

PRIVATE MEDICINE TRANSITION CONSIDERATIONS—A PRIVATE MEDICINE PRIMER

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Prior Talks/Presentations

- AAPP
 - (Private Medicine Compliance Talks/2009-present)
- MYCA/HelloHealth
 - Internal Corporate Webinar On Patient EHR Funding Options, 2010
- San Diego County Bar Association
 - Physician/Attorney Committee Concierge Medicine Panel Presentation, 2011
- LawReviewCLE
 - EHR Implementation and Risk Management, San Diego, 2011
 - National Webinar On EHR Liability Issues, Sarasota, FL 2012

WHAT IS “CONCIERGE” OR “PRIVATE” MEDICINE?

- “Concierge” or “boutique” or “private” or “retainer” or “subscription” medicine
- Wikipedia’s definition: “**Concierge medicine** (also known as **direct care**) is a relationship between a patient and a [primary care physician](#) in which the patient pays an annual fee or retainer. This may or may not be in addition to other charges. In exchange for the retainer, doctors provide enhanced care. Other terms in use include **boutique medicine**, **retainer-based medicine**, and **innovative medical practice design**. The practice is also referred to as membership medicine, concierge health care, cash only practice, direct care, direct primary care, and direct practice medicine. While all concierge medicine practices share similarities, they vary widely in their structure, payment requirements, and form of operation. In particular, they differ in the level of service provided and the amount of the fee charged. Estimates of U.S. doctors practicing concierge medicine range from fewer than 800[1] to 5,000.[2]”
[Citations omitted]
- Primary care physicians (internists, family practitioners, more lately cardiologists) agree to, in exchange for a privately paid monthly or annual fee or retainer that varies between \$200-\$3k/year (some pay upwards from \$5k-\$100k/year) provide extraordinary primary care benefits
- What are the typical private medicine subscription benefits? (There is much variation)
 - 24/7 access to the physician via telephone/text/email/mobile
 - Home visits/house calls
 - Immediate appointments
 - Coordination with other specialists
 - Unhurried lengthy physician visits
 - Not constrained by insurance/Medicare guidelines or reimbursements

AN ABBREVIATED PARTIAL HISTORY OF “PRIVATE” OR “CONCIERGE’ MEDICINE

- **1996:** Howard Maron, M.D. and Scott Hall, M.D. start MD2 (\$1000 per member per month, currently in five cities)
- **1997:** Garrison Bliss, M.D. and Mitch Karton, M.D. convert Seattle Medical Associates into a monthly fee practice (\$65/month)
- **1997:** Vern Cherewatenko, M.D. and David MacDonald, D.O. start SimpleCare
- **2000:** MDVIP opens their 1st clinic in Boca Raton Florida. Founded by Dr. Robert Colton and Bernard Kaminetsky. Currently 376 physicians and 120,000 patients. Purchased in 2009 by Proctor and Gamble for an undisclosed amount. \$1800/yr plus insurance.
- **2000:** Lewis and John Dare Center at Virginia Mason form the first hospital-based monthly fee practice. John Kirkpatrick MD was their 1st physician. \$3000/yr plus insurance.
- **2004/2005:** San Diego’s Scripps Clinic opens a Private Internal Medicine Center (PIMC) that mirrored the Virginia Mason model (currently 5 physicians, \$3,000/yr plus insurance).
- **2007:** Qliance opens after law is changed in Washington (state) to allow monthly fee practices to be non-insurance entities. First scalable monthly fee practice for mass consumption. Also: One Medical Group, Med Lion: very low annual fee primary care platforms.
- **2010:** Qliance reportedly seeking modification to Knox-Keane Act in California to enable monthly subscription primary medical care without meeting California insurance definition/requirements. Other California models like One Medical Group and Med Lion disclaim they are insurance, collect modest annual fees.

PRIVATE MEDICINE LEGAL ISSUES AND HISTORICAL BACKGROUND

- **2002:** California representative Henry Waxman takes on MDVIP – DHS’s Tommy Thompson issues a reprieve:

Are physicians are charging for services that overlap with Medicare reimbursed services?

"Insofar as the retainer fee under such an agreement is truly for non-covered services, such fees would not appear to be in violation of Medicare law."

