Wisconsin Simplified Cost Analysis
(WISCA)

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August 2015
INTRODUCTION

The Wisconsin Simplified Cost Analysis (WISCA) is designed to assist family planning programs in assessing the cost of providing core clinical services. This allows programs to set appropriate fees to recover the “reasonable cost” of the services they provide. This information is also useful in negotiations with third party payers regarding appropriate reimbursement for services.

Every successful business knows the importance of understanding all the costs involved in providing their product. Family planning programs continue to offer services in an era of uncertainty due to escalating costs, shrinking or static federal and state support, and increased competition. To survive, it is essential for family planning programs to implement strong business practices. This includes the collection and analysis of financial information that will provide insight to the real and complete costs of doing business. Only agencies with a sound financial management plan and a complete knowledge of the costs of doing business will remain financially viable. This becomes increasingly important as the US continues to implement health care reform.

APPROACH

The Wisconsin Simplified Cost Analysis (WISCA) was developed to assist family planning programs in Wisconsin to distribute costs (expenses) associated with the provision of family planning clinical services. Programs that have completed an earlier version of the Wisconsin Simplified Cost Analysis will find this process very similar to that earlier model. The cost of providing services is determined by using a Relative Value System (see page 10). Costs include direct costs, indirect costs, and in kind costs. Direct costs include expenses associated with providing a core procedure (i.e., personnel, materials, and other costs such as travel, consulting services, equipment, mail, and sub contracts). Indirect costs include expenses incurred to support direct care that are incurred for common or joint objectives and, therefore, cannot be identified readily and specifically with a particular project or activity (i.e., administration, housekeeping, rent, etc.). In kind contributions are goods or services that are provided at no cost to the program to further the goals and outcomes of the project. The key to obtaining accurate costs is to allocate expenses to the appropriate cost centers associated with the delivery of “Core” family planning clinical services (See page three (3)).

The Wisconsin Simplified Cost Analysis (WISCA) measures the cost of providing core clinical services (including in house laboratory services) in a family planning program. What do you want to know? The total unbundled cost to the program for putting each clinical and in-house laboratory service we provide, “out the door”.

The revised WISCA does not measure pass-through items including the cost of therapeutics or contraceptives used in the agency, non-clinical operations such as community education, public affairs or fundraising.

This version does provide a methodology for assessing the costs associated with lab specimens sent to outside reference labs.

**There are three steps** in the development of the basic Wisconsin Simplified Cost Analysis:

1. Collect cost data and allocate costs to the family planning program.
2. Collect utilization data on all services provided in the family planning program.
3. Determine the cost of each service and establish fees based on this information.

Each of these steps will be addressed in this manual and directions will be provided to assist the reader in establishing the system to be used in their own program. An explanation of how to complete each spreadsheet in the WISCA Excel workbook is included.

There are a number of attachments to this manual. Reference is made to each attachment in **bold** and the attachment name is provided in **Red**. (Attachments to the PDF manual can be accessed by clicking on the paper clip on the Adobe sheet. In earlier versions of Adobe Reader, click on the “Attachment” Tab.) To download a copy of Adobe Reader, place your cursor over the following link and follow the instructions that appear.  

To know what materials will be needed, programs should **review** the **Attachment to the Manual** titled “Checklist of items needed”. This provides an overview of what you will need for the completion of the workbook.

Collection of cost information is done through the **Cost Report**. The Cost Center Report is found in the Excel workbook that has been provided. The file is named “Wisconsin Simplified Cost Analysis 2015V-1” and is an attachment to this manual.

**NB: You should open the workbook to review each spreadsheet as you read this manual.**

You should save the workbook you are working on with a new name; i.e. your county or facility name to identify it from the original.

The WISCA Excel workbook is comprised of four separate tabs.

![Cost Report procedures Clinical Outside Lab](Image)

These will be explained in this manual.
1. **Collect cost data and allocate costs to the family planning program.**

Use the first tab in the workbook, “Cost Report” to document allowable costs for your family planning program. You must use the most recent one year of fiscal data available. You should use either a fiscal or calendar year. The time period may coincide with your annual audit.

