Recommended Analyses Utilizing Cost Analysis Results

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The table below lists the analyses that a Title X grantee can conduct for subrecipients upon completion of a cost analysis. It includes site-specific comparisons as well as site-to-grantee network comparisons. A subrecipient or site may also conduct this analysis for their sites/themselves respectively.

SITE-SPECIFIC COMPARISONS	
Analysis	**Purpose of Analysis**
Comparison Ratio: Comparison of Cost/ Relative Value Unit (RVU) to Conversion Factor	This analysis helps a site to understand if its costs are above, below, or on par with payer CPT reimbursement rates. The MCF is a value used in Medicare's payment formula that converts RVUs into Medicare-allowed payment amounts. Most third-party payers use the CF as a base to inform and set their CPT reimbursement rates. When the cost per RVU is between approximately 85% and 125% (.85–1.25) compared to the MCF, costs are most likely in alignment with PI and Medicare reimbursement rates. • When the cost per RVU is at the *lower* end of this range, particularly between 85%–99% (.85–.99) of the MCF, this most likely indicates that a family planning practice is healthy and operating efficiently. • When the cost per RVU is at the *higher* end of this range, particularly between 101%–125% (1.01–1.25) of the MCF, this most likely indicates that a family planning practice is operating less efficiently, **but** in an acceptable range. Cost per RVU lower than 85% could indicate that not all expenses were included in a cost analysis, that certain procedures may have been double counted, or another data issue. Cost per RVU above 125% could indicate that utilization data has been missed. If after correcting these errors, the ratio is still above 125%, consider implementing programmatic changes to increase utilization and decrease costs. See the Setting a Full Fee Schedule job aid for more information. However, since most private insurance (PI) reimburses at rates above Medicare rates, this site may not have significant financial concerns, depending on the % of PI in the payer mix and the amount of PI rates above the Medicare rates.
Comparison of Costs and Fees (or charges) to the Highest Private Insurance (PI) Rate by CPT Code	This analysis helps a site to identify any fees (or charges) that are lower than the highest PI contractual rates. If a fee for a CPT code is lower than the PI rate, this could indicate a need to adjust the fee to the PI rate—or slightly above it—to obtain contracted reimbursement rates for services. Most PI will pay the lesser of the reported charge on the claim or the contractual amount. PI revenue can help balance lower revenue amounts typically reimbursed from Medicaid and clients who pay based on an agency's sliding fee discount schedule. This helps to optimize charges and subsequent revenue gained under an agency's contract. It is also valuable to compare costs to charges and PI rates to analyze the financial health of your practice. Costs lower than charges and PI rates are indicative of a healthy practice. Costs per CPT code in excess of PI reimbursement rates indicate that further assessment of costs is needed (i.e., expense management and/or increased utilization).

SITE-SPECIFIC COMPARISONS	
Comparison of Visit Type	This analysis helps an agency to identify if there is a propensity of coding of certain visit types/levels that may impact revenue. Review Evaluation and Management (E/M) codes over time and by clinical services provider. Typically, a family planning agency has a mix of new and established patient codes, preventive and problem-focused visit codes, and a range in levels of 992xx coding with levels ranging from 1–5 based on the level of services and counseling provided. • If there is a higher % than expected low-level visit codes (i.e., 99201, 99202, 99211, 99212), this may indicate the clinical services providers are under-coding, resulting in lower revenue than expected. • If there are a higher % than expected number of high-level codes (i.e., 99204, 99205, 99214, 99215), this may indicate clinical services providers are over-coding their services and that the agency may be at risk of an audit and take-back of revenue. • If new patient codes are not captured, revenue may be missed as TPPs (private insurance and Medicaid) typically pay more for a new patient visit than an established patient returning to the practice. • Clinical services provider documentation and coding training may be helpful as follow-up.

SITE TO GRANTEE NETWORK COMPARISONS (OR SUBRECIPIENTS WITH MULTIPLE SITES)	
Note: In order to provide the analysis involving comparisons across a Title X grantee's network, it is critical for subrecipients to utilize the same cost analysis methodology.	
Analysis	**Purpose of Analysis**
Comparison Ratio: Comparison of Cost/ Relative Value Unit (RVU) to Medicare Conversion Factor	This analysis helps a site to compare its specific cost/RVU to the grantee network's average cost/RVU. It can help a grantee to determine if its network's average cost/RVU is on par with MCF. It can also help a grantee to compare groups of sites according to geography, setting (e.g., health department, FQHC, stand-alone family planning, etc.) or other characteristics.
Comparison of Costs and Fees (or charges) per CPT Code	This analysis helps a site to identify if its average costs and fees (or charges) per service are on par with the rest of the grantee network.
Comparison of New Visits to Total Visits	This analysis helps a site to identify if its new client volume is on par with the rest of the grantee network. A higher volume of new clients is typically associated with a healthier practice.

Remember to de-identify agencies if you are sharing their data with a network.

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