DEPARTMENT OF THE NAVY
BUREAU OF MEDICINE AND SURGERY
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IN REPLY REFER TO
BUMEDINST 4200.2D
BUMED-M4
25 Jul 2014

BUMED INSTRUCTION 4200.2D

From: Chief, Bureau of Medicine and Surgery

Subj: HEALTH CARE SERVICES CONTRACTING

Ref: (a) NAVSUPINST 4205.3E
(b) Federal Acquisition Regulation (FAR)
(c) 10 U.S.C. 1089 and 1091
(d) SECNAVINST 6300.3A
(e) Defense Federal Acquisition Regulation Supplement (DFARS)
(f) ASN (RD&A) memo of 20 Dec 04, Proper Use of Non-DOD Contracts
(g) NAVSUPINST 4200.83H
(h) DoD 5500.07-R of November 17, 2011

Encl: (1) Definitions/Acronyms
(2) Sample Technical Assistant Appointment Letter

1. Purpose. To provide policy and guidance for the effective management of health care contracting resources; and define roles, responsibilities, and duties for contract planning, execution, and management. This is a complete revision and must be read in its entirety.

2. Cancellation. BUMEDINST 4200.2C and BUMED Memo 4200 Ser M4/11UM44176 of 27 July 2011.

3. Scope. Applies to Naval Medical Logistics Command (NAVMEDLOGCOM), Navy Medicine Regions, and all Bureau of Medicine Surgery (BUMED) Budget Submitting Office (BSO) 18 activities with health care contracting requirements.

4. Definitions. See enclosure (1).

5. Background

a. BUMED has a tremendous stake in health care contracting. During Fiscal Year 2011, BUMED contracting offices had approximately 1,000 health care awards in place, providing over 4,000 health care worker full-time equivalents. Health care contracting directly contributes to the health and well being of every member of the Navy family.

b. This instruction provides basic information on health care contract types and the selection of the correct contract type for each requirement. Contracting Officer's Representatives (CORs) have a vital role in contract management, and those duties are enumerated in detail.

c. Reference (a) provides Navy-wide guidance concerning duties, responsibilities, and limitations of the COR.

6. Discussion

a. Business decisions. Prior to entering into any type of contracted health care service, it is important to consider the relationship of the medical treatment facility (MTF) to the overall plan for health care delivery in the region. Activities should consider contracting solutions in the context of total force manpower decision making. Among the issues for consideration are provisions of the TRICARE contracts, Department of Veterans Affairs (DVA)/Department of Defense (DoD) sharing, and other health care delivery vehicles. All factors and choices shall be considered to ensure the best business decision in each case.

b. Acquisition Planning. Successful health care services contracting demands proactive and ongoing acquisition planning by the MTF. Only with adequate planning can the MTF balance their needs against the ability of the marketplace to respond within the MTF's time and financial constraints. The following paragraphs explore the balance between financial (price) risk and performance risk when considering various contract solutions.

c. Direct Health Care Contracts. This section discusses the unique contract types used for the delivery of medical and dental services. Characteristics of the various contract types and indications for the use of each will be addressed. This section will also provide some information on the proper use of incentives in health care contracts.

(1) Factors influencing selection of contract type

(a) Apportionment of Contract Risk. There are two types of contract risk-price: price risk and performance risk. Price risk is the extent to which the contractor and the Government share responsibility for differences between projected costs and actual costs. Performance risk is the degree to which the contractor and Government share responsibility for variability in the time, place, and manner of delivery. The Contracting Officer (KO) shall select a contract type that apportions contract risk appropriately for the services to be acquired.

(b) Assessment of the Market. In acquiring health care services, the Navy shall compete with many other buyers who are also seeking to purchase what are often scarce resources. For example, registered nurses, radiologists, and dental hygienists are among the labor categories for which demand has continued to exceed supply. Some contract types work better than others in markets where the desired commodity is scarce.

(c) Cost Effectiveness. The price of health care services is a factor of the two elements previously discussed, risk and markets. The greater the risk assumed by the contractor, the higher the contract price. Likewise, the tighter the market for the desired services, the higher

the contract price. Urgent requirements or short duration requirements tend to exacerbate the risk and market effects. In addition, there are structural elements of some contract types that affect overall cost effectiveness.

(d) Efficiency in Placement and Administration. The total time necessary to put contract services in place is known as cycle time. The duration of cycle time is proportional to the value and complexity of the requirement being procured. Simple requirements of lower value require less planning, are more easily defined, have less complicated procurement procedures, and are more quickly put into place by the contract awardee. Just the opposite is true for higher value and more complex requirements. While some abbreviated procedures can be applied in truly urgent situations, there is no substitute for timely acquisition planning and decision making. If only a short time is available to process a procurement, fewer procurement options are available, costs tend to be higher, and chances for a problem, such as a gap in service, are greater. Even for the fastest of procurement methods, there still exists the need to define the requirement, advertise it, provide industry time to respond, review proposals, make award decisions, and approve and document the decisions. Each of those steps requires time. In addition to contract placement, the requiring activity and the KO shall also consider how the contract will be managed after awarded. This subject is addressed in detail in the section of this instruction that covers COR functions. Certain contract types require more administrative time and effort from both the requiring activity and the contracting office than others. In selecting the contract type, the KO shall consider the resources needed at the requiring activity and in the contracting office to effectively manage the contract.

(e) Character of Services. Contract medical and dental services may be personal or non-personal in nature. For a detailed description of personal services contracts (PSCs), see reference (b), part 37.104.

1. In a PSC, an employer/employee relationship is created between the Government and the contract health care worker, and Government personnel exercise relatively continuous direct supervision and control over the contract health care workers. PSC health care workers are usually integrated into the facility, working alongside Government personnel performing the same tasks. PSCs may be used for clinical positions only. Reference (c), Section 1091 provides authority for PSCs for health care workers and alleged acts of medical malpractice by personal services contract health care workers are covered under reference (c), Section 1089. Medical malpractice claims against personal services health care workers shall be processed per reference (d).

2. In a Non-Personal Services Contract (NPSC), the health care workers are supervised by the independent contractor. No employer/employee relationship exists between the Government managers and the contract health care workers. NPSCs are normally segregated in the facility or are performing the service from a remote location. The contractor is responsible for providing the entire service or function (for example, a complete emergency room or

ambulatory care clinic). NPSCs may be used for clinical or administrative tasks. The contractor indemnifies the Government for any liability-producing act or omission by NPSC health care workers that occurs during performance.

(2) Common Health Care Contract Types

(a) Definitive Agency Contract

1. Definition. A definitive agency contract, for purposes of this instruction, is a firm fixed price vehicle awarded to a single contractor who delivers a fixed level of service at a fixed price per year throughout the term of the contract (normally a base year plus options up to a total of 5 years). The contractor is required to furnish a qualified substitute if a health care worker leaves.