The program MUST be able to identify the agency expenses that are related to the provision of family planning services. The “art” of a good cost analysis is to determine which specific expenses should be included in the cost analysis spreadsheet. It is important to distinguish between “**core**” expenses (those that directly support core WH-FP/RH activities, such as contraceptive management) and “**non-core**” expenses charged to the grant and PGR (those expenses, which are allowable and legitimate expenses to the grant and PGR, are *not* core to family planning, such as any STD follow-up to treatment). The “non-core” would be those expenses that one would not expect to be folded into “full WH-FP/RH patient fees” and could include such things in addition to STD follow-up as: school and other community presentations, colposcopy follow-up and related activities, managed FPOS enrollment activities, program integration and coordination with WIC and PNCC (systems development), data collection, year-end reports, grant required activities (such as continuing education and training, meetings, webinars, the cost-analysis itself, quality indicator/performance measurement, etc.), WFPRHA-related activities, knowledge-sharing and networking as part to the statewide program development, etc.

**Allocation of Costs**

Most programs are part of a larger agency with family planning only one of several programs. This means that some of the program expenses are allocated directly to family planning while other expenses are connected to other programs or are part of shared indirect costs in the agency. You must determine a method for appropriately allocating expenses to family planning.

The allocation of personnel and other expenses may be done in a variety of ways. However, the methodology must accurately distribute expenses into each cost center. The more accurate the data, the more useful will be your analysis. In some instances estimates may be all that are available. However, the more precise you are, the better the outcome.

**Allocation of Staff**

The first task is to identify the staff that spends any amount of time during the year functioning in the family planning program. Because staff may work at different tasks while they are in the family planning program, you may want to identify how much time they spend in different functions. To do this you should allocate every person who has worked during the reporting period into one or more of the cost categories. For instance, a Nurse Practitioner may not be providing medical functions at all times. She may variously provide support for the laboratory,
for the pharmacy, for counseling, and as an administrator. Therefore, she should be allocated into those cost categories rather than have 100% of her time allocated into the medical cost category.

Time Study

The best way to allocate staff is through a time study. We have created a time study that can be used to determine what percent of time a staff person spends in family planning. It also allows you to determine how much of their family planning time is spent in specific cost categories or functions. There is also a description of some of the “core” activities that go into each cost category. The file “Time Study.xlsx” has the time study and “Time Study allocation instructions.pdf” provides information on how to identify activities in the cost categories. These are attached to this manual.

Allocating Other Expenses

The program also must allocate “other” expenses to the family planning program. The allocation must be done consistently to capture the real costs that occur in each cost category. There are several ways to do these allocations.

The program may use:
1) The percent of the total budget that is family planning;
2) The percent of patients, visits, or encounters that are for family planning;
3) The percent of FTEs in family planning compared to all FTEs.
4) Some other documented system.

The methodology must accurately represent expenses in each cost center. You should document your method(s) and explain any differences.

Allocation of In-kind and Volunteers

The program should allocate any individuals that volunteer in your program or are donated by some other agency. Remember, this represents part of the cost of providing services. If you did not have these volunteers or in kind staff you would have to pay for them. Be sure to include fringe benefits as part of the “fair market value” of these individuals. Also allocate any other in kind contributions such as administration, facilities, equipment, supplies, etc.

Cost Report.

Following is the first section of the “Cost Report” showing the Administrative Cost Category.
### Basic Information:

1. Label the form with your agency name.
2. Indicate the time period for the cost data provided.

### Cost Categories

The Cost Report is comprised of eight (8) cost categories. These are helpful for recording all the costs associated with providing family planning services. Following is a brief description of the items that should be recorded in each category.

**A. Administrative:**

This includes the general administrative activities such as project management, policy and procedure development, evaluation, training, billing, and word processing that is not directly attributable to the health care services. It may also include indirect costs allocated to the family planning program.

