

Cash practice alternatives: Considerations for physicians

Dealing with patients' health insurers is often complex and frustrating for physicians and their practice staff. Navigating the maze of health insurer contracts and contending with medical payment and other reimbursement rules that differ from health insurer to health insurer demands significant administrative cost and time. After investing in expensive practice management systems and submitting claims to patients' health insurers, physicians and their practice staff find that it can take weeks or even months to receive payment from these health insurers—if they receive payment at all. Health insurers also often change contracted rates with little or no notice, which makes it difficult to audit payments for accuracy. On top of all this, many physicians have been unable to negotiate rates that are adequate to cover increasing practice costs, leaving them with the feeling that maintaining the financial viability of their practices is beyond their control.

Physicians seeking ways to simplify their practices and reduce administrative overhead are evaluating whether limiting their financial dependence on health insurer contracts is a viable option. Many of these physicians are turning to an array of alternatives often referred to as “cash practices.”

What is a cash practice?

A cash practice refers to one or more of the following business practices and models:

- **Time-of-service collections**—minimize patient billing and the risk of not being paid by collecting the patient's financial responsibility (including deductibles, coinsurance and copayments) at the time of service.
- **Fewer health insurer contracts (hybrid model)**—reduce the number of health insurer contracts and continue to see patients in the terminated plans as an out-of-network physician—either collect payment in full from those patients at the time of service or accept assignment of benefits, billing the health insurer and collecting the balance from the patient once the health insurer has paid.
- **No health insurer contracts**—eliminate health insurer contracts altogether (including opting out of Medicare) and continue to see patients in the terminated plans as an out-of-network physician, collecting payment in full at the time of service.
- **Concierge primary care with no health insurer contracts**—implement a concierge (sometimes called “direct” or “retainer”) physician practice in which patients pay a monthly or annual fee that typically covers unlimited telephone and e-mail access to the physician and often a set of services.
- **Concierge primary care with health insurer contracts (mixed model)**—craft a mixed physician practice with selected health insurer contracts (e.g., Medicare participation) alongside concierge patients.

This educational resource is not intended to provide legal advice. Consultation with legal counsel is highly recommended prior to making any decision that may affect your practice.

This educational resource was developed through a cooperative effort between the American Medical Association Practice Management Center and Topline Solutions Inc, a subsidiary of NaviNet.

Understanding cash practice alternatives

Each cash practice alternative has many implications for you, your colleagues and your patients, so weigh each option carefully. In all cases, flexibility and the willingness to redesign some or much of your practice administration is necessary if you want to change the basis on which you are paid.

Time-of-service collections

Without changing your health insurer contracts or making dramatic changes in your practice administration, you can collect most copayments, coinsurance and deductibles from patients at the time of service. This approach avoids the payment delays that result when you wait for the health insurer explanation of benefits (EOB) and bill your patient weeks or even months after his or her appointment.

Implementing time-of-service collections allows you to:

- Receive your payment of the patient's financial responsibility immediately
- Lower administrative costs by eliminating the need to bill patients or pursue collection, except in special circumstances
- Improve patient service by providing cost information in advance or at the time of service
- Quickly identify patients who are reluctant or unable to pay so you can address their situations proactively and professionally and avoid months of billing expense and aggravation

You shouldn't need to make significant changes to your practice in order to collect at the time of service. You can continue to use your practice management system for billing Medicare, health insurers and certain patients who cannot or will not pay their share at the time of service, or for whom you waive the time-of-service payment policy. The number of practice staff you need will probably not change. If you use a billing service, however, this is an opportunity to renegotiate your service contract if the billing service's workload decreases as a result of reduced patient billing and collection follow-up.

Fewer health insurer contracts (hybrid model)

You may find you have more health insurer contracts than you can manage. Some health insurer contracts may represent a very small number of patients, while others may represent many patients but pay below the cost of services provided. Regardless of your mix of contracts, you should periodically assess each health insurer contract and decide whether it is in your best interest to continue as a participating physician.

