JSI RESEARCH AND TRAINING INST

Moderator: Tara Melinkovich
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Operator: Good afternoon. My name is (Julie) and I will be your conference operator today. At this time, I would like to welcome everyone to the All About Relative Value Units Conference Call. All lines have been placed on mute to prevent any background noise.

After the speakers' remarks, there will be a question and answer session. If you would like to ask a question at this time, simply press star, then the number one on your telephone keypad. If you would like to withdraw your question, press the pound key. Thank you.

Mrs. Tara Melinkovich, you may begin your conference.

Tara Melinkovich: Thank you. Welcome and thank you for joining us for part two of our three-part CoP analysis Webinar (forum). It pays to know your CoP, why and how to conduct an effective cost analysis presented by Gerry Christie, senior partner at Health Policy Analyst and Emily Kinsella at the Colorado Department of Public Health and Environment.

My name is Tara Melinkovich and I am from the National Training Center for Management and Systems Improvement funded by the Department of Health and Human Services' office of Population Affairs. We will begin shortly with the presentation.

Please be aware that there will be the opportunity to ask questions of the presenters. You may ask questions via the phone line by pressing star one or chatting your questions in via WebEx. If you have a question, but is not

addressed, we encourage you direct your question to the presenters through the Communities of Practice site.

The presentation materials and transcript will be posted on the National Training Center's Web site, www.fpntc.org, within a few weeks. After this Webinar, you will receive an e-mail with a link to an online evaluation. Please complete the evaluation by Wednesday, July 17.

The intended audience for this Webinar is Title X grantees and sub-recipient agency staff who are new to the cost analysis or in need of a refresher on how to conduct and update a cost analysis. Every successful business knows the importance of understanding all the cost involved in providing them products – in providing their products.

The need for family planning agencies to have a sound financial management plan and a complete knowledge of the cost of doing business have become increasingly important as the United States continue to implement health care reform. During today's Webinar, our presenters will discuss the Webinar one and the homework, Current Procedural Terminology or CPT code, relative value unit, utilization data and the post-Webinar one – or the post-Webinar two homework.

After attending this Webinar, you will be able to, first, describe the role relative value unit play in an effective cost analysis; second, list the steps involved in collecting the relative value unit for your clinic; and, lastly, list the steps involved in collecting and recording utilization data.

I would now like to provide a quick review of the Communities of Practice site, a Web-based forum that creates the opportunity for you to interact with both peers and the course facilitator. This is where you will access the course activities, including the links for each Webinar, activities between each Webinar and discussion.

The Webinar course and the supporting Communities of Practice will help you utilize the focus cost analysis workbook to be able to conduct the cost analysis for your agencies. This Communities of Practice site is not posted on

the National Family Planning Training Center's Web site, rather, it is hosted on the JSI e-learning site.

On the screen, you will see an image of the site. You should have received the link to the Communities of Practice site via e-mail and should have already created an account with JSI e-learning to access the site.

Once you have set up your account, you will be guided through the steps for each activity. You can also ask questions of the course facilitator and your fellow participants along the way. JSI staff are also here to help you if you have any question.

If you have not already accessed the Communities of Practice site, please do so following today's Webinar. We have chatted the registration link.

I now would like to introduce our presenters and course facilitator, Gerry Christie and Emily Kinsella, who, I believe, most of you are now familiar with from Webinar one.

Mr. Christie spent 33 years as a project director of a Title X program in a community-based organization, health-department based program. He currently provides technical assistance to state and local health departments and private health care providers around cost analysis, needs assessment and program development.

Ms. Kinsella spent the last six years as the family planning administrative consultant for the Colorado Department of Public Health and Environment. She helps Colorado Title X sub-recipient agencies meet the Title X non-clinical requirements, including cost analysis and sliding fee scales.

Let's hear from our presenters now. First, please welcome Emily Kinsella.

Emily Kinsella: Thanks, Tara. Thanks for that nice introduction. Gerry and I are glad to be back with you for this second Webinar. I just wanted to remind you, before we get into the background and the review of the last seminar and the homework, I want to remind you about the materials that are available on the Community of Practice Web site.

The manual for the focus cost analysis, which have detailed step-by-step instructions for how everything we're telling you, and these three Webinars are there, as well as the workbook that you can use to complete the information. So I just wanted to remind you about that. Some of you might be following along as we go through.

Another thing I wanted to remind you of, in response to some questions raised during the first Webinar, was the requirements of the Office of Population Affairs and Title X around a cost analysis. So these are the Title X regulations and program requirements.

Clients with incomes at or below 100 percent of the federal poverty level must not be charged. A schedule of discount is required for clients with incomes between 101 percent and 250 percent of the federal poverty level.

Title X fees charged to clients with incomes above 250 percent of the federal poverty level must be in accordance with the schedule of fees or sliding fee scale, as sometimes it's called. Title X fees must be designed to recover the reasonable cost of providing services. And Title X fees must be based on a cost analysis of all services provided by the project.

The Office of Population Affairs who oversees Title X does not require use of a specific cost analysis methodology. However, certain grantee agencies may require a specific methodology and/or specify how to submit cost data from service sites and sub-recipients.

So this is just a reminder that this focus cost analysis methodology is just one option of many options we're doing in cost analysis. It is a methodology that Gerry and I created together, combining the best of both of our methodologies.

On the Web site here and in your chat box are links to the Title X regulation and the Title X program requirements. So I'm going to hand it over now to Gerry to do a review of the first Webinar.

George Christie: Well, thank you, Emily. And it's great to be with you all again. We had a number of questions from the first Webinar. I thought there was some thoughtful input and some interesting concerns that people brought up and those – we've posted responses on the Communities of Practice.

So you should make sure that you are signed up for that and you can go on and see what kinds of questions and responses have been asked.

Well, now, we asked at the very beginning of the cost analysis what is it that we want to know. And, basically, we want to know what it costs your program to put each clinical and laboratory service that we provide out that door. That's an in-house laboratory service.

