Concierge Practices Even for Doctors Who Don't Like the Idea

Neil Chesanow

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Elitist Medical Practice?

Despite concierge medicine's reputation for being elitist, many doctors make the switch not because they want cushier lives but because they want more clinically challenging ones. In many cases, concierge practices enable them to better focus on their older, sicker patients, who rarely get the time they need in a conventional practice.

These are the patients, after all, whom many doctors presumably go into medicine to treat: those with complex diagnoses and complicated medication regimens -- the ones who give you a chance to practice at the top of your game.

Take Thomas W. LaGrelius, MD, a family physician and geriatrician in solo practice in Torrance, California, and internist Mario Ficarola, MD, the lead physician in a 5-doctor internal medicine group 38 miles away in Tustin, California. Both primarily see older patients with multiple chronic conditions. Both transitioned to concierge medicine -- LaGrelius in 2006, Ficarola in 2008 -- to be able to give these patients the time they need and were not getting elsewhere.

Many concierge physicians have cash-only practices, so it's commonly assumed that shunning commercial insurance or Medicare is the rule. Not so. Many concierge physicians take both. Ficarola is one of them. LaGrelius takes Medicare but is not on any commercial insurer panel. However, he does submit claims for patients as an out-of-network provider.

The doctors differ in one key respect. LaGrelius transitioned to a full concierge practice, in which all (in his case, most) patients pay an annual fee to be in the practice, and the overall number of patients is reduced so that the doctor has ample time to see those who remain. Ficarola transitioned to a mixed, or hybrid, concierge model, in which the panel remains the same, most patients are seen as they were before, and a smaller group are fee-paying concierge patients.

If you're considering a move to concierge medicine, how these doctors thought through their decisions -- from which practice model to choose to whether to hire marketing help -- can help to clarify your own thoughts on what's right for you.

The Making of a Concierge Doctor

Tom LaGrelius, 70, was a member of a multispecialty group of about 30 doctors in Redondo Beach, California, 21 miles southwest of Los Angeles, from 1974 to 1983. After completing his internship and residency at the University of Southern California Medical Center in Los Angeles, he joined the group, eventually rising to chairman of the board.

In the early 1980s, the group signed some HMO contracts. HMOs are often thought to have emerged in the 1990s, but in the early 1970s, almost 4 million Americans were enrolled in nearly 40 prepaid health plans, most of which were operating in California. [1] By 1980, about 8 million Americans were in HMOs. [1]

As chairman of the group, LaGrelius was given a seat on an HMO board, which he held for a few months. "I watched what they were doing," he says, "and it seemed to me something that I didn't want to do. They were in the business of denying care."

His gave his own board an ultimatum. "We joined an organization that I personally don't want to be associated with, and I want my name off the contract," he announced. His request was granted. "But when the group finally decided that everyone had to participate in the HMO, I resigned and opened a solo practice."

About half his patients followed him to the new practice: Skypark Family Medicine Group in nearby Torrance. LaGrelius has never joined an HMO and had resigned his last PPO contract decades before. Although he takes Medicare, "I am always considering opting out," he says. While the rest of his practice is cash-only, he submits claims for patients as an out-of-network provider.

"The practice was not initially terribly busy," LaGrelius admits. However, he had an established reputation in the community. He had privileges at local hospitals. And he did some marketing.

"I joined the hospital's public education forum and gave educational talks to the community," he says. "I passed out brochures to commercial businesses in the area. But by and large, it was mostly word of mouth from other patients in the practice that made it grow."

In 2005, when he decided to transition to a concierge practice, "I saw 1500 different individuals," LaGrelius says, "2400 individuals in the 2 years before. Most of those patients just came to me when they were sick."

Some of these patients had 20-30 medical problems. He was seeing 25 patients a day at his peak. He couldn't offer them the proper care in 15-minute visits.

Can Any Practice Become a Concierge Practice?

"I had gotten acquainted with Garrison Bliss in Seattle, who was one of the first concierge doctors in the country, running Seattle Medical Associates [now Qliance], because my father needed care," LaGrelius says.

