Out of Network (OON)
Concierge Practices
Opting Out
Direct Primary Care

What are the differences or issues in dealing with each of these scenarios?

Ginny Martin, CMA (AAMA), CPC, CPCO, CHBC

NATIONAL SOCIETY OF CERTIFIED
NSCHBC
HEALTHCARE BUSINESS CONSULTANTS

First, I'd like to take the opportunity to personally thank two wonderful colleagues;

Sean Weiss of Doctors Management for his invaluable insight into Out of Network laws and regulations

Also David Zetter of Zetter Healthcare for his counsel on ERISA.

I value their wisdom and their friendship and the fact that they are my colleagues within the NSCHBC.

A truly excellent organization, by the way . . .

NATIONAL SOCIETY OF CERTIFIED
NSCHBC
HEALTHCARE BUSINESS CONSULTANTS

Overview

- Topics Today May Appear To Be Similar, But They Are Very Different
  - Today, we're going to talk about Out of Network, then Concierge Practices, then Opting Out and lastly Direct Primary Care and the things to consider for each of these scenarios.
  - Each of these options require many of the same careful consideration by clients:
    - Is the specialty of the group enough to warrant special consideration by the insurer, i.e. a specialty with no significant presence in the market or a specialty with very few practitioners nationally?
    - What percentage of the practice is involved – again specialty is a consideration?
    - Are services currently being reimbursed enough to cover the cost of staffing and supplies to provide?
    - Can the practice negotiate with the insurer for Out of Network rates or is the practice at their mercy?
    - What does the contract say concerning Out of Network, Opting Out

Out Of Network Status & Reimbursement

- **IS THERE A FEDERAL STANDARD?**
- *There is **no single federal rule** that tells insurers what they must pay for every out-of-network practitioner claim.*
- Federal law regulates **some** out-of-network payment disputes via No Surprises Act
- It does **not** create a national fee schedule for all out-of-network care
- In practice, reimbursement is:
  - **Structured** in certain surprise-billing settings – mainly hospitals, ASC's
  - **Variable** outside those settings – totally dependent upon the insurer
- **Audience takeaway**
- The best short answer is:
  "Not a complete free-for-all, but not a fully standardized federal reimbursement system either."

Authorities
42 U.S.C. § 300gg-111
42 U.S.C. § 300gg-112
42 U.S.C. § 300gg-131
42 U.S.C. § 300gg-132

NATIONAL SOCIETY OF CERTIFIED NSCHBC HEALTHCARE BUSINESS CONSULTANTS

Out of Network – No Surprises Act

- **Where Federal Law Does Apply: The No Surprises Act**
  - **Covered categories**
    - **Emergency services**
    - **Certain non-emergency services** furnished by nonparticipating providers at participating facilities
    - **Air ambulance services**
- **What the federal framework generally requires**
  - Patient cost-sharing is generally limited as though the care were **in network**
  - The plan or issuer generally must issue an **initial payment or notice of denial within 30 calendar days**
  - If payment remains disputed, the matter can proceed to:
    - **Open negotiation**
    - **Federal independent dispute resolution (IDR)**
- **Important caveat**
  - The Act creates a **payment-dispute process**
  - It does **not** create a universal reimbursement amount for all claims

Authorities
45 C.F.R. § 149.110
45 C.F.R. § 149.120
45 C.F.R. § 149.130
45 C.F.R. § 149.510

Out of Network – Why Reimbursement Still Feels Fragmented

- **What usually drives payment**
  - **Plan language**
  - **Insurer payment methodology**
  - **Applicable state law**
  - **ERISA preemption issues**, especially for self-funded employer plans and plan documents
  - **ERISA remedies** are generally narrower than state law remedies
- **Why the landscape is still unsettled**
  - Federal law leaves many ordinary out-of-network claims to contract terms and other governing law
  - State surprise-billing rules may control in some settings
  - For self-funded plans, ERISA can limit the reach of state insurance regulation and depend on plan documents
  - Even within the federal surprise-billing framework, some implementing rules have been partially vacated in litigation
- **Takeaway**
  - **There is no universal federal reimbursement rule for all out-of-network claims**
  - **There is a federal framework for certain surprise-billing claims**
  - **Everything else is much more plan-specific and state-specific**