The unbundled cost for each service is what is critical here. The cost of services in each program is really driven by two things. This is a very simple, basic concept.

We have expenses on the one hand and we dealt with those expenses primarily in Webinar one how to gather those expenses, and we'll talk about that in just a couple of minutes.

And the second thing that tips the balance of the cost analysis is utilization – how many services are you providing, how many units of service are you providing. And that's going to be dealt with during this session and during the beginning of Webinar three. So these are the two things that become important for us – expenses and utilization.

Now to determine family planning cost, the focus cost analysis provides two options. option A deals with the cost report, which is a document that allows you to hold together all of your program expenses based on your general journal, based on your expenditure reports. And it's used if you do not have reports on hand that document the total cost.

So remember that these options are options that Emily and I have created. And option A really mirrors, to a large degree, the cost analysis methodology that I have developed. And option B mirrors the cost analysis methodology that Emily has worked with and that's the cost pool calculation.

So if the program already has aggregated reports, documenting family planning cost, then, they could use the cost pool allocation. Both of them ask you to back out unallowable cost. What we're looking at here are the core family planning costs, that which is expended to provide the clinical services – the services for which you are going to charge either your clients of third parties.

And you need to begin to look at these processes in a way that's going to help you understand what's going on in your agency. This will give you a clear picture of what it's costing you. So there are some things you need to take a look at in terms of entering the appropriate information.

For instance, with the cost report option A, you want to know if you have used an indirect cost rate or an administrative cost pool, but you can't use both. So if you tried to use both of those, things are not going to work out correctly.

Or have you used unallowable cost but put them into the yellow cell? That's where you can enter cells that are not going to be backed out. So you need to take a look at those costs that are not allowable and make sure you put them into the cross hatched cells in option A, and I'll show you this in just a minute.

And then, do you have both in-house and reference lab costs? The laboratory costs are going to become important because we're going to calculate out those costs that are done in the clinic. So you want to make sure you have the cost for doing in-house labs as opposed to the cost for sending labs to reference labs.

For the cost pool calculations, you want to make sure that you have reductions in the top section. The most common reduction that's being left out are community education or outreach cost. These are not costs that are going to be generated for your paying client or for your third-party payer.

So we're going to take a look at those kinds of expenses. And then there are other expenses that you don't want to have in there. For instance, if you have research cost or if you have costs that are related to staff parties or things like that. So you want to make sure that all of those things are backed out.

And, as a guideline, agencies are almost always going to have some costs that are going to be minus items that are billed to client separately. For instance, in option B you back out the cost of contraceptives and you back out the cost of pap smears. So it's important to take a look at that and understand what's going on.

So while we have them, is the process of making sure we have all of our expenses into our – either our cost report or our cost pool calculation – those expenses that relate directly to providing your clinical family planning services, so the salaries, wages and fringe benefits, then. They're going to allocate all the appropriate people that work in family planning into these – into the family planning cost report or the cost pool calculation.

And we talked about other direct expenses, things that are directly paid for to provide services to the family planning program and then indirect cost. If you have an – approved indirect cost (greater) or administrative cost pool, that would be included in there.

But indirect costs are those cost that you really can't trace to a specific program, a portion or a percent are – is allocated to individual projects such as utilities or rent or administration. So these are the kinds of things that we're going to take a look at in gathering your expenses.

So what we want to do now is review your homework. We want to review the completion of the cost report quickly and we want to review the completion of the cost pool calculation.

So, to do that, we're going to go to the workbook that was developed last time. Well, I didn't have the right thing up. Sorry. The workbook that was developed last time.

And here is the focus cost analysis – the cost report. And, remember, you're going to put in your agency name and the timeframe for the report. And with the cost report, you're going to document all of the costs that were related to family planning.

So you can do the total agency cost and then parse out the family planning cost. So as an example here, we have an executive director that we paid $58,000 and $29,000 or 50 percent time was paid out of the family planning budget, the direct family planning budget. And remember to use these notes sections because that's going to be helpful for you when you look at this the next time or when you – when someone comes along behind you and has to fill this out.

Notice also here we had an administrator that was paid $90,000 and the anticipation was 5 percent of that administrative time was going to family planning. So $4,500 was an indirect cost.

So the administrator does not keep specific time that they are going to put in family planning. They're not keeping a timecard necessarily, but there are some study that's been done to suggest that 5 percent of that individual's time is going to be an indirect cost to family planning.

And then, as another example, the finance director who is paid $73,200 and 5 percent went to family planning but it was an in-kind contribution. So the local health unit or the plan parenthood or the hospital allocated 5 percent as an in-kind contribution to the family planning program. So we can have direct family planning cost, indirect family planning cost and then in-kind contributions for family planning.

And as you go down, through here you can see we filled in a number of things, a number of things that are direct family planning cost. So the telephone which was billed to family planning was 23.66 and it was direct cost.

And then we had some other direct cost. And notice we've given you numbers of lines down here so you can put in things that you need to put in, so licensing and membership. We had direct family planning cost of $3,288.

Or bank charges. Perhaps these were bank charges that were related to collecting via credit card or bank charges affiliated with the family planning program direct family planning cost.

And then allocations, indirect cost. For instance, IT is a big allocation item now because IT systems are very pricy and a piece has to be allocated to family planning, but it's probably a direct cost rather – I mean, I'm sorry – an indirect cost rather than a direct cost.

So as you go down through here, take a look at these things that are supposed to be filled in. And I have given you some options. For instance, you can fill in the staff individually or you could use the medical payroll and put the whole amount in for family planning and how much was direct and how much was indirect if you chose to do that.

Laboratory, again, remember, you're going to split your in-house lab expenses from those expenses for sending labs out to a reference lab. And this is where the time study becomes useful, so if you have technicians or support staff that are working doing in-house lab, you want to pick up their amount. And then, if you have technicians that are involved in sending labs out to the reference lab, you want to pick their amount up, put it into the reference lab cost.

Pharmacy is an optional. And it's for information only, if you choose to fill that in, it will give you some information.