"My father lived in Seattle and wasn't getting optimum care. As things deteriorated, as the HMOs got going and doctors got busier, there just wasn't enough time. He had trouble getting ahold of his doctor. He had trouble having adequate time with him. I asked Garrison if he would take on my father. He did, and the care was incredible. He convinced me that a limited-panel practice was the optimal way to go."

LaGrelius had conferred with other thought leaders in the concierge movement as well, among them Edward Goldman, MD, Founder and now Chairman of MDVIP, a nationwide franchise of doctors in full concierge practices, and John Blanchard, MD, Founder of the American Society of Concierge Physicians (now the American Academy of Private Physicians), a trade group. When he was ready to make the move, he sought professional help.

"I realize that the vast majority of doctors have pretty much done it on their own or just ask their local attorney for advice with legal issues," he concedes. "But a lot of them have failed. And a lot of them have struggled, even the ones who have ultimately succeeded."

The Transition Process

Not every conventional practice is a candidate for a concierge conversion. Concierge medicine is an option for conventional practices that are already successful, not a lifeline for traditional practices that are underperforming, employed doctors who are striking out on their own without a substantial number of committed patients, or hospital-based physicians hoping to build a concierge practice from scratch with no established patient base from which to recruit.

"We probably turn away 60%-70% of the doctors who approach us," says Roberta Greenspan, Founder of Specialdocs Consultants, based in Chicago, the concierge marketing firm that LaGrelius hired to help him make the switch.

Specialdocs has transitioned over 100 conventional practices into full concierge practices in 28 states. Most take Medicare and commercial insurance.

The firm has 2 key questions for prospective clients: "How long have you been in the community where you are currently practicing, and how many patients have you seen in the past 2 years?" Greenspan says. "These are so important because the loyalty factor trumps everything."

"It's not how much money the patient has in their bank account; it's how loyal they are, how strong their feelings are for the physician," she explains. "Patients will say, 'I didn't really want to pay $1800 a year for a membership fee. That's a lot of extra money when I'm already paying so much for health insurance. But I'll do it because I don't want to leave Dr. Smith. He means the world to me.'"

As an indicator of patient loyalty, Specialdocs considers whether prospective clients have been in practice in the same community for a minimum of 8 years, but preferably 10 years or longer. If the doctor is a primary care physician, a panel of about 1600 patients over a 2-year period is also desirable.

That's because, even with long-time patients, only a fraction will opt to pay an annual fee -- which, among Specialdocs clients, averages about $1800 per year.

Standard offerings in concierge practices include same- or next-day appointments; visits with the doctor that last 30 minutes to an hour or longer, depending on a patient's needs; and the doctor's cell phone number for direct access 24/7.

"The only time my patients can't reach me is when I'm under general anesthesia," LaGrelius likes to joke.

In addition, concierge practices commonly offer lectures, workshops, and clinics as part of the annual fee. Depending on doctor and patient interests, these may include diet, nutrition, yoga, and cosmetics classes; acupuncture; ultrasonography; physical therapy; sports medicine testing; group counseling for patients with chronic diseases; and wellness seminars.

The amount of time the doctor plans to spend with patients and the extensiveness of other offerings must be weighed against a doctor's ability to deliver a concierge level of service without burning out. For LaGrelius (and many other concierge doctors), this meant capping his new practice at 600 patients; in the previous year in his conventional practice, he saw 1500 patients.

"If you're going to do a comprehensive wellness exam on everyone once a year, it takes an hour or two," LaGrelius says. "You can only do about 3 a day and take care of everyone else's medical problems. That limits you to a membership base of about 600 patients -- maybe 800 if they're younger, healthier people."

A consultant establishes the legal basis for offering noncovered services by a concierge practice, recruits patients, trains doctor and staff in how to deliver patient-friendly service, if necessary, and handles billing and collections for the annual membership fees that patients pay to belong. Concierge consultants do not generally get involved in the clinical side of a client practice.

Before deciding to transition, LaGrelius had his expert perform a demographic analysis of his conventional panel to see whether there was likely to be enough patients to support a full concierge practice. Surveys were conducted to gauge the level of patient interest. Patients received announcement letters, brochures, and other promotional materials created by the marketing firm.