Are physicians holding their patients hostage by forcing them to pay an access fee in order to receive Medicare benefits?

". . . physicians have some discretion regarding patients they choose to accept."

- **2002:** Centers for Medicare and Medicaid, CMS, outlined its position on concierge care in a March 2002 memorandum that states that physicians may enter into retainer agreements with their patients as long as these agreements do not violate Medicare law.
- **2003:** AMA issued guidelines for “boutique” practices in June 2003.
- **2003:** Department of Health and Human Services rules the concierge medical practices are not illegal.
- **2003:** Washington State Office of the Insurance Commissioner issues two “Technical Advisories” regarding monthly fee practices

GAO REPORT SURVEYS

CONCIERGE MEDICINE

- The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 directed GAO to study concierge care and its relationship to Medicare. GAO identified 146 concierge physicians and surveyed concierge physicians in fall 2004. GAO analyzed responses from 112 concierge physicians.
- Concierge care practiced by small number of physicians located mainly on the East and West Coasts. Nearly all of the 112 concierge physicians responding to GAO survey reported practicing primary care. Annual patient membership fees ranged from \$60 to \$15,000 a year, with about half of respondents reporting fees of \$1,500 to \$1,999 per year.
- The small number of concierge physicians makes it unlikely that the approach has contributed to widespread access problems. GAO's review "... suggests that concierge care does not present a systemic access problem among Medicare beneficiaries at this time...." DHS agreed with GAO's finding on concierge care impact on beneficiary access to physician services and indicated it will continue to "follow developments in this area."

Physicians see chance for riches in concierge medicine, but few follow through

Despite more doctors signing on, boutique practices remain a small part of the health care system.

By VICTORIA STAGG ELLIOTT, amednews staff. Posted Jan. 2, 2012.

- *A survey of 501 doctors released Dec. 13, 2011, by the Deloitte Center for Health Solutions found that 64% believe the concierge medicine practice, also called a retainer or boutique practice, that does not take insurance had the greatest chance of financial success in the age of health system reform.*
- <http://www.ama-assn.org/amednews/2012/01/02/bisb0102.htm>

Private Medicine Is Now—Patients Already Are Paying Out-Of-Pocket



- *65 year old couple is estimated to need \$240,000 to pay for medical costs throughout retirement*
- http://money.usnews.com/money/blogs/planning-to-retire/2012/05/10/fidelity-couples-need-240000-for-retirement-health-costs_print.html

The PCP: Under Pressure

In frustration, a Summit County physician hangs up his stethoscope

Guest Commentary

by Marc Shiffman, M.D.

Why is Dr. Shiffman hanging up his stethoscope?

- Practice expenses and complexities have increased
- Insurance companies choose profit over quality health care
- Low Medicare reimbursement rates means less revenue
- ACOs seem like the sole option, but ACOs do not serve rural or mountain communities
- <http://www.summitdaily.com/article/20120507/COLUMNS/120509885/1078&ParentProfile=1055>

Physicians See Private Medicine Opportunities

Practice setting	Primary care physician	Surgical specialist	Nonsurgical specialist
Administrative role in large health care delivery system	73%	69%	69%
Concierge medicine practice that does not take insurance	64%	66%	64%
Large system that owns health plan, hospitals and medical practices	60%	58%	61%
Large multispecialty group contracting with multiple plans and hospitals	65%	58%	69%
Large single-specialty group contracting with multiple plans and hospitals	60%	58%	74%
Large system that owns hospitals and practices and contracts with multiple plans	59%	54%	53%
Small single-specialty group contracting with multiple plans and hospitals	39%	25%	49%
Employee working for a health insurance company offshore	39%	31%	34%
Employee in employer-sponsored clinic where care is provided to employees	24%	16%	18%
Academic center where doctor can teach, research and treat patients in hospital or as outpatients	28%	21%	26%
Employee in retail setting as part of large retailer's health services	22%	17%	22%

Source: "Physician perspectives about health care reform and the future of the medical profession," Deloitte Center for Health Solutions, Dec. 13, 2011 (www.deloitte.com/assets/Dcom-United States/Local Assets/Documents/us_lshc_PhysicianPerspectives_121211.pdf)

Researchers polled a random sample of 501 physicians about what they believed would be the most financially successful practice setting in the age of health system reform. Physicians' responses organized by specialty.