But notice that we're picking up not only the cost of pharmaceuticals in here, but a pharmacist – if you have a consultant pharmacist that comes in or a pharmacy technician and that could be anybody that deals with the pharmacy in terms of packaging pills or doing labels, et cetera.

And sometimes you'll have office staff that will do the ordering and maintain the inventory, so all of those would be pharmacy expenses.

And we have a number of – as I roll down here to "Other", have a number of cells that are cross-hatched. These are unallowable costs. So if you have outreach workers, outreach workers are essential for the family planning program, but they're not an allowable cost in terms of charging to your – to your clients or to your third-party payers.

And the same thing, if you didn't have environmental expenses, notice what I did here. I put in staff and board expenses because those are unallowable and

fundraising expenses are unallowable. So there are a number of unallowable costs.

As I said earlier, one check you want to make is that you have not put unallowable cost into an area that has the yellow cell. Only – unallowable costs only go into the cross-hatched cells, so they are not picked up as part of the expenditures. And then you have your employee health and welfare and your facilities cost that get us down to a bottom line here for our medical cost – our medical and clinical cost of $822,653.

Now, this is a very similar process when we start talking about the cost pool calculation. The cost pool calculation asks you to take your total expenses for your family planning program, roll all of them together and you have an amount, in this case, $1.196 million. But then you have to back out some of those unallowable costs.

So if you had fundraising or lobbying that would not be allowable, so you'd back out that kind of money. If you had any restricted expenses, something that was given to you specifically for a project that didn't go into providing the clinical services, you would back that out.

Other unallowable expenses, such as board expenses or staff retreats, you will back out. And notice the instructions for that are here on the sheet over on the right-hand side and they are also specified in the manual. So you shouldn't have any problem in understanding what should be backed out.

And then, of course, we have these other expenses not to be charged – community education, outreach research, et cetera. So we're going to back that amount out from our total family planning expense which gives us a net amount of just over $1 million.

But then we're going to back out those items that are billed separately to clients. That is we're not bundling these up. You're going to have separate bills for these things.

So you would take – you would put in your contraceptives and any other pharmaceutical medications that you had. You would show pap smears and

then any other expenses for outside labs – the labs that you send out for RPRs or (Prometheus) or GCs or whatever else you might send to an outside lab. And you're going to back that out as well to get us to a bottom line net expense of $820,752.

Now, remember, this is very close to the cost report, $822,653. The different really is they – the fact that the cost report is going to focus in a bit more on specific program. So that's what your homework should look like.

And what we're going to do now is stop for a moment and see if there are any questions about the homework or the issues there before we really go back into today's relative value systems.

Tara Melinkovich: So if you have questions related to the review or the homework, just a reminder that you can chat your questions in or you can press star one to ask a question over the phone line. Operator, do we have anything – anyone on the line for question?

Operator: Not at this time, no.

Tara Melinkovich: OK. Great. So I think we will just go ahead and move forward. If you do have other questions that come up related to this homework, you can always ask them over the Communities of Practice site.

George Christie: So Emily is going to pick up here and take you through the introduction to relative values.

Emily Kinsella: Yes. Thank you, Gerry, for the review of the homework. So we are going to get into reviewing how to assign relative value units to the services you provide.

So it's important for you to be able to do this on your own. This is a little bit of a change maybe from what Gerry or I may have presented in the past, if you're familiar, where we provided you the relative value units. We really wanted to help you all learn how to do this for yourself to make you kind of self-sufficient at the cost analysis, so that's what we're going to go into here.

Now, to understand about the value units, we first have to talk about Current Procedural Terminology or CPT codes. So almost all cost analysis models rely on CPT codes and their associated relative values. Each CPT code, for every service, procedure or visit provided in the clinic has an associated relative value unit.

The "Procedures" tab in the focus cost analysis workbook will show these CPT codes. And we've – what we've put there are the most common ones provided in a family planning clinic. So Gerry will get into that, showing you the details of that a little bit later.

So CPT codes – hopefully, you all are very familiar with CPT codes. But just to put us on the same page here – CPT codes, you're assigning it for every service visit documenting that you provide.

Now, sometimes, your program is more than family planning. For example, you do primary care or STD services or something beyond family planning, but it uses the same code because an E&M visit is the same, whether it's family planning or primary care. In that case, what you need to do is be able to identify when that code is being used for family planning.

So the best way to accomplish this is to look at the ICD-9 code or the diagnostic code, so this is different than the CPT code. This is something that would be like V25.1 or something like that. That's the code that's assigned to the CPT code to say, "Why did I do that?" (To say), "Why did I do that 99211," or, "Why did I do that IUD insertion?" That would be kind of the reason. That – you can use that to help you figure out which CPT codes are family planning and which were not.

So relative value unit. As I said, there is a set of relative value for each CPT code. The relative value unit indicates the worth of a procedure in relation to other procedures. The worth here is not about cost – right here it's not about money.

So, for example, if you have Procedure X with a relative value unit of 40 and Procedure Y with a relative value unit of 20, it doesn't mean that Procedure X is a $40 visit and Procedure Y is a $20. It just means that Procedure X is

worth twice as much as Procedure Y because 40 is twice of 20. So each relative value unit really it's only important in how it relates to other relative value units.

(As a key thing), there's an established relative value unit for most of the service-related CPT codes. In our cost analysis we're presenting today, we used the resource-based relative value scale or RBRVS from the Centers for Medicaid and Medicare Services to determine the relative value of service.

The RBRVS consists of these elements – the physician or clinician work, the practice's overhead expenses and the cost of malpractice insurance. The RBRVS has been established over time and is updated on an annual basis and sometimes more frequently. For this cost analysis, we usually fully transition non-facility RBRVS to determine relative value units.

So, right now, Gerry is going to walk you through what all those things mean and really show you how you find these – the relative value units using RBRVS.

George Christie: Thanks, Emily. This is spelled out in your manual as well, but we wanted to show this to you so you had a real sense of what goes on and, hopefully, even this might be a little bit more refined than is in the – in the manual. But I think that you will find everything you need in the manual.

