

Retainer Practices Discussion Paper

Retainer Practice defined

Retainer (boutique/concierge care) practices charge patients a monthly or annual fee under terms of a contract in exchange for a physician's services-clinical and administrative. This is the same type of business model that is used in the larger business community where customers pay a fee for a promise of expert advice and/or services. This payment methodology is newer to the medical community; however, physician practices are businesses-assessing fees for services. In a retainer practice, many of the services are bundled and available and whether patients utilize those services is up to them. The main patient benefits are greater access to and more time with the physician.

Retainer Practice demand

Physician hassles with third-party payors has led some to return to practice models where patients pay in advance for medical services. Physicians want to care for fewer patients in order to allow more time to spend with their patients and less time performing administrative tasks required by private payors. Due to this, the retainer practice has received more attention. In the past, this type of practice model was to as ("boutique care" or "concierge care", which are less palatable than the true business payment model it actually is, which is a retainer practice.¹

Some physicians have chosen a full retainer practice and opted to not contract with any health plans. In this model, physicians provide direct services and collect payments directly from their patients, either at the time of service or in periodic (e.g., month, yearly) installments. Other physicians have blended the traditional and retainer practices, whereby, contracting with public and/or private health insurance payors. Even though retainer practices may simplify the administrative processes of practicing medicine, they create some ethical and legal concerns.

Legal Issues

Full Retainer Practice

Legal issues around retainer fees for physicians who do not accept health insurance-public or private- are minimal because the amount charged is driven completely by the marketplace.

Retainer and Traditional Practice Hybrid

The best way to determine whether direct billing the patient a retainer for services is appropriate is to contact each health plan with which the practice contracts and ask about each service for which a separate charge or retainer is planned. For information about Medicare, contact the local Medicare carrier. For Medicaid, contact the state Medicaid agency for their terms on charging patients directly.²

Without conducting initial research, a physician may have a compromised situation—legally, financially, and ethically. In March 2004, the Office of Inspector General for the Department of Health and Human Services issued an alert on concierge care that reminded doctors that physicians participating in Medicare are subject to civil money penalties if they request payment for already covered services from Medicare patients other than the applicable deductible and coinsurance. The alert cited a recent settlement with an internist who agreed to pay \$53,400 to resolve his liability for violating his assignment agreement with Medicare by asking his patients to pay a yearly fee of \$600 for services he said were not covered by Medicare. The services included "coordination of care with other providers" and "a comprehensive assessment and plan for optimum health and extra time spent on patient care." The inspector general charged that many of the services included in the fee were in fact covered by Medicare.³

Privately-funded health insurance plans also frown on physicians charging patients additional fees for services associated with covered benefits. The problem is that many of the services that physicians see as fair game are regarded by health plans as "bundled," or included with the payment made for other services, such as an office visit.

Physicians can always charge for a non-covered service, unless the health plan considers them to be bundled into a covered service. For example, most health plans don't pay for telephone calls or refilling prescriptions outside of an office visit, because the plans consider payment for these services to be bundled⁴. Some examples of successfully assessing patients for non-covered services are found below.

WHAT THEY'RE CHARGING FOR	
<ul style="list-style-type: none"> • School forms • Camp forms • Sports participation forms • Disability forms • FMLA forms • Life insurance forms • Paperwork for patient assistance programs • Referrals 	<ul style="list-style-type: none"> • Phone consults initiated by patients • E-mail consults • Refills or prescription changes handled outside of an office visit • Copies of medical records • Preauthorizations • No-shows

Once the hurdle of discovering what services are non-covered and non-bundled by health plans, the next hurdle is gain patients' acceptance to pay additional fees in the form of a retainer. As with any provided service, collections are extremely important. It is advisable to request payment at the time of service prior to the patient leaving the office.

Blended Retainer and Fee-for-Service

Note, a newer hybrid of a retainer practice design is to blend it with a fee-for-service/cash only model. This provides access to those unable or unwilling to pay a retainer fee to the physician.