2. Price Risk. In a definitive agency contract the contractor assumes the price risk because of the need to predict labor costs throughout the entire term of the contract (up to a total of five years). The contractor is at risk to properly evaluate and gauge the market in setting their price, and the Government is at risk for understanding the marketplace to be able to effectively evaluate the contractor's proposed price. Once that price becomes part of the contract award, it is not subject to increase solely because the contractor has to pay the health care worker more than projected, even if the health care worker salary is more than the amount the Government pays the contractor.

3. Performance Risk. In a definitive agency contract, performance risk is closely linked to price risk and most likely increases over the term of the contract if marketplace prices diverge from the rates proposed by the contractor. If the contractor's prices no longer support the recruitment and retention of workers, the level of performance received by the Government will suffer. Further, definitive agency contracts are relatively inflexible with regard to Government requested changes to performance. The KO may negotiate very modest changes to performance and execute a modification that reflects the changed work at a new price. Changes of any substance normally constitute "new work" and shall be accomplished through an entirely new procurement action. In the case of a personal services contract, there is also a 15 day termination clause that may be exercised by either party.

4. Assessment of the Market. Definitive agency contracts are most cost effective in robust to moderately tight labor markets. A tight labor market may result in an inflated price that reflects the cost of recruiting from outside the local market. The contractor may also increase their price to reflect unforeseeable labor dilemmas. A definitive agency contract allows the contractor to propose a more accurate and cost effective approach as the market is unlikely to change drastically.

5. Efficiency in Placement and Administration. Definitive agency contracts are used in a variety of procurement situations and have a relatively longer acquisition lead time, but the exact duration is greatly affected by the value and complexity of the requirement. Ease of

administration is similarly affected by dollar value and complexity. The administrative effort for most definitive agency contracts is relatively low because all pricing is fixed for the full term of the contract (i.e., no annual re-pricing of the fixed prices) and the contractor (agency) handles many of the human resources issues for the workers.

6. Character of Services. Definitive agency contracts are appropriate for either personal or non-personal services requirements. For PSCs, the contractor is usually a professional staffing firm that recruits, retains, and compensates the health care workers. For NPSCs, the contractor may be a health care management company or a medical group practice that delivers the service in question (e.g., a radiology or surgery practice).

7. Conclusion. Definitive agency contracts are an appropriate contract vehicle for stable requirements that involve multiple positions. These contracts also work well in situations that involve "coverage" positions, where every shift shall be scheduled and filled by the contractor (e.g., coverage of the Emergency Department by one registered nurse 24 hours per day).

(b) Individual Set Aside (ISA) Contract

1. Definition. An ISA is a firm fixed price contract made directly with the health care worker following streamlined procedures described in reference (e), Subpart 237.104. The qualifications of the health care workers are the key selection criterion, with award made to the most qualified candidate with whom the KO negotiates a fair and reasonable price.

2. Price Risk. Like a definitive agency contract, the ISA contractor proposes a fixed price per year for the term of the contract (usually a base year plus options up to a total of 5 years), so the price risk rests with the contractor. If the ISA contractor fails to propose a price high enough to account for inflation in the out years, or if the market changes to the extent that the ISA contractor's price is below market value, the contractor may request to terminate the contract by giving 15 days notice.

3. Performance Risk. The Government bears substantial risk for variability of performance in ISA contracts. If an ISA contractor leaves the contract before its scheduled expiration, the KO shall begin a new acquisition, since no substitutes are permitted on contracts with individuals. Likewise, if the Government needs a change with respect to the qualifications of the position or the quantity of services desired, a new acquisition will most likely be necessary. Contractor registration and reporting requirements may create burdens that dissuade some individuals from offering on ISAs.

4. Assessment of the Market. ISAs generally work best in a market that is robust for the desired services. Since the Government essentially becomes the recruiter for an ISA contract, potential to recruit from outside the local market is limited. If recruitment on a more regional or national basis is attempted, the time spent doing so will diminish the advantage of a fast procurement normally afforded by an ISA.

5. Cost Effectiveness. ISAs are generally a cost effective health care contract type because the overhead costs and profit of an agency contract are avoided. However, since the contract award is negotiated with the most qualified candidate, the price premium commanded by that individual may be greater than the savings accrued by avoiding agency costs for overhead and profit. It should also be noted that the ISA contract price contains costs in addition to labor. The ISA contractor also includes in his or her price the cost of benefits (health insurance, retirement plan, etc.) and self-employment taxes. The total proposed price shall be determined to be fair and reasonable before contract award can be made.

6. Efficiency in Placement and Administration. ISAs can often be put in place relatively quickly, but a lack of interested applicants within the locale greatly lengthens the time. Once in place, ISAs require significant resources to maintain. Since each ISA health care worker has a unique contract, the number of administrative actions necessary to maintain the contracts is multiplied by the number of ISA health care workers on board. Further, with no company as part of the contract relationship, the Government often has to assume some human resources functions to support the ISAs. Therefore, ISAs should not be used without restraint, but generally only for positions where the qualifications of the individual are of paramount importance. In addition, some variability in the contract invoice and payment process is inevitable throughout the life of the contract. While an agency contractor is expected to have the financial resources to withstand this variability, some individual contractors may be put in an awkward financial position by delays in payment.

7. Character of Services. ISAs are PSCs by definition. See reference (e), Subpart 237.104.

8. Conclusion. ISAs work best for physicians, advanced practice nurses, and allied health personnel in robust local markets. Those "high end" positions take full advantage of the ability to make a selection based on individual qualifications. There may be greater cost avoidance associated with agency overhead and profit for those positions. Those individuals are better able to absorb payment variability.

(c) Indefinite Delivery Type Contracts (IDTCs), including Multiple Award Task Order (MATO) Contracts

1. Definition. IDTCs are a class of contracts where all of the Government's delivery requirements are not known at time of award. Typically, the contract contains a minimum level of service that the Government guarantees to order from the contractor and a maximum level that may be ordered in the future. The Government may order, by way of task orders issued against the basic IDTC contract, any level of service between the minimum and the maximum. In a MATO scenario, the Government awards contracts to three or more vendors who then compete for individual task orders. Task orders are awarded on the basis of timeliness, price, and past performance, and in some cases technical merit is also considered.

2. Price Risk. In IDTCs, the contractor and the Government share price risk. Task orders are issued on a firm fixed price basis, so the contractor bears the price risk for each individual task order. Task orders for health care services may be issued for a single year or for multiple years if an option clause permitting the extension of services is included in the order. Price risk is mitigated in orders for a single year through the logical follow-on process. The parties negotiate pricing at the time a new order (a logical follow-on to the original order) is negotiated. Price risk is mitigated in multiple year orders through the inclusion of an Economic Price Adjustment (EPA) clause. The EPA clause permits option prices to be adjusted if the health care services component of the Consumer Price Index reaches a threshold value.

3. Performance Risk. If the contractor does an adequate job of assessing current market conditions and appropriately prices the task order, there is little performance risk for the Government. Generally, in task order contracting the contractor accepts the risk associated with variability of performance. The Government may change the level and type of service required with each task order as long as the need still remains within the scope of the original contract; the contractor retains the ability to appropriately price the modified requirement. If a contractor exercises the 15 day PSC termination clause, there can be disruption in service.

