

JSI RESEARCH AND TRAINING INST

Moderator: Paul Rohde
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Operator: Good afternoon. My name is (Tommy) and I will be your conference operator today.

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 during this time, simply press star then the number 1 on your telephone keypad. If you would like to withdraw your question, press the pound key. Thank you.

Tara, you may begin your conference.

Tara Melinkovich: Thank you. Welcome and thank you for joining us for our third and final installment in our three-part cost analysis webinar course, It Pays to Know Your Cost, Putting All the Pieces Together for 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 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 question from the presenters. You may ask questions via phone line by pressing star 1 or by chatting your questions in via WebEx. If you have questions that are not addressed, we encourage you to direct your

questions to the presenters through the Communities of Practice site. And this is the reminder that the Communities of Practice site is not hosted on the National Family Planning training centers website, rather it is hosted on the JSI e-Learning site.

If you have not already logged in to the COP site, you can do so by following the link chatted to the right of your screen. The presentation materials in transfer will be posted on the National Training Centers website 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 Friday, July 26th. The intended audience for this webinar is Title X grantees in sub-recipient agency staff who are new to cost analysis or in need of a refresher on how to conduct and update of cost analysis.

During today's webinar, our presenters will discuss a brief review of Webinars 1 and 2. They will discuss completing the focused cost analysis workbook, interpreting the focused cost analysis result, establishing your family fees and schedule of discounts, and how to do a cost analysis next time.

After attending this webinar, you will be able to, first, apply the expenses and utilization data to conduct an effective cost analysis. You will be able to utilize the focused cost analysis methodology to set informed fees and update your cost analysis annually.

I would now like to introduce our presenters and core facilitators, Gerry Christie and Emily Kinsella, who I believe most of you know very well now.

Mr. Christie spent 33 years as the Project Director of a Title X program in a Community Based Organization/Health Department based program. He currently provide technical assistance for state and local health department and private health care providers around cost analysis, needs assessment, and program development.

Ms. Kinsella spent the past six years as the Family Planning Administrator Consultant for the Colorado Department of Public Health and Environment.

She helps Colorado Title X sub-recipient agencies meet the Title X non-clinical requirement including cost analysis in sliding fee scale.

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

Emily Kinsella: Thank you, Tara. So, I'm going to start with a review of our previous webinar. So, before I get into this, I just want to remind everybody that the slides for the first two webinars are posted on the Communities of Practice website as our – the manuals, the workbook, and other materials to help you follow along with what we're doing. The full archive of the reporting for this will be on the National Family Planning Training Center website in a few weeks. I believe Tara said that but just to remind everybody.

And just another reminder that we're talking about in the three-webinar series the focused cost analysis methodology. This is the new methodology that really combined some of Gerry's cost analysis work as well my own and to create an easy to use and understand cost analysis methodology for you all.

So, just a reminder of what we talked about way back in Webinar 1 on June 28th. We started with what did we want to know in the cost analysis? We want to know the total cost to our program for putting each clinical and laboratory family planning service provided out the door. We want to know that unbundled cost for each service. So, what does each visit cost us? What does each pregnancy test cost us rather than what does the – a full exam on where many of those things would be included.

To do a cost analysis, it's really driven by two things, our expenses or our cost and our utilization of services. In Webinar 1, we focused a lot on determining our family planning cost. We talked about two options. Option A was the cost report which was a document that allowed – you to look at your allowable family planning cost and calculate what your total medical expenses related to family planning were. Option B was the cost full calculation and that is a tool that can be used for agencies that already have report where they've compiled their family planning cost such as – maybe they used reports

to compile this information for FPAR or something like that. So, there was two options we went through how to complete each one.

We also talked about allocating our family planning expenses and how we have to identify what expenses relate to family planning services versus other services we might provide in our clinic such as primary care or something else. We talked about allocating salaries, wages and fringe benefits, allocating other direct expenses, and allocating indirect cost including approved indirect cost rates or an administrative cost rules.

So now, I'm going to hand it back over to Gerry to review Webinar 2 in the homework.

Gerry Christie: Well, thank you, Emily, and good afternoon or good morning all of you. It's good to see so many people on the webinar again and this has been a tremendous experience. People from New England, to Alaska, Hawaii, to Florida, and this has been a really a national training activity and I'm very pleased to be able to participate in this.

And as Emily said, what we've done is try to put the best of a couple of worlds together. People have asked over and over again, "Well, can we have a cost analysis that's really fairly easy to do and to make some sense?" and that's what we've tried to do here.

So, your first homework was to go out and get your cost and Emily just covered that whether you used the cost report or the cost pool. And then, your homework after the last session was to take a look for RVUs for your agency. And we showed you how to go out and get those RVUs. I'm going to show you that again in just a minute just briefly. But we wanted you those RVUs to put them into the procedures tab and then to pick up the Geographic Practice Cost Indices for your particular state or your particular area. And also, to pick up the – if you decided to use 2013, for instance, to pick up the conversion factors so that you have the appropriate conversion factor.

So that was part one of the homework. And part two was for you to gather your family planning utilization data and to enter it into the clinical spreadsheet for the – of the focused cost analysis workbook. And, that

sometimes seems like it's pretty easy but it's not. So, lots of times you have to dig deep to find certain kinds of things that some people do not have a patient management system for instance that's going to show them all the information they might need about their in-house lab work or whatever. So, you need to think of where you're going to go and what you're going to do to get this information.

But let's first turn our attention to relative values and relative value units. And as we mentioned last time, you need to choose the correct CPT codes for your agency. Now, I want to emphasize again for you that what we have put together here is a cost analysis for a family planning program. It's a requirement of Title X as we said that you have a cost analysis. You understand what the reasonable costs of providing services are.

So, our main focus was to deal with a family planning program and I know that many of you have looked beyond that and your interest in some other things which can be done. But you need to tweak, you may need to tweak this a bit or you may need some help in tweaking this if you're going to go further into this.

But for family planning programs and we've given a list of the services or almost all of the services that would be used in a family planning program. We have the CPT codes and you need to go in and find the relative values. Choose the date that you're going to use, rather, it's going to be 2012 or 2013, we showed you where to get that last time. And to find the relative values for the CPT codes that you used in your organization and in your family planning program.