When you terminate a health insurer contract, your status will change from in-network (participating) to out-of-network (nonparticipating) for patients with coverage from that health insurer. When patients see you as a nonparticipating physician, you may collect your retail fee schedule instead of contracted rates. In most cases, a patient's nonparticipating benefits will entail a higher patient financial responsibility as a result of going out of network. This means you must collect more from patients as a nonparticipating physician than you did when you had a contract with their health insurer.

If you have a hybrid practice—that is, some of your patients see you as a participating physician (including Medicare and Medicaid) and others see you as a nonparticipating physician—you should bill based on a single retail fee schedule for the services you offer. The health insurers you have contracts with will pay you based on the discounted fees you have agreed to accept, and public health insurers will pay based on their fee schedules. You can still offer discounts from your retail fee schedule to patients who see you out of network and pay at the time of service, to patients who have financial hardship, or in other situations that you determine merit a lesser charge. You may publish your discounts, but be sure it's clear that they apply only to defined situations and you accept the lesser amount as a clearly identified discount applied to your standard billed charges. You may also negotiate directly with a patient to address a particular situation.

AMA Practice Management Center resource tip

The American Medical Association (AMA) has developed the educational resource “[Fee schedule analysis: Using your complete practice cost as a guide](#)” to help physicians and their practice staff recognize the need to establish their practice fee schedule based on what it actually costs to provide a service rather than basing their fee schedules on what a third-party payer or other entity wants to pay. This resource includes a 12-step guide to help physician practices create their own unique physician practice fee schedules with an easy-to-complete spreadsheet that will allow physician practices to include additional markup percentages to account for profit, contributions to reserves and future capital expenditures.

As a nonparticipating physician, you can:

- Collect payment directly from the patient at the time of service
- Choose whether to (1) accept assignment of benefits, bill the health insurer and collect the balance from the patient once the health insurer has paid; (2) collect from patients and provide itemized bills for them to submit to their health insurers; or (3) collect from patients and send courtesy bills on their behalf to their health insurers without taking assignment of benefits to save your patients from having to file claims themselves

Paring down your practice's health insurer contracts will not affect your relationship with the health insurers with which you have advantageous contracts. You'll continue to use your practice management system for billing Medicare, health insurers and certain patients who cannot or will not pay their share at the time of service, or for whom you waive the time-of-service payment policy. The number of practice staff you need will probably not change. If you use a billing service, however, this is an opportunity to renegotiate your service contract if the billing service's workload decreases as a result of reduced health insurer and patient billing and reduced collection follow up.

No health insurer contracts

You may find that taking an extreme approach—terminating all of your health insurer contracts and opting out of Medicare—is appropriate for your specialty, community environment and patient mix.

If you choose not to deal with insurance or government programs of any kind, your patients will be entirely self-pay and will choose you because of the services—or level of service—you offer. However, being independent of health insurer rules also means patients will not find you in any health insurer directories. If you are a specialist, you may also lose some, many or all referrals from participating physicians.

AMA Practice Management Center resource tip

In the current health care market, patients are seeking enhanced access to care and top-quality customer service. Offering patients the access and convenience they look for will help keep your practice competitive. Learn more about how you can improve your practice's offerings by reading the educational resource "[10 steps to enhance patient satisfaction in your practice](#)," created by the AMA Practice Management Center in collaboration with the Alameda-Contra Costa Medical Association.

You may find that without health insurer contracts or government program billing, you can greatly reduce overhead costs and establish an ultra-simple practice setting with minimal staff.

Concierge primary care with no health insurer contracts

A concierge physician practice (also known as a "direct" or "retainer" practice) enrolls patients for an annual fee in return for enhanced physician access and, in many cases, a set of services such as an annual comprehensive wellness exam. Concierge physician practices are almost always primary care practices but can also combine primary and specialty care (e.g., a cardiologist who provides the primary care for patients with chronic heart disease). Because you must attract patients who are willing to pay a fee in advance, this model is much easier to implement when you are established in the community and have a loyal patient base.

In a concierge physician practice, you decide what the annual fee will be and how many patients you will accept. Many physicians in this practice model accept between 300 and 700 patients. Once you have enrolled as many patients as you would like, you are not obligated to accept any more. You also decide which services to include under the annual fee, such as a wellness exam, unlimited e-mail and phone access, and laboratory tests you administer yourself.

