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GAO

Report to Congressional Committees

August 2005

PHYSICIAN SERVICES

Concierge Care Characteristics and Considerations for Medicare

GAO-05-929

August 2005

PHYSICIAN SERVICES

Concierge Care Characteristics and Considerations for Medicare

GAO Accountability · Integrity · Reliability

Highlights

Highlights of GAO-05-929, a report to congressional committees

Why GAO Did This Study

Concierge care is an approach to medical practice in which physicians charge their patients a membership fee in return for enhanced services or amenities. The recent emergence of concierge care has prompted federal concern about how the approach might affect beneficiaries of Medicare, the federal health insurance program for the aged and some disabled individuals. Concerns include the potential that membership fees may constitute additional charges for services that Medicare already pays physicians for and that concierge care may affect Medicare beneficiaries' access to physician services. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 directed GAO to study concierge care and its relationship to Medicare.

Using a variety of methods, including a nationwide literature search and telephone interviews, GAO identified 146 concierge physicians and surveyed concierge physicians in fall 2004. GAO analyzed responses from 112 concierge physicians. GAO also reviewed relevant laws, policies, and available data on access to physician services and interviewed officials at the Department of Health and Human Services (HHS) and representatives of Medicare beneficiary advocacy groups.

www.gao.gov/cgi-bin/getrpt?GAO-05-929.

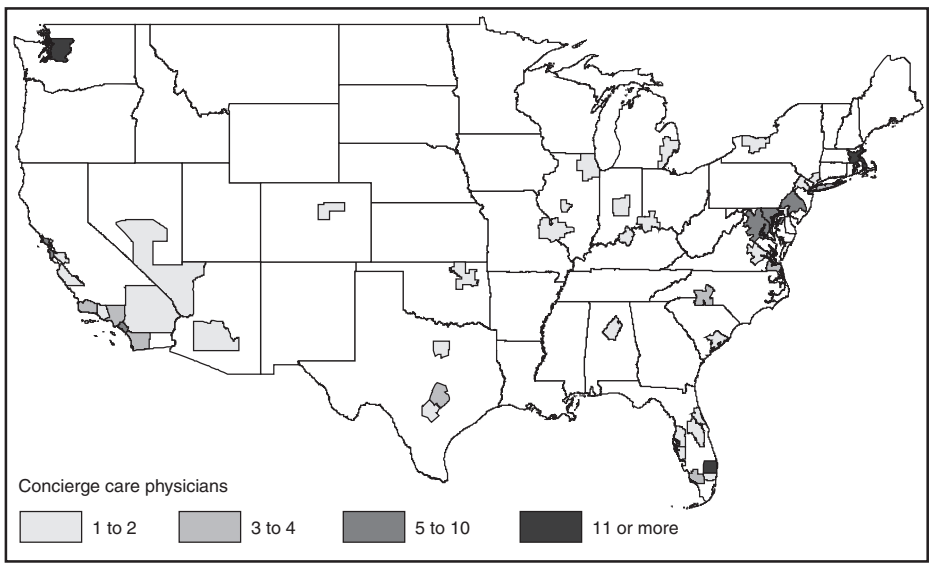
To view the full product, including the scope and methodology, click on the link above. For more information, contact A. Bruce Steinwald at (202) 512-7119 or steinwalda@gao.gov.

What GAO Found

Concierge care is practiced by a small number of physicians located mainly on the East and West Coasts. Nearly all of the 112 concierge physicians responding to GAO's survey reported practicing primary care. Annual patient membership fees ranged from $60 to $15,000 a year, with about half of respondents reporting fees of $1,500 to $1,999. The most often reported features included same- or next-day appointments for nonurgent care, 24-hour telephone access, and periodic preventive care examinations. About three-fourths of respondents reported billing patient health insurance for covered services and, among those, almost all reported billing Medicare for covered services.

Two principal aspects of concierge care are of interest to the Medicare program and its beneficiaries: compliance with Medicare requirements and its effect on beneficiary access to physician services. HHS has determined that concierge care arrangements are allowed as long as they do not violate any Medicare requirements; for example, the membership fee must not result in additional charges for items or services that Medicare already reimburses. Some concierge physicians reported to GAO that they would like more HHS guidance. The small number of concierge physicians makes it unlikely that the approach has contributed to widespread access problems. GAO's review of available information on beneficiaries' overall access to physician services suggests that concierge care does not present a systemic access problem among Medicare beneficiaries at this time. In comments on a draft version of this report, HHS agreed with GAO's finding on concierge care's impact on beneficiary access to physician services and indicated it will continue to follow developments in this area.

Location of Concierge Physicians Identified by GAO



Source: GAO analysis.

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Abbreviations

AMA	American Medical Association
CMS	Centers for Medicare & Medicaid Services
HHS	Department of Health and Human Services
MSA	metropolitan statistical area
OIG	Office of Inspector General
PMSA	primary metropolitan statistical area

GAO
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United States Government Accountability Office
Washington, D.C. 20548

August 12, 2005

The Honorable Charles E. Grassley
Chairman
The Honorable Max Baucus
Ranking Minority Member
Committee on Finance
United States Senate

The Honorable Joe Barton
Chairman
The Honorable John D. Dingell
Ranking Minority Member
Committee on Energy and Commerce
House of Representatives

The Honorable William M. Thomas
Chairman
The Honorable Charles B. Rangel
Ranking Minority Member
Committee on Ways and Means
House of Representatives

Concierge care is an approach to medical practice in which physicians charge their patients membership fees in exchange for enhanced services or amenities. Concierge physicians typically care for fewer patients than do doctors in conventional practice, and they are more readily available to member patients, for example, by cell phone or same-day appointments. The approach has attracted media attention in recent years. Critics contend that concierge care makes health care more lucrative for a few physicians and more convenient for some patients, but less accessible to patients who cannot or choose not to pay a membership fee. Proponents, in contrast, describe concierge care as both a rational response to patient demand for more personal care and a way for physicians to regain control of their medical practices and their lives. They say the approach allows concierge physicians to spend more time with their families, enhance their incomes, and spend more time on research and other professional activities. Because concierge care has gained attention only recently, little is known about how many concierge physicians there are or about how the approach could affect access to physician services.

Concierge care has also generated attention within Congress, the Department of Health and Human Services (HHS), and state governments. Federal attention has centered on how membership fees might affect beneficiaries of Medicare, the federal health insurance program for individuals aged 65 and older and certain persons with disabilities. Of particular concern is the potential that membership fees may constitute additional charges for services that Medicare already pays physicians for and that concierge care may affect Medicare beneficiaries' access to physician services. Members of Congress introduced bills that, if enacted, would have prohibited physicians from imposing membership fees on Medicare beneficiaries as a condition for the provision of a Medicare-covered item or service.[1] A few states are monitoring concierge care to ensure compliance with state insurance laws.[2]

Given the concerns about how concierge care might affect Medicare beneficiaries, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 required us to study and report on the practice.[3] As discussed with the committees of jurisdiction, this report addresses the following questions:

1. What are the characteristics of concierge care?

2. What aspects of concierge care are of interest to the Medicare program and its beneficiaries?

To obtain information on the characteristics of concierge care, we surveyed concierge physicians about their practices and the types of services and financial arrangements they offer. Because no comprehensive directory of concierge physicians was available, we identified concierge physicians through a variety of methods, including a nationwide literature search,

[1]See for example, the Medicare Equal Access to Care Act of 2003, H.R. 2423, 108th Cong., and the Equal Access to Medicare Act of 2003, S. 345, 108th Cong.

[2]In Washington, for example, the Office of the Insurance Commissioner is monitoring concierge care and has considered requiring that physicians who charge a set fee in exchange for comprehensive primary care meet all the requirements that apply to health maintenance organizations. The basis for this requirement is that an agreement to provide unlimited health services in exchange for a fixed fee results in the assumption of insurance risk.

[3]Pub. L. No. 108-173, § 650, 117 Stat. 2066, 2331. The conference report for the Consolidated Appropriations Act, 2004, Pub. L. No. 108-199, 118 Stat. 3, also directed GAO to study concierge care. H.R. Conf. Rep. No. 108-401, at 806 (2003).

telephone interviews, and referrals from other concierge physicians. We identified as concierge physicians those who (1) had established a direct financial relationship with patients in the form of a membership or retainer fee and (2) provided enhanced services or amenities, such as same-day appointments or preventive services not covered by patient health insurance. We located a total of 146 concierge physicians practicing in the United States. We received survey responses from 112 physicians who practiced concierge care in October 2004. Because these 112 respondents were not selected at random from a larger population of known concierge physicians, the information they provided cannot be projected to any other concierge physicians. We did not attempt to verify the accuracy of their responses.[4]

To review the aspects of concierge care that are of interest to the Medicare program and its beneficiaries, we reviewed documents and interviewed officials from two HHS entities responsible for administration and oversight of the Medicare program: the Centers for Medicare & Medicaid Services (CMS) and the Office of Inspector General (OIG). We also reviewed relevant sections of Medicare law and regulations; interviewed concierge physicians and their representatives; and in our survey, asked concierge physicians for their views on the guidance available from HHS on concierge care. To assess what is known about how concierge care may affect Medicare beneficiary access to physician services, we reviewed nationwide sources of information on Medicare beneficiaries' overall access to physician services, for example, reports by the Medicare Payment Advisory Commission. While we did not contact Medicare beneficiaries who were patients of physicians who converted to concierge practices, we contacted organizations that Medicare beneficiaries were likely to call with concerns or questions about concierge care, such as the 1-800-MEDICARE call line. We conducted our work in accordance with generally accepted government auditing standards from May 2004 through July 2005.

