PERFORMANCE WORK STATEMENT
(Includes associated Performance Requirements Summary (PRS))

In support of Defense Health Network Indo-Pacific MTFs supported by the Pacific/Hawaii Integrated Referral Management and Appointing Center (P/HIRMAC) delivering Patient Appointing Services (PAS), Referral Management Services (RMS) and Clear and Legible Reporting Services (CLR).

1. GENERAL:

1.1. The contractor shall provide centralized Patient Appointing Services (PAS), Referral Management Services (RMS), and Clear and Legible Report accountability Services (CLR) for Defense Health Network Indo-Pacific Military Treatment Facilities (MTF). Operational principles, practices, policies and performance will be in accordance with current Defense Health Agency (DHA) directives, guidelines, policies and standard business rules applying to appointing, referral management, and CLR services.

1.1.1. Patient Appointing Services (PAS), Referral Management Services (RMS), and Clear and Legible Report Services (CLR) will be provided to MTF TRICARE enrolled and empaneled beneficiaries, and selective Veterans Administration (VA) eligible beneficiaries within the Defense Health Network Indo-Pacific (DHN-IP). This contract supports all the Defense Health Network Indo-Pacific to include; Oahu-based medical and dental organizations to include; Tripler Army Medical Center (TAMC), Schofield Barracks (Desmond Doss) Health Clinic, 15th Medical Group (MEDGRP) Joint Base Pearl Harbor-Hickam, Naval Health Clinic (NHC) Hawaii Pearl Harbor, Branch Medical Clinic (BMC) Marine Corps Air Station (MCAS) Kaneohe Bay, Branch Medical Clinic (BMC) NSY Pearl Harbor, Wheeler Field Aviation Clinic, Naval Branch Health Clinic (NBHC) NAVCAMS EASTPAC, Naval Branch Health Clinic (NBHC) Marine Corps Base (MCB) Camp Smith and Community Based Medical Home (CBMH) Warrior Ohana, 5th MDG Dental Clinic, JBPHH; Makalapa Dental Clinic; JBPHH; Camp Smith Dental Clinic; Camp Smith; Wahiawa Dental Clinic; NCTAMS Wahiawa; Kaneohe Bay Dental Clinic, Marine Base Kaneohe; Scofield Barracks Dental Clinic, Schofield Barracks; Na Koa Dental Clinic, Schofield Barracks; TAMC Dental Clinic, Tripler AMC; Bhaskar Dental Clinic, Fort Shafter. This contract supports all Puget Sound MTFs within the Defense Health Network Indo-Pacific to include; Madigan Army Medical Center (MAMC), Naval Health Clinic Bremerton (NHCB), Naval Health Clinic Oak Harbor (NHCOH), the 62nd Medical Squadron, Presidio of Monterey California Medical Detachment (CALMED), all MTF subordinate activities, Fulton Dental Clinic, Lefler Dental Clinic, McClung Dental Clinic, Madigan Dental Clinic, McChord Dental Clinic, Okubo Dental Clinic, Naval Base Kitsap-Bremerton Dental Clinic, Naval Station Everett Dental Clinic, Oak Harbor Dental Clinic, and Presidio of Monterey Dental Clinic.

1.1.2.

1.2. BACKGROUND:

1.2.1. The Puget Sound enhanced Multi-Service Network (eMSM) was established IAW the Deputy Secretary of Defense (DepSecDef) memorandum dated 11 March 2013 with the mission to optimize utilization of MTF direct care resources, improve beneficiary access to care, enhance beneficiary satisfaction, and improve military readiness.

1.2.2. The Defense Health Agency released DHA Interim Procedures Memorandum Procedures, Hours of Operation, Productivity, Performance Measures and Appointing Types in Primary, Specialty and Behavioral Health Care in Medical Treatment Facilities (MTFs)" dated 4 February 2020, mandating the establishment of Integrated Referral Management and Appointing Centers (IRMACs). The directive to IRMACs included standardized business processes and practices, as well as performance management and reporting.

1.2.3. DHA operates and directs healthcare delivery services worldwide for TRICARE beneficiaries. The Defense Health Agency established Defense Health Networks to integrate operations of DHA Medical Treatment Facilities under a unified command structure in order to achieve economies of scale while enhancing delivery of medical services to TRICARE beneficiaries.

1.2.4. The overarching objective of this contract is to support the Defense Health Network Indo-Pacific (DHN-IP) MTFs in their mission to deliver quality, timely services to TRICARE beneficiaries. This contract will support the mission of eliminating unwarranted variation in patient appointing, referral management and CLR services in order to increase MTF capacity while providing the highest standards of patient service delivery and satisfaction.

1.2.5. The Pacific/Hawaii Integrated Referral Management and Appointing Center (P/HIRMAC) is co-located and at a common operations site that serves as the primary source for patient appointing, referral management and CLR services serving PIRMAC and HIRMAC beneficiaries. The operational intent of the P/HIRMAC is to serve as the patient's primary point of contact for appointing, referral and CLR services. The contractor will operate a call center that manages inbound and outbound calls from beneficiaries, validates beneficiary eligibility, schedules, cancels, and reschedules patient appointments in order to provide timely access to quality healthcare. Furthermore, this service will provide outbound calls in order to schedule specialty appointments for beneficiaries who have received a direct care specialty referral. The contractor will record each beneficiary call with the contractor-supplied computers that interface with the standardized Military Healthcare System (MHS) GENESIS electronic health record appointing and referral management system. Calls will be documented in MHS GENESIS using the most current DHA and DHN-IP policies. Additional services include processing appointment requests via the MHSG Patient Portal, as well as outbound calls for patient care cancellations and rescheduling. The contractor shall also generate outbound notification letters to beneficiaries referred to direct care specialty clinics.

1.2.6. The contractor shall execute referral management functions, in compliance with DHA and DHN-IP referral management standardized business processes, in order to deliver timely dispositioning of MTF generated specialty referrals. Referral management services are

designed to optimally support the delivery of specialty care services within access standards and facilitate the appointing of patients within the direct and/or the private sector care network of providers.

1.2.7. The Contractor shall provide CLR accountability services for MTF enrolled patients referred to the Managed Care Support Contractor (MCSC) civilian provider network. These time-sensitive services are necessary in order to ensure that the documentation of care delivered in the civilian network is retrieved and documented in the patient's permanent military healthcare record. These CLR include direct communication and coordination with civilian network provider offices in order to retrieve all documentation of healthcare services rendered and complete the communication cycle to the referring MTF health care provider.

1.2.8. The DHN-IP Healthcare Operations (HCO) Directorate coordinates and exercises operational oversight of contractor delivered services in support of the PIRMAC and HIRMAC direct care healthcare delivery system MTFs.

1.3. SCOPE OF WORK: The contracted services include delivering centralized PAS, RMS, and CLR to DHN-IP beneficiaries

1.3.1. Appointing services span a range of functions to include, but not limited to; verifying beneficiary eligibility via the Defense Enrollment Eligibility Reporting System (DEERS) system, updating patient demographic information, and scheduling beneficiary requests for MTF primary or specialty care appointments, as well as completing requests for cancellations and appointment rescheduling. The work includes completing outbound calls to facilitate the timely scheduling of appointments. With the expansion of integrated specialty service lines at sister MTFs, appointing agents will serve an important role in scheduling and coordinating appointments with other PIRMAC and HIRMAC MTFs in order to meet beneficiary health care needs within TRICARE access standards.

1.3.2. Referral processing supports the timely scheduling of specialty care referrals ordered by MTF providers. Referral services span a range of functions to include, but not limited to: identifications of specialty referrals to be deferred to the network, ensuring processing in accordance with DHA timeliness. To achieve DHA quality standards for access to specialty care, the processing of these referrals is highly time sensitive. The contractor's role includes a review of each MTF generated referral and determining a disposition as either "Appoint to MTF" or "Defer to Network (DTN)" based on specific MTF specialty clinic capabilities, capacities, and DHA access to care standards. The contractor likewise plays an important role in supporting force generation and Graduate Medical Education (GME) programs by maximizing the retention of complex specialty care within the MTFs to strengthen Military Services readiness within capability and capacity parameters.

1.3.3. Clear and Legible Report accountability is an essential component of the quality care continuum. Clear and Legible Report services span a range of functions to include, but not limited to: monitoring care delivered in the MCSC network and ensuring the return of clinical

care documentation to the MTF in accordance with DHA timeliness standards. MTF enrolled beneficiaries who are referred to civilian network care due to limitations in MTF specialty capability and/or capacity return to their MTF referring provider for care management. The referring MTF provider is reliant on the conclusions and recommendations documented in the CLR. The CLR ensures the retrieval of health care records from the civilian provider and the delivery of those documents to the beneficiaries' medical record. The contracted services includes the upload of network care (CLR) results into the electronic health record as well as conducting outbound calls and faxes in order to provide full accounting for network care results based on appointment and network claims data.

1.4. PHASE-IN/PHASE-OUT:

1.4.1. This contract includes a phase-in period to provide the contractor time to perform all tasks required to ensure complete preparation for successful performance at the start of contract operations. The required tasks during the phase-in period includes, but is not limited to, recruiting and training personnel, obtaining security clearances, submitting copies of credentials, determining and meeting training requirements, developing work plans and procedures, submitting performance report formats, and finalizing quality control plans and procedures.

1.4.2. PHASE-IN:

The contractor shall: (see Exhibit I – P/HIRMAC Transition Milestone Chart)

1.4.2.1. Ensure a smooth transition from the incumbent contractor to the follow-on contractor.

1.4.2.2. Become thoroughly familiar with work requirements and work procedures.

1.4.2.3. Complete personnel requirements including the hiring of personnel to ensure satisfactory performance beginning on the contract start date.

1.4.2.4. Obtain security clearances, as required

1.4.2.5. Complete training requirements and accomplish necessary training of contractor employees.

1.4.2.6. Complete the development of necessary work plans and procedures.

1.4.2.7. Demonstrate readiness to successfully perform required services on the contract start date.

1.4.2.8. Ensure performance requirement reporting data elements and formats are approved The contractor shall: (see Exhibit I – P/HIRMAC Transition Milestone Chart)

1.4.3. PHASE-OUT:

The contractor shall:

1.4.3.1. Cooperate fully to the extent required to permit an effective, orderly, and successful transition that will maintain mission continuity. This may include a collective weekly discussion between the incumbent contractor, follow-on contractor, and the KO on the status of the phase-out. All official files, manuals, charts, records, drawings, and other official documentation are the property of the Government and shall remain on location for use by the Government or follow-on contractor at the time of contract expiration. Reference FAR clause 52.237-3, Continuity of Service.

1.4.3.2. Reserved

1.4.3.3. Within seven working days following completion/termination of the contract, the contractor shall return all CACs issued to their personnel to the issuing office or the location specified by local policy/directives. Failure to comply with this requirement may result in withholding of final payment.

1.4.3.4. Within seven working days prior to the last day of the contract, a joint assessment shall be conducted with the COR of the status of all transition tasks.

1.5. SAFETY REQUIREMENTS. The contractor shall ensure PAS, RMS, and CLR agents maintain safety and health standards compliant with the requirements of the Occupational Safety and Health Administration (OSHA).

1.6. SECURITY REQUIREMENTS

1.6.1. Background Investigations. The contractor shall achieve the same level of trustworthiness for PAS, RMS, and CLR agents as required for government personnel with similar access to automated information systems (AISs) and networks containing Department of Defense (DoD) Sensitive Information (SI). The contractor shall meet the personnel security requirements for Automated Data Processing (ADP) access in DoDI 5200.02, DoD Personnel Security Program (PSP), for employees and subcontractor employees that require access to government IT systems or DoD SI, or are involved in developing, delivering, or supporting Information Technology (IT) systems and services, or safeguarding DoD SI within government or contractor systems. The contractor shall classify ADP/IT or related positions, submit appropriate paperwork for background investigations or proof of a favorable adjudication, ensure individuals receive requisite training, and document compliance. The contractor must complete a personnel background investigation and training before accessing the DoD AIS/networks or DoD SI. Details/discussions for completing and forwarding forms for requesting an investigation

will take place within seven calendar days after award of contract with the government IT Security Officer for the networks and systems being accessed.

1.6.1.1. The contractor shall comply with the most current version of all government privacy and security regulations and directives identified in Paragraph 6, Documentation, and other applicable DoD Service privacy and security instructions and regulations. In addition, the contractor shall comply with the most current version of all relevant rules and regulations that implement the applicable requirements of the Health Insurance Portability and Accountability Act (HIPAA) of 1996. This shall include the regulations at Parts 160 and 164 of title 45, Code of Federal Regulations, TRICARE Operations Manual 6010.51-M, August 1, 2002, Chapter 21, Section 3; DoD Health Information Privacy Regulation (DoD 6025.18-R); Privacy of Individually Identifiable Health Information in DoD Health Care Programs (DoDI 6025.18); the Privacy Act; and DoD Privacy Program (DoD 5400.11-R). Additions supplements, amendments, or changes to these publications may be issued during the life of the contract. Changes to mandatory publications which cause a change in performance that will increase or decrease price will be incorporated into the contract by mutual agreement of the parties

1.6.2. Use of Protected Health Information (PHI). The contractor shall use PHI for their designated project. The contractor shall not use the PHI to create databases or any other product not intended for use specifically for this requirement. The contractor shall destroy all PHI related to the requirement, that is not delivered to the government at the conclusion of the tasking. All hard drives containing unclassified data outside of DOD shall be removed and destroyed through sanitation of SI from storage media in a manner that gives assurance that the information is unrecoverable by technical means. Destruction of hard drives shall comply with National Institute of Standards and Technology (NIST) Special Publication 800-88, Revision 1, regarding destruction of computer hard drives prior to disposal.

1.6.2.1. Personally Identifiable Information (PII)/PHI that is processed and printed out on government or contractor Information Systems (ISs) and networks is considered SI and will be treated as “For Official Use Only” (FOUO) information, as directed by DoDD 5400.7, “DoD Freedom of Information Act Program.” . Any SI, e.g., PHI and privacy data, processed, printed, stored, or manipulated on government or contractor ISs and networks will be protected, marked, and labeled IAW DoD 5200.1-R.

1.6.2.2. The contractor shall maintain, transmit, retain in strictest confidence, and prevent the unauthorized duplication, use, and disclosure of PHI IAW the regulations at Parts 160 and 164 of title 45, Code of Federal Regulations, DoD Health Information Privacy Regulation (DoD 6025.18-R), the Privacy Act, and DoD Privacy Program (DoD 5400.11-R). The contractor shall ensure that beneficiary information is only accessible to employees, contractors, subcontractors, and government personnel having a need to know such information in the performance of their duties for this requirement.

1.6.3. The Risk Management Framework (RMF) is the standardized approach to the Assessment and Authorization (A&A) process within DoD. Each IS/network that undergoes RMF will have security controls implemented as defined in the NIST 800-53, must have

documented the security components and operation of the Information System (IS)/network, and must successfully complete testing of the required security controls. The contractor shall ensure RMF documentation and artifacts are available for review and are accurate. Each contractor IS/network must also comply with the requirements for Information Assurance Vulnerability Management (IAVM) to ensure that the security posture is maintained. Guidance regarding the requirement for IAVM can be found in the DoD Information Assurance Vulnerability Alert (IAVA), 30 Dec 1999. The contractor shall execute the RMF process by providing, for receipt by the KO within 30 calendar days following contract award, the required documentation necessary to receive an Authorization to Operate (ATO) and making their IS(s)/networks available for testing. The contractor shall mitigate the vulnerabilities identified for correction during the risk assessment process. These requirements shall be met before allowing authorized access when interconnecting with any DoD information system or network. System access is required to train new staff. The contractor shall meet these requirements within the first 30 calendar days of the transition.

1.6.3.1. IS/Networks Physical Security. The contractor shall employ physical security safeguards for IS/Networks involved in the operation/use of a centralized appointment system to prevent the unauthorized access, disclosure, modification, destruction, use, etc., of SI and to otherwise protect the confidentiality and ensure the authorized use of SI. In addition, the contractor shall support a Physical Security Audit performed by either the government or the contractor regarding the contractor's internal information management infrastructure using the criteria from Exhibit A - Physical Security Audit Matrix. The contractor shall correct any deficiencies identified by the audit within RMF requirements.

1.6.4. Government Information. All inquiries, comments or complaints arising from any matter observed, experienced, or learned of as a result of or in connection with the performance of this contract, the resolution of which may require the dissemination of official information, report to the COR and the KO.

1.6.4.1. Documents received from external sources requesting additional information beyond the access and ability of the contractor will be forwarded/routed to the COR for routing determination

1.6.4.2. United States Government (USG) records, copies of original results and reports, verified original data, corrected data and supporting final reports are maintained by the contractor, but remain the property of the USG. The COR will gain possession of files/results upon request or completion of the contract.