You may offer other services and charge separately for them. You may also charge for services involving an outside entity, such as a diagnostic facility. Some states have specific regulations that address what a concierge fee can and cannot cover. The AMA encourages you to check your state's laws and regulations. (See the section "[Getting there from here: Transitioning to a concierge physician practice](#)" for more information on outside assistance when planning a concierge physician practice.)

Most concierge patients have health insurance that covers some or all of the services you provide as out-of-network benefits. You may choose to provide these patients with itemized bills to submit to their health insurers or choose to submit bills to the health insurers (as nonparticipating) as a courtesy for your patients.

The size of your practice staff will depend upon the amenities you offer. Because you will not need to bill health insurers or patients beyond the annual patient fee, you will have less back-office staff work, but you may have to increase front-office staff work as you collect payments directly from patients and have an increased need for practice staff to personally answer patient calls. In addition, you may need to increase practice staff attention to (and resources for) making your waiting and exam rooms especially comfortable and aesthetically pleasing; your patients will likely be more sensitive to these elements of their visits due to the premium they pay.

Concierge primary care with health insurer contracts (mixed model)

You may have a concierge physician practice and continue as a participating physician with selected health insurers. Decide which health insurer contracts are worth keeping by taking into account your patient mix and the level of payments under each contract. Because much of the revenue you receive will be within the scope of your concierge arrangements, you can be very selective about the health insurer contracts you retain.

Some health insurers will not contract with concierge physicians. Make sure you examine the contracts you intend to keep for policies on this issue (including amendments that you have received since signing the original contract). You can continue to participate in Medicare so long as your concierge fee is clearly for services not covered by Medicare. A consulting firm or health care attorney with experience in concierge physician practice models can help you avoid trouble with regard to Medicare regulations.

Because you will retain relationships with health insurers with whom you have advantageous contracts, you will continue to use your practice management system for billing those health insurers, Medicare and patients. The number of practice staff you need will probably not change, but their roles may change significantly. If you use a billing service, this is also an opportunity to renegotiate your service contract because the service's workload will decrease as a result of reduced health insurer and patient billing.

Evaluating cash practice alternatives

How will transitioning to a cash practice affect my patients?

In general, patients accept how their physicians operate—few are shopping around for a physician practice that operates in a particular fashion. Many patients may prefer to pay at the time of service instead of being surprised by bills that come several months later, but they are rarely given the opportunity. Therefore, they will want to understand what you charge and what their choices are. Patients with health insurance who have always seen in-network physicians may be unclear on how it is different if their physician is considered out-of-network. Not many patients know about concierge medicine; of those who are aware, few have considered it for themselves.

Regardless of which cash practice model you choose, when you implement one of these alternatives, more of the cost of care will fall on your patients instead of on their health insurers. This cost shift may be because:

- You collect what patients owe at the time of service, which means more patients pay you everything owed.
- With fewer health insurer contracts, you have more patients who pay your retail fee schedule, instead of the patient share of the discounted contracted fee schedule you agreed to with the health insurer.
- Patients pay for additional access and services not covered under the concierge fee.
- Patients pay more for hospital or other referred services that are not covered by their health plans when the referral comes from an out-of-network physician.

Depending on the cash practice model you choose, your practice also may be somewhat or even significantly more expensive for your patients. If patients currently come to your practice only because you are considered in-network, they may leave your practice as a result of the cost. Of course, for most patients, selecting a physician is not based purely on cost. Patients who see you now may stay with you because they trust you and value the care you provide.

You can make the transition to a cash practice easier for your patients with good planning and effective communication. Without these, the transition can be uncomfortable—even painful—for your patients. It is *your* responsibility to be clear and factual in explaining how the new practice model will work so your patients can evaluate whether the change is affordable and worth the additional cost for concierge or out-of-network services. You are entitled to make decisions that are beneficial to you and that you believe will enable you to practice medicine as you see fit. Similarly, your patients will make their own decisions about how your business practices affect their relationships with you.

What about my colleagues?