<table>
<thead>
<tr>
<th>Financial Information</th>
<th>Total Agency Costs</th>
<th>Direct FP costs</th>
<th>Indirect FP costs</th>
<th>In-Kind contributions for FP costs</th>
<th>Total FP Cost (No outside lab, pharmaceuticals, outreach)</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. ADMINISTRATIVE:</td>
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<td>1. Executive Director/CEO</td>
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<td>2. Administrative/COO</td>
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<td>3. Administrative Support</td>
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<td>4. Finance Director/CFM</td>
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<td>5. Fiscal Support</td>
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<td>6. Medical Director</td>
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<td>7. Public Relations/Marketing</td>
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<td>9. Data Processing</td>
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<td>10. Staff Travel</td>
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<td>11. Telephone</td>
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<td>12. PTO</td>
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<td>13. Operating Interest</td>
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<tr>
<td>14. In Service &amp; Staff Education</td>
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<tr>
<td>15. Office Supplies</td>
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<tr>
<td>16-22. Other Allowable Admin. Exp. (specify below):</td>
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</table>

**TOTAL ADMINISTRATIVE**

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B. Medical/Clinical:
This is the provision of "hands-on" medical services by physicians, mid-level practitioners, and nurses in delivering a family planning method to a patient. It also includes the history, physical exam, determination of the method, the diagnosis and treatment of related problems, and initial patient education and “counseling”. This includes the full process from check in through the exam and check out (NOT the billing part of the visit.)

C. Laboratory:
This is divided into costs for lab tests performed in-house and those sent out to a reference (outside) lab. In-house costs are associated with laboratory services provided by the family planning program to clients for on-site laboratory testing such as pregnancy tests, dipstick urines, wet mounts, rapid HIV tests, etc. Reference lab costs include the activities associated with specimen collection and preparation for referral to outside reference laboratories and the cost paid for those tests (for example, Pap tests and Chlamydia and gonorrhea tests). This includes staff time involved.

D. Pharmacy:
NOTE: This category is optional for the WISCA and will be used for informational purposes only. The staff activities associated with purchasing, storing, inventorying, and dispensing contraceptives and other medications should be included. This may be useful in helping calculate the “true” acquisition cost of contraceptives.

E. Other health services:
Activities associated with health education, outreach and specialized counseling related to the family planning program. These are NOT direct “core” FP costs unless staff time is used in the clinic to provide “core” “billable” activities to clients.

F. Other:
All other activities related to the family planning program including family planning education, medical records expenses, insurance expenses, electronic health records, and any other expenses that have not been accounted for in earlier categories. (NOT Fringe Benefits or Facility costs which are documented later.) NOTE: Some of these rows are grayed out under the FP cost columns (for example: Bad debt expense and Revenue assessment). This is because these costs are not allowable to “core” family planning.

G. Employee health & welfare:
Fringe benefit expenses including FICA Tax, Workman's Compensation, Unemployment Insurance, Insurance, Pension, and other expenses. If you have volunteers or donated personnel, be sure to calculate the fair market value of fringe benefits for them.
H. Facility costs:
Costs related to the purchase/rent and maintenance of the facility. This includes housekeeping and maintenance (including personnel); rent or mortgage payments; minor repairs on equipment; security (of both staff and the facility); supplies; utilities; depreciation and more. NOTE: Some of these rows are grayed out under the FP cost columns (for example: start up). This is because these costs are not allowable.

Assembling FP Costs – The Cost Report

Note: If your accounting system has a cost center for family planning, use that to find the amount of direct and indirect costs that are related to family planning. If that information is not available in your system, you may allocate a portion of total costs to family planning using the proportion of total visits/encounters that are related to family planning (as defined by a V25-series ICD-9 code, visit type label in your scheduling system, or other reasonable method, as described on page 3 above.).

Column Headings

1. Total Costs – There are two options for using this column: First, enter all the cost data for your facility onto the numbered lines under each Cost Category. This will be for your total program and adjustments will be made for those costs not associated with the provision of family planning. Alternatively, you can enter only the expenses for the family planning program in this column. Then allocate these expenses to direct costs, indirect costs, and in kind contributions.