1.6.4.3. The contractor shall only conduct business with designated government personnel listed as points of contact (POCs). Names of authorized personnel shall be provided to the contractor by the COR, in writing, and updated as necessary throughout the contract.

1.6.5. TRUSTED ASSOCIATE SPONSORSHIP SYSTEM (TASS):

1.6.5.1. The contractor shall comply with agency personal identity verification procedures that implement Homeland Security Presidential Directive-12 (HSPD-12), Office of Management and Budget (OMB) guidance M-05-24, and Federal Information Processing Standards Publication (FIPS PUB) Number 201

1.6.5.2. The contractor shall comply with agency personal identity verification procedures in all subcontracts when the subcontractor is required to have physical access to a federally controlled facility or access to a Federal information system

1.6.5.3. The contractor shall ensure compliance with the provisions set forth below. For purposes of Federal Acquisition Regulation (FAR) 52.204-9, the government will designate a Trusted Agent (TA) for this contract. The government reserves the right to amend or supplement these provisions pursuant to the changes clause in the contract

1.6.5.4. The contractor is responsible for absences of PAS, RMS, and CLR agents due to expired identification and access documents. Such absences shall not relieve the contractor of its obligation to perform the services required under this contract.

1.6.5.5. The government will sponsor the PAS, RMS, and CLR agents for an Army Knowledge Online (AKO) account. All PAS, RMS, and CLR agents email addresses will identify them as a contractor and use the format firstname.lastname.ctr@health.mil. The government will discontinue AKO accounts when the PAS, RMS, and CLR agents no longer require access

1.6.5.6. The Government TA will send a notice through TASS to the AKO e-mail address provided IAW the above requirement. The PAS, RMS, and CLR agents' user ID and password will be provided in the email and shall require a change at first login. In the event the e-mail message is not received, the contractor may request the username and password from the TA and proceed to the website https://www.dmdc.osd.mil/tass to complete the process.

1.6.5.7. The PAS, RMS, and CLR agents shall log into TASS and complete the verification process by submitting the application to the TA for approval.

1.6.5.8. The application will be accepted, returned, or rejected by the TA. Notice as to whether the application has been accepted, returned, or rejected will be provided to the individual's e-mail address within 48 hours after submission. If the application is returned or rejected, the PAS, RMS, and CLR agents shall contact the TA and comply with the TA's guidance to attempt to correct and resolve the issues.

1.6.5.9. Upon approval of the application, the PAS, RMS, and CLR agents shall receive an e-mail sent to the address provided stating the Common Access Card (CAC) application was approved. The applicant must then go to a Real-Time Automated Personnel Identification System (RAPIDS) Issuing Facility to have the government credential issued. The PAS, RMS, and CLR agents must present two acceptable forms of ID, which may include Driver's License, Military ID, Contractor Company ID with picture and expiration date, charge card with picture imprinted, or passport.

1.6.5.10. Revalidation Requirements. The TA is required to revalidate all PAS, RMS, and CLR agents through TASS every 180 days. In the event revalidation is denied, the CAC credentials shall be revoked and the CAC will not be usable to login

1.6.5.11. Out-processing Requirements. When a PAS, RMS, and/or CLR agent's performance under this contract ceases, each agents shall personally bring the CAC to the TA and complete the Department of the Army (DA) Form 2962. The TA will revoke the CAC from TASS

1.6.5.12. The PAS, RMS, and/or CLR agents shall immediately report any lost or stolen badges to the COR within 24 hours or the next business day.

1.7. QUALITY CONTROL (QC). The contractor is responsible for quality control of all services provided. The contractor shall establish and maintain a complete Quality Control Plan (QCP) that shall ensure the requirements of the contract are provided as specified in this PWS. The contractor shall provide copies of the QCP to the KO and COR no later than 30 calendar days after contract award, and within five calendar days when changes are made thereafter.

1.8. QUALITY ASSURANCE (QA). The government is responsible for quality assurance and shall evaluate the contractor's performance under this contract IAW the Quality Assurance Surveillance Plan (QASP). The QASP is the government's internal plan for performing QA, and as such does not become part of the resultant contract.

1.9. PERSONNEL:

1.9.1. PAS, RMS, and CLR Center Management: The contractor shall provide on-site operations management to conduct the day-to-day management tasks of the call center.

1.9.2. Government Meetings. The contractor shall ensure on-site management attends, at a minimum, weekly meetings which may be conducted via teleconference or face-to-face (F2F) with the Network Operations Management team. The contractor shall attend F2F monthly meetings with each MTF and respective staff in each of the functional areas to include: PAS, RMS, and CLR and other meetings requested by the COR in order to support operational requirements. The contractor shall be prepared to travel to the various MTFs in order to interface with the MTF and clinic leaders whom they support.

1.9.3. The contractor shall ensure all staff are familiar with basic medical terminology and Microsoft Office products used with the beneficiary a PAS, RMS, and CLR processes and understand business rules addressing beneficiary category access to the direct care and network systems. The contractor shall ensure that PAS, RMS, and CLR agents possess a functional knowledge of the TRICARE Healthcare Program and are familiar with the terminology and inter-relationships of the ATC categories, appointment types, referral processes, detail codes, provider specialties, and ATC standards. The PAS, RMS, and CLR agents shall receive annual refresher training in these areas, as well as stay abreast with

TRICARE Program changes. The contractor shall provide proof of refresher training to the COR annually.

1.9.4. The contractor shall ensure PAS, RMS, and CLR agents possess appropriate customer service skills (telephone courtesy).

1.10. SEXUAL HARASSMENT/ASSAULT RESPONSE AND PREVENTION (SAPR-).

1.10.1. The contractor shall comply with OTSG/MEDCOM Policy Memo 19-019, Sexual Harassment/Assault Response and Prevention Program, 21 March 2019, or superseding DHA or DOD policy once issued and provided to the contractor. The SAPR- reporting requirements apply only to knowledge obtained by contractor personnel while performing services under this contract.

1.10.2. Contractor Reporting of Sexual Assault and Sexual Harassment Incidents under the SAPR- Program. The contractor shall require all personnel with knowledge of an incident of sexual assault occurring on a Government facility, to include a Government leased facility, where the contractor is providing services under this contract, to report the incident to the contractor who shall immediately (within 24 hours of gaining knowledge of the incident) report the incident in writing to the government's COR. This reporting policy also applies to sexual assault incidents involving DoD personnel that occur on the contractor's owned or leased facility under this contract. All incidents shall be reported whether they involve contractor personnel or Government personnel, or other individuals, when the incidents occur on a Government facility, or a Government leased facility

1.11. Hours of Performance. The contractor shall provide PAS/RMS and CLR services from Monday through Friday excluding federal holidays.

1.11.1. HIRMAC PAS hours of operation are from 6:00 a.m. to 6:00 p.m. Hawaii Aleutian Standard Time (HST)
1.11.2. PIRMAC PAS hours of operation are from 6:00 a.am. to 6:00 p.m. Pacific Standard Time (PST)

1.11.3. The Contractor may utilize telework as necessary to ensure continuing operations for contingencies including, but not limited to, inclement weather and pandemic such as COVID-19.

2. DEFINITIONS/ACRONYMS:

2.1. DEFINITIONS: The following is a list of basic definitions:

2.1.1. Appointment Error. Appointing Errors occur when: (1) a beneficiary is given the wrong appointment type for the level and type of care needed, (2) the appointing agent does not correctly complete the data elements, (3) the beneficiary is sent to the wrong location or the wrong provider, or (4) any other booking error that results in inconvenience to the beneficiary,

disruption of clinic effectiveness/efficiency, and failure to appropriately match TRICARE Prime beneficiaries to appointment slots reserved for Prime. Feedback regarding incorrectly scheduled appointments may be collected from beneficiaries, providers, clinic support staff, booking clerks, and appointment supervisors.

2.1.2. Appointing Agent. Individual who will schedule an appointment.

2.1.3. Average Speed of Answer. This is the cumulative total length of time of calls that are in queue or that are ringing before being answered by an Agent, divided by the total numbers of calls answered (measured in seconds). Calls must be answered by the Contractor by the 3rd ring.

2.1.4. Call "Blockage rate". Those calls that cannot be completed by the caller due to the call capacity of the telephone switch (i.e., all telephone lines are busy).

2.1.5. Call “Abandonment rate”: The number of callers whose calls were received by the telephone switch/ARU/ACD, but who disconnected (i.e., hung up before reaching an appointing clerk/scheduler) at any time during the entire call transaction.

2.1.6. Call “hold” Time. The total time the beneficiary is placed on hold or in queue by the telephone system or the contractor staff during the call. This includes the initial wait time and any subsequent times the beneficiary is placed on hold/in queue by the telephone system, appointment clerk/scheduler, or other contractor staff. This information shall be provided in 15-minute increments.

2.1.7. Call Processing Time. The total length of call to include call-waiting time, hold time, and talk time.

2.1.8. Centralized Patient Appointing Services. Appointing services span a range of functions to include, but not limited to,; verifying beneficiary eligibility via the Defense Enrollment Eligibility Reporting System (DEERS) system, updating patient demographic information, and scheduling beneficiary requests for MTF primary or specialty care do appointments, as well as completing requests for cancellations and appointment rescheduling. Contractor appointing staff working physically and functionally within a single call center located outside a federal installation in support of the DHN-IP located in the Defense Health Network Indo-Pacific, not to exceed 25 miles from a military facility.

2.1.9. Clear and Legible Report accountability services. CLR services span a range of functions to include but not limited to: monitoring care delivered in the MCSC network and ensuring the return of clinical care documentation to the MTF in accordance with DHA timeliness standards. CLR includes the receipt of documentation of medical services provided by network providers/facilities following a valid referral generated by an MTF provider.

2.1.10. CLR error. A CLR error occurs when (1) a report is sent to the incorrect provider or attached to an incorrect patient’s medical record, (2) a referral is incorrectly closed before or

after receiving reports from network providers, or (3) reports are uploaded that do not qualify as CLR.

2.1.11. Contracting Officer. A government employee having the authority vested by a Contracting Officer's Certificate of Appointment to execute, administer, and terminate contracts and orders, and modifications thereto, which obligate government funds and commit the government to contractual terms and conditions.

2.1.12. Contracting Officer's Representative (COR). An individual designated and authorized in writing by the contracting officer to perform specific technical or administrative functions. Only an employee of the USG may be appointed as a COR. A COR does NOT have authority to change any terms or conditions of the contract.

2.1.13. Direct Care. The DoD's system of Military Treatment Facilities that provides care to MHS authorized beneficiaries.

2.1.14. Drive-time standards. A specialty care drive time standard is the distance between a beneficiary's home address and the servicing MTF as defined by DHA and Network business rules. There are separate and distinct drive time standards for primary care, specialty care and out of area care.

2.1.15. Eligible Beneficiary. Eligible beneficiaries include TRICARE eligible beneficiaries, as well as Veterans Administration and/or civilians under special, previously authorized conditions.

2.1.16. Defense Health Network. A DHA designated Military Healthcare System comprised of MTFs. These treatment facilities collaborate to establish an integrated healthcare delivery system that supports high quality, timely access to care while serving to improve the readiness of the Force.

2.1.17. Enrolled Beneficiary. An MHS eligible beneficiary registered in the Defense Enrollment Eligibility Reporting System (DEERS) and who is enrolled in a TRICARE plan, including Active Duty Service members.

2.1.18. First Call Resolution (FCR). This is the total numbers of calls that were completely resolved during the course of the first inbound call initiated by the beneficiary.

2.1.19. IVR Average Response Time. The average amount of time, rounded to the nearest minute, it takes for an agent to answer a patient's call after the patient has finished listening to the voicemail and selected their desired phone menu option.

2.1.20. MHS GENESIS. A DoD electronic healthcare record system that is used exclusively in the DHA-IP. MHS GENESIS provides an integrated system for appointment scheduling, referral management functions as well as the management of patient care.

2.1.21. Managed Care Support Contractor (MCSC). Government contractors supporting the DoD TRICARE program. These contractors establish civilian provider networks that augment and support the capability and capacity of the Military Healthcare System. They are designed to operate seamlessly in support of TRICARE beneficiary healthcare.

2.1.22. Military Health System (MHS). The Military Health System incorporates all aspects of health services for the Department of Defense and its beneficiaries

2.1.23. Military Health System (MHS) Beneficiary. Any TRICARE eligible individual who is eligible to receive treatment in a Military Treatment Facility. Eligibility may be expanded to include Veterans Administration and/or civilians IAW DoD/DHA business rules

2.1.24. Military Treatment Facility (MTF). A military hospital or clinic.

2.1.25. Referral Management Services. RMS services span a range of functions to include but not limited to; identifications of specialty referrals to be deferred to the network, ensuring processing in accordance with DHA timeliness, and tracking status of network referrals. Contractor referral management staff will be collocated with PAS and CLR staff.

2.1.26. Secure Messaging System (SMS). A system that allows beneficiaries to communicate with their primary provider and healthcare team in order to ask for advice, receive test results, request prescription renewals, schedule appointments, or access health information resources for education and self-treatment

2.1.27. Unmet Demand. Unmet demand includes patient demand for care that could not be met within DHA Access to Care standards in the MTF from patients who tried to access the system but failed, including those who were not given an appointment and leaked to network specialty and behavioral health care.

2.1.28. Warm transfer. Person to person transfer of caller to an MTF clinic. Contractor stays with the caller a minimum of 45 seconds or until a successful hand off has concluded.'

2.2. ACRONYMS. The following is a list of acronyms found in this PWS:

2.2.1.

A&A	Assessment and Authorization
ACD	Automated Call Distribution
ASP	Appointment Standardization Phase III
ATC	Access to Care
ATO	Approval to Operate
C&A	Certification and Accreditation
CAC	Common Access Card

CIS	Contractor Interface System
COE	Common Operating Environment
CFR	Code of Federal Regulations
CLR	Clear and Legible Reporting
COR	Contracting Officer's Representative
DEERS	Defense Enrollment Eligibility Reporting Systems
DEPSECDEF	Deputy Secretary of Defense
DHA	Defense Health Agency
DHN-IP	Defense Health Network Indo-Pacific
DII	Defense Information Infrastructure
DISA	Defense Systems Information Agency
DoD	Department of Defense
DoDI	Department of Defense Instruction
DTN	Defer to Network
F2F	Face-to-face
FAR	Federal Acquisition Regulation
FIPS PUB	Federal Information Processing Standards Publication
FOUO	For Official Use Only
FTE	Full-time equivalent
HEDIS	Healthcare Effectiveness Data and Information Set
HIPAA	Health Insurance Portability and Accountability Act
HIRMAC	Hawaii Integrated Referral Management and Appointing Center
HSPD-12	Homeland Security Presidential Directive-12
IAVA	Information Assurance Vulnerability Alert
IAVM	Information Assurance Vulnerability Management
IAW	In Accordance With
IM	Information Management
IRMAC	Integrated Referral Management and Appointing Center
IS	Information Systems
IVR	Interactive Voice Response

IT	Information Technology
KO	Contracting Officer
MCSC	Managed Care Support Contractor
MTF	Military Treatment Facilities
MHS	Military Health System
NHB	Naval Hospital Bremerton
NHCOH	Navy Health Clinic, Health Clinic Oak Harbor
NIPRnet	Non-secure Internet Protocol Router Network
NIST	National Institute of Standards and Technology
OMB	Office of Management and Budget
OSHA	Occupational Safety and Health Administration
PIRMAC	Pacific Integrated Referral Management and Appointing Center
PAS	Patient Appointment Services
PCM	Primary Care Manager
PHI	Protected Health Information
PII	Personally Identifiable Information
PKI	Public Key Infrastructure
POC	Point of contact
PSP	Personnel Security Program
PWS	Performance Work Statement
QA	Quality Assurance
QC	Quality Control
QCP	Quality Control Plan
RAPIDS	Real-Time Automated Personnel Identification System
RM	Referral Management
RMC	Referral Management Center
RMF	Risk Management Framework
SAPR-	Sexual Assault Response and Assault Program
SI	Sensitive Information
SMS	Secure Messaging System

TA	Trusted Agent
TASS	Trusted Associate Sponsorship System
UCC	Urgent Care Center
USG	United States Government
VA	Veterans Administration

3. GOVERNMENT FURNISHED ITEMS AND SERVICES:

3.1. TRAINING:

3.1.1. The government will be responsible for furnishing the trainers, the training rooms, equipment, and materials required for the training. The government will provide initial and sustainment training (e.g., MHS GENESIS updates) on MHS GENESIS PAS, RMS, and CLR modules as required. The government will provide a MHS GENESIS training plan IAW the appointing, referral, and CLR processes of MHS GENESIS. The government will provide initial training on MHS GENESIS during phase-in. Using the government developed training plan and a government owned training database, the government will provide “train the trainer” MHS GENESIS training for up to 10 contractor personnel.