Results in Brief

Concierge care is practiced by a small number of physicians located mainly on the East and West Coasts. Nearly all of the 112 concierge physicians who responded to our survey reported practicing primary care. They differed, however, on the characteristics of their concierge practices, such as the membership fee charged, features offered, and whether they billed

[4]See app. I for details on our scope and methodology.

patient health insurance. For example, the amount of the concierge care membership fee ranged from $60 to $15,000 a year for an individual, with about half of respondents charging individual annual membership fees of $1,500 to $1,999. The most frequently reported features offered by concierge physicians responding to our survey included same- or next-day appointments for nonurgent care, 24-hour telephone access, and periodic preventive-care physical examinations. In addition, about three-fourths of the respondents reported billing patient health insurance for covered services and, among those physicians, almost all reported billing Medicare for covered services.

Two principal aspects of concierge care are of interest to the Medicare program and its beneficiaries: compliance with Medicare requirements and its effect on beneficiary access to physician services. HHS has determined that concierge care agreements are permitted as long as the arrangements do not violate any Medicare requirements; for example, the membership fee must not result in additional charges for items or services that are already reimbursed by Medicare. Various strategies for concierge care practice design have been developed to help concierge physicians avoid potential Medicare compliance problems, but most of our survey respondents expressed a need for more information from HHS to guide them. Although no national data directly address the impact of concierge care on beneficiaries' access to physicians, the information available as of 2004 on overall beneficiary access to services indicates that access has been good. The small number of concierge physicians makes it unlikely that the approach has contributed to widespread access problems. In addition, information from beneficiary advocacy organizations and on physician supply in communities where more concierge physicians practiced does not indicate that concierge care was contributing to any systemic access problems. In commenting on a draft of this report, HHS agreed with our finding about the effect of concierge care on Medicare beneficiary access to physician services, and also noted that it remains interested in concierge care and will continue to follow developments in the area.

Background

Physician practices that charge membership or retainer fees and provide enhanced services or amenities are referred to as concierge care or

retainer-based medicine.[5] The origins of this practice approach are often traced to a medical practice founded in Seattle, Washington, in 1996. Physicians in this practice provide comprehensive primary care to no more than 100 patients each and currently charge annual retainer fees of $13,000 for individuals. These physicians do not bill any form of patient health insurance. As more physicians have begun concierge practices, concierge care has become more diverse, comprising physicians who bill patient insurance, charge lower membership fees, and see more patients than the original Seattle practice.

The American Medical Association (AMA) has described concierge care as one of many options that patients and physicians are free to pursue. AMA in 2003 adopted ethics guidelines for physicians who have concierge care contracts—which AMA calls retainer contracts—with their patients.[6] These guidelines specify, for example, that physicians should facilitate the transition to new physicians for patients who choose not to join their concierge practices and that they must observe relevant laws, rules, and contracts.

The Medicare program was established by title XVIII of the Social Security Act, which governs how physicians bill for services that the program covers. Limits on what physicians may charge their Medicare patients depend on (1) the relationship between the physician and the Medicare program and (2) the type of service provided.

Physicians who provide services to Medicare beneficiaries may choose one of three ways to relate to the program: participating, nonparticipating, or opted out.

- *Participating*: Participating physicians agree to accept Medicare's fee schedule amount as payment in full for all covered services they provide to beneficiaries.[7] In accordance with the Medicare participation agreement, these physicians receive reimbursement directly from the

[5]We use the term *concierge care* because the statutory provision that mandated our work used this term.

[6]AMA Web site at http://www.ama-assn.org/ama/pub/category/print/11967.html, downloaded on March 16, 2005.

[7]Medicare's payment amount for physician services generally is determined by a fee schedule and includes 80 percent payment from the program and 20 percent beneficiary coinsurance, once the beneficiary's annual deductible has been met.

Medicare program and agree to charge beneficiaries only for any applicable deductible or coinsurance. More than 90 percent of the physicians and others who billed Medicare agreed to participate in Medicare in 2004.[8]

- *Nonparticipating*: Nonparticipating physicians do not agree to accept the Medicare fee schedule amount paid to participating physicians as payment in full for all covered services they provide to beneficiaries. They are still subject to limits on what they may charge, however, and those limits depend on whether they seek reimbursement directly from Medicare. When a nonparticipating physician files a claim to be reimbursed directly from Medicare, he or she must accept the Medicare fee schedule amount for nonparticipating physicians, which is 95 percent of the fee schedule amount for participating physicians, as payment in full and may charge the beneficiary only for any applicable Medicare coinsurance or deductible.[9] When a nonparticipating physician does not request reimbursement directly from Medicare, he or she may charge the Medicare beneficiary up to 115 percent of the fee schedule amount for nonparticipating physicians.[10]

- *Opted-out*: Physicians who opt out of Medicare are not subject to any limits on what they may charge their Medicare beneficiary patients, even for services that Medicare would otherwise cover.[11] Physicians who opt out of Medicare must agree not to submit for 2 years any claims for reimbursement for any of the services they provide to Medicare beneficiaries.[12] Contracts between opted-out physicians and their beneficiary patients allow them to make their own financial

[8]Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy* (Washington, D.C.: March 2005).

[9]42 U.S.C. § 1395w-4(g)(2)(C) (2000).

[10]A beneficiary may be reimbursed no more than 80 percent of the fee schedule amount for nonparticipating physicians, regardless of how his or her nonparticipating physician chooses to bill.

[11]This option became available through the Balanced Budget Act of 1997, which amended the Social Security Act to specify that physicians may enter into private contracts with Medicare beneficiaries. Pub. L. No. 105-33, § 4507, 111 Stat. 251, 439 (codified at 42 U.S.C. § 1395a(b) (2000).

[12]Reimbursement may be made in cases where opted-out physicians provide emergency or urgent care to beneficiaries with whom they do not have private contracts.

arrangements for services that would otherwise be covered by Medicare, effectively taking those services outside the program. These contracts must be in writing and they must clearly state that the beneficiary also agrees not to submit claims to Medicare and assumes financial responsibility for all services provided by that physician.

In addition to a physician's Medicare participation status, the type of service provided also determines whether limits apply to physician charges. Physicians and beneficiaries are free to make private financial arrangements for the provision of services that Medicare does not cover.

- *General standard for Medicare coverage*: Medicare law states that, to be covered, services must be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.[13] The scope of coverage and the exact type of service that may be reimbursed depend on the circumstances of each case. This medical necessity standard can result in situations where the same service—for example, a comprehensive office visit—is considered medically necessary and reimbursable by Medicare in some circumstances but not others.

- *Specific inclusion in Medicare coverage*: Medicare law also establishes coverage for certain specific services. For example, Medicare covers an initial preventive physical examination for beneficiaries who become eligible for Medicare on or after January 1, 2005. Other examples of specific preventive benefits established by statute include immunizations against pneumonia, hepatitis B, and influenza and periodic screening tests for early detection of certain cancers.

- *Specific exclusion from Medicare coverage*: Medicare law specifically excludes certain items or services—for example, personal comfort items, purely cosmetic surgery, hearing aids, and routine physical checkups except for the initial preventive examination for newly eligible beneficiaries.

Table 1 summarizes the limits on physician charges depending on their Medicare participation status and the type of service provided.

[13]42 U.S.C. § 1395y(a)(1)(A) (2000).

Table 1: Limits on Physician Charges for Medicare-Covered Services

Physician status	Medicare-covered services	Limits on physician charges
Participating	Medically necessary items or services and specific preventive or other benefits.	Medicare fee schedule amount for participating physicians. The beneficiary may be charged applicable deductible and coinsurance only.
Nonparticipating	Medically necessary items or services and specific preventive or other benefits.	Reimbursement claimed directly from Medicare: Medicare fee schedule amount for nonparticipating physicians, which is 95 percent of the amount for participating physicians. The beneficiary may be charged applicable deductible and coinsurance only. Reimbursement not claimed directly from Medicare: No more than 115 percent of the Medicare fee schedule amount for nonparticipating physicians. The beneficiary may be charged this entire amount and may be reimbursed 80 percent of the fee schedule amount for nonparticipating physicians.
Opted-out	None, except when emergency or urgent care is provided to a beneficiary with whom the physician does not have a contract.[a]	No statutory limits apply. The amount of payment is determined by contracts between physicians and patients.

Source: GAO analysis.

[a]Items or services provided by opted-out physicians to their beneficiary patients under private contracts are not covered by Medicare.

