CHAPTER 16
ADDENDUM B

GUIDELINES FOR RESOURCE SHARING WORKLOAD REPORTING

Background: The guidelines provided below are intended to provide the contractor and MTF personnel with a common basis for determining the full impact of resource sharing activities on MTF workload, measured in terms of admissions and outpatient visits. The "full-credit" workload determinations made on the basis of these guidelines are intended to be used as a starting point for negotiations between the contractor and the MTF concerning the percentage of the full-credit workload which should be reported to the Contracting Officer for use in the bid-price adjustment process. In accordance with Chapter 15, Section 6, paragraph 3.0., both the full-credit workload and the number of admissions and outpatient visits credited to each agreement for the purpose of the bid-price adjustment shall be certified by the MTF Commander or designee and reported to the Contracting Officer on a monthly basis during the health care delivery periods of the contract.

Key Question: The key question which these guidelines are intended to answer for each agreement is this:

> What is the number of admissions and outpatient visits reported by the MTF under the MEPRS (Medical Expense and Performance Reporting System), which would not have been accomplished without resource sharing?

Definitions: The following definitions apply to the guidelines presented in this document:

1. **Agreement**. Unless otherwise specified, refers to a resource sharing agreement entered into by the contractor and the MTF Commander.

2. **TRICARE Patients.** Patients who are eligible for benefits under the TRICARE program.

3. **Non-TRICARE Patients**. Patients who are not eligible for benefits under the TRICARE program.

4. **Personnel**. Personnel in general, whether providers or support staff.

5. **Project**. A set of associated agreements which combine to provide a service or a group of services in a given clinical area. For example, an operating room project might include separate agreements for anesthesiology, operating room nurses, and recovery room nurses.

6. **Providers**. Healthcare personnel who are granted privileges by the MTF Commander to provide patient care at the MTF. Examples are physicians, nurse anesthetists, podiatrists, psychologists, nurse practitioners, social workers, etc.

7. **Workload**. In the context of this document, workload generally refers to admissions or outpatient visits as recorded by the MTF.

Guidelines:

1. Only visits and admissions for TRICARE-eligible patients performed as a direct result of resource sharing agreements will be counted as resource sharing workload. Counts will be based on the same definitions used by the MTFs for visits and admissions, regardless of how the service performed is defined for purposes of TRICARE reimbursement. The MEPRS Manual provides the relevant definitions of visits and admissions (see Appendix B).

EXAMPLE 1: A physician office visit performed by a resource sharing provider is counted as a visit.

EXAMPLE 2: A surgery performed by a resource sharing provider is counted as an admission if the patient is admitted for that surgical procedure.

EXAMPLE 3: A mammogram or MRI generally will not be counted as a visit, even though it is a service which would be paid for under TRICARE, because it is not counted as a visit by the MTF. (See number 8 below for an exception to this rule.)

EXAMPLE 4: A telephone consult made by a resource sharing provider may be counted as a visit, if it is counted as a visit by the MTF, even though it might not be reimbursed under TRICARE (or as part of a resource sharing agreement).

EXAMPLE 5: "Same day surgeries," where an admission and discharge actually take place, will be counted as admissions.

EXAMPLE 6: "Ambulatory surgeries," where no admission takes place, will be counted as visits.

EXAMPLE 7: Procedures, such as endoscopies, colonoscopies, and outpatient podiatry procedures normally performed in a physician office or clinic setting will be counted as visits; however, if for some reason a patient is admitted to have such a procedure performed, it may be counted as an admission, if the MTF counts it as an admission.

2. Services performed by resource sharing providers for Active Duty Service Members, MTF Prime Enrollees and/or non-TRICARE patients will be paid for by the MTF in accordance with the terms of the agreement. Workload and costs associated with the provision of services to non-TRICARE patients will not be credited to the resource sharing agreement.

3. If the MTF has designated resource sharing operating room suites, all workload for TRICARE-eligible patients performed in those suites will be counted as admissions or visits, (see Note (2), immediately below), according to the definitions used by the MTF, and credited as workload to the resource sharing agreement. The same rule applies for any unit or activity which is established and maintained as a direct result of resource sharing, even if some MTF personnel also participate in the activities of the unit.

EXAMPLE 1: A designated TRICARE operating room where anesthesia and nursing services are supplied through resource sharing, even though OR technicians are provided by the MTF and surgeries are performed by MTF providers.

EXAMPLE 2: A pediatric intensive care unit established and maintained through resource sharing, even though some of the nursing staff is provided by the MTF.

NOTE 1: A necessary condition for this guideline to apply is that the unit or activity and the associated TRICARE workload would not exist in the absence of the resource sharing agreement. If this is not the case, then the proportional allocation guideline in 5. below applies.