3.1.1.1. The government will be responsible for making any changes to the government’s training plan as updates and/or revisions are made to MHS GENESIS and will provide inputs to the contractor so that they can update their training system and of their MHS GENESIS Training Course(s) curriculum.

3.1.2. Defense Health Network Specific Business Procedures. The government will provide the contractor with network specific business procedures for PAS, RMS, and CLR five working days after contract award. If procedures change throughout the life of the contract, the government will provide the contractor with updates.

3.2. Government Unique Training. The government will provide any mandatory training which is offered through government sources to the contractor’s agents who are performing services under this contract. The DHN-IP may elect to provide Network unique training to PAS, RMS, and CLR agents to enhance or improve services offered under this contract. The DHN-IP Office will provide such training at no additional expense to the contractor. When directed by the COR, PAS, RMS, and CLR agents shall attend all such training in a paid status as part of the normal services required and billed under the contract. Such training shall require a performance commitment by the contractor and the contractor shall reimburse the government (by means of a reduction in an invoice) if an PAS, RMS, and CLR agent fails to satisfy the performance commitment after the PAS, RMS, and CLR agent receives the government unique training. The amount of the reimbursement shall be the prorated cost of training, calculated based on the total cost of the training and the number of months by which the appointing, referral management or CLR agent fails to complete the performance commitment. The length of the

performance commitment shall be 12 months or until the end of all performance under this contract, whichever occurs first.

3.3. The DHN-IP, IAW DHA directives, will standardize similar or like clinical appointing criteria across the Network, to include disease management, population health, primary care medical home, and/or similar MTF services. The MTFs will work jointly within the DHN-IP to establish processes and deliverables, requirements, and information exchange for preventive, wellness and HEDIS appointing/ordering standardized criteria.

3.3.1. The Appointing, CLR and Referral Protocol/Business Rules Business rules will be provided electronically by the DHN-IP COR, upon request. Revisions to the appointing and referral criteria/business rules will be made to support the DHN-IP beneficiary appointing process.

4. CONTRACTOR FURNISHED EQUIPMENT AND RESPONSIBILITIES:

4.1. The contractor shall provide all required equipment and dedicated toll free access to interface with government telephony, to include the Automated Call Distribution (ACD) system. The contractor shall provide/support a toll- free number. The contractor will only use government-furnished computers for initial registration of the Common Access Card (CAC) (reference paragraph 4.2.1).

4.1.1. The contractor shall retain the current 1-800 telephone number to minimize distribution to the beneficiaries. The contractor shall provide sufficient capacity to support peak call volume to ensure the contractor meets telephone performance standards.

4.2. The contractor shall identify the connectivity configuration between the contractor and government, to include use of DoD LAN, NIPRNet, B2B, or Point-to-Point circuit, Internet connectivity.

4.2.1. The contractor will complete the following tasks to gain access to MHS GENESIS: complete background check paperwork (PSIP) online; submit DD 2785 to hospital security office to gain MHS GENESIS account access approval; complete MHS GENESIS training modules for the role the contractor will be performing; after receipt of clearance, CAC card and account access. The COR will facilitate the contractor with navigating the process.

4.3. The contractor shall provide hardware/software and telephony system needed to perform required services, browser to support Internet connectivity requirements, e-mail software to support appointment cancellation, CAC reader and middleware, browser, and e-mail versions that are compatible with DoD PKI.

4.4. PAS, RMS, and CLR Center Location. The appointing agents shall provide appointing and referral services via phone and electronic communication mediums from a non-military installation commercial location within any Military Facility, but not to exceed 25 miles. The

PAS, RMS, and CLR functions will be provided via a consolidated location. The government reserves the right to conduct site visits in all contractor-operated facilities.

4.5. Staffing. Maintain a current listing of employees, to include full-time equivalency (FTE) and part-time designation, who staff the PAS, RMS, and CLR Center. The contractor shall provide the list to the COR within 10 calendar days after start of full contract performance and by the fifth calendar day of every month thereafter. The contractor will notify the COR when an employee's status or information changes.

4.5.1. The contractor shall provide up to 10 personnel to receive training by the government to serve as MHS GENESIS trainers during the transition period. The contractor provided trainers shall be familiar with the use of PC applications and have at least three years of experience as trainers.

4.5.2. The contractor shall ensure all PAS, RMS, and CLR agents complete MHS GENESIS training and ensure PAS, RMS, and CLR agents submit evidence of training completion and competence to the MHS GENESIS contractor, Cerner, and a copy to the COR. Approved contractor MHS GENESIS trainers status is a requirement to start the MHS GENESIS ‘Train the Trainer’ program. The Government will conduct initial and sustainment ‘Train the Trainer’ training that will be scheduled and agreed upon by all parties. Training shall be conducted during the transition period before the start of contract operations.

4.5.3. MHS Genesis And Access To Care Training:

4.5.3.1. The contractor shall be responsible for all MHS GENESIS training of contractor employees following the government provided initial training provided as a result of MHS GENESIS system upgrades. The contractor shall ensure PAS, RMS, and CLR agents successfully complete training on MHS GENESIS before he/she is granted access by the government on MHS GENESIS.

4.5.3.1.1. The contractor provided MHS GENESIS PAS, RMS, and CLR agents training shall not be conducted on the “live” MHS GENESIS system. The government reserves the right to observe/monitor the contractors provided training sessions to ensure quality, consistency and adequacy of training.

4.5.3.2. Contractor provided training will also include training on general contract requirements and “Access to Care” procedures that are IAW current DHA policy and/or current applicable DHA references. Training will conform to DHA and DHN standards, policies, procedures, regulations, and statutes listing herein (See Section 6).

4.6. The contractor shall utilize Government approved MHS GENESIS training modules for Appointing, Referral Management and Clear and Legible Report accountability.

4.6.1. The contractor shall conduct technical training, which will focus on systems architecture, mandatory system procedures, security requirements, and functional operating procedures to

include PAS, RMS, and CLR. The curriculum will include the functions of MHS GENESIS to include, as a minimum, MHS GENESIS data entry, registration, appointment scheduling, and other MHS GENESIS functionalities. The contractor provided training will also include training on appropriate scheduling appointment protocols IAW MHS beneficiary “priorities of care” standards specified in Title 32, Code of Federal Regulations (32 CFR), Section 199.17 for TRICARE Prime beneficiaries under the TRICARE Program and how the Secretary of Defense plans to ensure that beneficiaries under TRICARE Prime who are seeking an appointment for health care will obtain an appointment within established access to health care standards.

5. DESCRIPTION OF WORK:PAS.
5.1.1. The contractor shall provide trained staff to meet the standardized DHA and Network-specific appointing criteria and business rules IAW DHA POLICY. The contractor shall ensure that phones are continuously staffed with trained personnel, sufficient to handle projected call volumes while achieving all performance standards, during the designated business hours.

5.1.2. Appointing agents shall schedule, reschedule, and/or cancel appointments as well as correct appointment- booking errors for all inbound and outbound calls and correspondence IAW DHA business policies and procedures.

5.1.3. Appointment Scheduling. After validation of eligibility, the appointing agent shall interpret the beneficiary’s request for an appointment and apply the appropriate appointing criteria and directives to the request IAW DHA POLICY. Appointing agents shall match the beneficiary’s request for service with the most appropriate ATC category, choosing the appropriate standard appointment types and detail codes that will appoint the beneficiary to an appropriate provider within the applicable DHA ATC standards.
5.1.4.
5.1.5. Provider Appointment Templates. The Contractor will utilize MHS GENESIS provider schedules.
5.1.6.
5.1.7. Appointment Cancellation Procedures. The contractor shall ensure appointing agents cancel, and if appropriate, reschedule beneficiary appointments at the request of the beneficiary IAW DHN-IP standardized business procedures. If the appointing agent is required to make an outbound call to the beneficiary, the beneficiaries registration information shall be verified and updated, if necessary, and will be compliant with HIPAA, DoD Health Information Privacy Regulation (DoD 6025.18-R), the Privacy Act, and DoD Privacy Program (DoD 5400.11-R).
5.1.8.
5.1.9. When a cancellation notification is received from the beneficiary, the appointing agent shall cancel the appointment and offer to reschedule the appointment IAW DHA and DHN-IP standardized business rules.
5.1.10.
5.1.11. If a cancellation request is received from clinic or MTF staff, the appointing agent shall contact the affected beneficiaries and offer to reschedule the appointment IAW DHA and DHN-IP standardized business rules.
5.1.12.

5.1.13. If a cancellation notification is received indirectly from the beneficiary via a recorded message on a contractor provided line or other automated means the appointing agent shall cancelled the appointment as requested by the beneficiary.
5.1.14.
5.1.15. Blocked Call Rate. The contractor shall provide sufficient phone lines to ensure there are no blocked calls.
5.1.16.
5.1.17. Call Abandonment. The contractor shall provide sufficient personnel to prevent call abandonment.
5.1.18.
5.1.19. Call Wait Time. The contractor shall ensure a live agent answers all calls within 60 seconds.
5.1.20.
5.1.21. Reserved.
5.1.22.
5.1.23. Defer to Network Patient Option. When MTF specialty access is not available within the TRICARE Access to Care standard, the Contractor will inform patients when a deferral to the network may result in a longer wait time for care than the direct care system using current MCSC data showing network access to care performance by specialty care type. Patients will be given the choice to wait for the next available MTF appointment or to be deferred to network. When patients choose deferral to network, the contractor will modify the referral and route it directly to the MCSC in accordance with DHA and DHN-IP business rules. TRICARE for Life (TFL) referrals that cannot be booked within access to care standards will be routed back to MTF Referral Management Offices (RMO) for specialty appointing in the MCSC network in accordance with DHA and DHN-IP policy. The COR will provide network “Days to Care” data for each MTF Prime Service Area (PSA) to the contractor monthly as provided by the Managed Care Support Contractor (MCSC).

1.1.1. Drive Time Mapping. The contractor shall maximize utilization of direct care capacity and will ensure that beneficiaries are scheduled at a PIRMAC and/or HIRMAC MTF within DHA ATC standards as well as drive time standards from residence to MTF. The contractor shall employ the same drive time mapping software system approved by the government for the MCSC.

1.1.2. First Call Resolution. Patients will be scheduled for MTF healthcare appointments in accordance with access to care standards. However, when there is not available MTF access available IAW DHA access to care standards, the contractor will follow DHN-IP standardized business rules in order to optimize utilization of the direct care system and promote maximum patient satisfaction. Appointing agents shall not ask beneficiaries to call back. Reported by volume and percentage measured and reported at MTF and specialty clinic level.

1.1.3. Mailed Correspondence. The contractor shall be responsible for mailing specialty care appointment information to beneficiaries within five business days of the third unsuccessful outbound call to the patient to schedule their MTF specialty appointment IAW DHA policy. These notifications shall contain standardized language as provided by the DHN-IP HCO

Directorate (Exhibit C – Example Outbound Letter Template). The contractor shall provide postage and mailing materials. The contractor shall maintain clinic level documentation of calls made, by date and time, corresponding success rates, and details of letters mailed with tracking of beneficiaries that eventually schedule the direct care specialty appointment in MHS GENESIS. The contractor shall provide the information to the COR upon request.

1.1.4. Mini-Registration/Quick Registration. The appointing agents, upon contact by the beneficiary, shall validate DEERs eligibility. If the beneficiary is already registered, the Appointing agents shall verify and update, as required, beneficiary information to include name, address, and the primary telephone number to support text message and/or reminder notifications. If the beneficiary is not registered in DEERS, the Appointing agents shall initiate a DEERS eligibility check and perform a mini-registration in the DEERS system. The appointing agents shall refer beneficiaries with enrollment issues to the MCSC for resolution.

1.1.5. Outbound Specialty Appointing Calls. The contractor shall make outbound calls to all patients with MTF specialty referrals beginning on day two following the date of the referral. The Contractor shall place up to three documented calls or until successfully contacting the patient. The third call will be no later than day 30 with a letter mailed no later than day 60, if contact has not been made or an appointment has not been scheduled. Contractor shall maintain date and time documentation of calls made, corresponding success rates and provide the government with a report by the fifth calendar day of the month.

1.1.6. Revisions. The contractor shall update requests for revisions to appointing instructions by the DHN-IP HCO Directorate in the system within three working days following receipt of request for revision of appointing instructions in writing.

1.1.7. Routing and transferring calls. Agents shall route and transfer calls to the appropriate location based on DHN-IP business rules.

1.1.8. Standard Telephone Customer Service Scripts. The contractor will employ standard customer service scripts provided by the DHN-IP HCO Directorate for all PAS, RMS, and CLR staff to optimize a positive patient experience. In the event of script changes submitted by the DHN-IP HCO Directorate Office, the contractor will incorporate changes within 72 hours of receiving changes submitted by the COR.

1.1.9. Unmet Specialty Demand. Unmet Primary and Specialty Care demand includes patient demand for care that could not be met within DHA Access to Care standards in the MTF. The contractor shall document and report all specialty care via MHS GENESIS, by service line and MTF, cases when the referral is deferred to network due to lack of MTF access.

1.1.10. Inclement weather and contingency operations:

1.1.10.1. In the event of inclement weather and/or contingency event, the contractor shall not ask that a beneficiary “call back”. The contractor shall have a contingency operation plan to execute large volume appointment cancellation notifications at the facility, network, MTF and/or

clinic level in the event of inclement weather and/or natural or man-made events that precipitate a base closure. The contractor shall ensure appointing agents take action to cancel and reschedule appointments and appropriately update the beneficiary information automated message within 1-hour of notification by the DHN-IP or MTF of closures or service curtailments. The contractor shall maintain all service performance standards as agreed upon within the contingency plan.

1.1.10.2. The contractor's plan should include procedures that will be implemented in the event systems are not operational, whether the issue is government or contractor related, to provide continued registration and appointing. The contractor's plan shall include a process to maintain full and/or partial operating capability during potential contingencies up to and including MHS GENESIS outages, internet outages, building power failure, phone line outage, etc. The contractor's contingency plan should evolve with capability and technology changes. The contractor will provide a copy of its contingency plan to the government for review and approve and acceptable plan no later than 15 calendar days prior to full contract performance start.

1.1.10.3. The contractor shall have a mechanism in place for MTFs to contact the Contractors Operation Manager after hours in the event that weather or emergency conditions necessitate MTF operational curtailment decisions are made outside the contract hours of operation providing alert rosters of lead personnel to the DHN-IP HCO Directorate.

1.1.11. Within 30 calendar days after beginning operation of full contract performance, the contractor will schedule with the government a date for a tabletop exercise with all MTFs to ensure the viability of the contractor's proposed contingency plans. Coordination of the tabletop exercise will be between the COR and the contractor.

1.1.12. Contractor shall record all calls and retain recorded calls for a minimum of 6 months, and will furnish copies of recordings upon request. Furthermore, the contractor shall conduct quality control monitoring on a minimum of 5% of each agent's calls monthly.

1.1.13. Customer Service and Satisfaction of Appointing. The contractor shall document and report complaints received, errors found, and the specific corrective action taken by the contractor. Errors shall include those identified by patients/beneficiaries, clinic and/or MTF staff, and those communicated directly to the contractor. Error rate shall remain less than 1%.

1.2. RMS.

1.2.1. Disposition Report. The Contractor shall disposition all routine referrals as either Appoint to MTF, Defer to Network, or route to MTF Referral Management Center (RMC) IAW standardized DHN-IP business policy. The contractor shall meet or exceed DHA referral management requirements: One hundred percent of Referrals dispositioned within one (1) business day from referral order date. One business day includes the order date plus the entire following day, excluding weekends and holidays. At the end of one (1) business day, the referral shall be available for booking at the MTF, to the MCSC, or routed to the RMC per DHN-IP business rules provided by the government.

1.2.2. The following referral types shall be forwarded and routed to the MTF RMC for further action. This is not a complete list and may be amended as needed.

1.2.2.1. Incomplete or unclear referrals.

1.2.2.2. Referrals to non-network or out of area

1.2.2.3. Referrals for ineligible beneficiaries, including Line of Duty (LOD) referrals and beneficiaries with direct care only benefits.

1.2.2.4. Referral requests generated from internal or network providers that require communication directly with network providers to determine coordination of services.

1.2.2.5. Referrals requiring waivers for non-TRICARE covered benefits, exceptions to policy, and medical travel.

1.2.3. Revision of referral instructions. Revisions to referral instructions by the DHN-IP HCO office will be updated in the system by the contractor. Contractor will input revisions within three working days following receipt.