   The form will automatically calculate a total for each category (e.g. A. Administrative; B. Medical/Clinical; C. Laboratory; etc.). If you do not have detailed line-item cost data, you may select a blank row in the category, label it and enter the full amount. This should only be done as a last resort.

   a) If you have additional cost subcategories, use the blank rows under the relevant lettered category. The formulas that calculate the totals for that category will include your new row(s).

   b) If your agency does not have any costs under a given category, leave it blank.

2. Direct FP costs - enter the dollar amount of direct costs for the relevant category that are related to “core” family planning services. Direct costs include expenses associated with providing a procedure or service (i.e., Project staff, Consultants, Project supplies, Publications, Travel, etc.). (Determine this amount using the FP cost center in your accounting system or
by allocation as described in the allocation section above (Starting on page 3). Be sure to identify the method used in the “Notes” section.)

3. **Indirect FP costs** - enter the dollar amount of indirect costs for the relevant category that are related to the provision of “core” family planning services. Indirect costs include expenses incurred to support direct care (i.e., administration, housekeeping, rent, audit and legal, etc.). (Determine this amount using the FP cost center in your accounting system or by allocation, as described in the allocation section above (Starting on page 3).)

4. **In-Kind costs** - enter the dollar amount of any in-kind contributions for the relevant category that are related to providing “core” family planning services. In-Kind costs include staff that is provided to the family planning program but is paid by some other entity. It also includes volunteers in the program that assist in providing “core” family planning services. Finally, it includes other goods and services that are provided to the agency that are not paid for by the family planning program but are used in providing services; for example free rent in a facility or supplies from another source. (Determine this amount using the FP cost center in your accounting system or by allocation.)

5. **Total FP costs** - this field will calculate automatically by adding the data entered into the direct, indirect and in-kind columns; no data entry is required.

6. **Notes** - enter any relevant notes about the costs in this row, e.g. if you used an estimation method to allocate costs to family planning, briefly describe that method.

The “Total Medical Cost” information at the bottom of the form is used in the cost analysis. This totals only the medical costs and excludes the non-medical and “pass through” costs. It will be brought forward automatically to the “Clinical” Tab, “Amount from Cost Report Calculation” (Cell C 70).

**Relative Values used for the services the program provides.**

It is important that programs understand the relationship between CPT codes and relative values in developing the WISCA. The use of relative values and appropriate coding allows the program to charge appropriately for services and maximize revenues. Almost all Cost Analysis models rely on CPT Code information and a Relative Value system. The calculations for WISCA involve assigning a Current Procedural Terminology (CPT) code for each service procedure or visit provided in the clinic.

**Current Procedure Terminology (CPT) Codes**

Current Procedure Terminology (CPT), a product of the American Medical Association (AMA), is a listing of descriptive terms and five digit numeric identifying codes and modifiers for
reporting medical services. The codes are reviewed and refined by the AMA on a regular basis and published with examples to facilitate the coding process.

Many of the visit types for family planning programs fall within the Evaluation and Management (E/M) Services guidelines. These focus on visits by new and established patients. Codes used by family planning providers for these services will include CPT 99201 to 99205 for new patients and CPT 99211 to 99215 for established patients. In addition, programs may use the Preventive Medicine codes for routine new (CPT 99384 to 99386) and established (99394 to 99396) visits. These are based on the age of the patient but still fit into the same relative value system. Programs should be sure that staff is up to date on the correct codes to use for the services they provide.

There are other visit types that are found in alternate sections of the CPT coding manual. Services such as IUD insertion or removal (CPT 58300, 58301), Diaphragm or cervical cap fitting (CPT 57170), Hormonal implant or removal (CPT 11981, 11982, and 11983), Injections (Depo shot - CPT 96372), Colposcopy (CPT 57511) and related services can also be coded. For the counseling portion of the form, the preventive counseling codes, (CPT 99401 to 99404) are provided for those programs that bill using these codes (See pages 11 and 12).

The codes are arranged in numerical order for ease of finding them. Once the significant CPT codes are established, the relative values for the agency can be generated. The relative values are found on the Procedures tab. The WISCA has identified the most common CPT codes used in family planning programs and entered them on the Procedures tab. For some programs the list may be too extensive. You do not have to use them all. Other programs may use additional CPT codes in their program. There is room to add up to ten (10) additional services, if needed.