Now remember, the relative value deals with the worth of a procedure, it's the relationship between one procedure and another procedure. So, we're really taking a look at how much goes into a particular activity or CPT code. We know it takes more to do a 99214 for instance which would be an established patient that's comprehensive visit. There's more decision making. There's more time involved in this that caused the problem is more complex. There's more activities in terms of how you have to support that. So, that's much more expensive than let's say a 99211 which is a brief, very often, a nurse visit

versus a practitioner visit. So that's the relationship. The worth does not relate necessarily. It does not relate to dollars at this point. It's the relationship between these two things.

Now, I just want to make sure that we all understand the nature of HCPCS codes or CPT codes. HCPCS stands H-C-P-C-S, stands for Healthcare Common Procedure Coding System. And this is the system that's been developed by CMS. There are two sets of codes. HCPCS Level I are identical to the CPT codes that has been developed by the American Medical Association. So, those are the codes that we're really looking at when we're talking about the services in our focused cost analysis.

Level II HCPCS codes are used by medical suppliers. They tell us about the supplies. So, for instance, J codes talk about the contraceptives or about the IUDs, and there are S codes that talk about certain kinds of services or the A codes which are the kinds of other supplies you might use if you might charge for including bandages et cetera.

So, we're looking at Level I CPT codes for the most part here. If you are trying to find a relative value for an A code, or a J code, or an F code, or a Q code, you're not going to find it. You may find, maybe able to deal with Q codes in that those unbundled services that a Medicaid program or perhaps one of your third party pairs, your insurance company has put together to pay you for a set of services and that's a billing code, a Q code. But you will not find a relative value in the relative value system for that. You will have – want to have to do one of two things, either break out the component parts of that Q code or more realistically, you can use of the payment from your third party payer as the relative value. Take the dollar sign away, use that as relative value and you can get some worth on that.

I'm going to post something to the Communities of Practice about these HCPCS codes in this issue. But I want you to understand that there are not going to be relative values for everything I've had. So, a couple of notes about lab serves which are the 80000 to 89999 codes, there are no relative values for those and we're not looking at those services, just a few in-house services.

And some folks have asked about vaccines and injections. Well that's 90281 to 97409. There are no values for those either. Those are descriptives – descriptors for the particular vaccine that's being used. What you need to count would be the immunization code, the 99271, wrong code, I'll give it to you in just a minute. But those are the codes you want to count as your – as we're doing that.

So, it's important to keep that in mind. Now, when we talked about the relative value scale, we mentioned that are three elements. There's the physician or clinician work and again, I would remind that you that clinicians are counted the same as physicians when it comes to the work factor. There's the practices – practice expense or the overhead expense and that's a net of malpractice because malpractices, the third element and it's calculated out separately. And remember that these three things are adjusted for your particular area.

When we talk about utilization data, we wanted you to determine and enter the number of services or procedures for the CPT codes that you use in your practice that were provided by your agency in one year. Now, it's going to be the same year as the fiscal information. You don't want to use two different years. Be sure that you're using the timeframe as that for the financial information. And you need to consider how you're going to include some visits and procedures that might be done referral at an offsite facility.

For instance, you might not have someone that can insert IUDs in your practice. And so to have IUDs inserted in your Title X patient, you may need to refer to a local physician. You pay that physician a fee for inserting the IUD. You may provide the IUD. They may provide the IUD but you pay a fee. You need to decide if you're going to count that person as part of your family planning program. If you count them in your FPAR, then you have to include the money that you pay to the physician for the service and you would count it as a 58300 IUD insertion.

So, you need to decide. If you're not going to count to folks, if you simply referred out, and you're not paying for it or you're not counting them then you wouldn't include the money that you would pay or you would not include that

as a procedure. So, you're going to count the CPT codes that are generally accompanied by a diagnostic code of V25.

Now, the V25 code could be the primary diagnosis. If it's primary, it's almost always a family planning visit. It could be a secondary diagnosis and if it's secondary, it really is going to take – you need to have to take a look at the primary diagnosis. It could even be tertiary, I mean, you could – it could be the third diagnosis down but if you really get involved in doing the counseling around the contraceptive, you provide the contraceptive, then that could be a family planning visit and you could count it. Remember, you need to consider, whether or not, you're going to count this visit on your FPAR and that's really an important piece for this.

So, I'm going to go to the relative values that we looked at last time. And remember, we went in to the Physician Fee Schedule, the relative value file and what I suggested that you do is to black with all of those columns that don't relate to what you need. You can create your own file which makes it easier for you to find things and put them on to the sheets. We use the work relative value, the fully implemented none facility practice expense or overhead expense. We used the malpractice relative value and then we have the fully implemented non-facility total.

Now, this fully implemented – if you're getting into 2013, you won't see this anymore because they're all – it's – everything is been transitioned now. So that's going to go away, you'll simply have to work. You'll have the non-facility practice expense, the malpractice expense, and the non-facility total.

And then, out here on the right hand side, you'll see the conversion factor and you just make a note of that. That's what you're going to pick up at some point in time. Define something. You make sure that you are in the first column and you can go to the "find" function. And, let's say I wanted to add something to our workbook, our procedures manual, a 99420. So, I say find the next one and notice it goes right down here to 99420 which is a health risk assessment test and it has the work relative value – no work relative value because it's not a clinician or a practitioner-based activity. But it does have a practice expense and a malpractice expense in a fully implemented total.

So, you can copy these four columns and you can move forward to your cost analysis. And down here, notice I put in 99420, the health risk assessment test. And if I go here and paste this, we have the numbers actually in the (inaudible) – yes, it's OK. We have the numbers and we will have all of the activities done automatically here when you put these in. So, your responsibility was to go up here and find those services your practice provides. Find the relative values and insert them here and the rest will be taken care of over here on the right-hand side because we're going to make those adjustments they made on your particular geographic area.

So for our example, we picked Kansas and the work is the same as the national. The overhead is reduced by 0.894 and the malpractice is reduced by 0.957. And notice, we have the conversion factor here. I have the 2012 conversion factor of 34.0376 and that's going to get us our final relative values.

