CA$H ONLY PRACTICE

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A New Future With an Old Business Model

Turning away third-party payers and requiring payment at the time of service restored this family physician's practice.

Three years ago, after separating from my group practice, I rediscovered an old-fashioned model of practice and found that it is not only desirable but also sustainable in today's health care environment. Ending my relationships with third-party payers and seeing patients who pay at the time of service has enabled me to decrease my overhead by 90 percent, which is the key to making this type of practice work. I'm earning as much as I did in my previous practice, but I'm working half as many hours. Once my practice matures, I'll be able to double my previous income.

My practice is similar to the practice I joined in 1979 in rural Virginia as a family physician in repayment of a National Health Service Corps obligation. The business model was payment at the time of service, and the practice filed Medicaid claims for indigent patients. The model was simple, market-sensitive, patient-oriented and financially viable.

Over the next two decades, I was fortunate to practice family medicine in two different stable multi-physician practices, one rural and one suburban. But insurance coverage, managed care and integrated health care systems added complexity to medical practice. High patient volume and quick service were increasingly necessary to keep the practice afloat. Over time, more resources had to be allocated to service the insurers and fewer resources remained to reward physicians for the clinical care they provided. The joy I felt for my profession began to wane. When I realized I could no longer provide the type of care I wanted – comprehensive, coordinated, continuous care – and still keep the practice financially viable, I took a radical step: I withdrew from participation in every insurance plan, including opting out of Medicare, and developed a business plan that allowed me to focus on my patients' health care.

How it works

Terminating my contracts with commercial health plans wasn't complicated; because I separated from my group, taking care of my patients became my group's

About the Author

Dr. Kraus is a solo physician in Richmond, Va. Conflicts of interest: none reported.

TIMOTHY COOK

responsibility, as did notifying them of my departure. Opting out of Medicare was not as easy. I had to agree in writing not to re-apply for provider status for at least two years. (See the "Medicare opt-out notice," below, which you can download from the online version of this article at http://www.aafp.org/fpm/20060200/74anew.html.) I also had to require any Medicare beneficiary who purchased my services to sign a document acknowledging that because I had opted out they were prohibited from submitting a claim to Medicare for reimbursement for the services I provided, although ancillary service providers (commercial labs, hospitals, other health providers) could still bill Medicare for the services they provided to my patients. (See the "Private contract with Medicare beneficiary," on page 77, which

MEDICARE OPT-OUT NOTICE

Medicare carrier address:

_____

_____

_____

Attn: Provider Enrollment

I, _____, declare under penalty of perjury that the following is true and correct to the best of my knowledge, information and belief:

1. I am a physician licensed to practice medicine in the state of_____. My address is at _____

_____, my telephone number is_____,

and my uniform provider identification number is _____. I promise that, for a period of two years beginning on the date that this affidavit is signed (the "Opt-Out Period"), I will be bound by the terms of both this affidavit and the private contracts that I enter into pursuant to this affidavit.

2. I have entered or intend to enter into a private contract with a patient who is a beneficiary of Medicare ("Medicare Beneficiary") pursuant to Section 4507 of the Balanced Budget Act of 1997 for the provision of medical services covered by Medicare Part B. Regardless of any payment arrangements I may make, this affidavit applies to all Medicare-covered items and services that I furnish to Medicare Beneficiaries during the Opt-Out Period, except for emergency or urgent care services furnished to Beneficiaries with whom I had not previously privately contracted. I will not ask a Medicare Beneficiary who has not entered into a private contract and who requires emergency or urgent care services to enter into a private contract with respect to receiving such services, and I will comply with 42 C.F.R. § 405.440 for such services.

3. I hereby confirm that I will not submit, nor permit any entity acting on my behalf to submit, a claim to Medicare for any Medicare Part B item or service provided to any Medicare Beneficiary during the Opt-Out Period, except for items or services provided in an emergency or urgent care situation for which I am required to submit a claim under Medicare on behalf of a Medicare Beneficiary, and I will provide Medicare-covered services to Medicare Beneficiaries only through private contracts that satisfy 42 C.F.R. § 405.415 for such services.

4. I hereby confirm that I will not receive any direct or indirect Medicare payment for Medicare Part B items or services that I furnish to Medicare Beneficiaries with whom I have privately contracted, whether as an individual, as an employee of an organization, as a partner in a partnership, under a reassignment of benefits, or as payment for a service furnished to a Medicare Beneficiary under a Medicare+Choice plan, during the Opt-Out Period, except for items or services provided in an emergency or urgent care situation. I acknowledge that, during the Opt-Out Period, my services are not covered under Medicare Part B and that no Medicare Part B payment may be made to any entity for my services, directly or on a capitated basis, except for items or services provided in an emergency or urgent care situation.

5. A copy of this affidavit is being filed with _____, the designated agent of the Secretary of the Department of Health and Human Services, no later than 10 days after the first contract to which this affidavit applies is entered into.

Executed on _____[date] by _____[Physician name]

_____[Physician signature]

Terminating my contracts with commercial health plans wasn't complicated. Opting out of Medicare was not as easy.

you can also download at http://www.aafp.org/fpm/20060200/74anew.html.)

In discussing my plans with several colleagues, I learned that one had extra space in his office. He offered to rent me a single exam room through an "at-will tenancy" arrangement, which means I pay him only when I'm seeing patients. I pay him $20 an hour, which covers my use of the furnishings, equipment, supplies and staff that he has available for his own practice. His staff answers my calls, schedules my appointments, greets my patients, obtains the paperwork needed to create and update my patients' charts and collects fees as my patients leave. They also collect and prepare lab specimens for me. The arrangement enables me to keep overhead low, at about 35 percent. It also rewards my colleague with a revenue stream that exceeds his fixed expenses.