Ethical Issues

Opponents of any type of retainer practice argue that retainer practices contradict the professional principle of ensuring equal access for all, may result in patient abandonment, should not promise better quality care for those who pay a retainer, and should see patients regardless of ability to pay.⁵ Some believe that retainer practices are a method for physicians to maximize their personal financial gain.

Proponents of the retainer practice share that they have more time to spend with and are more accessible to their patients. No longer is the physician racing from exam room to exam room due to the economical need to see 25-30 patients a day. More time spent active listening deepens the connection between the physician and patient and the information shared between the two. The AMA has developed ethical guidelines for retainer practices. See end of this paper for how to access them.

Change Preparation

Questions to ask before you consider a retainer practice:

- Do I have a plan to transition my patients who won't pay the fee?
- Am I willing to be on call 24 hours a day, every day?
- What services do I plan to offer?
- If still accepting health insurance, with which health plans will I continue to participate?
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 - What services do I plan to offer for the fee are ones that are considered non-covered by insurance?
 - Is it mandatory to have patients sign a waiver informing them of their financial responsibilities? (This is a good business practice to follow).
- If transitioning to a full retainer practice, what type of advanced notice is contractually required by health plans and Medicare?
- How many members do I need at the set fee to meet my overhead?
- During the transition, what financial outlay will be required to stay solvent?
 - Will another source of income be necessary?

Implementation Steps

After answering the questions above, the next step is to create a retainer practice contract and mail it along with a letter to existing patients about the change. The content of the letter should explain the concept of a retainer-based practice, clarifying the physician-patient relationship, defining the patients' financial obligations, willingness to assist patients who want to opt-out of the retainer practice, effective date of the change, and direct patients to contact the practice with any questions. Communicating to your patients will minimize flight from the practice as well as to ensure continuity of care.⁶ If wanting to privately contract with Medicare beneficiaries, it will be necessary to follow Medicare's opt out rules.

Retainer Contracts

Important issues to include in retainer contracts are what services are included in the retainer fee, how services will be billed and payment collected, termination and opt-out guidelines.⁶ It may be advisable to contact an attorney, colleague who has an existing retainer practice, or entity that specializes in retainer practices (see Resources).

Retainer fee

The established monthly or annual fee should be notably indicated and should identify which medical and non-medical services are included under the fee. The retainer fee should be payable upon execution of the contract. It is critical that patients fully comprehend what services will be provided and what their obligations are for paying for such services. Some examples of medical and non-medical services to offer are below.

Medical Services

- 24-hour/7-day a week access to the physician by cell phone or pager
- Preventive care visits
 - Annual physicals
 - Well baby checks
- Diagnosis and management of acute and complex medical problems
- Extended office visits
- Wellness programs and nutrition counseling
- Weight management
- Acute care visits
- Hospital visits
- Lab tests
- X-rays
- Prompt reporting of test results
- Prescription facilitation⁷
- Referral coordination
- House or place of business calls⁸
- Personalized care plan

Non-Medical Services Offered

Typically, the value-added services include:

- Same-day and extended-time appointments
- Minimal time in the waiting room
- E-mail communication with physician
- Newsletters
- Physician escorts to specialists or a hospital
- Performance measure reporting

Reimbursement

If continuing to accept payment from Medicare and health plans, the retainer contract should address how medical services will be billed and collected by the practice. Patients should clearly understand what medical services are included in their health plans and

what services are provided and included under the retainer fee. Ensure that the practice maintains compliance with all applicable laws, regulations and contracts.⁶

Fee-for-Service

It may be necessary to establish a fee schedule for services not otherwise covered in the retainer, i.e. house calls, nursing home visits. Establishing a fee schedule is challenging. Several options are available and shared in AAFP's "On Your Own, Starting a Medical Practice From the Ground Up" publication are: (1) use a professional consultant (see www.aafp.org/fpassist); (2) review the AAFP's survey results for office and hospital visit fees; and (3) use a percentage of Medicare's resource-based relative value scale (RBRVS).⁹ Certainly, another approach is to perform your own market research and contact the internists, urgent care centers, and other specialists to determine the prevailing market rates upon which fees can be based.¹⁰ Note, annual inflationary rate increases should be considered in order to stay current with the market rates. Alternatively, it may make sense to develop an hourly charge, like attorneys, with a minimum of a 15 minute charge.