1.2.4. Customer Service and Satisfaction of Referral Management. The contractor shall document and report complaints received, errors found, and the specific corrective action taken by the contractor. Errors shall include those identified by patients/beneficiaries, clinic and/or MTF staff, and direct to the contractor. Error rate shall remain less than 1%.

1.2.5. The contractor shall process incoming referrals (ROFR) from the MCSC network providers and MTFs according to DHA and DHN-IP requirements and standardized guidelines.

1.2.6. The contractor shall record and track status and disposition on all Prime/Select/VA/ ROFRs, MTF, and network referrals and communications received, per DHA and DHN-IP business rules.

1.2.7. The contractor shall review all referrals and appoint referrals to MTF or return to requester based on:

1.2.7.1. Clinical Capability per the MTF Referral Protocol Process (RPP)

1.2.7.2. Continuity of care; continuation of health care services from a specific individual professional provider as part of a specific procedure or service that was performed within the previous six months in order to not disrupt therapy or repeat services.

1.2.7.3. Drive time to closest MTF with capability (using government approved mapping software)

1.2.7.4. Reserved.

1.2.7.5. The contractor shall notify the requesting provider in cases when the referral is not accepted for review due to incomplete information, ATC standards, or other reasons.

1.2.7.6. Notify the referring MTF or requesting provider when a beneficiary appointed to the fails to book an MTF appointment.

1.2.7.7. The contractor shall respond to the MCSC, MTF or requesting provider regarding urgent priority referrals, via HIPAA-compliant 278, or other process as identified by the Government. Urgent priority referrals must be dispositioned by the MTF/eMSM within 90 minutes from receipt of the request. Appropriately received urgent priority referrals are automatically appointed to the MTF.

1.2.7.8. The contractor shall respond to the MCSC, MTF, or requesting provider regarding the MTF/DHN-IP routine priority referrals, via HIPAA-compliant 278, or other process as identified by the Government, within two business days from receipt of the request.

1.2.7.9. The contractor shall disposition routine referrals as ‘Appoint to MTF’ or ‘DTN to MCSC’.

1.2.7.10. The contractor shall communicate any referral closure, and the reason, to the referring provider within 1 business day of the referral closure and will annotate in the EHR. The referring provider/clinical team is then responsible for communicating to the patient within 1 business day that the referral was denied/cancelled, and whether or not a new referral will be ordered.

1.2.7.11. The contractor shall process all incoming routine referrals for acceptance to the MTF or declination and returned to the MCSC, MTF or network provider within one business day IAW DHA POLICY or current DHA directives.

1.2.7.12. The contractor shall administratively close all un-appointed referrals accepted by an MTF no sooner than 180 days beyond the order date.

1.3. CLR.

1.3.1. The contractor shall track and account for all MTF generated specialty care that are deferred to the network until closure IAW DHA POLICY. Closure occurs when the referring provider is notified that either a CLR is available for review, the referral is canceled by the patient, or notified the referral is closed IAW DHA policy and standardized business rules. Notification of administratively closed referrals is acceptable.

1.3.2. The contractor is not required to track follow-ups, but shall provide follow-up results to the referring provider if received and other as defined by DHA POLICY or current DHA requirements. There is no requirement to track durable medical equipment, ambulance, and hospice referrals.

1.3.3. CLR Accountability. Once CLR is received, the following process shall be followed:

1.3.3.1. The contractor shall process all CLR into the patient's permanent EHR within three working days of receipt, close the referral, and notify the referring provider and/or Primary Care Manager (PCM) that the CLR is awaiting their review IAW DHA POLICY or current guidelines.

1.3.3.2. The contractor shall use the following standard naming convention for CLR loaded into the EHR: "Network Results – SPEC Month/Day/Year (MM/DD/YY)" where the MM/DD/YY is the date the patient was seen, if available, or the date of the report. Use the same standard naming convention in the "Document Title" field for the associated CLR. Providers who generated the referrals will be notified the CLR is available via EHR. The contractor shall close the referrals in the EHR as "Results Received". This naming convention is subject to change upon notice IAW the DHN-IP standardized business rule

1.3.3.3. The contractor shall initiate efforts to capture the CLR upon request by the referring provider or no later than 60 calendar days from the date the referral was ordered or as soon as a claim is discovered, whichever occurs first. Consultants must send preliminary reports for urgent and emergency specialty care consultations to the referring provider within 24 hours. When a CLR has not been documented in the EHR, check the applicable claims database for a claim. If a claim is found, request the CLR from the rendering network provider. If there is no response from the provider within 10 calendar days, repeat the request. If the provider still does not provide the CLR, then initiate TRICARE contractor procedures as per the TRICARE Operations Manual and/or the Memorandum of Understanding with the TRICARE regional contractor. Additionally, forward a report to the COR each month that lists all provider names, SPEC care rendered, and referral Financial Identification Number (FIN) and Unit Identification Number (UIN) for which no CLR has been received after two attempts.

1.3.3.4. After 180 calendar days, if the CLR has not been received, the contractor shall close the referral as CRNRR in the EHR indicating a claim was reported, but no results were received and notify the referring provider. After 180 calendar days from the order date, if no claim or evidence is found indicating the patient utilized the referral in the network, then close the referral in the EHR as Not utilized (NU) in the EHR indicating the patient did not use the referral and notify the referring provider. If a patient cancels a referral, the contractor shall notify the referring provider.

1.3.4. Customer Service and Satisfaction of Clear and Legible Reporting. The contractor shall document and report complaints received, errors found, and the specific corrective action taken by the contractor. Errors shall include those identified by patients/beneficiaries, clinics and/or MTF staff, and direct to the contractor. Error rate shall remain less than 1%.

1.4. Reports. The contractor shall submit the following reports:

1.4.1. PAS.

1.4.1.1. Call Volume Handled by Appointing, Referral Management and CLR Agents. The contractor shall provide a monthly report that details the sum of all inbound calls routed to the agent queue(s). Call volume shall be reported as inbound, outbound, and total number of calls handled by the contractor. The contractor shall provide the government a report for PAS, RMS, and CLR by the fifth calendar day of the month. Data will be stratified at the MTF level and reported for each day of operations.

1.4.1.2. Inbound Call Volume Handled by the IVR. The contractor shall provide a monthly report that details the number of inbound calls handled to completion by the IVR. The contractor shall provide the government a report for PAS and RMS by the fifth calendar day of the month. Data will be stratified at the MTF level and reported for each day of operations.

1.4.1.3. The contractor shall provide a detailed report to the COR of the number of calls monitored, issues identified, and corrective actions taken to correct the issues. The contractor shall provide the government a report by the fifth calendar day of the month.

1.4.1.4. Customer Service and Satisfaction of Appointing. The contractor shall provide a detailed report of complaints received, errors found, and the specific corrective action taken by the contractor. Errors shall include those identified by patients/beneficiaries, clinic and/or MTF staff, DHA satisfaction survey tools (JOES), and direct to the contractor. The contractor shall provide the government a report by the fifth calendar day of the month.

1.4.1.5. Calls Monitored. The contractor shall provide a report that details the number of calls monitored, issues identified, and corrective actions taken to correct the issues. The contractor shall provide the government a report by the fifth calendar day of the month.

1.4.1.6. IVR Average Response. The contractor shall provide a report that details the average amount of time, rounded to minutes, that elapse for a contact center (Appointing and RM) to respond to a non-voice inbound customer contact. The contractor shall provide the government a weekly report by close of business (COB) by the second business day following the week reported.

1.4.1.7. Call Wait Time. The contractor shall provide a report that details the average call wait time. A live agent will answer the call within 60 seconds 90 percent of the time and within 90 seconds 100 percent of the time. This information shall be reported in 15-minute increments and list the average call wait time measured in seconds for each one-hour period by day of week. The contractor shall provide the government a weekly report by close of business (COB) by the second business day following the week reported.

1.4.1.8. Call Processing Time. The contractor shall provide a report that details the call processing time measured in seconds and reported in 15-minute increments by volume per hour/day of week for functional areas, PAS and RMS. The contractor shall provide the government a weekly report by close of business (COB) by the second business day following the week reported.

1.4.1.9. Blocked Call Rates. The contractor shall provide a report that details the number of calls that cannot be completed by the caller due to the call capacity of the telephone system. The contractor shall provide the government a report by the fifth calendar day of the month.

1.4.1.10. Call Abandonment. The contractor shall provide a report that details the number of callers whose calls were received by the telephone switch, but who disconnected (i.e., hung up before reaching an agent at any time during the call. Abandoned calls should be included in the Call Wait Time and Total Call Hold Time measures. The contractor shall provide the government a report by the fifth calendar day of the month.

1.4.2. RMS.

1.4.2.1. Dispositions. The contractor shall provide a report that details that report the number of referrals dispositioned, disposition category (DTN, MTF appointed or MTF RMC) and average days to disposition routine referrals. The contractor shall provide the government a report by the fifth calendar day of the month.

1.4.2.2. Disposition/Routing Error Rate. The contractor shall provide a report that details the referral disposition rate and routing error rate. The contractor shall provide the government a report by the fifth calendar day of the month.

1.4.2.3. Deferred to Network. The contractor shall provide a report that details all referrals deferred to the network due to lack of MTF capability or capacity. The report shall be stratified by specialty and MTF. The contractor shall provide the government a report by the fifth calendar day of the month. The contractor shall contact patients that have been DTN and provide them with DTN instructions.

1.4.2.4. Customer Service and Satisfaction of Referral Management. The contractor shall provide a detailed report of complaints received, errors found, and the specific corrective action taken by the contractor. Errors shall include those identified by patients/beneficiaries, clinic and/or MTF staff, and direct to the contractor. The contractor shall provide the government a report by the fifth calendar day of the month.

1.4.3. **CLR.**

1.4.3.1. CLR Processing. The contractor shall provide a report that details the number of MTF generated initial specialty care deferred to the network, the number of CLR uploaded into the EHR within 30 and 60 days, the total number of CLR reports not received after 180 days, beneficiary referrals canceled and CLR error rates. The contractor shall provide the government a report by the fifth calendar day of the month.

1.4.4. Operational procedures in the event systems are not operational. In order to provide continued registration and appointing services, the contractor's plan shall include a process to maintain full and/or partial operating capability during potential contingencies up to and including MHS GENESIS outages, internet outages, building power failure, phone line outage,

etc. The contractor's contingency plan should evolve with capability and technology changes. The contractor will provide a copy of its Contingency Plan to the COR no later than 2 weeks before start of contract operations. Contractor will utilize manual record keeping ensuring beneficiaries are not asked to call back. The plan shall be validated by tabletop exercise 2 weeks prior to start of contract operations and annually thereafter.

1.4.5. Inclement Weather Plan. In the event of inclement weather and/or natural or man-made events that limits beneficiary access to military installations and/or MTFs, the contractor shall have a contingency operation plan that maintains adequate staffing to support to execute large volume appointment cancellation notifications and patient rescheduling. The Call Center shall possess the capability to update the beneficiary information automated message within 1-hour of notification of notification by the DHN-IP or MTF of closures or reduced capacity. The contractor's plan shall be submitted to the COR for approval no later than 2 weeks prior to start of contract operations and annually thereafter.

1.4.6. Manpower Reporting. The contractor shall provide a report that details the labor hours required for performance of services provided under this contract for Patient Appointing, Referral Management, and CLR services. The report shall be separated by FTEs and part-time for each functional area. The contractor shall provide the government a report by the fifth calendar day of the month.

1.5. Performance Reports and Frequencies of Deliverables. The contractor shall provide the reports to the COR as detailed in 5.4. Reports should be clear, concise and provide measuring methodologies. All deliverables shall be provided in Microsoft PowerPoint, Excel and/or Word. All reports will be formatted 'presentation ready' and of appropriate professional standards suitable for dissemination to senior management officials and will not require additional rework in order to present to senior leadership forums. The contractor shall provide all reports to the government by the fifth calendar day of the month.

1.6. Additional reports may be requested, as needed, IAW revised DHA policy and/or requirements (i.e. new reporting tools that become available in MHS GENESIS).

1.7. Frequencies of Performance Reports formats. Performance reporting formats will be presented to the COR for approval within 30 days after contract award.

1.7.1. The contractor shall supply weekly reports by COB on the second business day following the week reported or based on the contract.

1.7.2. The contractor shall supply required monthly report by COB on the fifth business day following the last day of the month reported or based on the contract.

1.8. Contractor Manpower Reporting (CMR). The contractor shall report ALL contractor labor hours (including subcontractor labor hours) required for performance of services provided under this contract via a secure data collection site. The contractor is required to complete all required data fields using the following web address: https://www.sam.gov/.

1.8.1. Reporting inputs will be for the labor executed during the period of performance during each Government fiscal year (FY), which runs October 1 through September 30. While inputs may be reported any time during the FY, all data shall be reported no later than October 31 of each calendar year. Contractors may direct questions to the help desk at https://www.sam.gov/.

6. APPLICABLE REGULATIONS AND MANUALS:

6.1. The contractor shall comply with the most current version of all applicable government documentation, regulations, policies, and directives pertinent to management of appointment services in effect at the time of award. Supplements, amendments, additional policies, and/or changes to these publications may be issued during the life of the contract. Either any such changes to mandatory publications that cause a change in performance that will increase or decrease price will be incorporated into the contract by mutual agreement of the parties. All publications can be found on the worldwide web. In the event that a publication cannot be found, the COR will provide assistance upon request. This list includes, but is not limited to the following:

6.2. MANDATORY

Alcohol, Drug Abuse, and Mental Health Administration Reorganization Act of 1992 Privacy Act of 1974 Title VI of the Civil Rights Act of 1964 Section 504 of the Rehabilitation Act of 1973

DoD Directive 5400.11-R, “The Freedom of Information Act of 1967” Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Electronic and Information Technology Accessibility Standards (36 CFR 1194)

DoD Manual 5200.02, Procedures for the DoD Personnel Security Program (PSP), April 3, 2017 Parts 160 and 164 of title 45, Code of Federal Regulations

OMB Circular A-130

5 U. .S.C. § 552a, as amended 32 CFR 199

Rehabilitation Act of 1973, Section 508

Military Health System’s Guide to Access Success (15 Dec 2008)

DoD Instruction 8510.01, “Risk Management Framework (RMF) for DoD Information Technology (IT),” July 28, 2017

Subchapter III of Chapter 35 of title 44, United States Code Federal Information Security Management Act (FISMA) of 2002”

DoD Directive 8100.1, “Global Information Grid (GIG) Overarching Policy,” September 19, 2002

DoD Directive 8100.2, “Use of Commercial Wireless Devices, Services, and Technologies in the DoD GIG,” April 14, 2004

DoD Instruction 8500.01, Cybersecurity, March 14, 2014

DoD Instruction 8520.2, “Public Key Infrastructure and Public Key Enabling,” May 24, 2011

DoD Instruction 6025.18, Privacy of Individually Identifiable Health Information in DoD Health Care Programs, December 2, 2009

DoD Instruction 5400.11, DoD Privacy Program, January 29, 2019

Deputy Secretary of Defense Memorandum, Implementation of Military Health System Governance Reform, March 11, 2013

Deputy Secretary of Defense Memorandum, Implementing Congressional Direction for Reform of the Military Health System, September 28 2018

DHA-IPM-18-001, Interim Procedures Memorandum 18-001, “Standard Appointing Processes, Procedures, Hours of Operation, Productivity, Performance Measures and Appointment Types in Primary, Specialty, and Behavioral Health Care in Medical Treatment Facilities (MTFs), dated July 3, 2018.

6.3. REFERENCE DOCUMENTATION

Defense Information Infrastructure (DII) Common Operating Environment (COE) Integration and Runtime Specification (I&RTS), Version 4.0, dated 4 October 99, and subsequent updates.

MHS Information Management (IM)/ Information Technology (IT) Strategic Plan (on TRICARE Web Site). MHS IM/IT Program Plan, Volume I, and II, (on TRICARE web site)

MHS IM/IT Standard Operating Procedures for Annual Performance Planning and Reporting, September 2005 (on TRICARE Web Site)

MHS Information Assurance Policy Guidance, March 2007 MIL-STD 973, “Configuration Management,” 11 Feb 2000.

NBS SP500-153, “Guide to Auditing for Controls and Security: A System Development Life-Cycle Approach,” April 1988.

DoDD 8320.1M, “DoD Data Administration,” Mar 1994

DoD Manual 8020.1-M, Functional Process Improvement, 15 January 1993.

Department of Defense Joint Technical Architecture, Version 3.0, January 28, 2000 (DISA web site). MHS Office Automation Guidance, August 3, 2007

MHS Personal Computer Hardware Requirements, September 7, 2000. MHS Minimum Standard Notebook Hardware, September 7, 2000.

