Boutique Medicine's Quality Challenge: Can Specialized Registries Aid Consumer Choice?

written by Thomas Dent, M.D. | April 13, 2016

Many physicians—especially those in primary care—are angry about the practice of medicine. Dogged by high administrative overhead, they feel the pressure of shorter visit times to meet the practice's income needs. In some geographic areas, PCPs are opting out of Medicare assignment in large numbers and establishing boutique medicine practices (including "concierge medicine"). Indeed, as CMS pushes providers toward risk under Alternative Payment Mechanisms (APMs) and away from the traditional fee-for-service, concierge medicine has become an attractive alternative for physicians who are fed up with the system.

What does this trend mean for access and quality of care, especially when outcomes measurement becomes more difficult in the absence of quality data reporting? How will patients be able to make informed choices if this movement expands, and what will it mean for the various Value-Based Health Care and risk models being established by Medicare, Medicaid and commercial health plans?

Models of Boutique Medicine: A Focus on Direct Primary Care

There are multiple models of boutique medicine, but they all represent (at least in part) an escape from dealing with our current third-party payment system. The patient contracts directly with the provider and pays for added services. A so-called Direct Patient Contracting Practice (DPCP) has at least one of the following characteristics:

> Administrative service fee (retainer);
> Payment in cash at the time of service, with some providers not accepting insurance and requiring patients to get reimbursement from insurers on their own, if at all;
> Smaller patient panels.

A variation of this model, of particular importance to accessing primary care services under Medicare, is Direct Primary Care (DPC). In this model the primary care practice:

> Charges a periodic fee for services;
> Does not bill any third party a fee-for-service charge;
> Charges a per-visit fee that is less than the monthly service fee.

DPC is unique among the DPCP models because the Affordable Care Act (ACA) authorizes direct primary care to be included in the insurance exchanges when paired with a wrap-around low premium, high-deductible insurance policy covering services other than primary care.

With the DPCP there is obviously a significant loss of encounter data, given the loss of primary care billing data. What does this mean for quality and outcomes measurement?

Quality Measurement Under Boutique Medicine: Is it Possible?

Traditional quality measures require a denominator (eligible number of patients or instances for measurement) and a numerator (the identity and volume of patients who met the measure by receiving services or achieving outcomes defined by the measure). Together these elements determine a performance rate.

All of this information should be present in the primary care physician's EHR. Since one of the purposes of the DPC is to eliminate the overhead costs of billing, however, coding and billing experts would not be overseeing this data, increasing the risk of errors.

For example, a former client had very few patients who were eligible for the myocardial infarction measure. Nonetheless, he maintained that he had a large number of patients who'd had a prior myocardial infarction and questioned why we weren't reporting them. The reason? He was coding all these patients for diffuse atherosclerosis rather than myocardial infarction, so the patients weren't eligible for the measure. In order to measure quality, you must have a clear idea of which patients are being measured for what diagnosis.

Under Value-Based Health Care, outcome measures are increasingly utilized and attributed value. DPC practices must clear a significant hurdle to adjust for the high-risk patients in their practices. Capturing all of the relevant codes, both diagnostic and procedural, is essential.

Complicating any comparisons based on outcomes measures for DPC practices is self-selection bias. Under most iterations of boutique medicine, the patient population is more affluent. Affluence has a significant association with improved outcomes, creating an unfair advantage

when DPC practices are compared to traditional practices for performance on outcomes.

Finally, any comparisons of patient satisfaction will be weighted in favor of DPC practices. Patients paying out of their pockets for primary care services are more likely to be more satisfied than those who receive medical care from providers who take third party payments.

Can Value Be Measured Under Direct Primary Care?

The value proposition of the DPCP models is based on the implicit belief that the following are valuable:

> Annual physical examination or the "executive physical"
> Frequent visits and contact with primary care physician
> More time for patient visits

According to recent research, however, the merit of the annual physical has been vastly overstated and leads to more costs rather than better patient outcomes. As a primary care physician, I would like to believe more visits for certain patients are salutary, but when the number of primary care visits in a year doubles from an average of two to four, that raises some questions. My personal belief is that setting aside more time for patient visits would be valuable, but there is no rigorous proof.

This lies at the heart of the problem with determining efficacy of the Direct Primary Care model: There is no proof because no data is under review. This requires data collection and reporting, as well as being part of the "system." But this is what the providers are trying to avoid. The patient's sense of being monitored and cared for is the measuring stick for value, rather than real results.

In order for these practices to demonstrate meaningful improvement in their patient populations, however, there must be a comparison of the change in outcome results for the same population of patients before and after implementation of direct primary care services. Sufficient numbers of patients must be involved to assess the efficacy of this intervention. Data would need to be extracted from the EHR into a registry and then analyzed and validated. Outside claims data from payers, including CMS, would also be needed and fed in to the registry.

Patient Access and Quality Under Direct Primary Care: It Depends on Who You Are

There are many aspects of the DPC model that should be attractive to patients, particularly increased access to and time with their physician. However, if patients are paying for these

services, they will certainly only be attracted if they routinely need (or feel they need) to contact their physician with some frequency. This may create an unwanted self-selection bias that some physicians may find less than desirable.

At the same time, these models must not serve as a mechanism to rid practices of complex, highly utilizing, challenging patients. As an organization that measures quality, we believe it would be a terrible outcome if the pressures of performance measurement led in this direction.

In order to assess what will work best for patients, not just physicians, modifications of these models must be continuously assessed via outcomes measurement.

Public Health Reporting for Boutique Medicine: Does This Facilitate Better Patient Information?

One of the interesting possibilities for measuring the value and outcomes of boutique medicine practices is Public Health Reporting to Specialized Registries under Meaningful Use, and later MIPS. Physicians who opt out of the system are doing so to avoid the paperwork and the insurance system, and to make their practices more patient-focused. The Public Health Reporting requirements do not carry the same burdens, especially if EHRs can facilitate the transfer of data.

The level of administrative complexity is an issue that must be addressed in medicine, especially for small private practices lacking the infrastructure of hospital-employed groups. But there should be a way, in an age of data and measurement, where consumers can evaluate the quality of their choices and see comparative data. Concierge medicine should participate in some efforts to review and evaluate outcomes, and policy makers and health care systems should try to assist these groups through minimally-intrusive methods of data capture.

Image Credit: Ben Shafer