At the bottom of the Procedures tab are CPT codes for in-house lab tests, venipuncture and finger stick services, and specimen handling. These are the primary lab tests that will be “priced out” in the WISCA.

**Resource Based Relative Value System (RBRVS)**

There is a set relative value for each of the CPT codes. A relative value is a number that relates one service to all other services based on the amount of time, materials, and level of skill of the personnel involved in a particular service. Relative values indicate how much one procedure is “worth” in relation to another procedure. If procedure A’s relative value is 10.0 and procedure B’s is 5.0, procedure A is worth two times as much as B. If procedure B’s relative value is 5.0 and procedure C’s is 2.5, procedure B is worth two times as much as C. If another relative value scale indicates RVs of 30.0, 15.0, and 7.5 for procedures A, B, and C, the two scales are in agreement. Each relative value is important only in how it compares to other relative values.

While there are other sources of relative values, this model uses the Resource Based Relative Value System (RBRVS) established for use with the Medicare Physician Fee Schedule (MPFS).
This system provides a single set of relative values by which all services are scaled. Relative Value Units (RVUs) are established for each clinic procedure.

The Resource Based Relative Value Scale (RBRVS) consists of three elements:
- Physician (Clinician) work
- Practices (Overhead) expenses (net of malpractice expenses)
- Cost of malpractice insurance

The WISCA uses “Non-Facility” RBRVS. The non-facility relative value units will be used for services furnished in physician offices, free standing clinics, health department clinics, and ambulatory care settings.

We have identified the most common CPT codes used in family planning programs and attached the July 2015 release of relative values to them on the “Procedures” tab. These amounts have been amounts are adjusted to reflect the variation in practice costs from area to area. A geographic practice cost index (GPCI) has been established for every Medicare payment locality for each of the three components of a procedure’s relative value unit (i.e., the RVUs for work, practice expense, and malpractice). The GPCIs are applied in the calculation of a fee schedule payment amount by multiplying the RVU for each component times the GPCI for that component. This has been done for Wisconsin.

You do not have to do anything else on the tab unless there is a service you provide that is not listed. In that case you can identify the CPT code and the name of the service and place them on the row for “additional service”. Then you must look up the relative value for that service.

Following is an explanation of how to find the relative values.

Finding Relative Value Units

1. Go to the CMS webpage for Relative Value Files:
   http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files.html

2. Find the most recent file by date (which may be on the last page, or you can click the arrow next to “Calendar Year” in order to sort the files so the most recent year appears on the first page). Select the file with the highest letter attached for the year (i.e. RVU15B will be more recent than RVU15A).

3. Click on the date, which will bring you to a webpage where you can download the file.

4. Download the zip file. (NOTE: You may need to disable pop-ups in order to do this)
5. In the list of documents in the zip file, find the excel document that starts with “PPRVUxx.xlsx*” – This is the first document to open/save.
   a. Use the “find” function in Excel to find the CPT Codes used at your agency. (TIP: Copy these rows and the column headers into a separate worksheet for ease of use later).
   b. At the top of the document, locate the columns for “WORK RVU,” “NON-FAC PE RVU,” “MP RVU,” and “NON-FACILITY TOTAL” for every CPT code you use. These are the elements you will need to complete the Procedures tab of the WISCA.
   c. Copy the three (3) RVU elements (“WORK RVU” = work RVU, “NON-FAC PE RVU” = Overhead RVU, and “MP RVU” = Malpractice RVU) and the Non-Facility Total into the Procedures Form for every CPT code you use. (TIP: As a check that you’ve copied the correct info., the 3 elements should add up to the Non-Facility Total)

*Note: “xx” is the year of the “PPRVU”.

2. Collect utilization data on all services provided in the family planning program.

*The cost in your family planning program is driven by two things: Expenditures and Utilization. This section deals with the utilization side.

