

HEALTH CARE ISSUES

The Health Care Department at Murtha Cullina is pleased to provide clients and friends with information about topics of interest in the health care area.

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CONCIERGE MEDICINE

Physicians Try Personalized Attention As A Response To Managed Care “Assembly Line” Patient Relationships: Is There Anything Wrong With These Platinum Practices?

Doctors who want to provide better care to their patients have found a way to do so: create a “concierge practice.”

And affluent patients who want more attentive care are happy to pay an annual membership fee to belong to concierge practices.

Meanwhile disgruntled bystanders – including managed care organizations (“MCO’s”), patients of lesser means, and some physicians – are raising questions as to the legality and ethics of concierge practices.

This bulletin describes the contractual provisions which constitute the elements of the services provided in consideration of the payments made for the receipt of prioritized attention and services, and also analyzes the ethical and legal bases that have been the principal source of the criticisms that have surfaced.

The MCO treatment regimen of brief patient visits and rapid cycling of patients through physician offices led two Boston-based internists to revamp their practices. Steven R. Flier, M.D. and Jordan S. Busch, M.D., both internists at Beth Israel Deaconess Medical Center, decided to leave Boston’s Beth Israel to open a new medical practice that charges patients \$4,000 per year (\$7,500 for a family) on top of the medical costs covered by the patient’s MCO insurance subscriber contracts. Patient “members” of the Flier/Busch practice will receive amenities

Concierge medicine and the payment of annual membership fees by patients to obtain personal attention is a response to the treadmill of managed care “assembly line” medicine.

and personal attention that managed care dominated practices cannot provide in this pressured patient care environment. The Boston concierge practice will now provide same day appointments, round-the-clock cell phone access to the physicians, nutritional exercise physiology exams at patients' homes or health clubs, and personal accompaniment by internists to specialists' offices. The originators of the Boston “deluxe-fee” personalized practice stated that they changed their “managed care modus operandi” by cutting their patient load to 300 patients each so that they could provide closely-supervised service within the limitations of managed care. Physicians who now conduct a “personalized practice” have expressed satisfaction that they have the time to provide the type of hands-on care that they had been hoping to provide, and they have reacted favorably to their new practices in a variety of ways, *i.e.*, they feel “passionately about the program,” the program “lets them feel good about being a doctor again,” and they are now “fulfilling the spirit of the Hippocratic Oath.”¹

A small but growing number of doctors who have recoiled at the managed care “patient treadmill” have formed “concierge” practices as a turnkey solution to managed care. According to a New York Times article, these physicians charge members anywhere from \$1,500 per patient in Florida to \$5,000 per patient in Arizona. The article even reports that several patients in Seattle are charged \$20,000 by a practice that provides “. . . heated towel racks, marbled showers and personally monogrammed robes.” And several firms are creating franchises and are planning to add physicians to the “affiliated” physician network in New York, California, Illinois, Texas, Maryland and Virginia.

One firm that has successfully assisted physicians in the formation of these personal attention practices is MDVIP, Inc., a Florida-based value-added service organization that offers physicians who become “Affiliates” a full logistical support package that includes technology, training and business assistance. MDVIP, Inc. “Affiliated Physicians” must abide by MDVIP guidelines, including capping patient membership at 600. MDVIP's patients elect to become members by paying a \$1,500 membership fee. MDVIP's informational material states that by limiting the enrollment, MDVIP Affiliated Physicians and their staff can become more patient-focused and can spend more time satisfying the individual needs of their patients, “rather than rushing from one examination room to the next, trying to keep on schedule.”

In consideration for the payment of MDVIP's annual fee of \$1,500, members receive the following personalized services:

- Annual physical examination
- Comprehensive preventative care plan and lifestyle planning
- Same-day or next day preferred appointments
- Support personnel dedicated exclusively to members
- Physician availability 24 hours a day, seven days a week
- E-mail and fax access to physician
- Prescription facilitation
- Coordination of necessary referrals
- Claims facilitation for members
- Travel medical services
- Private reception area replete with amenities

Except for the physical examination (which includes a full medical history) and related laboratory work, the patients or their insurers are responsible for all other health care services, diagnostic tests and related treatments.

Positive expressions by physician-participants in these limited membership practices have been met by countervailing negative criticism by other physicians, which includes doubts about the ethical and legal propriety of these personalized service practices. Physician critics of “boutique medicine” membership arrangements have expressed concern that the system will be transformed into a two-tier grouping of patients as either “haves or have-nots.” Other physicians have characterized the payment for “white-glove” personal treatment as evidence of physician greed, while other critics have noted, stridently, that the transformation of some of these practices amounts to nothing more than a means for abandoning lower income patients in order to favor the wealthy.

