Direct Pay/Concierge/Blended Care: Where Is the Sweet Spot?

Part I: Practice and Physician Considerations

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Physicians are actively considering the direct pay and concierge models as a plausible option in providing more patient-oriented care. What are the major considerations and how do we attain accurate data that may help in sophisticated decision-making? Part I of this article provides an introduction of the models, typical patient contract configurations, and physician/provider and commercial payer considerations. Part II will discuss the access, cost, and value from a patient's point of view; patient loyalty and self-care; approaches for inviting patients and other providers; and community relations.

KEY WORDS: Private medicine; membership medicine; concierge healthcare; cash only practice; direct care; direct primary care; direct practice medicine; boutique medicine; immediate care; convenient care.

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This article is the first of two parts.

As more citizens choose high-deductible policies and insurers tighten up on provider fee schedules, concierge and direct pay are options worth considering from both the practice's and patients' points of view.

This two-part article introduces and reviews different concierge and direct-pay models, approaches to care, and most important considerations, including how to weigh the delicate balance of this heightened personalized level of care while reducing the size of your patient base.

As a traditional practice transitions to concierge or direct pay, the provider will need to know how to best introduce prospective patients to the new practice setting and encourage them to join. From the patients' point of view, it is necessary to be shown the benefits of access, cost, and value from this kind of offering. To complete the circle of care, we will need to recreate connection paths with other providers to remain involved for a team approach.

As we cover care from both perspectives, the following information should be able to help in decision-making for your specific specialty and patient base.

INTRODUCTION OF MODELS

All models offer personalized care and increased access to the physician, often with focused wellness examinations.

The concierge model arose in the 1990s. This model was first created for wealthy patients who could afford to pay to avoid the traditional office visit. The target population is high-end and insured.

The direct-pay model involves no insurance participation. These practices have total transparency with pricing and tend to have posted prices. Procedures and policies are straightforward, contributing to a collection rate greater than 93%! Interestingly, 70% of patients are insured individuals who want ready access to a provider.

It can be challenging to practice both concierge and "traditional" medicine in the same office setting.

In the blended model, the patient chooses his or her preferred approach of care within each practice. For example, some might choose a blend of concierge medicine and traditional insurance. Some physicians in the practice may participate in a concierge model, whereas others in the same practice follow the traditional fee-for-service model. With this model you can derive revenue from two streams—insurance and personal patient payments. However, it may defeat the purpose of simplifying office processes, as it will still be necessary to manage the layers of compliance and federally mandated regulations from

Medicare and commercial payers. In addition, it can be challenging to practice both concierge and "traditional" medicine in the same office setting, because concierge patients will expect to receive preferential access. Starting with a blended structure can be a benefit, however, as you have an already established patient base if or when you decide to transition to a direct pay practice.

A BRIEF TIMELINE OF CONCIERGE MEDICINE[1]

1996

- Drs. Howard Maron and Scott Hall established MD2 (pronounced "MD squared") in Washington and Oregon. The annual fee ranged from $13,200 to $20,000 per family.
- As the team physician for the national Basketball Association's Seattle Supersonics, Maron wanted to offer patients the same access to healthcare as was available to professional athletes.

2000

- The Virginia Mason Medical Center in Seattle began operating concierge medical services within its own facilities and used a portion of the profits from the practice to subsidize other programs and indigent care services.
- MDVIP was founded by Dr. Robert Colton and Bernard Kaminetsky, in Boca Raton, Florida. This concierge medicine practice and management company has established more than 700 concierge medical practices nationally.

2001 to 2002

- The American Medical Association (AMA) writes concierge physician guidelines: *Principles of Medical Ethics.*
- The ABIM Foundation (established by the American Board of Internal Medicine) and the European Federation of Internal Medicine define ethical principles and responsibilities governing contracts between the patient and physician, recommending that both parties be equal in mutual interest and autonomy.
- The Centers for Medicare & Medicaid Services outlines its position on concierge care, stating that physicians may enter into retainer agreements with their patients as long as these agreements do not violate any established Medicare requirements.
- Pinnacle Care establishes patient care with a one-time access fee for VIP service.
- The AMA counsel on medical services issues a report on special physician–patient contracts that concluded retainer medicine was a smaller, atypical model of care.

2003

- Dr. John Blanchard founds the American Society of Concierge Physicians, which later changed its name to the Society for Innovative Practice Design.
- The AMA issues guidelines for boutique practices in June 2003.
- The Department of Health and Human Services rules that concierge medical practices are not illegal, and the federal government (i.e., the Office of Inspector General) takes a hands-off approach.

2004 to 2006

- The American Osteopathic Association decides not to recommend an official policy on concierge care.
- MDVIP reports that 130 doctors within its network treat up to 40,000 patients worldwide (equivalent to a patient panel average of 307).