4. Assessment of the Market. Although no contract vehicle will provide the ability to purchase services that are simply not available, task order contracts are the most effective in tight labor markets because each of the contract awardees has a continuing presence in the market, thereby improving the chance that one or more will successfully locate scarce resources. Performance can be adjusted for each performance period to reflect changes in the market, if necessary.

5. Cost Effectiveness. Task order contracts are usually cost effective because annual pricing reflects market conditions at the time of task order award. While this may lead to higher prices in out years when compared to a definitive agency contract, the performance risk for the Government is greatly reduced in the out years. Competition among the contract awardees for new task orders helps to mitigate excessive pricing.

6. Efficiency in Placement and Administration. Complex indefinite delivery contracts require significant coordination and higher level approvals so they take a considerable time to put in place. However, once the basic contract is in place, individual task orders can be awarded in about 60 to 90 days after the requirement is defined. Like services can be combined into larger task orders, easing administration. The need to create new task order and funding documents each year adds work for both the requiring activity and the KO.

7. Character of Services. Services performed under IDTCs may be personal or non-personal.

8. Conclusion. Task order contracting provides a responsive and flexible contract vehicle that operates well over a wide range of circumstances.

(d) Department of Veterans Affairs (DVA) schedule. The DVA has established a Federal Supply Schedule for Professional and Allied Healthcare Staffing Services. The schedule, available through the General Services Administration web page, includes a wide variety of medical disciplines. NAVMEDLOGCOM, Acquisition Management Directorate, is the designated ordering office for the DVA Healthcare Staffing Services Schedule for orders above the procurement authority of the requiring activity. Since the DVA schedule is not a DoD contract, the Navy can use the DVA schedules on a PSC basis only if it supplements the DVA contract with a negotiated Navy Blanket Purchase Agreement (BPA). Use of the DVA schedule for NPSCs is subject to the justification requirements contained in references (f) and (g). Reference (f) is available at: http://www.acq.osd.mil/dpap/specificpolicy/Navy%20Policy%20re%20Non%20DoD%20Contract%20Use.pdf.

(3) Contract Incentives

(a) An incentive plan may be incorporated into a definitive agency contract, ISA, or IDTC contract to positively influence contractor behavior. Contract incentives provide the "carrot" which, when used together with the "stick" of contract remedies for non-performance, provide the Navy with an effective contract management regimen.

(b) Contract incentives provide the contractor, or the contractor's health care workers, with something of value in return for performance above contract requirements. "Something of value" may be monetary or non-monetary (additional time off, for example). Performance above contract requirements may be expressed qualitatively or quantitatively.

(c) The performance objectives, criteria for performance evaluation, and method of incentives administration shall be part of a formal incentive plan that is made part of the contract.

(d) Contracts may also include liquidated damages. When implemented, the contractor shall reimburse the Government for the costs incurred as a result of the contractor's failure to perform. Liquidated damages are not intended to be punitive, but merely to recover Government costs. Liquidated damages may only be assessed by the KO.

d. Franchise Fund Contracts

(1) The Government Management Reform Act of 1994 authorized a pilot program within six executive agencies for establishment of a franchise fund to provide common administrative support services that can be provided more efficiently through such a fund than by other means. Services are to be provided by such funds on a competitive basis.

(2) The contracts established by the Franchise Fund activities to competitively provide services have been variously known as Franchise Business Activity, Cooperative Administrative Support Unit, GovWorks, GoTo.Gov, and Fedsource.

(3) The resulting Franchise Fund contracts are non-personal services contracts intended for administrative services, and which, if used for health care services, lack the clauses necessary to properly indemnify the Navy in the event of medical malpractice. The Franchise Fund activities lack the authority to award PSCs; however Franchise Fund contracts have at times been marketed by proponents as a means to supplement existing staff in a manner that may create an employer/employee relationship according to reference (b), part 37.104.

(4) The use of Franchise Fund contracts is not authorized as a means for the provision of direct health care workers; such use may result in an improper and unenforceable contract that places the Navy treatment facility and the health care worker at an unacceptable risk.

(5) Franchise Fund contracts are an appropriate source of "common administrative support services" as stipulated in the authorizing legislation. BUMED field activities may use Franchise Fund contracts to acquire clerical, administrative, and information processing support, for example.

(6) Franchise Fund contracts are subject to the regulations regarding use of non-DoD contracts per references (f) and (g).

(7) Users of Franchise Fund contracts are cautioned to pay close attention to the fiscal details relating to such transactions, particularly when making purchases with annual appropriations. Such funds do not represent a method by which the life of an appropriation can be extended. Navy customers cannot create bank accounts with the Franchise Funds and transform deposits made to them from annual appropriations into funds that never expire for obligation purposes. Valid obligations shall still be created within the original life of an annual appropriation by satisfying three conditions: transferring funds currently available for obligation; executing a binding interagency agreement; and having a current bona fide need for the services to be provided under the Franchise Fund contract.

7. Policy

a. BUMED Health Care Services Procurement and Contracting Offices

(1) The BUMED procurement offices with simplified acquisition procedures purchasing authority may issue purchase orders for personal or non-personal health care services up to the dollar limit of that authority for the purpose of securing immediate or interim services while the long-term requirement is processed. If authorized by the cognizant contracting office, BUMED ordering officers may issue orders against established IDTC for health care services.

(2) NAVMEDLOGCOM, Acquisition Management and Analytics Directorate, is the BUMED contracting and technical management office for health care services requirements. The Directorate has approval authority for the technical specifications for all health care services

contracts. All health care services: statements of work (SOWs), performance work statements (PWS), statements of objectives (SOOs), and other contract specific documents are forwarded from the requiring activity to the Acquisition Management and Analytics Directorate.

(3) NAVMEDLOGCOM, Office of Counsel, serves as the contract law office for the BUMED BSO and provides legal review, advice, concurrence or approval, as appropriate, of the business, commercial, and acquisition law matters covered by this instruction.

b. Contracting Officer's Representatives (CORs), Alternate Contracting Officer's Representatives (ACORs), and Technical Assistants (TAs)

(1) CORs/ACORs are to be nominated in the COR Tracking (CORT) Tool by the COR Supervisor and appointed by the KO.

(2) CORs and ACORs perform identical contract administration functions. The ACOR performs in the absence of the COR. TAs are appointed by the COR Supervisor of the requiring activity to provide administrative or technical support to the COR/ACOR for contract administration functions per enclosure (2).

(3) All NPSCs for health care services shall be monitored by an appointed COR unless the three conditions at reference (e), Subpart PGI 201.602-2 are met.

(4) All PSCs for health care services shall be monitored by a COR. Depending on the value and complexity (multiple employees or varied types of employees) of the contract, TAs may also be appointed to assist in monitoring the services. Appointment of CORs and TAs will be as follows:

(a) A COR will be appointed for all health care services contracts. For larger, more complex contracts, the activity should consider assigning one or more TAs to assist with monitoring and surveillance.

