

**Understanding Ancillary & Unit Costs  
Community Clinic Assoc of LA County  
Coalition of Orange County Community Clinics  
Council of Community Clinics**

**2010 Annual Symposium**

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## **COMPONENTS OF COST PER VISIT – ANCILLARY COSTS**

Ancillary costs include laboratory, radiology, and pharmacy. These services can be performed on-site or off-site. A key consideration for health centers is whether they should continue to provide comprehensive services if they can contract with local providers of ancillary services at competitive rates and comparable quality.

Centers that have ancillaries included in their Medi-Cal rate must understand the cost of providing these services, and the implied portion of their rate used to cover ancillary cost.

## **COMPONENTS OF COST PER VISIT – ANCILLARY COSTS**

### **Drivers of Ancillary Costs:**

- **Range of Services Provided**
- **Utilization of Resources (“Resource Productivity”)**

### **How to Calculate Ancillary Costs:**

- 1. Calculate ancillary direct costs (salaries, fringe benefits, supplies).**
- 2. Calculate ancillary direct costs as a percentage of total facility direct costs.**
- 3. Apply direct costs percentage to total facility overhead costs.**
- 4. Add ancillary direct costs plus ancillary overhead costs to obtain ancillary total costs.**

## COMPONENTS OF COST PER VISIT – ANCILLARY COSTS

### *How to Calculate Pharmacy Costs?*

<b>Direct Pharmacy Costs</b>		
Salaries & Wages	\$	220,000
Fringe Benefits (25% of salary costs)	\$	<u>55,000</u>
<i>Subtotal</i>	\$	<u>275,000</u>
Direct Supplies	\$	<u>800,000</u>
<b>Total Direct Pharmacy</b>		<b>\$1,075,000</b>
 <b>Overhead Allocation</b>		
<u>Total Direct Pharmacy Costs</u>	<u>\$ 1,075,000</u>	
Total Direct Costs	\$11,854,406	= 9.07%
Pharmacy Overhead Costs (\$5,662,744 * 9.07% )		<u>\$ 513,611</u>
<b>Total Pharmacy Costs</b>		<b>\$1,588,611</b>

## RATE CONSIDERATIONS

<b>Pharmacy Cost per visit 2005 (rate setting year)</b>	<b>\$ 4.21</b>
<b>Total Rate 2005</b>	<b><u>\$ 105.25</u></b>
<i>Pharmacy % of total</i>	<b>4.0%</b>
<b>2010 rate</b>	<b><u>\$120.00</u></b>
<b>Implied Pharmacy Reimbursement/Visit</b>	<b>\$4.80</b>

**Compare to actual cost. If pharmacy cost is significantly more than \$4.80 per visit, and if the center's allowable cost is greater than its Medi-Cal rate, the center should consider a change of scope to carve out pharmacy.**

## **RATE CONSIDERATIONS**

On the flip side, centers who refer out lab and/or radiology, and pay the vendor for self-pay radiology lab, may want to consider doing a change of scope to bring these services into their rate.

Self-pay only ancillary expenses are not allowable costs. However if the center pays the vendor for ancillary costs for all patients, then all of the cost is allowable. Centers with significant Medi-Cal (which would essentially pay 100% of cost) and self-pay (where a portion of the cost could now be covered) may want to consider this analysis.

## COST REPORT CONSIDERATIONS

- If pharmacy is not included in your Medi-Cal rate, pharmacy costs are not included as allowable costs in setting your rate.
- The Medi-Cal cost report is set up to allocate a portion of overhead to non-reimbursable costs.
- A major portion of the cost of pharmacy is the pharmaceuticals. The cost of pharmaceuticals is not commensurate with the amount of overhead cost need to manage them. For example, if a health center had a total direct cost of \$10 million, \$1 million of which is for pharmaceuticals, 10% of their administrative costs probably does not go to administering the pharmaceuticals.
- Centers in this situation may want to use a different methodology to allocating administrative/overhead cost to pharmacy.