Physicians who impose charges on beneficiaries beyond the Medicare limits may be subject to civil monetary penalties.[14] The Secretary of HHS has delegated enforcement of Medicare limits to two different entities within HHS. CMS, which administers the Medicare program, has enforcement authority over the limits that apply to nonparticipating physicians. HHS OIG has enforcement authority over participating physicians' compliance with the terms of the participation agreement.

The Medicare law's limits on physician charges protect beneficiaries from additional charges for services they are entitled to receive under Medicare. The law does not, however, provide that a beneficiary has the right to receive services from any particular physician. Physicians are free to choose how they will interact with the Medicare program. They may decide to close their practices to new Medicare patients or decline to treat any Medicare beneficiaries at all.

[14]42 U.S.C. § 1320a-7a (2000).

Characteristics of Concierge Care

Concierge care is practiced by a small number of physicians, located primarily in urban areas on the East and West Coasts. Although nearly all of the concierge physicians who responded to our survey reported practicing primary care, they differed in many of the characteristics of practice design, including the annual membership fee charged, number of patients treated, features offered, whether they billed health insurance, and their relationship to the Medicare program.

Concierge Physician Location and Specialty

Concierge physicians are few in number and located primarily in urban areas on the East and West Coasts. Since the first Seattle practice was founded in the mid-1990s, the number of concierge physicians has been rising but remains small. We were able to locate 146 concierge physicians in the United States as of 2004—a small number compared with the more than 470,000 physicians who regularly submitted claims to Medicare in 2003.[15] The 146 concierge physicians we identified practiced in 25 states, with the greatest numbers in metropolitan areas on the East and West Coasts.[16] California had the highest number, with 26 concierge physicians, followed by Florida with 22, Washington with 21, and Massachusetts with 17. We identified 1 to 8 concierge physicians in 21 other states, though most of these other states had 5 or fewer. All but 2 of the concierge physicians we located practiced in metropolitan areas. We found the highest numbers of concierge physicians in the metropolitan statistical areas (MSA)[17] of Seattle (19); Boston (17); and West Palm Beach–Boca Raton, Florida (13). Figure 1 presents the locations of 144 concierge physicians we identified who practiced in MSAs throughout the nation.[18]

[15]Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy* (Washington, D.C.: March 2005).

[16]Other groups which have estimated the number of concierge physicians include the Society for Innovative Medical Practice Design (formerly the American Society of Concierge Physicians), which estimated that about 200 concierge physicians practice in the United States. AMA's Institute for Ethics located 144 concierge physicians, using the same identification approach that we followed, for its own study in 2003.

[17]An MSA is a geographic region consisting of a central county or counties that contains an urban area with a population of at least 50,000 plus any adjacent counties having a high degree of social and economic integration with the central county

[18]Two concierge physicians, both in Washington, were not located in MSAs.

Figure 1: Location of Concierge Physicians Identified by GAO, 2004

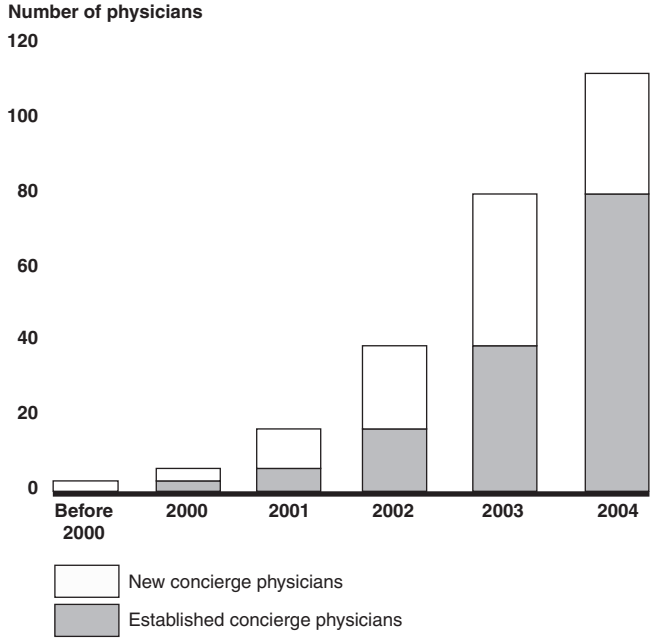
Source: GAO analysis.

Notes: This figure presents the practice locations of the 144 concierge physicians we identified who were located in MSAs. It does not include the 2 physicians located outside MSAs. We did not identify any concierge physicians in Alaska or Hawaii.

The number of physicians practicing concierge care has increased in recent years. Among the 112 concierge physicians who responded to our survey, the cumulative total number practicing concierge care has increased by

more than 10 times in the past 5 years (see fig. 2).[19] About two-thirds of the responding physicians reported that they began to practice concierge care in 2003 or later. The number of responding physicians starting to practice concierge care rose each year after 2000, except in 2004, although we did not include physicians who began practicing concierge care after October 2004.[20]

Figure 2: Yearly Growth in Number of Concierge Physicians



Source: GAO survey of concierge physicians.

[19]Converting a conventional practice to a concierge practice may take time. Our data on new and established concierge practices included physicians responding to our survey who charged membership fees and offered enhanced features to at least some of their patients in October 2004, although some of these physicians may have still been seeking additional concierge patients and continuing to treat some nonconcierge patients.

[20]Because our survey included only physicians who practiced concierge care during October 2004, it does not account for physicians who may have started and discontinued concierge practices before that date, or physicians who started to practice concierge care after October 2004.

Notes: *n* = 112 concierge physicians practicing as of October 2004. Data for 2004 do not include physicians who began practicing concierge care after October. The earliest year in which a physician in our survey reported beginning to practice concierge care was 1997.

Nearly all of the physicians who responded to our survey reported practicing primary care and most were not new to medical practice. Physicians reported practicing the primary care disciplines of internal medicine (about three-fourths of respondents) and family practice (about one-fourth of respondents). Survey respondents reported being in various stages in their medical careers, from relatively new to practice to decades of experience. More than two-thirds reported having been in medical practice for 15 years or more. The average length of time in medical practice was 19 years, and about one-fourth of the respondents reported being in practice for 25 years or more. See appendix II for additional information provided by survey respondents.

Characteristics of Practice Design among Surveyed Concierge Physicians

Concierge physicians responding to our survey reported a variety of practice characteristics. These included the amount charged to be a concierge patient, practice size, features offered, whether they billed patient health insurance, and their relationship to the Medicare program.[21]

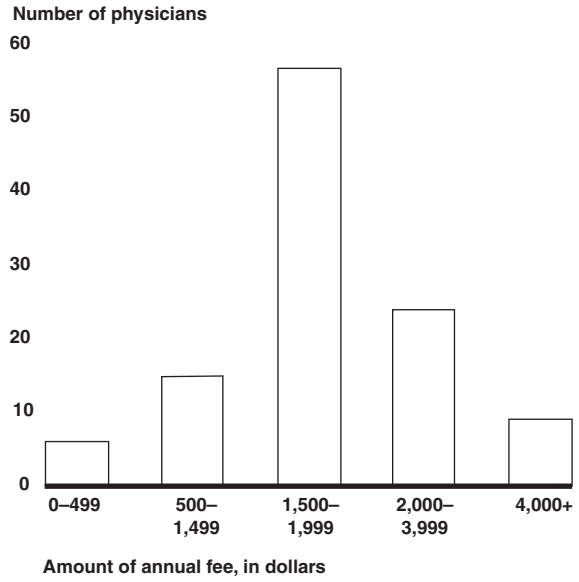
Amount of Annual Membership Fee

The annual membership fee for an individual to join a concierge practice ranged from $60 to $15,000 among the physicians responding to our survey. As shown in figure 3, more than 80 percent of respondents reported annual fees from $500 to $3,999; the most frequently reported annual fee was $1,500. Three-fourths of our respondents reported that they waived the membership fee for some of their concierge patients.[22] About one in eight of these physicians reported waiving the fees for 20 percent or more of their concierge patients.

[21]About one-third of our respondents were affiliated with a consulting firm that helps physicians establish and maintain concierge practices. This firm recommends that concierge physicians offer a program oriented toward preventive care, limit patients to no more than 600 for each physician, and submit claims to insurers for covered services.

[22]Our survey distinguished between concierge patients granted waivers of the membership fee but still offered the enhanced features of concierge care, and "nonconcierge" patients who were neither charged a membership fee nor offered the features associated with concierge care.

Figure 3: Annual Membership Fee for Individuals, October 2004



Source: GAO survey of concierge physicians.

Notes: *n* = 111 concierge physicians practicing as of October 2004; 1 respondent did not provide this information. The maximum reported annual individual membership fee charged was $15,000.

