that preclude any Non-Government advisors from divulging any information to which to which they may have had access during their participation in this acquisition.

L.3.7. Solicitation Questions.

Questions regarding this solicitation shall be submitted using Attachment L-10 Excel Spreadsheet titled "Offeror Questions." **The Government will answer all questions prior to the deadline for proposal submittal provided those questions are received by 12:00 PM Mountain Daylight Time (MDT) on Thursday, 13 July 2021.** Questions received after this date but before the deadline for proposal submission may be answered at the discretion of the CO.

Written questions must be submitted by email to:

Evan Zaslow, Contracting Officer
Telephone: 303-676-3991
Email: evan.j.zaslow.civ@mail.mil

Alternate POC: Marcus R. Webb, Contract Specialist
Telephone: 303-676-3906
Email: marcus.r.webb.civ@mail.mil

Government responses to questions pertaining to the solicitation will be provided to all potential Offerors in accordance with FAR 15.201(f). The Government reserves the right not to respond to any questions received concerning this solicitation after the question receipt date and time above. Accordingly, Offerors are encouraged to carefully review all solicitation requirements and submit questions to the Government early in the proposal cycle. It is not anticipated that the closing date for receipt of proposals will be extended.

The Government will post the answers to questions on the solicitation at http://beta.sam.gov.

L.4. PROPOSAL PREPARATION

PART/VOLUME	NAME
Volume I	Executed Offer, to include: • SF 33 • Completed Schedule B • Completed Section K Representations & Certifications • Completed copy of paragraph G.3.4 (Points of Contact) • Completed copy of paragraph H.3.2.1.1 (Guaranteed Network Provider Discounts) • OCI representation statement (L.2.6.4.) • Subcontracting Plan (L.5.2) • Overview Presentations (see L.6.3)
Volume II	Technical to include: • Written Technical Proposal (see L.6.1.)
Volume III	Past Performance (see L.7.)
Volume IV	Price/Cost (see L.8.) • Completion of H.3.2.1.1
Volume V	Financial Data (see L.9.) to include: • Guarantee Agreement for Corporate Guarantor

L.4.1. Electronic Proposal Submission and Proposal Due Date.
Only electronic proposals will be accepted. Offerors shall submit electronic proposals only, and hard copy format will not be accepted. Proposals shall be transmitted via DoD SAFE, https://safe.apps.mil, in accordance with L.4. DoD SAFE requires a drop-off code for non-DoD users, therefore prior to submission of an Offeror's proposal, the Offeror shall request a drop-off code from the Contracting Officer by email at evan.j.zaslow.civ@mail.mil. Drop-off codes will be valid for 14 days, so Offerors are encouraged to request a drop-off code as early as possible before the proposal due date. Alternate arrangements for proposal submission (DVD, other electronic submission means, etc.) may be requested by Offerors in the event technical issues prevent electronic submission via DoD Safe; however, such requests shall be submitted no later than one business day prior to the proposal due date and will be approved at the discretion of the Contracting Officer. However, any approved alternate arrangement for proposal delivery will not extend the proposal due date deadline.

Offerors shall submit electronic proposals in a searchable format (to include all tables and graphs) compatible with Microsoft Office 2016 applications (file formats of .docx, .xlsx, etc.), or Adobe Acrobat Pro 2017. Offerors shall use separate files to permit rapid location of all

portions, including exhibits, annexes, and attachments, if any. Offerors shall submit a zip file for each proposal volume. The naming convention for the zip file follows: [Offeror Name].[Volume#][Region].zip. Region shall be identified as E for East or W for West. Each volume's zip file shall include individual files for sub-volume contents listed in table L.4.

Example for East Region Proposal Submission:

OfferorA.VolumeIE.zip

Contents of OfferorA.VolumeIE.zip

- OfferorA.VolumeIE.SF33.pdf
- OfferorA.VolumeIE.Schedule B.pdf
- OfferorA.VolumeIE.Section K Representations and Certifications.pdf
- OfferorA.VolumeIE.Points of Contact.pdf
- OfferorA.VolumeIE.H.3.2.1.1 Guaranteed Network Provider Discounts.pdf
- OfferorA.VolumeIE.OCI representation statement.pdf
- OfferorA.VolumeIE.Subcontracting Plan.pdf
- OfferorA.VolumeIE.Overview Presentation.mp4

[add additional exhibits, attachments, etc. as necessary]

To avoid rejection of their offers, Offerors must make every effort to ensure their electronic submissions are virus-free. If, upon review of a submission, the Government determines that the submission or a portion thereof is infected by a virus or is otherwise unreadable, then the Government will treat the submission or portion thereof as unreadable pursuant to FAR 15.207(c). The virus scanning software used by the Government's e-mail systems cannot always distinguish a macro from a virus. Therefore, Offerors should be aware that sending a macro embedded in an e-mail message or an e-mail attachment may cause an e-mailed offer to be quarantined.

Proposals shall be submitted no later than 13 August 2021 at 12:00 PM Mountain Daylight Time (MDT). Proposal submissions received after this time will be considered late and may be rejected by the Contracting Officer.

L.4.2. Specific Instructions for the Price/Cost Proposal. The electronic price/cost proposal shall be submitted using the Microsoft Excel template provide by the Government. The template shall not be locked. Submitted files shall contain all formula, calculations, and worksheet/workbook links used to compute the proposed amounts. Formulas, calculations, and links shall not be hidden. Print image files or those Excel files/Excel worksheets containing only "values" are not acceptable. There is no page limit for the price/cost proposal Volume IV or for the financial viability/statements; however, brief but concise explanations, summaries, and worksheets are advised and appreciated.

L.4.3. Page Limitations. All proposal narrative materials shall be formatted at 8½ by 11 inch with one inch (1") margins on all sides and shall be double-spaced. The font for submissions shall be Times New Roman, not smaller than 12 point font; however, smaller fonts are permitted on illustrations, organization charts, supporting data exhibits, report listings or labels on process flows. Elaborate brochures or documentation, binding, detailed artwork, or other embellishments shall not be submitted. Footnotes on text pages shall also be in 12 point font. Proposals shall be marked with non-duplicative, sequential page numbers at the bottom of each page. Page limitations shall be treated as maximums. If a proposal exceeds any applicable page limit, the government will remove and not evaluate the excess pages of the proposal. Title pages, table of contents, and table of figures are excluded from page counts. The following table contains all page limit requirements. If there is a requirement for information to be submitted in the proposal, but it is not included in the following table, then a page limitation is not applicable. Page limits will be determined by the Contracting Officer using Microsoft Office 2016 and Adobe Acrobat Pro 2017 software.

Reference and Description	**Limit**
Organization Chart	3 pages
Written Technical Proposal	200 pages*
Past Performance Narrative	25 pages
Summary Description of Most Relevant Work (see L.7.3.)	3 pages per client

*Notes:

1. Attachments L-3e, L-3w, and the APM proposal documents do not count toward the Written Technical Proposal page limitation.
2. The APM proposal itself shall not exceed 10 pages.
3. Letters of commitment (see L.6.2.1.3.2) do not count toward the Written Technical Proposal page limitation.

L.4.4. Proposals will be reviewed for completeness and compliance with the solicitation and preparation instructions. If an Offeror (1) fails or refuses to assent to any of the terms and conditions of the RFP, (2) proposes additional terms and conditions of this RFP, or (3) fails to submit any of the information required by this RFP, then the Government may consider the offer to be materially non-compliant, which could make the offer ineligible for contract award. Offerors shall not include price information anywhere in the proposal package other than in the Price/Cost volume, and prices in completed Section B. All pages of each proposal shall be appropriately numbered and identified with the solicitation number.

L.4.5. If final proposal revisions are required (at the request of the CO), the Offeror shall follow the final proposal revision instructions provided by the CO.

L.5. VOLUME I, EXECUTED PROPOSAL

L.5.1. All documents requiring signatures may utilize the use of electronic signatures. Offerors shall commit in writing to fulfilling the terms and conditions of the contract. All representations and certifications, to include Section K, required by the solicitation shall be completed and provided in Volume 1. The provision in Section K, FAR 52.204-8, Annual Representations and Certifications, must be completed and submitted with the proposal. An online Representations and Certifications Application is available at https://sam.gov/SAM.

L.5.2. Offerors designated as large businesses shall include in Volume I a subcontracting plan as required by FAR 19.702, FAR 19.704, FAR 52.219-8 Utilization of Small Business Concerns, FAR 52.219-9 Small Business Subcontracting Plan, and DFARS 252.219-7003, Small Business Subcontracting Plan (DoD Contracts), Alt I. Please note that network providers are not considered subcontractors of the prime Contractor, and therefore health care services provided by network providers may not be counted in the subcontract plan. Additionally, Offerors are advised that Contractors may use the services and/or products of qualified nonprofit agencies for the blind or other severely handicapped to count toward meeting the subcontracting goal (see 10 U.S.C. Section 2410d) . The following 13 elements of FAR 19.704 are required to be included in Offeror's subcontracting plan:

(1) Separate percentage goals for using small business (including ANCs and Indian tribes), veteran-owned small business, service-disabled veteran-owned small business, HUBZone small business, small disadvantaged business (including ANCs and Indian tribes), and women-owned small business concerns as subcontractors;

(2) A statement of the total dollars planned to be subcontracted and a statement of the total dollars planned to be subcontracted to small business (including ANCs and Indian tribes), veteran-owned small business, service-disabled veteran-owned small business, HUBZone small business, small disadvantaged business (including ANCs and Indian tribes), and women-owned small business concerns;

(3) A description of the principal types of supplies and services to be subcontracted and an identification of the types planned for subcontracting to small business (including ANCs and Indian tribes), veteran-owned small business, service-disabled veteran-owned small business, HUBZone small business, small disadvantaged business (including ANCs and Indian tribes), and women-owned small business concerns;

(4) A description of the method used to develop the subcontracting goals;

(5) A description of the method used to identify potential sources for solicitation purposes;

(6) A statement as to whether or not the Offeror included indirect costs in establishing subcontracting goals, and a description of the method used to determine the proportionate share of indirect costs to be incurred with small business (including ANCs and Indian tribes), veteran-owned small business, service-disabled veteran-owned small business,

HUBZone small business, small disadvantaged business (including ANCs and Indian tribes), and women-owned small business concerns;

(7) The name of an individual employed by the Offeror who will administer the Offeror's subcontracting program, and a description of the duties of the individual;

(8) A description of the efforts the Offeror will make to ensure that small business, veteran-owned small business, service-disabled veteran-owned small business, HUBZone small business, small disadvantaged business, and women-owned small business concerns have an equitable opportunity to compete for subcontracts;

(9) Assurances that the Offeror will include the clause at FAR 52.219-8, Utilization of Small Business Concerns (see FAR 19.708(a), in all subcontracts that offer further subcontracting opportunities, and that the Offeror will require all subcontractors (except small business concerns) that receive subcontracts in excess of $750,000 ($1.5 million for construction) to adopt a plan that complies with the requirements of the clause at FAR 52.219-9, Small Business Subcontracting Plan (see FAR 19.708(b);

(10) Assurances that the Offeror will—

(i) Cooperate in any studies or surveys as may be required:

(ii) Submit periodic reports so that the Government can determine the extent of compliance by the Offeror with the subcontracting plan;

(iii) Submit the Individual Subcontract Report (ISR), and the Summary Subcontract Report (SSR) using the Electronic Subcontracting Reporting System (eSRS) (http://www.esrs.gov but is formally transitioning to http://beta.sam.gov), following the instructions in the eSRS;

(A) The ISR shall be submitted semi-annually during contract performance for the periods ending March 31 and September 30. A report is also required for each contract within 30 days of contract completion. Reports are due 30 days after the close of each reporting period, unless otherwise directed by the contracting officer. Reports are required when due, regardless of whether there has been any subcontracting activity since the inception of the contract or the previous reporting period.

(B) The SSR shall be submitted as follows: For DoD and NASA, the report shall be submitted semi-annually for the six months ending March 31 and the twelve months ending September 30. For civilian agencies, except NASA, it shall be submitted annually for the twelve-month period ending September 30. Reports are due 30 days after the close of each reporting period.

(iv) Ensure that its subcontractors with subcontracting plans agree to submit the ISR and/or the SSR using the eSRS;

(v) Provide its prime contract number and its DUNS number, and the e-mail address of the Offeror's official responsible for acknowledging receipt of or rejecting the ISRs to all first-tier subcontractors with subcontracting plans so they can enter this information into the eSRS when submitting their ISRs; and

(vi) Require that each subcontractor with a subcontracting plan provide the prime contract number, its own DUNS number, and the e-mail address of the subcontractor's official responsible for acknowledging receipt of or rejecting the ISRs, to its subcontractors with subcontracting plans.

(11) A description of the types of records that will be maintained concerning procedures adopted to comply with the requirements and goals in the plan, including establishing source lists; and a description of the Offeror's efforts to locate small business, veteran-owned small business, service-disabled veteran-owned small business, HUBZone small business, small disadvantaged business, and women-owned small business concerns and to award subcontracts to them.

(12) Assurances that the contractor will not prohibit a subcontractor from discussing with the contracting officer any material matter pertaining to payment to or utilization of a subcontractor; and

(13) Assurances that the Offeror will pay its small business subcontractors on time and in accordance with the terms and conditions of the subcontract, and notify the contracting officer if the Offeror pays a reduced or an untimely payment to a small business subcontractor (see 52.242-5).

L.5.3. Offerors must complete, sign, and date the offer at Blocks 12 through 18 of the Standard Form 33. Source selection procedures including the evaluation of offers received in response to the solicitation are projected to require 270 days to complete. As a result of this, the Government requires that the Minimum Acceptance Period identified in Item 12 of the Standard Form 33 be a minimum of 270 days. The Offeror's information for paragraph G.3.4, Contractor Points of Contact personnel, shall be included in this Volume.

L.5.4. Offerors shall acknowledge receipt of any amendments when submitting the offer and include the acknowledgements in this volume.

L.5.5. Offerors shall submit a completed original Section B in Volume I. Offerors are required to complete Section B, Supplies or Services and Prices/Costs. Offers submitted in response to this solicitation shall be in terms of U.S. dollars. Offerors are instructed to price the appropriate contract line items and sub-line items in Section B.

