What Does It Cost You to See a Patient?

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As the practice of medicine becomes more complex, there is an increasing need to understand what is involved in delivering the right service at the right time to the right patient. A basic component of managing any business is to understand the cost structure that goes into the provision of that service. This article identifies the cost components of one practice with the goal for the reader to apply the information to his or her own practice. How much does it cost to see a patient, and what are the components of that cost structure that add value to the patient service or what are the components that we can control? Setting the standard and developing the measurement of that process to form an internal benchmark will help ensure a successful practice in the long-term.

Key words: Business; profit, costs, fixed costs, variable costs, direct cost, indirect cost.

A question that I have enjoyed asking over the years to practice administrators and physicians is: "How much does it cost for you to see a patient?" The answer has mostly been: "I have no idea" or "$55.00." And when asked how the figure in the latter answer was calculated, I'm told: "That is what I charge for a routine office visit." These answers are a concern to say the least, leaving us to answer the question in a more realistic fashion.

WHY IS THIS IMPORTANT?

A successful business is measured by a positive bottom line or profit. Most medical practices have been very successful in generating a profit and staying in business. Will this be true in the future with declining reimbursement from managed care, the annual effort by the federal government to ratchet down Medicare allowances, and states reducing Medicaid payments? And what about the impact of pay-for-performance efforts and the rising costs of doing business, including payroll and costs of supplies, insurance, communication, electronic medical records (EMRs), and the like?

There are many statistics that have been used to benchmark practice activity and guide management to improve efficiency. These include full-time equivalents (FTEs) per physician, cost per square foot, and many more (see "Presenting Practice Financial Information," *Journal of Medical Practice Management*, 2007;23:97-103). But are these enough, and do they really answer the question of how effective your practice operation really is?

A successful business is measured by a positive bottom line or profit.

Consider the shampoo that you use daily. The manufacturer clearly knows how much it costs to develop, process, market, and distribute the shampoo. It also has a very good idea of what the expected profit is for each bottle of shampoo and for the expected annual sales volume. Does your practice have this same information?

The purchasers of the shampoo expect a quality product, available when needed, at fair price. Today's healthcare consumers and/or purchasers expect the same thing from your practice. They expect value for the dollar expended.

HOW DO WE GET TO THE ANSWER?

Table 1 presents a primary care solo practice financial statement for a 12-month period. The income and expense items are listed along with the posted activity for the

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Table 1. Overall Practice Activity

Category	Annual ($)	% of Income	Per Visit* ($)	Cost Category
All sources income	579,794	100.0	92.77	
Expenses				
Bank charges	1011	0.2	0.16	V/I
Billing service	16,368	2.8	2.62	V/I
Contributions	183	0.0	0.03	V/I
Depreciation	8410	1.5	1.35	F
Dues and subscriptions	2893	0.5	0.46	V/I
Insurance: business and malpractice	12,400	2.1	1.98	F
Insurance employee	16,255	2.8	2.60	V/D
Lab/outside diagnostics	30,548	5.3	4.89	V/D
Legal and accounting	6131	1.1	0.98	V/I
Marketing	9055	1.6	1.45	V/I
Medical supplies	33,618	5.8	5.38	V/D
Office supplies	17,912	3.1	2.87	V/I
Payroll	136,094	23.5	21.78	V/D
Payroll tax	10,581	1.8	1.69	V/D
Rent	55,491	9.6	8.88	F
Repairs and maintenance	1123	0.2	0.18	V/I
Taxes	1337	0.2	0.21	V/I
Telephone	6299	1.1	1.01	F
Training	53	0.0	0.01	V/D
Total	365,761	63.1	58.52	
Net income	214,033	36.9	34.25	

*6250 patient visits.
F, fixed; V/D, variable/direct; V/I, variable/indirect.

period and a percentage of income, a benchmark that is used by many to determine relative expense items (e.g., payroll 23.5% of income). To assist in answering the question of cost, two additional columns have been added. The column labeled "Per Visit" is the dollar amount divided by 6250 patient visits (99201–99205; 99211–99215; and 99241–99245) recorded during that time period. The last column identifies a cost category. The global look reveals income of $92.77, expense of $58.52, and profit of $34.25 per visit. If you look at more detail, this is total income and expenses including ancillary revenue as well as office visit activity (note a line item for lab/outside diagnostics). The key point is that for every patient visit that fit into the E/M codes selected, the cost was $58.52.

Let's look at this more closely. The last column is a key to understanding the question of costs and how best to manage them. Here's a quick cost accounting lesson: there are four basic costs: fixed, variable, direct, and indirect.

Fixed costs are those costs that stay the same regardless of whether you have one patient visit or 6250. Examples of true fixed costs are rent and malpractice insurance over the 12-month period under consideration. The table identifies four costs that for this purpose were considered fixed. That means that the fixed costs for the 6250 patients come to $13.22 per patient. If only one patient was seen by the practice, the fixed costs would be $82,600 per patient.

Variable costs are those costs that change with the number of patients seen. In our example, the total variable costs identified are $283,161 total or $45.31 per patient.