Now, I also will call your attention just quickly to the geographic practice indicators. Notice here – and this again is for 2012, you don't have to worry about the contractor or the locality rows – columns A and B. Here's the locality and for Alabama you'll notice that the work is 1.0, the practice expenses 0.878 and the malpractice is 0.474, very low in terms of malpractice but we can find other areas where things are a bit higher.

For instance in Arizona the work is the same, the practice expenses a little less but the malpractice is a little bit higher. So as we rolled down here we find Kansas which is what we used – and by the way we noticed up here the revised payment file with 1.0 physician work floor. That means that none of the work expense is going to go below 1.000. It can go above that.

So, if we look at Alaska which is one of the highest work areas, we've got 1.500. But if we go down here to Kansas the work is the same, 1.0 and here's our practice expense reduction and our malpractice expense reduction and we copy that and move it to our procedures tab, put it down here at the bottom and automatically, these are going to be calculated.

Now, one other thing I want to call your attention to, we'd had – we did unlock – somebody asked about unlocking the table because you couldn't get things into the geographic practice expense. We did that. We put that, posted that unto the Communities of Practice. So, if you haven't downloaded it recently, go back in and download so you can fill in this section on the practice expense.

Other things are unlocked. We left some of these cells that are in white locked because there are formulas in there and we don't want something to happen to those. And you'll notice down here for our in house lab services, we have calculated out the overhead relative value for these lab services. And those, we have locked as well because we had to calculate those – that those that are not available for you. You can go out and purchase those, you could go to the MGMA and purchase the book that will give you some of these but these can be calculated and we can – we'll find a way to post these for you in subsequent times but – and you can continue to use the same one because these are not going to change much it at all.

OK, so that's the process that we went through. And then we went to the clinical piece but before we move into that I'm going to see if there are any questions about what Emily or myself presented so far.

Tara Melinkovich: Thank you, Gerry. So this is a reminder that you can ask questions by pressing star 1 or you can chat your questions in and it looks like we already one that came through which is, how can we find the 2013 conversion factor?

Gerry Christie: When you download the Physician Fee Schedule, the PFS from the site that we gave you and that URL takes you directly to the site where you can download it. Download the most recent 2013 and when you go in you go all the way over the right-hand side. It's probably column AB on the Excel spreadsheet if you haven't taken the columns that you don't need out. Somewhere over by AB, it will be there and it will say conversion factor just as I was showing you on mine. So, you can pick that up pretty easily.

Tara Melinkovich:Great, thank you, Gerry, and we're pulling up that website again so that we'll chat it in the chat box for you and a reminder that it's also in your manual. So, are there any other questions at this time?

Operator, do we have any on the line?

Operator: There are no questions over the phone at the moment.

Tara Melinkovich:OK, (inaudible).

Gerry Christie: Let me just ...

Tara Melinkovich:Yes, go ahead, Gerry.

Gerry Christie: Let me just say something. I just want to make sure that everyone is clear about those relative values that we're really looking at relative values for the services that are provided in the family planning clinic so that you're not going to find some – we picked up all the ones that are for family planning. And again, I just need to say that if you're looking for something that has zero, zero, zero across there, then it's probably not something you're going to use in the family planning program. There maybe ways to find those but that can take you a little bit more.

Tara Melinkovich:Great, thank you, Gerry. So we just chatted (Paul) the link to find the RVUs and that's where you'll find your conversion factor as well. And then we had another question that just came through. Could you go through the steps to hide the column?

Gerry Christie: Sure.

Tara Melinkovich:Could you possibly read that for us Gerry?

Gerry Christie: Yes, let me go into – see, I got to go back and share my desktop here again but – yes, let me do this quickly for you. I'm pretty sure I can do this and what I need to do is – oh boy – I am a – OK, bear with me. Sing a song or something. We can (inaudible) off a turkey or something like that if we want to.

Let's go down to relative values, all right. I'm going to 2013. Go ahead ...

Tara Melinkovich:OK, are you ready, Gerry?

Gerry Christie: Yes, I'm going to go to 2013 and here is what's going to come up. Remember you're looking at PPRRVU13. So, if I open this up, what you're going to see when it comes out, you can see a whole number of columns. And here is our work RVU and here is non-facility PE. And here is our malpractice RVU. And you're going to want obviously HCPCS codes here and the description. And then, as you scroll over to the right, way over here – it wasn't AB, it's on Y but here's your conversion factor.

So, what you can do is simply highlight those. You don't need the modifier because that's not of use to you in the relative values. You might need it for something else. So, you can simply delete that column. And the status and not use for Medicare payments, you can delete that column. And the ones that aren't in yellow over here now, we'll delete those columns and what we're going to do is get all the way over here. So, we have just as I was showing you, the four columns and you can – we can even get rid of these, you don't even need these over here.

We have the four columns that we had looked at when I was showing it to you, work, the PE, the malpractice, this is – I didn't pick up the total, my bad so we can undo all that. You want to pick up the total as well because you want to copy that. So when it comes out finally, you're going to have the five columns, the work, PE, malpractice, total and then the conversion factor.

Tara Melinkovich:Great, thank you, Gerry. And so, it looks like we don't have any other questions at this time so we are going to move on and hand it back over to Emily.

Emily Kinsella: All right. Thank you, Gerry for that review of the second webinar and the homework. So, we're going to go on to completing the workbook, finalizing it.

And so, let me go into that. So, what you're going to need to complete the full workbook? You're going to need your completed cost report or cost full worksheet like we did in Webinar 1.

You're going to need your completed procedures tab with the resulting relative value units as Gerry just showed and as we covered in Webinar 2. You're also going to need your utilization data which you get from clinic visit records, your patient management system, lab logs, pharmacy logs, that kind of things. We reviewed that in Webinar 2 as well.

So, the first thing we have to do is transfer our total cost from the cost reports or cost full calculation into our clinical worksheet on the workbook. So, for the cost report, you use the total medical cost and for the cost full calculation you use net expenses.

So, let me show you how to do that. Here – OK – so all right. For the cost report – so this is the cost report option A, this is the one we completed. You're going to take here this total ...

Tara Melinkovich: Emily, I'm sorry I'm going to interrupt you really quick. It doesn't look like we are seeing your desktop.