Title 10, U.S.C., Chapter 55

DISA IAVA Process Handbook, Version 3, February 14, 2007

DoD Instruction, 6495.02, Sexual Assault Prevention Response (SAPR) Program Procedures, March 29, 2017

Army Regulation 600-20, Army Command Policy, 9 Nov 2014

7. PERSONALLY IDENTIFIABLE INFORMATION, PROTECTED HEALTH INFORMATION, AND FEDERAL INFORMATION REQUIREMENTS (Revised Oct, 2020)

General Requirements Overview - Personally Identifiable Information (PII), Protected Health Information (PHI) and Federal Information Laws

This Section addresses the Contractor's requirements under The Privacy Act of 1974 (Privacy Act), The Freedom of Information Act (FOIA), and The Health Insurance Portability and Accountability Act (HIPAA) as set forth in applicable statutes, implementing regulations and Department of Defense (DoD) issuances. In general, the Contractor shall comply with the specific requirements set forth in this Section and elsewhere in this Contract. The Contractor shall also comply with requirements relating to records management as described herein.

This Contract incorporates by reference the federal regulations and DoD issuances referred to in this Section. If any authority is amended or replaced, the changed requirement is effective when it is incorporated under contract change procedures. Where a federal regulation and any DoD issuance govern the same subject matter, the Contractor shall first follow the more specific DoD implementation unless the DoD issuance does not address or is unclear on that matter. DoD issuances are available at http://www.dtic.mil/whs/directives.

For purposes of this Section, the following definitions apply.

DoD Privacy Act Issuances means the DoD issuances implementing the Privacy Act, which are DoDI 5400.11, DoD Privacy and Civil Liberties Programs, January 29, 2019 and DoDI 5400.11-R, Department of Defense Privacy Program, May 14, 2007.

HIPAA Rules means, collectively, the HIPAA Privacy, Security, Breach and Enforcement Rules, issued by the U.S. Department of Health and Human Services (HHS) and codified at 45 Code of Federal Regulations (CFR) Part 160 and Part 164, Subpart E (Privacy), Subpart C (Security), Subpart D (Breach) and Part 160, Subparts C-E (Enforcement), as amended.

Additional HIPAA rules regarding electronic transactions and code sets (45 CFR Part 162) are not addressed in this Section and are not included in the term HIPAA Rules.

DoD HIPAA Issuances means the DoD issuances implementing the HIPAA Rules in the DoD Military Health System (MHS). These issuances are DoDM 6025.18, “Implementation of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule in DoD Health Care Programs,” March 13, 2019, DoDI 6025.18, Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule Compliance in DoD Health Care Programs, March 13, 2019, and DoDI 8580.02, Security of Individually Identifiable Health Information in DoD Health Care Programs, August. 12, 2015

Defense Health Agency (DHA) Privacy Office is the DHA Privacy and Civil Liberties Office. The DHA Privacy Office Chief is the HIPAA Privacy and Security Officer for DHA.

Records Management

When creating and maintaining official government records, the Contractor shall comply with all federal requirements established by 44 United States Code (U.S.C.) Chapters 21, 29, 31, 33 and 35, and by 36 CFR, Chapter XII, Subchapter B – Records Management. The Contractor shall also comply with DoD Administrative Instruction No. 15 (DoD AI-15), “OSD Records and Information Management Program” (May 3, 2013) and Records Management requirements outlined in the current TRICARE Operations Manual (TOM).

Freedom of Information Act (FOIA)

The Contractor shall comply with the following procedures if it receives a FOIA request and immediately contact the DHA FOIA Officer for evaluation/action:

The Contractor shall inform beneficiaries that DHA FOIA procedures require a written request preferably sent via the National FOIA Portal at: www.FOIA.gov. However, requesters may also submit requests via email at DHA.FOIA@mail.mil; or via postal delivery addressed to the DHA Freedom of Information Service Center, 7700 Arlington Boulevard, Suite 5101, Falls Church, Virginia 22042-5101. All FOIA requests shall describe the desired record as completely as possible to facilitate its retrieval from files and to reduce search fees which may be borne by the requestor. Contract and/or Modification numbers must be included in all FOIA requests seeking DHA procurement records. Although the administrative time limit to grant or deny a request (ten working days after receipt) does not begin until the request is received by DHA, the Contractor shall act as quickly as possible and respond to DHA within ten working days.

In response to requests received by the Contractor for the release of information, unclassified information, documents and forms which were previously provided to the public as part of routine services shall continue to be made available in accordance with previously established criteria. All other requests from the public for release of DHA records and, specifically, all requests that reference FOIA shall be immediately forwarded to DHA, ATTENTION: Freedom of Information Officer, for appropriate action. Direct contact, including interim replies, between TRICARE contractors and such requestors is not authorized. The Contractor shall process requests by individuals for access to records about themselves in accordance with directions from the DHA Freedom of Information Service Center. If such a requestor specifically makes the request under the Privacy Act or does not make clear whether the request is made under

FOIA or the Privacy Act, the Contractor shall process the request in accordance with directions from the DHA Privacy Office. If requestor specifically seeks PHI under HIPAA, the Contractor shall follow paragraph 8.1.6, relating to individual rights of access to PHI.

Systems of Records

In order to meet the requirements of the Privacy Act and the DoD Privacy Act Issuances, the Contractor shall identify to the DHA Contracting Officer (CO) systems of records that are or will be maintained or operated for DHA where records of PII collected from individuals are maintained and specifically retrieved using a personal identifier.

Upon identification of such systems to the CO, and prior to the lawful operation of such systems, the Contractor shall coordinate with the DHA Privacy Office to complete systems of records notices (SORNs) for submission and publication in the Federal Register as coordinated by the Defense Privacy, Civil Liberties, and Transparency Division, and as required by the DoD Privacy Act Issuances.

Following proper SORN publication and Government confirmation of Contractor authority to operate the applicable system(s), the Contractor shall also comply with the additional systems of records and SORN guidance, in coordination with the DHA Privacy Office, regarding periodic system review, amendments, alterations, or deletions set forth by the DoD Privacy Act Issuances, Office of Management and Budget (OMB) Memorandum 99-05, Attachment B, OMB Circular A-130, and Privacy Act of 1974 requirements applicable to contractors operating systems of records on behalf of federal agencies. The Contractor shall promptly advise the DHA Privacy Office of changes in systems of records or their use that may require a change in the SOR

Privacy Impact Assessment (PIA)

If DHA data is stored on a Contractor owned system, a PIA is required from the Contractor.
Data Sharing Agreement (DSA)

(Applies if contract requirements involve the use of DHA data (including PII/PHI, a limited data set, or de- identified data)

The Contractor shall consult with the DHA Privacy Office to determine if the Contractor must obtain a DSA or Data Use Agreement (DUA), when DHA data will be accessed, used, disclosed or stored, to perform the requirements of this Contract.

The Contractor shall comply with the permitted uses established in a DSA/DUA to prevent the unauthorized use and/or disclosure of any PII/PHI, in accordance with the HIPAA Rules and DoD HIPAA Issuances. Likewise, the Contractor shall comply with the DoD Privacy Act Issuances.

Prior to using any data involving PHI for research purposes, as defined by HIPAA, the Contractor must gain approval from the DHA Privacy Board. Thus, the Contractor shall comply with DHA Privacy Board requests for additional documentation.

To begin the DSA request process, the Contractor shall submit a DSA Application (DSAA) to the DHA Privacy Office. Upon approval, the requestor shall enter into one of the following agreements, depending on the data involved:

- DSA for De-Identified Data
- DSA for PHI
- DSA for PII Without PHI
- DUA for Limited Data Set

DSAs executed for contract support will expire after 1 year or at the end of the contract option year, whichever comes first. If the contractual use of DHA data will continue after the DSA expiration date, the Contractor shall submit a DSA Renewal Request template to the Privacy Office; however, if the DSA will not be renewed, the Contractor shall close the DSA by providing a Certificate of Data Disposition (CDD) to the DHA Privacy Office.

(Applies if contract requirements may include human subject research)

This Contract incorporates by reference the Protection of Human Subject Research clause in the Defense Federal Acquisition Regulation Supplement (DFARS) at 48 CFR 252.235-7004. A separate DFARS provision, 48 CFR 235.072(e), requires that the clause be incorporated in contracts that include or may include research involving human subjects in accordance with 32 CFR 219, DoDI 3216.02, and 10 U.S.C. 980, including research that meets exemption criteria under 32 CFR 219.101(b), the clause applies to solicitations and contracts awarded by any DoD component, regardless of mission or funding Program Element Code. Thus, in the event a contractor participates in a study or demonstration project or other activity that involves human subject research, then the contractor shall comply with Protection of Human Subject Research clause. COs may not determine whether an activity is exempt from human subject research requirements. If contractor activity appears to involve human subject research, then the

contractor shall consult the DHA Privacy Office, which may contact the Research Regulatory Oversight Office in the Office of the Under Secretary of Defense for Personnel and Readiness (OUSD(P&R)).

Privacy Act and HIPAA Training

The Contractor shall ensure that its entire staff, including subcontractors and consultants that perform work on this Contract receive training on the Privacy Act, HIPAA, and the federal regulations on confidentiality of substance use disorder patient records, 42 CFR Part 2. Refer to FAR 52.224-3 regarding specific requirements for Privacy Training appropriate to the

Contractor's scope of involvement with DHA's PHI and its regulatory responsibilities as either a Covered Entity, or Business Associate.

The Contractor shall ensure all employees and subcontractors supply a certificate of all training completion to the Contracting Officer's Representative (COR) within 30 days of being assigned and on an annual basis based on the trainee's birth month thereafter.

HIPAA Business Associate Provisions

Business Associate – General Provisions

The Contractor meets the definition of Business Associate, and DHA meets the definition of a covered entity under the HIPAA Rules and the DoD HIPAA Issuances. Therefore, a Business Associate Agreement (BAA) between the Contractor and DHA is required to comply with the HIPAA Rules and the DoD HIPAA Issuances. The contractor shall use the DoD BAA, which shall be used by all organizational entities within the DoD, referred to collectively as the "DoD Components", located at, https://www.health.mil/Military-Health-Topics/Privacy-and-Civil-Liberties/Privacy-Contract-Language/HIPAA-Compliant-Business-Associate-Agreement-for-the-MHS. b.i. and (3)b.ii.

Breach Response

[This paragraph 7.9 is inoperative, and all references herein to "paragraph 7.9" shall be deemed to refer to the TOM breach responses provisions, if the contract incorporates the TOM by reference.]

Definitions Related to Breach response

Breach means a loss of control, compromise, unauthorized disclosure, unauthorized acquisition, unauthorized access, or any similar term referring to situations where persons other than authorized users and for other than an authorized purpose have access or potential access to PII, whether physical or electronic. The foregoing definition is based on the definition of breach in DoDD 5400.11. Breaches are classified as either possible or confirmed (see the following two definitions) and as either cyber or non-cyber (i.e., involving either electronic PII/PHI or paper/oral PII/PHI).

A possible breach is an incident where the possibility of unauthorized access is suspected (or should be suspected) and has not been ruled out. For example, if a laptop containing PII/PHI is lost, and the contractor does not initially know whether or not the PII/PHI was encrypted, then the incident must initially be classified as a possible breach, because it is impossible to rule out the possibility of unauthorized access to the PII/PHI. In contrast, that possibility can be ruled out immediately, and a possible breach has not occurred, when misdirected postal mail is returned unopened in its original packaging. However, if the intended recipient informs the contractor that an expected package has not been received, then a possible breach exists until and unless

the unopened package is returned to the contractor. In determining whether unauthorized access should be suspected, the contractor shall consider at least the following factors:

- How the event was discovered;
- Did the information stay within the covered entity's control;
- Was the information actually accessed/viewed; and
- Ability to ensure containment (e.g., recovered, destroyed, or deleted).

A confirmed breach is an incident in which it is known that unauthorized access could occur. For example, if a laptop containing PII/PHI is lost and the contractor knows that the PII/PHI is unencrypted, then the contractor should classify and report the incident as a confirmed breach, because unauthorized access could occur due to the lack of encryption (the contractor knows this even without knowing whether or not unauthorized access to the PII/PHI has actually occurred). If the laptop is subsequently recovered and forensic investigation reveals that files containing PII/PHI were never accessed, then the possibility of unauthorized access can be ruled out, and the contractor should re-classify the incident as a non-breach incident.

A HHS breach is an incident that satisfies the definition of breach in Section 164.402 of the HIPAA Breach Rule. The text of the HHS definition states:

Breach means the acquisition, access, use, or disclosure of PHI in a manner not permitted under subpart E of this part [i.e. the HIPAA Privacy Rule] which compromises the security or privacy of the PHI.

HHS breach excludes:

Any unintentional acquisition, access, or use of PHI by a workforce member or person acting under the authority of a DoD covered entity or a business associate, if such acquisition, access, or use was made in good faith and within the scope of authority and does not result in further use or disclosure in a manner not permitted under the HIPAA Privacy Rule.

Any inadvertent disclosure by a person who is authorized to access PHI at a DoD covered entity or business associate to another person authorized to access PHI at the same DoD covered entity or business associate, or organized health care arrangement in which the DoD covered entity participates, and the information received as a result of such disclosure is not further used or disclosed in a manner not permitted the HIPAA Privacy Rule.

A disclosure of PHI where a DoD covered entity or business associate has a good faith belief that an unauthorized person to whom the disclosure was made would not reasonably have been able to retain such information.

Except as provided in this definition, an acquisition, access, use, or disclosure of PHI in a manner not permitted under this issuance is presumed to be a breach unless the DoD covered entity or business associate, as applicable, demonstrates that there is a low probability that the PHI has been compromised based on a risk assessment of at least the following factors:

The nature and extent of the PHI involved, including the types of identifiers and the likelihood of re-identification;

The unauthorized person who used the PHI or to whom the disclosure was made; Whether the PHI was actually acquired or viewed; and

The extent to which the risk to the PHI has been mitigated.

A cybersecurity incident is a violation or imminent threat of violation of computer security policies, acceptable use policies, or standard security practices, with respect to electronic PII/PHI. A cybersecurity incident may or may not involve a breach of PII/PHI. For example, a malware infection would be a possible breach if it could cause unauthorized access to PII/PHI. However, if the malware only affects data integrity or availability (not confidentiality), then a non-breach cybersecurity incident has occurred.

General

The breach response requirements shall be followed for all unauthorized use or disclosure of information regardless of whether the information is PHI or solely PII.

Because DoD defines “breach” to include possible (suspected), as well as actual (confirmed) breaches, the Contractor shall implement these breach response requirements immediately upon the Contractor’s discovery of a possible breach. These procedures focus on the first two steps (breach identification and reporting) of a comprehensive breach response program, but also require addressing the remaining steps: containment, mitigation (which includes individual notification), eradication, recovery, and follow-up.

The contractor shall establish internal processes for carrying out the procedures set forth below. These processes shall assign responsibility for investigating, classifying, reporting and otherwise responding to breaches and cybersecurity incidents. The contractor should consult with the DHA Privacy Office where guidance is needed, such as when the contractor is uncertain whether a discovered breach is the contractor’s responsibility (e.g., if the contractor discovers a breach not caused by the contractor), or how the contractor is to classify an incident (breach vs. non-breach, confirmed vs. possible, cyber vs. non-cyber). Under no circumstances will a contractor delay reporting a confirmed or possible breach to the DHA Privacy Office beyond the 24-hour deadline.. In conjunction with its initial investigation, the contractor shall immediately take steps to minimize any impact from the occurrence, proceed with further investigation of any relevant details (such as root causes, vulnerabilities exploited), and initiate further breach response steps.

In the event of a cybersecurity incident not involving a PII/PHI breach, the contractor shall follow applicable DoD cybersecurity and NIST requirements, which include United States-Computer Emergency Readiness Team (US- CERT) reporting (see paragraph 9.3). If at any point a contractor finds that a cybersecurity incident involves a PII/PHI breach (possible or confirmed), the contractor shall immediately initiate the reporting procedures set forth below.

The contractor shall also continue to follow any required cybersecurity incident response procedures and other applicable DoD cybersecurity requirements.

Contractors shall require subcontractors who discover a possible breach or cybersecurity incident to initiate the incident response requirements herein by reporting the incident to the contractor immediately after discovery. The time of that report to the contractor shall trigger the contractor's DHA Privacy Office reporting deadline (24 hours) under paragraph 9.3.2. If a cybersecurity incident is involved, the contractor's deadline for US-CERT reporting (1 hour) runs from the time the incident is confirmed. The contractor shall require the subcontractor to cooperate as necessary to meet these deadlines, maintain records, and otherwise enable the contractor to complete the breach response requirements herein. Alternatively, the contractor

Contractors shall maintain records of all breach and cybersecurity incident investigations, regardless of the outcome. Investigations identifying unauthorized disclosures must be logged for HIPAA and Privacy Act disclosure accounting purposes, whether or not individual notification is required under the HIPAA Breach Rule.
Contractors, when acting as HIPAA-covered entities, and not as business associates, are not subject to the breach response requirements herein. However, such contractors are subject to both the HIPAA Breach Rule (applicable to them in their capacity as covered entities) and DoD cybersecurity requirements (applicable to them in their capacity as DoD contractors).