After taking an administrative job in a large health care system, polled physicians identified "concierge or private medicine that does not take insurance" as the most likely opportunity.

"My choice for the economics book of the year . . ."

—David Leonhardt, *New York Times*

Overtreated

WHY TOO MUCH MEDICINE
IS MAKING US
SICKER AND POORER



UPDATED
WITH A NEW
PATIENT'S
GUIDE

SHANNON BROWNLEE

- *Though we can't articulate it, sometimes what we really need is not a doctor who delivers more care but one who seems to care more and has the time to make sure we understand what we need in order to be well.*
- Brownlee, Shannon, *Overtreated: Why Too Much Medicine Is Making Us Sicker And Poorer*, 2007, Bloomsbury USA, NY

Patient: Doctor, I don't feel well and I'm not sure why.



Doctor: I want you to meditate for 20 minutes, twice a day, exercise for at least 30 minutes a day, avoid processed foods, eat plenty of organic fruit and veg, spend more time in nature and less indoors, stop worrying about things you can't control and ditch your T.V. Come back in 3 weeks.



Primary Care, Everywhere:
Connecting the Dots Across the
Emerging Health Landscape

November 2011

- Fewer than 30% of physician practices in the United States have arrangements for patients to see doctors or nurses after hours, the lowest rank among 10 other industrialized countries.

➤ <http://www.chcf.org/~media/MEDIA%20LIBRARY%20Files/PDF/P/PDF%20PrimaryCareEverywhere.pdf>

October 2010 summary update of US private/concierge medical practice characteristics

Retainer-Based Physicians: Characteristics, Impact, and Policy Considerations

Elizabeth Hargrave
Ayesha Mahmud
Kate Quirk
NORC

Laura Summer
Jack Hoadley
Georgetown University

MedPAC
601 New Jersey Avenue, NW
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Washington, DC 20001
(202) 220-3700
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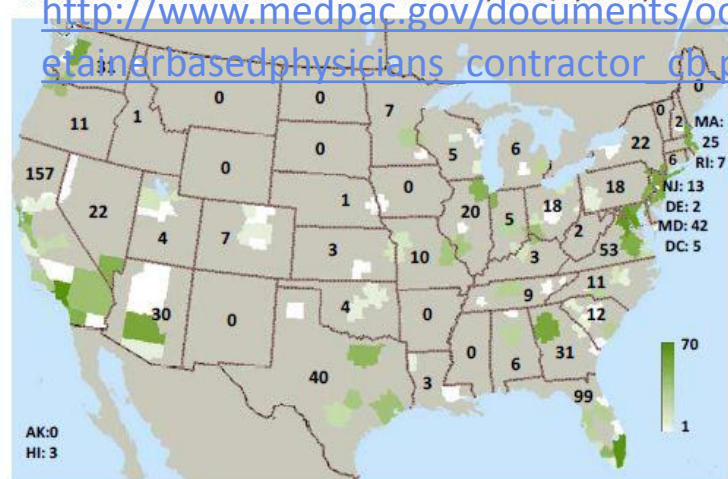
The views expressed in this report
are those of the authors.

No endorsement by MedPAC
is intended or should be inferred.

A study conducted by staff from NORC at the University of Chicago and Georgetown University for the Medicare Payment Advisory Commission