Emily Kinsella: OK.

Tara Melinkovich: So, do you want to try to lock – unshare and share it again?

Gerry Christie: (Inaudible).

Emily Kinsella: OK.

Tara Melinkovich: Are you getting it, Gerry.

Gerry Christie: I just came up when as you bounced out.

Tara Melinkovich: OK, I jump to get on that one but ...

Emily Kinsella: I just needed it. There we go. Sorry about that everybody.

OK, so now you can see it. On the cost report – this is the completed cost report and you take this box here, this 822,653 you're going to right click and copy it or you're just going to jot it down and you go over to your clinical worksheet. Let's try to go into this one and you paste it right here. So, you left click paste special and you paste the value.

And then – or if you did the cost full calculation, you're going to use this box, this 820,000 then copy you've go over and you paste into that box. So here it shows the – if you did it with the cost report how it works and this one shows with the cost full calculation.

So then, I want to go through a little bit what's happening in this workbook. The other thing we've done is our service utilization data. So, if you remember after Webinar 2, your homework was to find your utilization. How many implement insertions? How many pregnancy tests, that kind of thing you did and fill out this column here, that's column C.

So with his here it shows that already completed and we've already filled it out even these two additional ones if you had additional ones like Gerry was talking about. So then, let me go see what's happening on this worksheet. So here, we have our RVU value, your RBRVS and just copy directly over from that worksheet that Gerry just completed. So, you can see here the numbers there. It just gets copied automatically over here so that's already done for you. You've entered your utilization data. Everything else, once you copy your cost over everything else happens automatically for you but I'm going to go through what each column is doing.

So, column E here, your total service unit, for each CPT code, what's happening is it's multiplying the RVU by your service utilization, multiplying those two numbers together. It's then totaling how many service units at the bottom.

For column F, the adjusted cost per cost center – adjusted total cost for cost center, it just copied your cost amount from over here – over there. It's really just a placeholder for that cost amount.

What's happening in column G is it calculates how much each unit of service costs your program in the year you're evaluating. It takes the amount here that's 820,000 from cost full and divides it by this, the total service unit. So, it's dividing that number. And now, as you'll see it's the same number for everything. It copied the entire way down.

Then the service cost – this is telling us, this is what we want to know from our cost analysis is how much of that costing us? What is happening here is it's multiplying the relative value unit from column D times the average cost per service unit. You'll see there doing relative value times column G to give you your actual cost and it does that all the way down and that is the cost that you want to be looking at as a result of your cost analysis.

Let me unshare, get back to the slides. OK, making sure it worked. So this is what I just showed you that as you – when you enter your utilization data and you've entered your cost data, the rest of it happens for you and then you – those other cells calculate automatically which – what I talked about in detail is in the manual if you want to know what those calculations where.

And then column H gives you your agency cost and I'm going to turn it over here to Gerry to talk a little bit more about what you do, you have that cost and what you might do next.

Gerry Christie: Thanks, Emily. This is an important piece and as Emily said column H gives you the cost to provide each service for the time frame. Now, let's keep in mind when you're doing a cost analysis, you're looking retroactively at what it's costing you. Looking at a time period that's already gone by, so you're using the expenses from that time period and you're looking at utilization from that time period.

So this is what it cost you last year for that time period that you're doing the cost analysis for. It's not what it's going to cost you next year. So, you really need to take a look at what it cost you and compare that to column I which is your current full fee for each service. So, what you want to do is go to your fee schedule. Total the fees off that you were charging last year or the amount that you have put in place and see how things are going.

What are you doing in terms of making money, losing money, breaking even? This becomes very important. So, what we're going to do is show you again the cell that or the worksheet that Emily was just working at. We have over here, you know, here, we have the cost and the thing to do is now to start to put in the cost for what you charged last year.

Now, there's a couple of things to keep in mind here. Notice that you didn't do anything in terms of contraceptive capsule removal or reinsertion. Let's say you did 35 inserts and 19 removals but you didn't do an insert and removal at the same time which has a fee. Notice that the cost is calculated for you. Last year it would have cost you \$216.40. Now, the key here is the average cost per service unit and Emily was mentioning this.

Every relative value of every service generates a total number of service units and a service unit is a service unit is a service unit. It doesn't matter if it's a contraceptive capsule inserted. It doesn't matter if it's an IUD inserted. It doesn't matter if it's a Depo injection or a comprehensive examination.

It generates a number of service units and the key is to know what the cost per service unit is. So, in our examples – both of these by the way – whether you used the cost report or the cost full calculation came out to be a \$8 per service unit. So, we know what it cost to provide these services and in what it would have cost if we had provided these other services. Now, that would have adjusted because it would have changed the number of service units, but even so if you are going to add a service.

Let's say next year, want to do capsule removal and reinsertion, you have an idea of what it cost. So, you go in and put in your current fee and if we go over here, we can say that this was \$145. This is what you charged last year. And for a removal you charged \$165. And we look at that and say, "Oh, well OK, it cost me a \$136.56, I charged a \$145, I made \$8.44 at full fee based on what it cost me to provide this service," and the same thing here. It – I made \$12.19 to remove a capsule. But sometimes, we come down here and we take a look and let's say that we go to our services and we did a 99202 and we only charged \$45 for that. And for a 99203, we charged \$85. But as we look back, say, "Whoa, it cost me \$74.97," I lost \$29 every time I put one of those out the

door and it cost me \$108.87 but I only charged \$85 at full fee. I lost \$23 every time I put one of those at the door.

So, you want to put in your current fees. So, only here, we've done that. We've taken a look at the current fee and then, I'm going to go down here just quickly and clear this for a second to show you what happens for next year. So, here's the fee that we charged for the services. Here's the fee that we're going to put in for next year, potentially for the service we didn't provide. But all the way down, you're going to compare what it cost you to provide these services with what your fee was. And very often, what we find is that the current fees are a lot lower than what it really cost you to provide services.

Now, this happen sometimes because people set their fees based on what the Medicaid is going to reimburse them. And therefore, they know they have to have at least that amount so they make that their full fee what the Medicaid reimbursement is but that's not what it's costing them to provide the service. It's costing them a lot more.