Reporting Provisions

Immediately upon discovery of a possible or confirmed breach or cybersecurity incident, the contractor shall initiate an investigation. If the incident involves electronic PII/PHI, and if the investigation finds a confirmed breach or cybersecurity incident, the contractor shall report it, within 1 hour of confirmation, to the US-CERT Incident Reporting System at https://forms.us-cert.gov/report/, as required by the Department of Homeland Security (DHS).

Note: DHS no longer requires US-CERT reporting of non-cyber breaches or unconfirmed electronic breaches. However, DHS permits US-CERT reporting of unconfirmed cyber-related incidents on a voluntary basis. Thus, if a contractor is uncertain whether a possible cyber-related incident should be treated as confirmed and thus reportable, the contractor may voluntarily report the incident

Before submission to US-CERT, the contractor shall save a copy of the on-line report. After submitting the report, the contractor shall record the US-CERT incident reporting number, which shall be included in the initial report to the DHA Privacy Office as described in paragraph 9.3.2.

Note: Regardless of whether or not an incident is confirmed as a breach, the contractor must also investigate whether or not the incident impacts data integrity or availability of PII/PHI. If such impact is confirmed, then the incident is reportable to US-CERT as a cybersecurity incident. For guidance on investigating the impact on data integrity and availability, refer to DoD cybersecurity and NIST guidance.

The contractor shall provide any updates to the initial US-CERT report by email to soc@us-cert.gov, with the Reporting Number in the subject line. The contractor shall provide a copy of the initial or updated US-CERT report to the DHA Privacy Office if requested. Contractor questions about US-CERT reporting shall be directed to the DHA Privacy Office, not the US-

CERT office.

In addition to US-CERT reporting, the contractor shall report to the DHA Privacy Office by submitting the form specified below within 24 hours of discovery of a breach (possible or confirmed), unless the breach falls within a category that the Privacy Office has determined to be not reportable. This 24-hour period runs from the time of discovery, unlike the 1 hour US-CERT reporting period, which runs from the time a cybersecurity incident is confirmed. Thus, depending on the time period needed to confirm, the report to the DHA Privacy Office may be due either before or after the US-CERT report.

The breach report form required within the 24-hour deadline shall be sent by e-mail to: DHA.PrivacyOfficer@mail.mil. The contractor shall also e-mail the report to the CO, the COR and its usual point of contact at the applicable Program Office. Encryption is not required, because reports and notices shall not contain PII/PHI. If electronic mail is not available, telephone notification is also acceptable (at 703-275-6363), but all notifications and reports delivered telephonically must be confirmed in writing as soon as technically feasible.

Contractors shall prepare the breach reports required within the 24-hour deadline by completing the Breach Reporting Department of Defense Form DD 2959 (Breach of PII Report), available at https://www.esd.whs.mil/Portals/54/Documents/DD/forms/dd/dd2959.pdf. For non-cyber incidents without a US- CERT number, the contractor shall assign an internal tracking number and include that number in Box 1.e of the DD Form 2959. The contractor shall coordinate with the DHA Privacy Office for subsequent action, such as beneficiary notification, and mitigation. The contractor must promptly update the DD Form 2959 as new information becomes available.
When a Breach Report Form initially submitted is incomplete or incorrect due to unavailable information, or when significant developments require an update, the Contractor shall submit a revised form or forms promptly after the new information becomes available, stating the updated status and previous report date(s) and showing any revisions or additions in red text. The Contractor shall provide updates to the same parties as required for the initial Breach Report Form.

Individual Notification Provisions

If the DHA Privacy Office determines that individual notification is required, the Contractor shall provide written notification to beneficiaries affected by the breach as soon as possible, but no later than 10 working days after the breach is discovered and the identities and addresses of the beneficiaries are ascertained. The 10 day period begins when the Contractor is able to determine the identities (including addresses) of the beneficiaries whose records were

impacted. If notification cannot be accomplished within 10 working days, the contractor shall notify the DHA Privacy Office.

The Contractor's proposed notification to be issued to the affected beneficiaries shall be submitted to the DHA Privacy Office for approval. The notification to beneficiaries shall include, at a minimum, the following:

- Specific data elements,
- Basic facts and circumstances,
- Recommended precautions the beneficiary can take,
- Federal Trade Commission (FTC) identity theft hotline information, and
- Any mitigation support services offered, such as credit monitoring.

Contractors shall ensure any envelope containing written notifications to affected individuals are clearly labeled to alert the recipient to the importance of its contents, e.g., "Data Breach

Information Enclosed," and that the envelope is marked with the identity of the Contractor and/or subcontractor organization that suffered the breach.

If media notice is required, the contractor will submit a proposed notice and suggested media outlets for the DHA Privacy Office review and approval (which will include coordination with the DHA Communications Division).

In the event the Contractor is uncertain on how to apply the above requirements, the Contractor shall consult with the CO, who will consult with the Privacy Office as appropriate when determinations on applying the above requirements are needed.

The Contractor shall, at no cost to the government, bear any costs associated with a breach of PII/PHI that the Contractor has caused or is otherwise responsible for addressing.

(End of PII, PHI, and Federal Information Requirements)

8. Tobacco Free Medical Campus (TFMC)

In accordance with Army Regulation 600-63, paragraph 7-3, 14 April 2015; Operations Order 15-48 (Army Medical Command (MEDCOM) Tobacco Free Living – USAMEDCOM), 8 May 2015; and any Operations Order, regulation or other instruction implementing, defining or otherwise addressing the Tobacco Free Medical Campus (TFMC) on any military installation or DoD-controlled location, Contractor personnel are prohibited from using any tobacco product on or within any TFMC while performing under this contract. TFMCs are established at each installation or DoD-controlled location and include: (1) any property or non-residential building that is operated, maintained or assigned to support medical activities, including but not limited to, hospitals, medical laboratories, outpatient clinics (including medical, dental, and veterinary facilities), or aid stations operating for the primary purpose of delivering medical care and services for DOD eligible beneficiaries and /or meeting the mission of the Army Medical Command; (2) all other facilities in which medical activities or administration take place, to

include HQ MEDCOM and Defense Health Headquarters; (3) all internal roadways, sidewalks and parking lots; and (4) all sidewalks, parking lots and grounds external but adjacent to the building or related to the migratory corridors surrounding the medical facility. The Contractor shall obtain from the COR any orders, regulations, instructions or other documents implementing, defining or otherwise addressing the TFMC for any given installation or DoD-controlled location where Contractor personnel may perform under this contract and shall instruct Contractor personnel on the TFMC limitations for installations or DoD-controlled locations where they may perform under this contract.

9. Exclusion from Participation in Federal Health Care Programs (October 2015)

9.1. The Contractor shall not employ or contract with any individual or entity (hereinafter collectively referred to as “person”) to provide items or services that will be included in invoices submitted to the Government under this contract if such person is listed on the Department of Health and Human Services (HHS) Office of the Inspector General (OIG) List of Excluded Individuals and Entities (LEIE) or the TRICARE Sanctioned Provider List. The Government is legally prohibited from paying for provision of items or services by such persons. The prohibition extends to services beyond direct patient care, such as services of persons in executive or leadership roles and administrative and management services, whether or not such services are billed separately. The LEIE may be found at http://oig.hhs.gov/fraud/exclusions.asp, and the TRICARE Sanctioned Provider list at http://www.health.mil/Military-Health-Topics/Access-Cost-Quality-and-Safety/Quality-And-Safety-of- Healthcare/Program-Integrity/Sanctioned-Providers. The LEIE and TRICARE Sanctioned Provider List are hereinafter collectively referred to as “the Lists.

9.2. Prior to start of contract performance, the Contractor shall (a) query the Lists to determine whether the name of any person the Contractor employs or contracts with to provide services or items for which payment may be made under this contract appears on the Lists, and (b) certify to the Contracting Officer that the Contractor has queried the Lists and no such names appear on either of the Lists

9.3. During performance of the contract, and prior to persons other than those whose names were queried in accordance with paragraph 2, above, (hereinafter “new persons”) providing services or items under the contract, the Contractor shall (a) query the Lists as in paragraph 2, and (b) certify to the Contracting Officer that the names of such new persons do not appear on either of the Lists.

9.4. The Contractor is advised that during performance of the contract, MTF personnel will perform a recurrent recheck of the names of contractor personnel working in the MTF against the Lists, as specified in OTSG/MEDCOM Policy Memo 15-037. The Government will notify the Contractor in the event any contractor personnel working in the MTF appear on either of the Lists.

9.5. Should any person providing items or services under the contract appear on either of the Lists at any time during contract performance, the Contractor shall (a) in cases where the

Contractor identified the person, notify the Contracting Officer, and (b) promptly remove that person from the contract.

9.6. Violation of any aspect of the above paragraphs shall be considered a material breach of the contract and may result in termination of the contract.

9.7. The Contractor is further advised that, in accordance with Civil Monetary Penalties Law [CMP] (codified at 42 USC § 1320a-7a):

9.7.1. There are steep civil monetary penalties associated with billing the Government for providing items or services by a person on either of the Lists, and with failing to return to the Government any overpayments received for provision of such items or services.

9.7.2. Billing under the contract for provision of items or services by a person on either List may also result in exclusion of the person that employs or contracts with such person.

9.8. HHS OIG has issued a Special Advisory Bulletin on the Effect of Exclusion from Participation in Federal Health Care Programs with additional information on the CMP. The Special Advisory Bulletin may be found at http://oig.hhs.gov/exclusions/files/sab-05092013.pdf.

(End of Exclusion)

EXHIBITS

Exhibit List

EXHIBIT	DOCUMENT
A	Performance Requirements Summary
B	Example Primary Care Appointing Criteria
C	Example Specialty Care Appointing Criteria
D	Example Referral Guideline
E	Example Performance Report Formats
F	MHS GENESIS Direct Care Specialty Appointing Procedures
G	MTF Specialty Referral Notification Letter
H	Service Contract Act (SCA) Wage Determinations (WDs)
I	DHN-IP Phase-In Plan of Action & Milestones

Exhibit A - Performance Requirements Summary (PRS)

Performance Objective and PWS Paragraph	Performance Standard	Acceptable Quality Level (AQL)	Monitoring/ Surveillance Method
Paragraph 5.1.14. PAS: Mailed Correspondence	The contractor shall be responsible for mailing specialty care appointment information to beneficiaries within five business days of the third unsuccessful outbound call to the patient to schedule their MTF specialty appointment IAW DHA policy.	100 percent of the time	100% Inspection
Paragraph 5.4.7. PAS, RMS, and CLR: Manpower Reporting	The contractor shall maintain staffing IAW PWS staffing levels to provide PAS/CLR/RM functions IOT meet performance standards.	100 percent of employees reported by FTE, reported by required, on-hand, full-time and part-time.	100% Inspection Reported: Monthly
Paragraph 5.1.8. PAS: Call Abandonment	The contractor shall provide sufficient personnel to prevent call abandonment.	98 percent of the time.	100% Inspection Reported: Monthly
Paragraph 5.2.1. RMS: Disposition Report	The contractor shall disposition all routine referrals as either Appoint to MTF, Defer to Network, or route to MTF RMC. Contractor shall meet or exceed DHA referral management requirements. 100 percent of referrals	100 percent of the time.	100% Inspection Reported: Monthly

	dispositioned within one (1) business day from referral order date. One business day includes the order date plus the entire following day, excluding weekends and holidays. At the end of one (1) business day the referral shall be available for booking at the MTF, DTN to the MCSC, or routed to the MTF RMC per MTF RMC, CCR, or SAR requirements (Medicare, OHI, LOD, incomplete, complex etc.)		
Paragraph 5.2.4.10. RMS: Processing STAT/Urgent referrals	The contractor shall route all STAT/Urgent referrals to the MTF RMC within two hours upon receipt when located in the routine pool.	100 percent of the time.	100% Inspection Reported: Monthly
Paragraph 5.4.1.7. PAS: IVR Average Response	The contractor shall supply weekly reports by COB on the second business day following the week reported or based on the contract.	100 percent of the time.	100% Inspection Reported: Weekly
Paragraph 5.4.1.8. PAS: Average Speed of Answer	The contractor shall supply weekly reports by COB on the second business day following the week reported or based on the contract.	100 percent of the time.	100% Inspection Reported: Weekly

Paragraph 5.4.1.9. PAS: Call Wait Time	The contractor shall supply weekly reports by COB on the second business day following the week reported or based on the contract.	100 percent of the time.	100% Inspection Reported; Weekly
Paragraph 5.4.1.10. PAS: Call Processing Time	The contractor shall supply weekly reports by COB on the second business day following the week reported or based on the contract.	100 percent of the time.	100% Inspection Reported; Weekly
Paragraph 5.4.1.1.			
PAS: Call Volume Handled by Appointing, Referral Management and CLR Agents	The contractor shall supply required monthly report by COB on the fifth business day following the last day of the month reported or based on the contract.	100 percent of the time.	100% Inspection Reported: Monthly
Paragraph 5.4.1.2. PAS: Inbound Call Volume Handled by the IVR	The contractor shall supply required monthly report by COB on the fifth business day following the last day of the month reported or based on the contract.	100 percent of the time.	100% Inspection Reported: Monthly
Paragraph 5.4.1.4. PAS: Customer Service and Satisfaction of Appointing	The contractor shall supply required monthly report by COB on the fifth business day following the last day of the month reported or	100 percent of the time.	100% Inspection Reported: Monthly

	based on the contract.		
Paragraph 5.4.1.12. PAS: Blocked Call Rates	The contractor shall supply required monthly report by COB on the fifth business day following the last day of the month reported or based on the contract.	100 percent of the time.	100% Inspection Reported: Monthly
Paragraph 5.4.1.13. PAS: Call Abandonment	The contractor shall supply required monthly report by COB on the fifth business day following the last day of the month reported or based on the contract.	100 percent of the time.	100% Inspection Reported: Monthly
Paragraph 5.4.1.14. PAS, RMS, and CLR: Appointing, Referral Management, CLR Errors	The contractor shall supply required monthly report by COB on the fifth business day following the last day of the month reported or based on the contract.	100 percent of the time.	100% Inspection Reported: Monthly
Paragraph 5.4.2.1. RMS: Dispositions	The contractor shall supply required monthly report by COB on the fifth business day following the last day of the month reported or based on the contract.	100 percent of the time.	100% Inspection Reported: Monthly

Paragraph 5.4.2.2. RMS: Referral - STAT	The contractor shall supply required monthly report by COB on the fifth business day following the last day of the month reported or based on the contract.	100 percent of the time.	100% Inspection Reported: Monthly
Paragraph 5.4.2.3. RMS: Disposition/Routing Error Rate	The contractor shall supply required monthly report by COB on the fifth business day following the last day of the month reported or based on the contract.	100 percent of the time.	100% Inspection Reported: Monthly
Paragraph 5.4.2.4. RMS: Deferred to Network	The contractor shall supply required monthly report by COB on the fifth business day following the last day of the month reported or based on the contract.	100 percent of the time.	100% Inspection Reported: Monthly
Paragraph 5.4.2.5. RMS: Calls Monitored	The contractor shall supply required monthly report by COB on the fifth business day following the last day of the month reported or based on the contract.	100 percent of the time.	100% Inspection Reported: Monthly
Paragraph 5.4.2.6. RMS: Customer Service and Satisfaction of Referral Management	The contractor shall supply required monthly report by COB on the fifth business day following the last day of the month reported or based on the contract.	100 percent of the time.	100% Inspection Reported: Monthly

Paragraph 5.4.3.1 CLR: CLR Processing	The contractor shall supply required monthly report by COB on the fifth business day following the last day of the month reported or based on the contract.	100 percent of the time.	100% Inspection Reported: Monthly
Paragraph 5.4.6. PAS, RMS, and CLR: Training Status	The contractor shall supply required monthly report by COB on the fifth business day following the last day of the month reported or based on the contract.	100 percent of the time.	100% Inspection Reported: Monthly
Paragraph 5.5. PAS, RMS, and CLR: Performance Reports and Frequencies of Deliverables	The contractor shall supply required monthly report by COB on the fifth business day following the last day of the month reported or based on the contract.	100 percent of the time.	100% Inspection Reported: Monthly

(End of Exhibit A)

Exhibit B – Example Primary Care Appointing Criteria (SEE ATTACHED EXCEL DOCUMENT)

Exhibit C – Example Specialty Care Appointing Criteria (SEE ATTACHED EXCEL DOCUMENT)

Exhibit D - Example Referral Guideline

Developmental Concerns (Delay or High Risk)

I. **Indications for Specialty Care Referral**

A. Normal childhood development occurs along an anticipated course. Failure to achieve age-appropriate developmental milestones (Developmental Delay) or expression of an atypical course of development (developmental deviance) is cause for concern.