2007 to 2010

- *Concierge Medicine Today,* a concierge medical news agency, opens its doors to be an advocate for news pertaining to the concierge medicine, retainer-based, boutique, private-medicine and direct-care industry.
- The term "direct practice" is first used in legislation passed in Washington in 2007 that clarified that these practices were not insurance companies under state law, but did provide basic, preventive medical care.
- Concierge Physician of Orange County, California, a nonprofit group of existing concierge physicians, is founded with an estimated 35 concierge practices.
- Procter & Gamble purchases MDVIP in 2009.
- By 2010, most subscriptions/programs cost less than $135 per patient per month.

2012 to 2014

- MDVIP's personalized healthcare model declares a dramatic reduction in hospitalizations and over $300 million savings recognized for MDVIP's model. Of the physicians who apply to MDVIP, 12% are accepted.
- Family physicians and patients embrace direct-pay care.
- The American Academy of Family Physicians recognizes benefits and creates a Direct Pay Care policy.
- In 2014, Procter & Gamble announces the sale of MDVIP to a private firm, Summit Partners.

Today

According to *Concierge Medicine Today,* in January of 2015:

- There are approximately 12,000 concierge and direct-pay physicians in the United States.

Resources for Concierge Models

- State medical societies
- California Medical Group Management Association (CAMGMA): www.camgma.com
- California Medical Association: www.cmanet.org
- Medical Group Management Association (MGMA): http://mgma.com
- Sykes C, Tetreault M. *Direct Primary Care Consumer Guide, 2015 Edition: Closing The Gap Between Your Doctor, Your Health & Your Wallet.* Kindle edition.
- Direct Primary Care Coalition: www.dpcare.org
- *Concierge Medicine Today:* http://conciergemedicinetoday.org
- American Academy of Private Physicians: www.aapp.org
- Ideal Medical Practices: http://impcenter.org

- Over 80% of these physicians accept insurance within their practices; the remaining 20% have cash-only menu-style practices.
- Most membership medicine practices require patients to pay a fee upon each visit and have a lower monthly retainer fee (e.g., $135 per month).
- The typical direct-pay patient is between 40 and 59 years of age.
- Most of these practices tend to see 6 to 10 patients per day. Blended practices usually see more patients per day.
- Female physicians fill up their concierge practices 30% faster than men.
- Fifty-eight percent of membership medicine practices have one or two employees.

SPECIALTIES

The top specialties found in concierge medicine are primary care, family medicine, cardiology, pediatrics, and some ophthalmology. The most prevalent specialty is primary care, as it requires the least amount of equipment and does not need a hospital surgery suite.

A subspecialist may first need to initiate a hybrid concierge approach in which the practice continues to participate with insurances along with providing additional noncovered services for which a fee is charged.

The number one complaint from patients in traditional practices is "not having enough time with their providers." They want to feel 100% heard and cared for.

FEE SCHEDULES

The most typical patient contract configuration formulas in concierge care offer annual global fee or reduced fee-for-service models.

There is now, and surely will be in the future, a wide array of choices. Most formulas from which fees and annual fees are derived include a direct-pay reduced fee for service, either independently or along with a "subscription/retainer" fee. An enrollment fee is not uncommon, ranging from $40 to $100. As noted before, annual fees have come down in the last few years, as physicians design their plans according to their specific patient base and specialty.

The following criteria help determine your scheduling availability and fee structure: wellness benefits, patient age, number of included visits, and characteristics of your population.

The following examples illustrate various fee schedules:

- **HealthAccessRI:** Rhode Island is building a physician network in a subscription-based primary care system. The fee is $35 per month, with an initial enrollment fee of $80. An office visit costs $10.
- **Access Healthcare Apex, North Carolina:** Brian Forrest started out charging $25 per month and only $5 for a visit. This covered the bills as he started and created a threshold of a "break-in analysis" from which to grow.
- **Tufts University:** Tufts created a concierge practice known as the Pratt Diagnostic Center near Beacon Hill in Boston, Massachusetts, that charges patients an annual fee of $2000 per year. This helps offset the care that Tufts provides for the noninsured through its department of medicine.[2]
- **MedLion Clinics:** Dr. Samir Qamar wanted to offer an alternative to his concierge practice in Pebble Beach, California, where patients paid a retainer fee of $30,000.[3] He established MedLion Clinics, which has 16 locations in five states. The clinics charge a retainer fee of $59 a month and $10 per office visit and do not bill insurance.
- **Dr. Garrison Bliss, Seattle, Washington:** The monthly fee is based on age, ranging from $39 to $79 per month.[4] This can help fit with a possible limited service for Medicare patients, as they may need to pay more out of pocket for specialist care.