So, often we see – and – often we see this happening. The other thing that happens that lot or times. You know, we're family planning people. We have that altruism. We're public health people. We know that we've got to be careful how much we charge. We have county commissioners who don't want to charge the population too much but the reality is we set our fees so often to low, lower than it what it's costing us to provide these services.

But as I said, this is what it cost us last year. This service cost. This is what it cost us to the punitive time that we're doing our cost analysis. But what's it going to cost us this coming year, we've got to come up with an adjustment and we do that down here at the cost of living, COLA or margin cell.

And notice, it's something that we can add in. And the way we've look at this is – OK, we know that this is going to be certain increases in cost. I know for a lot of years, people don't get raises, but now, things are coming back. So, hopefully people are going to be able to get a raise and we think of what we're going to give people, 2.5 percent raise or maybe 3 percent rise. And if we

give them a raise, if we increase our salaries, then we've go to increase our fringe benefits too because our fringe benefits are often tied to this.

Now, and go on the other hand, sometimes, we're dropping back and not doing so much with health insurance and some programs of reduce the amount that they might put in for pensions and retirement but the reality is that, if you going to increase salaries and wages, the fringe benefits are probably going to go along with it because you going to have an increase of (cycle). You going to have an increase on other things that you have to pay.

So, let's say we decided that's 3 percent but it's not only salaries and wages that go into this. There are other things that the cost of equipment, as the cost of supplies, these that cost of the facility, this other cost that potentially are going to go up. So, we take a look at that and say, "Well, those might go up but they're going to go up a little bit more than 3 percent."

So, let's say, we decide that our cost of – and by the way, its not just our cost of living but we know that we give some discounts. So, we need to have little margin or little cushion in terms of where our prizes should be so that we're going to be able to support some of the discounts that we're giving to people. So, we might want to have a margin in there. We don't talk about profits because we're not a profit agency, some most of us but margin is OK. A margin is a cushion. We can build that in.

So, let's say, we decide, we're going to put in 4.3 percent for our COLA or margin for next year. Now notice, you just put in the 4.3. It comes up as a percent automatically but let's see what that does. That comes only here and it gives us a cost of living allowance and its going to come up with an adjusted cost. So, if we did the 4.3, I'm just going to say at the top, the other contraceptive capsule insert. I cost of last year a \$136.25 to provide that service. Our current fee is \$145. Our cost of living allowance is going to increase our cost by \$5.86. So, it's going to cost us a \$142.11 next year, all things being equal. This is a guesstimate now, right?

But all things being equal is going to cost us \$142. So, we need to come up with the proposed fee. Now, we could say, "Hey, OK, we've been doing OK.

We'll keep it at \$145 and move on." And the same thing for the removal, we – it's going to cost us \$160. We were at \$165. We'll keep that the same as well. You could decide that you needed to go a little bit higher than that. You could decide that you need to have a little bit more margin. You can put that in.

By the way, with this COLA or margin, you can sort of play "what if" games. What if it cost me 8 percent more? What if – what I'm going to have to charge then? But it's not just what if blue sky kind of thing. It's – OK, you need to good accounting procedures and make sure you have a good analysis of why you are coming with the COLA, the cost of living and the margin that you've come up with. So, you need to take a look at that. So, you go down from here and come up with the fees that you might charge and I've done that for this program.

Notice I said – OK, we'll stay at \$145 and \$165. But now, I'm going down to condyloma treatment for males. And notice, it cost me \$131.07 last year to provide. This is a simple destruction of penis lesions. Cost me \$131.07. My fee was \$75. So, right away, I was loosing money, lots of money right there. And our – my cost of living is – allowance is \$5.64. So next year, it's going to cost me \$136.71.

Now, I've got to make a decision. Do I bounce my fee from \$75 to – let's say \$138 or \$140? Do I almost double the fee? Can the traffic bear that? Are the males still going to come in and be able to afford that? Or do I go just a little bit higher or not a little bit but take it up to \$105.

So, in this instance, what I did was say, "OK, I'm going to do \$105 here and the same thing with females, \$105." But I realized, I put it in red. This is – these are going to be losers. I'm going to lose money on this and I've got to come up with some way to make sure I'm going to make a little bit more money or at least break-even some place else.

So, when I go down in here and I looked at the IUD insertion, it cost me \$70.20 last year. My current fee is \$85. Next year, it's going to cost me \$73. If I leave at \$85, I'm still plus and I put it in green. This is still a money

maker at full fee. So, in black, it's effectively neutral. It's plus or minus \$2 or \$3 or about the same. If it's red, I'm losing money. If it's green, I'm going to make some money and you can down through here and set your proposed fees just on the adjusted cost. So, that's one way to do it is look, adjust the adjusted cost.

Now, the proposed fees then become very important and in addition to this and I need to go back here for a second. In addition to this, we need to – are we suppose to do questions there, Tara? Sorry.

Tara Melinkovich: We were going to break for some questions but ...

Gerry Christie: But I'm just ...

Tara Melinkovich: (Inaudible) – go ahead, Gerry.

Gerry Christie: I'm just on such a roll, aren't I? You know, go ahead, Tara.

Tara Melinkovich: Yes. (Inaudible) roll, but I'm just going to affirm two seconds of really quick if people ask questions. We will have other opportunities at the end of the webinar. But feel free to chat at in any question now and press star 1 if you have a question over the phone.

Operator, do we have anybody joining the phone?

Operator: There are currently no telephone questions.

Tara Melinkovich: Great. So Gerry, you were on such a roll on. I'm just going to hand it back to you and I'm going to remind you that we have about 35 minutes left in the webinar.

Gerry Christie: OK, thanks. So, stop talking so much, Gerry. OK, so we're going to interpret some of these results then. And, we want to take a look at what our cost was last year as I said, and what our proposed fees are going to be. So, there couple of things that we need to do.

First, we need to take a look at the average cost per service unit, and you saw that for us it was \$1.8 this year, and if our services are causing us \$1.8 that's

right in the middle of the target – when we go back to the spreadsheet I'll show you – but at the top of that column there's a target, and it's 85 cents to a \$1.25.