L.6. VOLUME II, TECHNICAL PROPOSAL

L.6.1. Written Technical Proposal Submission. The Offeror shall submit a written technical proposal which effectively demonstrates the Offeror's understanding of the requirements and provides a successful technical solution for the prospective contract. The technical proposal shall clearly describe each element offered and demonstrate how the Offeror will meet or exceed the contractual performance standards. The Government reserves the right to incorporate any proposal strengths into the resultant contract.

L.6.1.2. The proposal shall not reflect a marketing or sales presentation. Unnecessarily elaborate proposals beyond those sufficient to present a complete and effective response to this solicitation are not desired. The proposal should illustrate the Offeror's capability, and clearly demonstrate the organization and methodology that will satisfy the solicitation requirements. The proposal should clearly describe the technical solution and overall approach to the solicitation requirements and address all of the subfactors identified in Section L which will be evaluated against the criteria specified within Section M of this solicitation. The proposal may have information on the Offeror's experience (for this purpose, experience refers to what an Offeror has done, not how well it was accomplished) in performing proposed processes and procedures. This information may be considered in the evaluation of technical proposal risk. However, any such information in the technical proposal will not be considered for purposes of the overall past performance rating as described in Section M.8. The price/cost proposal, past performance information, and financial information shall not be addressed in the technical proposal volume, and no part of the technical proposal shall incorporate by reference portions of other volumes of the proposal.

L.6.2. Technical/Management

L.6.2.1. Subfactor 1 - Network Management

L.6.2.1.1. The Offeror's proposal shall include its approach for developing and maintaining a provider network that:

a) Is accredited by a leading health quality measurement organization;
b) Is dynamically managed (designed to meet changing populations, enrollments, and health care needs);
c) Includes high-quality providers;
d) Meets access to care standards as defined in 32 Code of Federal Regulations (CFR) 199.17(p)(5);
e) Supplements services provided by the Military Medical Treatment Facilities (MTFs); and
f) Continuously maintains access to care standards as defined in 32 CFR 199.17(p)(5).

L.6.2.1.2. The Offeror's proposal shall clearly demonstrate how its network model:

a) Incorporates the beneficiary population;
b) Calculates the number of providers needed;
c) Determines minimum provider ratios;

d) Determines types of providers required;
e) Incorporates the needs of the MTFs as described in Section C, paragraph C.2.12.10;
f) Uses access wait time and travel/driving time standards for the TRICARE benefit (as defined in 32 CFR 199.17(p)(5)); and
g) Includes an approach to monitor and address network shortages.

L.6.2.1.3 Evaluation of Provider Sizing Model

L.6.2.1.3.1. The Offeror's proposal shall provide Attachment L-3e and/or L-3w (depending on which region(s) are proposed) applying each element of its sizing model to the following markets as a representative sample of the contract requirements:

East region proposals shall address:

Large Market - Tidewater - NMC Portsmouth, Langley - Eustis

Small Market - Small Market - Fort Drum, NY

Stand Alone - Moody AFB (AF-C-23rd MEDGRP-MOODY & AF-EC-93rd, AGOW-MOODY)

West region proposals shall address:

Large Market - Hawaii (Tripler)

Small Market - Ozarks (ACH LEONARD WOOD - Ft. Leonard Wood)

Stand Alone - AF-C-27th SPCLOPS MDGRP-CANNON - Cannon AFB

L.6.2.1.3.2. The Offeror's proposal shall apply its network sizing model to the entire region by state and provide Attachment L-9e and/or L-9w (depending on which region(s) are proposed) detailing the unique number of Primary Care Providers, Specialists (all types), institutional providers, and BH providers its model indicates are necessary for an adequate network (considering the TRICARE access to care standards at 32 CFR 199.17(p)(5)) and comparing these requirements with its current/existing networks to determine a percentage of new network build required by the Offeror. The Offeror shall disclose in its proposal the percentage of new network build required. If the Offeror proposes to use an existing parent company network or leased network, the Offeror shall attach a letter of commitment signed by the network owner indicating that the network identified in the proposal will participate in or join the Offeror's TRICARE network.

L.6.2.1.4. The Offeror's proposal shall describe how it will ensure the accuracy of its network provider directory.

The proposal shall detail the following:

a) Verification methods;

b) How the directory (and updates) will be shared with the Government and maintained in file formats that support software analytics;
c) Communication methods with network providers to support updates to the provider directory;
d) Verification of practitioners' affiliation with group practices, as applicable; and
e) Approach to periodically review claims data to ensure active provider participation and inclusion status in the provider directory.

L.6.2.1.5. The Offeror's proposal shall describe:

1) How it will adjust its network capabilities to ensure access to care if MTF capabilities change;
2) How it will adjust its network capabilities to ensure access to care if MTF capacities change; and
3) How it will respond to such changes on short notice. At a minimum, the Offeror shall describe its timeline for responding to changes in capabilities and capacities such that access to care standards are maintained

L.6.2.1.6. The Offeror's proposal shall describe its value based steerage model in a manner that demonstrates how beneficiaries will be referred to providers with demonstrated high quality outcomes while meeting TRICARE administrative standards (such as electronic claims processing, return of clear and legible consultation reports when requested, appointment availability, and secure communications with patients). The proposal shall describe a value based steerage model that demonstrates how the Offeror will:

a) Ensure compliance with access to care standards as defined in 32 CFR 199.17(p)(5);
b) Produce high quality health outcomes;
c) Optimize MTF workload (see Section C, paragraph C.2.12.10.1);
d) Assist the Government in achieving readiness of its medical force (KSA optimization); and
e) Control costs.

L.6.2.1.7. The Offeror's proposal shall describe its approach for maximizing the inclusion, in its networks, of providers that are connected to the eHealth Exchange or another Health Information Exchange (HIE) network or framework (such as the CommonWell® Health Alliance or Carequality) that connects with the Government's electronic health records system. The proposal shall describe the Offeror's approach to facilitating electronic access to network provider clinical data via MHS GENESIS.

L.6.2.2. Subfactor 2 – Clinical Management

L.6.2.2.1. The Offeror's proposal shall describe an effective process for managing referrals between the MTF and the Contractor's network providers (in both directions) in accordance with Section C, paragraph 2.7 and the TRICARE Operations Manual (TOM), Chapter 7, Section 5 and Chapter 8, Section 5. Specifically, the Offeror shall describe:

a) How and when its referral management systems and processes will direct TRICARE-eligible Prime network enrolled beneficiaries to the MTF (where applicable);

b) How and when its referral management processes will enforce the Point of Service Option for TRICARE Prime beneficiaries enrolled to the MTF who decline available care at the MTF;
c) The processes it will use for identifying TRICARE Select beneficiaries for potential voluntary "recapture" to MTFs (for the purpose of receiving specialty care), and how it will effect such recapture, when doing so aligns with the MTFs' capability and capacity for pertinent specialty care or procedures;
d) How its beneficiary education process will provide TRICARE Select enrolled beneficiaries with the tools necessary to make informed decisions about receiving care at local MTFs or military Centers of Excellence (COE) when the delivery of such care by the MTF or COE will enhance the readiness of the medical force;
e) How and when its referral management systems and processes will facilitate beneficiary referrals from MTFs to its network;
f) How its referral management processes will support continuity of referrals when beneficiaries change geographical regions;
g) How its referral management processes will be supported through network management activities;
h) How it will meet referral processing timeliness requirements;
i) How it will meet referral processing accuracy requirements;
j) How it will update its referral practices in response to Government updates to the list of diagnosis and procedure codes correlated with enhancing medical force readiness;
k) How it will ensure an accurate record of care provided to a beneficiary is readily available to all providers involved with the beneficiary's care; and
l) How it will hold providers accountable for timely return of clinical information (where care is referred out from an MTF to the Offeror's network).

L.6.2.2.2. The Offeror's proposal shall include the Offeror's proposed approach for designing, implementing, and maintaining integrated, comprehensive medical management programs for all care received by TRICARE-eligible beneficiaries in the private sector and for complementing medical management services available within the MTF. The Offeror's proposal shall address:

a) The design and approach it will use for implementing and maintaining integrated medical management programs (as defined at the TOM Chapter 7, Section 1 and TRICARE Manual, Definitions[1]) for all TRICARE-eligible beneficiaries receiving care in the private sector that supports medical care and behavioral health care;
b) How its medical management programs will complement the medical management services available in the MTFs (see DHA-PI 6025.20 (April 2019) regarding standardization of the medical management programs within the Military Health System);
c) How its medical management processes will capture and objectively document improvements in clinical outcomes;
d) The tools it will use to facilitate access to medical management programs and customer service information for providers, MTFs, and beneficiaries;
e) The interoperability of its medical management systems with MTFs, civilian inpatient facilities, and the TRICARE Pharmacy benefit program to provide essential information to

[1]Definitions are available at:
https://manuals.health.mil/pages/v3/DownloadManualFile.aspx?Filename=Definitions.pdf

providers and case managers and bi-directional feedback to and from MTF and private sector providers; and
f) The strategy it will use to identify and propose opportunities to integrate private sector care with the direct care system.

L.6.2.2.3. The Offeror's proposal shall describe its approach for implementing a Utilization Management (UM) program for TRICARE-eligible beneficiaries in accordance with TOM Chapter 7, Section 4. The Offeror's proposal shall describe:

a) Processes to communicate, collaborate, manage and implement a UM program for TRICARE-eligible beneficiaries;
b) Processes, criteria and systems that will be used to implement its UM program and framework for continuous improvement;
c) Processes that will be employed for identifying, preventing, and reducing or eliminating occurrences of unnecessary care and over- or under-utilization in private sector care, and for ensuring that care provided is appropriately authorized, and complies with the TRICARE benefits described in 32 CFR 199.4, 199.5, and the TPM; and
d) Processes to maintain and comply with its accreditation organization's written policies and documented procedures.

L.6.2.2.4. The Offeror's proposal shall describe its approach for implementing a Case Management (CM) program, in accordance with TOM, Chapter 7, Section 2, that will support and manage the health care of individuals with high-cost conditions or with specific diseases for which evidence-based clinical management programs exist. The Offeror's proposal shall demonstrate how its case management program for TRICARE-eligible beneficiaries will:

a) Support and manage the health care of individuals with high-cost conditions, who are high-risk, who experience high-utilization, or who have specific diseases for which evidence-based clinical management programs exist;
b) Employ an appropriate case assignment and caseload methodology to support the CM program including a dedicated point of contact for beneficiaries with sensitive, rare, and high-profile or high-visibility needs, as well as for beneficiaries needing care coordination or who are undergoing transitions of care;
c) Ensure CM staff are knowledgeable of community resources where CM enrolled beneficiaries reside;
d) Employ assessments and tools to identify beneficiaries in need (high-need and at-risk for readmission) of in-home services; and
e) Offer in-home CM services to beneficiaries that reduce the risk of inpatient readmission, including in-home visits to beneficiaries within 48 to 72 hours post discharge from inpatient care.

L.6.2.2.5. The Offeror's proposal shall clearly describe how its proposed Population Health (PH) Care platform will:

a) Utilize processes and systems, consistent with the limitations described in Section C, paragraph C.2.5.1., to reach at-risk, high-risk, high-cost beneficiaries and deliver person-centered interventions based on identified risks and needs;
b) Use outcome measures to show the effectiveness of the PH care delivered;
c) Integrate with the Offeror's case management and disease management programs; and
d) Integrate disease prevention and health promotion services into the population health care platform.

L.6.2.2.6. The Offeror's proposal shall describe its approach to providing predictive analytics, as described in TOM Chapter 7, Section 1, paragraph 5, (for data pertaining to TRICARE Prime and Select enrolled beneficiaries) via a real-time, beneficiary-centric data warehouse and industry analytic tools/system which incorporate a data analysis technique with evidence-based algorithms. The Offeror's proposal shall describe:

a) The methodology it will use for applying data stratification and predictive modeling to produce positive patient outcomes and measureable gains in health;
b) The integrated systems and processes it will utilize to comprehensively discover and correct gaps in care and medical errors, identify high-risk addictive behaviors, and identify potential quality issues for enrolled beneficiaries; and
c) The systems and processes it will use for standardizing medical error reduction while maintaining transparency and adhering to evidence-based medicine protocols, and that best enable extraction of actionable data from large databases of information and how that will be utilized to improve quality of care and patient perception of care.

L.6.2.2.7. The Offeror's proposal shall describe its approach for implementing a Clinical Quality Management (CQM) and patient safety program for TRICARE-eligible beneficiaries. The Offeror's proposal shall describe:

a) The systems and processes it will use for standardizing medical error reduction;
b) The processes it will use for providing oversight of provider adherence to evidence-based medicine protocols;
c) How it will provide transparency of its quality and safety management data to the Government; and
d) Processes it will use to utilize quality and patient safety data to improve beneficiary health outcomes.

L.6.2.2.8. The Offeror's proposal shall describe its approach for developing and continuously improving integrated, episodic and longitudinal telehealth services for TRICARE-eligible beneficiaries in accordance with TOM, Chapter 27 and TPM, Chapter 7. The Offeror's proposal shall describe how the Offeror will:

a) Promote and support the implementation of telehealth platforms and devices within primary and specialty practices throughout its network;
b) Employ a telehealth that will fill network adequacy voids, particularly in rural and remote areas;

c) Implement remote monitoring models and implement hub-and-spoke telehealth models with full service brick-and-mortar medical group hubs supported by digitally powered spoke centers;
d) Facilitate and promote integration and information sharing between its network and the direct care system including machine-to-machine interoperability between the Offeror, its network providers, and MHS GENESIS, including the use of any third party interoperability tools;
e) Identify and respond to beneficiary and provider educational needs in order to promote telehealth engagement; and,
f) Apply interoperability standards in sharing information between providers.

L.6.2.3. Subfactor 3 – Administration and Customer Service

L.6.2.3.1. The Offeror's proposal shall describe its approach in providing accurate, comprehensive customer service with knowledgeable, courteous, and responsive staff. The Offeror shall describe its approach for providing customer service via multiple avenues of access.

