Rethinking Primary Care Revenue Models

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Traditional FFS Model

- Contracts with insurance companies, health plans and other 3rd party payers.

- Bears the administrative burden and financial cost of managed care contracting, credentialing, and claim filing & processing.

- Coordinates and manages patient care within the terms and case management of the patient’s plan or policy.

- May not be compensated for all services provided for the patient.

- May have other restrictions and limitation placed on patient care.

- May have increased regulatory and contractual responsibilities.
Physician or Other Provider

Insurance Plan (Other 3rd Parties)

Patient

- Consumer Mind Set
- Wants to Develop or Maintain a Relationship with Provider
- Less Hassle
- Value-Added Services

- Less Clinical Restrictions
- Relationship with Patient
- Less Administrative Burden
- Regular Recurring Revenue
Where do physicians find themselves today?

- 81% of physicians describe themselves as either overextended or at full capacity, up from 75% in 2012.

- 69% of physicians believe that their clinical autonomy is sometimes or often limited and their decisions compromised. (↑ in employed providers and heavy insurance)

- 44% of physicians plan to take one or more steps that would reduce patient access to their services, such as cutting back on patients seen, retiring, working part-time, closing their practice or seeking a non-clinical job.

- 78% identify patient relationships as one of the most satisfying factors about practicing medicine (85% in primary care).

Traditional FFS/Managed Care  

versus  

Membership Medical Care  

- Concierge VIP  
- Direct Primary Care  
- Hybrid Models Cash & Some Insurance  

Definitions vary widely within the industry.
Membership Medical Care

- Contracts directly with the patient for access to care. Some restrictions.
- Opportunity for enhanced relationship with the patient.
- No administrative burden or reduced administrative burden of dealing with 3rd party payers
- More autonomy in respect to patient care and case management.
- More autonomy in respect to the financial compensation received for services rendered.
- No or less restrictions and limitation placed on patient care.
- No or less regulatory and contractual responsibilities.
- Smaller patient panel
Also Known As

• Concierge Healthcare
• Membership Medicine
• Direct Primary Care
• Direct Care
• Direct Practice Medicine
• Retainer-Based Medicine
• Cash-Only Practice
• Boutique Medicine
• Personalized Healthcare
• Hybrid Models
• Contract Carrying Medicine
• Cash-Only Practice
### Characteristics of Various MMC Models

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<thead>
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<th>Component</th>
<th>Yes</th>
<th>No</th>
<th>Maybe</th>
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<tbody>
<tr>
<td>Contract with Patient</td>
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<tr>
<td>Primary Care Services Defined</td>
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<tr>
<td>Annual or Monthly Retainer</td>
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<tr>
<td>Expanded Access or Service</td>
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<td>Per Visit Fee</td>
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<tr>
<td>Charge for Lab or X-ray</td>
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<td>✓</td>
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<tr>
<td>Accepts Insurance</td>
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“These concierge medical services are really convenient. I can get a check up, dinner reservations and show tickets.”
How many MMC practices are there?

“It is important to note that industry physician surveys, investment analysts and industry experts tell the DPC Journal’s research arm, The Concierge Medicine Research Collective that they believe there are an additional 6,000 physicians who practice some form of Medical Membership Care (MMC)—albeit Concierge Medical Care or DPC, across the U.S. at this time (December, 2014) equating to a total or approximately 12,000 MMCs operating in the U.S.—representing a total of just less than 6% of all licensed primary care physicians in the U.S. According to most accurate observers and news reports in recent past, we caution that exact numbers (< 300 DPC; 5-6K Concierge Care) are hard to track. The shift by physicians, despite hype, has been gradual. However, the positive data coming out of the MMC marketplace, usage, and acceptance by consumers is growing at a moderate rate.”

“7% of physicians now practice some form of direct pay/concierge medicine, while 13% indicate they are planning to transition in whole or part to this type of practice. 17% of physicians 45 years or younger indicate they will transition to direct pay/concierge practice.”

Sources of Data

The Direct Primary Care Journal
Editor-In-Chief, Michael Tetreault
http://directprimarycarejournal.com/

Concierge Medicine Today
Editor-In-Chief, Michael Tetreault
http://conciergemedicinetoday.org/

The Physicians Foundation
2014 Survey of American’s Physicians: Practice Patterns and Perspectives conducted by Merritt Hawkins
http://www.physiciansfoundation.org/about-us


States with leading # of MMC practices

States with demand higher than existing practices/fewest practices

States that are best places to start a practice

States with continuing growth and market

Map created by inQuiseek, Data Source: Tetreault, CMT 2014, 2015
Is DPC the right model for you as a physician?

- Personality
- Work style
- Practice Community Demographics
- Mission/Vision
- Patient Demographics
DPC Patient Profile

 Millennials (early 30s) or Generation X (45-55) are considered to lead the future trend as DPC patients. An earlier 2005 survey indicated the highest percentage of patients were 65 or older including a moderate number of patients with chronic conditions (DM, CAD, HTN).

 Patients value a more personal relationship with their physician and are willing to pay for it.

 Patients are more consumer-oriented and willing to make financial choices related to healthcare.

 Over half (59%) have a combined household income of < $95,000. A large % have executive salaries.

 Breakdown of Memberships by type:
   Individual: 49%
   Couple: 23%
   Family with dependents: 21 %
   Business Owners/Executives 4%
Factors in Retaining Patients

- Clear communication when a practice converts to a DPC model.
  - Written communication
  - Clear contracts
  - Clear expectations about services and terms
- Deliver what you promise.
- Transitioning Care for Patients who will no longer be included in the panel.
- Most DPC and other membership medical care models have 90% patient retention.
Insurance and DPC

- Patients will still have to have insurance for ancillary services, referrals, hospital services and specialists.