Now, what makes that the target? That's years of experience in working with this cost analysis. This is a really strong range. If you're at 85 cents, the cost per unit, you're very strong program, you're efficient, you got a good amount of utilization and, you know, can you be at 0.80? Obviously. Absolutely. But as you start to get below 0.85, 0.80 then the question comes up, are you a (mill)? Are you really doing things appropriately? Are you giving all the services that you should give? Or, have you included everything? Have you included all your expenditures for the services that you're giving?

On the other side of that, 1.25 or a little bit higher still an acceptable area to be in, in terms of your cost per service unit. It does mean you're getting little costly and you need to ask yourself some questions about that. Have I put in too many expenditures? Have I count – extra counted something? Have I not picked up some of the utilization? So, the target is very important. And then, they compared your cost with what your costs were last year, and we just did that before we came forward.

So, what we want to do now is take a look at the proposed fee. And you're going to compare your proposed fees with your adjusted cost, which we just saw, with our margin or COLA, and you want to compare them with the reimbursement rates, and that's really the important thing that I'm thinking about right now. The reimbursement rate is what you are going to get paid by Medicaid or by other third party payers. So that's going to be important. And, we're going to talk about that in just a second, but you need to have a list of what you get paid. You need to know what Medicaid pays you for each your CPT codes and what your highest paying third party payer or you can list them all out and see what they pay you. That's going to be important. So, the reimbursement rates become important.

And then you're going to review your proposed fees against some other standard fees in the community. Are you at the right level? Are you competitive with other people in the community? So you're going to take a

look at what are the usual in customary fees? What are the standard fees that people are charging and make sure that you have all of these things in place as you begin to look at this information? And then you really want to take a look at how you're deal with your other cost.

If you look at your charges last year and you are losing money you need to ask yourself a whole bunch of questions. Are you using appropriate staff to provide the services? Are you using mid-levels in a way that you should use other kinds of activities?

So, all of these becomes an important aspect for you. What are the fees in your area? Are you competitive? Are you offering the same services? Are you offering fewer services or more services than other providers? Should you focus in on an array of services or a range of services that you can do better? Or, should you add new services because others aren't providing those and maybe there's something you should be providing? Can you afford to provide the same set of services? Can you take a look at the discounts you're offering and when you're offering these discounts? What's going to happen with discounts? So, very often people will offer discounts to bring people in. And then, will the folks continue to come back to pay your full charges. So, this is all an important aspect.

So, let me just show you again on our workbook where we look at this. And it's really over here on the right-hand side. And, I didn't add – sorry, I went really too far – didn't add lots of these. But here, we left you some column. Here's the column for Medicaid reimbursement and this is by state. So, you pick your state and get the Medicaid reimbursement. And these are going to be different for different state. Some states reimburse quite well. Other states don't reimburse much at all.

And by the way, I've had some real good success with cost analysis in state programs going to their rate setting agencies to get some of the rates increased based on the fact that as we took a look at the cost analysis they could show that it's costing much more than what they're being reimbursed. Now, not everybody is going to do that and not all states are in that position or mindset to add reimbursement to family planning, but certainly they can do it.

So, I gave you a couple of examples. You can go down here. You'll see that sometimes your cost is – here's individual counseling – preventive counseling for instance your adjusted cost is \$64.91. Your proposed fee is \$60. Medicaid is only going to pay \$39.92 but your third party reimbursement might be \$92.56.

So, what you also want to do is go over to this column, third party reimbursement and I put in the highest amount but the reality is on your workbook, all of these columns over to the right are open and accessible to use, so if wanted to put in Blue Cross Blue Shield in their reimbursement and UnitedHealthcare in their reimbursement and (ATMA) in their reimbursement and Columbia Health in their reimbursement or whatever you have, you could put that in because you want to know what the highest reimbursement is here, you want to be able to create a fee schedule that's going to help you capture the most money that you can from all those third party.

So, it's important to come up with this proposed fee, take a look what's going to be positive or negative. By the way, most of our lab fees are in the positive side or at least the break even side but some of the other fees, we have much more difficulty in getting up to those fees, the amounts that we feel we need to do. And I would just put for the Title X program and underscore if we have – do a good job on our schedule of discounts and apply it fairly and appropriately and the people that need to get the discounts are going to get them and we don't have to worry quite so much about what that top fee is. Remember, we're looking for the reasonable cost of providing our services here.

So, with that, I'm going to turn it back to Emily to talk about establishing Title X fees and schedules of discounts.

Emily Kinsella: Thanks, Gerry. I think you've kind of given me a good intro. So, I want to talk more about – so you done this cost analysis. Now, how you do set your Title X fees and your sliding fee scale or schedule of discount?

So, your fee scale for Title X will be based on the outcome of the cost analysis. The cost analysis tells you what your reasonable cost of providing

services is. And this, you should look at your fee scale and compare it your cost analysis so that you can create a Title X fee scale that generate sufficient income along with all your other sources of revenue such as your Title X grant, your client fees, your Medicaid, private insurance that kind of thing, to maintain the program.

For Title X, these fees – that proposed fee column on the cost analysis represents what you would charge – what your full charge, full fee to clients up or below 250 percent – sorry, up or above, sorry, 250 percent of federal poverty level would be. And your fee schedule should – and some would mirror your cost analysis. It should list every one of those CPT codes, every item that you will charge a client for.

I just want to talk a little bit about determining Title X fees for contraceptive supplies, medications, and outside labs. So, obviously, as we've mentioned a couple of times, this methodology only determines cost for your procedures and your in-house labs. So it's – your office visits or procedures, that kind of thing. It doesn't necessarily or it doesn't tell you what you should be – what your cost is for supplies, medication, outside labs. But for those things, the great thing is you know a little bit already about their cost. You know how much you purchase them for, that's part of the cost. So, one way to think about that is your cost for those is your purchase price plus your – a reasonable handling fee.

So, some people set charges for those items based on that purchase price plus a reasonable handling fee. And that handling charge or handling fee could – is done in variety of ways. It could be – you could do a set amount for each item, you know, you add \$5 to everything. Or it could be set percent for each item. You have 10 percent to every item. Or it might be a more complex system of, you know, and you (really) cost this much but then we have to have a refrigerator and all these things but , you know, pills just can sit in our closet and are pretty easy. So you really – this methodology leads it up to you to determine how – what handling fee might add to those supplies and lab, and it – but it should be based on – it should be well justified and it should be in writing so that – so it's a well-established procedure.