(b) For MATO contracts, a COR will be appointed for each treatment facility covered by the contract. The COR will be designated in each task order written against the contract. A TA may be appointed for a task order for which contract surveillance by the COR would be difficult, such as for services at a branch clinic.

(c) For Federal Supply Schedule BPAs, a COR will be appointed depending on the value and complexity of the requirement per reference (e), Subpart PGI 201.602-2.

(5) BUMED field activities with many individual contracts should consider nominating one or more CORs to manage the facility's total contracting program. A COR from among that group can then be appointed to each contract according to the plan of the facility.

(6) The number of CORs employed/appointed at a facility should be commensurate with the number, value, and complexity of contracts in place. Generally, many services aggregated in fewer contracts will require fewer CORs, while a similar amount of service spread over a larger number of contracts generates more COR requirements. Also to be considered is the number of personal services supervisors to be overseen by the COR(s) and the number of TAs supporting the COR(s). The higher the number of TAs, the more the day-to-day administration is dispersed, but the greater the oversight, coordination, and communication requirements for the COR(s). In general, one COR for each $10 million of annual health care service contracts is a suggested initial planning figure. That figure should be adjusted based on analysis of the other factors cited in this paragraph and shall be periodically re-evaluated based on observed efficiency and outcomes of contract administration activities.

(7) For every contract with an appointed COR, there shall be nominated and appointed an ACOR who shall perform COR duties during the absence of the COR.

(8) The COR/ACOR/TA designation does not change or supersede the established line of authority or responsibility of any organization.

(9) Reference (a) establishes competencies and required training, tied to the complexity of the contract. The minimum training for firm fixed price contracts is KO's Representative with a Mission Focus (Course #CLC 106), the on-line COR course hosted by the Defense Acquisition University (DAU). Reference (a) permits contracting agencies to require additional, mission specific training in addition to CLC 106. Before being appointed COR on a Navy Medicine health care services contract, individuals must complete CLC 106 and the Medical Services COR Course taught by NAVMEDLOGCOM. CLC may be accessed at DAU's Continuous Learning Home Page: https://learn.dau.mil/html/clc/register.jsp. The schedule for NAVMEDLOGCOM's Medical Services COR Course may be accessed on the MIL/GOV side of NAVMEDLOGCOM's Home Page: www.nmlc.navy.mil, under NAVMEDLOGCOM Training. If a COR must be appointed before he or she has had the opportunity to take the NAVMEDLOGCOM COR course, the KO may require the completion of CLC 222 before the individual may be appointed provisionally. In other words, CLC 222 may be considered satisfactory interim training in lieu of CLC 106 and the NAVMEDLOGCOM course, depending on the size and complexity of the contract in question, if the individual cannot get to the NAVMEDLOGCOM course. The COR must attend the NAVMEDLOGCOM COR course at the first reasonable opportunity. CORs and ACORs appointed to BUMED health care contracts shall be certified by attending the COR training course presented by NAVMEDLOGCOM and designed specifically for health services contracts.

(10) Reference (a) requires a minimum of 8 hours COR refresher training every 3 years. Navy Medicine health care CORs may satisfy this requirement by retaking either CLC 106 or the NAVMEDLOGCOM course. For active CORs/ACORs, refresher completion shall be not later than 3 years from the date of initial COR training or the date of the previous refresher. CORs/ACORs shall attend refresher training after any 3 year period of inactivity as a COR/ACOR.

(11) TAs designated in BUMED health care contracts are encouraged to attend CLC 106 and the Medical Services COR Course taught by NAVMEDLOGCOM. In lieu of COR course attendance, prior to appointment, the prospective TA shall demonstrate to the KO familiarity with basic contract administration concepts and procedures.

(12) The authority of the COR/ACOR/TA is restricted by reference (a) in providing technical direction, clarification, and administrative duties within the scope of the contract. No COR/ACOR/TA has the authority, either by individual action or by cumulative effect of actions, to change the scope, delivery schedule, cost or fee, labor mix, quality standards, or other contract terms or conditions.

c. Franchise Fund contracts. BUMED field activities shall not use Franchise Fund contracts for the provision of health care services.

d. Support of Small and Small Disadvantaged Business. The BUMED procurement and contracting offices will actively support small and small disadvantaged health care services businesses by establishing aggressive, but attainable utilization goals, and effective outreach programs. The NAVMEDLOGCOM and Fleet logistics Center, Norfolk/Philadelphia site, small business utilization specialists are effective resources for small and small disadvantaged business issues.

e. DVA Schedule. NAVMEDLOGCOM is the only authorized Navy ordering office for use of these contract vehicles for actions above the procurement authority of the requiring activity.

f. Non-DoD Contracts. Non-DoD contracts shall be used for the procurement of non-personal health care services only as provided in references (f) and (g). Additional guidance on the proper use of non-DoD contracts is available on the NAVMEDLOGCOM web page under Acquisition Policies.

8. Duties and Responsibilities

a. Deputy Chief, Human Resources (BUMED-M1)

(1) Identify manpower and personnel policy changes that have the potential to impact contracting initiatives, and identify budget impacts that may result.

(2) Ensure compliance with the requirements of Office of Management and Budget Circular A-76, Performance of Commercial Activities, and the implementing BUMED instruction, Strategic Sourcing Program, when applicable.

b. Deputy Chief, Medical Operations (BUMED-M3)

(1) Provide project management of Navy Medicine-wide health care contracting initiatives. Identify and distribute funding associated with such initiatives.

(2) Provide financial workload and demographic data gathering, evaluation, and analysis for all national or centralized contracting initiatives.

c. Deputy Chief, Installations and Logistics (BUMED-M4)

(1) Develop and provide health care contracting policy guidance.

(2) Provide project management of Navy Medicine-wide health care contracting initiatives. Identify and distribute funding associated with such initiatives.

(3) Ensure that all Navy Medicine-wide instructions, policy letters, etc., adequately address and consider implications for contract personnel within Navy Medicine facilities.

(4) Ensure compliance with the requirements of Office of Management and Budget Circular A-76, Performance of Commercial Activities, and implementing BUMED instruction, Strategic Sourcing Program, when applicable.

d. Deputy Chief, Resource Management and Comptroller (BUMED-M8)

(1) Provide funds for health care services contracting to activities via the appropriate Navy Medicine region.

(2) Provide project management of Navy Medicine-wide health care contracting initiatives. Identify and distribute funding associated with such initiatives.

(3) Provide financial workload and demographic data gathering, evaluation, and analysis for all national or centralized contracting initiatives.

(4) Identify manpower and personnel policy changes that have the potential to impact contracting initiatives, and identify budget impacts that may result.

e. Commanders, Navy Medicine Regions

(1) Establish a region-wide business case analysis (BCA) process. Ensure that each facility quantitatively and objectively evaluates contract initiatives in terms of the facility's overall health care delivery strategy and alternative sources of the required health care.

(2) Review BCAs submitted by facilities to ensure that the proposed project is consistent with region/facility health care delivery goals; that the projected return on investment has been accurately calculated; and that the projected return on investment is positive (i.e., sufficient to offset the investment costs).