The firm also trained LaGrelius and his staff in the niceties of concierge service, stationed a representative in the old practice to explain the benefits of the new practice to patients after their visits with the doctor, and installed a direct phone line to the firm's headquarters in Chicago, enabling patients to call Specialdocs for answers to their questions while they were still in the office.

"Every patient whom I talked to, I would get on the phone or refer them to that line and the consultant would describe to them what the practice was going to be like and sell it to them," LaGrelius says. "She actually explained it and sold it and was incredibly effective at that. It was very labor-intensive."

A transition lasts about 6 months. Then the new concierge practice "goes live."

Is It Ethical to Let Patients Go?

For many doctors, a full concierge practice presents a moral dilemma. First you create a special class of patients who receive better treatment than everyone else because they can afford to pay for it. Then those who can't afford or don't want to pay the annual fee must leave the practice at a time when primary care doctors are in short supply and the healthcare marketplace is about to be flooded with newly insured entrants courtesy of the Affordable Care Act.

LaGrelius, who reduced his panel by well over 50%, doesn't see it that way.

"I take care of a lot of very complicated patients," he says. "The interesting thing about those who joined my concierge practice is that they were the most complex patients in my conventional practice -- the ones who had the most need of care. And the new patients who joined my practice are incredibly complex."

"Being the only boarded geriatrics specialist in the community who is in private practice, I got a lot of very complicated seniors with 25-30 medical problems and who are on a lot of medications. We keep them out of the hospital and we keep them well. I don't think that would happen in any other setting. We're making a huge difference in these people's lives and saving a ton of money."

Some of his traditional patients chose not to join the new practice because they felt they didn't need more care. Others needed it but didn't want it.

"I remember one patient," LaGrelius recalls. "He called me up and said, 'I don't want you to do this, because I just want to come in and see you when I'm sick.' I said, 'George, the last time I saw you was 5 years ago, and I put you in the hospital when you had lobar pneumonia that nearly killed you. You didn't come back for follow-up or get your pneumonia vaccine. I don't do that anymore. I want to take care of people who want optimal care and whose care is optimized. I can only do that with a few hundred patients if I'm going to take care of patients who are complex and difficult, which is what I like to do.'"

George didn't join the new practice.

However, those who opted not to join were not "kicked out," as is often charged by critics of the concierge movement.

"Every one of my patients who left the practice was connected with another primary care doctor if they wanted help connecting," LaGrelius says. "No one who failed to make a decision on whether to join the practice was ever turned away. If they got sick, I took care of them until they were over that illness, and then transitioned them into membership in the practice or to some other physician. That's the obligation of any doctor: to make sure their patients are cared for."

Moreover, patients who wanted to join the new practice but couldn't afford the annual fee received "scholarships" in which the fee was waived.

"A lot of patients are scholarship patients," LaGrelius says. "I made it clear to my patients when I transitioned that if they truly couldn't afford the practice, all they had to do is explain that to me and they would be admitted free. I still take scholarship patients who are referred to me by other people in the practice."

In fact, scholarships and discounts for patients who can't afford the fee are commonly built into the practice models of marketers of concierge services.

"We insist that our doctors reserve about 10% of their membership for scholarship patients, plus another percentage of patients whom we encourage them to discount -- usually by 50%," Roberta Greenspan says. "Additionally, we set up a fee structure for our clients that always includes an 'adult couple' discount and frequently includes a lower annual fee for younger patients -- usually under age 40 or 45, depending on the makeup of the practice."

A More Comfortable and Relaxed Lifestyle

In his new practice, renamed Skypark Preferred Family Care, instead of seeing 25 patients a day, LaGrelius now sees an average of 15 patients.

"I do 2-4 comprehensive wellness exams a day," he says. "They take at least an hour. Some patients are there for a couple of hours. Then each of them gets a follow-up visit a couple of weeks later when we go over a care plan, and that takes a half-hour. Office visits are a half-hour long. That's pretty much minimum."