So, I think, Gerry's referred to this, but just, you know, a reflection that your Title X fees, they need to be reflective of your operational cost as you're getting from the cost analysis, but they also need to be competitive with the market, with various things going on. They also need to be reasonable. We can't charge our clients \$400 for every visit. So, we have to kind of think about all of those things when we're setting our Title X sliding-fee scale or schedule of discount.

Tara Melinkovich: So, now we're back at question. So, we have had some questions coming through. And then, please add additional questions if you have them right now.

The first one goes back to the relative value unit in the workbook. The question is, you have 11981 through 11983 on the RVU page that are linked to 11975 to 11977 on the clinical page, why is this?

Gerry Christie: That's because we screwed up. The correct relative values with this year are 11981 to 11983. Those changed this year so – or in 2012. So, it used to be 11975. When we've started to put this together, we put it down as 11975. When I went in and did the relative value, I picked up the 11981, 11983. The relative value that's coming forward to the clinical page is going to be the relative value for 11981 to 11983. If you want to just change those numbers, go ahead. We can post another version if we need to. So, that's why that's there. And thanks, (Ken), that's a good pick up. I thought you to get that.

Tara Melinkovich: OK, great. Thank you, Gerry. So we – it sounds like the CPT post were updated. We will update the worksheet to address that. We'll upload it to the Communities of Practice site, and then it will be archived with all the other materials that are archived on that NTC Web site.

So, the next question is, (Yuri) asked, reporting required charges to approximate – to approximate cost, how do you reconcile setting up fees with consideration on tiered reimbursement rate?

Gerry Christie: Well, this is from an FQHC, a CHC program. And yes, you're right that UDS does ask for that but so does family planning. I mean, Title X is asking you to establish fees based on a set of reasonable charges or reasonable cost. So, this

– this is not an inconsistent position. The inconsistency sometimes comes with what the top of the scale is going to be. And if you're CHC and you're doing primary care, the top of your scale, the 200 percent and that's your full fee for family planning Title X, the top of your scale is 250 percent or 251 percent and that should be the full fee of the reasonable cost of providing services.

So, that's going to be a little bit different and – now I've already work for a lot of community health centers, most programs are getting to a point where they can either one have a patient management system where they can put in multiple fees and is not a problem. Or two, they have to come up with a system where they can charge the higher fees for the family planning services and then discount down to their primary care services. But that's something you're going to probably need some technical assistance when it gets to that.

I think it's beyond that purview in this right now.

Tara Melinkovich:OK. Thank you, Gerry.

The next question is actually for OPAs. I'm hoping too that you can run on this. It says, "What is considered reasonable for handling charges and margins, is there an OPA expectation or can you use market?"

(Sue): This is (Sue). And there's not a specific answer from OPA on that. I think that depending on what the market is in your particular area that that's a reasonable way to approach it. And I think the basic, I guess, thing that OPA is that the one issue that OPA would take into consideration, for instance, if you were being assessed during a review would be whether the way that you're setting your fees could be viewed as presenting a barrier to care for people better, even people that can pay, this is an unreasonable way that you're setting it. But there's not a set OPA amount or anything of that nature.

I also know that I've heard some providers talk about the fact that when they've done a cost analysis of services, that actually if they took into account, everything that it – every cost that they actually would price themselves out of

the market. So, I think that whatever your market is in your area does have to be taken into consideration.

Gerry Christie: Can I just add to that (Sue) a little bit? And I think that's a very good answer. The thing is you have to be competitive. You need to be competitive to your local market and that makes perfect sense. You don't want to price yourself out nor do you want to be so far below that it's unreasonable either.

(Sue): Right, right. Completely agree.

Tara Melinkovich: Great, thank you.

So the next question is, is there a free resource for regional average or median insurance reimbursement rate?

Gerry Christie: I do not know of a free resource. You can get – go on to CMS Web site and you can get the CMS reimbursement rate to calculate out what the physician fee would be. But actually, what we have for the relative value is what the physician fee would be in your area.

Now, generally, Medicare pays at about 85 percent of that fee. Private insurance companies pay at somewhere between 125 percent and 140 percent of that fee. So, if you take the relative value for your area, that's a reasonable area to look at this. But there's no – other than that, there's no real free, I mean you can go to Ingenix, MGMA has books that they put out. There's the book that Ingenix puts out by zip code, the first three numbers in your zip code and it will give you the 25 percent, (step) 50 percent, 90 percent. But that's really are just the percentile in terms of what the average cost is.

Now, that's useful but those are pretty pricey books and you almost have to buy those every year. So – and I just have not found – essentially a free resource for that one.

Tara Melinkovich: OK. Thank you, Gerry.

It looks like we have a couple of other questions in the queue, but I'm want to make sure that we're able to get through all of the contents. So, if you have

submitted a question that you don't feel was addressed through this last answering session, please ask them through the Communities of Practice and we will be able to address those through that. And also, some of these questions around charges and contracting with insurance agencies. And that we will be having a webinar as part of our revenue cycle series that will address contracting with third party tiers and so on. We'll go into a lot more detail about that.

And on that note, I'm going to hand it back to Emily to cover how to do a cost-analysis next time.

Emily Kinsella: Great. Thank you, Tara, and thanks for all the great questions you guys are asking, great questions throughout this entire webinar and on the Communities of Practice so it's nice to get to interact with you in that way.

So, I'm going to go over how to do a cost analysis next time, but before I do that, I just wanted to talk about a couple of tools that we're working and creating for you. We've had a couple of people say, "How do I know if I'm going this right? How do I know I've done my cost analysis correctly?"

So, one thing we're going to – we've created – we're creating is that, like a self-check – kind of self-check checklist that you kind of go through and like, "Did I put my name? Did I attend all my visits?" And some little tips on, you know, like Gerry was talking about. This number should between 0.85 and 1.25. A couple of those things for each workbook. So that – when that's ready, that'll be posted on the Communities of Practice page and then it also on that – the Family Planning National Training Center site when it gets archived.