(3) Ensure that each BCA incorporates a thorough analysis of the ability of the marketplace to support the requirement and thereby advances realistic expectations for costs and potential for success. The market analysis shall be incorporated as part of the complete procurement package forwarded for acquisition.

(4) Review requests for health care contract funding with the intent to evaluate opportunities to aggregate requirements to achieve cost and mission accomplishment efficiencies.

(5) Establish a regional policy to ensure adequate collaboration on contract development at the facility level. The policy shall include a requirement for formal facility approval of the completed requirement to validate funding availability and appropriate service integration. The following individuals, as applicable, should approve each contract initiative: Director of the applicable clinical area; Director, Health Care Operations; Director, Resource Management; Head Material Management; and Deputy Commander/Executive Officer. A policy regarding those contracts that require approval at the regional command is also warranted.

(6) Review and approve Acquisition Strategies for procurements that affect multiple facilities within the region.

(7) Serve as an advisor to the Source Selection Authority for procurements that affect multiple facilities within the region.

(8) Establish region-wide and facility-specific marketing plans to enhance the position of Navy facilities within the competitive marketplace. The plans should market the attributes identifying Navy Medicine as the employer of choice among quality providers by illustrating the benefits and rewards of working within the Navy facility. Develop the plan(s) and the requisite materials to assist with efforts to recruit the best possible contract candidates.

(9) Evaluate facility processes that impact the efficient and timely accession of contract personnel. Security procedures (including background checks), orientation requirements, and credentials review and privileging processes that are inconsistently or arbitrarily applied adversely impact the ability to recruit identified candidates.

f. Commanders, Commanding Officers, and Officers in Charge for Navy Medicine Activities

(1) Manage health care service contracts within existing budget.

(2) Become familiar with health care contract types and the factors that affect their selection.

(3) As an extension of the business planning process, ensure an adequate acquisition planning process that provides a BCA for each initiative, considers alternate solutions, evaluates market conditions, and considers facility strategic objectives.

(4) Ensure adequate collaboration among facility staff in developing health care service contract requirements. Ensure an adequate internal approval process for acquisition plans, requirements definition, and funding availability, see paragraph 8.e.(5).

(5) Contact the NAVMEDLOGCOM Acquisition Management and Analytics Directorate regarding the technical requirements definition aspects of health care services contracts, and submit all completed health care services SOWs to Acquisition Management and Analytics Directorate for approval.

(6) Collect and analyze relevant financial, workload, and demographic data for contracting initiatives as necessary, with emphasis on availability and pricing of health care workers in the local marketplace. Develop Independent Government Cost Estimates (IGCEs) in coordination with the NAVMEDLOGCOM.

(7) Forward approved health care contracting requirements or procures locally within authority, documenting that any and all requirements for consideration of Office of Management and Budget Circulation A-76 cost comparison have been met, when applicable.

(8) Recommend for nomination to the COR Supervisor a COR and ACOR from within the command and for each health care contract according to the COR/ACOR policy given in paragraph 7.b. Selection of the COR/ACOR should be given the same care and consideration as that given to any key position within the organization. Nominations should be made during the acquisition planning process to enable the individuals to gain expert knowledge of the contract by participating in all aspects of contract development and execution.

(9) Ensure that all individuals nominated as COR or ACOR are qualified by experience and training to satisfactorily perform the required duties. In addition to the training required by the policy section above, CORs/ACORs should meet the following criteria:

(a) Personal Attributes. Experience has proven that the characteristics most desirable for CORs are: Leadership, integrity, credibility, communication and analytical skills, as well as technical and administrative competence.

(b) Grade, Position, and Experience. The COR should be of sufficient grade and hold a position in the organization commensurate with the complexity of the contract to effectively manage and advocate for the contract. The COR should have access to organization decision makers for purposes of advising and coordinating on health care contracting issues.

(c) Type of Contract or Service. Assess whether the COR will be providing day-to-day management of contractor employees (PSCs) or retrospectively monitoring the quality of completed contractor performance (NPSCs). Determine the level of clinical knowledge that the COR will need to effectively carry out the management or monitoring.

(d) Extent of Contract Administration. Assess whether the COR will need contract management expertise or general administrative expertise.

(e) The COR Supervisor shall affirm at nomination the performance of the designated functions will be addressed as part of the COR's performance assessments. Individuals whose primary duties involve the performance of COR functions should have at least one critical element related to those duties. Part-time or collateral duty CORs may have COR functions assessed as part of their other professional or administrative responsibilities but need not have a separate COR critical element.

(10) Maintain close liaison with assigned COR to remain fully apprised of contractor performance and identify potential problems to ensure appropriate and timely action is taken.

(11) Effectively utilize the expertise of the COR by including the COR in contract planning or performance meetings and communications.

(12) Assign one or more TAs for more complex contracts to assist the COR in executing routine contract administration, monitoring, and surveillance duties.

(13) Ensure that additional subject matter experts are available to the COR.

(14) Include COR performance in periodic performance evaluation and fitness reports. Determine if COR duties are being performed in a satisfactory manner. If duties are not being performed in a satisfactory manner, coordinate potential corrective actions with the KO.

g. NAVMEDLOGCOM

(l) Acquisition Management and Analytics Directorate and Lead Contracting Executive (LCE) for BUMED

(a) Serve as senior procurement official for BUMED BSO.

(b) Provide contracting policy and guidance for BUMED and field activities within guidelines and authority established by Naval Supply Systems Command (NAVSUP).

(c) Actively support BUMED, NAVSUP, and Navy policy with respect to utilization of small and small disadvantaged businesses in health care contracting.

(d) Appoint ordering officers. Provide oversight, guidance, and support to authorized ordering officers.

(e) Provide COR training.

(f) Provide training support to the Navy Medicine Professional Development Center.

(g) As LCE for BUMED, monitor and manage Defense Acquisition Workforce Improvement Act for acquisition personnel, collect and analyze enterprise wide metrics, manage authority for procurement offices, promulgate best business practices, and lead strategic sourcing commodity management to include healthcare services.

(h) Serve as the BUMED cognizant technical manager for health care contracting, providing a focal point for health care contracting analysis, health care metrics, and lessons learned.

(i) Advise BUMED on health care contracting policies and initiatives.

(j) Provide consultative support and advice to field activities regarding the availability and proper use of various alternative health care delivery methods.

(k) Develop technical specifications for the BUMED health care contracting program. Provide draft technical specifications to activities upon request. Assist activities to develop and tailor specific SOW.

(l) Perform technical review and exercise approval authority for all health care services technical specifications for Navy Medicine activities prior to submission to the cognizant contracting office.

(m) Provide technical review of health care services technical specifications for commands outside Navy Medicine upon request.

(n) Collect and analyze relevant financial, workload, and demographic data for contracting initiatives as necessary. Develop IGCEs in coordination with the requiring activity.

(o) Propose pricing and incentive strategies during development of health care services contracts.