So here's the site we're going to go to. We're going to go to www.cms.gov and you got the whole thing there. You can copy this and put it into your – as a URL into your Web browser. And you will go right to this.

And what we want to do is up a pane, the updated relative value for the focus cost analysis. So the manual tells you the step-by-step instructions. And what I'm going to do is show you what happens when you go to that URL.

And when you go to the URL, this is what you are going to see on your screen. It's going to come right up to this PFS relative value files. PFS stands for Physician Fee Schedule. And you'll notice that it has the calendar year.

Yours might come up like this. It might start 2003 and it goes through 2003, 2004, et cetera. But you're going to want the more recent one. So if you click on calendar year, notice it takes it into descending order from the – from the current date.

And you're going to look for the particular relative values that you want. Now, the last one in 2013, RVU13C, will be the most recent for 2013. They start out with RVU13A and that was in – published in December of 2012 and then, a revision to A and then B and then C.

What I'm going to do is pick 2012 RVU12D. This was the last one that was put out in 2012. I'm only going to pick that because that's the one we've used to give you an example.

So when you go to this, you click on the date and it's going to bring you up to a place where you can do a download – "Details for Calendar Year: 2012". Notice this was Physician Fee Schedule revised for the October 12th released according to Continuing Resolution 8017. And right here is where you will click and download a zip file.

So downloading that zip file, what I usually do is create a new folder on my desktop of in my documents and I download this zip file to that folder. So if we do this, here is the example that I have.

I did a folder called "RVU2012D" and this is the zip file in there. But when you click on that zip file, you'll see there are a number of files within that zip file. Now, there's three things that are of interest to us.

The first one, and it's spelled out in your – in the manual – is the PPRRVU12 Excel file, XLSX. So that's the one we're going to work with first. But I want to call your attention to two other files in here that you would use, and I'm going to show you these as we go along – the GPCI2012 XLSX and the 12 location, LOCCO file, which you may or may not use depending on your location, your state or where you are in a large state, but I just want to point that out to you as something that's of value as well.

So once you have this, you download the PPRRVU12 file and it's going to look like this. Now, I've highlighted this a little bit for this. I've highlighted the five column that you really want here.

What we want is the work RVU. This is the clinician or physician work value and we've pointed that out to you in an earlier slide. And then, as you said, we used the fully implemented non-facility practice expense RVU.

Now, fully implement, they would do their transition at CMS for a while. But it's all been transitioned already. So, now, we got to fully implement it.

We use non-facility because that's what we are – ambulatory care programs, family planning clinics, planned parenthood, local health units are ambulatory care non-facilities. So those are the RVUs that we will use. And even if you're a hospital-based clinic and you're running a family planning clinic, you should use the non-facility RVUs to determine your cost for your family planning program.

And then, over here, we have the malpractice RVU or so that's different, and then the fully-implemented non-facility total. And then, as we go over here further, you'll see one other column that's important to us and that's called the conversion factor.

Now, what I do is I take a look at – actually, there's one other – I've already erased one file, it's D. It's – but you didn't need it. But I go in and I take out – I eliminate the files that you don't need.

So we could highlight D and E, for instance and delete those. And that's going to move the work RVU and the fully-implemented non-facility PE RVU together. And we do that again for the rest of them.

And what we come up with is what I call a values table. And this makes your life infinitely easier in terms of being able to select the values that you want and put them into the appropriate field in your procedures manual, so – "Procedures" tab. So we have the work RVU, the fully-implemented practice expense, the malpractice RVU, the total and then the factors.

Now, how are we going to find what we want? Well, many of you are familiar with Excel, but if you are in this first A column, you can go up to "Find" and you can say go and find 99201 common procedure for family planning programs to use. And, in fact, notice that 99201, 202, 03, 04 – all the way down to 99215 are right there.

So you could, for instance, copy the CPT codes and the description and the relative values, but not the conversion factor. I went too far. Sorry. And make note of the conversion factor which is 34.0376 and then you are simply going to take these and copy them to your focus cost analysis – I actually have laid out those things for you.

So – but you can copy them here and you could put – if you didn't have any numbers in here, you could go to here, paste these and now you have your CPT code and you have your relative values, your work value, your overhead value, your malpractice value and your total relative value. So this is how you would pick these up.

The whole process is to make sure that you are able to find these and that you understand what the conversion factor is. So want to make sure that you look over here and see the conversion factor because that's going to be important for you a little bit later as we bring these together.

But any number that you want, anything that you need to find – for instance, if we go back here and we go up into 11981, you could go back and find 119 – wrong one, sorry. I'm sorry. You could find 11981 and here's 981, 982, 983. And if you just want to copy the relative values, you copy them to your procedures and there you have the appropriate relative values.

OK. So that's the step for gathering the procedure codes. And I'm going to pause here to see if there are any questions regarding these steps.

Tara Melinkovich: Great. Thanks, Gerry. So, just as a reminder, to chat your questions in or you can also press star one to ask a question on the phone. We have a question that came through while you were speaking, Gerry. That was, is there a way to unlock the spreadsheet to add a row?

George Christie: I actually thought we gave people an unlocked spreadsheet. And I have to go back in there. If it is locked, we'll give you the – we'll give you the password. But I think – I thought all of these workbook was unlocked, so let me double check that.

Tara Melinkovich: OK. So we can double check that after the Webinar and we'll make sure that they are unlocked. The next question that we have here is where does the conversion factor enter into the calculation?

George Christie: The conversion – I'm going to get to that in our next step. But the conversion factor helps us gross up the relative value so they are manageable. It actually gives us an idea of what the Medicare physician fee is and that's useful in understanding what some of our charges are going to be, and we'll talk about that a little bit in three. But it goes down in the bottom of our – of our "Procedures" tab. So let me show you that in just a minute when we get back there.

Tara Melinkovich: OK. Great. Thanks, Gerry. We have another question here that came in privately through the chat. If looking for RVUs for July 2012 through June 2013, which file should be used?