## COMPONENTS OF COST PER VISIT – ANCILLARY COSTS

### *How to Calculate the Significant Cost Components of Pharmacy?*

Total Pharmacy Costs	\$1,588,611
Total Scripts	53,000
Total Visits	110,000

$$\begin{aligned}\text{Cost per Script (Total Costs / Scripts)} &= \$1,588,611/53,000 = \$ 29.97 \\ \text{Cost per Visit (Total Cost / Visits)} &= \$1,588,611/110,000 = \$ 14.44 \\ \text{Script per Visit (Scripts / Visits)} &= 53,000/110,000 = 0.48\end{aligned}$$

Question: Can the health center get scripts filled locally for less than \$29.97 per script?

## COMPONENTS OF COST PER VISIT – ANCILLARY COSTS

- ***Availability of Other High Quality Providers*** - Are there local pharmacies, easily accessible, that can provide high quality pharmaceutical services? In urban centers this may not be an issue since there are local organizations which can perform the ancillary services without inconveniencing the patients. However, in a rural area, the center may need to incur the additional cost of providing the ancillary services in order to ensure access and high quality services to their patients.
- ***Cost Competitiveness of Other Providers*** - The cost per script of \$29.97 should be compared to other local pharmacy providers. If other pharmacies can fill scripts for less cost, the CHC should consider using outside pharmacy providers.

## COMPONENTS OF COST PER VISIT – ANCILLARY COSTS

- ***Reduction of Fixed Costs*** - When a CHC reduces services, it needs to determine what to do with the fixed assets associated with those services. For example:
  1. If a CHC stops providing direct radiology services, it must determine what to do with the available space and equipment that had been used to provide radiology-related services.
  2. Additionally, as part of the evaluation process to contract out the ancillary services, the health center should calculate how much of their fixed costs can be reduced with the elimination of the direct services or reallocated to other programs within the health center.

CALCULATING MEDICAL & BEHAVIORAL HEALTH UNIT  
COSTS

## WHY CALCULATE A CHARGE SCHEDULE BASED ON COSTS?

- Historically, providers' charge structures have not been based on the cost of each service provided, but rather on environmental conditions and the targeted patient population.
- A fee schedule based on costs is a list of services by Current Procedural Terminology (CPT) code with their associated cost. CPT codes are developed by the American Medical Association to provide a standard coding system for each medical procedure.
- BPHC PIN 98-23 suggests that FQHCs should base their charges on cost.
- By understanding the cost of each service by CPT code, providers can analyze the adequacy of proposed payment options.

## WHY CALCULATE A CHARGE SCHEDULE BASED ON COSTS?

- To Ensure Compliance with the Bureau of Primary Health Care's (BPHC) Indicators:

	<b>CHARGES &lt; COSTS (WITHOUT CBCS)</b>	<b>CHARGES = COSTS (WITH CBCS)</b>
Cost per Visit	\$ 100	\$ 100
Charge per Visit	\$ 70	\$ 100
Sliding Fee Discount	40%	58%
Sliding Fee Discount per Self-Pay Visit	\$ 28	\$ 58
Amount Requested from Patient	\$ 42	\$ 42
330 Grant	\$ 550,000	\$ 550,000
Self-Pay Visits	10,000	10,000
330 grant per Self Pay Visit	\$ 55	\$ 55
<b>Sliding Fee as % of 330 Grant</b>	<b>51%</b>	<b>105%</b>
<b>Charges as % of Cost</b>	<b>70%</b>	<b>100%</b>
<b>Compliant</b>	<b>No</b>	<b>Yes</b>

## STEPS TO COMPLETE A CHARGE SCHEDULE BASED ON HEALTH CENTER COSTS

1. Determine average cost per visit.

*Example: Cost per Visit = \$100*

2. Determine average RVU per visit.

*Example: RVUs per Visit = 1.94*

3. Determine cost per RVU.

*Cost per Visit (\$100) / RVUs per Visit (1.94) = \$51.55 per RVU*

4. Apply RVU cost to procedures.

*RVU for 99213 = 1.39*

*1.39 x \$51.55 = \$71.65*

## DETERMINE AVERAGE COST PER VISIT

Step 1: Determine average cost per visit for all services based on data from Medicare cost report.