But aside from expressions of embarrassment and, perhaps, envy about these health care “catered services” for the well-to-do, there have been no specific references to any ethical principles adopted by the American Medical Association, or those enacted by other Medical Societies. While some physicians and their associations have stated that the concept “leaves a bad taste in their mouths,” that adverse reaction does not provide a basis for equating discomfort with an ethical violation. The AMA’s Council on Ethical and Judicial Affairs has not taken an official or public position on the subject, but the Council’s Chairman has stated that the physicians’ obligation to meet the needs of their communities is not compromised so long as no more than 10 percent of the physicians in a geographical service area practice “boutique medicine.” Since many physicians express doubts as to whether “concierge care” will ever enlist more than a small fixed number of internists who practice in high-income areas, the failure of physicians to serve the needs of their geographical patient service areas is not likely to occur. Thus, the ethical anxiety expressed in the charge that physicians will neglect the overall medical community due to the practice of concierge care has no supportable basis in fact.

Dr. Michael Grodin, director of medical ethics at Boston University School of Medicine, says he does not believe concierge practices are unethical. And Joseph Newhouse, director of health policy and research at the Harvard School of Public Health, says that Drs. Flier and Busch – the Beth Israel dropouts – simply responded rationally to a market failure.²

With respect to legal issues, the Centers for Medicare and Medicaid Services are conducting a preliminary inquiry to determine whether physician special attention charges to members for services covered by MCO contracts or by Medicare constitute a “double-billing” potential violation. But these claims appear to have no merit since the physician’s personal attention fee charged to a Medicare patient is a fair market value payment for a physical exam, and that service is not covered by the Medicare payment provisions. In order to avoid this problem, some physicians have made it clear that their special service charge is made by one of the physician’s new entities, and the other entity charges for services that are covered by insurance.

The federal Anti-Kickback Statute and state anti-kickback correlative statutes (based on the language of the federal statute) have also been cited as bases for legal violations asserted against concierge care physicians. But there appears to be no legal basis for claiming a violation of the federal Anti-Kickback Statute, since a violation requires a finding that a person “knowingly and willfully” offered to pay or accept remuneration to induce referrals of patients whose clinical treatment procedures are reimbursed under the Medicare and Medicaid programs.

MDVIP does not arrange for the referral of member patients to physicians who are Affiliated Physicians in the MDVIP network, and the members are not directed to choose a particular physician. Nor does MDVIP grant its Affiliated Physicians an exclusive right to practice personal service medicine within a specified geographical area. And the receipt of payment by an MDVIP physician for an enrollee’s comprehensive physical exam is not an illegal duplicate

Ethical concerns over “two tier” medicine and legal claims that membership fees may contravene Medicare coverage limitations and MCO “balance billing” prohibitions have not been found to violate those ethical and legal principles.

payment for a Medicare reimbursed physical exam since Medicare neither covers nor reimburses for that routine diagnostic procedure. Congressional representatives have claimed that the boutique care membership fee might violate Medicare even if the fee is for services that Medicare does not cover, since conditioning the provision of Medicare services on the physician's receipt of the annual fee has been alleged to mean that the patient is paying for the opportunity to receive covered benefits. But this viewpoint has been ably contested by MDVIP officials, who responded that the Center for Medicare & Medicaid Services "grossly misstates" the applicable Medicare principles since the MDVIP membership fees are charged for personal care and are predicated as payments for "preventive and wellness" planning, and surely Medicare does not cover those services.

Since managed care pressures have required physicians to squeeze more patients into shorter appointments, some physicians are trying to rid themselves of the rapid assembly line managed care pressures by asking a select group of affluent patients to pay an annual fee for "personal attention service." Although there have been both ethical and legal concerns voiced by skeptical physicians and patients critical of these preferential service programs, there have been no authoritative determinations by either federal or state agencies or by the courts that there is anything unethical or illegal about these voluntary programs that respond effectively to the crush impacted on personal and caring medicine by the MCO "hurry the patient along" health care market.

If you have any questions concerning the ethical and legal issues that have been addressed by members of the firm's Health Care Department in considering the proposed implementation of these medical personal attention programs, please be good enough to call Anne Hanford or Michael Kogut at (617) 457-4000 or Stephen E. Ronai at (203) 772-7712 of our Health Care Department for advice and assistance on this subject.

1. These quotations are from an article in the January 14, 2002 New York Times entitled "Doctors' New Practices Offer Deluxe Service for Deluxe Fee" by Pam Belluck.

2. The Boston Globe, March 5, 2002, "Gold-plated medicine," p. C1.

3. Senator Bill Nelson of Florida has recently introduced legislation in Congress (S.1592; A Bill To Prohibit A Physician Medicare Provider From Receiving Medicare Payment If The Provider Charges A Membership Fee As A Prerequisite For The Provision Of An Item Or Service To The Patient) which seeks to deprive Medicare Part B physician-participants of Medicare payments if they also receive a membership fee from a Medicare patient who is also a "concierge practice" paying member. The bill has been met by objections from representative physician interests who seek to conduct a personal attention membership fee-based practice without losing reimbursement for Medicare covered services since the provision of lifestyle planning and other preventative services to Medicare members does not duplicate in any manner the medical care services which Medicare covers.

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