B. Children suspected of having Developmental Delays (social-emotional, communication, motor, cognitive) should be initially evaluated by their Primary Care Manager (PCM) and then referred to "M Peds Developmental" for comprehensive clinical evaluation and diagnosis. Please reference the specific Referral Guidelines for Autism Spectrum Disorders (ASD), for concerns related to social delays and/or autism. Prior to referral for developmental delays, please ensure you have documented your concerns (i.e. observations, interactions, results of formal screening, risk factors), screened for vision/hearing impairments and have started the process of community based developmental supports (see General Referral concepts below). These referral guidelines are best applied to children under the age of 8 years old. Guidelines for Academic delay can be considered through Adolescence.

C. American Academy of Pediatrics (AAP) recommends universal developmental screening, including screening for Autism Spectrum Disorders, with specific autism screening by 18months.

1. Universal developmental screening is recommended at ages 9 months, 18 months AND either 24 or 30 months. Additional screening is indicated anytime there is a parent or provider concern regarding development.

2. The Department of Pediatrics at Madigan Army Medical Center utilizes the Ages and Stages Questionnaire (ASQ) for universal screening, although other tools are available for use (Denver II, Parents Evaluation of Developmental Status (PEDS)).

3. Modified Checklist for Autism in Toddlers - Revised (MCHAT-R) or Communication and Symbolic Behavior Scales, Developmental Profile - DP Infant Toddler Checklist (CSBS ITC) are easy and free tools to screen for ASD.

II. Referral for Specific Developmental Delay:

A. <u>Social-Emotional Delay (concern for an Autism Spectrum Disorder</u>

1. Toddlers who fail an MCHAT-R or have social and/or language delays on ASQ screening should be <u>further evaluated by their PCM</u> (consider the MCHAT Follow up interview, MCHAT- R/F follow up interview) to determine if there is a concern for an ASD. Deficits in joint attention, social communication, language and play skills are important red flags. Based on specific guidelines in the MAMC Referral Guidelines for Autism Spectrum Disorders, the PCM should refer children with suspected ASD to Developmental Pediatrics. (WILL HAVE A LINK HERE TO THE ASD REFERRAL GUIDELINES WHEN THEY ARE APPROVED AND PUBLISHED)

2. If emotional regulation and behavior skills are delayed but there is low suspicion for an Autism Spectrum Disorder, it is reasonable to begin with referral for Parent Management Training through Behavioral Health with a plan for reassessment after 4 - 6months of intervention.

3. Some options include: New Parent Support Group (NPSG), Imbedded Behavioral Health Consultants (IBHC), Military Family Life Consultants (MFLC), Families Overcoming Under Stress (FOCUS), Child and Family Behavioral Health (CAFBHS), Zero to Three (http://zerotothree.org/)

B. Communication Delay

1. All children with communication delay require a formal Audiology evaluation to rule out variable hearing deficits. This must be ordered prior to, or concurrent with, referral to Developmental Pediatrics.

2. All children suspected of having language or communication delay, should have initial screening at the primary care level (i.e., ASQ, CSBS ITC, MCHAT).

3. If there is a concern for isolated delay in language skills or articulation skills (ALL other domains of development are appropriate and there are no social concerns), the child can be referred directly to the Speech Clinic at Madigan for formal testing of their receptive and expressive language skills.

4. If there are concerns for two or more developmental domains, children should be referred to “M Peds Developmental” for Global Developmental Delays AND concurrently referred for Early Intervention Services or School Based services as outlined below.

C. Motor Delay

1. All children suspected of having motor delays and/or problems with mobility, should have initial screening at the primary car e level (i.e. ASQ, Denver II, PEDS).

2. The PCM should consider a Creatine Kinase (CK) level for any boy who is not walking by age 15-18 months.

3. For children with motor delays or deviant motor development (early rolling and/or early handedness), attention should be paid to growth patterns (macrocephaly, microcephaly, failure to thrive) and neuromuscular exam (Are reflexes normal? Is there clonus or atypical mobility? Is hypotonia or hypertonia present?). Vision impairment should be considered and formal testing ordered if examination or history denotes concern.

4. If there is a concern for isolated delay of motor skills (ALL other domains of development are appropriate) and the child is low risk (no perinatal adversity) with a normal neurologic examination, refer the child to “M Peds Developmental” with a specific request for evaluation by the Pediatric Physical Therapist.

5. For all other concerns related to motor delays or deviant motor development, including children who have tone abnormalities or an abnormal neuromuscular exam, the child should be referred to Developmental Behavioral Pediatrics with a specific request to evaluate motor skills in the context of either multiple delays or abnormal neurologic status.

6. If there are concerns for two or more developmental domains children should be referred to Developmental Behavioral Pediatric s for Global Developmental Delays AND concurrently referred for Early Intervention Services or School Based services as outlined below.

D. Global Developmental Delays (including concerns related to cognitive and adaptive skills)

1. If there are developmental concerns for two or more domains, children should be referred to Developmental Behavioral Pediatrics for Global Developmental Delays AND concurrently referred for Early Intervention Services or School Based services as outlined below.

2. Hearing evaluation is required for all children with communication delays (newborn hearing screen is not adequate).

3. Vision screening is highly encouraged for children with global developmental delays (office screening may be appropriate).

4. Specify in the referral which areas of development are of concern.

5. See guidelines above related to PCM responsibilities for initial evaluation in each developmental domain.

6. See detailed guidelines below regarding general referral concepts

E. Academic Delay (concern for cognitive skills and/or learning disorders)

1. Children age 5 years and older may present to their PCM with concern for poor academic skills. The differential for academic problems is broad and includes psychosocial adversity, Attention Deficit Hyperactivity Disorder (ADHD), emotional or mood disorders, Learning Disability(s) and neurodevelopmental disorders related to cognition and learning.

2. The PCM should evaluate and treat the following:

   a) ADHD

   b) Emotional disturbances and mood disorders

   c) Psychosocial adversity (trauma, abuse, bullying, family dysfunction)

3. School aged children should be referred to their school district for psychoeducational testing and consideration of an Individualized Educational Plan (IEP) or 504Plan. Psychoeducational testing should specifically include “Academic Achievement testing and IQ testing” if f there is concern for a Learning Disability (LD). After testing has been completed, children can be referred to Developmental Behavioral Pediatrics for review, interpretation and any indicated treatment planning based on psychoeducational testing results. Please note that Development al Behavioral Pediatrics does not perform formal psychoeducational testing.

4. Children with a known history of learning or academic concerns (Intellectual Disability, Learning Disability, Academic underachievement) can be referred to Developmental Behavioral Pediatrics for consultation and review of their IEP. Transition times (starting middle school, graduating high school) can be especially problematic for children and adolescents with academic or learning challenges.

5. Families who feel frustrated with their IEP or school based supports can contact PAVE/STOMP (Partnership for Action. Voices f or Empowerment/Specialized Training of Military Parents) or the WA State Educational Ombudsman for assistance and tips on educational advocacy.

F. <u>Referral for children at High Risk of Developmental Delay:</u>

1. Prematurity

   a) Upon NICU discharge, any infant considered high risk by the discharging neonatologist (extreme prematurity or small for gestational age, prolonged ventilation, cardiac or respiratory arrest, sepsis, complicated or unexpected course, etc.) should be transitioned into the NICU follow up clinic.

   b) All infants born at 32 weeks EGA or earlier should be referred to “M Peds Developmental” at 6 months corrected age for multidisciplinary assessment.

PCM should ensure audiology and ophthalmology follow up is up to date at time of referral.

c) Any infant born between 32 and 37 weeks EGA with a complicated neonatal course or manifestation of developmental delay, should be referred to Developmental Behavioral Pediatrics at 6 months corrected age for multidisciplinary assessment. PCM should ensure audiology and ophthalmology follow up is up to date at time of referral.

2. Other Perinatal Adversity (hypoxic-ischemic encephalopathy, neonatal meningitis).

a) Upon NICU discharge, any high risk infant should be transitioned into the NICU follow up clinic.

b) Term infants with significant perinatal adversity should be referred to Developmental Behavioral Pediatrics at 6 months of age for multidisciplinary assessment. PCM should ensure audiology and ophthalmology follow up is up to date at time of referral.

3. Chronic condition associated with Developmental Disability (DD) or Developmental Delay (genetic condition, chemotherapy, renal failure).

a) Any infant/child with a chronic medical condition that is associated with DD or has an increased risk of DD, should be referred to “M Peds Developmental” for early risk prevention, evaluation of current skills and recommendations for intervention and continued surveillance. Referral should state the specific condition or risk factor and results of PCM initiated formal developmental screening.

b) PCMs should be familiar with clinical practice guidelines available for routine healthcare maintenance for children as established by the American Academy of Pediatrics for specific conditions such as Trisomy 21. This information can be accessed at https://www.aap.org/en- us/professional-resources/clinical-support/Pages/Clinical-Support.aspx

4. Psychosocial Adversity (non-accidental trauma, neglect, foster care, extreme poverty, loss of a parent)

a) Any infant/child with exposure to psychosocial factors associated with DD or associated with an increased risk of DD, should be referred to “M Peds Developmental” for early risk prevention, evaluation of current skills and recommendations for intervention and continued surveillance. Referral should state type of psychosocial adversity and results of PCM initiated formal developmental screening.

II. General Concepts for all referrals:

- Physical examination by the PCM should include determination of the child's OFC, review of growth parameters, assessment for obvious congenital anomalies or dysmorphic features, full neuromuscular examination and descriptive observations of the child's behavior and interactions.

- Simultaneous referral for community resources is highly encouraged.

    - Children under 36months of age must be referred to Birth-to-Three or Early Interventions Services (EIS) for evaluation and provision of an Individualized Family Service Plan (IFSP) and home based interventions under federal statute. There is no CHCS/ALHTA referral option for EIS; parents must contact their county representative or call Child Find through the WA State **Family Health Hotline at 1-800-322-2588.**

        - **Consistent with PCMH objectives, a nurse or case manager can initiate contact for a family.**

    - Children 3 years old and older must be referred to their local school district for evaluation of developmental/cognitive/academic abilities and provision of an Individualized Education Plan (IEP) as indicated by their performance. There is no CHCS/ALHTA referral option for IEP evaluations; parents must contact their local school district or go call the WA State **Family Health Hotline at 1-800-322-2588.**

        - T**o expedite this process, parents should request an evaluation through the school district in writing.**

        - **Consistent with PCMH objectives, a nurse or case manager can assist a family with this process by offering a drafted letter requesting services that the parent then signs and provides to the local school district.**

- Children with an established diagnosis of developmental disability or developmental delay (specific or global) may be referred for review of current needs to include indications for therapy (ST, OT, PT, feeding therapy), educational supports, community advocacy, etiologic work up (if indicated and not already accomplished) and medication management for behavioral symptoms/co-existing conditions.

- Once an initial diagnosis is established, an etiologic work up has been initiated, and the child has been established with appropriate medical, community and educational supports, consultative management may only be required semi-annually, during

transition (beginning high school or entering a transitional program) or when new findings/complications/concerns associated with the diagnosis are identified.

- All referrals related to concerns for Developmental delays or high risk screening, should be reviewed by the Developmental Behavioral Pediatrics Clinic prior to release to outside agencies.

II. When referring a patient, please include as much of the following information as possible (OK to cut and paste this into consult request): (Note: Do not change this section)

A. **Provisional diagnosis; clear and concise**

B. **Duration of Problem**

C. **Prior treatments**

D. **Current treatments/medications**

E. **Diagnostic studies obtained (imaging, labs, other tests, etc.)**

F. **Primary reason for consult; clear and concise.**

III. Diagnosis/Definition

Delayed or disordered development is that which occurs later than expected for age or that which follows a deviant or disordered pattern representative of underlying pathology. In general, developmental milestones which are delayed more than two standard deviations below the mean for age, are considered significantly delayed and warrant further evaluation. Children who are late in achieving milestones, but are between one and two standard deviations below expected for age, may demonstrate less severe functional impairments but will still benefit from early detection, further etiological evaluation and early intervention. Atypical or delayed development may indicate an increased risk of other medical, emotional and behavioral complications. Developmental delays may be the presenting symptom of an unrecognized and yet untreated medical condition. Children may demonstrate delays in a specific domain of development, such as isolated Language Delay, or they may manifest delays in multiple areas. Factors which contribute to delay or the risk of delay include genetic predisposition (Fragile X syndrome or a family history of delayed language), nutritional factors (lead, iron deficiency, failure to thrive), environmental opportunity and exposure, chronic illness (repeated hospitalizations, metabolic disorders, congenital cardiac disease), prematurity and complications of prematurity (interventricular hemorrhage), psychosocial factors (maternal depression, poverty). The differential diagnosis includes autism spectrum disorders, sensory

impairments (vision or hearing deficits), neuromuscular diseases (cerebral palsy, neural tube defects), ADHD, and other social-emotional problems.
Per the 2006 AAP Policy Statement on developmental screening, "children with developmental disorders should be identified as children with special health care needs, and chronic-condition management should be initiated. Identification of a developmental disorder and its underlying etiology may also drive a range of treatment planning, from medical treatment of the child to family planning for his or her parents."

IV. Initial Diagnosis and Management

Pathway for evaluation of Developmental Delay:

Parents of individuals referred for evaluation related to a developmental concern will be asked to complete an information packet prior to evaluation. Information requested is dependent on the child's age and medical history, but may include a medical intake questionnaire, a copy of the child's Individualized Family Support Plan (IFSP) or Individualized Education Plan (IEP), a developmental skills inventory, reports from community therapists and parent/teacher behavior rating scales. Referrals will then be prioritized for scheduling in one of the following clinics:

A. Infant Toddler Clinic (ITC):

First time evaluation for developmental concerns for children 6 months (corrected age) through age 3 years old. Infants and toddlers referred for global delays or referred for early screening due to increased risk for delay, are often seen in ITC. ITC is a multidisciplinary clinic which incorporates Developmental Pediatrics, Pediatric Psychology, Social Work and Speech Pathology. Evaluation takes between 2 -4 hours per child and will include a full neurodevelopmental history, a neurogenetic physical exam, review of perinatal/medical history, review of IFSP/prior evaluations/Audiology record, review of social stressors and the home environment, and formal developmental screening/testing as indicated by the presenting history (Bayley Scales of Infant Development-III, CSBS ITC, Child Development Inventory (CDI), Capute Scales). A summary of testing scores and recommendations is mailed home to the family after the team conference.

B. Developmental New Consult (D60)/Fellows Clinic (FC):

First time evaluation for academic concerns, isolated delays at any age, or global delays for children 3 years old and older. D60/FC evaluations will include a full neurodevelopmental history, a neurogenetic physical exam, review of perinatal/medical history, review of IFSP/IEP/prior evaluations/Audiology record, review of social stressors and the home environment, and formal developmental screening/testing as indicated by the presenting history (CDI, Social Communication Questionnaire, PPVT-4, KBIT-2). If

applicable, information will be sought from parents and teachers to gain an understanding of behavior across environments.

C. Neuromuscular Clinic (NMC):

First time evaluation for developmental concerns for any age child who has an abnormal neuromuscular exam or tone abnormalities, OR a child with a known neuromuscular diagnosis which impacts development (i.e. cerebral palsy, neural tube defect). NMC is a multidisciplinary clinic which incorporates Developmental Pediatrics, Pediatric Neurology, Pediatric Genetics, Pediatric Physical Therapy, and Pediatric Orthopedics (occasionally Pediatric Neurosurgery, Pulmonology and Urology will also be represented). Evaluation takes between 2 -4 hours per child and will include a full neurodevelopmental history, a neurogenetic physical exam, review of perinatal/medical history, review of prior evaluations, review of social stressors and the home environment, review of genetic predisposition (including a formal pedigree), review of current therapies/equipment and determination of needed therapies and equipment, and formal developmental screening/testing as indicated by the presenting history. A summary of testing scores and recommendations is mailed home to the family after the team conference.

D. Consult may be re-routed to Madigan Speech Clinic:

Referrals which indicate a concern for isolated communication delay will be discussed with the PCM to determine if they wish to place a consult directly with “M Speech Pathology” or initial referral can re-routed for formal language testing with a speech pathologist. Recommendations will be sent back to PCM and may include more extensive evaluation with a Developmental pediatrician, community therapy or continued surveillance.

E. Consult may be re-routed to Madigan Pediatric Physical Therapy:

Referrals which indicate a concern for isolated motor delay will be routed with in the Developmental Clinic for formal evaluation with a Pediatric Physical Therapist. Recommendations will be sent back to PCM and may include more extensive evaluation with a Developmental pediatrician, community therapy or continued surveillance.

