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The Fraud of Concierge Medicine

Recently Johnny Mauffray, Associate Director, Physician Development MDVIP,, A Procter & Gamble Company visited Southeast Texas Medical Associates, LLP (www.jameslhollymd.com). Mr. Mauffray left two articles for my review:

1."Personalized prevention care model versus a traditional practice: comparison of HEDIS measures, " *The International Journal of Person Centered Medicine* (Vol 2 Issue 4 pp 775-779).-- http://www.ijpcm.org/index.php/IJPCM/article/view/305

2. "Personalized Prevention Care leads to Significant Reductions in Hospital Utilization," *The American Journal of Managed Care*, Vol. 8, No. 12, pp 3453-e460). -- http://www.ncbi.nlm.nih.gov/pubmed/23286675

It appears that MDVIP is establishing its own distorted literature to legitimize its so-called "model of care" which MDVIP is promoting as superior to current practice models. I have studied mdVIP before and published the following about why concierge medicine is not a model of care which promotes the public health and why it is not in the public interest:

- Concierge Medicine and the Future of Healthcare
- Entrepreneurship vs Professionalism Part I: Drivers of Healthcare Cost
- Entrepreneurism versus Professionalism Part II: Republicans and Democrats Both Have it Wrong

The following are disturbing things about MDVIP:

- Looking at their website, there is no diversity - all patient pictures are of Caucasians
- Worse still, looking at the pictures of the 547+ physicians listed who "belong" to MDVIP, they are all Caucasian, except for one Asian.
- They pay Proctor and Gamble $500 a year per patient for services rendered by mdVIP. In some indirect way these patients 'belong" to Proctor and Gamble, which may be an illegal relationship in many states.
- They claim to be patient-centered but create their model by excluding all but the well-off and healthy from their model.

- They do not say what would happen to "their patients" if they become unable to pay their annual fee of several thousand dollars.
- In fact, the patient does not have a professional relationship with a physician but has a financial contract which apparently will be abrogated if they become unable to pay their annual fee.
- In my article on concierge medicine above there is a chart contrasting Patient-Centered Medical Home and Concierge Medicine. This chart shows why the claim by MDVIP of being patient-centered is false.

	Medical Home	**Concierge Medicine**
Method	Transforming the practice to benefit all patients.	Artificially limiting the size of the practice to benefit the few.
Goal (Unique to the Model of care)	Collaborating with the patient to produce coordinated care	Improving patient convenience
Public Policy	Increasing access to care for all patients	Significantly deceasing or eliminating access to care for 80% of patients
	Deceasing cost of care	Increasing patient cost of care
	Eliminating Ethnic Disparities in care	Probably eliminating ethnic diversity in the practice
Dismissal from practice	No structural reason	Non-payment of franchise fee presumably
Treatment content	Evidenced-based medicine	Evidenced-based medicine
Record System	EHR with electronic patient management tools	EHR unclear how extensive
Transitions of Care	Plan of Care and Treatment Plan with care coordination	Undetermined
Barriers to Care	Evaluated and addressed	Presumably none exist due to patient selection on economic basis
Standards of Care	Published Quality Metrics	Undetermined
Endorsements available	Quality by NCQA, AAAHC, etc	Corporate by claimed affiliation with Mayo, Cleveland Clinic and others

With a workforce shortage in primary care, MDVIP and Concierge physicians eliminate all but a small percentage of their former patients leaving the other patients without a "medical home." With only 500 or so patients, all of whom by financial screening are middle or upper class, they tout themselves as the solution to healthcare quality in America. You cannot improve healthcare in American by excluding from your care all of those for whom there are financial barriers to care and/or those who need a great deal of care. What happens to the others? I would like to see the following on MDVIP's patient population:

1. Ethnic distribution of those whom they keep in their practice and of those whom they discharged from their practices.

2. Socio-economic distribution of those whom they keep in their practice and the same information for those whom they discharged from their practice.
3. The mean and standard deviation of the HCC/RxHCC coefficient aggregates for their patient populations which they keep in their concierge practice and the same information for those whom they discharged from their practice.
4. The education, gender, age and primary language of their population which they keep in their practices and the same for those whom they eliminated from their practices.
5. The number of patients dismissed from the MDVIP practice who could not find a new physician.

