Establishing Patient Contracts: As Easy as ABC

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Due to increasing health insurance premiums, many small business owners are unable to provide benefits to their employees. Some are now opting to negotiate directly with physicians for preventive and acute care services. When properly implemented, these agreements have resulted in huge savings for employers as well as decreased insurance headaches for providers. This article describes how to perform an activity-based cost analysis to decide whether this form of healthcare services is right for your practice.

Key words: Activity-based cost; cost analysis; capitation; employee health services; time studies.

With health insurance premiums skyrocketing, many small business owners are unable to provide health benefits to their employees. Some are now opting to negotiate directly with physicians for preventive and acute care services. This has resulted in huge savings for employers as well as fewer insurance headaches for providers. But before you can decide what rates to charge these small businesses, you need to have a strong grasp of your cost for services.

An ABC analysis can be used to evaluate new services in a practice such as bone densitometry or laser therapy.

An activity-based cost (ABC) analysis is a great technique used by many healthcare organizations to evaluate these costs. The key concept is to identify an activity, such as providing a medical service, with the costs associated to perform the activity. ABC analysis can also be used to evaluate new services in a practice, such as performing bone density examinations or laser therapy.

OPPORTUNITY COST

Before establishing an employer contract, analyze your opportunity cost. Ask yourself, "Does the clinic have excess capacity?" In other words, can you accommodate additional patients or will the new contract mean that new patients will simply be replacing other patients? In addition, what else could be done with the physician time, staff time, or your facility? Once you've answered these questions, you can gain a better picture in deciding if employer agreements would be a good fit. Keep in mind that if you can't negotiate a fair discount or capitation rate with the employer, then it would be smarter to use your clinic time pursuing other ventures.

CAPITATION OR DISCOUNTED FEE FOR SERVICE?

Most physicians would prefer to set up a discounted fee-for-service agreement with small businesses. Beware, because if not handled properly, this method could result in a loss of total net revenue for the practice. For example, if a practice collects $300,000 and has overhead of $150,000, the physician would take home $150,000. However, if services were discounted by 30% resulting in collections of $210,000, the physician would now take home only $60,000, assuming overhead stays the same.[1] Discounted fees could force providers to work twice as hard in order to make the same amount of money. If you decide on discounted fees, make sure the rates established meet your desired profit margin.

With capitation, payments are made per-member-per-month, independent of the amount of patient services utilized. Although capitation is much riskier than discounting fees, it forces your practice to manage care efficiently and monitor revenue closely. Again, use caution

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because all capitated agreements bear a degree of uncertainty by shifting risk to the practice. The benefits of capitated agreements are that they provide steady revenue for the practice and minimize billing expenses as fees are paid regardless of patient visits. Private employers also like being able to budget for this monthly.

EVALUATING A CONTRACT

Whether you decide on capitation or discounted fees, the ABC analysis will help you uncover your costs for services. For our purposes, we will apply the ABC analysis to a sample capitation. Imagine a small company approaches you to serve as the exclusive primary care provider for its 100 employees at a capitated rate of $210 per member annually based on an estimated three visits per employee. In this case, most of us would be more than happy to jump on guaranteed income of $21,000 a year. But wait, the employer then asks that a few ancillary services be included for each employee once a year. The additional services requested include a complete blood count (CBC), basic metabolic panel (BMP), and lipid panel. Although you are able to perform these tests in your office and your patient visits are not at full capacity, you start to wonder if the contract is still worth it. Before jumping into the ABC analysis, I want to share my previous experience with a capitation agreement.

PATIENT POPULATION

During my first few years as medical director of a community health clinic, our facility held a capitated contract with a regional VA hospital to provide ambulatory care and ancillary services for 191 veterans. I knew right away that this was not an ideal patient mix for a capitated contract. However, just as in many small communities, politics played a key role in negotiating the agreement. We were paid a small amount per veteran per month. Unfortunately, many veterans treated the clinic like a coffee shop and frequented our office almost weekly. To make matters worse, most veterans had multiple diseases requiring several lab draws despite the fact that we'd be paid only for blood tests once a year per veteran.