Authorities
42 U.S.C. § 300gg-111(a)(3)(K)
29 U.S.C. § 1144(a)
29 U.S.C. § 1144(b)(2)(B)
Texas Medical Assn. v. U.S. Dept. of Health & Hum. Servs., No. 6:22-cv-450-JDK (E.D. Tex. Aug. 24, 2023

Concierge Practices

- **Differences Between Concierge and Traditional Practices**
  - Typically, The Biggest Difference Is The Number of Patients. Healthcare entities with employed physicians typically thousands while Concierge see less.
- **A Concierge Practice Still Participates In Insurance Contracts**
  - They Typically Offer The Patient Services Not Covered By Their Insurance
    - More Time (Longer Appointments) With The Physician
    - Easier Access To Care (24/7)
    - Direct Access via Online Portal (like MyChart), Email or House Calls
    - Care Provided By A Physician (or Designated NPP)
    - Same Day or Next Day Appointments With Physician (or Designated NPP)
    - Focus is on Wellness and Preventive Care
- **What Are The Financial Considerations**?

Concierge Practices – Financial Considerations

- **Insurance Costs:**
  - The patient is still responsible for insurance premiums and any copay or deductible amounts for the services billed to insurance as well as secondary or Part D plan premiums in the case of Medicare.
- **Additional fees for concierge services**
  - Are monthly and can range from less than $100 per month to over $500 per month depending upon the level of concierge services contracted for. Executive services offer things such as genetic testing, nutrition counseling and full-body scans. Some Executive services are $500-$800.
  - Additionally, areas of the country where medical care is not as readily available can see fees as high as $1,000.00 per month.

Continued....

Concierge Practices … Financial Considerations

- **Things For Patients To Watch For When Contracting for Concierge Services:**
  - **Set Up Fees**: Many Practices Charge An Upfront "Joining Fee", Depending Upon Level of Services Chosen And Area of The Country. ($100 - $1,000)
  - **Age Tiered Pricing**: Younger, Healthier Patients May Pay Less for Concierge Services (Less than $100 per Month), While Seniors, Typically With More Co-Morbidities Pay More ($275-$500 per Month).
- **Things Providers Who Offer Concierge Services Need To Watch For**
  - **Collection of Concierge Fees**: Successful Collection Should Be Set Up As Automatic Fees, Either Applied To Credit Cards Automatically or Set Up As ACH Bank Payments.
  - **Written Contracts With Patients:** Specifically Outlining The Services They Will Receive, Ensuring Nothing Provided Will Conflict With Insurer Contracts.

Opting Out

- The Act of “Opting Out” Has Several Applications:
- Opting Out of Medicare:
  - Providers Must File An Affidavit With Their Medicare Administrative Contractor Stating They Are Opting Out. The Initial Period Is Two Years With Automatic Renewals. For A Participating Provider, The Affidavit Must Be Filed Within Thirty Days Before The Start of A New Calendar Quarter
  - Providers Remain In an Opt Out Status for The First Two Years, Unless The Provider Is A First Time Opt Out Provider And Decides To Cancel The Opt Out Status Within 90 Days Of Filing Their Affidavit (Grace Period).
  - They May Not Bill Medicare Or Be Paid By Medicare For Any Service The Patient Receives, Nor Will Any Providers Acting Upon Referrals From The Opt-Out Provider Be Paid For Services Resulting From The Referral. In Addition, The Opt Out Provider Cannot Prescribe Medications Paid For By Medicare Part D

Opting Out … Continued

- Opting Out of Medicare Cont:
  - Providers Cannot Opt Out As A Group, Must Do So Individually.
  - Providers Who Opt Out May Not Bill As Part of A Participating Group, Rather Must Bill Individually. Participating Groups May Not Receive Any Compensation For An Opt Out Provider.
  - The Opt Out Provider Must Sign A “Private Contract” With Medicare Beneficiaries They Will Treat For Non-Emergency Services Prior To Any Services Being Rendered.
  - The Private Contract Language Must State Pt Understands Medicare Won’t Pay For Services, Nor Will Supplemental Policy Or Part D.
  - The Private Contract Language Must Also Indicate If The Provider Is Excluded From The Medicare Program.
  - A Sample Private Contract Form Is Available On The CMS Website Under Forms.