The other thing we are going to work on doing is giving you a sample-completed workbook. Probably the one we've using to show you as we've been selling things out. But then, putting it in a way that you can edit it so that you can – accidentally and try to put your information in and does not work you for you correctly, but we thought that maybe helpful for you as you're doing it. You just look at somewhat pretend the data but – then you

can check, OK this is what the (RView) when Gerry pulled the (RView) with this, inline with this so that's currently close so I maybe I did that right.

So, we're going to work on getting those materials ready for you and we will post them on the Communities of Practice Web site and the Family Planning National Training Center site.

All right. So, how do I do a cost analysis next time?

Well, the good news is you now have all the tools you need to do it. We've walked you through everything you need to do and you're basically just repeat what we've gone through. So, you're going to take your cost analysis workbook. You might need to update some CPT codes obviously in learning. But then you'll update your expenses, you'll redo either your cost report or cost full calculation which everyone you did in the option A, the cost report or, option the B, the cost full calculation. You update the RVUs and pull on, you know, maybe 2013 RVUs this time, you're going to make sure you're going to do you geographic practice indicator, update those, you'll update the conversion factor on the procedures pane. And then you'll pull utilization data for the same year as your financial. So, it might be the next fiscal year, the next grant year.

Basically, do those three steps again and you can do it next year or the year after. So, it's pretty easy and we're excited to have given you the tools to be able to do it.

Tara Melinkovich:Great. Thanks, Emily. So we'd like now – this is the end of our webinar, we'd like to open it up for questions around how to complete it next time. So, if anybody has any additional question around continuing to use this methodology to complete a cost analysis, please feel free to ask them in now, you can press star 1 or you can chat them in.

We do have a little bit of time to address some of the last few questions that we didn't address last time. So, I'm going to ask this one that says, in the previous cost analysis workbook, the first tab was dedicated to allocation and distribution of cost which induced square footage of the clinic space used for

family planning, how does this new cost analysis methodology account for this old information?

Gerry Christie: I saw that question from my friend (Kelly) in Alaska. This is an important question for those of you who have used some other cost methodologies. That is accounted for in the cost report. And when you get to the facilities, you're going to use the same kind of methodology you used in the other cost analysis methodology to allocate the facilities' cost that are family planning cost onto the sheet. So you could put in the first column the total cost for you facilities and then you could put the amount of direct cost or indirect cost or in kind contributions for those facilities and it would be based on the same concept. It would be used to allocate the facility's cost in to the cost report.

Again, we've tried to make this a little maybe easier. I still feel comfortable with folks using portions of the other cost methodology to gather some of the information that they need. I had someone from another state, asked me if they could use the former sheet for the allocation of (staff) and that's a perfect way to do things, you could allocate the (staff) into cost centers based on your time study in a way you allocated those before too.

And this doesn't mean that you have to change cost analysis methodology that we started out in the first session. There were a number of methodologies out there. The Family Planning Councils of America has one that they've used. I have one – Emily has one – there are several others out there that could be used. And if you're using one and it fills the bill for you, if it gets you to the cost of individual services so you can establish your fees, then by all means you can continue to use those cost analysis methodologies.

Tara Melinkovich:OK, great. Thank you, Gerry. There's another question that says, last time we did a cost analysis, we added a usual and customary charge of a 125 percent for commercial insurance billing, is this still a reasonable thing to do?

Gerry Christie: Well, let me clarify that. There are a lot of programs that used a usual and customary fee on their schedule of discounts. It cannot be just for commercial insurance, you cannot have any fee that's just for insurance. It has to be for a category of people.

So, if you have a schedule of discounts that goes from 101 to 150 and 151 to 200, et cetera. And then you have one at 251 which are the – which are the charges, the reasonable charges for family planning for Title X, you have to have another (step) for usual and customary. So, people that are making 350 percent of poverty would pay that usual and customary fee. So, it depends on how you – what your grantee is going to allow you to do with your schedule of discounts and how it gets broken down. Do you want to mention anything about that (Sue)?

(Sue): No. I think you've done a great job of that. I would completely agree with what you said.

Gerry Christie: Thanks.

Tara Melinkovich: Great, thank you. So, this is a reminder that if you have questions that were not addressed during this webinar, please ask them through the Communities of Practice site. (Paul) just re-chatted the link to that site.

It will remain open for two weeks following the webinar. A reminder that the Communities of Practice site is not hosted on the National Family Planning Training Center site, rather, it is hosted on the JSI e-Learning site. After two weeks, we will close the Communities of Practice site, and all supporting documents for this webinar and all three webinars will be archived on the National Training Center's website.

At this time, we will open up a poll in the polling panel on the right of your screen. Please take a moment to answer this quick question, "How would you rate the length of this webinar today? Too long, just right, or too short?"

And while you're completing the poll, we'd like to announce some upcoming National Training Center activities.

The next webinar series offered by the National Training Center for Management and Systems Improvement is Revenue Cycle Management, The Steps Title X Agencies Must Take to Get Paid. The first webinar is on Wednesday, July 24th. And CNE credits are being offered for each webinar.

This is the one I referenced a little bit ago that will cover contracting with third party payers.

I'd also like to call your attention to the Ask the Expert sessions on the upcoming Title X Family Planning National Grantee meeting in Seattle. There are experts including Mr. Gerry Christie from this webinar, of course, will be available late afternoon before the conference during breakfast, break, and evening to address specific questions you may have or to help you identify areas of opportunity.

And here is also a list of the next five upcoming training activities offered by all the National Training Centers. Please visit the NTC website to learn more about these and other upcoming training activities.

And before we say goodbye, I would like to remind you to please complete the brief evaluation by Wednesday, July 17th – no, that's not right – by next Friday. I believe, next Friday is the 26th.

In order to receive Continuing Nursing Education Credits or Certificate of Attendance, you must complete the online evaluation. We have chatted the link to the evaluation and you will receive shortly an e-mail with the evaluation link and completion instruction.

Thank you for your participation in today's webinar and all of the activities between each webinar. Thank you to our presenters very much, Gerry Christie and Emily Kinsella, for sharing your expertise and experience. Have a great afternoon.

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

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