Glitz and glamour or good medicine?
Underneath the glitter of high-paying concierge medicine, physicians relish a return to the so-called good old days of patient care and focus.

The idea of a concierge evokes images of a luxury hotel with an attentive service person at your beck and call — ready to provide whatever extra amenities will make your stay more enjoyable.

When it comes to medical practices, it has become an umbrella term covering a variety of (usually primary care) practice models that share some common traits:

• An annual retainer or subscription fee charged to patients to participate in the program
• Dramatically reduced patient panels per physician/provider
• Immediate phone, e-mail or personal access to physicians on 24 hours a day, seven days a week
• Same-day or next-day office appointments
• A strong emphasis on wellness, prevention and health management coaching

Most observers trace the history of concierge medicine to the 1996 formation of Seattle ( Wash.)-based MD International, although its founder, Howard Maron, MD, says he came up with the concept — not the name.

Range of options

While some practices emphasize the extra amenities that come with upgrading your primary care experience, others present themselves as offering solid, basic medical care “the way it was supposed to be” — a close, personal relationship with your primary care physician. The membership fees allow physicians to reduce the number of patients they need to see to break even. That, in turn, gives doctors more time for each office encounter, for returning phone calls quickly and for managing each patient’s total care.

Practices develop their images differently — from the luxurious, pampered-patient ambiance to practical, laidback family atmosphere. Those who criticize concierge practices often condemn them for creating a two-tier health system that caters exclusively to the rich who can afford to join “medical country clubs.”

Some practices charge hefty membership fees in the neighborhood of $24,000 per year for a family of four.

But for many practices, retainers run considerably less — especially for those that opt out of all third-party billing. Eliminating the insurance department results in tremendous overhead savings, which can be passed on to patients in the form of lower fees.

Frustration

Kenneth Hertz, FCMPE, principal consultant for MGMA Health Care Consulting Group, explains that physician frustration and patient dissatisfaction has been the impetus for concierge medicine. Facing flat revenues and rising expenses, physicians feel pressure to increase productivity — at the expense, some say, of forfeiting quality and meaningful doctor-patient relationships.

Today’s market realities, Hertz says, “prevent physicians from delivering the kind of care they were trained for — and want to deliver.”

David Albenberg, MD, a family physician in Charleston, S.C., echoes that viewpoint. His frustration with life in a typical group practice led him to strike out into the world of direct-pay medicine. Managing thousands of patients, dealing with insurers and government payers, struggling with coding and audit threats,
Learning the lingo

- Concierge — a catchall term for practices that offer enhanced service in exchange for a subscription, membership or retainer fee paid upfront by the patients
- Direct care/direct access — terms that emphasize foregoing the middle man at the insurance company; medical decisions are up to the doctor and patient
- Direct pay — a term that usually describes a practice that has opted completely out of billing insurance payers and accepting benefits assignment

and scrambling to maintain productivity left him feeling like someone (or something) else was always trying to take control away from physicians. The complexity and pressure were draining the joy and satisfaction out of the profession, he says.

Hertz notes that physicians and politicians have leveled sharp criticism at concierge physicians.

Not only do these professionals question doctors’ ethics for creating — or exacerbating — medical elitism, but they are hastening the impending doomsday-esque physician shortage by reducing their patient panels by up to 90 percent.

But Albenberg asks those who raise the ethics question, “Tell me what’s ethical about cutting corners and shortchanging patients in the name of efficiency and productivity?”

Typically, direct-pay practices tend to be small operations — two or three physicians at the most — but some major players have joined the movement. Sean Glenn, MBA, MHSA, associate administrator of internal medicine, Mayo Clinic, Scottsdale, also serves as administrator for the Medallion program, a pilot concierge medicine practice. Encouraged by the success of programs like the Virginia Mason Medical Center’s Dare Center in Seattle, Glenn and his team developed a two-physician practice-within-a-practice that offers concierge medicine services for patients willing to pay the $5,000 annual subscription fee.

Unlike pure direct-pay models, Mayo’s Medallion program bills third-party payers. The payer mix is about 60 percent Medicare (compared with 50 percent Medicare in Mayo’s other services) and 40 percent commercial insurance. To avoid running afoul of third-party payer rules, Medallion’s policies and contracts carefully describe subscription fees as payment for noncovered services only. And despite Mayo’s decision not to do any broad marketing during the pilot project, the response has been remarkable.

Being affiliated with Mayo reassures patients that they are signing on for a quality program with easy access to its specialist and ancillary services, according to Glenn. Integrated referral and reporting processes help avoid care fragmentation that can occur with outsourcing.

Mayo support staff, including dedicated appointment and billing specialists, is trained to handle Medallion’s unique protocols and billing issues.

It’s not difficult to see why patients who can afford the retainer love the concept, and it’s even easier to see why the model — especially the direct-pay-only version — works financially. It allows practices to:

- Decrease staff by phasing out insurance and coding departments
- Reduce front-desk staff to reflect daily patient volumes, which are oftentimes cut in half
- Develop a patient panel of 300 to 400 per physician and charge each of them $3,000 per year upfront ($900,000 to $1.2 million in revenue)

Many direct-pay primary care physicians report significant improvement in personal income, according to Albenberg. He is happy to report that his own income averages about twice what his colleagues in traditional third-party payer practices are making.