(p) Provide customers with technical guidance and assistance concerning the health care contracting process. Serve as an ongoing resource to assist customers through the acquisition process.

(q) Participate as cognizant technical manager during pre-proposal and post-award conferences.

(r) Develop and disseminate to field activities procedures for effective, consistent, and accurate technical evaluation of offer or proposals in response to health care services solicitations.

(s) Chair the technical evaluation committee for high value or complex solicitations or as requested by field activities.

(t) Review the technical evaluation reports which result from reviews conducted by field activities.

(u) Provide contract administration support for KOs and CORs/TAs through development of contract administration plans (CAPs), quality assurance surveillance plans, and incentive award plans.

(v) Review contract administration and performance documentation from CORs.

(w) Provide ongoing technical advice to KOs and CORs for contract administration issues and policies.

(x) Serve as BUMED's program manager for the health care contracts and acquisition databases.

(2) Office of Counsel. Serve as the business, commercial, and acquisition law advisors for the BSO-18.

h. KOs

(1) Exercise authority addressed in reference (b), part 2.101, with final approval authority on all contract actions.

(2) Select the appropriate contract type for health care contracting requirements, seeking input from the requiring activity and NAVMEDLOGCOM, Acquisition Management and Analytics Directorates, as needed.

(3) Provide contract administration. Exercise the authority to change the terms and conditions of the contract through execution of modifications.

(4) Prior to award, officially appoint the COR and ACOR in writing and specifically designate the COR in the contract as the only authorized representative to act on the KO's behalf. Provide specific duties, responsibilities, restrictions, qualifications, and feedback procedures in the appointment letter. Only one COR and ACOR may be appointed per task order. CORs/ACORs may be appointed to more than one contract/task order.

(5) Maintain regular communication with the CORs per reference (a).

(6) Annually assess performance of CORs, including COR files, and provide reports to the commanding officer per reference (a).

(7) Ensure the nominated COR and ACOR hold positions of responsibility commensurate with the complexity and technical requirements of the contract.

(8) Ensure the nominees have received approved COR training and periodic refresher training and understand the duties, responsibilities, and limitations of the position.

(9) Review contract administration and performance documentation from CORs.

(10) Encourage designation of TAs as appropriate within the policies given in paragraph 7 above.

(11) Develop and approve acquisition plans and source selection plans in cooperation with NAVMEDLOGCOM Acquisition Management and Analytics Directorate.

i. COR/ACOR

(1) All CORT Tool user accounts are migrated over to the Wide Area Work Flow (WAWF) CORT Tool applications. The CORT Tool is a web-accessible application that allows DoD components to nominate CORs and track appointments, terminations, and training. It is also a web-based portal for CORs to file and maintain reports and other pertinent documentation. Use the following steps to create a new CORT Tool account.

(a) Access the WAWF site at: https://wawf.eb.mil.

(b) Click on “Accept”.

(c) Click on “New User”.

(d) Click on “Registration” under WAWF/EDA/CORT Tool/BI Tool User Registration.

(e) Select “Government” user type.

(f) Under System, select CORT Tool.

(g) Select Common Access Card registration.

(h) Click on “Next”.

(i) Select “User Profile” edit link and complete all fields.

(j) Select the "User Security Questions" edit link. Select three security questions and provide responses.

(k) Select "CORT Users Roles"; click on the "Add" link.

1. From the dropdown menu, select role, location code type, and organization name.

2. Enter a valid Department of Defense Activity Address Code.

(l) Click on "Save."

(m) Click on "Register."

(n) Receive an e-mail from WAWF entitled "WAWF Self Registration has been submitted."

(2) WAWF users should add the appropriate CORT role to their current profile.

(3) If you have any questions or run into any issues, contact NAVMEDLOGCOM and ask for a DoD CORT representative or e-mail NMLC-CORT@med.navy.mil.

(4) Serve as the command's technical point of contact for contracts to which appointed. Maintain complete, current copies of all contracts to which appointed. Provide technical advice or clarification of the technical specification when requested by staff, the contractor, or the KO.

(5) Accomplish monitoring and surveillance of contractor performance. Inspect, document, and report contractor performance.

(6) Initiate contract remedies per direction from the KO. Issue Contract Discrepancy Report (CDR) to the contractor to document unsatisfactory performance; provide copies to the KO and the NAVMEDLOGCOM health care program analyst. Obtain the contractor's response to the CDR, document an evaluation of the acceptability of the response, include a recommendation/finding to the KO as appropriate, and promptly forward the completed CDR to the contractor, the KO, and the NAVMEDLOGCOM health care program analyst.

(7) Submit an annual report detailing the contractor's performance to the KO per the process provided in the CAP. Enter annual report information into the Contractor Performance Assessment Reporting System if assigned by the KO as an Assessing Official Representative.

(8) Review contractor invoices to ensure appropriateness of types and quantities of services being performed. Certify or reject invoices in a timely manner to ensure the payment due dates set forth in the contract are met.

(9) Notify the KO of anticipated and actual variance between quantities ordered and quantities performed.

(10) Monitor the use of Government furnished equipment, material, and property in the possession of contractors.

(11) Coordinate and facilitate complete and timely credentials submissions between the BUMED field activity and the contractor using the applicable Professional Affairs Coordinator (PAC) staff at the field activity. Expeditiously inspect the credentials of each contract employee. Submit complete, compliant credentials packages to the PAC. Return incomplete or noncompliant packages to the contractor with appropriate notation of issues. Track expiring credentials for purpose of ensuring contract compliance.

(12) Include, on all correspondence to the contractor, a declination of authority statement as follows:

> "I have neither the authority nor the intent to change the terms or conditions of this contract. This contract can only be changed by a written modification issued by the contracting officer. If you believe that I am requesting an effort outside the scope of this contract, promptly notify the contracting officer. Additionally, this shall not be construed as an authorization for new work or additional work not already contained in the contract."

(13) Perform other duties as designated in the CAP of the contract.

(14) Comply with standards of conduct and avoid conflicts of interest as set forth in reference (h).

(15) Maintain complete and accurate COR contract files for annual review by the KO.

(16) Attend NAVMEDLOGCOM-provided health care services COR training class prior to beginning performance as COR/ACOR. Must complete CLC 106 and the Medical Services COR Course taught by NAVMEDLOGCOM prior to beginning performance as COR/ACOR.

(17) Attend NAVMEDLOGCOM-provided health care services COR refresher training class not later than 3 years from the date of attending initial COR training or the date of the previous COR refresher training. Attend minimum of 8 hours COR refresher training every 3 years. Navy Medicine health care CORs may satisfy this requirement by retaking either CLC 106 or the NAVMEDLOGCOM course.

(18) COR duties are not re-delegable. The ACOR is appointed to act only in the absence of the COR.

j. Technical Assistant (TA)

(1) Perform duties as per this instruction: The TA appointment letter, the CAP; reference (a), and other documents as directed by the KO.

(2) Provide the COR with timely input regarding technical clarifications for the SOW, possible technical direction to provide the contractor and recommend corrective actions.