You practice medicine within a system of physicians, other health care providers and facilities. You refer patients to other physicians and receive referrals yourself. You admit patients to hospitals, render services in various facilities, and send patients for laboratory and radiological tests. Any changes you make in your practice can and will affect other physicians. This educational resource was developed through a cooperative effort between the American Medical Association Practice Management Center and Topline Solutions Inc., a subsidiary of NaviNet.

and facilities with which you share responsibility for care of your patients. If you terminate a health insurer contract, the referral patterns of your colleagues who are participating physicians may have to change, along with your facility relationships. This is because most managed care contracts require contracted physicians to refer only to other contracted physicians, and some managed care contracts reduce hospital and other health facility benefits if the patient is referred by a non-contracted physician.

It is your responsibility to let your colleagues know about your plans to become a cash practice, to terminate some or all of your health insurer contracts, or to implement a concierge model. Not informing colleagues in advance of your transition can backfire, especially when you are terminating a health insurer contract. Your colleagues who remain contracted will need time to establish alternative call and referral arrangements to meet their contractual obligations, and you will want to retain their goodwill and positive recommendation. Proactive communication will be a key to successfully making the changes you desire within the time frame you want.

Which model will work for me and my practice?

No single physician practice model works for every physician. Depending on your specialty, the nature of your practice, the characteristics of your patient mix, whether you have partners, your lifestyle desires, your environment and community, and even your personality, some combination of these cash practice components may or may not be right for you. Regardless of which model you pursue, your financial success and personal satisfaction will depend on your ability to deliver quality medicine and to honor the commitments you've made to your patients.

Are my personality and working style conducive to building a successful cash practice?

As you move away from your reliance on health insurers for most of your income, you'll become increasingly dependent on your patients to pay you at the time of service, on a retainer basis or at your fee schedule (i.e., the patient's out-of-network rates). How can you increase the odds that enough of your patients will stick with you and, in many cases, pay you more than they do now?

Think about other service providers: lawyers, accountants, fitness trainers, tailors. You choose them based on their personalities, work styles and results, punctuality, availability and willingness to solve problems, and how they treat you as a client. These are the same criteria your patients may use to evaluate you and your medical services when they are deciding whether they are willing to pay more for your services. If you are not interested in enhancing these aspects of your practice, you may be better off leaving your health insurer contracts and referral patterns undisturbed.

Is the type of medicine I practice appropriate for a concierge practice in particular?

Most concierge medicine today is centered around the provision of primary care services. The basic concept, virtually unlimited access and a more personal physician-patient relationship, depends on the ability of the patient to receive his or her core medical care from the concierge physician. If you are not a primary care physician but could incorporate primary care for a subset of the general patient population (e.g., patients with heart disease), there may be concierge opportunities for you as well. If primary care is beyond your capability or outside your interests, this physician practice model may not be a good fit for your practice.

Getting there from here: Transitioning towards a cash practice

Time-of-service collections

If you decide to incorporate cash practice principles in your practice by collecting from patients at the time of service but leave your health insurer contracts in place, you will be able to manage the transition with the cooperation of your practice staff and won't need outside assistance. It's best to review your health insurer contracts prior to the switch because a minority of health insurer contracts require the physician to wait until the EOB is received before collecting anything from the patient. Regardless of contract language, you must make a good faith effort to collect the patient's financial responsibility according to your contracted fees and the patient's benefits.

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If you are an office-based physician practice and you want to collect the patient financial responsibility at the time of service, the following are some key components for successfully implementing this change:

1. Develop a written financial policy for patients to read and sign.
2. Deliver clear instructions to your practice staff, informing them that collecting from patients is part of the check-in and check-out process. Make sure that your practice staff communicates with patients about their financial responsibility openly and matter-of-factly.

AMA Practice Management Center resource tip

In the current health care market, patients are seeking enhanced access to care and top-quality customer service. Offering patients the access and convenience they look for will help keep your practice competitive. Learn more about how you can improve your practice's offerings by reading the educational resource "[10 steps to enhance patient satisfaction in your practice](#)," created by the AMA Practice Management Center in collaboration with the Alameda-Contra Costa Medical Association.