This leads to an important lesson. Always look at demographic factors, like age and sex of the patient population, to determine the amount of services that will be required in a capitation contract. For example, males between 20 and 29 years of age use half as many medical services as the average patient. On the other hand, Medicare patients use about twice as many medical services as younger patients.[2] Make sure to ask the contractor for the previous year's utilization of patient services if available. This will aid in calculating the monthly fee per member needed to cover both the healthy and the sick patients. Remember, it only takes a few very sick patients to blow your profit margin.

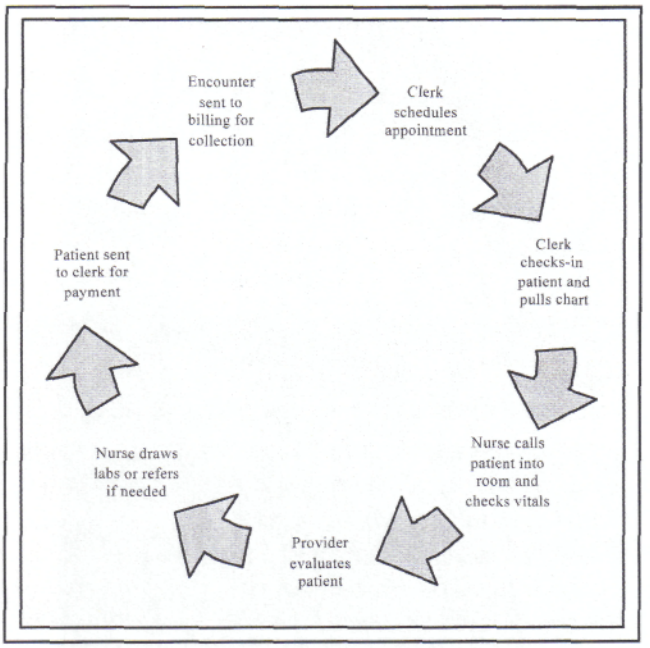

Figure 1. Patient encounter cycle.

COST FOR SERVICES

In an ABC analysis, costs are grouped into activities involving *direct care* and *indirect care*. Examples of direct care expenses include: scheduling the appointment, patient check-in, nurse or medical assistant time, physician time, patient check-out, and most importantly, billing and collection. Indirect care expenses include: building and equipment, utilities, office supplies, malpractice insurance, and administration. Costs can further be categorized as *fixed, variable*, or *semi-variable*. Fixed costs remain the same regardless of the number of patients seen. Variable costs are dependent on the number of patients treated or procedures performed. Semi-variable costs (also called step-variable) remain the same up to a certain threshold and then increase. For our purposes, we will focus on *direct care* and *indirect care* costs. In order to measure cost, we can use time studies and historical data.

Time Studies

Time studies have many benefits for a practice. Companies use time studies to analyze office efficiency and adequate staffing. The easiest way to perform a time study is by attaching a time sheet to the patient's chart and having each employee log time spent performing his or her duties during the patient's visit (Figure 1). Although these studies may involve several months of data collection, they provide valuable information about clinic operations. In our clinic, we discovered that extra staff time was spent completing new patient forms, searching for charts when patients arrived, and pursuing lab results once the patient was already in the exam room. By making small changes such as pulling charts

Staff Cost per Minute

Staff	hourly pay	pay/minute
front desk clerk	$8.50	$0.14
nurse	$14.00	$0.23
physician	$75.00	$1.25
biller	$11.00	$0.18

Direct Care Cost

	volume	value	pay/minute
Schedule the appointment	3	minutes	$0.14
Patient check-in	5	minutes	$0.14
Nurse time	5	minutes	$0.23
Physician time	15	minutes	$1.25
Lab draws (divide by 3)	3	minutes	$0.23
Patient check-out	5	minutes	$0.14
Billing and collection	0	minutes	$0.18

Activity-based cost per visit	
Schedule the appointment	$0.42
Patient check-in	$0.70
Nurse time	$1.15
Physician time	$18.75
Lab draws	$0.69
Patient check-out	$0.70
Billing and collection	$0.00
Cost for CBC, BMP, Lipid panel (divide by 3 visits)	$8.00
Total direct cost per Visit	$29.72