Collections

To keep collections and bad debt to a minimum, collect full payment upon delivery of services. Some retainer practices provide patients either with a copy of the CMS-1500 form so that they can file the claim with their health plan or will submit the initial claim on behalf of the patient. Any medical necessity or allowable fee dispute usually defaults to the responsibility of the patient.

Termination

Retainer contracts should include a specific period of time, which is typically for a one-year period and with automatic one-year renewal terms, unless either the physician or patient decides to terminate the contract. Include the terms to terminate the contract. For example, "agreement can be terminated prior to its anniversary date by either party with at least a 30 day advanced written notice sent by certified mail".

Opt-out

An opt-out provision should be part of the retainer contract that enables the patient to terminate the contract without undue inconveniences or financial penalties, in order to comply with the AMA ethical guidelines for retainer practices.

Parting Thoughts

Retainer practices are not a panacea for all. Knowing the practice's patient panel as well as the marketplace prior to making the transition to a retainer practice model is critical. However, there are physicians who have enjoyed great success and liberation from the current healthcare financing albatross by implementing a retainer practice design.

Resources

- Retainer Practices, AMA Resolution 6 (2001) <http://www.ama-assn.org/ama1/pub/upload/mm/369/ceja128.pdf>.

- Society for Innovative Medical Practice Design - <http://www.conciergephysicians.org/>
- OIG Alert to Physicians regarding surcharges and retainer fees – <http://oig.hhs.gov/fraud/docs/alertsandbulletins/2004/FA033104AssignViolationI.pdf>.
- MDVIP is the National Leader in Concierge **Medicine** - <http://www.mdvip.com/>

¹ Mike Norbut, *AMNews*, Appeal of retainer practices: Boutique care goes mainstream, Aug. 4, 2003, <http://www.ama-assn.org/amednews/2003/08/04/bisa0804.htm>.

² Leigh Ann Backer, Should You Charge Your Patients for "Free" Services?, *Family Practice Management*, July/Aug 2004, <http://www.aafp.org/fpm/20040700/43shou.html>.

³ OIG Alerts Physicians about added charges for covered services, March 31 (2004), <http://oig.hhs.gov/fraud/docs/alertsandbulletins/2004/FA033104AssignViolationI.pdf>.

⁴ Leigh Ann Backer, Should You Charge Your Patients for "Free" Services?, *Family Practice Management*, July/Aug 2004, <http://www.aafp.org/fpm/20040700/43shou.html>.

⁵ Retainer Practices, AMA Resolution 6 (2001) <http://www.ama-assn.org/ama1/pub/upload/mm/369/ceja128.pdf>.

⁶ Steven M. Harris, Lay the groundwork for retainer practice, *AMNews*, Dec. 1, 2003. <http://www.ama-assn.org/amednews/2003/12/01/bica1201.htm>.

⁷ MDVIP, Membership benefits, <http://www.mdvip.com/memberserv.htm>.

⁸ Higher Care, Member benefits, <http://www.higher-care.com/higher%20care/benefits.htm>.

⁹ Julie Henry, RN, MPA and James Bare, MHCA, On your own, Starting a Medical Practice From the Ground Up, American Academy of Family Physicians, <https://secure.aafp.org/catalog/viewItem.do?itemId=2316&productId=611&categoryId=11>.

¹⁰ James R. Dykes, MD, Making Time to Listen, *Family Practice Management*, Sep 2004, <http://www.aafp.org/fpm/20040900/45maki.html>.