"Office visits are comfortable and relaxed," LaGrelius says. "I've got 4 people here passing out coffee and fresh-baked cookies and waffles and warm blankets, and smiling and being helpful to everyone."

In the office, in the few moments that patients wait for LaGrelius to appear, they sit in what he calls a "non-waiting room" -- decorated to look like a cozy living room in a private home. He doesn't offer special weight-loss clinics, nutrition seminars, or group sessions for patients with chronic conditions; such information is part of the preventive education given one-on-one to each patient, he says.

His patients are like family, LaGrelius says. Most have been with him for years. An avid pilot who owns 2 small planes, he occasionally flies patients to picturesque Catalina Island, a 10-minute flight away, as his guests for lunch and a couple of hours of sightseeing on Wednesday afternoons -- his half-day off. He has taken as many as 3 patients at a time -- the youngest 10, the oldest 98.

"We talk about whatever they want to talk about," he says. "These days, it's hard to avoid talking about the Affordable Care Act. That's what everyone wants to know about."

If patients are up for it, he wows them with some aerial maneuvers before heading home. These jaunts are extremely popular, he says, and are booked months in advance.

But what patients are paying for is less about fresh-baked cookies and sightseeing trips and more about enough time with the doctor. "It's leisurely," LaGrelius says of patient visits. "The last thing I say when I walk out of a patient's room is, 'Are you sure there isn't anything else you want to talk about?' It's never one problem at a time and I have to go like most practices are running these days. I'm virtually never behind now. Even with an occasional emergency, the practice runs very smoothly."

His biggest complaint: Despite having both his cell phone and home phone numbers and carte blanche to use them, his patients don't call him enough.

"Probably 90% of the time, after 10 PM my phone never rings," LaGrelius says. "They're incredibly respectful of my time."

He wishes they would be a tad less respectful. "'Why are you reluctant to call me when something goes wrong?'" he asks patients in frustration. "'Why do I see you 2 days later and you've taken care of that cut badly? I want you to call me when something happens.'"

"People pour peroxide in their wounds without calling me!" he exclaims in exasperation. "Not smart. I'd rather have them call me when the problem occurs -- immediately, whatever time of day or night it is -- so I can deal with it and not have to deal with the complications of how they managed it wrong."

Practice Fees and Revenues

To be a member of Skypark Preferred Family Care, patients 18-45 years old pay $1050 a year, those 46 and over pay $2100, adult couples pay $3000, single parents pay $2300, and families pay $4200.

With a panel of 600 patients, some of whom are nonpaying members, "I'm probably earning 50% more than I was in the previous practice," LaGrelius says.

"I'm working just as hard," he adds, "but I'm working differently. Back in the old days, there was a line in my waiting room. Now my waiting room is empty."

He estimates that 80% of his revenue now comes from annual fees.

This is as it should be for a full concierge model to succeed financially, says Roberta Greenspan of Specialdocs. Nevertheless, some clients are disconcerted to discover that only a relatively small portion of the revenue in a full concierge practice, even one that takes commercial insurance and Medicare, is derived from copays and reimbursements, as it was in a conventional practice.

"Physicians need to switch mental gears from depending on office visit fee collections as the majority of their revenue stream to recognizing that in a transitioned practice, the majority of their revenue stream is derived from annual fees," Greenspan says. "Generally, 80%-85% of all revenues in a well-transitioned practice should be derived from annual fees."

But it isn't just fees that can boost revenues. In a full concierge practice, a patient panel may be reduced by 75% or more. Thus, fewer staffers and less office space are often needed. Downsizing both can significantly reduce practice overhead.

"If a physician's revenues in a traditional solo practice are about $600,000 with an overhead factor of 65%, this results in a practice net of $210,000," Greenspan says, laying out the math. "By transitioning to a personalized care/concierge model, even if revenues remain the same but the overhead factor is reduced to, say, 55%, this will result in a practice net of $270,000, a significant increase."

Well and good, but concierge physicians tend to have an independent streak, even when they hire experts to advise them. LaGrelius is one of them. His staff all spent many years with the practice; he had no intention of letting any of them go, even though it might have improved his profit picture. He had 4 staffers when he saw a panel of 1500 patients. He still has 4 staffers.