In his low-overhead, cash-only practice, the author works half as many hours as he did in traditional practice and earns the same income.

Start-up costs for the new practice were minimal. They included securing phone lines, a credit card payment processor, a business license, lab coats, a paper shredder and printed forms including prescription pads.

To keep overhead expenses low, the author rents an exam room and staff from another physician's practice on an "at-will tenancy" basis.

Although I do not file claims for patients and thus am not a covered entity for purposes of the Health Insurance Portability and Accountability Act (HIPAA), I adopted confidentiality protocols that fall within HIPAA guidelines.

Fees for my professional services are $50 for 15 minutes, and this covers all services, including but not limited to forms and reports completion, minor surgery, venipuncture, specimen preparation and handling, and electrocardiography. The lab bills the patient or insurer directly for its services. The fee for my at-will tenancy covers the expenses the other practice incurs in collecting and preparing lab specimens for my patients. My fee is based on the assumption that I ought to be able to earn $250,000 a year, as I once did. This requires $400,000 in gross receipts, assuming overhead of about 35 percent. At $50 per 15 minutes, eight hours a day, five days a week, 50 weeks a year, I can hit that mark.

The service clock starts when I greet the patient in the reception room and stops when dictation (done in presence of the patient) is complete. "Oh, by the way" patient inquiries restart the original clock. A handful of times over the last three years I've treated patients who have needed referrals for specialty care and whose insurers require that the referral be made by the in-network physician that the patient designated as his or her primary physician. In these cases, I've called that physician and discussed the case with the patient present. This has worked well in each case, enabling me to be compensated for my time and the patient to leave with the assurance that a referral would be generated.

After the visit is complete, the patient pays the fee and is given a charge slip that lists appropriate CPT and ICD-9 codes and the amount paid. Patients are free to submit a claim to their insurance carriers for reimbursement, with the exception of Medicare patients, as noted earlier. About twice a year, a Medicare patient forgets about the terms of our private contract and submits a claim to Medicare. In these cases, I've been able to address the problem simply by supplying the patients with a copy of our signed agreement.

How patients have responded

Patients have responded well to my new practice. When my patients in my previous practice were told that I was no longer with the group, many contacted me to discuss their options. I had already given my cell phone number and e-mail address to all of my patients, so they knew how to reach me. Initially, just 50 of my 3,000 patients followed me to my new practice, but my practice has since grown to 600 charts. Except for a precipitous drop in the number of HMO patients I see, my payer mix hasn't changed that much. About 85 percent of my patients have some type of commercial insurance. Ten percent are Medicare beneficiaries. Five percent have no insurance.

He sees many fewer HMO patients than he did in traditional practice, but otherwise his patient mix hasn't changed much, except that insured patients are submitting their own claims.

I haven't marketed my practice; word-of-mouth referrals are my best source of new patients. When I ask insured patients

why they see me when they could see an in-network physician down the road and perhaps pay less, the most common answers are because our visits aren't rushed and they believe I have their best interests, rather than their insurers' interests, in mind. Another reason patients say they prefer my practice is that I incorporate preventive care with their sick visits, which saves patients the hassle and expense of separate visits for sick and well care.

The lesson from my experience is that the old "cash-at-the-time-of-service" business model is alive and well. It is both professionally and financially rewarding and offers family physicians a viable alternative to the world of third-party reimbursement. FPM

Send comments to **fpmedit@aafp.org.**

PRIVATE CONTRACT WITH MEDICARE BENEFICIARY

This agreement is between Dr. _____ ("Physician"), whose principal place of business is _____

_____, and patient _____ ("Patient"), who

resides at _____ and is a Medicare Part B beneficiary seeking services covered under Medicare Part B pursuant to Section 4507 of the Balanced Budget Act of 1997. Physician has informed Patient that Physician has opted out of the Medicare program effective on _____/_____/_____ for a period of at least two years and is not excluded from participating in Medicare Part B under Sections 1128, 1156, or 1892 or any other section of the Social Security Act.

Physician agrees to provide the following medical services to Patient (the "Services"): Evaluation & Management, Consultation and Professional Component Services.

In exchange for the Services, the Patient agrees to make payments to Physician pursuant to the Fee Schedule: $50/15 minutes (or any portion thereof) of physician time.

Patient also agrees, understands and expressly acknowledges the following:

- Patient agrees not to submit a claim (or to request that Physician submit a claim) to the Medicare program with respect to the Services, even if covered by Medicare Part B.
- Patient is not currently in an emergency or urgent health care situation.
- Patient acknowledges that neither Medicare's fee limitations nor any other Medicare reimbursement regulations apply to charges for the Services.
- Patient acknowledges that MediGap plans will not provide payment or reimbursement for the Services because payment is not made under the Medicare program, and other supplemental insurance plans may likewise deny reimbursement.
- Patient acknowledges that he or she has a right, as a Medicare beneficiary, to obtain Medicare-covered items and services from physicians and practitioners who have not opted out of Medicare, and that the patient is not compelled to enter into private contracts that apply to other Medicare-covered services furnished by other physicians or practitioners who have not opted out.
- Patient agrees to be responsible to make payment in full for the Services and acknowledges that Physician will not submit a Medicare claim for the Services and that no Medicare reimbursement will be provided.
- Patient understands that Medicare payment will not be made for any items or services furnished by the physician that would have otherwise been covered by Medicare if there were no private contract and a proper Medicare claim were submitted.
- Patient acknowledges that a copy of this contract has been made available to him or her.
- Patient agrees to reimburse Physician for any costs and reasonable attorney fees that result from violation of this Agreement by Patient or his beneficiaries.

Executed on _____ [date] by _____ [Patient name]

and _____ [Physician name]

_____ [Patient signature]

_____ [Physician signature]