Direct costs are those costs that are directly related to delivery of services to patients. To put it another way, these add true value to the patient. The table identifies these as V/D, and they are $227,149 total or $36.34 per patient visit.

Indirect costs are those costs that are not related to direct patient care but are used to support the delivery of patient care. In all cases, the practice cannot exist without some of these costs. They are identified a V/I in the table, and they are $56,012 total or $8.96 per patient visit.

It is important to understand these cost categories because your management effort will be directed at them. Obviously, worrying about fixed costs on a daily basis is a waste of time. Variable costs, on the other hand, relate to activity in the office, and therefore can and should be controlled regularly. It would also make the most sense to look first at those costs that are indirect or have the least impact on the direct value received by the patient.

Figure 1 helps identify the percentages of fixed, direct, and indirect costs for our model. All costs identified as direct and indirect are variable. It is important to understand this ratio because it will help guide you as you consider what to do about your costs. One key point to remember is that cost control does not necessarily mean cost cutting, layoffs, etc. It may be that you could shift costs to a direct revenue area or to assist in meeting your patient satisfaction goals. It might be nice to have the billing staff actually have time to answer the patients' questions or make collection calls that result in improved collections.

How do this overall model and these percentages compare with your practice? A better question is: how

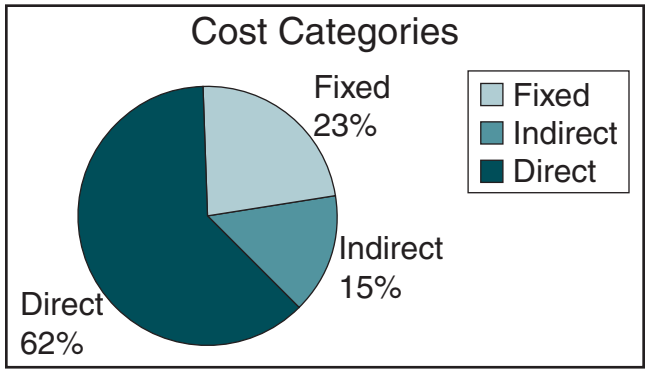

Figure 1. Percentages of fixed, direct, and indirect costs.

does your per-patient breakdown for 2006 compare with that of 2007? Are there changes that are more easily identified by this exercise that will help you in better managing your practice?

Let's now look a little further at the breakdown and answer the specific question as to how much it costs to see a patient. Table 2 identifies 70% of the line item costs in Table 1 as costs associated with office visits. The exception relates to the line item for outside lab, which has been removed because it does not relate directly to the office visit cost. It was determined that 70% of the overall revenue generated came from office visits, and that is the guide used in this example. It is recommended that you look more closely into your cost breakdown and come as close to actual as you can. Payroll records, square footage allocated to patient vs. ancillary activity, etc. will give you a more specific figure.

Table 2 reveals a cost per patient visit of $37.54 that has effectively carved out all costs not associated with patient visits. This is a very important number, and determining it is one of the real goals of this exercise.

WHAT DO YOU DO WITH THIS INFORMATION?

Given the above cost accounting process, where do you go first to look at your efficiency and to better control costs? The correct answer is to start with indirect costs. A statistic that should encourage you to look at these costs is that according to W. Edwards Deming, a leader in the total quality management movement, fully 25% of the work that is done by employees is wasted, redundant, or rework.[1] Let's consider the number of denials that you receive. How many of those are mistakes that could have been corrected initially, or DRIFT (done right the first time!)? Stopping to analyze your hourly costs of claims processing, you could save a significant dollar amount by changing your input processes. This may not directly result in reduction of employee staff but may eliminate the need to add more staff, or the collection percentage may improve.

Table 2. Example of Office Visit Activity Only*

	Annual ($)	Per Visit ($)
Office visit income	405,856	64.94
Expenses		
Bank charges	708	0.11
Billing service	11,458	1.83
Contributions	128	0.02
Depreciation	5887	0.94
Dues and subscriptions	2025	0.32
Insurance: business and malpractice	8680	1.39
Insurance: employee	11,379	1.82
Lab/outside diagnostics	N/A	N/A
Legal and accounting	4292	0.69
Marketing	6339	1.01
Medical supplies	23,533	3.77
Office supplies	12,538	2.01
Payroll	95,266	15.24
Payroll tax	7407	1.19
Rent	38,844	6.21
Repairs and maintenance	786	0.13
Taxes	936	0.15
Telephone	4409	0.71
Training	37	0.01
Total	234,650	37.54
Net income	171,206	27.39

*6250 patient visits.
N/A, not applicable.

Variable costs are controllable almost on a daily basis; therefore, you require an awareness of what these costs are and what steps you can take to control them. Controlling these costs can be achieved through better purchasing contracts, managing employee overtime, flex scheduling, eliminating rework, inventory control, and appropriate utilization of supplies.