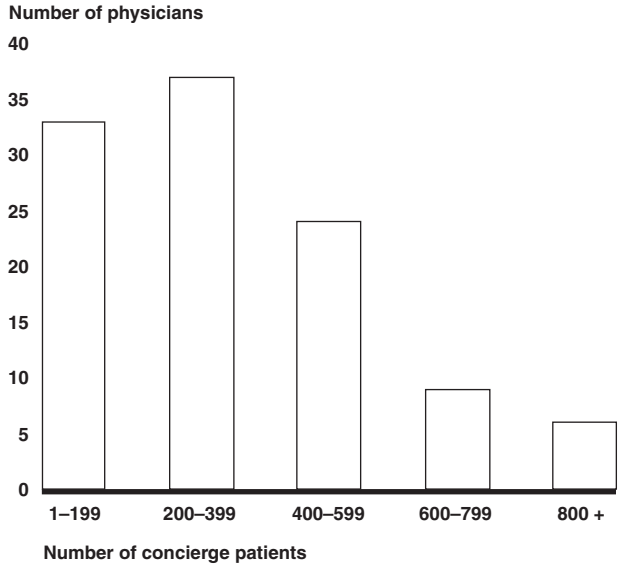
Practice Size

Concierge physicians responding to our survey reported, on average, 491 patients under their care as of October 2004—significantly fewer than the average of 2,716 patients they reported for the year before beginning to practice concierge care. Of the total patients they reported in October 2004, an average of 326 were concierge patients—that is, patients who either paid the membership fee or had the fee waived, and were offered the enhanced services or amenities associated with membership.

Nearly two-thirds of responding physicians reported having fewer than 400 concierge patients (see fig. 4). Concierge physicians also reported seeing fewer patients per day: the average number of patients physicians reported seeing on a typical day fell to 10 in October 2004 from 26 in the year before they began practicing concierge care.[23]

[23]Information on the number of patients seen per day was provided by 101 of the 103 physicians who reported that they established their concierge practices in the same community in which they had practiced before converting to concierge care.

Figure 4: Number of Concierge Patients under the Care of Individual Concierge Physicians, October 2004



Source: GAO survey of concierge physicians.

Notes: *n* = 109 concierge physicians practicing as of October 2004; 3 respondents did not provide this information. The maximum reported number of concierge patients was 980.

Many respondents reported that they were still establishing their concierge practices and had set targets for the number of concierge patients in their care. Respondents reported target numbers for concierge patients ranging from 10 to 1,300; the two most frequently reported goals were 300 and 600 concierge patients (reported by 23 and 30 respondents, respectively). About 80 percent of respondents reported that they had not yet reached their target number of concierge patients as of October 2004. About 1 in 2 of the respondents who began concierge care in 2001 or earlier reported having met their goal for the number of concierge patients in their practices, compared with about 1 in 7 of those who reported starting their concierge practices on or after January 1, 2002.

Concierge physicians may continue, for various reasons, to treat some nonconcierge patients. Thirty-six, about one-third of survey respondents, reported that their individual practices included some nonconcierge patients, while about two-thirds had practices consisting entirely of concierge patients. Physicians who continued to see nonconcierge patients reported doing so for various reasons: to ensure continuity of care for patients who did not join the concierge practice, to maintain a combined

concierge and conventional practice, or to see patients as part of a subspecialty practice.[24] Less frequently reported situations in which respondents reported seeing nonconcierge patients included seeing family members of their concierge patients occasionally as a courtesy or when urgent needs arose, and covering for other doctors who were out of town.

Features Offered

The concierge physicians responding to our survey reported offering a variety of features, some of which were offered by nearly all the respondents, others by relatively few (see table 2). The most frequently reported features were same- or next-day appointments for nonurgent care, 24-hour telephone access, and periodic preventive-care physical examinations.

Table 2: Features Offered by Concierge Physicians, October 2004

Feature	Percentage of respondents offering feature
Same- or next-day appointments for nonurgent care	99
24-hour telephone access	99
Periodic preventive-care physical examination	99
Extended office visits	96
Access to physician via e-mail	94
Access to physician via cell phone or pager	93
Wellness planning	93
Nutrition planning	82
Coordination of medical needs during travel	82
Patient home or workplace consultations	78
Smoking cessation support	77
Preventive screening procedures	72
Newsletter	71
Stress reduction counseling	67
Private waiting room	63
Mental health counseling	60
Online or other electronic access to personal medical records	42

[24]Subspecialties for which concierge physicians reported seeing nonconcierge patients included pulmonary medicine, endocrinology, and nephrology.

(Continued From Previous Page)

Feature	Percentage of respondents offering feature
Accompaniment to specialist appointments or medical procedures	38
Home delivery of medication by physician or office staff	31
Priority for diagnostic tests in affiliated medical facilities	27
Other (e.g., visits to homebound patients, lecture series on wellness and nutrition, assistance for patients' family members, or an on-site assistant to help patients with insurance)	31

Source: GAO survey of concierge physicians.

Note: *n* = 112 concierge physicians practicing as of October 2004.

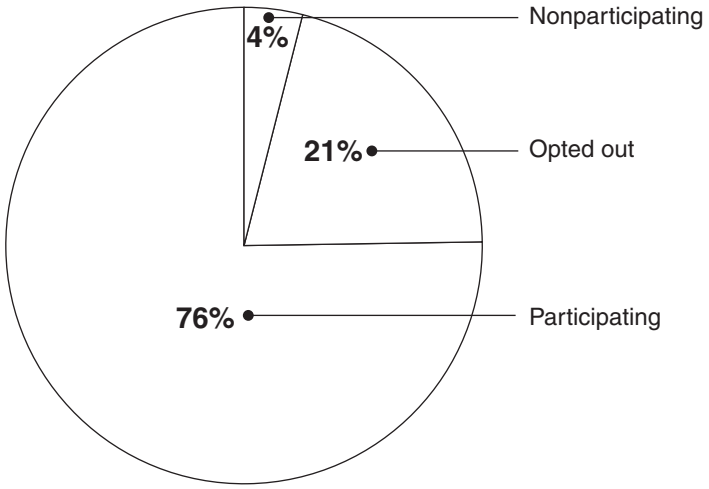
When asked to list the most important features of concierge care that were not routinely available to their nonconcierge patients, respondents most frequently cited features related to increased time spent with patients, direct patient access to the physician at any time, same- or next-day appointments, and comprehensive preventive and wellness care.

Interaction with Patient Health Insurance and Medicare

Concierge physicians responding to our survey reported different ways of interacting with patient health insurance and the Medicare program. Eighty-five, approximately three-fourths, of respondents reported that they billed patient health insurance for covered services. Of these 85 physicians, 79 reported they billed Medicare and 6 reported they did not. About one-fourth of the concierge physicians responding to our survey reported that they did not submit any claims to patient health insurance, including Medicare.

About three-fourths of our survey respondents reported that they were Medicare participating physicians, and about one-fifth had opted out of Medicare as of October 2004 (see fig. 5). Nationwide, relatively few physicians—approximately 3,000 in 2004—have opted out of the Medicare program.

Figure 5: Medicare Participation Status of Concierge Physicians Surveyed by GAO, October 2004



Source: GAO survey of concierge physicians.

Notes: *n* = 111 concierge physicians as of October 2004; 1 respondent did not provide this information. Percentages do not add to 100 due to rounding.

Aspects of Concierge Care of Interest to Medicare and Its Beneficiaries

Two principal aspects of concierge care are of interest to the Medicare program and its beneficiaries: its compliance with Medicare requirements and its effect on beneficiary access to physician services. HHS has established general policy on concierge care and alerted physicians to areas of potential noncompliance. Although concierge physicians have followed various strategies to ensure compliance with Medicare requirements, most physicians responding to our survey indicated more HHS guidance would be helpful. Available measures of access to care as of 2004, while not directly addressing concierge care, indicate that Medicare beneficiary access to physician services has been good. The small number of concierge physicians makes it unlikely that the approach has contributed to widespread access problems.

Compliance with Medicare Requirements

HHS has established general policy on concierge care and has alerted physicians to areas of potential noncompliance. Concierge physicians have expressed the need for additional guidance and have taken various steps—such as structuring their practices in an attempt to avoid associating their membership fees with Medicare-covered services or opting out of Medicare—to avoid compliance problems.

CMS outlined its position on concierge care in a March 2002 memorandum to CMS regional offices that CMS officials told us remains current as of June 2005. The memorandum states that physicians may enter into retainer agreements with their patients as long as these agreements do not violate any Medicare requirements.[25] For example, concierge care membership fees may constitute prohibited additional charges if they are for Medicare-covered items or services. If so, a physician who has not opted out of Medicare would be in violation of the limits on what she or he may charge patients who are Medicare beneficiaries.[26]

HHS OIG has addressed the consequences of noncompliance with Medicare billing requirements. In March 2004, HHS OIG issued an alert "to remind Medicare participating physicians of the potential liabilities posed by billing Medicare patients for services that are already covered by Medicare."[27] The alert stated that "charging extra fees for already covered services abuses the trust of Medicare patients by making them pay again for services already paid for by Medicare." As an example, the alert referred to a Minnesota physician who paid a settlement and agreed to stop offering personal health care contracts to patients for annual fees of $600. According to HHS OIG, these contracts included at least some services that were already covered and reimbursable by Medicare. The alert advised participating physicians that they could be subject to civil monetary penalties if they requested payment from Medicare beneficiaries for those services in addition to the relevant deductibles and coinsurance charged for these services. In addition, the alert noted that nonparticipating physicians may also be subject to penalties for overcharging beneficiaries for covered services.