(3) Assist in monitoring and surveillance of contractor performance. Inspect, document, and report contractor performance.

(4) For those contracts on which serving as both TA and supervisor of contract staff, provide supervision of contract staff in a manner commensurate with the supervision of Government staff providing the same or similar services. Attempt to correct contract performance issues through supervisory means, per contract provisions and the policies, responsibilities, and prohibitions contained in this instruction.

(5) Identify contractor deficiencies to the COR.

(6) Review contract/task/delivery order deliverables and invoices, recommend acceptance/rejection and provide the COR with documentation to support the recommendation.

(7) Notify the COR of anticipated and actual variance between quantities ordered and quantities performed.

(8) Evaluate the contractor's proposal for specific task order requirements and identify for the COR any potential problems, areas of concern or issues to be discussed during negotiations.

(9) Assist in coordinating and facilitating complete and timely credentials submissions between the BUMED field activity and the contractor using the applicable PAC staff at the field activity. Assist in inspecting the credentials of each contract employee prior to submission to the PAC to ensure compliance with contract qualification requirements. Help track expiring credentials for purpose of ensuring contract compliance.

(10) Review contractor status and progress reports, identify deficiencies to the COR and provide the COR with recommendations regarding acceptance, rejection, and/or Government technical clarification requests.

(11) Provide detailed written reports of any trip, meeting or conversation to the COR subsequent to any interface between the TA and contractor.

(12) Include, on all correspondence to the contractor, a declination of authority statement as follows:

> "I have neither the authority nor the intent to change the terms or conditions of this contract. This contract can only be changed by a written modification issued by the contracting officer. If you believe that I am requesting an effort outside the scope of this contract, promptly notify the contracting officer. Additionally, this shall not be construed as an authorization for new work or additional work not already contained in the contract."

(13) Comply with standards of conduct and avoid conflicts of interest as set forth in reference (h).

(14) Upon nomination, demonstrate familiarity with contract administration concepts and processes to the KO in a manner prescribed by the KO or attend NAVSUP approved/ NAVMEDLOGCOM provided health care services COR training class (attendance at the class is recommended).

k. CORs, ACORs, TAs, and Government officials other than the KO are prohibited from activities that are the sole responsibility of the KO, as follows:

(1) Making commitments or promises to contractors relating to award of contracts.

(2) Writing contract requirements around the product or capacity of one source.

(3) Soliciting proposals.

(4) Modifying the stated terms of the contract or entering into any understanding, agreement, modification, or change order deviating from the terms of the basic contracts. Issuance of any instructions that would constitute a change to the contract shall be avoided.

(5) Issuing instructions to contractors to start or stop work. (This prohibition shall not be interpreted as prohibiting action to immediately stop an action by contract staff that is causing or has the potential to cause injury or harm to a patient or staff.)

(6) Approving items of cost not specifically authorized by the contract or authorizing additional work to be performed.

(7) Directing changes.

(8) Executing supplemental agreements.

(9) Obligating funds.

(10) Rendering a decision on any dispute or any questions of fact under the disputes provision of the contract.

(11) Taking any action with respect to termination, except to notify the KO that the activity wishes to terminate.

(12) Authorizing delivery or disposition of Government furnished property.

(13) Allowing the contractor to perform work outside the scope of the contract.

(14) Giving guidance to contractors, either orally or in writing, which might be interpreted as a change in scope or terms of the contract.

(15) Directing or supervising contractor employees, unless the contract is a PSC.

(16) Discussing procurement plans or any other advance information that might provide preferential treatment to one firm over another when a solicitation is issued for a competitive procurement.

(17) Disclosing any source selection, proprietary, or privacy information pertaining to the solicitation, award, or performance under a contract.

9. Records. Records created as a result of this instruction, regardless of media and format, shall be managed per SECNAV M-5210.1 of January 2012.

10. Reports. The reports required in paragraphs 8h(6), 8i(5), 8i(6), 8i(n), 8j(3), 8j(9), 8j(10), and 8j(n) are exempt from reports control per SECNAV M-5314.1 of December 2005, Part IV, Paragraph 7(j) and 7(p).

11. Forms. The following U.S. General Services Administration forms are available electronically at http://www.gsa.gov/portal/forms/type/SF.

a. Standard Form 26 (Rev. 5-11), Award/Contract.

b. Standard Form 33 (Rev. 9-97), Solicitation, Offer, and Award.

M. L. NATHAN

Distribution is electronic only via the Navy Medicine Web site at:
http://navymedicine.med.navy.mil/directives/Pages/default.aspx

## DEFINITIONS/ACRONYMS

1. Administrative Change. A modification signed only by the Contracting Officer (KO) and having no effect on price, performance, or delivery.

2. Alternate Contracting Officer's Representative (ACOR). The Government official appointed in writing by the KO who functions as the technical representative of the KO for a specific contract, for a specified period of time during the absence of the COR.

3. Authorized Ordering Activity. The activity designated in an indefinite delivery type contract (IDTC) to issue delivery orders or task orders under that contract.

4. Blanket Purchase Agreement (BPA)

5. Bureau of Medicine and Surgery Procurement Offices. The procurement authority granted to contracting officers at each activity is specified in NAVSUPINST 4200.81g and by a Letter of Delegation through the NAVSUP chain of command.

6. Business Case Analysis (BCA)

7. Budget Submitting Office (BSO)

8. Bureau of Medicine and Surgery BUMED

9. Change Order. A written order signed by the contracting officer which directs the contractor to make changes in performance. The Changes Clause of the contract prescribes the limits of the authority of the contracting officer to make changes. Change orders are not subject to the consent of the contractor.

10. Complete Procurement Package. Includes an approved definition of the requirement, Performance Work Statements (PWS), Statements of Work (SOWs), Statements of Objectives (SOO), an Independent Government Cost Estimate (IGCE), a funding document, a list of potential sources, an Acquisition Strategy per reference (g), and Management and Oversight Process for the Acquisition of Services (MOPAS).

11. Constructive Change. An unauthorized change made simply by the action or inaction of the Government which results in contractor performance different from, or in excess of, the original contract requirements.

12. Contract. An agreement between the Government and contractor expressing terms and conditions affecting price, performance, and delivery. The agreement includes an offer, acceptance, and consideration between competent parties stated in clear terms and conditions.

13. Contract Administration Plan (CAP). The plan that establishes procedures to ensure satisfactory administration of health care service contracts either retained by the KO or delegated to an authorized representative other than the Administrative Contracting Officer.

14. Contract Discrepancy Report (CDR). The report that documents unsatisfactory contractor performance.

15. Contract Modification. Any alteration to the contract (see administrative change, change order, and supplemental agreement.)

16. Contracting Officer (KO). Government official who, by position or appointment, is authorized to bind the Government in contracts acting as an agent for the Government.

17. Contracting Officer's Representative (COR). The Government employee responsible for assuring contractor performance through monitoring and surveillance, documentation, and liaison with the contractor and the KO. The COR is nominated by the commanding officer, appointed in writing by the KO, and is specified in the contract. The COR has no authority to resolve contract disputes or obligate funds. A full list of COR duties and authority limitations are provided in the "Duties" section of this instruction.