Albenberg notes that even when other physicians comprehend the financial concept, they usually raise two issues that make them apprehensive: controlling utilization and being chained to their cellphones, pagers and e-mail 24 hours a day, seven days a week.

“What they don’t understand,” Albenberg notes, “is that they imagine what it would be like managing this kind of physician access with their current load of several thousand patients. That would be impossible.”

His experience has not been that bad.

Albenberg considered and dismissed the idea of requiring office visit co-pays so people would think twice before coming in. It just didn’t fit the image they were trying to develop in their practice, and he was concerned that it made their plan look even more like an insurance
program subject to state insurance regulations.

Albenberg was into his third year before things began to stabilize and he felt financially secure.

Glenn notes that Mayo’s program continues to spark some controversy, as some question whether the Medallion program is true to Mayo’s heritage and vision to provide high-quality care for patients regardless of their ability to pay.

One surprise for the Mayo program was that a large number of enrollees were very sick and somewhat isolated from family and social support and tended to use the system more than expected. Nevertheless, the Medallion program surpassed every goal for enrollment and is paying for itself after 15 months of operation, Glenn says.

For a closer look at Mayo’s experience ...

Hear Sean Glenn, MBA, MHSA, Medallion administrator, along with R. Scott Gorman, MD, Medallion medical director, and Ruth Ingall, operations manager, present “Mayo Clinic’s Medallion Program: Lessons Learned in Concierge Medicine,” Tuesday, Oct. 25, 2011, at MGMA’s Annual Conference in Las Vegas.

Despite success stories, Hertz reminds professionals that some physicians are not cut out for concierge medicine and prefer the “treat-‘em-and-street-‘em” high-productivity model. But for doctors longing for a taste of the old days, direct-pay medicine can look very attractive.

Developing a concierge practice

MGMA Health Care consultant Kenneth T. Hertz, FACMPE, advises practices contemplating a retainer-based practice not to waste a lot of energy and time reinventing the wheel. Rather, seek out successful concierge practices and emulate their best practices. Do your research to avoid operational and legal missteps that could seriously hinder your chances for success. Here are a few tips, based on Hertz’s experience and observations from professionals in the field:

Analyze and strategize. Study patient demographics and the local market, and evaluate current physicians and support staff. Develop financial models and timelines with specific milestones:

• Will there be sufficient demand? Do enough patients have the financial resources to participate?
• Are your physicians able to adapt to the concierge practice style, which involves closer, more involved relationships with patients? Can they handle the idea of high accessibility and virtually being on call 24 hours a day, seven days a week?
• Can your staff provide the level of customer service this program demands?
• Do you want to pursue a hybrid practice that continues to bill insurance or a pure, direct-pay program? This entails unplugging from third-party contracts, notifying patients, helping patients find new providers, dismantling your insurance department and setting up new systems, which can take a full year.
• What benefits, amenities, extra services and programs will you offer to patients who participate?
• How will the program affect staffing? What positions will be eliminated or created? What training will be required?

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• How much will it cost for patients to participate? How many patients can a physician manage at this level?
• How much will you have to charge patients to provide sufficient revenue to make the program profitable?
• How will you handle patients who will not (or cannot) transition to the retainer-based model?
• How long will it take to put systems into place, train staff, transition nonparticipating patients to new providers, announce and promote the new program and arrive at a “go-live” date?

Prepare carefully. Refine your strategies and avoid taking shortcuts.
• Make sure contract and marketing language doesn’t mislead patients

or create a risk-bearing situation that could leave you open to accusations of starting an insurance company. Maryland has considered regulating concierge practices under state insurance laws. By offering care benefits for a flat fee, a practice assumes a certain level of risk similar to a mini-health maintenance organization. A sick patient who comes in often will consume more resources than a healthy patient who seldom shows up.
• Develop your patient notifications in compliance with state rules and ethical guidelines to avoid accusations of abandonment.
• Review current health plan provider contracts. If you want to stay in, make sure your new program doesn’t breach your contract. If you want to get out,

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look at termination and nonrenewal requirements as well as separation clauses — especially provisions for patient notification and transfer.
• Review hospital and other institutional staff bylaws to see if your new plan could affect physician privileges.
• Prepare your staff for the transition. Determine if you will cut positions and how you will phase them out. (Some billers need to stay long enough to clean up old accounts receivable.) Determine and budget for any separation pay or benefits like job-placement assistance. Develop your training strategy: Will you use outside training resources? How and when will you provide the necessary training?
• Prepare your marketing strategy and materials. Consider focusing on a narrow target market within your existing patient base. Create professional, attractive literature that clearly describes and promotes the benefits of the new plan. Make sure staffers know how to answer questions that the marketing materials will engender.
• Identify and attempt to partner with other physicians in the area to whom you can direct patients who won’t or can’t transition to your new plan. Have a list of providers that are accepting new patients.
• Encourage physicians to network with other concierge physicians — perhaps outside the immediate market or through the American Academy of Private Physicians (aapp.org) — for

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