Unless a concierge physician opts out of Medicare, the question of Medicare coverage is central to whether a concierge care agreement complies with the program's limits on patient charges. HHS OIG's March

[25]HHS refers to concierge care contracts as "physician-patient retainer agreements."

[26]The memorandum also states that retainer agreements could be problematic if they attempt to substitute for Medicare supplemental insurance policies. CMS officials reported encountering problems with physicians offering unregulated supplemental policies in the mid-1990s. In June 2005, CMS officials told us that, while such substitutions are not allowed, they are no longer concerned that retainer arrangements are being used as substitutes for Medicare supplemental insurance.

[27]Office of Inspector General, *OIG Alerts Physicians about Added Charges for Covered Services* (Washington, D.C.: Department of Health and Human Services, Mar. 31, 2004).

2004 alert provided three examples of services offered by the physician in Minnesota: coordination of care with providers, a comprehensive assessment and plan for optimum health, and extra time spent on patient care. HHS OIG did not indicate which, if any, of those three services were already covered by Medicare. The resulting uncertainty, about which features of the Minnesota physician's concierge agreement formed the basis for HHS OIG's allegation that he violated the Medicare program's prohibition against charging beneficiaries more than the applicable deductible and coinsurance, generated concern among some concierge physicians.

According to HHS OIG officials, HHS OIG has not issued more detailed guidance on concierge care because its role in this area is to carry out specific delegated enforcement authorities, not to make policy. HHS OIG addresses each situation in its specific context. Physicians with questions about their own concierge care agreements may obtain guidance specific to them from HHS by requesting an advisory opinion. HHS OIG's Industry Guidance Branch issues advisory opinions on matters that fall within its enforcement authority. It covers provisions of Medicare law that prohibit knowingly presenting a beneficiary with a request for payment in violation of a physician's participation agreement.[28] Consequently, any participating physician who operates or is considering starting a concierge practice could request an advisory opinion. Advisory opinions are legally binding on HHS and the requesting party as long as the arrangement is consistent with the facts provided. The process involves a written request that meets certain requirements, plus a fee. Advisory opinions are not available for hypothetical situations, "model" situations, or general questions of interpretation. Officials with HHS OIG reported that as of May 2005, the Industry Guidance Branch had received very few inquiries regarding advisory opinions about concierge care agreements, and no opinions have been issued on this subject.

Most of the physicians who responded to our survey indicated that more guidance from HHS on how Medicare requirements might affect concierge care is needed. Although about one-fourth of respondents said that the information available from HHS was clear and sufficient, more than half reported that it was not. Of those who reported that the guidance was not clear and sufficient, about one-third stated that information was available

[28]42 U.S.C § 1320a-7a(a)(2) (2000).

from other sources, including private attorneys, the Society for Innovative Medical Practice Design, and concierge care consultants (see table 3).

Table 3: Concierge Physicians' Views on HHS Information about How Medicare Requirements Might Affect the Practice of Concierge Care, October 2004

View	Percentage of physicians
The information available from HHS is clear and sufficient	26
The information available from HHS is not clear and sufficient, but clear and sufficient information is available from other sources	18
The information available from HHS is not clear and sufficient, and clear and sufficient information is not available from other sources	34
Don't know/no opinion	22

Source: GAO survey of concierge physicians.

Note: *n* = 111 concierge physicians as of October 2004; 1 respondent did not provide this information.

Medicare compliance is an important consideration in how concierge physicians set up their practices. For example, concierge physicans should avoid including services covered by Medicare in their concierge agreements to ensure that no additional charges are associated with those services. Different strategies have been undertaken to accomplish this. One such strategy emphasizes the convenience and availability of concierge physicians as the primary benefit of membership. Another strategy is to focus on preventive care, linking the membership payment only to screening that Medicare does not cover. Some concierge physicians opt out of Medicare, thus avoiding potential compliance problems; opting out requires physicians to forgo all Medicare reimbursement for 2 years.

Information on Medicare Beneficiary Access to Physician Services

Most of the concierge physicians responding to our survey reported having patients who were Medicare beneficiaries; however, the numbers of beneficiary patients they reported as part of their concierge and previous nonconcierge practices are very small compared to the more than 40 million Medicare beneficiaries. Surveys and national sources of information on beneficiary access to care do not address the impact of concierge care directly. In the absence of direct measures of the impact of concierge care on Medicare beneficiaries' access to physician services, we reviewed available nationwide data and other indicators about beneficiaries' experiences overall. These sources showed that overall access to physician services has not changed substantially in recent years.

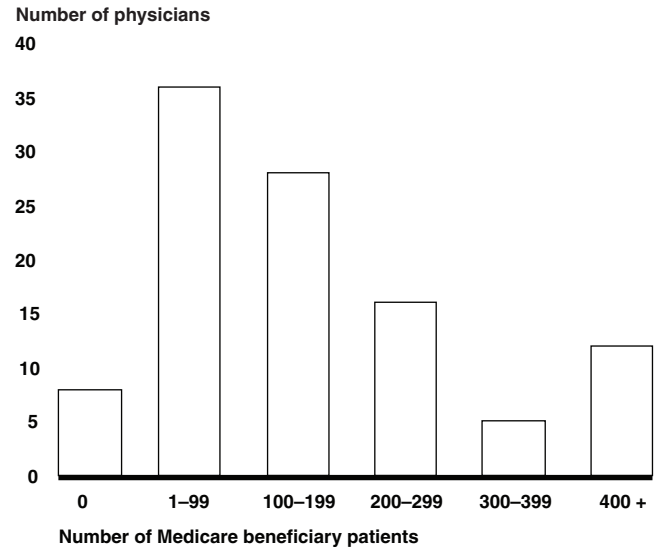
Medicare Beneficiary Patients of Surveyed Concierge Physicians

Estimates provided by 105 of the respondents indicated that about two-thirds of the estimated 19,400 Medicare beneficiaries who were patients of these physicians in October 2004 were considered concierge patients.[29] The rest were nonconcierge patients who were neither charged a fee nor offered enhanced services. Physicians who continued to see nonconcierge patients reported doing so for various reasons, including to ensure continuity of care for individuals who had not yet found a new physician and to maintain a practice consisting of both concierge and nonconcierge patients.

On average, Medicare beneficiaries represented about 35 percent of the total number of patients—concierge and nonconcierge—that responding concierge physicians reported having in their care as of October 2004. Eight of the 105 physicians who provided this information reported having no Medicare beneficiaries in their practices at all; 36 reported treating some, but fewer than 100 Medicare beneficiaries among their patients; and 12 reported having 400 or more Medicare beneficiaries under their care (see fig. 6).

[29]The term concierge patients includes all patients who are offered enhanced services or amenities, including those whose membership fees have been waived.

Figure 6: Medicare Beneficiary Patients of Concierge Physicians, October 2004



Source: GAO survey of concierge physicians.

Notes: *n* = 105 concierge physicians as of October 2004; 7 respondents did not provide this information. Includes Medicare beneficiaries who were nonconcierge patients of concierge physicians. The highest number of Medicare beneficiary patients reported was 2,825.

Concierge physicians who responded to our survey reported that, on average, Medicare beneficiaries in their previous nonconcierge practices joined their concierge practices in about the same proportion as their patients overall. When physicians begin practicing concierge care, existing patients may choose not to become concierge patients. Patient counts provided by responding physicians indicate that, on average, Medicare and non-Medicare patients who were under their care before they began concierge care chose to join as concierge patients in roughly similar proportions.

Table 4 shows the average numbers of Medicare and non-Medicare patients responding physicians reported were in their practices before and after their conversion to concierge care. The numbers of beneficiaries that responding concierge physicians reported in their practices are relatively small—for example, the total number of Medicare beneficiaries that 88 responding physicians reported treating before conversion to concierge care was fewer than 100,000—compared to the nation's more than 40 million Medicare beneficiaries.

Table 4: Patients from Physicians' Conventional Practices Who Joined Physicians' Concierge Practices

	Average number of patients		
Status of practice	**Total**	**Medicare**	**Non-Medicare**
Before conversion to concierge care	2,716 (*n* = 97)	1,069 (*n* = 88)	1,632 (*n* = 88)
After conversion to concierge care	301 (*n* = 94)	138 (*n* = 85)	157 (*n* = 85)

Source: GAO survey of concierge physicians.

Notes: Although there were 112 unique respondents who practiced concierge care in October 2004, not all respondents answered each question. This table presents information about the patients who became members of the physicians' concierge practices. It does not count individuals who may have remained under the care of their physicians as nonconcierge patients.

Respondents reported engaging in a variety of activities to help Medicare beneficiaries choosing not to join the physician's concierge practice find new physicians. These activities included designating a staff person to help with transition questions, referring patients to other physicians within a group practice, calling new physicians to discuss a patient's medical history, and remaining available to treat all patients until they had found a new primary care physician. Additional activities reported include bringing a new physician into the practice to take on the concierge physician's previous patients and speaking individually with each patient. We did not contact Medicare beneficiary patients of the concierge physicians in our survey to determine how many of them had sought or found new physicians. See appendix II for additional details on actions physicians reported taking to help Medicare patients who did not join their concierge practices to find new physicians.