- Membership Medical Care, when combined with catastrophic major medical coverage meets the requirements of the ACA. Employers and payers are looking at these models more closely.

- Some costs may qualify for reimbursement from Health Savings Accounts (HSA).

- Costs do not generally qualify for Flexible Spending Accounts (FSA).

- ACA has lead to more High Deductible plans. Some consumers are willing to absorb the out of pocket costs and reserve the high deductible plans for hospitalization and critical care.

- Some managed care plans restrict picking and choosing which services can be billed and require deductibles and co-pays to apply to all services.

- Hybrid practices may choose to retain some commercial plans if those plans are compatible with practice demographics and goals.
Direct Pay Practice Profile

- 81% of the surveyed DPC practices identified themselves as solo practices; < 20% identified as group practices.

- 80% of the surveyed DPC physicians reported their specialty as either internal medicine or family practice.

- Average number of employees in DPC practice is 1 – 3.

- 53% of the surveyed DPC practices indicated they accept cash, credit and debit card payments.

- 47% of the surveyed DPC practices indicated they either accept or bill some insurance companies for some services.

- 90% of surveyed DPC practices indicated they were financially performing better than the previous year.

- 50% of the surveyed DPC practices indicated they include home visits as a retainer service; 38% indicated that no home services were provided; 12% indicated that there is an additional, nominal charge for house calls.
More Quick Facts About DPC

• Panel size is usually 600 - 800 patients. VIP concierge models < 600. in 2015 report from *DPC Journal*, 60% had less than 300 patients which was unsatisfactory.

• Price is not always the determining factor in patient/member participation.

• Average monthly membership fee was $135.

• DPC models attract Gen X and Millennial generations < 45 years old.

• Physician salaries in DPC typically compare with those in traditional practice.

  “A 2012 Medscape study found that the average salary for a primary care physician ranged from $156,000 to $315,000, while Bloomberg Businessweek reported that the average salary for a Concierge Physician ranged from $150,000 to $300,000.” via [http://conciergemedicinetoday.org/2014-concierge-physician-salary-report/](http://conciergemedicinetoday.org/2014-concierge-physician-salary-report/)
LEGALITIES
Defining Services In Retainer

*What is the patient paying for in the retainer?*

This is critically important for the provider and the patient/member to understand. Service covered in the retainer must be clearly defined and communicated to the patient member. For hybrid practices, the retainer fee must **not** include services which are covered by Medicare or another payer-specific insurance contract. The retainer fee must be for non-covered services in these cases.

Examples of services provided under MMC retainers:

- Primary care
  - Annual or periodic examinations
  - Care of acute and/or chronic conditions
  - Basic Lab Panels
- Priority Appointments (appointment within a certain window)
- Priority Access (email, cell phone, house calls)
- Extended Appointment Times
- Spa-like amenities or features
- Specialty services: Weight loss, Behavior or Lifestyle Modification, Cosmetic procedures, Special Labs
Legal and Compliance Concerns

1. **Medicare**: CMS/Medicare prohibits a participating provider from collecting more than deductibles and copayments in respect to the beneficiary’s covered services. OIG has ruled in a number of cases that the subscriptions fee charged to Medicare patients did include overpayment of (incidental or comingled) covered services.

   - Can a physician contract with a Medicare patient?
   - Participation agreement
   - Non-participating providers who do not accept assignment can directly bill the patient 115% of the limiting charge per the Physician Fee Schedule. May submit claims. (115% of 95% of PFS allowable)

   - **Opting out of Medicare**
     - 2 year minimum
     - Must be done within 10 days after signing first contract or at least 30 days before the end of the first quarter of the effective date of the first contract
Legal and Compliance Concerns

Medicare (continued)

• Instructions on Opting Out:  

• Must notify patients and enter into private contract to provide services to a Medicare patient.

  *In a 2014 survey, approximately 34% of primary care physicians already exclude or limit Medicare patients and 41% exclude or limit Medicaid patients.*

2. **State Insurance Laws:** Because of the passage of SENATE BILL NO. 516 in 2014, Louisiana does not subject DPC to the insurance laws. In other states, this is not the case. The retainers or subscription fees can be considered prepayment of medical services or as an insurance premium to guarantee the provision of certain services.

3. **Existing Insurance and Managed Care Contracts:** Some contracts may have provisions which restrict the provider from excluding some services from coverage. You may not be able to pick and choose what to bill the plan. The plan may require that all deductibles and copays be collected. Terminating a contract will automatically make you “out of network” for any services you were to provide and bill.
Legal and Compliance Concerns

4. **Electronic Communication:**
   - There is a concern when offering electronic communication with patients through cell phones, email, messaging or texting that PHI be safeguarded.
   - Consult *LAC 46XLV.7505B* for guidance on patient evaluation via electronic means. “An online, electronic or written mail message, or a telephonic evaluation by questionnaire or otherwise, does not satisfy the standards of appropriate care.”

5. **Medical Abandonment:** If by changing types of practice models you exclude or terminate relationships with certain patient groups, you must follow all the requirements for notifying the patients of a change in practice, making sure there is a transfer of records, and providing that no patient is denied care in the active treatment phase of a condition. *LAC46XLV.7603.4b, 10b*
Legal and Compliance Concerns

6. **Elitist Care:**
   - Concerns exist (perceived and through surveys) that membership medical care or DPC is restrictive in the care of elderly populations and that these practices do not treat a less diverse patient population.
   - Physicians must be sensitive to fulfilling their professional responsibility to provide indigent or uncompensated care in other environments.
Other Citations

Boden, Timothy W. “Concierge Medicine: Glitz and glamour or good medicine?” *MGMA Connexion*, October, 2011, p.50-55.


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