Fixed costs are not controllable as often. However, they are controllable at the time of contract negotiation. Obviously, you can look at the cost of space and determine if the office size is correct or the office location best fits the practice plan. Both of these points make the space lease agreement negotiable at the appropriate time. In this day of implementation of an EMR system, you can consider shifting file-storage space into revenue-generating space providing a better return on investment for this fixed cost. Malpractice costs may be reduced by each physician attending either in person or online the risk management education programs offered by the vendor.

Personnel costs may be either or both variable and fixed. In a one-doctor practice, three employees may be essential, and there is no way to cut back; therefore, they are considered fixed costs. However, in a larger practice with a new billing system with electronic remittance and other bells and whistles, there may be an opportunity to reduce staff. This controls variable expenses but increases fixed costs due to the purchase of the new software. An application service provider software solution may be a variable cost if it is priced by provider or transaction. Employee costs may be reduced as well by looking at

health insurance: going from your current plan to a high-deductible plan or not offering employee health insurance until employees have been employed for 90 days or six months. Eliminating an employee also reduces health insurance and other benefit costs, therefore the variable cost amount decreases.

Of course, a large part of the equation is how you treat the income of a physician. I think it best to identify a physician as a cost whether the physician is an employee or an owner. This gives a truer picture of the "real" costs and creates a better look at the goal of full awareness. Let's assume that the physician's income is $200,000, which adds $32.00 ($200,000/6250 visits) more to the cost of seeing a patient and brings the total cost per visit to $69.54. This then is the true cost to see a patient.

There are a couple ways to look at how your price (what you get reimbursed from Medicare and managed care) relates to your costs. One is to set your price based upon costs, or cost-led pricing, when you can set the price. The other is to adopt a position of price-led costs. In this day and age of difficult contracting and the never ending annual battle of Medicare reduction threats, it seems to me that a key starting point is to understand what the price is in the marketplace and to develop a cost model based upon that price.

Negotiating for a managed care contract will become more reasonable if you can truly break down costs even further.

When you meet with the contract representatives from managed care, you will be aware of how much it costs to see a patient. Negotiating for a managed care contract will become more reasonable if you can truly break down costs even further. Our cost model includes everything done for the office, including lab and possibly other ancillary services. So to get specific in looking at a 99213 visit, which would have an allowance close to $60, you would want to break down those costs that can be associated directly with office visits. Does this mean you actually lose money on each 99213 visit? It could, and thus requires serious review. Or does it mean the average cost per visit is $69.54, which includes new patients, consults, and higher level visits, meaning that you are still making money? Figure 2 is intended to help you gain a better understanding of how to look at cost and return. What is your calculated cost per visit by specific CPT code, and what are your Medicare allowances for those key office visit codes. How does each allowance relate to the cost? You can also look at these figures for your managed care contracts.

Cost to see a patient	$69.54	
	Medicare allowance	Difference
99203		
99213		
99243		

Figure 2. Compare your Medicare allowance to the sample cost.

If you refer back to Table 1, the percentage of profit, not considering physician cost, is 36.9%. If you back out the $32.00 physician cost and use the overall cost figure from Table 2 of $37.54, you could look at your managed care contracts or Medicare allowances in another way. Everything must have a return of 36.9% above the cost base in order to achieve the targeted return for the practice.

I am sure each of you in looking at Table 1 felt that there are some obvious changes that could be made such as bank charges, marketing, and perhaps rent, telephone, and supplies. In comparing this practice with yours, there may be things that you can look at internally to begin your own cost control process.

A key goal of the practice is to be to be a high-quality, low-cost provider.

As pay-for-performance and related programs expand, there will be more information available to the consumer and the employer about the most cost-effective providers. True, this is mostly driven by utilization and protocol compliance, but it is also driven by the payor setting fees and recognizing the most cost-effective provider. A key goal of the practice is to be to be a high-quality, low-cost provider.

These data are not presented with the single goal of your development of a cost-cutting strategy or layoff plan. Rather, they are presented as a challenge for you to look at your practice in such a way to determine the most cost-effective means to add value to your patients. Your total costs may be in line but not assigned properly. Perhaps you can change the job of an indirect employee (through automation) and provide higher patient satisfaction or the addition of an ancillary service. The net outcome could be very positive to current patient retention or new patient recruitment.

You also can now look at a trend line of data by comparing year over year, or you may want to look at this information quarterly. The right sequence depends upon the time you have available, the ease of gathering the data, and the volatility that you feel your practice is facing. Even though this might be "fun" information to have, it is most important to look at it appropriately in terms of effort, time, and benefit. The trend line of results will tell

you if you have a problem and need to take a serious look at the situation at hand.

CONCLUSION

The medical practice today is a business and must be run as a business. The medical practice is much more complex than ever before. If we do not understand the basic principles associated with what it costs us to deliver our product, it will eventually become impossible to survive. Start out with a basic measure, and compare year over year to see what has happened. Then as you gain a better understanding of your practice, you can choose to get more sophisticated in your analysis. This information presented routinely to the management team and physicians will help all gain a better understanding. One of your ongoing goals is to create true value for your patients. It will also help answer the question that is so often asked: "Why are our expenses going up, and what are YOU doing about it?" ■

REFERENCE

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