L.6.2.3.2. The Offeror's proposal shall describe its approach to creating (new) first time appointments with network providers for enrolled beneficiaries upon request and explain how its call center will be capable of handling incoming beneficiary calls and creating appointments with network providers. The proposal shall describe Offeror's approach for ensuring that its call center will be capable of handling incoming beneficiary calls and that the Offeror will create appointments with network providers that:

a) Meet beneficiary medical needs (appropriate care);
b) Meet the TRICARE appointment access standards (appointment wait time and driving/travel time) as described at 32 CFR 199.17(p)(5); and
c) Ensure beneficiaries continue to pay in-network rates through completion of the episode of care.

L.6.2.3.3. The Offeror's proposal shall describe the Offeror's approach for developing provider training materials, how it will measure the impact of such training on provider behavior, and how it will assess provider understanding of marketing and training materials. The proposal shall describe how the Offeror will incorporate measures to improve provider marketing and training. The proposal shall address how the Offeror will consider provider message saturation and message understanding in developing provider training materials.

L.6.2.3.4. The Offeror's proposal shall describe its outreach methods to providers and beneficiaries. The proposal shall describe how the Offeror will develop its annual plan for beneficiary outreach, the Offeror's strategy for identifying beneficiary outreach opportunities, measures the Offeror will use for evaluating the effectiveness of its strategies, and the Offeror's process for updating its annual plan. The description should also explain how the Offeror will develop its Annual Education Plan and any approaches the Offeror will use for monitoring, implementing, and updating the Annual Education Plan.

The proposal shall describe the Offeror's approach for identifying and responding to:

a) Beneficiary educational needs; and
b) Provider educational needs;

The proposal shall also describe the Offeror's proposed provider outreach methods for recruiting new TRICARE providers and its strategies for retaining existing TRICARE providers. The proposal shall also describe the methods the Offeror will use to ensure the information it provides to beneficiaries regarding the TRICARE program and benefit is accurate and complete.

L.6.2.3.5. The Offerors proposal shall describe its management approach for hiring and retaining, throughout the life of the contract, qualified, experienced leadership personnel in the following areas:

a) Establishing/Maintaining Networks
b) Referral Management
c) Medical Management
d) Enrollment
e) Customer Service
f) Claims Processing
g) Management

The proposal shall describe the Offeror's process for identifying and vetting qualified candidates and any measures the Offeror will use to monitor and ensure the effectiveness of performance of leadership personnel. The Offeror shall identify the approach it will use to determine which positions, within its organization, require an individual who has knowledge and experience integrating the private sector care system with the direct care system.

The Offeror shall not submit, in response to this criterion, resumes or summarized qualifications for individual personnel the Offeror intends to employ to perform contract requirements. The Offeror may provide a qualitative description of the knowledge, skills, abilities and experience required for positions.

L.6.2.3.6. The Offeror shall describe its Quality Management/Quality Improvement (QM/QI) Program which, at a minimum, shall include the following major program components: quality control activities, quality assurance functions, organizational responsibilities for quality management, written processes to be followed to ensure consistent quality outcomes, and written processes for monitoring and resolving identified quality problems. The Offeror shall demonstrate its approach to communicating with the Government any problems and resolutions identified by the Quality Management/Quality Improvement Program.

L.6.2.3.7. The Offeror's proposal shall describe its plan and timeline to craft its internal beneficiary-facing website, including its timeline for testing compliance with all applicable requirements and testing user accessibility. The proposal shall include a wireframe mockup of the website's front page to demonstrate the Offeror's ability to meet the TRICARE brand standard.

L.6.2.3.8. The Offeror shall describe its proposed program integrity approach to identify and implement cost-containment and anti-fraud strategies to combat and prevent unnecessary spending, the provision of non-medically necessary supplies or services, over-utilization of care, and/or the provision of inappropriate care in the TRICARE program. The Offeror shall also describe the process and frequency by which it will obtain data about potential fraud and abuse, perform comprehensive fraud and abuse risk assessments to identify specific fraud and abuse schemes and risks, and assess the likelihood and significance of such risks.

L.6.2.4. Subfactor 4 – Claims and Systems

L.6.2.4.1. The Offeror's proposal shall describe its approach for providing a readily adaptable (to changing TRICARE claims processing requirements), scalable (describes how the system will adapt to volumes of TRICARE claims and upcoming alternate payment models) claims processing system which incorporates industry best practices. The Offeror's proposal shall describe its timeline for incorporating TRICARE claims processing changes from change order initiation though testing. The Offeror's proposal shall describe its approach to achieve Capability and Maturity Model Integration (CMMI) Level 4 of its claims processing system at the time of contract award.

L.6.2.4.2. The Offeror's proposal shall describe how its proposed claims processes and methods will ensure claims processing timeliness and accuracy standards are met. The Offeror shall describe how its processes will result in achievement of auto adjudication processing rates and how its processes will minimize reprocessing rates.

L.6.2.4.3. The Offeror's proposal shall describe the processes it will use, in its claims system, to accurately incorporate unique elements of the TRICARE benefit: apply TRICARE deductibles, co-pays, coinsurance, cost shares, catastrophic caps, referral/authorization requirements, and point-of-service (POS) provisions by beneficiary type, into its claims processing systems.

L.6.2.4.4. The Offeror's proposal shall describe how it will comply with the basic and derived security requirements of NIST Special Publication 800-171 for the processing, storage, and transmission of any DoD controlled unclassified information. The proposal shall include a planned compliance timeline for each of the 14 families of requirements.

L.6.2.4.4.1. The Offeror shall perform a "basic" self-assessment for each covered contractor information system(s) that is relevant to the offer as prescribed in the DFARS clause 252.204-7019, and post the summary level score(s) into the Supplier Performance Risk System (SPRS).

L.6.2.4.4.2. RESERVED

L.6.2.4.4.3. RESERVED

L.6.2.4.4.4. The Offeror shall describe its plan to: 1) track the flow down to subcontractors of covered defense information, to include DoD controlled unclassified information, and 2) assess compliance of its subcontractors with the flow down requirements, in accordance with DFARS

clause 252.204-7020. (Note: For purposes of this solicitation, institutional, professional and other providers as defined in 32 CFR 199.6 are not subcontractors.)

L.6.2.4.5. RESERVED

L.6.2.4.6. The Offeror's proposal shall describe its approach to designing and implementing Alternate Payment Models (APMs) that incorporate the following characteristics:

Cost neutrality with the following considerations:

- Calculated at a population or model-based level for implementing an APM
- Based on historical utilization
- Incorporating risk and wage adjustments

The Offeror's proposal shall also discuss any factors or potential characteristics of its APMs that may require pre-approval by the Government (during contract performance) and how it will identify such factors, and take into account the time associated with obtaining Government approval for such factors, as it designs its APMs.

L.6.2.4.7. The Offeror's proposal shall describe its approach to negotiating contracts with network providers for a mix of APMs in the HCPLAN categories 2, 3, and 4 (excluding 3N and 4N). The proposal shall identify the provider type(s) that the Offeror will target for APM arrangements that constitute 15% of healthcare payments to network providers during the first option year of the contract and how the Offeror will thereafter expand APMs to meet annual requirements in accordance with the Section H, paragraph H.18.

L.6.2.4.8. The Offeror shall submit a sample APM proposal that incorporates the following information (TRM, Chapter 18, Section 1, paragraph 4.6):

a) Category and sub-category from the HCPLAN framework;
b) Target provider and beneficiary population for the APM. The sample APM shall target at least one of the following chronic diseases or conditions: diabetes, chronic obstructive pulmonary disease, asthma, congestive heart failure, hypertension, history of stroke, coronary artery disease, mood disorders, obesity and other chronic diseases and conditions relevant to the TRICARE beneficiary population;
c) Expected expenses paid to providers;
d) How the costs associated with the APM will be tracked, including the total percentage of network costs that are covered by APMs;
e) Target savings for the service after the APM is implemented for Contract Year (CY) 1, CY 2, and CY 3;
f) How the Offeror will demonstrate and measure that the cost of the APM at the model level, including the cost of care and any special APM payments to providers or amounts collected from providers, did not exceed the aggregate cost of care that would have been incurred under applicable TRICARE maximum allowable charges;
g) APM attribution method; and
h) How the Offeror will measure the following DHA APM goals:

(1) Quality of care
(2) Patient outcomes
(3) Beneficiary satisfaction

L.6.2.5. Subfactor 5 – Transition Management

L.6.2.5.1. The Offeror shall provide an Integrated Master Plan (IMP) and Integrated Master Schedule (IMS) which details the Offeror's approach to meeting transition in requirements (TOM Chapter 2). The IMP and IMS shall demonstrate the Offeror's approach to the Integrated Product and Process Development framework. The IMP and IMS, for purposes of the proposal, will be limited to a Level 3 work breakdown structure. The IMP/IMS must be congruent with and reference all contract transition requirements and Contract Data Requirements Lists (CDRLs) with due dates prior to the start of healthcare delivery. (Note: The IMP/IMS can be a separate attachment to the proposal which will not count towards the page limitation for the written technical proposal.)

L.6.2.6. Subfactor 6 – Future Potential Demonstrations/Product Improvements

L.6.2.6.1. Advanced Primary Care (APC)

L.6.2.6.1.1. The Offeror’s proposal shall describe its approach for identifying and including APC groups in its provider networks (for an APC demonstration or product improvement) that:

a) Have demonstrated high value in delivery of care, using risk-adjusted, industry-standard metrics for appropriateness, clinical outcomes, and financial performance;
b) Provide care through an integrated, multi-disciplinary team utilizing evidence-based medicine;
c) Offer patient-centric options (e.g., Same or next day appointments, extended appointment length, extensive use of digital health tools, embedded telehealth, chronic condition registries, medication adherence programs, collocation of behavioral health services, and management of life style risks);
d) Focus on prevention, chronic care management, and management of life style risks; and
e) Support robust connections with the medical neighborhood and community-based services.

L.6.2.6.1.2. The Offeror’s proposal shall describe the governance and administrative infrastructure that will be necessary to support integration of APCs, including how the Offeror will:

a) Calculate the number of APC providers needed;
b) Determine minimum APC provider ratios;
c) Determine and manages provider panel size;
d) Ensure interoperable medical record and data transfer capabilities;
e) Develop standards for data collection and medication reconciliation; and
f) Facilitate and track timely referrals.

L.6.2.6.1.3. The Offeror's proposal shall include its approach for designing and implementing an APC monitoring and continuous improvement program, including:

a) Metrics for financial performance, beneficiary experience, and risk-adjusted clinical outcomes using standard industry factors and metrics;
b) Integrated systems and processes for assessing APC performance and comprehensively discovering and correcting gaps in care, medical errors, and potential quality issues for beneficiaries; and
c) Mechanisms and processes for providing continuous feedback to APC providers to improve value-based care delivery.

L.6.2.6.1.4. The Offeror's proposal shall clearly describe how it will use its APC engagement and communication strategy to:

a) Identify and respond to beneficiary educational needs and promote the use of APC providers;
b) Use incentives that are otherwise authorized under the TRICARE program to steer beneficiaries to APC providers; and
c) Identify, and steer to APCs, individuals with high-cost conditions, who are high risk, who experience high utilization, or who have specific diseases for which evidenced-based clinical management programs exist.

L.6.2.6.1.5. RESERVED

L.6.2.6.1.6. The Offeror's proposal shall provide a narrative that describes its experience in developing and implementing APC programs and services, including:

a) Years providing such program and services;
b) Number of clinics or facilities in operation over period of time;
c) Applicable credentials such as certified Patient Centered Medical Home (PCMH);
d) Vendor partnerships;
e) Performance measurement and improvement tools;
f) Continuous improvement initiatives; and
g) Value-driven care and population-based care payments.

L.6.2.6.2. RESERVED

L.6.2.6.3. RESERVED

L.6.2.6.4. Care Collaboration Tools Requirements

L.6.2.6.4.1. The Offeror's proposal shall clearly describe its approach for implementing an integrated care collaboration program that facilitates virtual provider-to-provider consultations (eConsult), including how it will:

a) Promote information sharing and collaboration across the direct and private sector care systems to ensure coordination of care;
b) Support medical force provider Knowledge, Skills, and Abilities (KSAs) through increased access to specialist expertise; and
c) Include e-Consults in its strategy for mitigating network shortages.

L.6.2.6.4.2. The Offeror shall describe the policies, processes and systems for supporting its care collaboration program, including:

a) Systems and platforms to facilitate e-Consults;
b) Standards for machine-to-machine interoperability between the Direct Care System and selected network providers participating in the e-Consult project;
c) Reporting and monitoring mechanisms to track and trend e-Consults by providers, measure provider satisfaction, and assess impact on value; and
d) Billing and reimbursement methodology for e-Consults.

L.6.2.6.4.3. The Offeror's proposal shall clearly describe its communication and education program, including provider education on:

a) e-Consult capabilities, requirements and incentives;
b) e-Consult policies and procedures; and
c) Billing and reimbursement.

L.6.2.6.5. RESERVED

L.6.2.6.6. RESERVED

L.6.2.6.7. RESERVED

L.6.2.6.8. RESERVED

L.6.2.6.9. Virtual Value Network (VVN)

L.6.2.6.9.1. The Offeror's proposal shall describe its approach for identifying and including high-value providers in its Virtual Value Network, including:

a) Selection criteria for high value providers;
b) Risk-adjusted, industry-standard metrics for appropriateness, clinical outcomes, and financial performance;
c) Aggregation and scoring methodology for provider value; and
d) Data sources used to assess provider value.

L.6.2.6.9.2. The Offeror's proposal shall describe its approach to making VVN provider value ratings and metrics available to beneficiaries 24 hours a day, 7 days a week, including:

a) Web and app based tools;
b) Call center services; and
c) Secure, HIPAA compliant technology platforms.

L.6.2.6.9.3. The Offeror's proposal shall include its approach for designing and implementing a VVN provider monitoring and continuous improvement program, including:

a) Metrics for financial performance, beneficiary experience, and risk-adjusted clinical outcomes;
b) Integrated systems and processes for assessing VVN provider performance and comprehensively discovering and correcting gaps in care, medical errors, and potential quality issues for beneficiaries; and
c) Mechanisms and processes for providing continuous feedback to VVN providers to improve value-based care delivery.