F. See Autism Spectrum Disorders Referral Guidelines for information on referrals related to ASD concerns. If a child referred to “M Peds Developmental” is seen in one of the above clinics and the consulting provider has concerns for an ASD, specific evaluation f or ASD will be arranged.

If Developmental Delay is confirmed:

- Once a child has been identified to have developmental delay, the treatment plan will include medical, behavioral, and educational interventions, social and family supports, and a targeted etiologic work up.

  - Medical and Behavioral supports include Speech Therapy, Occupational Therapy, Physical Therapy, Feeding Therapy, Behavior Therapy, Early Intervention services, treatment of sensory deficits, pharmacologic support and care of comorbid conditions.

  - Educational supports (IFSP or IEP) may include social-emotional support, specific school- based therapies, educational advocacy or Special Education resources based upon each child's need.

  - Community supports include, but are not limited to, Exceptional Family Member Program (EFMP), PAVE, New Parent Support Group, online resources (www.zerotothree.org), CAFBHS, Imbedded Behavioral Health Consultants (IBHC)

  - Enrollment in EFMP must be initiated once a child is identified to have developmental delays which require intervention.

  - Etiologic evaluation is recommended based on each child's unique needs and is planned through shared-decision-making with parents. Medical evaluation typically includes CK for toddlers with motor delay. Fragile X PCR and broad genetic testing through microarray (CGH). Hearing and vision will be screened if not already done so. Physical exam and medical history may prompt further investigation to include expanded genetic testing, imaging or metabolic testing. A specific underlying etiology is only found in 10-25% of children with global developmental delays.

  - Medication management will be considered for children with co-morbid ADHD, mood disorders or behavioral problems such as extreme irritability/aggression. Medication management is co-managed between Developmental Pediatrics and the PCM. For example medication could be initiated in Developmental Pediatrics and once stable, transferred to the PCM for continuity care. Atypical antipsychotic medications may require more intensive monitoring by both PCM and specialist.

I.Ongoing Management and Objectives

- The goal of comprehensive treatment for children with developmental delay is to achieve maximal levels of motor, cognitive, communication, social, intellectual, emotional, adaptive and community functioning. This is achieved through a thorough understanding of the neurodevelopmental and neurobehavioral dysfunction, the associated medical

problems, mode and success of communication and mobility, level of cognitive function, psychosocial adjustment and family function.

- Objectives for management are to achieve successful family and community function, achieve developmentally appropriate adaptive skills and self- care skills, to foster personal and family adjustment and to provide proper education and vocational rehabilitation as indicated for each unique child.

- Particular areas of concern will be early identification of any progressive, reversible or treatable etiology and co-morbid medical problems.

- Treatment plans will focus on communication, cognitive function and how this impacts education, social function (play, relationships), impact of sensory deficits or sensitivities, impact on feeding/nutrition/growth, fostering self-worth and self-esteem, fostering appropriate levels of independence/adaptive skills, management of behavioral problems (elopement, impulsivity, inattention, aggression, sleep routines, toileting). Treatment plans will aim to support each child in achieving his or her maximum potential.

- Educational and community advocacy will be highlighted during transition times of greatest impact (Developmental Preschool, Kindergarten, entering Middle School, entering High School, extended High School and transition to adult care).
- There will be an emphasis on maximizing behavioral interventions and avoiding polypharmacy for children with severe neurobehavioral manifestations. For children who require atypical antipsychotics for behavioral stabilization, good practice guidelines will be followed to ensure appropriate monitoring is achieved pre-initiation and at appropriate intervals. Efforts to avoid or mitigate adverse medication effects will be balanced with the severity of the target behaviors and discussed thoroughly with parents and/or patient.

9 Criteria for Return to Primary Care

- In some cases, co-management between Developmental Behavioral Pediatrics and the PCMH is necessary.

- Completed specialty care evaluation with established diagnosis, functional levels and recommendations that can be accomplished within the PCMH model.

- Development is deemed to be within appropriate range for age.

- Diagnosis of specific or global developmental delay has been established, appropriate etiologic evaluation has been completed and the child is connected with appropriate medical, behavioral, community and educational supports tailored to his/her needs.

- PCMs can manage or coordinate behavioral health care for mild behavioral problems and typical behavioral concerns (i.e. enuresis) in the context of the child's known developmental level.

I.

- PCMs can monitor and continue interventions such as ST, OT, PT, Feeding therapy, behavioral therapy, Early Intervention Services and Special Education supports.

- Continued medication management for comorbid ADHD and/or mood disorder once medications and dosing are deemed stable by the Specialty provider. PCMs are encouraged to initiate telephone or email contact with Developmental Behavioral Pediatrics should new questions arise regarding medication choices and dosing. Infrequently, patients may need to be referred back to Developmental Pediatrics to reassess medication management options.

References

1. *AAP Policy Statement: Identifying Infants and Young Children with Developmental Disorders in the Medical Home: An Algorithm for Developmental Surveillance and Screening.* AAP Council on Children with Disabilities. Pediatrics 2006:18;1

2. Gerber, J., Wilks T., Erdie-Lalena, C. *Developmental Milestones: Motor Development.* Pediatrics In Review 2010; 31;267

3. Gerber, J., Wilks T., Erdie-Lalena, C. *Developmental Milestones 2: Cognitive Development.* Pediatrics In Review 2010; 31;363

4. Gerber, J., Wilks T., Erdie-Lalena, C. *Developmental Milestones 3: Social-Emotional Development.* Pediatrics In Review 2011; 32;533

WA Early Support for Infants and Toddlers (information on Early Intervention Services): http://www.del.wa.gov/development/esit/families.aspx

MCHAT is available online at: https://www.m-chat.org/mchat.php

CSBS Infant Toddler Checklist is available online at: http://www.brookespublishing.com/resource- center/screening-and-assessment/csbs/csbs-dp/csbs-dp- itc/

Last Review for this Guideline: **July 2015**
Referral Guidelines require review every three years.

Maintained by the Madigan Army Medical Center - Quality Services Division Clinical Practice and Referral Guidelines Administrator

(End of Exhibit D)

Exhibit E – Example Performance Report Formats (SEE ATTACHED PDF)

Exhibit F – MHS GENESIS Direct Care Specialty Appointing Procedures

Hawaii IRMAC Direct Care Specialty Appointment Procedures using MHS GENESIS

PURPOSE: To standardize initial specialty care appointing in the PIRMAC and HIRMAC Military Treatment Facilities (MTF) personnel for all categories of beneficiaries.

If a patient requires a specialty care referral, the health care provider (HCP) will enter the referral request in MHS GENESIS. The health care provider will instruct the patient to call the P/HIRMAC in two working days to schedule an appointment.

The clinic will provide the patient a printed document with the following information: date the referral was ordered, requested clinic, requested date range, HCP that ordered the referral and diagnosis. Clinics may provide the patient with a standardized MTF patient instruction sheet. For consistency, any Patient instruction sheets the clinics use must be sent to the P/HIRMAC for reference in order to assist advising the patient.

Review of specialty referrals prior to appointing will be the exception since this unnecessarily delays beneficiary appointing and is not the standard in civilian medical organizations. Exceptions may be granted by the MTF Commander in writing. All Commander endorsed exceptions must be sent to the P/HIRMAC for reference.

All referrals will be accepted for appointing to the direct care system or deferred to the network within 1 business day from the order date. One business day includes the order date plus the entire following day, excluding weekends and holidays. If referrals have not been reviewed by the 2nd duty day, the P/HIRMAC agent will approve the referral and schedule an appointment according to the clinic criteria guidelines. For example, a referral entered on Monday may be booked anytime on Wednesday.

The P/HIRMAC will monitor routine referrals in which patients have failed to call for an appointment. Agents will attempt to contact patients with approved referrals no less than three times on three separate days (first message NLT business day 3 and final message not earlier than calendar day 14), after order date, or until the appointment is booked, whichever effort concludes first. Each attempt to contact the patient should be documented in the EHR. The

contractor will also initiate a phone call to contact the patient via primary telephone NLT the 14 days, and they will mail letter after 30 days if phone/secure messaging not efficient on contacting the patient.

If the patient is contacted but decides they no longer require the referral, the scheduler will delete the referral order, and specify the reason for deletion: “patient contacted and did not wish to use referral”.

If a patient cancels an initial specialty care appointment and then calls at a later date to reschedule, the P/HIRMAC will search past appointments back 90 days to verify that the patient was referred there. If the cancelled appointment is within the last 90 days, the agent will book an appointment using the MHS GENESIS ‘self-refer’ function.
Similarly, if a patient misses an initial appointment and calls to reschedule, agents will search appointment history and follow the aforementioned guideline.

Direct care referrals are only valid for up to 180 days. If a referral was entered 180 days or greater, the agent will send a secure message to the referring HCP and PC Team that it is no longer valid and they will close out the referral.

The P/HIRMAC agents will only book routine priority referral requests. All referrals with any other priority status should be directed to the receiving MTF clinic directly for assistance.

The P/HIRMAC agents will follow review comments annotated on the referral request. The comments override clinic criteria guidelines in order to ensure that the referring providers detailed instructions support high quality, timely care. Clinics must annotate scheduling instructions at the beginning of the form’s comment section.

The reason for an appointment must be annotated when the appointment has been scheduled. If no reason is entered in the diagnosis section and the patient is unsure of the reason, enter “initial visit (name of specialty)”.

Patients with referrals may also contact the MTF Referral Management Centers for guidance, assistance or clarification.

If an agent sees that a referral has been deferred to the network, the clerk will inform the patient of this status and provide any annotated network clinic information to the patient.

Booking priority for ALL Specialty Clinics:

1. Book per appointment request review comment.

2. If the specialty is available at another direct care facility, the contractor will offer the option of going to the another proximal P/HIRMAC facility. If the patient declines, proceed to step 3.

3. Attempt to warm-transfer to specialty clinic. If unsuccessful, proceed to step 4.

4. If no appointments are available within access standards:

4.1. Sample script: “Our next available appointment is DATE which is outside of our access standards. I can offer you a referral to the network or you may wait for the next available appointment. The wait time on the network for this type of appointment is approximately ## days. That would put the appointment at DATE. Which would you prefer?”

4.2. Network specialty access to care data will be provided via the “Days to Care” report for each MTF Prime Service Area will be provided by the P/HIRMAC COR on a monthly basis.

4.3. NOTE: If the specialty is not listed on the Days to Care report or the Average is 0, use this script: “Our next available appointment is DATE which is outside of our access standards. I can offer you a referral to the network or you may wait for the next available appointment. Which would you prefer?”. NOTE: The goal is to retain the maximum volume of care within the MTF specialty care system.

5. If the patient chooses to go to the network: Sample Script Your referral will now be deferred to a network provider, please allow 48 hours for the TRICARE contractor to re-process your referral.”

5.1. If the patient is TRICARE Prime

5.1.1. You can call the TRICARE contractor NLT 7 days at [enter phone number] or go online at [enter website] to check the status of the consult. If you decide later that you would prefer to come back to the MTF for this appointment, you may call [Referral office number].”

5.2. If the patient is TRICARE Plus

5.2.1. You can go to www.medicare.gov to find a provider that is located at a facility that is convenient for you or you can call [referral office number] for information on where to go for care or questions regarding your referral. If you decide later that you would prefer to come back to the MTF for this appointment, you may call [referral office number].”

5.3. Change clinic name on consult to [your referral office hospital location name] and annotate in the review comment that there are no appointments available within Access to Care (ATC) standards. This is VERY important and is MANDATORY by policy.

6. If patient chooses to stay at the MTF, thank them for their loyalty and book the next available appointment according to established guidance.

6.1. Ensure you document that the patient refused to go to the network in the appointment comment.

7. If there are no appointments available, generate a SAR “ALL APPOINTMENTS REFUSED” with free text “Patient refused Network”.

NOTES:

1. Patients that have Family Member Prefix 40 or 50 series may be deferred but let them know they will have to use their other health insurance (OHI). If they do not have other health insurance, you may recommend they visit www.healthcare.gov to get signed up for a health insurance plan that works for them. These patients are Space- Available (Space A) and should use their OHI.

2. Medicare patients may have different wait times than what is listed.

3. SELL your clinic as much as possible! We have great care! Your Clinic Chief/Head or administrative officer/GPM can give you talking points for your clinic and what you do better than clinics in the network.

4. If a patient later decides to return to the MTF and the consult is less than 90 days old, you should book the appointment using the self-referral function.

(End of Exhibit F)

Exhibit G – MTF Specialty Referral Notification Letter (SEE ATTACHED MEMORANDUM)

Exhibit H - Service Contract Act (SCA) Wage Determinations (WD)

This requirement is subject to the Service Contract Act. Notice of Wage Determination
The U.S. Department of Labor, Wage Determination 2015-5539 (Rev.30), dated, 12/02/2025 is applicable to this requirement. The full text can be downloaded at https://sam.gov.

(End of Exhibit H)

Exhibit I – DHN-IP Phase-In Plan of Action & Milestones

Phase-In Task	Start Week #	End Week #	Responsible Lead
Phase-In Plan and In-Process Review (IPR) Schedule	1	1	DHN-IP HCO & MTF Interface
Hawaii MTF Overview	1	1	DHN-IP HCO & MTF Interface
Approve facility location	1	1	Contractor
CAC Access & Request Process	1	1	DHN-IP HCO Office

Assign MHS GENESIS User Roles	1	1	DHN-IP HCO Office
The Government will provide initial training on MHS GENESIS	1	4	DHN-IP HCO Office
Government MHS GENESIS system support and Information Security POC Coordination	2	2	DHA, DHN-IP HCO Office, Contractor
Systems Interface & Compatibility Testing	2	2	DHA, DHN-IP HCO Office, Contractor
Telephony system interface and connectivity validation	2	2	DHA, DHN-IP HCO Office, Contractor
Submit staffing & management plan	3	3	Contractor
MHS GENESIS Train-the-Trainer Concept of Operations	3	3	DHA Network Office
Demonstration: Appointing Functions, Process Maps & Business Rules	4	4	DHN-IP HCO Office SMEs
Demonstration: Referral Management Functions, Process Maps & Business Rules	4	4	DHN-IP HCO Office, MTF RM SMEs
Demonstration: CLR Accountability Functions, Process Maps & Business Rules	4	4	DHN-IP, MTF CLR SMEs
Submit Performance Report Formats IAW Performance Requirements Summary for Acceptance	4	4	Contractor
Validate Performance Reporting alignment with DHA POLICY	4	4	DHA, DHN-IP HCO Office
MHS GENESIS Appointing Functions & Tip Sheet Training	5	5	DHA, DHN-IP HCO Office
Referral Management Functions & Tip Sheet Training	5	5	DHA, DHN-IP HCO Office
CLR Accountability Functions & Tip Sheet Training	5	5	DHA, DHN-IP HCO Office
Demonstrate Automatic Call Distribution (ACD) system & scripting	6	6	DHN-IP HCO Office
Approve IVR scripting for approval	6	6	DHN-IP HCO Office

Approve ACD solution / scripting.	6	6	DHN-IP HCO Office
Submit Exhibit F- Systems Redundancy & Contingency Plan	7	7	Contractor
Approve continuity of service plan	7	7	DHN-IP HCO Office
Demonstrate Staff Proficiency: Appointing, Referral Management & CLR processing. Knowledge, Skills and Ability evaluation	8	8	Contractor, DHN-IP HCO Office
Validate Secure Messaging Proficiency	8	8	DHN-IP HCO Office
Validate Background/Security clearance and CAC status	8	8	Contractor, DHN-IP HCO Office
Validate mandatory training status (HIPAA, Sexual Harassment, etc.)	8	8	Contractor, DHN-IP HCO Office
Submit Analysis of Staff Proficiency: Appointing, Referral Management & CLR processing	8	8	DHN-IP HCO Office
Submit training plans for Appointing, Referral Management & CLR services	10	10	Contractor
Test 1-800# and scripts	10	10	DHN-IP HCO Office
Test and validate IVR options and recording	10	10	DHN-IP HCO Office
Test and validate after-hours recording	10	10	DHN-IP HCO Office
Test voice recording software	10	10	DHN-IP HCO Office
Test contingency/continuity of service delivery plan	10	10	DHN-IP HCO Office
Final review of Performance Reporting Formats (Appointing, RM, CLR) and reporting schedule	10	10	DHN-IP HCO Office
Complete full systems validation test & issue report	11	11	DHN-IP HCO Office
Approve full systems performance	11	11	DHN-IP HCO Office
Approve completed transition	12	12	DHN-IP HCO Office

Issue Authority to Operate	12	12	Contracting Officer

(End of Exhibit I)