Implement a fast and inexpensive way to electronically verify patients' eligibility and benefits in advance or at the time of service. There are a number of portals, clearinghouses and even practice management systems that enable such verification. Take advantage of the HIPAA electronic standard transactions for eligibility verification—verifying this way is less expensive than manual verification and may facilitate instant response. Some practice management systems have the ability to take the list of patients for the following day directly from the appointment scheduling system and submit it to a clearinghouse to check the patients' eligibility overnight. If your system has this feature, you could have an eligibility report for that day's patients waiting for you every morning. If your practice management system does not have this feature, your practice staff can verify your individual patients' eligibility a day or two in advance of their appointments.

AMA Practice Management Center resource tip

Physician practices can save significant administrative time and expense by electronically performing routine functions, such as verifying patient eligibility and contacting the health insurer about the status of a claim. The AMA has developed the educational resource "[Understanding the HIPAA standard transactions: The HIPAA Transactions and Code Set rule](#)" to help physicians more fully understand the HIPAA electronic standard transactions, the HIPAA Transactions and Code Set rule and how this rule impacts the physician practice. This resource explains how physician practices can prepare themselves for using the electronic standard transactions and how physicians can ensure that health insurers with which they are contracted comply with the HIPAA electronic standard transactions. Available to AMA members at www.ama-assn.org/go/pmc, this resource also provides a [survey](#) that physicians can use to determine the extent to which their practice management software and billing vendors comply with the HIPAA Transaction Code Set rule.

3. Ensure your practice staff uses the electronic eligibility response information coupled with practice management system tools to calculate the cost of services according to the patient's health insurance coverage and appropriate copayments, coinsurance and deductibles.
4. Accept the full range of payment methods, including credit cards, debit cards and electronic checks. For expensive procedures, you may want to consider offering third-party credit, which pays you directly by lending to the patient—you may wish to check with your bank for suggestions.

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AMA Practice Management Center resource tip:

One of the best ways to ensure receipt of your patients' payment responsibility is to offer the option of credit and debit card payments. Learn how to maximize the benefits of accepting credit and debit card payments by contracting with a payment processor that suits your practice's specific needs and by recognizing how you may be able to save on fees with your current processor. The AMA Practice Management Center has developed the educational resource "[Shopping for a credit or debit card merchant agreement: Guidelines for physicians](#)" to help you improve your practice's bottom line.

5. Review your contracts to see if any of them prohibit you from collecting co-insurance or deductibles at the time of service. You may wish to consider negotiating an exemption for your practice, especially if you have successfully implemented a time-of-service collection process for patients covered by health insurers that do not impose such a limitation.

Fewer health insurer contracts (hybrid model)

If you are a typical physician practice with a host of health insurer contracts and Medicare participation, you may benefit from obtaining outside help before embarking on more substantial changes. Terminating health insurer contracts can be complicated for a busy physician practice to handle unless you have practice staff who can be dedicated to the task. Due to time constraints, writing letters and notifying health insurers may be more than you and your practice staff can handle, and if you miss a deadline for notifying the health insurer of your intent to terminate, you may inadvertently renew your contract for another year.

There are excellent consultants who are adept at managing these processes and may be worth the expense. They can help you by identifying health insurer contracts that involve only a small number of patients or ones that involve a large number of payments that pay you below the cost to provide services. Your state or county medical association or national medical specialty society may be able to recommend a consultant, or you can access a messenger model organization that, for a membership fee, can help you understand your health insurer contracts, outline the requirements for renewing and terminating them, and monitor timetables for you.

With fewer health insurer contracts and more patients who are seeing you out of network, there are several steps that will help you succeed:

1. Develop a written financial policy for patients to read and sign.
2. Deliver clear instructions to your practice staff, informing them that collecting from patients is part of checking in and out. Make sure that your practice staff communicate with patients about their financial responsibility openly and matter-of-factly.

AMA Practice Management Center resource tip

In the current health care market, patients are seeking enhanced access to care and top-quality customer service. Offering patients the access and convenience they look for will help keep your practice competitive. Learn more about how you can improve your practice's offerings by reading the educational resource "[10 steps to enhance patient satisfaction in your practice](#)," created by the AMA Practice Management Center in collaboration with the Alameda-Contra Costa Medical Association.