L.6.2.6.9.4. The Offeror's proposal shall clearly describe how its engagement and communication strategy:

a) Identifies and responds to beneficiary educational needs that promote the use of VVN providers; and
b) Uses incentives that are otherwise authorized under the TRICARE Program to steer beneficiaries to VVN providers.

L.6.2.6.9.5. RESERVED

L.6.2.6.9.6. The Offeror's proposal shall provide a narrative that describes the experience that the Offeror has in developing and implementing VVNs, including:

a) Years providing such program and services;
b) Vendor partnerships;
c) Performance measurement and improvement tools;
d) Continuous improvement initiatives; and
e) Incentive programs.

L.6.2.6.10. RESERVED

L.6.2.6.11. RESERVED

L.6.3. Overview Presentations

L.6.3.1. The Offeror shall include with its proposal an "Overview Presentation." Overview presentations are intended to give Government evaluators a contextual illustration of the Offeror's technical proposal. The Offeror's overview presentation shall be pre-recorded without real-time interactive dialogue and should not merely repeat requirements, but rather provide a contextual explanation of how its technical approach will meet the Government's stated requirements (excessive theatrics are discouraged). The Offeror shall submit one electronic copy of its overview presentation at the time of proposal submission.

L.6.3.2. The Offeror's overview presentations shall not exceed 60 minutes from beginning to end of runtime.

L.6.3.3. The Offerors shall submit its overview presentations in one of the following formats: self-timed, Microsoft Power-Point presentation; self-timed, Adobe Acrobat presentation; Windows Media Player compatible file (.mp4, .wmv, .avi,).

L.7. VOLUME III, PAST PERFORMANCE INFORMATION

L.7.1. As used throughout L.7. Volume III, Past Performance, the term "Offeror" applies to the prime contractor which may be an individual company, subsidiary, affiliate, or individual entity/entities of a joint venture. A "first-tier subcontractor" means a subcontractor that will have a subcontract directly with the prime contractor valued in excess of $100 Million (inclusive of all contract options). Institutional, professional, and other health care providers as defined in 32 CFR 199.6 are not considered subcontractors.

L.7.2. The Offeror shall provide a narrative which specifically describes the past performance that the Offeror and its first-tier subcontractor(s) have in performing work the Offeror deems recent (see M.8.3) and relevant (see M.8.4) to this solicitation. Within the narrative, the Offeror shall explain which aspects of the past performance it considers to be relevant to the requirements of this solicitation.

L.7.2.1. Offerors shall discuss any management or corrective actions employed in resolving problems, if any, and the effects of those actions in terms of improvements achieved or problems resolved (e.g., improved quality performance indicators or other management indicators) associated with its past performance or past performance submitted on behalf of its first-tier subcontractor(s).

L.7.3. In addition to the narrative described in L.7.2., the Offeror shall submit up to ten (10) recent contracts or agreements reflecting its work most relevant to the solicitation. The ten (10) most relevant contracts or agreements may be for its own work or the work of its first-tier subcontractor(s). Each contract or agreement submitted shall include information regarding the customer and a verified point of contact for the customer (name, title, address, phone number) who is able to discuss the performance with the Government. Each contract or agreement submitted shall also include information on the functions performed, the time period covered, and the aspects of the work that are most relevant (see M.8.4) to the solicitation. A description

shall be provided for each reference not to exceed three (3) pages per reference. The Offeror shall state if it has submitted fewer than 10 (ten) contracts or agreements.

L.7.4. If the Offeror, or any first-tier subcontractor(s), has/have had any contracts terminated for default or cause within the last three years from date of the solicitation release, the Offeror shall include documentation detailing the reason for the termination. The documentation shall identify the customer and its address, along with the customer's contracting official, and contact information. For any contract terminated for default or cause, actions taken (or that will be taken) to prevent similar failures from reoccurring should also be included.

L.7.5. If the Offeror, or its first-tier subcontractor(s), was/were formed solely for the purpose of proposing on this solicitation and the parent company, predecessor, affiliate, or individual party/parties to a joint venture has/have relevant past performance, the Offeror shall follow the Section L.7 instructions and submit the past performance information of the applicable entity/entities. The Offeror shall also describe the resources possessed by that entity and explain the scope and extent to which that entity would be involved in the performance of the T-5 contract. For joint venture members, the Offeror shall explain the efforts that each such entity would perform under the T-5 contract.

L.7.6. The Offeror shall submit a completed past performance questionnaire (See Attachment L-12, Past Performance Questionnaire (PPQ), Sections 1 and 2 only) for each of its references and its first-tier subcontractor(s)'s references that were submitted pursuant to L.7.3. The Offeror shall send Section 3 of the questionnaire to references to be filled out independently and be returned directly to the Government. References will return the completed questionnaires directly to the Government as directed on the Questionnaire (Attachment L-12). It is the Offeror's responsibility to ensure the references complete the questionnaires. The questionnaires shall be completed by the cognizant representative of the contract or program, the customer; or, if it is a Government contract, by the Contracting Officer (CO) or Contracting Officer's Representative (COR) for the contract or program. Questionnaires shall not be completed by employees representing the interests of the Offeror or its first-tier subcontractor(s) whose performance is being reviewed on the PPQ, including its own employees and those of parents, affiliates, subsidiaries, subcontractors, and other team members.

L.7.7. The Offeror shall submit a record of its compliance with FAR 52.219-8 Utilization of Small Business Concerns and 52.219-9, Small Business Subcontracting Plan including past eSRS, if applicable, and all correspondence with the cognizant CO or Small Business Specialist regarding its compliance for the past three (3) years on current or past Government contracts. There is no page limit applicable to this information.

L.7.8. Many companies have acquired, been acquired by, or otherwise merged with other companies, and/or have reorganized their divisions, business groups, or subsidiary companies. If an Offeror or first-tier subcontractor provides past performance information rendered by a predecessor company, a "roadmap" describing all such changes in the organization must also be submitted in order to facilitate the Government's relevancy determination. The Offeror or first-tier subcontractor shall describe how the past performance efforts of a predecessor company are

relevant to this solicitation. This information will not count against the Offeror's past performance narrative page count.

L.7.9. The Government will gather and use recent and relevant past performance data from other sources including, but not limited to the Contractor Performance Assessment Reporting System (CPARs) and other Government databases.

L.8. VOLUME IV PRICE/COST ORGANIZATION/INSTRUCTIONS

L.8.1. "Data Other than Certified Cost or Pricing Data" may be requested from the Offeror to support the price reasonableness of its proposal.

L.8.2. Section B. The completed Section B in Volume I constitutes the price portion of the "offer" to the Government. The unit prices, carried to two decimal places ($0.00), multiplied by the estimated quantity for each respective CLIN/SLIN shall be the extended amount in Section B, with no rounding. For all CLINs/SLINs, if there is a discrepancy between the proposed unit prices extended by the estimated quantities and the Offeror's proposed extended amounts, the proposed unit prices shall be presumed to be correct and extended by the Government supplied quantities. If an Offeror enters a zero dollar figure ($0.00) entered or a line item left blank will be interpreted as the CLIN/SLIN shall be provided at no additional cost to the Government. In the event there is a discrepancy between the proposed CLIN/SLIN amounts or unit prices in Volume IV, Price/Cost and the completed Section B in Volume I, the amounts on the completed Section B in Volume I shall prevail.

L.8.3. RESERVED

L.8.4. Price Evaluation Template (Attachment L-5e/L-5w)

L.8.4.1. The solicitation includes two Price Evaluation Templates: one for the East Region (Attachment L-5e) and the other for the West Region (Attachment L-5w). The Templates are labelled either East or West Region. The Template tab entitled "Healthcare Cost & Discount" has differing figures for the Government's Estimate of Underwritten Healthcare Costs (HCC) and the Projected Allowed Amount for Underwritten HCC Delivered by Network Providers on Non-OHI Claims between the two regions. The Price Evaluation Template tab entitled "Section B" has inputs tailored to the specific region for the CLINs X003 PMPM eligible quantities.

L.8.4.2. In order to facilitate the Government's price/cost evaluation, the Offeror shall use the Price Evaluation Template workbook provided with the solicitation (Attachment L-5e/L-5w). The Price Evaluation Template is a set of simple Excel spreadsheets, following the general cost element configuration common in federal Government contracting. The Government will use the Price Evaluation Template to analyze the Offeror's submitted Total Evaluated Price.

L.8.4.3. The Government acknowledges that the Offerors' accounting/estimating systems, policies, and practices will differ therefore the Offeror may introduce any adjustments to the Template that it believes are needed to present its proposed costs and prices accurately and in accordance with its accounting/estimating systems, policies, and practices. The Offeror may

submit a pricing narrative (with no page limitations), which shall address and provide justification for any adjustments to the Template.

L.8.4.4. The Offeror is responsible for its own proposal data entered into the Price/Cost Evaluation Template submission. All data entries, cell calculations, and links among spreadsheets and files shall be checked and verified by the Offeror as correct.

L.8.5. RESERVED

L.8.6. RESERVED

L.8.7. RESERVED

L.8.8. RESERVED

L.8.9. RESERVED

L.8.10. RESERVED

L.8.11. RESERVED

L.8.12. RESERVED

L.8.13. RESERVED

L.8.14. RESERVED

L.8.15. RESERVED

L.8.16. Professional Employees' Compensation Plan per FAR 52.222-46

L.8.16.1. The Offeror shall submit a Total Compensation Plan (TCP) setting forth the salaries and fringe benefits proposed for the professional employees, as defined in Title 29 CFR Part 541, who will work under the proposed contract, as prescribed in FAR 52.222-46. The Offeror shall include supporting information for the proposed plan such as recognized national and regional compensation surveys and studies of professional, public and private organizations, used in establishing the total compensation structure. In addition, Offerors are cautioned that lowered compensation for essentially the same professional work may indicate lack of sound management judgment and lack of understanding of the requirement. The professional employee job category, salary rates or ranges must be identified.

L.8.16.2. If DCAA has performed an Executive Compensation Review for the Offeror, a copy shall be included in the proposal.

L.8.17. Government Provided Plug-In Figures. For purposes of the Government's evaluation of Total Evaluated Price, Offerors shall use the following costs/prices for identified CLINs

below. The referenced costs/prices have been pre-populated in Price Evaluation Templates L-5e/L-5w, and Offerors shall not modify these prices.

CLIN(s)	Description	Price
1001 (East Region)	Underwritten Healthcare Costs OP1 East Region	$6,587,839,900
2001 (East Region)	Underwritten Healthcare Costs OP2 East Region	$6,863,494,228
3001 (East Region)	Underwritten Healthcare Costs OP3 East Region	$7,172,351,468
4001 (East Region)	Underwritten Healthcare Costs OP4 East Region	$7,495,107,284
5001 (East Region)	Underwritten Healthcare Costs OP5 East Region	$7,832,387,112
6001 (East Region)	Underwritten Healthcare Costs OP6 East Region	$8,184,844,532
7001 (East Region)	Underwritten Healthcare Costs OP7 East Region	$8,553,162,536
8001 (East Region)	Underwritten Healthcare Costs OP8 East Region	$8,938,054,850
1001 (West Region)	Underwritten Healthcare Costs OP1 West Region	$5,886,119,497
2001 (West Region)	Underwritten Healthcare Costs OP2 West Region	$6,132,411,808
3001 (West Region)	Underwritten Healthcare Costs OP3 West Region	$6,408,370,339
4001 (West Region)	Underwritten Healthcare Costs OP4 West Region	$6,696,747,004
5001 (West Region)	Underwritten Healthcare Costs OP5 West Region	$6,998,100,620
6001 (West Region)	Underwritten Healthcare Costs OP6 West Region	$7,313,015,147
7001 (West Region)	Underwritten Healthcare Costs OP7 West Region	$7,642,100,829
8001 (West Region)	Underwritten Healthcare Costs OP8 West Region	$7,985,995,366
1002, 2002, 3002	Future Potential Demonstrations (OPs 1-3)	$15,000,000 (Each CLIN)
4002	Future Potential Demonstrations OP 4	$3,000,000
1007, 2007, 3007, 4007, 5007, 6007, 7007, 8007	Service Assist Teams	$100,000 (Each CLIN)
1005, 2005, 3005, 4005, 5005, 6005, 7005, 8005	MTF/Guard/Reserve/MSO/VSO Briefings	$100,000 (Each CLIN)

L.8.18. Underwritten Healthcare

L.8.18.1. Underwritten Healthcare Cost CLINs 1001, 2001, 3001, 4001, 5001, 6001, 7001, and 8001. The Government has provided the estimated "Underwritten Healthcare Costs" for each option period, 1 through 9, for each Region identified in the Regional Map, (Attachment L-14) and in the Price Evaluation Template Attachment L-5e or Attachment L-5w. These estimates are based on TRICARE's actual allowable healthcare costs; they do not include credits (reductions) for any network discounts. The Offeror shall not propose its own estimated healthcare costs, but use those supplied by the Government.

Note: The costs for administering and managing the underwritten healthcare costs are considered "administration" costs, included in the Offeror's PMPM SLINs X003AA, X003AB, X003AC and X003AD proposed fixed unit prices; they are not considered indirect costs added to or as cost factors applied to the underwritten healthcare costs.

L.8.18.2. Guaranteed Network Provider Discounts. The Offeror may propose guaranteed network provider discounts for each option period. A guaranteed network provider discount shall consist of a percentage figure, not a fixed dollar amount, for each option (the proposed discount figure shall be carried out to one decimal place (00.0% or 0.000)). The guaranteed network provider discount proposed by the Offeror will be measured as an overall discount for care by civilian network providers, using the same measurement methodology and data specifications described for the Network Discount Guarantee in Section H.3.2.1. The Offeror's proposed percentage will be applied against Government's provided estimate of "Civilian Network providers/non-Other Health Insurance (OHI) claims" for each option period, 1 through 8. The resulting product, the calculated Offeror's discount amount, shall be subtracted from the Government provided "Underwritten Healthcare Costs." The difference between the Government's estimate of Underwritten Healthcare Costs and the Offeror's proposed discount amount plus the Offeror's proposed fixed fee is its proposed CLINs 1001, 2001, 3001, 4001, 5001, 6001, 7001, and 8001 Underwritten Healthcare Costs. This amount shall be entered into the Completed Section B in Volume I of the Offeror's proposal.