Total Costs	\$1,600,000
Minus Dental (Inc. Overhead)	(300,000)
Minus Pharmacy (Inc. Overhead)	(200,000)
Outside Contracted Lab for Self Pay Patients	<u>(100,000)</u>
Total Covered Costs	\$1,000,000

Billable Visits = 10,000

$$\text{Cost per visit} = \frac{\$1,000,000}{10,000} = \$100/\text{visit}$$

Health centers that perform dental procedures should prepare two separate charge schedules, one for medical and one for dental procedures.

## USING THE NATIONAL PHYSICIAN FEE SCHEDULE RELATIVE VALUE FILE

### *Missing RVUs*

- Because Medicare has a separate payment methodology for laboratory, radiology, immunization, certain surgical and other procedures, there are no corresponding RVUs. RSM has replicated the methodology that HCFA uses to calculate all other RVUs in developing RVUs for these procedures.
- The source of RVUs for dental procedures are those published by Relative Value Studies, Inc. This assigns RVUs by CDT code, as assigned by the American Dental Association.

## DETERMINE AVERAGE RVU PER VISIT

**Step 2: Using relative value scale (RBRVS) determine the relative intensity of average visit (any period).**

CPT Code	Occurrences in Period	x	Relative Value Unit (RVU)	Weighted RVUs	
99211	320	x	.57	182	
99212	1,600	x	1.01	1,616	
99213	4,616	x	1.39	6,416	$\frac{\text{Total RVU}}{\text{Billable Visits}} = \frac{19,400}{10,000}$
99214	1,200	x	2.20	2,640	
...				...	
93875	413	x	2.00	826	$= 1.94 \text{ average RVU per visit}$
73080	150	x	.85	128	
73540	100	x	.90	90	
				19,400	

DETERMINE AVERAGE COST PER RVU

**Step 3: Determine average cost per Relative Value Unit**

$$\frac{\text{Average cost per visit} = \$100}{\text{Average RVU} = 1.94} = \$51.55 \text{ cost per RVU}$$

## DETERMINE COST PER PROCEDURE

### Step 4: Apply unit cost to services provided

	<b>CPT Code</b>	<b>RVU</b>	<b>Cost per RVU</b>	<b>Cost Based Charge</b>
New Patient	99202	1.72	51.55	\$ 88.67
	99203	2.56	51.55	131.97
	99204	3.62	51.55	186.61
	99205	4.60	51.55	237.13
Established Patient	99212	1.02	51.55	52.58
	99213	1.39	51.55	71.65
	99214	2.18	51.55	112.38
	99215	3.17	51.55	163.41
X-Ray	73080	0.85	51.55	43.82
	73540	0.89	51.55	45.88

## BENCHMARKING RVU INDICATORS\*

CENTER	Cost per Visit	Rank	RVU per Visit	Rank	Cost per RVU	Rank	Ratio of Non-Office Visit Procedures to Office Visits	Rank
Health Center A	\$ 93.17	76	2.42	9	\$ 38.50	89	0.90	55
Health Center B	181.33	6	1.46	85	124.20	1	0.71	69
Health Center C	129.30	33	2.40	11	53.88	61	1.67	13
Health Center D	159.88	13	1.98	40	80.75	15	1.80	10
Health Center E	77.35	86	1.88	52	41.14	86	0.52	77
<b>Median</b>	<b>\$ 112.00</b>		<b>1.93</b>		<b>\$ 59.58</b>		<b>1.06</b>	
<b>N =</b>	<b>92</b>		<b>92</b>		<b>92</b>		<b>92</b>	
<b>Quartile Analysis</b>	<b>High</b>	<b>Low</b>	<b>High</b>	<b>Low</b>	<b>High</b>	<b>Low</b>	<b>High</b>	<b>Low</b>
First Quartile	\$ 231.57	\$ 143.29	2.76	2.19	\$ 124.20	\$ 74.02	2.73	1.53
Second Quartile	\$ 142.29	\$ 112.25	2.15	1.93	\$ 72.91	\$ 59.58	1.51	0.71
Third Quartile	\$ 111.75	\$ 95.49	1.93	1.68	\$ 59.57	\$ 49.13	1.51	0.71
Fourth Quartile	\$ 95.11	\$ 60.74	1.62	1.15	\$ 48.89	\$ 32.65	0.71	0.04

\*Data extracted from RSM proprietary National Ambulatory Care Database.