October 2010 • No. 10-9

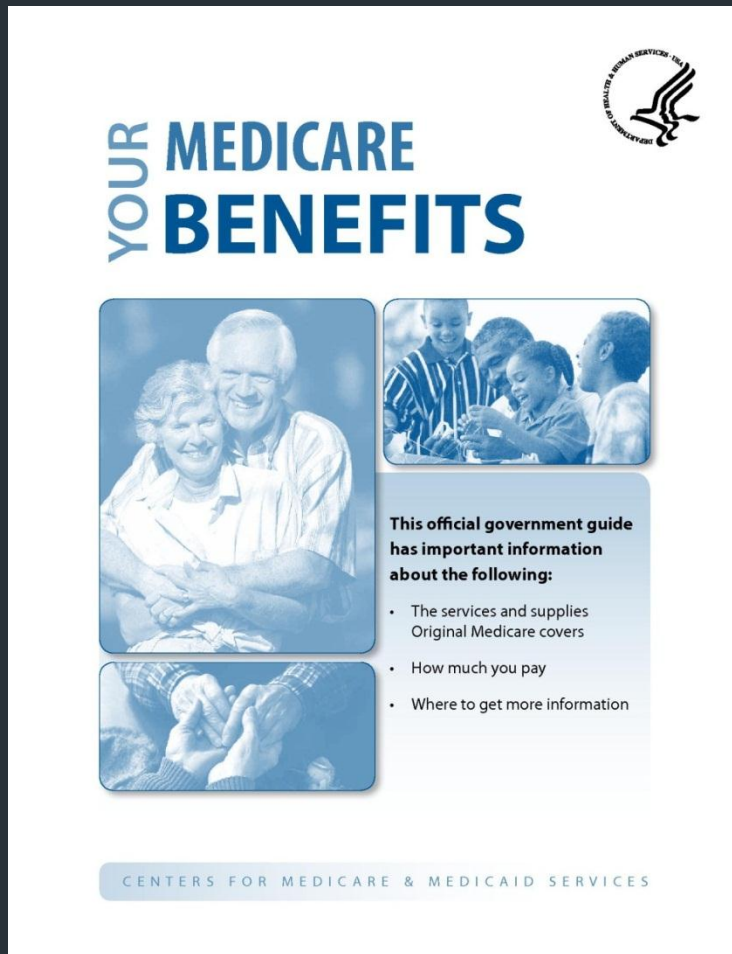
Exhibit 1. Distribution of Identified Retainer-Based Physicians, By Metropolitan Area



Source: Analysis of information for 756 retainer-based physicians identified by NORC in October 2009.

http://www.medpac.gov/documents/oct10_retainerbasedphysicians_contractor_cb.pdf

MEDICARE COMPLIANCE



YOUR MEDICARE BENEFITS

This official government guide has important information about the following:

- The services and supplies Original Medicare covers
- How much you pay
- Where to get more information

CENTERS FOR MEDICARE & MEDICAID SERVICES

- Step One: Understanding Medicare Coverage
 - <http://www.medicare.gov/publications/pubs/pdf/10116.pdf>
 - Once you understand what Medicare covers, you can start the process of allocating private medicine fees to services/amenities not covered by Medicare.

MEDICARE NONREIMBURSABLE

- Telephone evaluation & management
- Online evaluation and management service
- Preventive medicine counseling and/or risk factor reduction intervention
- Management of Home Care professionals
- Analysis of clinical data stored in computers
- Unusual travel
- Administration and interpretation of health risk assessment instrument
- After hours availability
- Family history (genetic susceptibility to other disease/history of other cardiovascular diseases /sudden cardiac death)

OIG ALERT – MARCH 31, 2004



For Immediate Release
March 31, 2004

OIG ALERT

Office of Inspector General
330 Independence Ave., SW
Washington, D. C. 20201
Phone: (202) 619-1343

OIG ALERTS PHYSICIANS ABOUT ADDED CHARGES FOR COVERED SERVICES

Extra Contractual Charges Beyond Medicare's Deductible, Coinsurance: A Potential Assignment Violation

Acting Principal Deputy IG Dara Corrigan today reminds Medicare participating physicians of the potential liabilities posed by billing Medicare patients for services that are already covered by Medicare.

Medicare participating providers can charge Medicare beneficiaries extra for items and services that are not covered by Medicare.

Participating providers may also, of course, charge beneficiaries for any Medicare deductibles and coinsurance without violating the terms of their assignment agreements. But when participating providers request any other payment for covered services from Medicare patients they are liable for substantial penalties and exclusion from Medicare and other Federal health care programs.