L.8.18.3. The Offeror's proposed guaranteed network provider discount percentages, the calculated discount dollar amounts, the Offeror's proposed fixed fee, and the resulting proposed Underwritten Healthcare Costs shall be clearly identified in its price proposal. The Price Evaluation Template (Attachment L-5e or Attachment L-5w) includes a worksheet that provides a format for the Offeror to document its guaranteed discount percent figures, calculate the discount dollar amounts, insert its proposed fixed fee, and derive the proposed healthcare costs: the tab entitled Healthcare Cost & Discount.

L.8.18.4. Within the price/cost proposal volume, the Offeror shall affirmatively agree to accept all risks of future conditions that may impact the Offeror's ability to obtain provider discounts and shall not include conditions or qualifications to limit risk. The Offeror shall further agree that the guaranteed network provider discount shall not be adjusted for any action by the Government, including unilateral contract changes, allowable rates, and payment methodology.

L.8.18.5. The Offeror's proposed guaranteed network provider discount percentage figures in the Price Evaluation Template **shall be identical** to those percentage figures entered into the table of Section H.3.2.1.1. Guaranteed Network Provider Discounts (negative incentive).

L.8.18.6. RESERVED

L.8.18.7. Fixed Fee. Offerors shall propose a fixed fee for underwritten healthcare cost. That fixed fee shall be added in the designated cells of the Price Evaluation Template and a component of underwritten healthcare CLINs 1001, 2001, 3001, 4001, 5001, 6001, 7001, and 8001. This awarded fixed fee is not subject to change regardless of differences between actual and estimated underwritten healthcare costs.

L.8.19. Managed Care Support Services CLINs X003

L.8.19.1. (PMPM/Administration Costs) SLINs X003AA, X003AB, X003AC, and X003AD. The Offeror shall include all its program administration costs in the proposed PMPM price. The

PMPM price shall include all effort necessary to perform all contract requirements unless otherwise specifically instructed to price in another CLIN within Section B. Since CDRLs are Not Separately Price (NSP), any costs associated with production of CDRLs during healthcare delivery should be captured under CLINs X003. Attachment L-13, Government Estimate for PMPM, includes the estimated member months for each option period for each region. SLIN X003AA is for the first three months of the calendar year, SLIN X003AB is for the fourth through sixth months of the calendar year, SLIN X003AC is for the seventh through ninth months of the calendar year, and SLIN X003AD is for the tenth through twelfth months of the calendar year. The Offeror shall use the Government estimates for PMPM contained in Attachment L-13 for the respective region in Section B. PMPM estimates are only provided semi-annually for the option periods, therefore, the quantities under SLINs X003AA and X00AB will be the same and those under SLINs X003AC and X003AD will be the same.

L.8.19.2. Award Fee. Offerors shall not propose a price for the $20,000,000 pool available for award fee per year of healthcare delivery.

L.8.19.3. Earned Performance Incentive. Offerors shall not propose a price for Earned Performance Incentive.

L.8.20. RESERVED

L.8.21. Contract Data Requirements List (CDRL) (DD Form 1423) CLINs 0002; X006; 9002. The reports shall be not separately priced (NSP) in Section B, Form 33. However, in accordance with DFARS 215.470, Estimated Data Prices, DoD requires estimates of the prices of data in order to evaluate the cost to the Government in terms of their management, product, or engineering value. The Offeror shall provide an estimated cost for each CDRL in each option period. The Price Evaluation Template (Attachment L-5e or Attachment L-5w) provides a worksheet for the Offeror to enter its estimated costs.

L.8.22. Service Assist Teams (SATs) CLINs X007. For Total Evaluated Price and proposal purposes, the Offeror shall use the estimated amount of $100,000. A ceiling amount of $200,000 has been established by the Government. The Offeror shall not propose different costs for X007 CLINs.

L.8.23. MTF/Guard/Reserve/MSO/VSO Briefings CLINs X005. For Total Evaluated Price and proposal purposes, the Offeror shall use the estimated amount of $100,000. A ceiling amount of $200,000 has been established by the Government. The Offeror shall not propose different costs for X005 CLINs.

L.8.24. RESERVED

L.8.25. Transition-In, Transition-Out, and Extension of Services.

L.8.25.1. Transition-In CLIN 0001. The Offeror shall propose a firm-fixed-price for its transition-in effort.

L.8.25.1.1. Transition-In Milestone Payments SLINs 0001AA, 0001AB, 0001AC, and 0001AD. The Offeror shall allocate the following percentages of its CLIN 0001 price to SLINs 0001AA, 0001AB, 0001AC, 0001AD:

SLIN 0001AA: 5% of CLIN 0001 total price
SLIN 0001AB: 10% of CLIN 0001 total price
SLIN 0001AC: 40% of CLIN 0001 total price
SLIN 0001AD: 45% of CLIN 0001 total price

L.8.25.2. Contract Data Requirements List (CDRL) (DD Form 1423) Transition-In CLIN 0002. The reports shall be not separately priced (NSP) in Section B, Form 33 and the cost of the CDRLs during Transition-In should be included in the Offeror's firm-fixed-price for Transition-In CLIN 0001.

L.8.25.3. CLIN 9001 Transition-Out. Transition-Out consists of one CLIN. The Offeror shall propose a firm-fixed-price for its transition-out effort. The Offeror shall not propose an amount for the Award Fee during Transition-Out.

L.8.25.4. Contract Data Requirements List (CDRL) (DD Form 1423) Transition-Out CLIN 9002. The reports shall be not separately priced (NSP) in Section B, Form 33 and the cost of the CDRLs during Transition-Out should be included in the Offeror's firm-fixed-price for Transition-Out CLIN 9001.

L.8.25.5. Extension of Services. For CLIN 9003 6-Month Option Period Extension, for purposes of calculating the Total Evaluated Price, Offerors shall propose 50% of the total price of Option Period 8 (note: this is not inclusive of transition-out).

L.8.26. TRICARE Reserve Select, TRICARE Young Adult, TRICARE Retired Reserve, Continued Health Care Benefit Program (CHCBP) (East Region) and Prime/Select Enrollment Premiums/Fees. The Premiums/Fees collected for these programs by the Contractor will be forwarded to the Government. Offered prices should not include cost offsets.

L.8.27. Excessive Pass-through Charges - Identification of Subcontractor Effort, per FAR 52.215-22, for this solicitation, this requirement applies to the total cost of work performed for all of the following CLINs: X007 SATs, X005 MTF/Guard/Reserve/MSO/VSO Briefings.

L.8.28. RESERVED

L.8.29. Future Potential Demonstrations/Product Improvements (CLINs X002). For Total Evaluated Price and proposal purposes, the Offeror shall propose $15,000,000 for each of CLINs 1002, 2002, and 3002, and $3,000,000 for CLIN 4002. The Offeror shall not deviate from the prescribed amounts for X002 CLINs.

L.9. VOLUME V, FINANCIAL

L.9.1. Financial Viability. The Offeror must demonstrate adequate financial resources to

perform the prospective contract or demonstrate an ability to obtain adequate financial resources. Offerors shall submit the financial data listed below on the Offeror, any parent corporation, and any incomplete or pending status of prior or prospective significant merger candidates.

L.9.2. The Offeror shall submit the following:

a. The Offeror's most recent Dun and Bradstreet (D&B) Comprehensive Report, or if not available, another rating company report that is essentially equivalent to D&B (e.g., A.M. Best Company).
b. Annual Reports for the Offeror's three most recent fiscal years (including audit opinions).
c. Balance Sheets, Income Statements, Statement of Retained Earnings, and Statements of Cash Flows for the same period of time as b. above.
d. Statement of projected quarterly cash flows for a one year period beginning with the start of the contract (i.e., transition base period).
e. DCMA Form 1620 04-04 Guaranty Agreement for Corporate Guarantor (Attachment L-8).

L.9.2.1. Offerors shall clearly label all financial statements as "audited" or "unaudited," and include the date last audited, audit opinion, auditor's name, and the date of any certification of the financial statements by the responsible company official. All off-balance sheet arrangements and related party transactions must be clearly disclosed and explained.

L.9.2.2. The Offeror shall also identify and explain any audit report opinions that are other than a "Clean" or "Unqualified Opinion," any audit findings, and any required corrective action plans.

L.9.2.3. An Offeror without audited financials shall provide historical documents such as tax returns, projected income statements and balance sheets, and narrative documentation supporting its ability to obtain financial resources to perform the contract.

L.9.2.4. The Offeror shall submit copies of adverse financial items uncovered in any of the last 3 years' State Insurance Department audits, as of RFP release date, if applicable. Offerors shall provide a supporting narrative, including a brief description of anomalies in the submitted financial data and a brief description of any projected increases and decreases in the Offeror's business base.

L.9.3. The Offeror shall include a guarantee from the Offeror's holding or parent company, or owner(s), if applicable, indicating its willingness to guarantee complete and faithful performance of the Offeror and to provide the Offeror all necessary and required resources, including financing, which are necessary to assure the full, complete and satisfactory performance of the contract. The format to be used for this guarantee is DCMA Form 1620 04-04 Guaranty Agreement for Corporate Guarantor (Attachment L-8). A signed copy shall be included in Volume V. Failure to provide this guarantee, if applicable to the Offeror, may result in the CO making a determination that the Offeror is not responsible, and thus ineligible for award (FAR 9.105).

L.10. Offeror's Financial Systems

L.10.1. Adequate Accounting System. The Offeror shall have an accounting system capable of handling a cost-reimbursement type of contract. The Offeror shall provide documentation that its accounting system is capable of tracking and segregating cost data in sufficient detail to administer the contract. Acceptable documentation is an accounting system approval letter from the DCMA Administrative Contracting Officer (ACO) and/or a DCAA pre or post award audit stating that the Offeror's accounting system is "acceptable" or "adequate." For the Offeror without government contract experience, it should contact its cognizant DCMA office to initiate the pre-award audit process with DCAA as soon as possible.

L.10.2. The Offeror shall include a summary description of the DCMA/DCAA approval status of its estimating system, purchasing system, and Cost Accounting Standards (CAS) Disclosure Statement in its proposal. Copies of the ACO approval letter and DCAA pre-award/post-award audit reports shall also be provided. Finally, the Offeror shall describe any anticipated changes to its accounting, estimating, billing, and purchasing systems or CAS Disclosure Statement.

(End of Section)

SECTION M
EVALUATION FACTORS FOR AWARD

M.1. SOLICITATION PROVISIONS

FAR 52.217-5 Evaluations of Options (Jul 1990)

Except when it is determined in accordance with FAR 17.206(b) not to be in the Government's best interests, the Government will evaluate offers for award purposes by adding the total price for all options to the total price for the basic requirement. Evaluation of options will not obligate the Government to exercise the option(s).

M.2. BASIS OF EVALUATION

M.2.1. This is a best value source selection conducted in accordance with Federal Acquisition Regulation (FAR) Part 15.3, Source Selection, as supplemented by the Defense Federal Acquisition Regulation Supplement (DFARS). These regulations are available electronically at https://www.acquisition.gov. The Government will select the best overall offers (one for each Region), based upon an integrated assessment of the submitted offers, utilizing the technical/risk, past performance, and price/cost factors described below. The Government will also apply a fourth factor, Small Business Participation, which it will evaluate offers on an Acceptable/Unacceptable basis. This fourth factor will not be included in the integrated assessment or trade-off process; however, award will not be made to an Offeror with an unacceptable rating under any factor or subfactor. The Government seeks to award to the Offerors (one for each Region) that meet or exceed the requirements described in the solicitation and that provide the best value to the Government. Application of this best value, trade-off methodology may result in an award to a higher rated, higher priced Offeror, where such a decision is consistent with the evaluation factors, and the Source Selection Authority (SSA) reasonably determines that the overall benefit associated with the non-price factors outweighs the cost difference. In making the trade-off between the non-price factors and the price factor, the SSA will base the source selection decision on an integrated, comparative assessment of proposals against all source selection criteria in the solicitation (described below).

M.2.1.1. The Government will award one contract per Region to meet the T-5 requirement. An Offeror is limited to the award of one Region. In other words, the Government will not award both Regions to a single Offeror. The Government intends to select awardees in the following order: (1) West Region, (2) East Region (see RFP Regional Map, attachment L-14). For each region, the Government will evaluate only those proposals submitted for that region. The Government reserves the right to award the Regions in a different order if the Government determines it will best meet the Government's interests.

M.2.2. The Government will review proposals for completeness and conformity with Section L before they are evaluated in accordance with this Section. The Government reserves the right to reject incomplete or non-conforming proposals at the discretion of the Contracting Officer.

M.2.3. Evaluation Approach. The Government will evaluate the extent to which the proposal exhibits a clear understanding of the work requirements and whether the proposal demonstrates an ability to meet or exceed those requirements.

M.3. EVALUATION FACTORS. The Government will evaluate each proposal against the following factors and subfactors.

Factor 1 – Technical/Risk

Subfactor 1 – Network Management
Subfactor 2 – Clinical Management
Subfactor 3 – Admin/Customer Service
Subfactor 4 – Claims and Systems
Subfactor 5 – Transition Management
Subfactor 6 – Future Potential Demonstrations/Product Improvements

Factor 2 – Past Performance

Factor 3 – Price/Cost

Factor 4 – Small Business Participation

M.4. EVALUATION FACTOR RELATIVE IMPORTANCE

- Factor 1, Technical/Risk, is the most important factor.
- Technical/Risk Subfactors 1 through 5 are weighted equally and are, individually, more important than Technical/Risk Subfactor 6.
- Factor 2, Past Performance, is less important than Factor 1.
- The non-price evaluation factors (Factors 1 and 2) when combined, are significantly more important than Factor 3, Price/Cost.
- Factor 4 does not fall into the relative importance of factors for award because it will be rated on an Acceptable/Unacceptable basis only. Therefore, Factor 4 will not be included in the integrated assessment; however, an Offeror must receive an Acceptable rating for this Factor in order to be eligible to receive an award.