3. Post a list of the services you offer and your fee schedule. This can be short and simple. For example, a physician practice that offers primary and urgent care but does not accept insurance may list the following services with prices: new patient house calls and office visits, established patient house calls and office visits, and any after-hour and weekend surcharges. You can discuss your fee for clinical services, such as diagnostic tests or procedures, directly with the patient.
4. If appropriate for your practice, establish a written discount policy applicable to patients who have financial hardship, pay at the point of service or meet other conditions that you determine merit a discount.
5. Implement a fast and inexpensive way to electronically verify patients' eligibility and benefits in advance or at the time of service. There are a number of portals, clearinghouses and even practice management systems that enable such verification. Take advantage of the HIPAA electronic standard transactions for eligibility verification—verifying this way is less expensive than manual verification and may facilitate instant response. Some practice management systems have the ability to take the list of patients for the following day directly from the appointment scheduling system and submit it to a clearinghouse to check the patients' eligibility overnight. If your system has this feature, you could have an eligibility report for that day's patients waiting for you every morning. If your practice management system does not have this feature, your practice staff can verify your individual patients' eligibility a day or two in advance of their appointments.

AMA Practice Management Center resource tip

Physician practices can save significant administrative time and expense by electronically performing routine functions, such as verifying patient eligibility and contacting the health insurer about the status of a claim. The AMA has developed the educational resource “**Understanding the HIPAA standard transactions: The HIPAA Transactions and Code Set rule**” to help physicians more fully understand the HIPAA electronic standard transactions, the HIPAA Transactions and Code Set rule and how this rule impacts the physician practice. This resource explains how physician practices can prepare themselves for using the electronic standard transactions and how physicians can ensure that health insurers with which they are contracted comply with the HIPAA electronic standard transactions. Available to AMA members at www.ama-assn.org/go/pmc, this resource also provides a **survey** that physicians can use to determine the extent to which their practice management software and billing vendors comply with the HIPAA Transaction Code Set rule.

6. Ensure your practice staff uses the electronic eligibility response information coupled with practice management system tools to calculate the cost of services according to the patient's health insurance coverage and appropriate copayments, coinsurance and deductibles. These tools will ensure you charge your fee schedule for out-of-network services and contracted rates for patients who see you as an in-network physician.
7. Accept the full range of payment methods, including credit cards, debit cards and electronic checks. For expensive procedures, you may want to consider offering third-party credit, which pays you directly by lending to the patient—you may wish to check with your bank for suggestions.

AMA Practice Management Center resource tip:

One of the best ways to ensure receipt of your patients' payment responsibility is to offer the option of credit and debit card payments. Learn how to maximize the benefits of accepting credit and debit card payments by contracting with a payment processor that suits your practice's specific needs and by recognizing how you may be able to save on fees with your current processor. The AMA Practice Management Center has developed the educational resource "[Shopping for a credit or debit card merchant agreement: Guidelines for physicians](#)" to help you improve your practice's bottom line.

No health insurer contracts

To make a physician practice without health insurer contracts work, there are a few recommended steps you should follow:

1. Develop a written financial policy for patients to read and sign.
2. If you want to continue to see Medicare patients, create a private contract to be signed by Medicare patients that explains that you have opted out of the Medicare program, that your services are not covered by Medicare and that neither you nor the patient can submit the cost of your services to Medicare for reimbursement. Medicare has specific rules you must follow.
3. Post a list of the services you offer and your fee schedule.
4. Accept the full range of payment methods, including credit cards, debit cards and electronic checks.

AMA Practice Management Center resource tip:

One of the best ways to ensure receipt of your patients' payment responsibility is to offer the option of credit and debit card payments. Learn how to maximize the benefits of accepting credit and debit card payments by contracting with a payment processor that suits your practice's specific needs and by recognizing how you can save on fees with your current processor. The AMA Practice Management Center has developed the educational resource "[Shopping for a credit or debit card merchant agreement: Guidelines for physicians](#)" to help you improve your practice's bottom line.