Indirect Care Cost

Total visits last year 4,500

	annual cost	cost/visit
Administration	$ 50,000.00	$11.11
Building and equipment	$ 35,000.00	$7.78
Film and lab costs	$ 4,000.00	$0.89
Malpractice Insurance	$ 18,000.00	$4.00
Miscellaneous	$ 2,500.00	$0.56
Total indirect cost per visit		$24.33

Total direct and indirect cost per visit	$54.05
Expected number of patient visits annually	300
Total Annual Cost for 300 visits	**$16,216.00**
Gross Pay for 300 Visits	**$21,000.00**
Net Profit	**$4,784.00**

Figure 2. Spreadsheet for calculating costs. Data within dotted boxes can be modified based on your own data. CBC, complete blood count; BMP, basic metabolic panel.

prior to scheduled patient visits and placing labs in the chart *prior to* calling the patient into the exam room, staff and patient times were significantly decreased. In addition, new patients are now advised to arrive early to fill out paperwork or offered the option to print out forms from our Web site to be completed before their visit. Although we haven't stepped up to electronic medical records, these small changes have helped streamline patient visits.

Time studies can also be used to calculate *direct* patient care cost with the highest level of accuracy. When calculating activity cost per staff member, be sure to include salary as well as benefits. Break each employee's pay down to the minute. For example, if the front desk clerk were paid a total of $8.50 an hour, then each minute would amount to approximately 14 cents. Use this method to calculate the rest of the staff's activity cost per minute. Once all of the staff's cost per minute is calculated, chart the amount of time it takes each employee to complete his or her part of a patient visit.

In our sample contract, each patient will have labs drawn only once out of the three visits, therefore time spent drawing labs as well as the cost for the CBC, BMP, and lipid panel should be divided by three. Keep in mind that cost will also vary based on the use of nurses or medical assistants as well as the type of provider examining the patient. Remember, in a capitated contract, billing time is nonexistent as the per-member-per-month fees have already been negotiated. To make things easier, you can simply plug these data into an Excel spreadsheet such as that shown in Figure 2.

Historical Data

Historical data can be used to reflect the average costs associated with *indirect* care. Items that should be included are: administrative support; building and equipment (taking into account all utilities); film and lab supply costs; malpractice insurance costs; and miscellaneous items such as office supplies. To find administrative costs using historical data, divide the total administrative staff cost by the number of patient visits annually. For example, if your clinic administrator is paid $50,000 dollars (with benefits) and you had 4500 visits the previous year, then your administrative cost would be $11.11 per patient visit. Use this method to find the rest of the indirect costs per patient. You can also benchmark your costs with other practices of your size through the Medical Group Management Association. Once again, simply input the numbers into the spreadsheet and allow it to perform the calculations.

Results

Based on our example, the practice would theoretically spend $54.05 per patient visit, with a total of $16,216 for 300 patient visits. The practice could potentially benefit from this capitated contract with net earnings of $4784, which is a profit of approximately 23%. This amount may vary from practice to practice depending on total expenses and office efficiency. Once again, this spreadsheet can also be applied for discounted fee-for-service agreements because staff activity costs remain essentially the same with a few modifications for billing and ancillary services. Remember, once you have covered the fixed costs of the clinic, then each additional patient under contract is contributing to covering the variable costs and then the overall profit of the clinic.

FINAL REMARKS

Negotiating contracts directly with employers could eliminate the headaches of dealing with insurance companies, but it comes with some risks. Always weigh your opportunity costs first. If your practice has no other ventures in the pipeline, then an employer contract may be ideal. Whether you decide on capitation or discounted fees, you need a strong grasp of your cost for services. Remember to consider patient population when negotiating capitated contracts because it only takes a few sick patients to lose money for the entire group. In addition, spend extra time making your office as efficient as possible to help cut expenses. Benchmark your practice's costs with other facilities your size to see how you compare. Finally, before you accept a new contract or consider a new service for patients, perform an ABC analysis to see if it will be a financially rewarding endeavor for your practice. ■

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