M.5. EVALUATION OF FACTOR 1, TECHNICAL/RISK

The Government will determine a Technical Rating (Table M.5.1.) and a Technical Risk Rating (Table M.6.2.) for each of the subfactors. The Government will evaluate each proposal to determine how well it satisfies the Government's requirements, applying the subfactors stated herein. If an Offeror's proposal fails to address any of the specified elements of a subfactor, then the Government may find the Offeror's proposal ineligible for award.

M.5.1. Technical Rating

M.5.1.1. For each of the subfactors of the Technical/Risk factor, the Government will evaluate the quality of the Offeror's technical solution for meeting the Government's requirement and will assign one of the Technical Ratings described in Table M.5.1. Subfactor ratings will not be rolled up into an overall color/adjectival rating for the Technical/Risk factor.

M.5.1.2. A "strength" is an aspect of an Offeror's proposal that exceeds specified performance or capability requirements in a way that will be advantageous to the Government during contract performance. The Government may assign multiple strengths to a subfactor; however, if the Government determines an aspect of the proposal to be a strength, that strength will be credited to only one subfactor. The Government will have the sole discretion in determining which subfactor the strength best fits. The Government will not assess strengths for the Past Performance, Price/Cost, or Small Business Participation Factors. A "deficiency" is a material failure of a proposal to meet a Government requirement or a combination of significant weaknesses in a proposal that increases the risk of unsuccessful contract performance to an unacceptable level. A "weakness" means a flaw in the proposal that increases the risk of unsuccessful contract performance. A "significant weakness" in the proposal is a flaw that appreciably increases the risk of unsuccessful contract performance.

TABLE M.5.1. – TECHNICAL RATINGS

Color Rating	Adjectival Rating	Description
Blue	Outstanding	Proposal indicates an exceptional approach and understanding of the requirements and contains multiple strengths.
Purple	Good	Proposal indicates a thorough approach and understanding of the requirements and contains at least one strength.
Green	Acceptable	Proposal indicates an adequate approach and understanding of the requirements.
Yellow	Marginal	Proposal has not demonstrated an adequate approach and understanding of the requirements.
Red	Unacceptable	Proposal does not meet requirements of the solicitation and, thus, contains one or more deficiencies and is unawardable.

M.6. TECHNICAL RISK RATING

M.6.1. The Government will also utilize the subfactors of the Technical/Risk factor for evaluating proposal risk. The Government will assess the degree to which the Offeror's proposed approach has the potential for disruption of schedule, increased cost, degradation of performance, the need for increased Government oversight, and/or the likelihood of unsuccessful contract performance.

M.6.2. The Government will assign a risk rating for each of the Technical/Risk subfactors as described in Table M.6.2. Subfactor risk ratings will not be rolled up into an overall risk rating for the Technical/Risk factor. The risk evaluation will include, but not be limited to, an evaluation of the Offeror's proposed approach, method, or process for completing tasks and the Offeror's demonstrated experience in performing tasks (including experience in performing a proposed approach, method, or process).

TABLE M.6.2. - TECHNICAL RISK RATINGS

Rating	Description
Low	Proposal may contain weakness(es) which have little potential to cause disruption of schedule, increased cost or degradation of performance. Normal contractor effort and normal Government monitoring will likely be able to overcome any difficulties.
Moderate	Proposal contains a significant weakness or combination of weaknesses which may potentially cause disruption of schedule, increased cost or degradation of performance. Special contractor emphasis and close Government monitoring will likely be able to overcome difficulties.
High	Proposal contains a significant weakness or combination of weaknesses which is likely to cause significant disruption of schedule, increased cost or degradation of performance. Is unlikely to overcome any difficulties even with special contractor emphasis and close Government monitoring.
Unacceptable	Proposal contains a material failure or a combination of significant weaknesses that increases the risk of unsuccessful performance to an unacceptable level.

M.7. EVALUATION OF TECHNICAL/RISK SUBFACTORS

M.7.1. RESERVED

M.7.2. Technical Subfactors

M.7.2.1. Subfactor 1 – Network Management

M.7.2.1.1. The Government will evaluate the effectiveness of the Offeror's proposed approach for developing and maintaining a provider network that:

a) Is accredited by a leading health quality measurement organization;
b) Is dynamically managed to meet changing populations, enrollments, and health care needs;
c) Includes high quality providers;
d) Meets TRICARE access to care standards as defined in 32 CFR 199.17(p)(5);
e) Supplements services provided by the Military Medical Treatment Facilities (MTFs); and,
f) Continuously maintains compliance with TRICARE access to care standards as defined in 32 CFR 199.17(p)(5).

M.7.2.1.2. The Government will evaluate how effectively the Offeror's network model:

a) Incorporates/addresses the size, scope, and distribution of the beneficiary population;
b) Calculates the number of providers required;
c) Determines the minimum ratio of providers required;
d) Determines the types of providers required;
e) Incorporates the needs of MTFs in support of optimization (see Section C, paragraph C.2.12.10.);
f) Uses access to care appointment wait time and drive/travel time standards for the TRICARE benefit (as defined in 32 CFR 199.17(p)(5)); and
g) Includes an approach for monitoring and addressing network shortages.

M.7.2.1.3. Evaluation of Provider Sizing Model. For the purposes of this paragraph, a "new network" is a network (or portion thereof) that is completely outside of an Offeror's existing network.

M.7.2.1.3.1. The Government will evaluate the Offeror's proposed network size for each of the identified markets (see Section L.6.2.1.3.1.) to determine the effectiveness of the Offeror's sizing model. The Government will evaluate whether the Offeror's model calculates an accurately sized network for each market using the Offeror's submitted provider volumes (attachment L-3e and/or L-3w, depending on which region is proposed). The Government will evaluate whether a network is accurately sized based on beneficiary population. The

Government will evaluate the Offeror's proposed network build timelines against the required transition timelines.

M.7.2.1.3.2. The Government will evaluate the size and extent of the Offeror's proposed new network build (as described in Attachments L-9e and/or L-9w, depending on which region is proposed) and the adequacy of the evidence the Offeror provides demonstrating that it is and will be authorized to use as part of its TRICARE network any existing network (proposed as part of its new network build) not owned by the Offeror. If the Offeror proposes to use any parent-entity networks or leased networks, the Government will evaluate the letter(s) of commitment signed by the cognizant network owner(s) to assess the readiness/willingness of the owner(s) to participate in or join the Offeror's TRICARE network.

M.7.2.1.4. The Government will evaluate the effectiveness of the Offeror's proposed approach for ensuring the accuracy of its network provider directory, including how the Offeror will:

a) Verify information in the directory;
b) Share the directory (and updates) with the Government and maintained in file formats that support software analytics;
c) Communicate with network providers to ensure provider information is updated in the directory within timeliness standards;
d) Maintain provider affiliation with group practices in the directory; and
e) Use claim information to ensure active provider participation and inclusion (or exclusion) from the directory.

M.7.2.1.5. The Government will evaluate the effectiveness of the Offeror's proposed approach for responding to changes in MTF capabilities and capacities including:

a) How the Offeror' will adjust its network capabilities to respond to changes in MTF capabilities;
b) How the Offeror will adjust its network capabilities to respond to changes in MTF capacities; and
c) How the Offeror will respond to changes on short notice and whether the Offeror's minimum timelines for response to changes to capabilities and capacities are appropriate.

M.7.2.1.6. The Government will evaluate the effectiveness of the Offeror's approach for referring beneficiaries to providers with demonstrated high quality outcomes while meeting TRICARE administrative standards (such as electronic claims processing, return of clear and legible consultation reports when requested, appointment availability, and secure communications with patients). The Government will evaluate how effectively the Offeror's value based steerage model will:

a) Ensure compliance with access to care standards as defined in 32 CFR 199.17(p)(5);
b) Produce high quality health outcomes;
c) Optimize MTF workload;
d) Assist the government in achieving readiness of the medical force through Knowledge Skill and Ability (KSA) optimization; and
e) Control costs.

M.7.2.1.7. The Government will evaluate the effectiveness of the Offeror's proposed approach for maximizing the inclusion, in its network, of network providers that are connected to Health Information Exchanges compatible, at a minimum, with the CommonWell® Health Alliance Platform. The proposal shall clearly demonstrate how the Offeror will include providers connected to Health Information Exchanges in MTF referral networks to facilitate electronic access to clinical data with MHS GENESIS (refer to attachment J-14, MHS Genesis Performance Work Statement).

M.7.2.2. Subfactor 2 – Clinical Management

M.7.2.2.1. The Government will evaluate the effectiveness of the Offeror's proposed approach for managing referrals between the MTFs and its private sector network in accordance with Section C, paragraph 2.7. and the TRICARE Operations Manual (TOM), Chapter 7, Section 5 and Chapter 8, Section 5 including:

a) How and when its referral management systems and processes will direct/refer TRICARE Prime network enrolled beneficiaries to the MTF (where applicable);
b) How and when its referral management processes will enforce the Point of Service Option for TRICARE Prime beneficiaries enrolled to the MTF who decline available care in the MTF;
c) How its processes will identify TRICARE Select enrolled beneficiaries for potential voluntary "recapture" to MTFs (for the purpose of receiving specialty care), and will effect such recapture, when doing so aligns with the MTFs' capability and capacity for pertinent specialty care and procedures;
d) How its beneficiary education process will provide TRICARE Select enrolled beneficiaries with the tools necessary to make informed decisions about receiving care at local MTFs or military Center of Excellence when the delivery of such care by the MTF or COE will enhance the readiness of the medical force;
e) How and when its referral management systems and processes will direct beneficiary referrals from MTFs to its network;
f) How its referral management processes will support continuity of referrals when beneficiaries change geographical regions;
g) How its referral management processes for managing referrals will be supported through network management activities;
h) How it will meet referral processing timeliness requirements;
i) How it will meet referral processing accuracy requirements;

j) How it will update its referral practices in response to Government updates to the list of diagnostic and procedure codes correlated with enhancing medical force readiness;
k) How it will ensure an accurate record of care provided to a beneficiary is readily available to all providers involved with the beneficiary's care, and;
l) How it will hold providers accountable for timely return of clinical information (where care is referred out from an MTF to the Offeror's network).

M.7.2.2.2. The Government will evaluate the effectiveness of the Offeror's proposed approach for designing, implementing, and maintaining integrated, comprehensive medical management programs for all care received by TRICARE-eligible beneficiaries in the private sector and for ensuring its medical management services complement those available within the direct care system. The Government will evaluate:

a) Whether the Offeror's proposed integrated medical management program for TRICARE eligible beneficiaries receiving care in the private sector supports medical care and behavioral health care;
b) How the Offeror's medical management programs will complement the standardized medical management services available in the MTFs;
c) How the Offeror's medical management processes will capture and objectively document improvements in clinical outcomes;
d) Whether the Offeror's medical management tools will facilitate access to medical management programs and customer service information for providers, MTFs, and beneficiaries;
e) The relative interoperability of the Offeror's proposed medical management systems with MTFs, civilian inpatient facilities, and the TRICARE Pharmacy Benefits Program, including the capability of those systems to provide essential information to providers and case managers and bi-directional feedback to and from private sector providers; and
f) The effectiveness of the Offeror's proposed strategy for integrating private sector care with the direct care system.

M.7.2.2.3. The Government will evaluate the effectiveness of the Offeror's proposed approach for implementing and operating a Utilization Management (UM) program for TRICARE-eligible beneficiaries. The Government will evaluate:

a) How the Offeror proposes to communicate, collaborate, manage, implement and maintain a UM program for TRICARE-eligible beneficiaries;
b) The processes, criteria and systems the Offeror proposes to use to implement and maintain the UM program and framework for continuous improvement;
c) How the Offeror's UM program will support the identification, prevention, and reduction or elimination of occurrences of unnecessary care, over- or under-utilization of care in the private

sector system, and that care provided is appropriately authorized, and complies with the TRICARE benefits described in 32 CFR Parts 199.4 and 199.5, and the TPM; and
d) How the Offeror will maintain and comply with its accreditation organization's written policies and documented procedures.

M.7.2.2.4. The Government will evaluate the effectiveness of the Offeror's approach for implementing a Case Management (CM) program, in accordance with TOM Chapter 7, Section 2, for TRICARE-eligible beneficiaries and how the program will support and manage the healthcare of individuals with high-cost conditions or with specific diseases for which evidence-based clinical management programs exist. The Government will evaluate:

a) How the Offeror proposes to support and manage the healthcare of individuals with high-cost, high risk, high utilization conditions or with specific diseases for which evidenced-based clinical management programs exist;
b) Whether the Offeror proposes to employ an effective case management and caseload methodology that will support all beneficiaries requiring CM, care coordination, or assistance for beneficiaries during transitions of care, in addition to beneficiaries with sensitive, rare, and high-profile or high-visibility needs through a staffing plan and caseload assignment methodology;
c) How the Offeror proposes to ensure its CM staff are knowledgeable of community resources where CM enrolled beneficiaries is located;
d) How the Offeror proposes to employ assessments and tools to identify beneficiaries for in-home CM services; and
e) The Offeror's proposed approach for offering timely in-home CM services to beneficiaries that reduce the risk of readmission and for carrying out first in-home visits to beneficiaries within 48 to 72 hours post discharge from inpatient care.

M.7.2.2.5. The Government will evaluate the effectiveness of the Offeror's proposed approach for its Population Health (PH) care platform, including:

a) The processes and systems it will utilize, consistent with the limitations described in Section C, paragraph C.2.5.1., to reach at-risk, high-risk, high-cost beneficiaries and deliver person-centered interventions based on identified risks and needs;
b) How it will use outcome measures to show the effectiveness of the PH care delivered;
c) How it will integrate its PH activities with its case management and disease management programs; and
d) How it will integrate its disease prevention and health promotion services into its PH care platform.