"I promised my staff that they would have better lives, better working conditions, they would all get raises, and none of them would be let go," he says.

With 900 fewer patients, they still have enough to do?

"Oh, they're busy," LaGrelius says, "but in a very happy, cheerful, relaxed way. They're not running around like chickens with their heads cut off. They are busy but never rushed."

How Much Does a Consultant Cost?

The fees charged by consultants vary widely and depend on how extensive the concierge services are, as well as a consultant's reputation, longevity, and clients. However, taking a percentage of the annual fees that patients pay is standard. This is why consultants are selective in the practices they take on as clients. If membership targets aren't reached, both practice and consultant lose money.

Specialdocs clients, for example, sign a 3-year contract and pay a one-time retainer fee of $17,000. A transition usually takes about 6 months, during which patient recruitment and physician and staff training occur.

After the transition is complete, a fee structure kicks in. The fee for the first year (which is actually a year and a half into the contract) is19% of all collections (for the concierge part of the practice only), and thereafter the fees work on a sliding scale: 15% of all concierge fee collections for the second year, and then 12% of all fee collections for the remaining 7 months of the contract.

After this, clients have the option to renew on an annual basis. There's no retainer fee involved with renewal; the fee is 10.5% of all collections. For this, Specialdocs handles fee collections from patients and provides consulting support services, including marketing initiatives, physician branding, and legal services. It does not get involved in managing the clinical side of the practice.

Must All Your Patients "Go Concierge"?

Internist Mario Ficarola was facing the same dilemma as Tom LaGrelius when he decided to switch to a concierge practice in 2008. He already had a busy practice, which is a must to realistically consider a transition to concierge medicine, but was dissatisfied with how he was forced to practice due to a heavy patient load.

"I had way too many patients with complex medical problems, mostly geriatric patients, and not enough time," he recalls. "I didn't feel that I could do an adequate job in 15-minute appointments. I needed a concierge practice to free up time to be able to spend more time with patients, be more thorough, and get

back to the focus on prevention and patient education. That was not tenable when having to see 20 patients or more a day."

But Ficarola, who had a panel of about 2000 patients before he transitioned, did not even consider switching to a full concierge practice with its reduced panel size. That would have meant letting many patients go. Most of his patients had been with him for decades. His goal was simply to free up enough time each day to adequately treat a core group of his sickest patients -- and still see all the others, who didn't require as much time -- without burning out.

This is the model for a mixed, or hybrid, practice: Most patients continue seeing the doctor for 15-minute visits and paying copays -- Ficarola takes both commercial insurance and Medicare; he never considered a cash-only practice -- while a relatively small number of patients pay an annual fee to receive greater access and visits that last however long is necessary.

Ficarola's patient panel is now approximately 1800 patients; only about 90 patients are members of the concierge part of the practice, for which they pay an annual fee of $1600. If a husband and wife are concierge members, their dependent children, if they have them, receive free memberships.

Time slots from 8 -9:30 AM and 1:30-2:30 PM are reserved for concierge patients, who may require a half-hour to an hour or more of the doctor's time because of multiple comorbidities and complex regimens. Sometimes the 4:30 PM time slot is available too. If all of the slots aren't needed on a given day, conventional patients are scheduled in. Otherwise they are seen at other times for the usual visits.

"I used to see 20-22 patients a day," Ficarola says. "Now I see about 14 a day. I still spend the same amount of hours in the office. But the work is less compressed and more enjoyable."

How a Hybrid Model Works

Ficarola didn't switch to concierge medicine for the money. He figures that his revenues before and after are about the same. It was his working conditions that he sought to improve.

"That's what I'm getting from this hybrid practice," he reflects. "I feel much less stressed. I enjoy my encounters with patients because of that extra time. We can get involved more in personal things. They feel free to talk about other family members, which I don't mind them doing because it affects them emotionally. I'm able to educate them better, discuss side effects of medication that they didn't even know they were having because they never told me, and they reveal things that a lot of patients don't want to waste the doctor's time on because they see we're pressured. When they don't see the pressure, they reveal more, and then they learn more too."