Clinical Form

This is the form used to determine the cost of the provision of "hands-on" medical services by physicians, mid-level practitioners, and nurses in delivering family planning services to a patient including in house lab services. This does not include laboratory services provide by a reference lab or pharmacy services. Activities included are the history, physical exam, determination of the method, the diagnosis and treatment of related problems, and initial patient education and “counseling”. The CPT codes are the ones used on the Procedures tab. The Final RVUs are brought forward automatically from the Procedures tab to Column “D” on this tab.

Many of the CPT codes used in this cost center are those in the E/M section of the coding manual. It also includes those associated with other office practices (i.e. IUD insertion/removal; condyloma treatment; diaphragm fitting; injections; etc.)

The Counseling in this section relates to preventive counseling around a specific area designed to change behavior and/or reduce risk. Counseling is, generally, provided by a staff person trained specifically in the area (i.e. nutrition, behavior modification specific to STD’s or HIV, smoking cessation, nutrition, etc.). The counseling must be documented in the chart; including a record of
the clock time spent doing the actual counseling. The CPT codes are those in the E/M section of
the coding manual for individual counseling based on fifteen-minute intervals (99401 – 99404).
There are additional counseling codes that may apply. Most family planning providers DO NOT
provide billable counseling services. That which family planning providers refer to as
“counseling” is, most often, patient education.

Patient education occurs during the course of a family planning visit. It is often referred to as
initial education, intake, contraceptive “counseling”, exit interview, etc. This activity is part of
the “core” family planning service and does not result in an individual billable event. The time
spent in these activities should be treated as medical support services or as part of the provision
of an exam.

An orientation to the Clinical Form

1. The first column (A), “Service/Procedure,” lists the names of frequently used family
   planning CPT codes. These have been used on the “Procedures” tab.

2. The second column (B), “CPT Codes,” lists the associated CPT Codes. These two columns are in the same order as the list on the Procedures tab.

3. The third column (C), is the place to enter utilization for all services provided by the program
   for the year. This is discussed soon.

4. The forth column (D) “RVS Value,” lists the associated RVU for each CPT Code brought
   forward from the Procedures tab.

5. The next 4 columns (E through H) are where the Cost Analysis calculations occur:
   i. Column E, is the “Total Service Units” of each CPT code for which you
      had utilization. Each line in Column C (Service Utilization) is multiplied
      by the corresponding line in Column D (RVS Value). The total number of
      Service Units is then summed at the bottom of Column E.

   ii. Column F, the “Adjusted Total Cost per Cost Center” is only used as a
       place holder for the net amount from the Cost Report worksheet that has
       been brought forward to cell C 70.

   iii. Column G, the “Average Cost per Service Unit” calculates how much
       each unit of service cost the program last year - The amount from the Cost
       Report is divided by the Total Service Units (at the bottom of Column E)
       to give an average cost per service unit. (This number is the same for all
       rows).
iv. Column H, the “Service Cost” – Column G is multiplied by the RVU for each CPT code to determine the Cost For Each Service that you provided.

These calculations are done automatically as you enter the utilization data on Column “C”.

**FP Utilization**

1. Complete the utilization column on the Clinical Form using data for the **same time frame** as the fiscal data on the Cost Report. Do not include visits and procedures done by referral at an off-site provider (Examples: IUD or implant Insertions done by a referral Physician paid for by the program).

2. If there is a question if the CPT code counts are related to the family planning program, count CPT Codes that are accompanied by an ICD-9 V25 code as the primary or secondary diagnosis.

3. Complete the utilization for lab services provided **In-house**. This list only includes tests that are done “in-house”, not those sent to an outside reference lab.

**Column H is the cost of providing each service during the timeframe of the analysis.** Review the “Average Cost per Service Unit” and compare yours to the expected target range (0.85 – 1.25). If you have costs above the target you need to examine why the cost is high. (Are the expenses too high? Is the utilization too low?).

Column (I) is used to enter your program’s current fee scale charges. This is your full fee for each service. Compare the cost of providing each service to your full charge for last year by comparing them to column “H” to determine if the agency made money, lost money, or broke even on their full fee charges compared to their cost for the last year. This is the time to start a review of efficiencies that can be implemented in the program and to ask critical questions.