NOTE 2: In the operating room example above, admissions and outpatient visits which occur at the MTF because of the agreement may be counted even though the workload units reported under MEPRS for the operating room itself may not be admissions or visits, provided that the admissions or visits reported under the agreement are reported under MEPRS somewhere, are not reported as resource sharing workload in conjunction with another agreement, and would not have occurred without the agreement.

4. If resource sharing provides the entire staff for a nursing unit or other activity, then all TRICARE admissions or visits performed as a result of that agreement may be counted as resource sharing workload. Services by resource sharing personnel performed for non-TRICARE patients on such a unit will be paid for by the MTF according to the terms and conditions of the agreement, and the costs associated with that care will not be counted as healthcare costs under the contract.

EXAMPLE: A nursing unit staffed entirely by resource sharing personnel. All TRICARE patients would be counted as admissions (unless the admission was counted under another agreement). Costs associated with services to non-TRICARE patients, if any, would be reimbursed by the MTF. All resource sharing costs, except those reimbursed by the MTF for non-TRICARE patients, would be allowed as healthcare costs under the contract.

5. When resource sharing personnel staff only a portion of a nursing unit or other activity in which MTF and resource sharing personnel work as part of a patient care team providing care to all classes of patients on the unit, workload performed on the unit will be credited to the resource sharing agreement in proportion to the relative contribution of resource sharing personnel to the production of the workload on that unit. This will generally be done in proportion to the percentage of staff provided to the unit through resource sharing, except that the number of units of workload so calculated may not exceed the actual number of units provided for TRICARE patients on the unit.

EXAMPLE: Suppose there are 100 admissions to a nursing unit in a given month, 60 of which are TRICARE patients and that 50% of the staffing of the unit is provided through a resource sharing agreement. Then 50 of the admissions may be counted as resource sharing admissions, and all costs associated with the agreement may be counted as healthcare costs.

NOTE: In applying this guideline, it may be necessary to specify in the agreement on what basis the proportional counting will take place. For example, in the above illustration, the

resource sharing agreement may supply 75% of the RNs, 30% of the ward clerks and 25% of the LVNs, for a total of 50% of the ward's personnel, and these may be distributed differently on different shifts and on different days. Although the average coverage may be 50% of the staffing of the unit, it may be dependent primarily on the number of RNs present. In such a situation, the proportion used for allocating TRICARE admissions to the unit may be weighted more toward the proportion of RN coverage, if this is specified in the agreement. The guiding principle should be how the various types of resources supplied affect the volume of TRICARE workload. In no case may percentages of different classes of personnel be added together to achieve a result (e.g., 20% of the LVNs and 30% of the RNs would not allow the contractor to take credit for 50% of the workload on the unit, unless this actually represented 50% of the staff of the unit).

6. In the case of the resource sharing agreement in which equipment is the only resource provided, the terms of the agreement, as they pertain to counting of workload, must be approved by the Lead Agent in advance. If the equipment is clearly the primary enabling factor in producing the workload, then TRICARE visits or admissions performed using that equipment may be credited to the agreement. Care may be provided to non-TRICARE patients with the equipment without compensation by the MTF, as long as so doing does not affect the volume of services provided to TRICARE patients or otherwise result in increased costs to the contractor; however, an agreement may specify circumstances under which MTF reimbursement for use of the equipment for the care of non-TRICARE patients will be required. All contractor costs associated with equipment-only agreements may be counted as healthcare costs under the contract, except those which are paid by the MTF for care provided to non-TRICARE patients.

EXAMPLE 1: A laparoscope supplied to increase the capability of the MTF to perform surgeries for TRICARE patients.

EXAMPLE 2: A laser to allow more ophthalmologic procedures to be performed.

EXAMPLE 3: A treadmill to allow more cardiology patients to be seen.

NOTE 1: An equipment-only agreement for a piece of durable equipment should have a specified term, and may specify a proportional rule for counting workload as agreed upon by the contractor and the MTF in consideration of the value of the equipment and its relative contribution to the production of workload. (For example, all surgeries performed with a resource sharing laparoscope might be counted as resource sharing workload for a period of one year, or one visit may be counted for every two visits conducted using a particular piece of equipment.) The intent here is to avoid a situation where, for a relatively small, one-time investment, the contractor may be credited with a large volume of workload for the duration of the contract.

NOTE 2: Lead Agent approval is not required in the case of significant patient devices, such as artificial joints or pacemakers, agreements for which may be credited with the MTF workload unit applicable to the service enabled by the device.

NOTE 3: If the contractor and the MTF commander agree that it is appropriate to do so, a similar proportional counting approach (providing less than one-to-one credit in terms of resource sharing workload) may also be used in non-equipment agreements to avoid a

disproportionate workload credit for a relatively minor resource sharing contribution; however, prior approval of the Contracting Officer is required.