Nationwide and Community Indicators of Beneficiaries' Access

The number of concierge physicians, and the number of Medicare beneficiaries the physicians reported in their previous nonconcierge practices, are relatively small, and therefore national surveys of samples of Medicare beneficiaries are not likely to include many beneficiaries who come into contact with concierge care. In the absence of data to directly assess the impact of concierge care on Medicare beneficiaries' access, however, national surveys can provide general information about the availability of physicians and beneficiary access to care. Overall, national surveys showed that Medicare beneficiary access to physician services has been good, in some cases better than access for individuals with private health insurance.

Surveys targeting both Medicare beneficiaries and physicians revealed that overall access to physician services has not changed substantially in recent years. Most beneficiaries surveyed reported that they have not had a problem finding a primary care physician. Of those who did report a problem, only a small percentage attributed their difficulty to physicians' refusing to take new Medicare patients. Most beneficiaries attributed problems to transportation barriers or their difficulty finding a physician they liked, not to a shortage of primary care physicians who accepted Medicare. Of physicians surveyed, most reported accepting at least some new Medicare patients.[30] Analysis done by the Medicare Payment Advisory Commission of Medicare claims data also revealed that the number of physicians who treated Medicare patients grew at a more rapid pace than the Medicare beneficiary population from 1999 to 2003.[31] Results from our review of Medicare claims data from April 2000 and April 2002 indicated increases throughout the country in both the percentage of beneficiaries who received physician services and the number of services provided to beneficiaries who were treated.[32]

Physician supply data from the Seattle, Boston, and Southeast Florida metropolitan areas, where we found concierge care is relatively prominent, suggested that physicians there were relatively plentiful. The ratio of physicians to overall population in each of these metropolitan areas exceeded the nationwide average for all metropolitan areas in 2001. Because concierge physicians treat fewer patients than do physicians in conventional practices, a community needs other available physicians to take on Medicare beneficiaries who choose not to join a concierge practice. Even in communities where the concierge physician population was largest, however, the number of concierge physicians we identified was small compared with the physician population as a whole.

Information about Experiences of Individual Beneficiaries

CMS officials informed us that CMS has not established a special tracking system for beneficiary complaints about concierge care because the practice is not sufficiently widespread to raise concerns about access to care. Similarly, officials with call centers for 1-800-MEDICARE and CMS

[30]See app. I for a list of the sources we reviewed.

[31]Medical Payment Advisory Commission, *Report to Congress, Medicare Payment Policy* (Washington, D.C.: March 2005).

[32]GAO, *Medicare Fee-for-Service Beneficary Access to Physician Services: Trends in Utilization of Services, 2000 to 2002*, GAO-05-145R (Washington, D.C.: Jan. 12, 2005).

contractors handling beneficiary inquiries and complaints reported that they have received a small number of calls from beneficiaries about concierge care. Because of the low volume of calls on this subject, the majority of these call centers do not have tracking codes for responses to calls about concierge care.[33] Of the 15 CMS contractors who process claims for physician services and responded to our inquiry, only 1 reported establishing a code to track concierge care inquiries.[34] This contractor established the tracking code in response to our inquiry about concierge care in February 2005.[35] As of April 2005, none of this contractor's call centers reported receiving any beneficiary calls about concierge care.

Because of the relatively high number of concierge physicians in the Seattle metropolitan area, CMS's Seattle regional office has been following concierge care, but so far it has not identified an impact in Medicare beneficiaries' access to care. The Seattle office's efforts are part of an agencywide effort to monitor beneficiary access to care through reports in the media and from the CMS divisions that interact with beneficiaries. According to CMS officials in the agency's Seattle regional office, that office has received a small number of calls about concierge care from physicians and beneficiaries, mainly asking whether concierge care is permitted under Medicare law. Seattle regional office officials said they respond in accordance with CMS guidelines: they do not review specific concierge care agreements but help beneficiaries by providing a list of local physicians who participate in Medicare. The CMS Seattle regional office has not found indications that beneficiaries who choose not to pay their physician's membership fees have had problems locating new primary care physicians.

We did not contact Medicare beneficiaries who were patients of physicians who converted to concierge care to determine how many of them had sought or found new physicians. We did, however, contact organizations that Medicare beneficiaries might call with problems or concerns,

[33]It is possible that some beneficiaries have called Medicare claims contractors about concierge care and had their inquiries identified more generally, for example, as "miscellaneous."

[34]Fifteen contractors responded to our inquiry out of a total of 18 contractors who process Medicare claims for outpatient physician services.

[35]This contractor processes claims for physician services for California, Maine, Massachusetts, New Hampshire, and Vermont.

including AARP and the Medicare Rights Center.[36] Like CMS, officials with these organizations reported receiving a few calls from beneficiaries about concierge care, and none reported complaints from beneficiaries about finding a physician or about access to services because of concierge care. Officials with these groups also reported that they have not developed a formal system to track the issue. According to officials from these organizations, calls from beneficiaries about concierge care are usually requests for help interpreting the letters from their physicians explaining the physicians' conversion to concierge care.

Concluding Observations

Although the number of physicians practicing concierge care has grown in recent years, the total number remains very small. Available measures of Medicare beneficiaries' overall access to care, while not directly addressing concierge care, indicate widespread availability of physicians to treat them. The small number of concierge physicians at the time of our review, along with information from available measures of access to services, suggests that concierge care does not present a systemic access problem for Medicare beneficiaries at this time.

Agency and Other Comments

We provided a draft of this report for comment to HHS. In its comments, HHS agreed that concierge care has had a minimal impact on beneficiary access to physician services at this time. HHS noted, however, that the agency is interested in developments in concierge care and will continue to follow this area and to evaluate whether any further steps are indicated. See appendix III for HHS's written comments. HHS also provided technical comments, which we incorporated where appropriate.

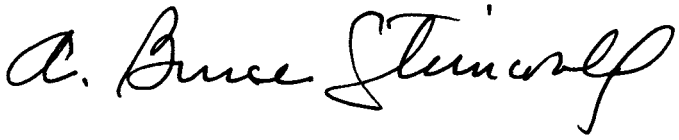
We also provided a draft to the Society for Innovative Medical Practice Design, formerly the American Society of Concierge Physicians, which had no comments.

We are sending copies of this report to the Secretary of HHS, the Inspector General of HHS, the Administrator of CMS, and appropriate congressional committees. We will also provide copies to others upon request. In

[36]See app. I for a list of the organizations we contacted.

addition, the report is available at no charge on the GAO Web site at http://www.gao.gov.

If you or your staff members have any questions about this report, please contact me at (202) 512-7119 or steinwalda@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made major contributions to this report are listed in appendix IV.



A. Bruce Steinwald
Director, Health Care

Scope and Methodology

To obtain information on the characteristics of concierge care, we surveyed concierge physicians about their practices and the types of services and financial arrangements they offer. Because no comprehensive directory of concierge physicians was available, we compiled our own list of concierge physicians to survey. We focused our survey on physicians who, as of October 2004, (1) had established a direct financial relationship with patients in the form of a membership or retainer fee and (2) provided enhanced services or amenities, such as same-day appointments or preventive services not covered by patient health insurance.[1]

We identified concierge physicians through a variety of methods, including a nationwide literature search, telephone interviews, and referrals from other concierge physicians. With the assistance of a contractor, we compiled an initial list of potential survey participants, contacted them to confirm that they met the criteria for inclusion in our survey, and requested referrals to additional concierge physicians. We used a variety of sources to establish our initial list of potential survey participants, including a nationwide Internet search of articles in newspapers, business journals, and medical publications; attendance at the first annual meeting of the American Society of Concierge Physicians (now known as the Society for Innovative Medical Practice Design); and a list of physicians affiliated with a consulting firm that helps physicians establish and maintain concierge practices. This process yielded a final mailing list of 187 individuals.

We mailed the questionnaires in November 2004, after pretesting it with concierge physicians and incorporating suggestions from several reviewers familiar with concierge care; we followed up with nonrespondents during December 2004 and January 2005. Two questionnaires were returned as undeliverable; we removed those names from our total count of potential concierge physicians. The total we used to calculate the response rate for our survey was therefore 185.

We received responses to our survey from 129 physicians, yielding an overall response rate of 70 percent. Of the respondents, 112 physicians confirmed that they practiced concierge care—that is, they reported that they charged a retainer or membership fee for enhanced services or

[1]The scope of our work did not include physicians who imposed additional charges solely to cover the costs of routine administrative services, such as filling out forms. In addition, our results do not include the views of nonconcierge physicians or physicians who may have once practiced concierge care but no longer do.

amenities—as of October 2004. We analyzed only the information provided by these 112 physicians. Because these 112 respondents were not randomly sampled from a larger population of known concierge physicians, the information they provided cannot be projected to any other concierge physicians. We did not attempt to verify the accuracy of their responses.