Opting Out … Continued

- Medicare Cont:
- Referring, Ordering, Prescribing Physician Status
  - After a physician Opts Out of Medicare, they may re-enroll with Medicare as a Referring, Ordering, Prescribing Physician meaning they can order tests, refer patients to other providers (who will be paid), prescribe medications, etc.
  - They still cannot be paid for services rendered to Medicare patients. Opting Out extends to any Medicare Advantage Plan.
  - They can be paid for Emergency services to a Medicare patient, but only if they do not have a contract in place with that patient.

Opting Out … Continued

- Opting Out of Commercial Plans
  - Evaluate patient population for accurate number of patients covered by plan
  - Each contract has their own participation, opt out rules. Be sure your client knows what those are.
  - Some plans only allow written termination receipt during specified periods – i.e. within 30, 60 or 90 days of the plan year anniversary or automatic renewal kicks in and the physician is locked in for another year.
  - Physicians are subject to State Rules regarding Opt Out status and also “No Surprises” Act rules.
  - Opting Out of a Commercial Plan, things to be aware of are:
    - Patients Must Be Notified Before The Opt Out Status Date
    - Patient May Not Be Able To See Physician Except On a Cash Basis
    - Payment for services is as a “Out of Network” provider.
    - Payment for services may not be allowed – need to review contract terms before decision.
    - Patient costs will increase.

Direct Primary Care

- National Network of DPC Physicians
  - The Physician Opts Out of all traditional insurance plans
  - Patient load is much less – typically in the 400-600 range vs. 1,500 – 2,000 patients in a health system employment situation
  - Primary Care Only although numerous specialists have joined the network to provide specialty services on a cash basis
  - No Surprises Act applies
  - Services provided typically include Comprehensive Annual Physicals, Wellness Counseling, Screenings for Cancer, Diabetes Risk Assessments, Cardiovascular Evaluations, Acute and Urgent Care - Simple Lacerations, Sprains, Burns.

Direct Primary Care - Continued

- **A DCP Practice Offers The Same or Enhanced Services as Concierge**
  - More Time (Longer Appointments) With The Physician and Unlimited Access
  - Easier Access To Care (24/7)
  - Direct Access via Online Portal (like MyChart), Email or House Calls
  - Care Provided By A Physician (or Designated NPP)
  - Same Day or Next Day Appointments With Physician (or Designated NPP)
  - Focus is on Wellness and Preventive Care
  - Wellness or Nutrition Counseling
  - EKG's, Rapid Strep, Urinalysis, Pregnancy Tests, Laceration Repair
  - Mental Health – Screenings and Support for Anxiety & Depression
  - Coordination For Lower Cost Diagnostic Studies and Prescriptions
  - Stronger Physician/Patient Relationships

Direct Primary Care - Continued

- **Financial Arrangements:**
  - Written contract with each individual patient, although some practices have “Family Plans” with the number and ages of individuals clearly stated.
  - Patient must maintain high deductible insurance for hospital services, specialist services, etc. Many times, the DCP provider has a network of lower fee specialists, labs, etc. the patient can pay out of pocket.
  - Monthly fee which is much less expensive than Concierge fees, ranging from $75.00 to $100.00 per month, usually dependent upon the age of the patient and their physical status.
  - Fee is a recurring and automatic – charged to a credit card or ACH payment. This is critical for a successful DCP practice.
  - Recent legislation allows HSA’s to pay the premiums (monthly fees).

Direct Primary Care - Continued

- **Other:**
  - DPC Physicians Opt Out of All Insurance Plans Including Medicare.
    - They may re-enroll with Medicare as a Referring, Ordering, Prescribing physician, allowing referrals, orders, prescriptions, etc.
  - DCP Physicians report a higher level of satisfaction with the quality of the care they provide to patients, their relationships with their patients and the ability to spend quality time with their families. A recent poll by the AAFP shows 96% of DCP physicians are very happy they made the switch.
  - Interestingly, some health systems are now employing DPC physicians, especially since our aging population is quite willing to pay more for a quality relationship with their doctors.

Questions?

- Thank You!!!

NATIONAL SOCIETY OF CERTIFIED
NSCHBC
HEALTHCARE BUSINESS CONSULTANTS