George Christie: The file that you should use relates to what your fiscal year is. So, generally, if people are going to use fiscal year 2012, I would go back and do the 2012. And I did that as the example here only because, when we started out with this, it was a few months ago and the 2013s weren't as stable. But if you are going to, let's say, do your cost analysis from July 2012 through June 30, 2013, I would go ahead and use the 2013 values and plug those in.

Tara Melinkovich: OK. Great. Thanks. So the next question, I'd like to hear from both of you, Emily and Gerry, and then also OPA can weigh in on this. Are there any state restrictions to using either option A or option B?

Emily Kinsella: This is Emily. I would check with your state. As we said in the beginning of the Webinar that OPA doesn't mandate a specific methodology. But your state may have a specific methodology or approach they want you to use.

George Christie: I guess I would concur with that. Certainly, unless the state says something or your grantee – it may not be the state, but your grantee wants you to do something in a particular way, then, you can use either one. But if they have a preference or have their own cost analysis methodology, then, you'll probably want to stick with that.

Tara Melinkovich: Great. Thanks, Gerry. Sue, would you like to weigh in on that?

(Sue): Can you hear me?

Tara Melinkovich: Yes.

(Sue): OK. Great. What Emily and Gerry said is exactly right. OPA does not have any (side) on that issue. So it is up to the grantee or, you know, if the grantee wants to delegate that down to individual agency levels in terms of which method they prefer to use, then, that's fine. But OPA does not have any bearing on that so,

Tara Melinkovich: Great. Thank you, Sue, for that perspective as well. We have one other question that is RVUs you pulled up were national. Aren't there regional RVUs?

George Christie: There are adjustments. And as soon as we move back to the Webinar process, we are going to talk about the regional adjustments. So, yes, that's very astute.

They are the national RVUs. But there are regional adjustments that are done through the Geographic Practice Cost Indexes, sometimes called the GPCIs. And we will talk about those when we finish the question discussion section.

Tara Melinkovich: Great. Thanks, Gerry. Do we have any additional questions on the phone, operator?

Operator: No. We do not have any question over the phone at this time. OK. Great. So, before we get started, I'm going to open up a quick poll just to touch base on how people are experiencing the Webinar today.

It's in the right-hand column of your screen. If you could please just weight in on how the speed of the presentation is going so far for you. And we'll leave it open for a little bit, maybe about 30 seconds more and then we'll close it and we'll move on.

And I know you guys can't see this on the other end of the screen, but we are watching you weigh in. So that's how we're waiting. We are waiting silently to see how people are weighing in.

OK. It looks like the speed of the presentation so far is just right. So we'll keep moving forward at that speed. Thank you. And so I believe we will now hand it over to Gerry to continue.

George Christie: Thanks, Tara. And I'm surprised at that. As a matter of fact, so most people know that I speak way too fast. And – so I'm glad that we're moving along at the correct pace for you all.

So as our questions are so astutely pointed out, the values that we were showing you, the RVU values are the national standard. And they are modified for local use using the GPCIs, the Geographic Practice Cost Indexes, and I'll show you this in just a second.

These geographic adjustments are based on analysis of the cost and fees in various areas. And those cost include the cost of staff, the cost of clinicians. It includes the cost for malpractice in certain areas. And it includes the practice expense cost.

So those are some of the variations. And this is done by government studies of these economic factors from locality to locality. And what you will see as we look at the GPSI table here, and I'll show you the other part in a minute, but here, for instance, is the 2012 revised payment and I put in that national value.

When you go to the GPSI file, when we see the GPSI file, it does not have the national value in there. So I put that in just so you see it. But, for instance, the value is – the work value is never going to go below 1.0. This is what

Congress has decided this is how physicians maintain their payment level so that work value is never going to go below 1.0.

But in some places, it's certainly going to go above that; it's more costly. So if we take a look at Alaska as an example, it's 50 percent above the national standard. And we know it's costly. I see some of our friends from Alaska on the line here listening to this, but we know it's costly to hire practitioners in Alaska and that's the reason why it's 1.5 as an example.

And, in other places, it's 3 percent higher. Or in D.C., in the Maryland, Virginia suburbs, it's about 5 percent higher. So you can see that in some places, it's higher. But it will never go below 1.0.

So – and the practice expense can vary as well. In Alaska, it's almost 7 percent higher than the national standard, but in Alabama it's about 12 percent lower than the – than the national standard.

And the malpractice thing indicator is one that really varies. So there's not much malpractice expense in Alabama. It's more than 50 percent lower than the national standard. But if we get to Connecticut, it's 25 percent higher than the national standard, so you can see that this varies all over the place.

And I would call to your attention just two other things. Here, you notice that California – I have three of them in here, but there are nine different locations. There's Anaheim, Santa Ana, Los Angeles, Ventura, San Francisco, Berkeley, Oakland and then the rest of California. So you need to take a look at that.

And the same kind of thing is Baltimore and the surrounding counties and then the rest of Maryland. So if you take a look at Iowa or Kansas, they are single states. There's nothing different for any other part of the state. They remain the same.

So the conversion factor which somebody brought up just before we took the break or as we took the break is used to multiply those adjusted relative values. It's used by CMS to set physician reimbursement, as I say, although that's not truly the reimbursement that Medicare is going to give to physicians. It's the standard on which they make adjustments.

But this factor can be used as a constant for the cost analysis and it gives us a relative value that becomes a little bit more useful I think in understanding what's going on. And when we get to Webinar three, again, we're going to show you some different issues around that.

So remember we were in a zip file. And we mentioned that GPCI was there and we could take a look at that. So if we go to the GPCI, you'll notice this is what the GPCI looks like. And, again, it still has a 1.0 physician floor. This is for 2012D.

As we go down through here, we can see all the different areas. And I just wanted to point out to you that one other file on – within our zip file is the location file. So if you are in, let's say, California.

Here are the different areas in California and what is covered by them. And I actually highlighted one I thought was useful down here. I thought I highlighted it, maybe I didn't.