In addition to the 112 physicians practicing concierge care in October 2004 and responding to our survey, we confirmed—through, for example, telephone interviews conducted by us or our contractor—the concierge status of an additional 34 physicians who did not return our questionnaire. This process yielded a total of 146 confirmed concierge physicians. To analyze the geographic practice locations of these 146 physicians, we assigned the physicians' zip codes to larger geographic units called metropolitan statistical areas (MSA) or primary metropolitan statistical areas (PMSA), as defined in 1999 by the Office of Management and Budget.

To review the aspects of concierge care of interest to the Medicare program and its beneficiaries, we reviewed relevant provisions of Medicare law and documents from the Department of Health and Human Services (HHS), including Centers for Medicare & Medicaid Services (CMS) policy manuals and internal memorandums, information posted on the CMS Web site, an alert published by the HHS Office of Inspector General (OIG), and correspondence between interested parties and HHS officials regarding concierge care. We also interviewed CMS officials at CMS headquarters and in the Seattle regional office, officials with HHS OIG, and concierge physicians and their representatives and, in our survey, asked concierge physicians for their views on the guidance available from HHS on concierge care.

To assess what is known about how concierge care might affect Medicare beneficiary access to physician services, we reviewed national surveys and reports on overall Medicare beneficiary access. Because so few physicians and beneficiaries are affected by concierge care, concierge physicians or their patients are unlikely to be randomly chosen to participate in surveys on access to physicians by Medicare beneficiaries. National surveys and analysis on beneficiary access to physician services are also not sufficiently detailed to address concierge care, but they can provide information about physician availability and beneficiary access to care overall. The sources we consulted targeted beneficiaries, physicians, or both and included the following:

- Bernard, Shulamit, et al. *Medicare Fee-for-Service National Implementation Subgroup Analysis.* Prepared for the Centers for Medicare & Medicaid Services. Research Triangle Park, N.C.: Research Triangle Institute, 2003.

- Center for Studying Health System Change. *Community Tracking Study (CTS) Section Map*. Washington, D.C.: October 2004. http://www.hschange.org/index.cgi?data=10 (downloaded October 2004).

- Centers for Medicare & Medicaid Services. *Medicare Current Beneficiary Survey.* Baltimore, Md.: September 2004. http://www.cms.hhs.gov/MCBS/default.asp (downloaded October 2004).

- GAO. *Medicare Fee-for-Service Beneficiary Access to Physician Services: Trends in Utilization of Services, 2000 to 2002*. GAO-05-145R. Washington, D.C.: January 12, 2005.

- Lake, Timothy, et al. *Results from the 2003 Targeted Beneficiary Survey on Access to Physician Services among Medicare Beneficiaries*. Prepared for the Centers for Medicare and Medicaid Services. Cambridge, Mass.: Mathematica Policy Research, Inc., 2004.

- Medicare Payment Advisory Commission. *Report to the Congress: Medicare Payment Policy.* Washington, D.C.: 2005.

- Schoenman, Julie, et al. *2002 Survey of Physicians about the Medicare Program*. Prepared for the Medicare Payment Advisory Commission. Bethesda, Md.: Project HOPE Center for Health Affairs, 2003.

Because concierge physicians generally treat fewer patients than physicians in conventional practices, we assessed community-level data on physician supply to see if other physicians might be available to take on Medicare beneficiaries who choose not to join a concierge practice. We calculated physician-to-population ratios in communities where we found the highest numbers of concierge physicians and compared them to the average ratio for all metropolitan areas in the United States. To calculate this ratio, we used data from a 2003 HHS Health Resources and Services Administration database known as the Area Resource File. This database included county-level data on active, nonfederal, office-based, patient-care physicians from the 2001 American Medical Association Physician

Masterfile database and county-level resident population data from the U.S. Census Bureau for 2001, which we aggregated by MSA and PMSA.

We did not contact Medicare beneficiaries who were patients of physicians who converted to concierge practices. We obtained information from organizations likely to receive calls from Medicare beneficiaries to determine whether individual beneficiaries were reporting concerns about concierge care or difficulty finding new physicians. We obtained and analyzed information from officials at CMS, call centers for 1-800-MEDICARE, and 15 of 18 CMS contractors that process Medicare claims for outpatient physician services. We spoke with representatives of AARP, the American Bar Association's Commission on Law and Aging, the Center for Medicare Advocacy, the Health Assistance Partnership of Families USA, and the Medicare Rights Center.

We conducted our work in accordance with generally accepted government auditing standards from May 2004 through July 2005.

Summary of Physician Responses to GAO Concierge Care Survey

This appendix summarizes the results from questions we asked physicians who practiced concierge care as of October 2004. We sent surveys to 185 physicians with valid addresses whom we had identified as potential concierge physicians. We obtained responses from 129 individuals, for an overall response rate of 70 percent, and analyzed the responses from 112 physicians who practiced concierge care in October 2004.

The following tables and figures present information on reported characteristics of the 112 concierge physicians who responded to our survey and their practice settings (table 5), the estimated number of patients in their individual practices (table 6), goals for the total number of concierge patients when physicians' practices are fully established (fig. 7), annual membership fees charged by physicians who did and did not bill insurance (fig. 8), actions concierge physicians reported taking to help Medicare beneficiaries who did not join their concierge practices find new physicians (table 7), concierge physicians' views on the sufficiency of HHS guidance on concierge care and Medicare (table 8), and concierge physicians' views on remaining in medical practice and treating Medicare beneficiaries if concierge care were not an option (table 9).

Table 5: Characteristics of Concierge Physicians and Their Practices, October 2004

Characteristic	Category	Respondents
Year physician began concierge care	1997	2
	1998	0
	1999	1
	2000	3
	2001	11
	2002	22
	2003	41
	2004	32
	Total responses	**112**
Years physician in medical practice	1–9	14
	10–19	44
	20–29	45
	30 and above	9
	Total responses	**112**

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Characteristic	Category	Respondents
Physician specialty	Internal medicine	84
	Family practice	24
	Other (e.g., emergency medicine)	1
	Total responses	**109**
Practice setting	Solo	41
	Group	65
	Other (e.g., partnership, management group, and integrated delivery system)	6
	Total responses	**112**
Number of physicians in group practice[a]	1–9	51
	10–19	6
	20–29	1
	30–39	1
	40–49	2
	50 and above	3
	Total responses	**64**
Number of concierge physicians in group practice[a]	1	10
	2	30
	3	24
	4	4
	5	4
	Total responses	**72**
Status of transition to concierge care	All physicians	
	Complete	22
	In progress	90
	Total responses	**112**
	Physicians who began concierge care during 2001 or earlier	
	Complete	9
	In progress	8
	Total responses	**17**
	Physicians who began concierge care during 2002 or later	
	Complete	13
	In progress	82
	Total responses	**95**

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Characteristic	Category	Respondents
Treated some nonconcierge patients	Yes	36
	No	76
	Total responses	**112**
Reasons for seeing nonconcierge patients[b]	To ensure continuity of care for patients who did not join concierge practice	14
	As part of a combined concierge and conventional practice	11
	As part of a subspecialty practice (e.g., pulmonology, nephrology, endocrinology, cardiology, and sleep medicine)	11
	Other (e.g., occasionally as a favor for family members of concierge patients, to treat indigent and Medicaid patients, and to cover for other physicians)	13
Practice accepting new concierge patients	Yes	101
	No	11
	Total responses	**112**
Practice open to new Medicare concierge patients	Yes, only those who pay the membership fee	62
	Yes, and would consider waiving the membership fee	33
	No	3
	Total responses	**98**
Billed patient health insurance for covered services	Yes	85
	No	26
	Total responses	**111**
Of those who billed patient health insurance, billed Medicare for covered services	Yes	79
	No	6
	Total responses	**85**
Relationship to Medicare	Participating	84
	Nonparticipating	4
	Opted-out	23
	Total responses	**111**

(Continued From Previous Page)

Characteristic	Category	Respondents
Age ranges of concierge patients	Percentage of patients aged 20 or younger	
	0	26
	1–24%	76
	25–49%	3
	50–74%	1
	75% and above	0
	Total responses	**106**
	Percentage of patients aged 21 through 64	
	0	0
	1–24%	4
	25–49%	36
	50–74%	42
	75% and above	24
	Total responses	**106**
	Percentage of patients aged 65 or older	
	0	3
	1–24%	28
	25–49%	34
	50–74%	37
	75% and above	4
	Total responses	**106**

Source: GAO survey of concierge physicians.

Notes: Although there were 112 unique respondents, not all respondents answered each question. The total number of responses expected for each question varied; for example, only physicians who stated that they were accepting new patients were asked whether they were accepting new Medicare patients.

[a]Totals include the responding physicians. The responses for group practice include some physicians who responded to the "other" category for practice setting and nonetheless provided information about multiphysician practice settings.

[b]Physicians could select more than one response to this question.