- Are you using appropriate staff to provide the services?
- Should Mid-levels do more or be deployed or employed differently?
- Can nurses be used differently?
- Do you have sufficient utilization?
- Can you / should you continue to provide the same services?
- Can you afford to stay in business?
3. Determine the cost of each service and establish fees based on this information.

Interpreting the Results

As stated above, Column H gives you the agency cost to provide each service during the timeframe of WISCA and Column I shows the full charges you had in place for each service.

Agencies can estimate the potential costs in the coming year by adding a percent in the “COLA/Margin” cell (C 72). This allows for a cost of living adjustment (COLA). This should be in the form of a whole number that will be converted to a percent (i.e. for a three percent COLA and two and one half percent margin the entry would be 5.5). You do not have to enter the percent sign. This will appear as and be treated as a percent. This percent can be adjusted to institute “what if” scenarios regarding the setting of fees for the coming year. These changes are shown in Column “J” with the cost for the coming year displayed in column “K”.

Column “L” (“Proposed Fee”) is used after the input of the COLA/Margin to establish fees for the coming year. These should be high enough to capture the anticipated (“reasonable”) cost of providing each service. Compare the Proposed Fee (L) with the Adjusted Cost (K).

Columns “M” and “N” can be used to compare the current fee and/or the proposed fee to Medicare reimbursement and to third party reimbursement to the agency. Also review the “Proposed Fee” against standard fees from other agencies, private providers or published guidelines. What are the costs of comparable services in your area?

- Are you competitive?
- Do you offer more than, the same, or fewer services as other providers?
- Can you afford to continue offering the same set of services?
- What “discounts” are you offering and when?

Laboratory Form

The basic WISCA is designed to provide costs for procedures and in-house labs. If you allocate staff to “outside lab” expenses, you can use the “Outside lab” tab to determine the cost associated with laboratory services for tests sent to an outside reference laboratory. Most Healthcare Common Procedure Coding System (HCPCS) codes are in the 80000 series for laboratory services. They are found in the RBRVS but do not have relative values assigned. The relative values for these codes have been established based on the Clinical Diagnostic Laboratory Fee Schedule published by CMS. In most instances the “National Limit” value is used as the relative value for these tests. If there is no “National Limit”, the specific payment for the state is used. Tests in this category are limited to those that are a direct part of the “core” family planning program, as defined in your proposal and/or contract. A large number of tests have
been included to cover the diversity of family planning programs. These are listed by HCPCS (CPT) codes.

1. Complete the utilization column on the Outside Lab form using data for the same time frame as the fiscal data on the Cost Report.

   Note: As the utilization information is inserted, the spreadsheet will automatically calculate the rest of the columns.

2. Place the utilization data on Column “C” for each test you sent to an outside reference lab. Tests are listed in CPT/HCPCS Code numerical order. This list includes only tests sent to a reference lab. (Tests done in-house are recorded on the Clinical form.)

3. After you enter an utilization number on Column “C”, go to the corresponding cell on Column “I” and enter the cost, or average cost, you paid to the reference lab for that test last year (i.e.: utilization on “C12” and price on “I12”).

4. If you do not have HCPCS code information or price information, it should be available on your lab reports or from special reports from your reference lab(s).

   **Interpreting the Results**

1. Column “G” (Average cost per service unit) tells how much the in-house expenses the each unit of service cost the program last year. This is an “add on” to the charge for the test from the reference lab.

2. Column “J” (Total Base cost) tells how much it cost the program last year to provide each specific lab test.

3. Column “K” (Current Fee) can be used to compare the current fee with the cost of providing a test last year.

4. Cell “C 72” can be used to put in a percentage for increased cost of living or a needed margin for the coming year. The percent should be based on your best estimate of increases to salary, fringe benefits and other factors. This provides the information for Columns “L” and “M”.

5. Column “N” can be used to set next year’s proposed fee based on the information on Column “M”.

6. Columns “O” and “P” can be used to compare the current fee and/or the proposed fee to Medicaid reimbursement and to third party reimbursement to the agency.