But if we were to take a look at New Jersey for instance, and it says, "Northern New Jersey". That means it's Bergen, Essex, Hudson, Hunterdon, Middlesex, Morris, Passaic, Somerset, Sussex, Union and Warren counties. So this gives you the counties that each of these areas is going to cover.

So if we go back to the GPCI, I selected Kansas for ourselves this time for our cost analysis. So what we can do, you would highlight your state or your location and copy it just like we did the relative values and bring it back to the spreadsheet and come down here at the bottom and see where it says "Geographic Practice Cost Indicators" down at the bottom of the sheet.

You'll simply copy the location and the values into this – into this site. And then, notice right here above it, it says 2012 conversion factor. So with the 2012 conversion factor, we determined that that was 34.0376, we'd enter that. And now, you'll see what happens if we go up here to our 99201, for instance.

Our total relative value on a national level is 1.26. However, we're going to adjust it to Kansas, so the work stays the same. It's 0.48, it's still – one times

that is 0.48. But the overhead or the practice expense is less in Kansas. Notice it's 0.894.

So if we take a look, the 0.74 has been multiplied by 0.894 and it gives us 0.66 instead of 0.74 for the adjusted overhead. And the malpractice is 0.975. That's not going to change 0.04 much but it will change some others.

So instead of having a total relative value or 1.26, our relative value is 1.18 for Kansas multiplied by our conversion factor and we have 40.16 for our final relative value.

Now, if I go over to a completed cost, and notice the – you should put in up here what it is that you are using. I put in 2012 August was the RVS that I use, so the physician schedule that I used. If you used 2013, when you open it up, it will tell you what the date is. And you should use the most recent one. I think the most recent one is C on 2013 – no, D, not C, on 2013. You would put that in there.

And then all you'll have to do, you don't have to copy the CPT codes unless you have some additional ones you want to put in. But we've calculated all the appropriate CPT codes we think for a family planning program.

Now, notice that we have colposcopy and biopsy and cryosurgery. We don't have LEEP. So if you do LEEP, you could come down here and you can take up the CPT code and LEEP and get the relative value and put it in. There's space for you to add 10 services that you could be providing here. So this is the – this is the process.

Below that are education and counseling. I want to talk about this just briefly. This is for counseling that is billable counseling. It's 99401, 402, 403, 404.

This is individual counseling that results in behavior modification or behavior change. It is done by someone who is specifically trained to do that kind of counseling. And it's counted in 15-minute segments.

So family planning very often talks about contraceptive counseling at the end of the visit. Well, realistically, we're doing contraceptive education. When

we do our initial education, it's education; it's not counseling, it's not pre-counseling.

We are telling people about the exam, we're telling people about the different methods, we're doing that education. The exit interview is the education that goes on.

So unless you have, let's say, your nurse practitioner have some specialized time set up for nutrition counseling or if you have a nutritionist and the nutritionist does nutrition counseling and you bill that to a – to the client or to a third party, you're not going to have counseling activities.

But some programs do have that. And I want to make sure we have that in here.

The only thing that you can't change, and I'm – we – we're saying this strongly – these in-house lab, the relative values, we had to go out and find and calculate. They are based on overhead or the practice expense for these labs, for the in-house labs. The only one that is on the relative value is 99000 which handling or conveyance of a specimen.

And the handing or conveyance of a specimen can only occur once during a visit. So it doesn't matter how many labs you send out. You have one handling or conveyance of specimen.

But if you have that, you really want to make sure that you're capturing the number of those that you're doing and you have a relative value for these. So the process is fairly clear. We have Kansas down here, the adjustments have been made to everything.

These are done automatically. You shouldn't touch anything over here or change anything. If you change – if you put anything in, you put it into the yellow cell, not into any other cell. So we have plenty of room over here for you to put that in. The calculation is done, the total adjusted relative value and then the final relative value is there.

So this is the process that we go through to get the relative values. It's something, as Emily pointed out, that both her program and my program have done for you in the past. But we want to set you free.

This is your opportunity to go in and pick up the information that you need. But I want to remind you all that we are only dealing with in – with the services, the procedures in the clinic and the in-house labs on those focus cost analysis. We're not dealing with the cost of pharmaceuticals. We'll talk about that and we'll talk about the cost of labs going to outside reference labs in Webinar three, but this is specifically dealing with the things that are happening in the clinic, those services.

So, OK. Again, time to see if there's any questions or discussions about that part of the presentation.

Tara Melinkovich: OK. Great. Thanks, Gerry. So it looks like we just got a chat in here that says workbook is indeed locked. User cannot enter the (CCI).

So we will solve that problem right after we all get off the phone today. And, well, before we do that, we do have a question that says, the RVU has no relation to the cost of services as mentioned earlier. But help me understand again what is the importance of this weight.

George Christie: I'm sorry. Can you repeat that?

Tara Melinkovich: Yes. So – and this might relate to actually Emily's section before, talking about RVUs. But it says, RVU has no relation to the cost of services as mentioned earlier. But please help me understand again what is the importance of this weight.

Emily Kinsella: So I think…

George Christie: Go ahead, Emily.

Emily Kinsella: Go ahead, Gerry.

George Christie: Well, the importance of the relative value, the – it's the relative worth. And as you just saw when we went through these, we have the work factor and the –

and the practice expense. So it's not what it costs to do this or what it's going to cost to provide this service as much as how much is invested.

How much time does the clinician have to take? What's the decision-making process? How complex is the decision-making? What kind of history has to be taken?

How expensive is it in terms of the kind of room where you provide this service? Some services can be provided almost anywhere. If you do a Depo shot – I mean, I've seen Depo shots being given in the administrator's office. Maybe that's not the appropriate thing to do, but they can be done there.

Whereas if you are going to do an IUD insertion, you need the exam room, you need the table, you need the equipment to go along with that. So that's the work. Each of these things is weighted or worth more or less based on those factors and that includes the malpractice.

Some things have a much heavier malpractice weight to them than do others. So that's how the weight or the importance of these things is determined.