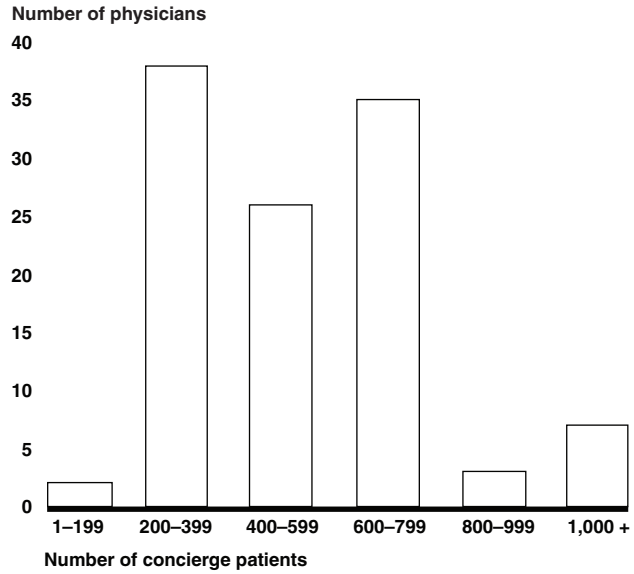
Table 6: Estimated Number of Patients in Individual Practice, October 2004

Patients	Total number of patients	Number who were Medicare beneficiaries
Concierge patients	Minimum: 3	Minimum: 0
	Maximum: 980	Maximum: 590
	Mean: 326	Mean: 129
	Mode: 600	Mode: 0
	Total responses: 109	**Total responses: 105**
Nonconcierge patients	Minimum: 0	Minimum: 0
	Maximum: 4,000	Maximum: 2,800
	Mean: 166	Mean: 57
	Mode: 0	Mode: 0
	Total responses: 109	**Total responses: 105**
Total patients	Minimum: 20	Minimum: 0
	Maximum: 4,035	Maximum: 2,825
	Mean: 491	Mean: 185
	Mode: 200 and 600 (multiple modes exist)	Mode: 0
	Total responses: 109	**Total responses: 105**

Source: GAO survey of concierge physicians.

Notes: Although there were 112 unique respondents, not all respondents answered each question. Physicians were asked to provide their best estimates if specific patient counts were not available.

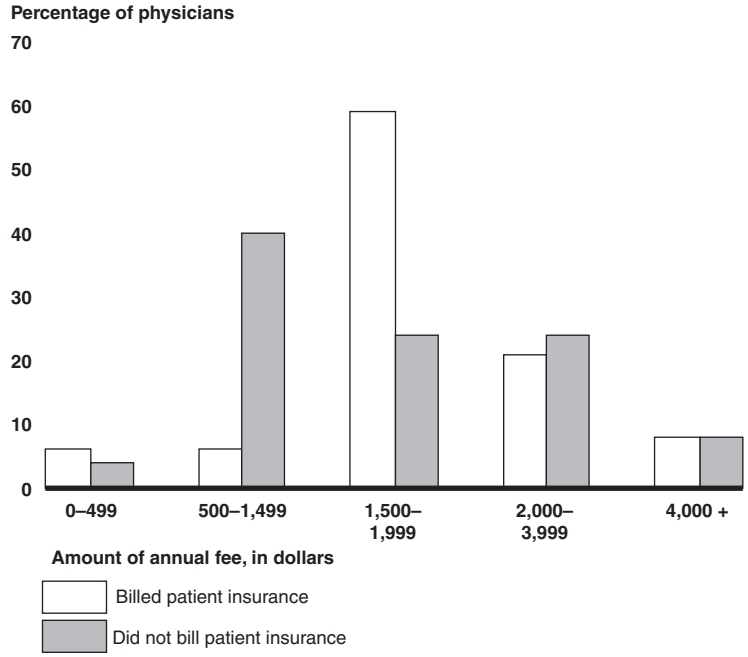
Figure 7: Physicians' Goals for Total Number of Concierge Patients, October 2004



Source: GAO survey of concierge physicians.

Notes: *n* = 111 concierge physicians practicing as of October 2004; 1 respondent did not provide this information. Physicians were asked their individual goals for the number of concierge patients in their care. The largest reported goal for number of concierge patients was 1,300.

Figure 8: Annual Membership Fees Charged by Physicians Who Did and Did Not Bill Patient Insurance, October 2004



Source: GAO survey of concierge physicians.

Notes: n = 110 concierge physicians as of October 2004; 2 respondents did not provide this information. Fees represent those charged for an annual individual adult membership.

Table 7: Actions Concierge Physicians Reported They Took to Help Medicare Patients Who Did Not Join the Concierge Practice Find New Physicians

Action	Percentage of physicians who reported each action, for approximately how many patients			
	None	Some	Most	All
Designated a staff person to help patients in transition (*n* = 81)	15	3	5	78
Forwarded patient medical records to new physicians (*n* = 83)	6	13	11	70
Remained available to treat all patients until they had found a new physician (*n* = 84)	7	11	15	67
Referred patients to physicians within group practice (*n* = 81)	19	16	25	41
Provided patients with a list of area physicians who accept new Medicare patients (*n* = 80)	28	26	8	39
Referred patients to physicians outside the practice who accept new Medicare patients (*n* = 83)	13	51	8	28
Coordinated with patients' insurance companies to verify that all patients chose new physicians (*n* = 77)	66	17	7	10
Referred patients to their insurance or managed care organizations for physician lists (*n* = 77)	61	30	3	7
Called new physicians to discuss patient history (*n* = 81)	12	80	3	5
Wrote individual letters on behalf of patients to new physicians (*n* = 76)	46	49	3	3

Source: GAO survey of concierge physicians.

Notes: Percentages do not necessarily add to 100 because of rounding. Although there were 112 unique respondents, not all respondents answered each question.

Table 8: Concierge Physicians' Views on the Information Available from HHS about How Medicare Requirements Affect Concierge Care, October 2004

Subject	Responses	Number of physicians
The information available from HHS is clear and sufficient	Yes	29
	No, but clear and sufficient information is available from other sources	20
	No, and clear and sufficient information is not available from other sources	38
	Don't know/no opinion	24
	Total responses	**111**
More official guidance is needed from HHS on how Medicare requirements might affect concierge care	Yes	67
	No	20
	Don't know/no opinion	24
	Total responses	**111**

Source: GAO survey of concierge physicians.

Note: Although there were 112 unique respondents, not all respondents answered each question.

Table 9: Concierge Physicians' Views on Remaining in Medical Practice and Treating Medicare Beneficiaries if Physicians Were Unable to Practice Concierge Care

Subject	Responses	Number of physicians
If not able to practice concierge care, would have continued in the clinical practice of medicine	Definitely yes	11
	Probably yes	34
	Don't know/no opinion	16
	Probably no	32
	Definitely no	18
	Total responses	**111**
Of those physicians who would have remained in medicine without concierge care, interaction with Medicare beneficiaries	Would have treated Medicare beneficiaries as a participating physician	25
	Would have treated Medicare beneficiaries as a nonparticipating physician	5
	Would have treated Medicare beneficiaries under private contracts and opted out of Medicare	7
	Would not have treated Medicare beneficiaries	1
	Don't know/no opinion	7
	Total responses	**45**

Source: GAO survey of concierge physicians.

Notes: Although there were 112 unique respondents, not all respondents answered each question. Only physicians who stated they would have definitely or probably continued in the clinical practice of medicine were asked how they would treat Medicare beneficiaries if they were unable to practice concierge care.

Comments from the Department of Health and Human Services

DEPARTMENT OF HEALTH & HUMAN SERVICES Office of Inspector General

Washington, D.C. 20201

JUL 19 2005

Mr. A. Bruce Steinwald
Director, Health Care
U.S. Government Accountability Office
Washington, DC 20548

Dear Mr. Steinwald:

Enclosed are the Department's comments on the U.S. Government Accountability Office's (GAO's) draft report entitled, "PHYSICIAN SERVICES: Concierge Care Characteristics and Considerations for Medicare" (GAO-05-776). The comments represent the tentative position of the Department and are subject to reevaluation when the final version of this report is received.

The Department provided several technical comments directly to your staff.

The Department appreciates the opportunity to comment on this draft report before its publication.

Sincerely,

Daniel R. Levinson

Daniel R. Levinson
Inspector General

Enclosure

The Office of Inspector General (OIG) is transmitting the Department's response to this draft report in our capacity as the Department's designated focal point and coordinator for U.S. Government Accountability Office reports. OIG has not conducted an independent assessment of these comments and therefore expresses no opinion on them.

HHS COMMENTS ON THE U.S. GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED, "PHYSICIAN SERVICES: CONCIERGE CARE CHARACTERISTICS AND CONSIDERATIONS FOR MEDICARE" (GAO-05-776)

The Department of Health and Human Services (HHS) appreciates the opportunity to comment on the U.S. Government Accountability Office's (GAO) draft report.

General Comments

The growth of concierge care has been the subject of some debate in the past few years. Much of the concern has focused upon the impact concierge care may have on beneficiary access to physician services. HHS agrees with the GAO's finding indicating that concierge care has had a minimal impact at this time. However, we remain interested in developments in concierge care. Therefore, we will continue to follow this area and to evaluate whether any further steps are indicated.

GAO Contact and Staff Acknowledgments

GAO Contact

A. Bruce Steinwald (202) 512-7119 or steinwalda@gao.gov

Acknowledgments

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