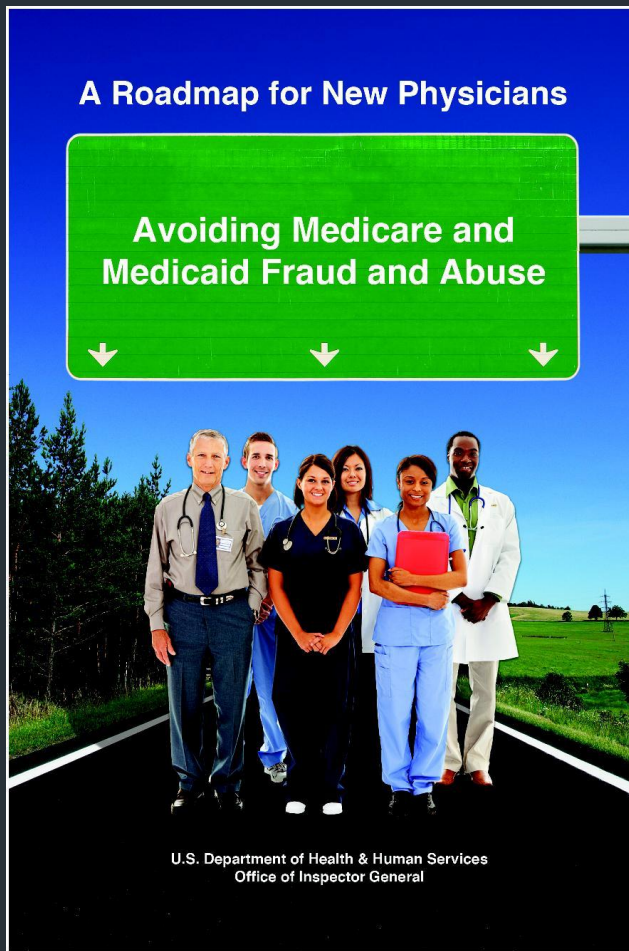
"We are hearing reports about physicians asking patients to pay additional fees, and we believe this is an ideal time to remind physicians and Medicare patients about this potential liability. Charging extra fees for already covered services abuses the trust of Medicare patients by making them pay again for services already paid for by Medicare," Corrigan said.

-- MORE --

- Alert from Office of Inspector General, March 31, 2004
- <http://oig.hhs.gov/fraud/docs/alertsandbulletins/2004/FA033104AssignViolationI.pdf>

OIG ALERT 03-31-04

- OIG alleged a physician violated his assignment agreement when he presented to his patients -- including Medicare beneficiaries – a “Personal Health Care Medical Care Contract” asking patients to pay an annual fee of \$600.
- Physician characterized services to be provided under the contract as “not covered” by Medicare but OIG alleged some contracted services were covered and reimbursable by Medicare: “coordination of care with other providers” and “a comprehensive assessment and plan for optimum health” and “extra time” spent on patient care. OIG claimed some of these services were covered and reimbursable by Medicare (which ones?).
- OIG alleged that each contract presented to this physician’s Medicare patients constituted a request for payment for covered services in violation of the physician’s assignment agreement.
- Physician agreed to pay a settlement to OIG and terminate offering the contracts to patients.
- *“If participating physicians decide they want to charge patients additional fees they should be mindful that they are subject to civil money penalties if they request any payment for already covered services from Medicare patients other than the applicable deductible and coinsurance,”* Corrigan said.



- *A Roadmap for New Physicians: Avoiding Medicare and Medicaid Fraud and Abuse*, U.S. Department of Health & Human Services and Office of Inspector General
- <http://oig.hhs.gov/compliance/physician-education/index.asp>



Assignment Issues in Medicare Reimbursement

Most physicians bill Medicare as participating providers, which is referred to as “accepting assignment.” Each year, Medicare promulgates a fee schedule setting the reimbursement for each physician service. Once beneficiaries satisfy their annual deductible, Medicare pays 80 percent of the fee schedule amount and the beneficiary pays 20 percent. Participating providers receive the Medicare program’s 80 percent directly from the Medicare program and bill the beneficiary for the remaining 20 percent. Accepting assignment means that the physician accepts the Medicare payment plus any copayment or deductible Medicare requires the patient to pay *as the full payment for the physician’s services and that the physician will not seek any extra payment* (beyond the copayment or deductible) from the patient. Medicare participating physicians may not bill Medicare patients extra for services that are already covered by Medicare. Doing so is a violation of a physician’s assignment agreement and can lead to penalties.