PHYSICIAN/PROVIDER CONSIDERATIONS

Why Am I Here?

Physicians often wonder, "Am I here to care for patients, or to fill out paperwork and meet compliance requirements?" The concierge and direct pay approach is proactive and attentive to individual needs—by *all* parties. From the patient's point of view, one can easily embrace this as a personal investment in one's self.

Are You Ready? Is It the Right Path?

- Do your patients insist on easy access and same-day office visits or other ancillary services?
- How many Medicare patients do you care for now?
- Would you be willing to opt out of Medicare?

Medicare Opt-Out Affidavit: J11 Part B

I, _____ , being duly sworn, depose and say:

(First, Middle Initial, Last Name)

- Opt-out is for a period of two years. At the end of the two year period, if I wish to remain opt-out, I will complete a new affidavit that is submitted to the carrier, as well as issuing new contracts with my patients.
- Except for emergency or urgent care services (as specified in the Medicare Benefit Policy Manual Publication 100-02, Chapter 15 §40.28), during the opt out period I will provide services to Medicare beneficiaries only through private contracts that meet the criteria of §40.8 for services that, but for their provision under a private contract, would have been Medicare-covered services.
- I will not submit a claim to Medicare for any service furnished to a Medicare beneficiary during the opt-out period, nor will I permit any entity acting on my behalf to submit a claim to Medicare for services furnished to a Medicare beneficiary, except as specified in §40.28.
- During the opt-out period, I understand that I may receive no direct or indirect Medicare payment for services that I furnish to Medicare beneficiaries with whom I have privately contracted, whether as an individual, an employee of an organization, a partner in a partnership, under a reassignment of benefits, or as payment for a service furnished to a Medicare beneficiary under a Medicare Advantage.
- I acknowledge that during the opt-out period, my services are not covered under Medicare and that no Medicare payment may be made to any entity for my services, directly or on a capitated basis.
- I acknowledge and agree to be bound by the terms of both the affidavit and the private contracts that I have entered into during the opt-out period.
- I acknowledge and understand that the terms of the affidavit apply to all Medicare-covered items and services furnished to Medicare beneficiaries by myself during the opt-out period (except for emergency or urgent care services furnished to the beneficiaries with whom I have not previously privately contracted) without regard to any payment arrangements I may make.
- I acknowledge that if I have signed a Part B participation agreement, that such agreement terminates on the effective date of this affidavit.
- I acknowledge and understand that a beneficiary who has not entered into a private contract and who requires emergency or urgent care services may not be asked to enter into a private contract with respect to receiving such services and that the rules of §40.28 apply if I furnish such services.
- I have identified myself sufficiently so that the carrier can ensure that no payment is made to me during the opt out period. If I have already enrolled in Medicare, I have included my Medicare PTAN, if one has been assigned. If I have not enrolled in Medicare, I have included the information necessary to opt-out.
- I will file this affidavit with all carriers who have jurisdiction over claims that I would otherwise file with Medicare and be filed no later than 10 days after the first private contract to which the affidavit applies is entered into.

_____ Date _____

Physician Signature

The following information is necessary to complete your Opt-Out request, please provide all applicable information.

Physician Address: Address _____ Telephone Number _____

City _____ State _____ Zip Code _____ Specialty _____

NPI _____ PTAN (if applicable) _____

Social Security Number _____ Date of Birth _____

School Information _____ Year of Graduation _____

E-mail Address _____ Also, please provide a copy of applicable licensure.

Figure 1. Medicare Opt-Out form.

- Are you comfortable with utilization of cutting-edge technology such as HIPAA-compliant communication venues and telemedicine?
- How loyal are your patients? Will they follow you for a modest (or not so modest) fee?

A Lifestyle Choice

Imagine a new family doctor, aware of the of primary care shortage and wanting to see all the patients he or she can, still willing to sign on with an insurance company as a participating provider that reimburses less than financially

2. I promise that, for a period of two years beginning on the date that this affidavit is signed, I will be bound by the terms of both this affidavit and the private contracts that I enter into pursuant to this affidavit.

3. I herby confirm that, except for emergency or urgent care services (as specified in 3044.28), during the opt out period I will provide services to Medicare beneficiaries only through private contracts that meet the criteria of 3044.8 for services that, but for their provision under a private contract, would have been Medicare-covered services.

4. I hereby confirm that I will not submit a claim to Medicare for any service furnished to a Medicare beneficiary during the opt out period, nor will I permit any entity acting on my behalf to submit a claim to Medicare for services furnished to a Medicare Beneficiary, except as specified in 3044.28.

5. I hereby confirm that, during the opt out period, I understand that I may receive no direct or indirect Medicare payment for services that I furnish to Medicare beneficiaries with whom I have privately contracted, whether as an individual, an employee of an organization, 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.