5. Consider establishing a Web site that includes your practice information (e.g., services available, fees, hours, payment policies) and provides administrative help, such as online appointments, secure e-mail and, if you cannot collect at the time of service, online bill pay. Electronic tools empower your patients, reduce your workload and improve your practice's efficiency. A good Web site may also attract patients willing to go outside their health insurance plan for the care they desire. Hire a professional to make sure you are "searchable" on the Internet.
6. Implement a simple billing and accounts receivable system or other record-keeping program.

Getting there from here: Transitioning to a concierge physician practice

Obtain expert help for transitioning to a concierge practice model

Planning and implementing the transition to a concierge physician practice requires expert help, including assistance in conforming to state laws and regulations regarding what can be covered in the patient's annual retainer fee. If a concierge physician practice is your goal, you have a couple of choices:

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- **Hire a concierge consulting firm.** There are a few nationally known health care consulting firms that specialize in helping physicians understand, configure and implement a concierge physician practice. These firms tailor their services to your specific needs and will act as a partner, working with you for as long as necessary and handling the process so you can continue to practice medicine. The cost is significantly less than the expense of using a concierge franchise.
- **Seek out a concierge franchise.** Franchises use a proven model and usually have internal marketing, legal and support staff. They typically have the manuals, operating guidelines, communication materials and other tools necessary to establish your concierge practice. They are expensive and usually require a multiyear contract, under which a significant percentage of your concierge fees is paid to the franchise company. If you do not want to make a lot of decisions and the cost is worth it for you, look into utilizing a franchise.

In addition to getting the help you need to establish your concierge physician practice, you may also want to join an association that encompasses concierge medicine. An association offers camaraderie and a chance to access to experts of this evolving sector of medicine.

Concierge primary care with no health insurer contracts

Administrative components of a concierge physician practice include the following steps you will need to follow:

1. Develop a written contract for patients to sign, covering what is and is not included within the concierge fee, and a financial policy for patient payments (for example, whether your concierge fee will be due annually or monthly).
2. Create a private contract to be signed by Medicare patients that explains that you have opted out of the Medicare program, that your services are not covered by Medicare, and that neither you nor the patient can submit the cost of your services to Medicare for reimbursement.
3. Post a list of the services you offer and your fee schedule.
4. Accept the full range of payment methods, including credit cards, debit cards and electronic checks.
5. Implement a simple billing and accounts receivable system, or other record-keeping program.

Concierge primary care with health insurer contracts (mixed model)

If you wish to establish a mixed model concierge physician practice, there are a few steps you will need to follow:

1. Develop a written contract (which should cover what is and is not included within the concierge fee) and a written financial policy regarding patient payments for your patients to sign.
2. Deliver clear instructions to your practice staff, informing them that collecting from patients is part of checking in and out. Make sure that your practice staff communicates with patients about their financial responsibility openly and matter-of-factly. Create new job descriptions addressing the changes in your financial relationships with patients, including answering questions about concierge fees and patient reimbursement from their health insurers.
3. Implement a fast and inexpensive way to electronically verify patients' eligibility and benefits in advance or at the time of service. There are a number of portals, clearinghouses and even practice management systems that enable such verification. Take advantage of the HIPAA electronic standard transactions for eligibility verification—verifying this way is less expensive than manual verification and may facilitate instant response. Some practice management systems have the ability to take the list of patients for the following day directly from the appointment scheduling system and submit it to a clearinghouse to check the patients' eligibility overnight. If your system has this feature, you could have an eligibility report for that day's patients waiting for you every morning. If your practice management system does not have this feature, your practice staff can verify your individual patients' eligibility a day or two in advance of their appointments.

4. Ensure your practice staff uses the electronic eligibility response information coupled with practice management system tools to calculate the cost of services according to the patient's health insurer coverage and appropriate copayments, coinsurance and deductibles.
5. Post a list of the services you provide and the fees for patients who are seeing you as an out-of-network physician.
6. Be sure your practice accepts a full range of payment methods, including credit cards, debit cards and electronic checks.

Considering transitioning to a concierge physician practice: Self-assessment guide

Answering the following questions will help you determine whether a concierge physician practice model is right for you.