The second, less common, way to obtain Medicare reimbursement is to bill as a non-participating provider. Non-participating providers do not receive direct payment from the Medicare program. Rather, they bill their patients and the patients seek reimbursement from Medicare. Although non-participating providers are not subject to the assignment rules, they still must limit the dollar amount of their charges to Medicare patients. Generally, non-participating providers may not charge Medicare beneficiaries more than 15 percent in excess of the Medicare fee schedule amount. It is illegal to charge patients more than the limiting charge established for physicians’ services.



Excluded providers may not receive Medicare payment either as participating or non-participating providers.

You may see advertisements offering to help you convert your practice into a “boutique,” “concierge,” or “retainer” practice. Many such solicitations promise to help you work less, yet earn more money. **If you are a participating or non-participating physician, you may not ask Medicare patients to pay a second time for services for which Medicare has already paid.** It is legal to charge patients for services that are not covered by Medicare. However, charging an “access fee” or “administrative fee” that simply allows them to obtain Medicare-covered services from your practice constitutes double billing.

Case Example of a Physician Violating an Assignment Agreement by Charging Beneficiaries Extra Fees

- A physician paid \$107,000 to resolve potential liability for charging patients, including Medicare beneficiaries, an annual fee. In exchange for the fee, the physician offered: (1) an annual physical; (2) same- or next-day appointments; (3) dedicated support personnel; (4) around-the-clock physician availability; (5) prescription facilitation; (6) expedited and coordinated referrals; and (7) other amenities at the physician's discretion. The physician's activities allegedly violated the assignment agreement because some of the services outlined in the annual fee were already covered by Medicare.





JAN 26 2012

TO: Marilyn Tavenner
Acting Administrator
Centers for Medicare & Medicaid Services

FROM: /S/ Stuart Wright
Deputy Inspector General
for Evaluation and Inspections

SUBJECT: Memorandum Report: *Lack of Data Regarding Physicians Opting Out of Medicare*, OEI-07-11-00340

This memorandum report provides information about data limitations that we encountered while conducting a review of physicians who opted out of Medicare. The lack of complete data prevented us from conducting a full review of physicians who have opted out of Medicare. We plan to conduct a full evaluation when a complete data source of opted-out physicians is available.

SUMMARY

In April 2011, we began an evaluation entitled *Impact of Physicians Opting Out of Medicare*. The objectives of the evaluation were to determine the extent to which and reasons why physicians opt out of the Medicare program, and the effects of physician opt-out on Medicare beneficiaries. We specifically sought to answer:

- What are the characteristics (i.e., specialty, location, practice type, gender) of physicians who opt out of Medicare?
- Has the number of opted-out physicians increased or decreased over time?
- Why do physicians choose to opt out of the program?

In the course of our review, we determined that the Centers for Medicare & Medicaid Services (CMS), Medicare Administrative Contractors (MACs), and legacy carriers (i.e., Medicare claims payment contractors) do not maintain sufficient data regarding physicians who opt out of Medicare. As a result, we are unable to conduct the proposed evaluation at this time.

Memorandum Report: Lack of Data Regarding Physicians Opting Out of Medicare

Q: Is opting out really the
long-term answer? Now?
On a long term basis?

<http://oig.hhs.gov/oei/reports/oei-07-11-00340.pdf>

BASIC PRIVATE MEDICINE PRACTICE MODELS

- Private Retainer/Subscription
 - For all primary care needs, regardless whether covered or not by Medicare (but without constituting insurance)
 - *Opt out of Medicare/private contract with patient*
- Direct Private Fee for Covered Services
 - Menu of medical services for private fee
 - Medicare participating, Non-Par or Opted Out
 - Contracted to Private Health Care Plans (PPO) or not
 - Regardless whether covered or not by Medicare
 - *Opt out of Medicare/private contract with patient*
- Fee for Non-Covered Services
 - Private fee/retainer/subscription for services or amenities not covered by Medicare or private insurance plans
 - May or may not opt or non-par