18. Contractor. The offeror identified in block 15A of SF 33 or block 7 of the SF 26 and its health care workers who are providing services under the contract.

19. Contracting Officer Representative Tool (CORT)

20. Defense Acquisition University (DAU)

21. Defense Federal Acquisition Regulation Supplement (DFARS)

22. Department of Defense (DoD)

23. Department of Veterans Affairs (DVA)

24. Economic Price Adjustment (EPA)

25. Federal Acquisition Regulation (FAR)

26. Fleet Logistics Center (FLC)

27. Indefinite Delivery Type Contracts (IDTCs)

28. Independent Government Cost Estimates (IGCE)

29. Individual Set Aside (ISA)

30. Lead Contracting Executive (LCE)

31. Medical Treatment Facility (MTF). The DoD hospital or medical center requiring services under these contracts. The abbreviation "MTF," includes ambulatory care centers, all branch medical clinics, medical administrative units, branch medical annexes, and other subordinate clinical activities specified in these contracts. The abbreviation "MTF" also refers to any military treatment facility within the scope of these contracts.

32. Multiple Award Task Order (MATO)

33. Naval Medical Logistics Command (NAVMEDLOGCOM)

34. Naval Supply Systems Command (NAVSUP)

35. Non-Personal Services Contract (NPSC). A contract under which the personnel rendering the services are not subject, either by the contract's terms or by the manner of its administration, to the supervision and control usually prevailing in relationships between the Government and its employees. No employer-employee relationship exists between the Government and the contract workers.

36. Ordering Officer. The individual designated by a contract's Procuring Contracting Officer with authority to place orders against that contract.

37. Performance Work Statement (PWS). A document that describes the Government's requirements in terms of results rather than process. It defines the specific requirements the contractor shall meet in performance of the contract, the standard of performance for the required tasks, the quality level the government expects the contractor to provide, and the timeframes for performance. It emphasizes contractor control of the work by describing what is to be performed rather than how it is to be performed.

38. Personal Services Contract (PSC). A contract that makes the contractor personnel appear to have an employer-employee relationship with the Government. The Government retains management authority of the personnel providing the services and has a contractual obligation to provide relatively continuous supervision and control of contract staff.

39. Professional Affairs Coordinator (PAC)

40. Quality Control. Those actions taken by a contractor to control the provisions of services so the requirements of the PWS are met.

41. Service Contract. A contract that directly engages the time and effort of a contractor whose primary purpose is to perform an identifiable task rather than furnish an end item of supply. A service contract may be either personal or non-personal.

42. Statement of Objectives (SOO)

43. Statement of Work (SOW). A document that accurately describes the Government's needs for essential or technical services in terms of the desired output or end product. The SOW becomes a part of the procurement solicitation package (and resulting contract) and describes the scope of work, schedule for performance, staffing requirements, and personnel qualifications.

44. Supplemental Agreement. A contract modification signed by both contractor and KO to make a change to the contract. Usually affects price, performance, or delivery.

45. Task Order Contract. A contract for services that does not procure or specify a firm quantity of services (other than a minimum or maximum quantity) and provides for the issuance of orders for performance of the tasks during the period of the contract.

46. Technical Assistant (TA). The MTF, dental treatment facility, or other field activity representative who may be assigned to provide technical or administrative assistance to the COR. TAs may be assigned to assist and support the COR but shall not be given the authority to provide any technical direction or clarification directly to the contractor.

47. Wide Area Work Flow (WAWF)

**SAMPLE TECHNICAL ASSISTANT APPOINTMENT LETTER**

4200
Ser Code/Serial
Date

From: Commanding Officer, _____
To: Technical Assistant, _____

Subj: APPOINTMENT AS TECHNICAL ASSISTANT TO THE CONTRACTING OFFICER'S REPRESENTATIVE

Ref: (a) NAVSUPINST 4205.3E

1. Per reference (a), you are hereby appointed as a Technical Assistant (TA) to Contracting Officer's Representative (COR) for:

Contract Number: _____
Contractor: _____
COR: _____

2. As TA, you are assigned to provide technical assistance and support to the COR in the administration of the contract described above. You may assist the COR in executing assigned inspection and monitoring duties; however, you may not provide any technical direction or clarification directly to the contractor. Any need for technical direction or clarification should be brought to the attention of the COR for appropriate action. You are to perform your duties per reference (a) and any amplifying instructions provided herein.

3. In accomplishing your duties as TA, you are cautioned to carefully monitor your behavior/ actions to ensure that, in the case of a non-personal services contract, you do not through your actions change the contract into a personal services contract. (See FAR 37.1 and DFARS 237.1.)

4. You are not authorized, either by this letter, or by reference (a), to take any action, either directly or indirectly, that could result in a change in the cost/price, quantity, quality, place of performance, delivery schedule, or any other terms or conditions of the contract (or task/delivery order). You may be held personally liable for any unauthorized acts. Whenever there is the potential that discussions may impact any of the areas described above, immediately stop discussions and notify the COR.

5. Your specific duties are as follows: (This section of the TA letter should be tailored to address the specific duties the COR wants the TA to perform.) The following are examples of duties that may be assigned to the TA:

Subj: APPOINTMENT AS TECHNICAL ASSISTANT TO THE CONTRACTING OFFICER'S REPRESENTATIVE

a. Identify contractor deficiencies to the COR. Review contract, task, delivery order deliverables, recommend acceptance/rejection, and provide the COR with documentation to support the recommendation. Assist in preparing the final report on contractor performance for the applicable contract, task, delivery order following the format and procedure prescribed by the COR. Identify the contractor noncompliance with reporting requirements to the COR. Evaluate the contractor's proposals for specific task or delivery orders and identify problems and areas of concern or issues to be discussed during negotiations to the COR.

b. Review contractor status and progress reports, identify deficiencies to the COR, and provide the COR with recommendations regarding acceptance, rejection, and/or Government technical clarification requests.

c. Review invoices for the appropriate mix of types and quantities of labor, materials, and other direct costs, and provide the COR with recommendations to facilitate COR certification of the invoice.

d. Provide the COR with timely input regarding technical clarifications for the Statement of Work, possible technical direction to provide the contractor, and recommend corrective actions.

e. Provide detailed written reports of any trip, meeting, or conversation to the COR subsequent to any interface between the TA and the contractor.

_____
Commanding Officer or Designee Signature

TA Acknowledgement:

I have reviewed and understand my nomination and the duties, responsibilities, and limitations of the TA function.

Signature: _____ Date: _____
TA Nominee

Contracting Officer Acceptance:

Signature: _____ Date: _____

The TA shall retain one copy of this letter, signed by both parties; provide one copy to the Contracting Officer (ordering officer) for retention in the contract (task or delivery order) file; one copy to the COR for retention in the COR's contract file; and one copy to the initiating official. Distribution shall be completed within 10 days of receipt.