The following are public records of SETMA's patient population and performance::

1. Public Reporting - Reporting by Type -- public reporting by provider name of provider performance on over 300 quality metrics incuding HEDIS for 2009-2013.
2. EPM Tools - HCC/RxHCC Risk Tutorial -- patient HCC/RXHCC coefficient aggregate showing the chronicity and severity of illness of patients seen by SETMA.
3. Being Accountable For Good Preventive Care -- an article published by SETMA on good preventive care in a diverse population of over 40,000 patients.

SETMA's data is based on all patients no matter whether they are insured or not, well educate or not, have adequate resources for their healthcare or not. When SETMA decided to become a Patient-Centered Medical Home in 2009, we did not exclude our sick patients. We included everyone and determined to improve the help of all patients. Rather than charge patients a premium to be a part of SETMA, the partners of SETMA founded The SETMA Foundation. Annually, SETMA partners give $500,000 of their money to the Foundation That money cannot profit SETMA but is used to pay for the care of our patients who cannot afford their care. We pay for our patients' medications, transportation, surgeries, dental care, etc, as well as treat them at no charge at SETMA.

The following is a link t a description of SETMA's Model of Care: SETMA's Model of Care Patient-Centered Medical Home: The Future of Healthcare Innovation and Change.

The greatest fraud of concierge medicine is the pretense of being patient-centric. The problem is they are patient-centric only for the patients left after they impose a tax on being a part of the concierge practice and after abandoning patients unable or unwilling to pay the tax, many of whom they have cared for for years, because they could not or would not pay the tax. They contrasting of concierge medicine and medical home above indicates why NCQA, AAAHC, URAC and the Joint commission should not allow concierge practices to apply for PC-MH recognition or certification. If these organizations allow concierge practices to receive their approval, they will have abandoned any moral imperative they have as accrediting bodies. There is noting in the mission of medical home, in the Triple Aim or in ACOs which allows for the exclusion of eople who cannot afford a financial premium upon their care or for the exclusion of those who have complex, chronic health conditions. In addition if the Agency for Healthcare Quality and Research tacitly embraces concierge medicine as they currently do by listing one of the above two articles as "articles of interest," they will do a disservice to the advancement of quality medicine.

Apparently, the *International Journal of Person Centered Medicine* was created to promote concierge medicine. Of the journal the inaugural editor says: ""Person-centered Medicine is dedicated to the promotion of health as a state of physical, mental, social and spiritual well-being as well as to the reduction of disease. It is founded on the articulation of science and humanism to enhance personalized understanding of illness and positive health, clinical communication, and respect for the dignity and responsibility of every person, at individual and community levels. The Journal Editorial Board is drawn from all major medical specialities and health disciplines and is constituted by the world's most distinguished thinkers in the field. Regional Editors are being appointed for North America, Latin America, Europe, Africa, Asia, and Oceania. Professor Andrew Miles said: 'The *Int J Pers Cent Med*, creating as it does an international forum for the exchange of ideas and the promotion of scholarly debate, is an extremely important contribution to the advancement and operationalisation of humanistic medicine in our times. I am honoured to be invited to be the inaugural Editor-in-Chief at this exciting time of paradigmatic change within medicine. I recommend the journal as essential reading for all clinicians and trainees and to all those academic disciplines with an interest in or responsibility for the promotion of person and people-centered medicine' **The methodology of the above article. published by the Int Journal of Person Centered Medicine, violates fundamental principles of science. The article contrasts outcomes in practices which randomly accept all patients and suggests, under the guise of science, that superior preventive health outcomes, based on preselected panels of patients who pay a fee to be in the cohort, demonstrate the superior methodology of concierge medicine.** This is a flagrant quasi-science perpetrated fraud. It implies that a non-randomized, small group of patients selected for pecuniary reasons by a group of physicians apparently intent on decreasing their responsibilities and increasing their income, is a valid sample for scientific study contrasted against a randomly selected population of patients. After violating sound scientific principles, concierge medicine then boasts that its excellent numbers for preventive care in a fraction of their previous patient population is evidence of the superiority of the concierge model. If SETMA selected 500 pages for study based on their ability to pay for their care and excluded from consideration the other tens of thousands of patients we care for, everyone would cry foul; why would this same principle not also apply to MDVIP.

