New ACP paper explores impact of 'concierge' and other direct patient contracting practices

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The American College of Physicians (ACP) today released a position paper exploring the factors driving the growth of "concierge" and other "direct patient contracting practices" (DPCPs) and the "limited" evidence on their impact on patient care. A summary of the paper, Assessing the Policy and Patient Care Implications of 'Concierge' and Other Direct Patient Contracting Practices, is in today's Annals of Internal Medicine online edition, with a link to the full paper.

"We found that physician interest in concierge, direct primary care, and other arrangements where physicians contract directly with patients for payment of services, is largely driven by frustration with reimbursement and billing hassles with payers and the strong desire voiced by physicians to spend more time with each patient," said Wayne J. Riley, MD, MPH, MBA, MACP, president of ACP, "yet there is limited evidence on the impact of such practices on quality, cost, and access to care. This paper provides practical recommendations that physicians who are considering DPCPs should consider, especially to mitigate any potential adverse impact on access for lower-income patients. We propose a robust agenda for additional research on the efficacy of this expanding practice modality."

For the purposes of this paper, ACP defines a DPCP as any practice that: (1) directly contracts with patients to pay out-of-pocket for some or all of the services provided by the practice, in lieu of, or in addition to,

traditional insurance arrangements and/or (2) charges an administrative fee to patients, sometimes called a retainer or concierge fee, often in return for a promise of more personalized and accessible care. This definition of DPCPs therefore encompasses retainer, "concierge," "boutique," cash-only, direct primary care, and direct-specialty-care practices.

The paper found that growing physician interest in DPCPs is based on the premise that access and quality of care will be improved if patients have a greater responsibility to pay directly for services provided by physicians and other health professionals in the practice, without third-party payers imposing themselves between the patient and the physician. Yet, ACP notes that there is little in the way of high quality, independent research on the impact of DPCP models on quality and access.

While a review of the literature notes that there are potential benefits to DPCP models—including providing patients with better access and more time with physicians and fewer administrative burdens on the practice—there are concerns that DPCPs may cause access issues for patients, especially among patients who cannot afford to pay directly for care.

The paper offers policy, practical, and ethical issues that should be considered by physicians who are considering entering into such a practice model, as well as steps they should take if they are already in a DPCP, to ensure that lower-income and other vulnerable patients are not disadvantaged.

In the paper, ACP offers the following recommendations:

1. ACP supports physician and patient choice of practice and delivery models that are accessible, ethical, viable, and that strengthen the patient-physician relationship.

2. Physicians in all types of practice must honor their professional obligation to provide nondiscriminatory care, to serve all classes of patients who are in need of medical care and to seek specific opportunities to observe their professional obligation to care for the poor.

3. Policymakers should recognize and address pressures on physicians and patients that are undermining traditional medical practices, contributing to physician burn-out and fueling physician interest in DPCPs.

4. Physicians in all types of practice arrangements must be transparent with patients, offering details of financial obligations, services available at the practice, and the typical fees charged for services.

5. Physicians in practices that choose to downsize their patient panel for any reason should consider the impact these changes have on the local community including patients' access to care from other sources in the community and help patients who do not stay in the practice find other doctors.

6. Physicians who are in or are considering a practice that charges a retainer fee should consider the impact that such a fee would have on their patients and local community, and particularly on lower income and other vulnerable patients, and consider ways to reduce barriers to care for lower income patients that may result from the retainer fee.

7. Physicians participating, or considering participation, in practices that do not accept health insurance, should be aware of the potential that not accepting health insurance may create a barrier to care for lower income and other vulnerable patients. Accordingly, physicians in such practices should consider ways to reduce barriers to care for lower-income patients that may result from not accepting insurance.

8. Physicians should consider the Patient-Centered Medical Home (PCMH) as a practice model that has been shown to: improve physician and patient satisfaction with care, outcomes, and accessibility; lower costs; and reduce health care disparities, when supported by appropriate and adequate payment by payers.

9. ACP calls for independent research on DPCPs that addresses:

A. The number of physicians currently in a DPCP, where DPCPs are located geographically, projections of growth in such DPCPs, and the number of patients receiving care from DPCPs;

B. Factors that may undermine the patient-physician relationship, contribute toprofessional burnout, and make practices unsustainable, and their impact on physicianschoosing to provide care through DPCPs;

C. The impact and structure of DPCP models that may affect their ability to provide accessto underserved populations;

D. The impact of DPCPs on the health care workforce;

E. Patients' out-of-pocket costs and overall health system costs;

F. Patients' experience with the care provided, and on quality and outcomes;

G. The impact of physicians not participating in insurance and therefore not participating innational quality programs, interoperability with other electronic health record systems,and the associated impact on the quality and outcomes.

"This paper neither endorses nor opposes concierge and other DPCPs, rather, it offers ACP's assessment of the evidence on the policy and

patient care implications of DPCPs," Dr. Riley concluded, "in order to inform discussion among policymakers, researchers, the public, and physicians themselves about the potential implications of DPCPs."

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