## UNIT COSTING FOR DENTAL

1. Calculate total dental cost
2. Calculate total dental RVUs (available from [http://www.doh.ihs.gov/edr/documents/CDT%202009-2010\\_IH%20Codes\\_LOC\\_RVU\\_Complete.pdf](http://www.doh.ihs.gov/edr/documents/CDT%202009-2010_IH%20Codes_LOC_RVU_Complete.pdf))
3. Calculate cost per dental RVU
4. Apply cost per RVU to specific codes

## UNIT COSTING FOR NON-CPT RELATED SERVICES

In many instances, health centers perform non-medical, or “enabling” services, which enhance the provision of medical care to patients. Enabling services do not have CPT codes and a Relative Value Units associated with them. Accordingly most payors do not reimburse the health center for performing these enabling services. These services may include:

- Counseling and Social Services
- Interpretation
- Patient Advocacy
- Health Education

## PROCESS FOR DEVELOPING RVUS FOR ENABLING SERVICES

### Step 1: Develop standard coding methodology and Daily Service Tracking Form

- β Work with staff to identify and define the enabling and medical services performed by providers. A provider is anyone performing a direct HIV/AIDS service to a client.
- β Define enabling services at the unit level, with standard durations and provider types for all services. Assign a standard coding system to each enabling service.
- β Develop a Daily Service Tracking Form for each provider type, listing the codes and duration for the services performed by that specific provider. Each form may include blank columns for tracking the frequencies of service performed and patient identification number, as well as blank lines for provider name and date.

## SAMPLE TAXONOMY

Services must be defined at a level that can be easily tracked.

<b>Code</b>	<b>Service</b>	<b>Time/Definition</b>
CM001	Pharmacy Refills	15 minutes
CM002	Case Management Intake Assessment	1 hour
ED001	Individual Educ. - Counselor - Brief	0-15 minutes
ED002	Individual Educ. - Counselor - Interm.	20-40 minutes
ED003	Individual Educ. - Counselor - Extend.	45+ minutes
MD001	Support Group - Physician	3 hours
MH001	Mental Health Counseling	20-30 minutes
MH002	Drug Rehab Referral	45 minutes
NU001	Intake Nutritional Assessment	20-40 minutes
NU002	Individual Educ. - Nutritionist Brief	0-15 minutes
RN001	Nursing Triage	Telephonic & On-site
SS001	Referral to Social Service	1 hour
SS002	Outreach - Education	4 hours

## PROCESS FOR DEVELOPING RVUs FOR ENABLING SERVICES

### Step 2: Perform one month time study of services performed

- β For a four-week period, provider tracked all enabling services performed using the Daily Service Tracking Form.
- β It is necessary to use the Daily Service Tracking Form because the MIS system does not typically capture the frequency of services performed. The one month time study is the minimum length of time necessary to capture a representative sampling of services.
- β The CPT codes provided during the time study period can be taken from the MIS system and combined with the enabling services provided to form the basis of the Unit Cost per Service Analysis.

## PROCESS FOR DEVELOPING RVUs FOR ENABLING SERVICES

### Step 3: Developing RVUs for Enabling Services

- ⌘ Since enabling services are not codable by CPT codes, none of the RVU scales, including RBRVS, have corresponding RVUs.
- ⌘ Thus, it is necessary to develop RVUs for the unique enabling services delivered by the HIV/AIDS providers. To do so, it is necessary to use common elements – provider time, provider salary, overhead expense – to create RVUs equivalent to those in RBRVS.

## PROCESS FOR DEVELOPING RVUs FOR ENABLING SERVICES

### Step 4: Calculating a Cost Factor for each RVU and a Cost per Service

- β The results of the time study are used to calculate a cost per RVU. This includes both the enabling services tracked using the Daily Service Tracking Form and the medical services provided from the MIS system.
- β Calculate the cost per RVU by:
  1. Multiplying each service code's frequency by its RVU to calculate a weighting factor.
  2. Adding the weighting factors for all services to arrive at total RVUs.
  3. Dividing the total organizational costs by the total number of RVUs to derive a cost per RVU.
  4. Multiplying cost per RVU by each service's RVU to arrive at a cost per service.