SETMA received the following:

"The plaque arrived on April 23, 2013 and read: '**Texas Physician Practice Award presented to Southeast Texas Medical Associates, LLP for Providing Exceptional Preventive Health Care Services using Health Information Technology**.' Awarded by The Texas Physician Practice Quality Improvement Award Committee, the committed is made up of the TMF Health Quality Institute (Texas' CMS Quality Improvement Organization), the Texas Medical Association and the Texas Osteopathic Medical Association. Because our Nurse Practitioners are also included in the award, SETMA has recommended expanding the sponsoring organizations to include the Texas Nurses Association. The Committee commented further, 'Congratulations on this significant accomplishment, which illustrates your commitment to delivering quality care to all patients. Your award demonstrates that SETMA has an exceptional team.' 'Quality care to all patients' is one of the major goals of healthcare reform and one of the foundational principles of an ACO. This award is also an affirmation of SETMA's decision in 2000 to begin tracking quality metrics performance and our 2009 decision to begin public reporting of performance by provider name. The results are now posted on SETMA's website www.jameslhollymd.com under Pubic Reporting for 2009-2013."

The above referenced concierge articles notes the following conclusion, "..the results from this retrospective chart review support our belief that the MDVIP primary care model providess (sic) more of the recommended preventive care services when compared to national health plans and delivers possibly better clinical outcomes. Further research is necessary to demonstrate that this personalized, preventive care model and increased physician contact time results in better health outcomes and ultimately lower healthcare costs." The only thing the MDVIP journal's data proves is that it is possible to select a subset of your patients for evaluation and prove that that subset has better preventive care than the whole. Unfortunately for SETMA is that we do not select a subset of patients but we audit all patients. Still the CMS study of SETMA's care of Fee-for-service Medicare beneficiaries by RTI international proved that SETMA's outcomes, coordination and costs were superior to similar practices. See Medical Home Feedback Report for SETMA II October 2011.pdf

MDVIP's work on reducing readmissions is equality flawed being based on a pre-selected subset of their former practices rather than a random-controlled group of patients. With 16,848 patients discharged from the hospital over the past 48 months, the two attachments above address the processes SETMA has put in place to deal with readmissions. The following is a sample of our data.

	2009	2010	2011	2012	2013 (1st Quarter)
30-Day Readmit Rate	**11.24%**	**13.41%**	**23.19%**	**7.22%**	**16.67%**
PN Any APR-DRG	**10/89**	**11/82**	**16/69**	**7/97**	**6/36**
30-Day Readmit Rate	**27.27%**	**35.71%**	**30.30%**	**10.34%**	**9.09%**
PN FFS Mcare 65+	**3/11**	**5/14**	**10/33**	**3/29**	**1/11**

We believe that tools and processes we have designed over the past 14 years will allow us to address the problem of readmissions in a sustainable fashion without firing from our practice patients who have great needs. It is my hope that concierge medicine will be recognized for what it is, an aberration and that it will be rejected by academia, by quality standard organizations, by NCQA, AAAHC, URAC and Joint Commission and by mainstream medicine. Do physicians have the right to adopt a concierge model of practice. Legally? Yes. Morally, it is highly questionable whether this is a professional model of care which fulfills our responsibility to our communities and to our patients

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Dr. Holly's Answer to Dr. Weil (Link at top) - 06/12/2013

Dr. Weil's conclusion that MDVIP's reduction in hospital admissions may be due to improved care ignores the logical and obvious conclusion that it is due to adverse selection. This means that MD VIPis selecting only well-to-do patients who are healthier. Please see my analysis above

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