FEDERAL LEGAL ISSUES/IMPEDIMENTS

- Federal Laws (Medicare/Medicaid/Social Security/HIPAA):
 - Anti-Kickback/Anti-Self Referral Laws
 - Compliance With Medicare Schedules/Plans
 - Patient Protection and Affordable Care Act of 2010
 - Institutionalizes revenue integrity (RAC audits)
 - Brings “Fraud” and “Abuse” much closer together in the Federal False Claims Act.
 - Fraud has burden of proof including intent
 - Abuse was mistaken claims submissions
 - Now they’re both just “False Claims” with “Improper Payments”.
 - Private physicians are *not* immune
 - Cannot Bill For “Covered” Services (A Moving Target!)=Fee For Non-Covered Services
 - Wire Fraud/Honest Services Statutes
 - Electronic Medical Records/Electronic Communications (Patient Consent)

PRIVATE MEDICINE BUSINESS MODELS

- Self-Conversion
 - Physician hires consultant/CPA/attorney and starts to self-convert into private medical practice
- Assisted Conversion/Management
 - Physician contracts with local or national business that specializes in private medicine conversion and/or administration and management
 - Business handles patient/business and patient/physician contracts
 - Business normally compensated with percentage of gross practice revenue
 - Planning considerations
 - Commitment time?
 - HIPAA compliance – Business Associate Agreement
 - Transitions – Death, disability, retirement, etc.
 - Patient transition (AMA Guidelines – No promises, no abandonment)
 - Non-compete exposure?
- Hybrid
 - Pros
 - Cons
- ACO/Gainsharing Agreements
- Home Health Concepts?

PRACTICE CONVERSION AMA ETHICAL GUIDELINES

- ⦿ Voluntary?
- ⦿ Continuity of care considerations
- ⦿ Appropriateness of care
- ⦿ Compensation—retainer contract
- ⦿ Access to care in the community:
protecting care for all
- <http://www.ama-assn.org/resources/doc/code-medical-ethics/8055a.pdf>

SOLUTION PATHS TOWARD LEGAL COMPLIANCE

- Fee For Non-Covered Services (Medicare Compliance)
 - Case Management (per member per month fee)
 - Telephone Evaluation & Management
 - Management of Home Care
 - Genetic/Family History
 - Analysis of clinical data stored in computers (e.g., ECGs, blood pressures, hematologic data)
 - Unusual travel (e.g., transportation and escort of patient)
 - Supplies and materials provided by the physician over and above those usually included with the office visit or other services rendered (list drugs, trays, supplies, or materials provided)
 - Unlisted preventive medicine service (tailor this description to the services offered by private practice)
 - Administration and interpretation of health risk assessment instrument (e.g., health hazard appraisal)

STATE LAW INSURANCE COMPLIANCE RISKS

- ⦿ Unlimited services/flat fee as insurance
- ⦿ Patient termination/refund rights/escrow
- ⦿ Patient load vs. practice capacity
- ⦿ Failure to collect co-pays/nondiscrimination
- ⦿ Inducements (No free rides...)
- ⦿ Excessive/False/Discriminatory Medical Bills
- ⦿ Telemedicine mandates/requirements

PRIVATE INSURANCE PLAN CONTRACT COMPLIANCE

- ⦿ Charging additionally for contracted service (No)
- ⦿ Refusing plan patients absent subscription (problem, may violate contract – Blue Cross/Blue Shield/Other plans)

THE GOVERNMENT IS SEARCHING FOR SOLUTIONS: ARE YOU SPEAKING UP?

Hatch, Baucus Lead Finance Committee Members in Bipartisan Effort to Combat Waste, Fraud, and Abuse in Medicare & Medicaid Programs

In an open letter to members of the health care community Senators write, "Drawing on the collective wisdom and accumulated insights of thousands of professionals and individual experiences could offer a fresh perspective and potentially identify solutions that may have been overlooked or underutilized."

"We believe federal efforts would be strengthened by input from members across the health care community – providers, payers, health plans, contractors, non-profit entities, consumers, data analytics entities, governmental partners, and patients. Drawing on the collective wisdom and accumulated insights of thousands of professionals and individual experiences could offer a fresh perspective and potentially identify solutions that may have been overlooked or underutilized."

<http://www.finance.senate.gov/newsroom/ranking/release/?id=d2527088-4f4c-434f-863f-5e980aaa2637>

QUESTIONS?

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