Like Tom LaGrelius, Ficarola sought professional help to make the transition: Concierge Choice Physicians (CCP), a concierge marketing firm in Rockville Centre, New York. It specializes in establishing hybrid practices. CCP has transitioned 250 doctors in 23 states to concierge practices. Ninety percent are hybrid practices and 10% are full concierge practices. Most take commercial insurance and Medicare.

"For a startup, you can estimate what your patient demographics are, but someone actually needs to analyze your practice and do a risk assessment to see whether you'll lose patients by making a change," Ficarola observes. "All of that is very labor-intensive. I'm not a do-it-yourselfer, so I Ieft the marketing and demographic studies to professionals. Plus I'm not very good at billing, collecting, marketing, and a lot of the business aspects of things."

A hybrid model offers 2 benefits over transitioning to a full concierge practice, according to Wayne Lipton, CCP's Managing Partner: You don't need a minimum number of concierge patients -- who can be challenging to recruit, particularly in a slow-growing economy -- for the model to produce significant revenue gains, and your other patients aren't priced out of the practice.

"The hybrid model is a reaction to the fact that not every doctor can get 600 patients who are willing to pay for a concierge program," Lipton says. In addition, "it's terrible -- it's literally heartbreaking -- to have to say to a group of people, 'You have to pay or else you have to leave the practice.'"

"The hybrid approach affords many doctors an opportunity to enhance their revenue, still participate in insurance plans, not disenfranchise people, and create greater satisfaction for themselves and their patients," says Lipton.

If a doctor in a hybrid practice is seeing the same number of patients as before, but now some patients are seen for at least twice as long per visit, won't the doctor be bucking for burnout, rather than working at a more relaxed pace?

Not necessarily, Lipton maintains. "The solution that has worked time and again is to limit the number of new patients allowed into the practice for a short period of time," he says. "There is natural attrition in every practice -- about 5% a year -- so by not adding in new patients, who take up a large amount of time for some time, it equalizes out nicely."

Why Buy the Cow When the Milk Is Free?

Why pay an annual fee -- which can range from $1500 to $5000, depending on the doctor's specialty and the services offered, but which averages about $1800 among his clients, Lipton says -- when patients can see the same doctor for the cost of an insurance copay?

A hybrid model may not be for you if maximizing revenue is the primary goal, Lipton admits. A mixed practice is mainly for physicians who want to maintain a relationship with all their current patients, get relief from heavy workloads and stress from struggling to meet overhead costs, and seek security and stability amid marketplace uncertainty -- without drastically changing the practice.

"By now, most of my patients know I have this option," Ficarola says. "If patients are new, I tell them about it. They can elect to join the concierge part of the practice or stay traditional. Many times a patient will say, 'I'm really satisfied with your traditional practice.' I've even had people use the old analogy 'Why buy the cow when the milk is free?' They feel they're getting what a concierge patient would receive. They're so satisfied that they don't think they need to upgrade to a concierge membership."

Ficarola is fine with this. Most patients don't need more time with him. The sicker ones who do -- including those with diabetes, heart failure, emphysema, and dementia -- know who they are, or their families and caretakers do.

"The demographics of my practice are elderly, very conservative patients who are not necessarily interested in bells or whistles or workshops and seminars and clinics," he says. "They'd rather be one-on-one with me than in group therapy, so to speak. They were willing to pay extra for more of me."

"These are patients whom I've had for many years -- decades," he adds. "We've grown fond of each other. They realize that the insurance companies cannot pay me enough for that extra time that we feel they need."

His practice, Tustin Irvine Internal Medicine, is not luxuriously appointed. There's no coffee or tea, no snacks, no upgraded waiting room, no weight loss or nutrition seminars. "That's not what we have here," Ficarola says. "If my office were in a more upscale town, that would be the expectation. But my patients would look at it as frivolous, unnecessary."

