

Cash-Only Practice: Could It Work for You?

The cash-only model involves some risk, but it can also bring many rewards.

Although contracting with health plans can produce a wealth of patients for a medical practice, it can also increase practice overhead substantially and result in deeply discounted fees. As a result, many family physicians have had to see more patients in a day and work more hours just to maintain their income. Others have responded to these pressures by reinventing an old practice model – cash-only practice. The articles on the following pages describe how three family physicians have implemented this simpler model of practice and how it has affected their practice's financial viability and their satisfaction with the care they deliver. A cash-only practice might not work in every market, but it merits consideration by family physicians who are prepared to take a risk and motivated to make fundamental changes in the way they practice.

Back to the future

The “cash only” term means simply that patients pay at the time of service. They may pay with a credit or debit card, check or cash. The key is that no third-party payers are involved to complicate the transaction or the relationship. In its purest form, cash-only practice means not participating with any insurer; however, the practice may provide insured patients with a completed CMS-1500 form to enable them to file their own claim. This arrangement generally enables much lower overhead because claims processing, patient billing and countless hassles related to managed care can be eliminated. In some cases, physicians will contract with a limited number of better-paying health plans and submit claims to them while requiring that other patients pay at the time of service. This limits reductions in overhead but may be necessary to ensure that the patient panel is big enough to generate sufficient revenue for the practice, at least in the short term.

The newest variation on cash-only practice is concierge or membership practice in which physicians have a small

panel of patients who can afford to pay high out-of-pocket costs for their health care. Patients usually pay a combination of an annual retainer fee and fee-for-service in exchange for value-added services, such as 24/7 access to the physician and house calls.

Is it feasible?

A careful review of health plan contracts is essential to determining whether a cash-only practice could work for you. ➤



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A cash-only practice, particularly one that serves patients with private insurance who are willing to pay cash and submit their own claims, must avoid several legal and contractual pitfalls. For example, although it's not common, some of the more restrictive health plans may prohibit physicians who terminate their contracts from seeing their members for a certain period of time. In most cases, PPO enrollees will be able to see out-of-network physicians, pay at the time of service and receive reimbursement from the health plan, although it may not reimburse them in full. Co-pays and deductibles may also be higher for out-of-network care. Most HMOs won't provide any coverage for care provided by physicians they don't contract with, so it is harder to attract these patients to a cash-only practice.

The high costs and low reimbursement associated with health plan contracts have renewed interest in cash-only practice.

Cash-only practices collect fees at the time of service.

Some health plan contracts and state insurance regulations may include restrictions that inhibit cash-only practice.

State insurance regulations should also be evaluated. Some states protect enrollees in particular private insurance plans from being billed for amounts beyond what their insurance company pays, except for co-pays and deductibles. You may need to enlist a health care attorney to help you determine the extent to which such regulations apply to your situation.

Many physicians in cash-only practice elect to opt out of Medicare, which means taking the following steps: notify current patients, colleagues and other interested parties; file an initial affidavit with Medicare and a new affidavit every two years to maintain opt-out status; privately contract with the Medicare patients; and initiate office procedures to identify new patients who are Medicare beneficiaries and ensure that prior to the visit they are notified of the opt-out status and its implications.

Physicians who decide to continue as participating providers under Medicare must be careful when offering discounts to privately insured or uninsured patients who pay in full at the time of service. Title XVIII of the Social Security Act says a provider can be

excluded from Medicare if he or she charges the program "substantially in excess of his [or her] usual charge" for the same service.

The rules related to treating Medicaid patients on a cash-only basis vary and should be evaluated by contacting the Medicaid agency in your state.

Key questions

Below are some questions to consider as you evaluate whether cash-only practice is right for you:

- Can the local market support this type of practice? A community with large numbers of uninsured patients and affluent patients with or without insurance might be a good environment for a cash-only practice. To determine whether insured patients would constitute a significant part of your patient panel, consider the types of health plans in your market. Since HMO patients typically get no out-of-network benefits, more PPO and high-deductible health plans in the area could mean more insured patients in your panel. If there are large employers in your area, find out what type of benefits they offer. Also consider whether there are other cash-only practices in the area.

- Would existing patients be willing to transition to the cash-only practice? To find out, ask your patients – either informally or through a survey. If too few would be willing to make the transition, you could consider keeping your contracts with the better-paying health plans, at least temporarily.

- What services would you offer? Would lab tests be a part of the practice? Would you see patients in the hospital?

- How much would you charge? You can perform your own market research to determine what other practices in your area charge. As long as there is no discussion about setting rates collectively, this type of communication among physicians is permissible. Or you could hire a practice consultant who is familiar with your local market to

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help you design a fee schedule. Cash-only practice is conducive to time-based fees, which are easier to manage from an administrative standpoint.

- What financial outlay would be required to stay solvent during the transition period? It may be necessary to work part-time for another practice or urgent care center to maintain one's financial stability during the startup or transition period.
- What overhead is vital to the practice, and how many patients will be necessary to cover these expenses? Consider the systems that will be required to collect cash at the time of service. Also decide which clinical tasks would be delegated, and which ones you would perform.
- What would your obligations be to your current patients? This depends on your health plan contracts, and whether you would be converting an existing traditional practice or leaving a practice to start a new one.

These are just a few of the issues to consider as you evaluate the feasibility of cash-only practice. For more advice, see the AAFP resource at <http://www.aafp.org/x36306.xml>.

Criticisms

Cash-only practice has its share of detractors. Some say that only affluent, healthy patients can benefit from cash-only services and that widespread use of the model would only compound access problems for uninsured patients. Some worry that cash-only practice contributes to fragmented care. Another concern is that it reduces the physician's scope of practice to treating acute problems because insured patients with chronic illnesses are less likely to want to pay for out-of-network care on a frequent, ongoing basis and chronically ill patients who can't afford insurance may tend to avoid routine preventive care.

Whether cash-only practice is right for you depends on a host of factors, perhaps the most notable one being whether your local market can support it. Under the right circumstances, it enables family physicians to recapture autonomy, spend more time with patients, work fewer hours and maintain a satisfying income. **FPM**

Send comments to fpmedit@aafp.org.

Some practices continue contracts with better-paying health plans while charging other patients cash.

A thorough market and financial analysis is vital to determining the viability of cash-only practice.

Although some aspects of cash-only practice are controversial, it is serving some family physicians well.