Emily Kinsella: And I would just add, this is Emily, that they will become important in completing the cost analysis; they're an important part of that. And it's also important to use these standard relative value units. So we're really comparing apples to apples that your cost analysis and your results are comparable to mine, that we viewed kind of the same basis and standardized process.

George Christie: That is a good point. Let me follow up on that, Tara, just for a second. That's a good point that Emily just made.

There are other relative values out there. And if the relative values on different scales, they may be different numbers, but if they're in the same relationship, that's OK. But we use the RVRVUs because it's a standard and the relative values cut across all the services. So it cuts across placing Implanon and placing IUDs, which the IUDs are in the surgical section, for instance; and doing the EM or preventive service exam.

So it cuts across the whole thing and gives a weight for all of those relative to one another where some of the other relative value systems do not do that. They only give a weight relative to others in their own category, for instance, in surgery or in EM or whatever.

Tara Melinkovich: Great. Thank you, Gerry. And thank you, Emily. Another chat just came through asking if the slides will be available. And, yes, they will be available. They will be archived.

The Webinar itself will be archived and the slides will be archived on the Family Planning National Training Center Web site. In the meantime, we can also upload the slides to the Communities of Practice site if you would like to access them earlier. So that's something we can do in the next couple of days.

George Christie: I think that's a good – go ahead.

Tara Melinkovich: Go ahead, Gerry.

George Christie: I just want to say I think that's a good idea because we do have that link in there. So we want to make sure people can get those links and be able to get out to those Web sites.

Tara Melinkovich: Yes. And we have also chatted the links. Any of the links that are chatted in the chat box, you can actually copy and paste yourself participants. They – you can't through the Webinar if you have tried to actually click on the slide; you'll know that. So do we have any questions on the phone line at this time?

Operator: No. We still do not have any question.

Tara Melinkovich: No. OK. So then, I'd like to hand it over to Emily to continue.

Emily Kinsella: Great. So, moving on from the relative value units and the "Procedures" tab, now we're going to open the "Clinical" tab, the final tab in our workbook. And I want to just start – it's, to me, a little bit overwhelming when you first see it, so I want to start by just showing you what is in it and what's – a little bit about it, a little orientation to it and then we'll get into it a little bit more.

So, looking at this, this is the third tab to clinical. The first row is – column A, I'm sorry. The first column A, column A, is the service – or procedure name, so contraceptive capital (intra). That would be implant on insertion or an IUD removal, 99201.

So the second column, column B, tells you the CPT code and then column A is the common name. Column C is what we're going to talk about in a little bit. That's the service utilization frequency information which we'll be talking about in a minute.

Column D is RVUs and they magically copied over from what Gerry was just showing you. So they've automatically moved over to this workbook for you. And then, the – column E through G – sorry, through H – we're going to talk a little bit more about those in Webinar three. That's where the actual cost analysis happens.

And then column I is where you can enter your currency to compare the result. And we'll talk about those, E and beyond, in the next Webinar. (This is one intact and) give you a little orientation to it because it can be a little bit overwhelming the first time you look at it. So going back to the Webinar, here in the slide it has what I just told you; it's also in the manual.

The next thing we need to calculate or find now that we found the RVUs, for those same CPT codes on the same visits, procedures, E&M codes, counseling visits, in-house labs, we need to figure out the utilization data for it. How many IUD insertions did we do? How many pregnancy tests did we do? How many 99211 visits? How many 99401 visits?

So this is the number of visits we do, not the number of people we saw. We get used to in Title X the unduplicated or unique users. But this is actually the number of visits we do.

You can find this data a variety of places. It might be in – from clinic visit records. You might have a patient management system. You might have something that collects this kind of data to report it on (Aspar), on some of the pregnancy-(type) lab information you might find on lab blogs or other internal documents.

So in tabulating how many of these services and procedures using the CPT codes we did, we need to do it for a one-year period. We need to use the same time period we used for our financial information. So the last time I talked about that it could be a calendar year, it could be fiscal year, it could be – maybe your grant period which is – might be June 30th to June 29th. It needs to match the financial information you're using.

As I talked about last time, you need to consider how you will include visits and procedures done via referral. So if at your clinic, you can't do IUD insertions, maybe your providers aren't trained, and you're referring to a local OBGYN, you could – you have two options there.

You can either leave both those costs and those visits out of your cost analysis or you can include them. You know, it might be a good idea to include them. If you're counting those visits and costs for your family planning annual report, it's probably a good thing to get an idea of what is that costing you even though you may not be able to control very much how much the OBGYN charges you for it. They may just charge you $100 (for that), but you've paid your cost.

So just be consistent, either leave them both in or leave them both out. The cost and the utilization data for those types of procedures – just be consistent with both.

So, as we talked about before, you're going to count the CPT codes that are accompanied by a family planning diagnosis code, a family planning ICD-9 code, so the D25 code as a primary or secondary diagnosis.

So I'm going to just show you – we won't go to questions yet – let me just give you an example of how this is done. Hold on. OK. It should be coming up. OK.

So we're back at this – the clinical page of the workbook. We have our RVUs. So now we could say we pulled this information and we might say, "I have done 35 Implanon insertions and 19 removals," and so on and so forth,

going down. And, basically, as with the rest of this workbook, in the yellow is where you enter and then everything else calculates for you.

So – and, again, you would put your agency name at the top so we know who you are. But here you see I filled out one. And if you don't do a certain procedure, that's OK. Leave it blank.

Going down, it's just filled out. Same with what Gerry was talking about RVUs. Hey, you do LEEPs and you want to calculate that. You could enter LEEP here as an additional service and you would put how many LEEPs you did in that time period.

And then (as the capping), it really mirrors RVU procedure spreadsheet, but here you're just doing your utilization data and calculating it and entering it. And then the rest of the cost analysis will happen automatically, and we're going to talk – it doesn't do it here because I told it not to.

But that's what we're going to talk about on the next Webinar is really what happens then and what do we do with that. So you might – as you're playing at home, you might see these columns start filling out with lots of interesting numbers.

So that is how to enter the utilization data. I think we're going to take – see if there's any questions on that part.