7. When multiple resource sharing agreements are involved in the provision of services to the same patient for a single visit or admission, only one visit or admission will be counted as resource sharing workload. The MTF and the contractor involved must agree on procedures and internal controls to ensure that no multiple counting of resource sharing workload occurs.

8. As a general rule, resource sharing agreements should relate directly to admissions and visits which take place in the patient care work center to which the resources are supplied; however, this does not preclude agreements which include support services outside of that work center, such as an additional laboratory tech to support increased TRICARE workload at a clinic supported by resource sharing. Under such circumstances, workload shall be reported based on the impact of the resources supplied directly to the patient care work center, with no additional workload credited to the support functions. However, with the permission of the Lead Agent, agreements may be established which credit admissions or visits to a support service agreement based on the impact that agreement has on a patient care work center, if it can be clearly demonstrated that a resource sharing agreement is responsible for enabling a TRICARE visit or admission at the MTF (i.e., in the absence of the agreement, the visit or admission would not have occurred).

EXAMPLE 1: An echo-cardiogram tech is supplied to a radiology department to allow more cardiology visits to take place. Cardiology visits for TRICARE-eligible patients enabled by this agreement may be counted as visits although the echo-cardiogram itself would not be counted as a visit by the MTF.

EXAMPLE 2: An MRI tech is provided through resource sharing to allow an orthopedic clinic to provide more visits for TRICARE-eligible patients.

NOTE: In all such situations the increased TRICARE workload attributable to the agreement may be credited to the agreement provided that the admissions or visits would not otherwise have occurred, that they are not being counted in association with another resource sharing agreement, that the workload relationship and method of counting are specified in the agreement, and that the agreement has been approved by the Contracting Officer. All associated resource sharing costs may also be counted as healthcare costs, except those which are paid by the MTF for services to non-TRICARE patients in accordance with the terms of the agreement.

9. No workload will be credited to a resource sharing agreement solely on the basis of supplies provided. In general supplies will be considered as resources provided in support of a particular agreement involving personnel, or equipment, or both. Exceptions to this rule must be authorized by the Lead Agent.

EXAMPLE 1: In an operating room supported by resource sharing personnel and supplies, workload will be credited based on the personnel assets provided; the supplies and associated costs will be considered to be in support of the workload performed by the personnel provided.

EXAMPLE 2: In a clinic staffed by a resource sharing provider, if the agreement covers the costs of prescription drugs prescribed by the provider, the drugs and costs associated with them will be considered in support of the provider agreement.

NOTE: This guideline does not apply to agreements for the provision of significant patient devices, such as artificial joints or pacemakers (See Note (2) under Guideline 6.)

10. If the contractor and the MTF Commander agree that it is appropriate to do so, a proportional counting approach (providing less than one-to-one credit in terms of resource sharing workload, as indicated in Note (1) under Guideline 6 may also be used in non-equipment agreements to avoid a disproportionate workload credit for a relatively minor resource sharing contribution; however, prior approval of the Lead Agent is required.

NOTE: Given that the workload credit reported for purposes of the bid price adjustment will be subject to negotiation in accordance with Section G of the RFP, situations in which this guideline need be applied should be rare.

11. In conjunction with the foregoing guidelines, there must be a monthly certification of the impact of resource sharing workload on MTF workload, jointly prepared by the MTF and the contractor. Disputes will be resolved by the Contracting officer or a designated representative. The certification will summarize number of admissions and visits credited to each individual agreement and the total number of admissions and visits enabled by resource sharing at the MTF during the month. Visits and Admissions shall be categorized by beneficiary type [active duty dependents (ADD) and non-active duty dependents (NADD)]. These are the categories currently specified in the bid price adjustment process. Prenatal and postnatal OB visits shall also be separately accounted for. These jointly prepared and certified reports will form the basis for the resource sharing workload counts reported in the contractor's monthly resource sharing report and used in the bid price adjustment process. Each monthly report shall be signed by the designated MTF and contractor representatives.

Cost Accounting Note: Except where otherwise indicated above, all contractor healthcare costs associated with resource sharing workload reported in accordance with the above guidelines may be counted as healthcare costs under the contract.

Implementation Note: Full implementation of these guidelines will require specification in each agreement of the method of counting to be used. Given the complex nature of healthcare and the variety of settings in which it is provided, it is likely that not all present and future agreements are adequately addressed by the guidelines as written. If assistance in applying these guidelines is needed, the Contracting Officer's Representative (or the Alternate Contracting Officer's Representative for the appropriate Lead Agent Region) should be contacted. He or she will provide guidance or request further direction from the Contracting Officer.