M.7.2.2.6. The Government will evaluate the effectiveness of the Offeror's approach to providing predictive analytics (for data pertaining to TRICARE Prime enrolled beneficiaries with network PCMs and TRICARE Select enrolled beneficiaries) via a real-time, beneficiary-

centric data warehouse and industry analytic tools/systems, which incorporate a data analysis technique with evidence-based algorithms including:

a) How the Offeror's proposed approach will apply data stratification and predictive modeling to produce positive patient outcomes and measurable gains in health.
b) How the Offeror's proposed approach and methodology will utilize integrated systems and processes for comprehensively discovering and correcting gaps in care and medical errors, identifying high-risk addictive behaviors, and identifying potential quality issues for Network Prime and TRICARE Select enrolled beneficiaries.
c) How the Offeror's systems and processes for standardizing medical error reduction while maintaining transparency and adhering to evidence-based medicine protocols, and that best enable extraction of actionable data from large databases of information, will be utilized to improve quality of care and patient perception of care.

M.7.2.2.7. The Government will evaluate the effectiveness of the Offeror's proposed approach for implementing a clinical quality management and patient safety program for TRICARE-eligible beneficiaries, including:

a) The systems and processes it will use for standardizing medical error reduction;
b) The processes it will use for providing oversight of provider adherence to evidence-based medicine protocols;
c) The transparency of its processes for providing quality and safety management data to the Government; and
d) Its processes for utilizing quality and patient safety data to improve beneficiary health outcomes.

M.7.2.2.8. The Government will evaluate the effectiveness of the Offeror's proposed approach for designing, implementing, and continuously improving comprehensive telehealth services supporting episodic and longitudinal care for TRICARE-eligible beneficiaries, including how the Offeror will:

a) Implement, promote, and support telehealth platforms and devices within primary and specialty practices throughout its provider network,
b) Use telehealth to address network adequacy voids, particularly in rural and remote areas.
c) Use telehealth to implement remote monitoring including implementing hub and spoke telehealth models
d) Facilitate and promote integration and information sharing between its network and the direct care system including through machine-to-machine interoperability between the Offeror, its network providers, and MHS GENESIS, and how it will use third party interoperability tools.
e) Identify and respond to beneficiary and provider educational needs to promote telehealth services.
f) Use and apply interoperability standards that promote information sharing between providers.

M.7.2.3. Subfactor 3 – Administration and Customer Service

M.7.2.3.1. The Government will evaluate the effectiveness of the Offeror's proposed customer service approach, including how the Offeror will ensure that customers receive accurate and comprehensive information from knowledgeable, courteous, and responsive staff and how the Offeror will provide customer service via multiple avenues of access.

M.7.2.3.2. The Government will evaluate the effectiveness of the Offeror's proposed approach for creating new, first time appointments for beneficiaries with network providers upon beneficiary request and the effectiveness of its approach for ensuring that its call center will be capable of handling incoming beneficiary calls and that the Offeror will create appointments with network providers that:

a) Meet the beneficiary's medical needs (appropriate care);
b) Meet the TRICARE appointment access standards (appointment wait time and driving/travel time) as described at 32 CFR 199.17(p)(5)); and
c) Ensure the beneficiary continues to pay in-network rates through completion of the episode of care.

M.7.2.3.3. The Government will evaluate the effectiveness of the Offeror's proposed approach for developing provider training materials, measuring the impact of such training materials on provider behavior, accurately measuring provider understanding of TRICARE marketing and training materials, and using those measurements to improve provider marketing and training outcomes. The Government will also evaluate how the Offeror proposes to consider message saturation and impact on provider understanding in its approach to developing provider training materials.

M.7.2.3.4. The Government will evaluate the effectiveness of the Offeror's proposed methods for outreach to providers and beneficiaries, and its approach for developing an annual beneficiary outreach plan, identifying beneficiary outreach opportunities, and utilizing measures for evaluating the effectiveness of its strategies and processes for updating the outreach plan.

The Government will also evaluate effectiveness of the Offeror's proposed approach for developing an annual education plan and its proposed approach for monitoring, implementing, and updating the annual education plan.

The Government will also evaluate the Offeror's approach to identifying and responding to beneficiary and provider educational needs

Finally, the Government will evaluate the effectiveness of the outreach methods the Offeror proposes to use to recruit new TRICARE providers and retain existing TRICARE providers.

The Government will evaluate the Offeror's proposed methods for ensuring the information it provides to beneficiaries regarding the TRICARE program and benefit is accurate and complete.

M.7.2.3.5. The Government will evaluate the effectiveness of the Offeror's proposed processes for hiring and retaining (throughout the life of the contract) qualified leadership personnel who possess knowledge and experience in the following areas:

a. Establishing/Maintaining Networks
b. Referral Management
c. Medical Management
d. Enrollment
e. Customer Service
f. Claims Processing
g. Management

The Government will evaluate the effectiveness of the Offeror's proposed approach for identifying and vetting qualified leadership candidates and the measures it proposes to use to monitor and ensure the effectiveness of performance of leadership personnel. The Government will evaluate the effectiveness of the Offeror's approach for determining which positions, within its organization, require incumbents who possess knowledge and experience in integrating the private sector care system with the direct care system. The Government will not evaluate the qualifications, skills, or qualities of specifically identified or identifiable staff members/personnel employed (or to be employed) by the Offeror.

M.7.2.3.6. The Government will evaluate the effectiveness of the Offeror's proposed Quality Management/Quality Improvement Program Plan, including the effectiveness of the Offeror's proposed approach to communicating (to the Government) problems and resolutions identified as part of the Quality Management/Quality Improvement Program Plan. The evaluation will include an assessment of the timeliness and adequacy of the Offeror's proposed communications methods and the appropriate use of communications media (e.g., email, telephone, face-to-face meeting).

M.7.2.3.7. The Government will evaluate whether the Offerors' internal, beneficiary facing web page development timeline meets the T-5 implementation timeline and whether the wireframe mockup meets the TRICARE brand standards.

M.7.2.3.8. The Government will evaluate whether the Offeror's approach will effectively identify and implement cost-containment and anti-fraud strategies. Evaluation will include review of the process and frequency by which the Offeror proposes to obtain data about potential fraud and abuse, perform comprehensive fraud and abuse risk assessments to identify specific fraud and abuse schemes and risks, and assess the likelihood and significance of such risks.

M.7.2.4. Subfactor 4 – Claims and Systems

M.7.2.4.1. The Government will evaluate the effectiveness of the Offeror's proposed approach for providing an adaptable (to changing TRICARE claims processing requirements), scalable (describes how the system will adapt to volumes of TRICARE claims and upcoming alternate payment models) claims processing system which incorporates industry best practices. The Government will evaluate the reasonableness of the Offeror's proposed timeline for incorporating TRICARE claims processing changes from change order initiation through testing and implementation. The Government will evaluate the effectiveness of the Offeror's plan to achieve certification of its claims processing system at CMMI Level 4 at the time of contract award.

M.7.2.4.2. The Government will evaluate the effectiveness of the Offeror's proposed claims processes and methods and how these processes and methods will result in the Offeror meeting claims processing timeliness and accuracy standards, to include achieving auto adjudication rates and minimizing reprocessing rates.

M.7.2.4.3. The Government will evaluate the effectiveness of the Offeror's proposed processes for accurately applying, in its claims processing system, unique elements of the TRICARE benefit: TRICARE deductibles, co-pays, coinsurance, cost shares, catastrophic caps, referral/authorization requirements, and point-of-service (POS) provisions by beneficiary type).

M.7.2.4.4. The Government will evaluate the effectiveness of the Offeror's proposed plan for complying with each of the 14 families of requirements of NIST Special Publication 800-171 for the processing, storage, and transmission of any DoD controlled unclassified information. The Government will evaluate whether the Offeror's proposed timelines will meet requirements for the T-5 start of health care delivery.

M.7.2.4.4.1. The Government will evaluate the Offeror's reported summary level score for its current basic self-assessment in the Supplier Performance Risk System (SPRS) to assess the Offeror's ability to implement the NIST Special Publication 800-171 by contract award.

M.7.2.4.4.2. RESERVED

M.7.2.4.4.3. RESERVED

M.7.2.4.4.4. The Government will evaluate the effectiveness of the Offeror's proposed plan to track the flow down of covered defense information, to include DoD controlled unclassified information, and to assess the compliance of its subcontractor(s).

M.7.2.4.5. RESERVED

M.7.2.4.6. The Government will evaluate the effectiveness of the Offeror's proposed approach for designing and implementing Alternate Payment Models (APMs). The Government will evaluate:

a) The method(s) the Offeror proposes to use to compute cost neutrality of proposed APMs;
b) The completeness of the Offeror's description of the calculation methodology (i.e., population, model-based) to be used for implementing APMs; and
c) How the Offeror will incorporate consideration of historic TRICARE program claims data (historical utilization) and risk and wage adjustments when determining whether an APM satisfies the cost neutrality requirement.

The Government will also evaluate the Offeror's approach for identifying any factors or potential characteristics of its APM design approach that may require pre-approval by the Government (during contract performance) and how it will account for the Government approval requirement as it designs and implements APMs.

M.7.2.4.7. The Government will evaluate the effectiveness of the Offeror's proposed approach for negotiating APM contracts with network providers. The Government will evaluate:

a) How the Offeror will achieve the 15% of healthcare payments to network providers standard through a mix of APMs (HCPLAN categories of 2, 3, and 4) during the first option year of the contract;
b) Which provider type(s) the Offeror will target for APM arrangements; and
c) How the Offeror will expand annual APM payments to meet requirements of TRM Chapter 18 and Section H, paragraph H.18.

M.7.2.4.8. The Government will evaluate the effectiveness of the Offeror's sample APM proposal, specifically how the proposal:

a) Identifies the HCPLAN category and subcategory;
b) Identifies the provider type and targeted beneficiary population. APMs must address at least one chronic disease and condition relevant to the TRICARE beneficiary population, including, but not limited to, diabetes, chronic obstructive pulmonary disease, asthma, congestive heart failure, hypertension, history of stroke, coronary artery disease, mood disorders, and obesity.
c) Includes an estimate of expenses paid to providers;
d) Includes a description of how the Offeror will establish accurate attribution methods, the approach to track APM costs, and the total percentage of network costs that are covered by APMs;
e) Includes expected savings for the service following implementation of the APM over the initial year, second year, and third year;
f) Demonstrates (via objective measures) that the cost of any APM at the model level, including the cost of care and any special APM payments to providers or amounts

collected from providers, will not exceed the aggregate cost of care that would have been incurred under applicable TRICARE maximum allowable charges;
g) Demonstrates an accurate APM attribution method; and
h) Proposes effective performance measures and measure levels that will evaluate quality of care, patient outcomes and beneficiary satisfaction under the APM.

M.7.2.5. Subfactor 5 - Transition Management

M.7.2.5.1. The Government will evaluate the effectiveness of the Offeror's proposed Integrated Master Schedule and Integrated Master Plan (IMP/IMS) and its compliance with stated contract transition-in requirements as described in TOM Chapter 2 and Section C, paragraph C.2.12.19.

M.7.2.6. Subfactor 6 - Future Potential Demonstrations/Product Improvements

M.7.2.6.1. Advanced Primary Care

M.7.2.6.1.1. The Government will evaluate the effectiveness of the Offeror's proposed approach for identifying and including Advanced Primary Care (APC) provider groups in its provider network. The Government will evaluate the effectiveness of the Offeror's approach for ensuring the APC provider groups it selects:

a) Demonstrate high-value in delivery of care using risk-adjusted, industry-standard metrics for appropriateness, clinical outcomes, and financial performance;
b) Provide care through an integrated, multi-disciplinary team utilizing evidence-based medicine;
c) Offer patient-centric options;
d) Focus on prevention, chronic care management, and management of life style risks; and,
e) Support value-driven care, population-based care payments, and robust connections with the medical neighborhood and community-based services.

M.7.2.6.1.2. The Government will evaluate the Offeror's proposed approach for creating a governance and administrative infrastructure that will effectively support integration of APCs into its network, including how the Offeror proposes to:

a) Calculate the number of APC providers needed;
b) Determine minimum APC provider ratios;
c) Determine and manage provider panel sizes;
d) Ensure interoperable medical record and data transfer capabilities;
e) Develop standards for data collection and medication reconciliation; and,
f) Facilitate and track timely referrals.

M.7.2.6.1.3. The Government will evaluate the effectiveness of the Offeror's proposed approach for monitoring and continuously improving APC performance including:

a) How the Offeror will measure success using metrics for financial performance, beneficiary experience, and risk-adjusted clinical outcomes using standard industry factors and metrics;
b) The integrated systems and processes the Offeror will use to assess APC performance and comprehensively discover and correct gaps in care, medical errors, and potential quality issues for beneficiaries; and,
c) The mechanisms and processes the Offeror will use for delivering continuous feedback to APC providers to improve value-based care delivery.

M.7.2.6.1.4. The Government will evaluate the effectiveness of the Offeror's proposed approach for engaging and communicating with beneficiaries to encourage the use of APC providers, including how the Offeror will:

a) Identify and respond to beneficiary educational needs that promote the use of APC providers;
b) Use incentives that are otherwise authorized under the TRICARE Program to encourage beneficiaries to use APC providers; and
c) Identify, and steer to APCs, individuals with high-cost conditions, who are high risk, who experience high utilization, or who have specific diseases for which evidenced-based clinical management programs exist.

M.7.2.6.1.5. RESERVED

M.7.2.6.1.6. The Government will evaluate the Offeror and first-tier subcontractors' experience with implementing Advanced Primary Care models. The Government will use the following data points to evaluate an Offeror's experience:

a) Years providing such program and services;
b) Number of clinics or facilities in operation over period of time;
c) Applicable credentials such as certified Patient Centered Medical Home (PCMH);
d) Vendor partnerships;
e) Performance measurement and improvement tools;
f) Continuous improvement initiatives; and,
g) Value-driven care and population-based care payments.