Tara Melinkovich: Great. And we actually have a couple of questions that came through in the chat. As a reminder that you can also ask questions by phone by pressing star one.

So this question I think you got at this already a little bit, Emily – what we're going to cover next time. But how did RVUs translate into dollars?

Emily Kinsella: We will talk about how that happens next time. So as you saw on that clinical sheet, we use the utilization data and then RVUs and there will be some calculations that happen that we'll go through in detail what exactly is happening next time where the relative value units are applied to your utilization data.

Tara Melinkovich: Great. Thank you.

George Christie: Emily?

Emily Kinsella: Yes?

George Christie: Emily, can you go back and show the spreadsheet again?

Emily Kinsella: Yes. It should be coming up.

George Christie: I just wanted to point out, as it's coming up, if you look at column E, which is the total service units, that's the one that becomes very important because these are the units of service you provided during the year. So some things are worth more. Remember, they are more valuable.

So if you take a look at the capsule removal, it's 142.65. And there were 19 of those. It generated 2,710 units of service.

And some things are less valuable. So if we were to go down to 99202, for instance, with a value of 69.54, you did a 131 of those. It generated 9,109 service units.

The key here is the number of service units – Emily, if you go down to the bottom there – the number of service units that were provided by the agency. And we want to get a cost per service unit. That's what's going to be important as we move forward in the next Webinar.

So that's how it's going to get translated to dollars once we know how many service units there are and what each service unit costs. So a service unit is a service unit is a service unit. It doesn't matter if it's an IUD insertion, an Implanon placement, a brief exam or a hematocrit or a hemoglobin.

They have a number of service units. Those that are more highly weighted that have more value produce more service units and, therefore, we're going to get the cost per service unit based on the service units that are provided. So I hope that's clear.

I think it will be clear next time. But it's right there. That's really an important piece on this sheet.

Emily Kinsella: To just be clear, Gerry, I think this is obvious. But what's happening in this column E is that column C, the service utilization data, is being multiplied by the relative value to get that number.

George Christie: Yes. Good.

The only other point I would make on this sheet is where Emily pointed out, if you had some additions, if you put them in on the – on the procedures – if you added something, the name and the procedure code and the relative value are going to come directly to this – to this sheet, to this clinical sheet.

So the additional service one there, then, you would – you would pick – that would be picked up from your – from your "Procedures" tab if you've added one in over there. So you can't do one without the other.

Tara Melinkovich: Great. Thank you, Gerry and Emily. We do have one other question that came through privately in the chat. It's can you tell us again which columns to include when copying and pasting from the PFS Excel Spreadsheet?

Emily Kinsella: Yes. So, Gerry, I'm going to hand it back to you so you can show that since you have the PF spreadsheet on your computer.

George Christie: Yes. Help me with the question again.

Tara Melinkovich: OK. So tell us again which columns to include when copying and pasting from the PFS Excel Spreadsheet?

George Christie: From the values. I got you. I got you. OK. So you are going to use the work RVU, the fully-implemented non-facility practice expense RVU and the malpractice RVU and then the total.

The factor is important, but notice the factor is the same all the way down. So when you go to the – to the pieces that you want, actually I – when I copy them the very first time, the only thing you really need to do is copy the work,

the PE, the malpractice and the total and those you can copy right back over to your worksheet.

So we're going to go back here. I'm going to go back to this worksheet and we'll go up here. And this is where you would copy them. This is where you would paste them and they will come in right here. So you're copying work, overhead or PE and malpractice and total.

Tara Melinkovich: Great. Thank you very much, Gerry. And just a reminder that these steps are also outlined in the manual which is available on the Communities of Practice site. So if you, you know, just need to practice and read some more about all of these complicated steps is that's where you can get that.

And so, now, we're going to move on – it doesn't look like we have any other questions. So we're going to move on to the homework.

Emily Kinsella: OK. So the homework is to look up the RVUs for your agency and complete the "Procedures" tab in the workbook and be sure to use the appropriate DPCI for your location. If it's just your state or if you're more complicated like California, where you're going to have to look up your individual city or county, use the appropriate GPCI.

And then gather – on top of that, gather your family planning utilizations data and enter it into the "Clinical" tab of the focus cost analysis workbook. So in Webinar one, we completed the "Cost" tabs, one of either option A or option B. And now, for this homework, we're completing the "Procedures" tab and starting on the "Clinical" tab with our utilization data.

Tara Melinkovich: Great. Thank you, Emily. And, as a reminder, as people start going through their homework, if you have questions, Emily and Gerry are available to answer them through the Communities of Practice site. And so we could guess that you start collecting your homework and finalizing your homework a little early, so if you do run into questions you can access our – the course facilitators.

And if you had questions today that were not addressed during this Webinar, please ask them through the Communities of Practice site. And, again, this is

not hosted on the National Family Planning Training Center's Web site. It is hosted on the JSI e-learning site and here on the slide is an image of what that site looks like. And we are going to chat again the participant set-up link and how to get started with that if you have not already.

So, on that note, we look forward to seeing you at our final Webinar in the cost analysis series, putting the pieces together for an effective cost analysis, on July 19th from 2 to 3.30 Eastern Time.

At this time, we would also like to open up a poll in the polling panel on the right of your screen. Please take a moment to ask – answer this quick question about the length of our Webinar. Do you feel that today's Webinar was too long, just right or too short?

So we'll leave that open while I am finalizing and closing out our Webinar today. We will chat a link of the online evaluation. Please complete the brief evaluation by Wednesday, July 17th.

In order to receive continuing nursing education credits or a certificate of attendance, you must complete the online evaluation. In addition to it being chatted at the end of our Webinar today, you will also receive an e-mail with instructions on how to complete the evaluation in your inbox.

So, thank you for your participation in today's Webinar. Thank you to our presenters, Gerry Christie and Emily Kinsella, for sharing their expertise and experience. And we will get off and unlock those spreadsheets right away. Thank you.

Operator: This concludes today's conference call. You may now disconnect.

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