CCP helps client practices market such concierge services as wellness seminars and weight loss clinics, which are one justification for the fees that patients pay. But Ficarola's patients aren't interested in these noncovered services, he says.

CCP also trains doctors and staff to deliver the level of service that concierge patients expect. But Ficarola didn't feel the need for that either.

"They offered it," he says. "But to be honest, my staff actually is quite good. They treat our traditional patients the same way they would our concierge patients. There wasn't much tweaking needed inside the office."

"However, the firm helped me locate all my patients," Ficarola says. "That was a very big deal. They sent announcement letters, spoke to patients, had someone in the office who was making follow-up calls, and recruited my first 80 concierge patients. And they handle all billing and collecting, which is huge."

Revenues and Fees in a Hybrid Practice

Ficarola earns the same in a hybrid concierge practice as he did in a conventional practice. "If I were age 32 and not 62, my focus might be more on building the practice or increasing revenue," he says. "I was more than content with maintaining revenues and doing a better job in a more relaxed environment."

"This is not the model to choose if you want to get rich," concedes CCP's Wayne Lipton. A full concierge practice has more revenue potential -- although it also incurs more risk. Hybrid programs can increase practice revenue from 5% to 50%, he says, "although most practices will see an increase of 15% to 25%."

"The nice part about it is that it doesn't add any expenses," he says. "So there's an opportunity for a doctor to make $50,000, $75,000, even $100,000 or more a year, over and above revenues earned from the clinical side of the practice. In some instances, it will be less," he adds. "They could make $25,000 or $30,000 more."

"In a hybrid model, you can only win," Lipton insists. "If you get 1 member, you're ahead of the game. If you get 10 members, you're 10 times more ahead of the game. There's no downside. There's only an upside."

CCP, which transitions conventional practices to both full and hybrid concierge models, charges no retainer fee. New clients sign a 5-year contract "with discounts along the way based on the number of patients who start in a program," Lipton says. A transition takes about 6 months. Clients then pay a flat fee of $500 per patient per year, minus discounts for meeting enrollment targets. After 5 years, clients have the option to renew. Most do, Lipton says.

The Future of Medicine?

Are doctors like Tom LaGrelius and Mario Ficarola -- and their practice models -- the future of medicine? Many observers think so. LaGrelius, who chairs the steering committee of a new concierge organization, the American College of Private Physicians, which launches in January, gives talks at medical schools in his area. To students who initially are turned off by a career in primary care, his recounting of what's possible in a concierge practice is a revelation.

"My gosh, you can do this?" they respond incredulously when he tells them about his practice and lifestyle: the visits ample enough to treat complex patients, the relaxed pace, the civilized ambience, the time for jaunts to Catalina. "They become enthusiastic about primary care again," he says.

LaGrelius disagrees that concierge medicine poses a threat to the supply of primary doctors nationwide. Its impact will be just the opposite, he contends. "If anything, concierge medicine is going to grow the number of primary care doctors," he believes.

"We're going to eventually develop a cadre of young doctors who want to go back to primary care because they can do what my doctor did when I was a kid: have a great practice, really take care of sick people, and not just turn a crank on CPT codes," he asserts.

The ability to start a concierge practice will also lure many specialists back to primary care, he's convinced.

"I have a good friend, a cardiologist, who's about to convert to concierge medicine," LaGrelius offers by way of example. "He currently does about 10 echocardiograms a day in his office. He's in the cath lab all day long, and he's burning out. He says, 'Why don't I just convert to concierge medicine, take 600 of my sickest cardiology patients, and care for all their problems?'"

CCP's client roster includes a growing number of cardiologists, gynecologists, gastroenterologists, and rheumatologists, who typically serve as primary doctors for patients with certain chronic conditions, in addition to the majority of doctors who practice concierge medicine: internists and family physicians.

"A lot of subspecialty internists are getting ready to say, 'I'm going back to my first love -- primary care -- and care for the sickest diabetes or cardiology or rheumatology patients, do fabulous work with them, keep them out of the hospital 60%-70% of the time, and do wonderful preventive care,'" LaGrelius predicts.

"This," he concludes, "is what the whole country needs to move to."

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