M.7.2.6.2. RESERVED

M.7.2.6.3. RESERVED

M.7.2.6.4. Care Collaboration Tools Requirements

M.7.2.6.4.1. The Government will evaluate the effectiveness of the Offeror's proposed approach for implementing an integrated care collaboration program that facilitates virtual provider-to-provider consultations (eConsult) including:

a) How it will promote information sharing and collaboration across the direct and private sector care systems to ensure coordination of care;
b) How it will support medical force provider Knowledge, Skills, and Abilities (KSAs) through increased access to specialist expertise; and,
c) How it will include e-Consults in its strategy for mitigating network shortages.

M.7.2.6.4.2. The Government will evaluate the effectiveness of the Offeror's proposed approach for supporting e-Consults and an integrated care collaboration program, including the effectiveness of the:

a) Systems and platforms the Offeror will use to facilitate e-Consults;
b) Standards for machine-to-machine interoperability the Offeror will apply between the Direct Care System and selected network providers participating in the e-Consult project;
c) Reporting and monitoring mechanisms the Offeror will use to track and trend e-Consults by providers, measure provider satisfaction, and assess impact on value; and,
d) Billing and reimbursement methodology the Offeror will use for e-Consults.

M.7.2.6.4.3. The Government will evaluate the effectiveness of the Offeror's proposed approach for communicating with and educating providers on:

a) e-Consult capabilities, requirements and incentives;
b) e-Consult policies and procedures; and,
c) Billing and reimbursement.

M.7.2.6.5. RESERVED

M.7.2.6.6. RESERVED

M.7.2.6.7. RESERVED

M.7.2.6.8. RESERVED

M.7.2.6.9. Virtual Value Network (VVN)

M.7.2.6.9.1. The Government will evaluate the effectiveness of the Offeror's proposed approach for identifying and including high-value providers in its Virtual Value Network including:

a) How it will select high-value providers;
b) How it will use risk-adjusted, industry-standard metrics for appropriateness, clinical outcomes, and financial performance;
c) How it will aggregate and score provider value; and,
d) Which sources of data it will use to assess provider value.

M.7.2.6.9.2. The Government will evaluate the effectiveness of the Offeror's proposed approach for providing beneficiaries 24 hours a day, 7 days a week access to VVN provider value ratings and metrics, including its ability to:

a) Provide web and app based tools;
b) Provide call center services; and,
c) Use secure, HIPAA compliant technology platforms.

M.7.2.6.9.3. The Government will evaluate the effectiveness of the Offeror's proposed approach for monitoring and continuously improving VVN provider performance, including:

a) How it will measure success using metrics for financial performance, beneficiary experience, and risk-adjusted clinical outcomes using standard industry factors;
b) The integrated systems and processes that will be used to assess VVN provider performance, and comprehensively discover and correct gaps in care, medical errors, and potential quality issues for beneficiaries; and,
c) The mechanisms and processes for delivering continuous feedback to VVN providers to improve care delivery.

M.7.2.6.9.4. The Government will evaluate the effectiveness of the Offeror's proposed approach for engaging and communicating with beneficiaries to drive the use of VVN providers. The Government will evaluate how the Offeror proposes to:

a) Identify and respond to beneficiary educational needs that promote the use of VVN providers; and,
b) Use incentives that are otherwise authorized under the TRICARE Program to encourage beneficiaries to use VVN providers.

M.7.2.6.9.5. RESERVED

M.7.2.6.9.6. The Government will evaluate the Offeror's experience in developing and implementing VVNs. The Government will use the following measures to evaluate an Offeror's experience:

a) Years providing such program and services;
b) Vendor partnerships;
c) Performance measurement and improvement tools;

d) Continuous improvement initiatives; and,
e) Incentive programs.

M.7.2.6.10. RESERVED

M.7.2.6.11. RESERVED

M.8. EVALUATION OF FACTOR 2, PAST PERFORMANCE

M.8.1. The Government will evaluate past performance information, submitted by Offerors in accordance with Section L and obtained through other sources, to determine how well an Offeror and its first-tier subcontractors have performed in the past on recent, relevant work. The Government's past performance evaluation will result in an assessment of each Offeror's probability of meeting the solicitation requirements. The Government will assign one overall performance confidence assessment rating for each proposal.

M.8.2. When assessing the Offeror's performance confidence, the Government will use the Offeror's past performance proposal, past performance questionnaires, and additional information the Government obtains from the Offeror's customers listed in the proposal. The Government may or may not, at its sole discretion, use relevant past performance information from other customers known to the Government, Past Performance Information Retrieval System (PPIRS), Contractor Performance Assessment Reporting System (CPARS), Federal Awardee Performance and Integrity Information System (FAPIIS), Electronic Subcontract Reporting System (eSRS), and other sources of useful and relevant information including the Government's own internal records.

M.8.3. For the purpose of this solicitation, recent past performance means performance under contracts that are currently ongoing or that have concluded within three (3) years of the RFP release date. In assessing a contract's performance period in order to determine if the contract qualifies as "recent," the Government will consider the entire period of performance of the contract to include any transition-in and phase-out periods. The Government will also review and consider the dates of performance found on contract documents, CPARs, and Past Performance Questionnaires signed by customers.

M.8.4. The Government will evaluate recent (M.8.3.) past performance deemed relevant in terms of scope and the magnitude of effort and complexities as it relates to the requirements for this solicitation. Assessment of relevancy will be based on those functions the Contractor or subcontractor will be performing on this solicitation. For example, for the purposes of relevancy, "scope" will only be assessed on claims processing services if that is the only function the subcontractor will be providing. Past performance history deemed "Not Relevant" will not be considered when determining the performance confidence rating.

M.8.4.1. The Government will assign one of the following relevancy ratings to each contract provided by the Offeror as specified in table M.8.4.1.

TABLE M.8.4.1. PAST PERFORMANCE RELEVANCY RATINGS	
Degree	**Description**
VERY RELEVANT (VR)	Past/present performance effort involved essentially the same scope and magnitude of effort and complexities this solicitation requires.
RELEVANT (R)	Past/present performance effort involved similar scope and magnitude of effort and complexities this solicitation requires.
SOMEWHAT RELEVANT (SR)	Past/present performance effort involved some of the scope and magnitude of effort and complexities this solicitation requires.
NOT RELEVANT (NR)	Past/present performance effort involved little or none of the scope and magnitude of effort and complexities this solicitation requires.

M.8.4.2. For the purposes of this solicitation Relevancy of each recent past performance reference will be evaluated by considering Scope, Magnitude and Complexities of the reference in comparison with the requirements of T-5, as identified in Table M.8.4.2.

TABLE M.8.4.2. T-5 SCOPE, MAGNITUDE AND COMPLEXITIES FOR COMPARISON TO PAST PERFORMANCE REFERENCES	
Scope	A Federal program Requires integration with Government health facilities Provides all types of health care
Magnitude	Total health care costs >$5B/year 24 states Network contains 250,000 providers Network contains 6000 facilities 3 million covered lives 25 million claims/year
Complexities	The following tasks are to be performed under T-5 requirements: 1) Establish and maintain provider networks 2) Maintains a provider directory 3) Claims processing 4) Uses value based payment models 5) Provides management of referrals to specialty care 6) Provides Medical Management services 7) Provides Utilization Management services 8) Provides Case Management services 9) Uses Predictive Modeling to manage populations 10) Provides a patient safety program 11) Provides telehealth services 12) Customer service 13) Enrollment functions 14) Transition functions

M.8.5. Quality

M.8.5.1. Once a relevancy rating has been determined, the Government will review all available information to determine the quality of performance for each of the contracts. The Government will identify negative findings noted in Past Performance Questionnaires (PPQ) and allow the Offeror the opportunity to respond to the findings. Lack of performance information (non-return of a PPQ) will not be considered negative performance.

M.8.5.2. In assessing quality of performance, the Government will consider the Offeror's past performance in compliance with clause FAR 52.219-8, Utilization of Small Business Concerns; clause FAR 52.219-9, Small Business Subcontracting Plan.

M.8.6. Performance Confidence Assessment

M.8.6.1. The Government will assess a performance confidence assessment rating relative to the Offeror's ability to successfully perform the requirements of this solicitation through an integrated assessment of the past performance information from M.8.3., M.8.4. and M.8.5.

M.8.6.2. Each Offeror will be assigned one of the performance confidence ratings below as specified in table M.8.5.2.

TABLE M.8.6.2. - PERFORMANCE CONFIDENCE ASSESSMENTS

Rating	Description
SUBSTANTIAL CONFIDENCE	Based on the Offeror's recent/relevant performance, the Government has a high expectation that the Offeror will successfully perform the required effort.
SATISFACTORY CONFIDENCE	Based on the Offeror's recent/relevant performance, the Government has a reasonable expectation that the Offeror will successfully perform the required effort.
NEUTRAL CONFIDENCE	No recent/relevant performance record is available or the Offeror's performance record is so sparse that no meaningful confidence assessment rating can be reasonably assigned.
LIMITED CONFIDENCE	Based on the Offeror's recent/relevant performance, the Government has a low expectation that the Offeror will successfully perform the required effort.
NO CONFIDENCE	Based on the Offeror's recent/relevant performance, the Government has no expectation that the Offeror will be able to successfully perform the required effort.

M.8.6.3. If an Offeror without past performance history submits information from a predecessor company, a parent organization or joint venture member, this information will be considered in rendering a performance confidence rating. The rating will consider the amount of involvement the parent organization or joint venture member will have in the daily operations of the Offeror.

M.8.6.4. If an Offeror does not have past performance relevant to this solicitation, the Government will assess a "Neutral Confidence" performance confidence rating and the Government will not evaluate the Offeror's past performance favorably or unfavorably (see FAR 15.305 (a)(2)(iv).

M.9. EVALUATION OF FACTOR 3, PRICE/COST

M.9.1. Each Offeror's Price/Cost proposal will be evaluated based upon the Government's calculated Total Evaluated Price (TEP). Evaluation of options shall not obligate the Government to exercise such options.

M.9.2. Total Evaluated Price (TEP). For the purpose of determining Best Value, the Government will use the TEP for each Offeror. The TEP will be the sum of all priced CLINs. Earned Performance Incentive and Award Fee will be excluded from the TEP.

M.9.3. The Government will evaluate each Offeror's Total Compensation Plan (TCP) for professional employees (FAR 52.222-46) on an acceptable or unacceptable basis. The Government will consider regional or national compensation and inflation surveys submitted by an Offeror to substantiate the Offeror's proposed TCP. Fringe benefits will be compared to the equivalent of a Federal employee on a qualitative basis (i.e.: defined benefit plan will be considered equivalent to a defined contribution plan). TCP without adequate survey data to substantiate salaries and benefits will be considered unacceptable. An Offeror proposal with an unacceptable TCP will be deemed ineligible for award.

M.9.4. Cost Realism Analysis (Applicable to CLINs 1001, 2001, 3001, 4001, 5001, 6001, 7001, and 8001 Underwritten Healthcare Costs Only).

M.9.4.1. CLINs 1001, 2001, 3001, 4001, 5001, 6001, 7001, and 8001 Underwritten Healthcare Costs.

The Government has provided the reimbursable cost estimates for underwritten healthcare costs. The application of the Offeror's guaranteed network provider discounts will be the only adjustments to CLINs 1001, 2001, 3001, 4001, 5001, 6001, 7001, and 8001. The Government will make the adjustments to all offers according to the Price Evaluation Template, tab entitled Healthcare Cost & Discount. The Offeror's proposed underwriting fixed fee will not be subject to a most probable cost evaluation. It will be included as proposed in the Total Evaluated Price.

M.9.4.2. RESERVED

M.9.5. Extension of Services. In the calculation of TEP, the Government will add 50% of the total proposed price of Option Period 8, excluding transition-out, for the 6-month option to extend services under FAR 52.217-8, Option to Extend Services.

M.9.6. Reasonableness. The Government will evaluate the Offeror's TEP for reasonableness. CLINs/SLINs will also be reviewed for unbalanced pricing in accordance with FAR 15.404-1(g). The Government will not conduct any price realism analysis on the TEP or individual CLINs/SLINs, except for as described under the Underwritten Healthcare Cost CLINs.

M.9.7. Defense Contract Audit Agency (DCAA). DCAA and/or the Defense Health Agency (DHA) will conduct a review of Offerors' and/or subcontractors' healthcare or claims processing cost accounting systems in order to determine if an Offeror's accounting system is adequate for award of a cost reimbursement type contract in accordance with the Contracting Officer's responsibility determination.

M.10. EVALUATION OF FACTOR 4, SMALL BUSINESS PARTICIPATION

M.10.1. The Government will evaluate the subcontracting plan and participation of small businesses on an acceptable/non-acceptable basis. Acceptable – Proposal clearly meets the minimum requirements of the solicitation (Strengths are not assessed for this evaluation). Unacceptable – Proposal does not clearly meet the minimum requirements of the solicitation. The Contracting Officer (CO) will evaluate the subcontracting plan submitted under Volume I for compliance with Section L.5.2.

M.10.2. The Government will assess how the Offeror's proposed subcontracting goals compare with the following subcontracting goals. The Government will assess the extent the Offeror identifies businesses in the Plan and demonstrated good faith efforts or plans to meet the below goals using small business, veteran-owned small business, service-disabled veteran-owned small business, HUBZone small business, small disadvantaged business (which includes historically black colleges, Alaska Native Corporations (ANCs), Indian Tribes and minority institutions in its goal), and women-owned small business subcontractors to the maximum practicable.

The Subcontracting goals are as follows:

- Small Business Subcontracting: 25%

    - Women-Owned Small Businesses (WOSB): 5%
    - Small Disadvantaged Businesses (SDB): 5%
    - Veteran-Owned Small Business (VOSB): 3%
    - Service-Disabled Veteran-Owned Small Businesses (SDVOSB): 3%
    - Historically Underutilized Business Zone (HUBZone) SBs: 3%
    - The AbilityOne Program (National Industry for the Blind/SourceAmerica): 1%

M.11. Financial Viability. As part of the CO's responsibility determination (FAR 9.1), the CO will evaluate the Offeror's financial viability to ensure the Offeror has adequate financial resources to perform the prospective contract or demonstrates an ability to obtain adequate financial resources. If an Offeror fails to submit the required financial information, the CO may make a determination the Offeror is not responsible and thus ineligible for award.

(End of Section)