1. Do you wish you could schedule long appointments and get to know your patients, their lifestyle issues and emotional needs?

Any physician practice changes that result in fewer patients and higher per-patient revenue will afford and require more time per patient. This means less hustle and bustle in your practice, more same- and next-day appointments, and fewer bookings weeks and months into the future. Depending on your personal measures of success, such an alteration can be wonderful or worrisome.

2. Do you guard your personal time, or are you willing to be accessible around the clock? Would you happily give your cell phone number to hundreds of patients, or do you long for uninterrupted weekends and evenings?

The impact of offering more patient access is tricky to evaluate in advance. In a concierge physician practice, you may have to be available to hundreds of patients at any time, but they are patients you know well and see often. Be aware that your current on-call experience is not comparable to the unlimited personal access of a concierge physician practice setting.

3. Are you up to date on primary care medicine? If you are now an office-based specialist, would you want to alter your workday to combine primary care and the specialty or chronic care you now offer?

If you have the desire and skill to assume responsibility for primary care, you can blend a concierge physician practice with a consulting physician practice. If this doesn't sound compelling or satisfying, the risk of making such a change is significant.

AMA policy E-8.055: Ethical guidelines for concierge physician practices

Be clear about the financial terms and do not pressure patients to agree to the arrangement. If you are aware of constraints in a patient's coverage regarding a concierge contract, discuss them with your patient. Patients who wish to opt out should be able to do so without undue hassles or penalties.

Do not promote your retainer-style practice as providing better diagnostic care and therapeutic services. If you have both concierge and non-concierge patients, be especially careful to meet the same diagnostic and therapeutic standards for each. Remember that all patients are entitled to courtesy, respect, dignity, responsiveness and timely attention to their needs.

Continuity of care requirements apply. During the transition to a concierge physician practice, you must make it easy for patients who do not agree to the retainer arrangement to transfer to other physicians. If certain patients are unable to transfer, you may be obligated to continue caring for those patients.

Within your concierge practice, you will still provide services that can be billed to health insurers. It's imperative that you clearly define what is and is not covered under the concierge fee. Regardless of how clearly you make those distinctions, when you do bill health insurers, continue to comply with all relevant laws, rules and contractual requirements.

All physicians have a professional obligation to care for those in need regardless of the ability to pay, especially when the need is urgent. You should continue to seek opportunities to fulfill this obligation.

Keys to effectively evaluating your practice and transitioning to a cash practice

Be honest. Be honest about what you're looking for. Don't make significant changes in your professional life simply because you are unhappy with the status quo. Make sure you're going toward something that you want, not just away from what you do not want.

Get help. Get help if you decide to make a change. If you are going to be nonparticipating with health insurers, a consultant can make sure you meet your deadlines and obligations, and avoid the collegial and health insurer debacles that often result from a haphazard process.

Communicate. Talk over your plans with colleagues and patients. Dropping health insurer contracts without letting other physicians know of your new status can cause all types of problems for them and their patients. When you change your practice model, you are also forcing changes on your patients, so let them know exactly what you are doing and why. Encourage their questions and answer them.

Find tools. Carefully evaluate your practice management system and other tools that can simplify your practice. An arrangement without practice staff, computer systems and overhead could turn out to be more trouble than it is worth. Collecting from patients at the time of service when you have multiple health insurer contracts can be difficult in a busy physician practice without calculation and collection tools.

Be patient. Your practice will not change overnight. You may find you personally need time to adjust to a new way of running your business. If you have done your homework and made the right decision for *you*, it is worth enduring the surprises and difficulties in order to have the professional life you deserve.

Questions or concerns about practice management issues?

AMA members and their practice staff can e-mail the AMA Practice Management Center at practicemanagementcenter@ama-assn.org for assistance.

For additional information and resources, there are three easy ways to contact the AMA Practice Management Center:

- Call **(800) 262-3211** and ask for the AMA Practice Management Center.
- Fax information to **(312) 464-5541**.
- Visit www.ama-assn.org/go/pmc to access the AMA Practice Management Center Web site.

The AMA Practice Management Center is a resource of the AMA Private Sector Advocacy unit.