Figure 2. A section of a sample physician-patient contract.

supportive levels. Then the insurance company denies provider participation because its "panel is full." Why wouldn't a primary care provider at least consider being 100% independent of insurance participation?

Of course this is an option!

Need a Few More Concerns to Ponder? Try These:

- Burnout;
- The cost of compliance versus simplification of processes; and
- Family.

Support Staff Redefined

It is speculated that eliminating insurance billing and participation cuts 40% of the practice's overhead expenses, enabling them to keep the fees low.

Medicare

Medicare does not cover membership fees for concierge care. Doctors who provide concierge care must still follow all Medicare rules, however[5]:

- Are you contracted with Medicare as a participating provider and accepting assignment? You cannot charge extra for Medicare-covered services. This means that the membership fee cannot include additional charges for items or services that Medicare already covers.
- If you know that Medicare will not cover this service, a written notice known as the Advance Beneficiary Notice of Noncoverage, must be presented to the patient before he or she accepts the service or coverage in question.
- Doctors who do not accept assignment can charge the Medicare-approved amount for Medicare-covered services with a 15% limit, called a *limiting charge*.
- All Medicare doctors (regardless of whether or not they accept assignment) can charge for items and services that Medicare does not cover.
- Doctors also can "opt out" with Medicare. There is a form to be completed, and a contract must be signed with each patient, notifying them that you will not be filing Medicare claims (Figures 1 and 2).

Starting in 2019, the proposal increases Medicare premiums for high-income beneficiaries and adds new charges for new enrollees. The charges for new enrollees include a home health copayment, changes to part B deductible, and a premium surcharge for seniors who have also purchased a supplementary insurance whose generous benefits are seen as encouraging overuse of Medicare services.

The Affordable Care Act enables the direct-pay care model to be offered on health exchanges *as long as* it is packaged with wraparound policies to cover catastrophic another medical costs.

AND MORE TO BE CONSIDERED?

As doctors opt out of Medicare, Medicaid, and other government programs, there will be a severe shortage of physicians. Therefore, it is speculated that *any* physician will have to see some of those patients in order to maintain his or her medical license.

On examining the health spending and the income growth track of GDP and national health expenditures from 2004 to 2019, it becomes probable that the increase in

income growth does not meet the increase in anticipated healthcare expenditures. Major purchasers of healthcare, including the federal government and large employers, are trying to reign in the increasing costs of insurance premiums. Thus a greater percentage of healthcare expenditures (up to 50%) is becoming the patient's responsibility—and this is *with* coverage!

COMMERCIAL PAYERS: DIRECT PAY AND TELEMEDICINE?

Payers

Concierge models or "cash" practices may or may not be directly addressed within your contract, depending on the age of the agreement and your geographical location. Although some payers clearly state they will not have a relationship with some concierge models, some insurances will actually have a separate contract with the practice if only certain providers are offering concierge care.

Telemedicine

Medicare will be reimbursing physicians for chronic care management, including ACO "Next Generation" rules approving audio/video for patients in rural areas.

Commercial insurers in 22 states are now covering telehealth and mobile health services.[2]

In 2014, the World Market for Telehealth predicted that "the number of patients using telehealth services will rise from fewer than 350,000 people in 2013 to 7 million in 2018. Furthermore, revenue for telehealth devices and services is expected to reach $4.5 billion, up from $440.6 million in 2013."[6] It will behoove those who want to be part of this trend to be up-to-date with national compliance and regulations, especially if yours is a multistate practice.

REFERENCES

1. Tetreault M. The history of concierge medicine in America. *CMT/DPC Journal.* October 4, 2013. Updated March 16, 2015; www.linkedin.com/pulse/history-concierge-medicine-america-1996-present-day-michael-tetreault. Accessed April 13, 2015.
2. Huff C. New practice model evolves: 'direct care.' *ACP Internist.* January 2015; www.acpinternist.org/archives/2015/01/practice.htm. Accessed April 13, 2015.
3. Wysocki A. 'Concierge doctor' latest perk for the wealthy. December 27, 2013; www.tytnetwork.com/2013/12/27/concierge-doctor-latest-perk-wealthy/.
4. Concierge medicine myths and realities. *Concierge Medicine Today.* October 4, 2013; http://conciergemedicinetoday.org/2013/10/04/concierge-medicine-myths-realities/. Accessed April 13, 2015.
5. Concierge care. www.medicare.gov/coverage/concierge-care.html. Accessed April 13, 2015.
6. Palmer C. Three key ideas for getting started with tele health. EPsych Blog. August 22, 2014; http://blog.epsychtoday.com/latest-news.html/three-key-ideas-for-getting-started-in-telemedicine. Accessed April 13, 2015.