**Developing Acquisition Costs for Pharmaceuticals**

There are a number of possible “costs” associated with the “acquisition” of any pharmaceutical. These include:

1) The actual purchase price
2) The average purchase price

3) The staff time involved

4) The storage space

5) Acquisition Costs

a) One technique to use is the Percent Increase Method (PIM).

1. Calculate the cost of all pharmaceuticals (agency or FP only).

2. Determine the costs to support the purchase, storage, labeling, and distribution of all pharmaceuticals (agency or FP only).

3. Divide the support by the cost to obtain a percent.

4. Add that percent to the cost (actual or average) for each individual purchase.

b) An alternate, but similar, method has been developed by your colleagues in WI. The OHC Cost Calculation is found in the outline below:

1) Calculate the cost of all pharmaceuticals (agency or FP only). This can be on the average weighted costs of OHCs (including Plan B) or on utilization.

2) Obtain the Total Pharmacy Overhead Costs

   a. Determine the Personnel cost allocated to Pharmacy based on a time study.

   b. Calculate the Facility overhead costs allocated to Pharmacy (costs to support the purchase, storage, labeling, and distribution of all pharmaceuticals) OR the Indirect costs allocated to Pharmacy.

3) Determine the Percent of Oral Hormonal Contraceptives (OHCs) to Total contraceptive Supplies (OHC $ / total contraceptive $ purchases)

4) Determine the Pharmacy overhead allocated to OHCs.

5) Insert the Number of OHC cycles (including EHCs).

6) Calculate the pharmacy overhead per OHC cycle.

7) Insert the weighted average OHC cost by invoice cost (or Utilization).

8) Determine the weighted average total OHC cost per cycle.
### OHC Cost Calculation

<table>
<thead>
<tr>
<th>Personnel cost allocated to Pharmacy</th>
<th>Calculate based on time study</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility overhead costs allocated to Pharmacy OR</td>
<td>Calculate based on time study</td>
</tr>
<tr>
<td>Indirect costs allocated to Pharmacy</td>
<td></td>
</tr>
<tr>
<td><strong>Total Pharmacy Overhead Costs</strong></td>
<td><strong>0.00</strong></td>
</tr>
<tr>
<td>Percent OHCs of Total Supplies</td>
<td></td>
</tr>
<tr>
<td><strong>Pharmacy overhead allocated to OHCs</strong></td>
<td><strong>$0</strong></td>
</tr>
<tr>
<td>Number of OHC cycles (including EHCs)</td>
<td>0</td>
</tr>
<tr>
<td><strong>Pharmacy Overhead per OHC cycle</strong></td>
<td><strong>$0.00</strong></td>
</tr>
<tr>
<td><strong>Weighted Average OHC Invoice Cost</strong></td>
<td><strong>$0.00</strong></td>
</tr>
<tr>
<td><strong>Weighted Average Total OHC Cost per Cycle</strong></td>
<td><strong>$0.00</strong></td>
</tr>
</tbody>
</table>

This process can be used for other pharmaceutical supplies as well.

**Determining costs for outside labs and pharmaceuticals if you do not use the Laboratory form or the Pharmaceutical worksheet:**

Family planning programs may have to set their own charges for supplies and medications and outside labs based on actual costs to the program. Costs for supplies, medications and outside labs may include the purchase price, plus a reasonable “handling charge” that includes estimates for ordering, keeping inventory, storing, and distributing the item. Examples of handling charges include:

- A set amount for each item (i.e. $5)
- A set percentage for each item (i.e. 10%)
- A more complex system that varies by item

Programs may decide their own method for determining the handling fee that is added to these items; however, the agency should have this method in writing and must ensure that it results in reasonable charges.

**Determining costs for visits and procedures done at a referral provider:**

For agencies where certain family planning visits and procedures are done at a referral provider (for example: IUD or Implant insertions), these visits and procedures should not be included in the cost analysis. The full fee charge for these visits and procedures should be set at what your program pays the referral provider. For example, if a referral provider charges your agency $150 per IUD insertion, then the full fee for this procedure on your agency’s sliding fee scale would be $150 and would then slide from there.

*The total costs of an OHC cycle from initial order through point of distribution and all supply management in between.*